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Not Trying: Reconceiving the Motherhood Mandate

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NOT TRYING: RECONCEIVING THE MOTHERHOOD MANDATE

by

KRISTIN J. WILSON

Under the Direction of Wendy Simonds

ABSTRACT

Infertile and childless women think about, live with, and defend their status as mothers and as nonmothers, arguably more so than other women for whom motherhood comes about accidentally or relatively easily in accordance with a plan. Within this group of infertile and childless women are those who are otherwise socially marginalized by factors like class, race, age, marital status, and sexual identity. This dissertation asks about the ways in which marginalized infertile and childless women in America make sense of their situations given the climate of "stratified reproduction" in which the motherhood mandate excludes them or applies to them only obliquely. While other researchers focus on inequalities in access to treatment to explain why many marginalized women eschew medically assisted reproduction and adoption, I emphasize women's resistance to these attempts at normalization. I take a critical, poststructural,

feminist stance within a constructivist analytical framework to suggest that the medicalization, commodification, and bureaucratization of the most available alternative paths to motherhood create the role of the “infertile woman”—i.e., the white, middle class, heternormative, married, “desperate and damaged” cum savvy consumer. By contrast, the women who participated in this study are better described as the “ambivalent childless” (i.e., neither voluntary nor involuntary) and the “pragmatic infertile.” These women experience infertility and childlessness—two interrelated, potentially stigmatizing “roles”—in ways that belie this stereotype, reject the associated stigma in favor of an abiding, dynamic ambivalence, and re-assert themselves as fulfilled women in spite of their presumed deviance.

INDEX WORDS: Infertility, Childlessness, Intersectionality, Marginalization, Medicalization, Adoption, Procreative politics, Reproduction

NOT TRYING: RECONCEIVING THE MOTHERHOOD MANDATE

by

KRISTIN J. WILSON

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

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NOT TRYING: RECONCEIVING THE MOTHERHOOD MANDATE

by

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December 2009

DEDICATION

For Evan and Leo

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This work bears my name but I did not do it all by myself. Far from it. Dan Kercher took the second shift for too many months to count, caring for our household and our children all while working full-time. Besides that vital labor, he sweetly provided loads of encouragement and insight all along the way. He also graciously let me write about him as I wrote about our shared experience with infertility.

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CHAPTER 1: ENTERING "OTHERHOOD"

Regardless of the cause, however, and regardless of age, infertility wreaks inestimable havoc on those who suffer from it—from *The Baby Business* (Spar 2006:16)

"How're you doing with your plight?" asked my new fertility doctor upon entering the exam room. While sitting fully-clothed awaiting this initial consultation, I looked over the thick files that comprised my fertility history up until that point (it would get much thicker in the coming years). There was much more to the experience than these papers indicated. The files included the results of the examination by an OB/GYN who palpated my reproductive organs and performed tests for HIV, gonorrhea, and chlamydia, all state of Georgia requirements to receive intrauterine insemination (IUI)—tests not required, of course, for conventional attempts at pregnancy.

There were files from the dozen or so IUIs I underwent at a for-profit clinic (which changed hands during my tenure as a patient), a place I eventually left as it became clear that the timing of my cycles invariably failed to match the schedule of the moonlighting doctor. (The procedure is quick and simple: insert semen-filled syringe into the cervical os and push the plunger. Yet it is a felony to perform it oneself—or for a friend or partner—in Georgia.)

Several pages documented the extensive blood work and medication regimen accompanying the next three cycles that took place at a non-profit, women-centered, more technologically-outfitted clinic. Ultrasound printouts of multiple, robust, fertility-drug enhanced egg follicles—one time nine primed eggs were released—and records describing the "healthy," motile, "normal" donor sperm were attached to brief, scrawled notations attesting to the negative

results. The medical staff omitted any mention of the 105˚ fever that spiked half an hour after the last insemination, nor did they record the prescription for emergency high-dosage antibiotics used to kill the apparent infection. I would have to relay this dramatic incident to the new doctor myself.

My records did not include the semen tests, blood work, and surgical procedures that my partner went through. His diagnosis of irreversible sterility—mentioned on all of my medical forms—was upsetting enough, but the subsequent discovery that we could no longer purchase private health insurance for him as a result was both appalling and absurd. Nowhere among the medical memos could one find any data about my or my partner's feelings of inadequacy, the disruption of our expected life plan and the destabilization of our gendered expectations of biological and genetic motherhood and fatherhood. Also missing from the files was my frustration at the paradoxical loss of control over my body at the same time obedient hyper-control was prescribed. To wit, the daily pattern involved taking my basal body temperature, noting every abdominal twinge, ingesting chaste tree oil, dandelion tinctures, milk thistle caplets, Clomid tablets, and inserting progesterone suppositories, suffering concomitant hot flashes, night sweats, irritability, and—worst of all—dry mouth. On a monthly basis, we dropped everything to race to the clinic when the urine dipstick yielded a "high fertility" readout on my Clearblue-brand ovulation computer. The clinics listed only the dosages for Clomid and progesterone. One could not discern from these documents the cyclical build up of hope, followed by tearful disappointment, and then hope built anew.

Despite all of the emotional, financial, and medical trials experienced over the previous several years of infertility, the doctor's question bothered me. His choice of the word plight implied victimhood, a label I rejected. Still, his inquiry suggested that he empathized with me,

that he was not going to dismiss the psycho-emotional and social impact of infertility. His purpose in asking the question may have been to assess my emotional stability or to solicit a summary of the relevant tests, treatments, and procedures that I already had completed or tried. I responded, “I don’t really think of it as a plight.”

“Well, journey, then,” he replied sarcastically as he barely suppressed an eye-roll and exhaled with exaggerated patience. Although the advice literature suggests to infertile women that they approach treatment as a journey to self-discovery and to well-earned, meant-to-be motherhood, this concept also failed to capture my experience. The daily hassles and discomforts, the monthly highs and lows, the frustrating, painful, time-consuming encounters with harried doctors, bored clinicians, and intrusive medical protocols felt less like a journey and more like a slog, or perhaps most like walking in circles.

The opposing concepts of plight and journey evoke respective images of an unwitting victim who lacks agency and an adventuresome, savvy traveler uninhibited by institutions and social structures. I knew from personal experience informed by a feminist sensibility that infertility could not produce universally downtrodden women nor could medicalization—with its pathologizing of both women’s bodies and women’s abilities to exert control over their own bodies—permit an unfettered, affirming path to motherhood. In this dissertation project, I set out to explore the interstices and limits of these competing narratives.

I wondered about the majority of “infertile” women who did not seek treatment; only about 36 percent of those diagnosed with “infertility” do so (CDC 2004). I knew that my social status as a white, middle-class, well-educated, married woman placed me squarely within the hegemonic constructions of the “Infertile Woman,” a career-oriented woman who delayed childbearing and, now desperate for motherhood, is able to tap into the social, cultural, and

financial capital needed to make use of medically assisted "conception." As a sociologist, it was readily apparent to me throughout my plight/journey that—in the context of fertility treatment—class, race, age, sexual identity, and marital status mattered to the medical world, to friends, family, co-workers, and acquaintances, and to wider society. These social markers carried a definite moral subtext.

How then, I wondered, do more marginalized women make sense of infertility and childlessness, decide whether or not to pursue treatment, and navigate the gatekeeping institutions that supervise alternative paths to motherhood? This largely unexplored realm of the infertility/fertility divide frames this dissertation project.

Many medical professionals, psychologists, and sociologists characterize infertility as a life crisis that negatively affects marriages, job performance, social relationships and general psychological and physical health (e.g., Abbey, Andrews, and Halman 1992, Greil 1991, 2009, Inhorn et al. 2009 [2007], Monga 2004, Van Balen 2002) that the majority of women who receive a medical diagnosis of infertility do not seek treatment or attempt adoption begs the question: why not? My research suggests that the usual reasons given—cost, lack of insurance coverage, and moral objections—do not fully explain this phenomenon.

My work represents a departure from existing research in that most infertility researchers concern themselves primarily with the disruption caused by infertility (Becker 2000, Greil 1991, Inhorn and Van Balen, eds. 2002, Inhorn, ed. 2009, Matthews and Matthews 1986), though several now focus also on inequalities in *access* to treatment to explain why few marginalized women participate in medically assisted reproduction and adoption (Culley, ed. 2009, Greil 2009, Inhorn et al. 2009, Johnson 2009). Instead of beginning with the assumption that infertility and childlessness are disruptive and highlighting the institutional barriers to the available cures

and marginalized women's shortage of "cultural health capital" (Mamo 2007), I show instead the processes by which women *resist* such attempts at normalization. In particular, I look at the experiences of several socially marginalized women who do not actively seek help for their childlessness. This strategy differs markedly from virtually all other infertility studies, which recruit almost exclusively from treatment contexts. The women I interviewed do not even identify readily as "infertile" (even despite medical diagnoses as such), nor can they accurately be called "involuntarily childless" or "voluntarily childless." Instead, they epitomize significant new categories of "ambivalent childless" and the "pragmatic infertile." I investigate the ways in which these women challenge the current descriptive binary, as they negotiate and reconceive the motherhood mandate given the American system of "stratified reproduction" (Ginsburg and Rapp 1995) in which society values certain women (i.e., white, middle class, educated, married) as mothers while disparaging all others.

Infertility and involuntary childlessness are fairly meaningless concepts for the study participants. These women claim that they will pursue motherhood when and if they can perform the role perfectly, according to their varied constructions of ideal motherhood, but only if fate and circumstances allow it. Many of them, though not all, indicate that they can find fulfillment—and maintain their identities as women—without becoming mothers, by entering "otherhood." Cultural proscriptions and financial insolvency do not account for their avoidance of the new reproductive technologies and adoption; they resist these normalizing institutions because they are ambivalent about motherhood and pragmatic about their status as infertile and/or childless. In a nutshell, my theory is that women pursue infertility treatment or adoption depending on degrees of ambivalence and pragmatism about motherhood and childlessness. The character of their "otherhood" constructs and their relative satisfaction within that structure (their

identity sufficiency), their decision-making and beliefs about motherhood achievement versus ascription (*decisive efficacy*), and their degree of investment in the motherhood mandate (subjective *role applicability*) all interact with their disposition toward treatment (their *normalizability*). They resist procreative technologies and adoption because they are ambivalent about childlessness and pragmatic—not desperate—about their infertility.

Word Binds, Coercive Metaphors, and the "Fertility World"

"Infertility" and "childlessness" are loaded terms that connote an array of social meanings particularly about motherhood and women's roles that often conflate gender, sexuality, and biological sex. To start with, the standard medical definition of *infertility* is hardly an objective, scientific one; it is through-and-through a social and cultural construction. In medical usage, it means that a woman has not gotten pregnant after six months of "unprotected" and "regular" heterosexual sex if she is under 35 years of age, or after 12 months if 35 or older. This inexact rule-of-thumb assumes failure to "conceive" to be the result of mechanical, hormonal, or other physiological problems and does not always account for frequency of sex, timing, time elapsed since taking oral or injectible contraceptives, multiple partners and their fertility, nor sexual behavior patterns like position, withdrawal, and washing. In addition, a quick scan of cross-cultural experiences with infertility indicates that, in some societies, a woman may experience "infertility" if she does not give birth to a son, if she does not bear a child free from perceived defects, or if she does not "conceive" in a matter of months following marriage (Greil 1991, van Balen and Inhorn 2002).

Disease—or, perhaps more appropriately, dis-ease—etiology in infertility is notoriously difficult to identify, with a large percentage (usually reported as 20 percent of cases) of causes designated as "unexplained." Moreover, the accepted delineation of infertility does not distinguish between those who wish to get pregnant and those who do not. In actuality, one woman's "infertility" may be another's good fortune. Not all who seek medically assisted conception (either low-tech procedures and drugs or the new reproductive technologies) are technically "infertile." They may simply lack a fertile male partner (i.e., single women, lesbians, celibates, and the fertile half of a heteronormative couple). The National Survey for Family Growth (NFSG) survey by the Centers for Disease Control (CDC), which lists infertility figures only for married women aged 15-44 years (defined as the "childbearing years"), puts forward the broader notion of "impaired fecundity," a concept that includes married and unmarried women who report problems getting pregnant and problems sustaining pregnancy. According to NSFG (2002) figures, 11.8 percent (7.3 million) of all American women aged 15-44 experienced "impaired fecundity," and 7.4 percent (2.1 million) of *married* American women were diagnosed as "infertile." The "ever-infertile" include about 38 percent of women, who are identified by incidence of infertility advice-seeking, and 15-20 percent is an oft-used—but debated—estimate for current levels of medically-diagnosed infertility (Greil 2009, Guzick and Swan 2006, Stephen and Chandra 2006). A recent international survey estimates that nine percent of individuals worldwide are infertile (Boivin et al. 2007). Despite breathless reports to the contrary (e.g., Gregory 2007, Spar 2006)—there are distinct moralizing and financial interests in exaggerating the problem—the rates of infertility appear to be fairly consistent over time and across societies, although poverty, racism, and uneven access to quality healthcare lead to much higher rates of infertility among marginalized peoples (Inhorn 2007, Nsiah-Jefferson and Hall 1989).

Drawing conclusions from the published numbers is tricky because infertility is itself a slippery concept, a hazy diagnosis. Its operationalization is problematic. There is a world of difference, for instance, between polycystic ovarian syndrome (PCOS) or a malformed uterus due to *in utero* exposure to the drug DES (two well-known reasons for female-factor infertility), and, say, presumed infertility merely resulting from the male partner's sperm-reducing affinity for jockey shorts, laptops, or hot tubs. The latter cause is easily remedied. Whether infertility can be "cured" or not is another fuzzy topic. Hysterosalpingograms (HSGs)—a (painful) process of shooting dye into the fallopian tubes to test their openness—may unblock tubes for some, consequently "restoring" fertility via a happy side-effect of a diagnostic tool. Clomiphene citrate (AKA Clomid) stimulates many a reluctant ovary to produce viable eggs—and occasionally promotes the gross, occasionally lethal over-production of eggs. (Treatments can introduce greater harm than help at times). *In vitro* fertilization bypasses the tubes and requires only a functioning uterus and the proper hormone balance (which can be approximated pharmaceutically, if necessary). All manner of surgeries, procedures, and drugs exist to enhance a woman's chances of becoming pregnant. A woman can be fertile at one age, infertile later on, and then fertile yet again—with medical intervention and sometimes without it—before eventually "aging out" of fertility. Infertility is not concrete, definable, or stable as a medical or analytical category; therefore, it should not be surprising that neither does it confer a static identity. Indeed, my respondents' stories cast doubt on the common and scholarly assumption (and self-fulfilling prophecy) of infertility as a default master status and an inevitably devastating, gender-fraught experience.

Medically assisted "conception" ("fertilization" better describes the biological process; "conception" is metaphysical etymologically) and adoption are two ways for infertile women to

become mothers. These options do not cure; rather, they alleviate the social condition of *involuntary childlessness.* This term is popular with feminist researchers and other social scientists for several reasons: 1) it is a substitute for "infertility," that recognizes the condition as a social one, not intrinsically biological or medical, 2) it includes a wider spectrum of women (i.e., singles and lesbians who do not have procreative sex with biological males), 3) it obscures the "blame" for the condition (its origin as "female-factor" or "male-factor" is less relevant to women's experience of the condition), and 4) it is thought to be less laden with stigma; (many—including authors in the premier medical journal *Fertility and Sterility*—equate "infertile" explicitly and implicitly with the nasty old word "barren"). Women are thought to suffer from involuntary childlessness or else be *voluntarily childless*, but the adjective *"childfree"* describes the latter condition in a more positive, agentic way.

Frank van Balen and Marica Inhorn's (2002) write that, "infertility may be defined as the *process* of not being able to have children, involuntary childlessness may be viewed as the final *state or condition* resulting from infertility" [11, their emphasis]. These authors attempt to re-define the meanings of words that persistently conjure images that fail to match with the experiences of the women and men whom they study. For all of the clinical-sounding vocabulary surrounding the word nowadays, "infertile" is inescapably associated with barrenness, emptiness, unproductiveness, a lack. Its linguistic opposite, "fertile," means bountiful, rich, abundant, lush, prolific, and luxuriant. The former designation can be a powerful stigma, signifying loss and inadequacy, whereas the latter confirms one's rightful place in the generative circle of life: as a mother, a nurturer and giver of life. Similarly, "pregnant" means full. Logically, then, not-pregnant is empty; infertile women are thought to be "unfulfilled." Motherhood, in this discourse, signifies the ultimate in fulfillment. Indeed, the Standard North American Family

(Smith 1993), that most basic family form—as socially constructed, reified, and glorified—consists of a provider-father, a devoted mother, and their offspring. The woman in this family represents the comparative ideal for all other women.

Significantly, involuntary childlessness is not necessarily final, and it does not necessarily result from infertility. It is inappropriate to label celibates, singles, and lesbians as "infertile" when the functioning potential of their reproductive systems is unknown. Extending this logic, male-factor infertility (or a boyfriend's or husband's refusal to have children) does not always doom the woman partner to "courtesy infertility" or involuntary childlessness; she can switch partners, and some women— a couple of my respondents among them—do just that. And, as I imply above, women's fertility status can change unpredictably, without obvious medical reasons.

A major finding of this study is that the poles of voluntary and involuntary childlessness are just as arbitrary as fertile and infertile. "Voluntary" suggests that a woman makes a conscious "choice" to forgo motherhood, to "give up" having children, perhaps, the story goes, in favor of career ambitions or other supposed self-indulgences. Hidden are the myriad and many non-choices that lead to that presumed decision. For example, is childlessness *voluntary* when a woman never finds the right partner, when she dislikes sex but would otherwise like to have children, or when she lacks the financial position or social support to raise children like she thinks one should? Is childlessness still *involuntary* if a woman refuses to use the new reproductive technologies (NRTs) that are available to her or when she changes her mind after having her tubes tied? What of the intent of women who *do* have children? Researchers and the general public rarely consider whether that condition is voluntary or involuntary for the simple fact that we fall into thinking that it is the natural order of things. Childlessness is the deviant

status. At least that is the case for women. In contemporary American society, women are thought to fall into one of three camps: 1) mothers (along a spectrum of bad and good mothers), 2) the desperate and damaged infertile (curable through amazing technological miracles or, less desirably, via heartwarming adoptions), or 3) the militantly childfree (often suspected of careerism and/or lesbianism). The reality, of course, is much more complex.

Whether a woman is called infertile, involuntarily or voluntarily childless, a nonmother, or childfree, the available labels refer to something that is missing. She is *not* fertile and/or *not* the mother of a child. She is less that child or free from children. In either case, her master status is that of a woman who confounds others, who disrupts her prescribed role, who does not fit, who must be repaired, pitied, or, at least, explained.

Alternatives to Infertility and Involuntary Childlessness

There are at least four ways—with plenty of room for variation within each—for women to address infertility and involuntary childlessness. They can pursue medical help; they can attempt to adopt (or become stepmothers); they can declare themselves “childfree” and find life satisfaction in other ways; or they can forever bemoan their childlessness. There are formalized social structures in place that foster these first two possible responses.

Infertility is big business. The industry in the United States generates at least three billion dollars annually (Spar 2006). Market analysts (e.g., buscom.com, medtechinsight.com) in 2000 reported that infertility was a 3.65 billion dollar industry with growth projections between 10-36 percent annually. As of 2006, 483 fertility clinics provided assisted reproductive technology (ART), with IVF topping the list of services. The number of private physicians and small clinics

that provide relatively low-tech treatment, like the IUI procedures I tried, number in the thousands (Spar 2006). The large number of articles published monthly in the American Society of Reproductive Medicine's (ASRM) flagship journal *Fertility and Sterility* attest to the fact that new technologies, pharmaceuticals, and tests are constantly being developed to treat infertility. There is also a booming cottage industry in the publication of self-help, complementary medicine, and advice books. At the vanguard are pre-implantation genetic diagnosis (PGD) techniques that laboratory experts can use to ensure that the largest, pre-screened ova—perhaps even cryopreserved or "donated" by a (financially compensated) Ivy League graduate in her twenties—are individually fertilized by intracytoplasmic sperm injection (ICSI) with similarly pre-screened sperm—possibly attained surgically from a subfertile male partner via testicular sperm extraction (TESE). Next, the resulting *in vitro*-produced embryos are selected for genetic quality—Steinberg (1997) notes the "eugenic logic of IVF"—and then placed in the consumer-patient's uterus. Harvard business professor Deborah Spar (2006) likens the industry to that of luxury goods. Only 14 states mandate insurance coverage for infertility, possibly with the complicity of fertility clinics which enjoy the fiscal fruits of low supply and high demand (Spar 2006). Most women who want the services have to pay exorbitant sums out-of-pocket. A single cycle of the PGD protocol mentioned above would cost upwards of $40,000 in most cases.

Within this growing industry sector, is a burgeoning subspecialty in reproductive tourism. In contrast to the United Kingdom and Australia, where many of the tourist-patients originate, there is remarkably little government regulation in the infertility industry in the United States. America's particular history created the circumstances wherein reproductive politics constitute proverbial hot potatoes for lawmakers. On the one hand, they have to consider the many well-to-do, well-connected (mostly white) constituents who rely on NRT for family building, the

enriched and empowered medical specialists who serve these patients, and the groundswell of public and scientific support for stem cell research, which has an ancillary and logical connection to NRT (also called assisted reproductive technologies and advanced reproductive technologies, shortened to “ART”). On the other hand, legislators and other elected office-holders must contend with perennial agitation from anti-choice religious conservatives who are already in paroxysms over the hundreds of thousands of stem cells and frozen embryos that continue to proliferate (Mundy 2007). Avoidance is the prudent and prevailing strategy. The result is a Wild West industry that continues to grow rapidly in ways that are largely unchecked. Opportunities abound for both abuse (e.g., charlatanism and dangerous experimentation) and emancipatory use (e.g., lesbian and queer family-building) of these technologies.

Foster care and adoption have been conceptualized as non-medical alternatives to infertility or involuntary childlessness (Altstein and Simon 2001, Traver 2008). It is important to note, though, that many adopters first attempt to get pregnant with medical assistance, often exhausting their medical options and nearly emptying their bank accounts by paying for several cycles of IVF (Jacobson 2008). Adoption occupies the bottom tier in the hierarchy of routes to parenthood; it is frequently the last resort and there are numerous barriers to access and to success.

As with medical infertility treatment, adoption is a growing business in which demand exceeds supply. There is a dearth of healthy, white babies, the preferred children for the white, middle class couples who comprise 90 percent of the population of prospective adoptive parents. Roughly 60 percent of the available domestic children are black, Latino, or classified as racially mixed. To encourage foster care and adoption of these and other “special needs” children (who also include children with medical or mental health conditions, sibling groups, and youngsters

over age two), the federal government and most states provide financial incentives such as tax credits, free health insurance for the children, and monthly stipends. But most adopters want healthy infants (particularly girls—perhaps because baby girls are lesser signifiers of their genetic fathers' virility) (Rothman 2000[1989]). These prospective parents also wish to avoid the "risk" associated with adopting children from birth mothers who may change their minds or who may demand more of a relationship than the adoptive parents want to accommodate (Dorow 2006, Rothman 2000 [1989], Jacobson 2008).

International adoption—on the rise since the 1990s—enables a supply stream of 20,000 babies who come to the United States each year with no birth-family strings attached (Bureau of Consular Affairs 2008). Domestic adoptions number about 100,000 children. Half of these are private adoptions that are "voluntary" on the part of the birthmother and the other half are public—and mostly involuntary, resulting from court-mandated removal of children from the birthmother's custody (U.S. Department of Health and Human Services, Child Welfare Information Gateway 2008). Segments of the industry enact a bit of a pyramid scheme in which hopeful would-be parents queue up for the few available children; eventually, given enough time, placements are made only to leave even greater numbers of desirous women and couples waiting in the wings for their match with a child.

Adoption, in another parallel with medical treatment, usually entails hefty fees and extreme surveillance by outsiders—in this case, by licensed social workers and family court judges—who assess the potential parents' "fitness" (moral, social, financial, and physical) for raising children (with medically assisted conception, biological fitness is more meticulously examined and manipulated). However, adoption is in many ways qualitatively different from medically assisted routes to motherhood.

First, plenty of people who are neither childless nor infertile adopt children. These adopters may have biological children, stepchildren, and/or grown children, for example. Obviously, children who are adopted have other parents, their biological progenitors. Unlike NRT-created children, adopted ones are more apt to be stigmatized; detractors refer to the lack of prenatal care, the possibility of *in utero* drug or alcohol exposure, attachment problems associated with presumed inadequate attention in the pre-adoptive weeks, months, or years; the inheritance of birthparents' presumed innate inadequacies; and the presumed weakness of the emotional and kinship bonds between the children and their adoptive families. This stigma often trumps the "spoiled identity" (Greil 1991, after Goffman 1963) attributed to the infertility of the adopting parents.

Thus, the fantasy about who is saving whom changes. In using NRTs, the newly-created miracle babies save their parents from the stigma of childlessness and restore their normativity. Adopters, in contrast, are thought to save their adopted children from poverty, abuse, and reduced life chances, and sometimes even from governments with repressive gender ideologies (e.g., China). These narratives construct medically assisted conception and adoption as morally-correct, productive undertakings, but only as applied to the mainly white, middle class, married women and couples who choose to and are able to surmount obstacles to parenthood. The inextricable imperialist and eugenic aspects of intra-country as well as global power relations surrounding alternative routes to parenthood are often left unacknowledged.

Accessing Motherhood and "Otherhood"

Journalist Liza Mundy (2007:xv) writes, "The spectacle of someone trying to have a child can be more inflammatory than the spectacle of someone trying not to have one." In this statement, Mundy recognizes the scrutiny on women seeking alternatives paths to motherhood as well as the contentiousness of the NRTs. Several researchers (Lasker and Borg 1994, Becker 2000, Inhorn et al. 2009 [2007], May 1995) note that infertile women seeking motherhood face financial barriers, stressful medical procedures, psychological effects, lack of reliable information, moral and religious dilemmas, legal questions, and threats to personal relationships. Despite these difficulties, women will go to great lengths to become mothers if the cultural imperative is sufficiently strong, the medical procedures promising and comfortingly routinized, the success stories common and hope-inspiring, and the desire to mother persistent and prolonged.

These women are in the minority among childless women. In fact, just 44 percent of infertile-diagnosed white women seek medical treatment whereas only 31 percent their African American counterparts do so (CDC 1995). A tiny percentage of these two groups attempts adoption in order to become mothers. We know from the analysis of survey data that class, race, income, age, marital status, and education factor into who forges ahead with infertility treatment (and, by extension, eventually pursues adoption) and who does not (Stephen and Chandra 2001), but the reasons for these distinctions are less clear. The present project sets out to clarify the reasons for differential access and to offer a model for understanding the social mechanisms involved.

The motherhood ideology that applies to white, middle class married women in the U.S. shifts for poor women and women of color. Discursive legacies from colonialism, slavery, and anti-immigrant sentiment continue to call into question their fitness for motherhood and their right to make procreative decisions. The *fertility* of poor women and women of color is constructed as a social problem but their *infertility* is not. As medical ethicist Alan Meisel explained when asked what the medical profession was doing about class (and race) disparities in infertility care, "[obtaining] the essentials in life for one's own health is more crucial than the possibility of creating more people" (quoted in *Pittsburgh Post Gazette* 1997). In this framing it is nearly unfathomable that poor women would suffer from infertility. Although social control of procreation affects all American women, institutional surveillance and government policies more directly target poor and minority women. The assumption of fecundity and concomitant irresponsibility underlies this system of control. The infertility and childlessness of poor and minority remains understudied and ignored.

Involuntarily childless lesbians and single women are completely left out of the statistics-gathering and subsequent discussions on helpseeking and fertility treatment. Often, these women defy convention by not having romantic relationships with men. For this reason, patriarchy constructs single women and lesbians as immature, cold or "frigid," undesirable, selfish, and career-oriented –- the opposite qualities thought to make for a good mother. But the significant and well-documented rise of intentional (and politicized) medically-assisted and adoptive motherhood among single women and lesbians attests to the relevance of these groups of women to research on childlessness (Agigian 2004, Mamo 2007, Jacobson 2009). Single women and lesbians can no longer be dismissed as insouciantly childfree or pathetic old maids; motherhood calls some of them and not others. For lesbians—and probably for single women as well—their

marginalized status becomes subordinate to their status as mothers (Naples 2003), perhaps bolstering any impetus to pursue motherhood through medical help or adoption. How these women negotiate the roles of and routes to motherhood and nonmotherhood (i.e., “otherhood”) is another concern of this dissertation. I explore the multiple complex interactions between their shared constructions of womanhood vis-á-vis motherhood and their own (in)decisions, attitudes, feelings, and (in)actions.

This dissertation looks broadly at the experiences related in qualitative interviews with 25 infertile and childless women who vary by class, race and ethnicity, sexual identity, marital status, culture, and country of origin. The purpose of the study is to answer the following key questions: How do infertile and/or childless women, who are also socially marginalized in other ways, define themselves and conform to, cope with, resist, and reformulate the motherhood mandate decreed by a pronatalist society that excludes them? How do they parley their multiple consciousnesses into their accounts of infertility and childlessness? In what ways do their various social statuses influence the discourse as well as the non-discursive elements of their experiences? And how do all these processes interact and influence their approaches toward assisted reproduction and adoption?

Chapter 2, “Defining Women,” traces the definitions of womanhood, motherhood, infertility, and childlessness throughout the course of American history with special attention to disparities along the axes of class, race, and sexual-identity. This backdrop helps to elucidate contemporary women’s experiences and understandings which invariably draw from long-standing stereotypes, themes, and imagery. This chapter also includes a review of the relevant feminist scholarship on infertility and childlessness. The gaps in this work underscore the need for expanding infertility research beyond the white, middle-class, heteronormative, married

populations that comprise popular, medical, *and* academic constructions of the hapless infertile as well as the need for building new theories and making more connections regarding the complexities of *not* seeking motherhood amid infertility and childlessness. Chapter 3, "Researching Women," concerns the dilemmas presented by my attempts at a feminist methodology, the difficulties—and the resulting unexpected insights—of recruiting and interviewing a nonexistent population and the nexus of reflexivity, subjectivity, and validity in analysis.

The spectrum of motherhood and womanhood as defined and disputed by the study participants comprises Chapter 4, "Motherhood from the Margins," where I also define the analytic category *identity sufficiency*. Chapter 5, "Indecisions," connects these ideas with participants' reasoning about their own motherhood or otherhood status and the decisions, or lack thereof, about when and under what circumstances becoming a mother will be, or would have been. Rather than constructing motherhood as an achievement, they tend to see it as ascribed by supernatural forces, not entirely controllable by personal will or medical intervention. These factors play into a continuum of *decisive efficacy* that interrelates with the other variables.

Chapter 6, "Conceiving Complexities," discusses the ways in which the participants by turns realize and ignore, cope with and deny, regret and accept their infertility and/or childlessness, behavior and attitudes that I describe as *role applicability*. In Chapter 7, "Defying Normalization," focuses on the respondents' dubious takes on and subversive intent toward assisted reproduction and the adoption bureaucracy. The medicalization of childlessness (nonmotherhood) is what creates much of the need for assisted conception and adoption, two institutions that operate to normalize these women by enabling motherhood. The respondents'

positions—related in gradations of *normalizability*—demonstrate how it is that infertility and childlessness do not always demand treatment, that identity sufficiency, decisive efficacy, and role applicability surrounding motherhood influence whether or not they submit to these normalizing processes.

Between the involuntarily childless and the childfree, beyond infertility and fecundity, are the *ambivalent childless* and the *pragmatic infertile*. These women accommodate and reiterate the prevailing hegemonies of motherhood and infertility. But their life experiences reveal plenty of examples of resistance, refusal, and subversion of these dominant and dominating discourses. The ambivalently childless locate good reasons for motherhood and equally compelling reasons for otherhood, expecting life to unfold as it will. Similarly, the "pragmatic infertile"—who differ from the former group by their quasi-identification with the somewhat pejorative, permanent-sounding label "infertility"—determinedly place their faith in the supernatural, rather than with the medical providers and adoption bureaucrats who can make mothers of them. Both groups emphasize *not trying* to become mothers until they have achieved their ever-shifting goals of optimal readiness, thus ensuring that they only become ideal mothers if they become mothers at all. In contrast to the infertile women other researchers describe, this process is less fraught with anxiety. It is, in another sense of the phrase, *not trying*.

Despite misgivings about the all-too-common hyperbole, I do not wish to wholly dismiss the "plights" and "inestimable havoc" wreaked upon the suffering infertile—my personal experience and that of many others attests to the pain and disruption involved—nor do I want to imply that treatment access should be constricted in the least. However, this investigation reveals women's extradiscursive experiences with childlessness and infertility. That is, their lived experience, which contrasts with the available narratives, strongly suggests the need to re-

imagine the meanings of these phenomena and to construct a counternarrative. A new theory of infertility/involuntary childlessness discards the dichotomy of feminine-and-fulfilled mothers on one side and failed women (or liminal potential mothers) on the other—the childfree-by-choice fading to invisibility and increasingly likely to be suspected of infertility and regret.

From the margins comes clarity. Infertility happens to other women. Probably some of these infertile women are predisposed to seeking treatment just as treatment itself reifies "infertility." And those who do not seek treatment convince themselves, perhaps, that they do not want to be mothers (or mothers of additional children) anyway. Most of the women I interviewed, nevertheless, do not see themselves as suffering from a "desperate curse" (Spar 2006:2) but neither do they passively accept childlessness or infertility. For the most part, they mitigate the threats to their culturally-informed notions of womanhood by living satisfying, *fulfilled* lives, with or without children.

CHAPTER 2: DEFINING WOMEN

And when Rachel saw that she bare Jacob no children, Rachel envied her sister; and said unto Jacob, Give me children, or else I die.—Genesis 30:1, King James Bible

Procreation is a fact of life. Actually, it is *the* fact of life. And this biological function has always occurred within particular cultural, social, and political circumstances. No matter when or where, power relations—especially gender relations—frame the experience. Pronatalism and patriarchy in America has its roots, of course, in Judeo-Christian tradition and an agrarian past. Men, as biblically-prescribed heads of the family, gained status, wealth, and immortality by having many sons (just like the Old Testament's Father Abraham) to work the fields and tend the animals, to represent and carry on the family name. Women were charged with bearing and rearing children, all in obeisance to their husbands, clergy, and God. But there have always been women who did not get pregnant or carry to term (or who did not produce sons or enough sons) and these women took the blame for their "barrenness." Modern medical knowledge of male sterility aside, infertility treatment usually occurs on women's bodies, women spearhead the pursuit of adoption, and women still shoulder most of the stigma associated with childlessness. So-called barren women used to be objects of scorn and pity; today's infertile and childless women are too, although in increasingly subtle and nuanced ways which vary according to social status.

Two oft-cited histories of infertility in the United States went to press at the same time: Elaine Tyler May's (1995) *Barren in the Promised Land* and *The Empty Cradle* by Margaret Marsh and Wanda Ronner (1996). May solicited hundreds of letters from childless and infertile

Americans that she analyzes through the triptych of race, class, and gender alongside an examination of eugenics, parental fitness, compulsory parenthood, voluntary childlessness, and the rise of politically-contested new reproductive technologies. Marsh and Ronner, an historian and gynecologist, respectively, rely on diverse primary sources to report the medical history of infertility. The following historical sketch draws heavily on the work of these authors to contextualize historical and contemporary definitions of infertile and childless women.

Goodwives and Witches

The 16th and early 17th century colonists had large families, with many children who could work the fields and eventually increase the population. Households were permeable and "barren" women typically cared for apprentices, relatives, and unrelated orphans and these children, in turn, worked for their new family. Children at this time were not considered "innocent" and "precious"; being a part of family often meant providing needed labor.

Women who had not given birth or whose children all died were more likely than demonstrably fertile women to be accused of witchcraft in Puritan communities. There were distinct advantages to childlessness, however. The risks of death in childbirth and the loss associated with high infant mortality were all too real. Native Americans were suffering from disease and warfare and, consequently, their birth rates plummeted. Africa-born indentured servants and slaves had difficulties creating and sustaining families in part because their numbers were initially quite small and also because they were subject to the whims of those who could sell them or move away, callously leaving loved ones behind. Poor white women, the servants of the middle class, could be whipped or made to work extra years if they had children. Still,

members from all of these marginalized groups as well as wealthier whites sought spiritual help and consulted with herbalists to bring on pregnancy, actions that invited witchcraft accusations. Infertility was a punishment for religious lapses and worldly interventions were not permitted.

Lonely Spinsters, Good "Breeders," and Chinese Slave-Girls

Beginning with the late 18th century Revolution and continuing into the era of westward expansion known as Manifest Destiny, American whites—rich and poor alike—contributed to the project of nation-building by having many children. According to May (1995), idea that an important reason to have children was to bring "happiness" to their parents grew in popularity at this time. The "cult of true womanhood" characterized women as rightfully dedicated mothers (Welter 1966).

Those who could not bear children or whose children died young were generally pitied. Native Americans continued to suffer greatly from the genocidal result of westward progress. Some Native American women lost their children to assimilation projects in the guise of orphanages or to "orphan trains" that stopped at frontier outposts to supply childless families with workers/heirs. Enslaved Africans were forced to "breed." Those women who got pregnant were sometimes relieved of work, a practice that encouraged many women to fake pregnancy. Some enslaved African women resisted by aborting their pregnancies or committing infanticide rather than risk losing their children to the auction block or to a punishing life under the overseers' whip. Many enslaved women were pressed into service as "mammies" to their masters' white children, thus beginning a long history of providing childcare and domestic work to the dominant group even while sacrificing their own procreative and mothering prospects

(Davis 1981). Still some enslaved women endeavored to get pregnant when they encountered difficulty, primarily turning to herbal remedies (Marsh and Ronner 1996).

Chinese women, first brought over in small numbers to serve as prostitutes or house slaves—known as Mui Tsais, were treated as commodities and often prevented from marrying or from reuniting with their spouses (Yung 1995). They were forcibly sterilized, and when that did not work, they were made to have abortions. Exclusionary policies—some of which targeted Chinese women specifically because they were thought to spread venereal disease and to seduce unsuspecting "white boys"—resulted from the "yellow peril" panic in the late 1800s and early 20th century and made it clear that Chinese women were certainly not valued as mothers (Silliman et al. 2004, Yung 1995).

Republican Mothers Redux and "Overbreeding" Immigrants

Society and families changed dramatically in Victorian times up until World War II. For example, the companionate family, which became responsible for "fulfilling the emotional and psychological needs of its members," replaced, for the middle class at least, the kind of traditional family that was tasked primarily with providing education, economic security, and social welfare (Mintz and Kellogg 1988:108). Among whites, having children was considered a civic virtue and children were greatly sentimentalized. Wealthier women had fewer children and spaced them further apart with the help of abortion, birth control, and abstinence. Despite the "race suicide" panic that called on white Protestants to stop shirking their civic duty and propagate their race, immigrant fertility outpaced that of the native-born WASPs. In 1920, nonetheless, 20 percent of women were childless, the highest rate ever recorded (May 1995).

Attempts at social engineering—which included outlawing abortion (due to fear that white women were using it too much)—largely failed, but eugenic ideas settled themselves into the American consciousness, and my research results suggest that they never went away.

At this time, infertility became a medical problem and a social problem. Doctors and politicians were not worried about the fertility of African American women or that of working class immigrants, but physicians did carry out a significant program of reproductive surgery and experimentation on these women. Medical experimenters gradually learned from poor women's bodies how to treat "mechanical" and hormonal imbalances among apparently infertile middle and upper class women, culminating in the first *in vitro* experiments in the 1930s.

For a long time, men were thought to be fertile as long as they were not impotent. Toward the end of the Victorian era, it was becoming to clear to some doctors that gonorrhea and other conditions could lead to azospermia and this realization soon led to insemination techniques, including donor insemination. At first, women could order self-help books and kits to accomplish insemination but public dissent and the professionalization of medicine put a stop to that freedom.

Childlessness among suffragists and other early feminist leaders as well as among the utopian communities that proliferated at the time was a matter for public debate. The post-Revolution concept of "Republican motherhood," in which women had a nationalistic obligation to bear and raise children who would become solid citizens regained strength (Berry 1993: 89, May 1995, Mintz and Kellogg 1988). A few gifted women leaders could be childless as long as they promoted motherhood, took in orphans, or otherwise propped up the role of mothers. Those, like Margaret Sanger, and others who argued for birth control were demonized but yet still very influential. In this environment, many infertile and childless women went underground; that is,

they were not apt to engage in the public debates about dangerously low birthrates and procreative autonomy. Probably due to untreated health problems, poor black women had the lowest birthrates even at a time when birthrates were generally sinking among all groups.

Women who were involuntarily childless had little recourse; medical treatments were still more likely to render women permanently infertile than to help them (Marsh and Ronner 1996). A physician at the time lamented, “There is still, I am sorry to say, a tendency on the part of many general practitioners to recommend a little ‘stretching and scraping’ to every disappointed bride who comes to them” (Child [1920] quoted in May 1995:76). Marsh and Ronner suggest that doctors felt they could not refuse women who “demanded” infertility treatment even if there was little likelihood of success from the procedures available. May, on the other hand, implicates doctors’ fiscal attraction to the lucrative business in infertility as well as their efforts to make their reputations by exercising their newly-acquired expertise. For their part, childless women, including single women, were, for a time, encouraged to adopt from the overflowing children’s homes. By 1920, though, baby shortages were the norm and the emerging adoption establishment began to weed out the “unworthy” from the pool of prospective adopters.

Fertile Wives, Frigid Women, and the Feeble-Minded

The post-war Baby Boom and public awareness of Nazi atrocities subdued the cries of race suicide and the concern over birthrates. Children as a “national obsession” was clinched, public life declined, and the view spread of the family as a haven from outside pressures (May 1995). This pronatalism was less a call to action and more a hegemonic practice; 95 percent of women said they intended to have children (May 1995). Everybody was doing it. A new wave of

middle class and working class families were moving to the suburbs with the help of huge government housing subsidies. Those who could not have children found a medical community that offered "hope"—the industry's eternal buzzword—and relatively little scientific knowledge. Research picked up the pace significantly, though, and the medical journal *Fertility and Sterility* was started to facilitate its progress in surgical techniques and pharmaceutical fixes. In addition to the popular investment in science and technology, an "ideology of domesticity" prevailed (May 1995).

Infertility and childlessness were considered to be more personal tragedy than evidence of moral shortcomings or malingering. Nevertheless, the Freudian notion of "frigidity," frequently used to describe women who subverted gender roles, sometimes by forgoing motherhood, pointed the accusing finger at women for their own infertility once again. If neither the (empty) promises of medicine nor psychological "acceptance" of one's calling as a woman yielded children, adoption was a final option that could allow a woman to simulate expectations. Adoption, the "second best" alternative to having one's "own," was considered a therapy for infertility. It was no longer about finding homes for needy children. Adoptive families wanted babies that they could "raise as their own" and secrecy, in an attempt to pass as a biological, nuclear family, was the norm. Only white, middle class families were permitted this option, and a concerted effort ensued to search out, find, and remove children from "feeble minded" (a proxy for lower class) parents and other poor whites and to subsequently place them with "good families" (May 1995, Marsh and Ronner 1996, Fessler 2006).

Poor women, including a small percentage of African Americans, sought medical treatment for infertility, usually in the form of insemination (March and Ronner 1996) but many more poor women and women of color found themselves sterilized—often just after a hospital

birth—without their permission. Compulsory and coerced sterilization began in prisons and mental hospitals and extended to public maternity wards and free clinics. It did not stop until the mid-1980s despite a 1970s feminist outcry that curtailed the routinization of the practice. Arguably, providing experimental birth control drugs and devices—and even undue pressure to use safe contraceptives—in low-cost clinics in more recent years constitutes *de facto* sterilization as well (Davis 1998, Roberts 1997). But in the 1950s, black women who wanted children but could not have them had little in the way of options through formal channels like doctors and adoption agencies. The tradition of family fluidity, in which a childless woman (or anyone) might take in a child who is a relative or non-relative, prevailed. While white families became increasingly small and focused inward, black families and Latino families continued a more communal existence, a system fostered by segregation and an historical legacy of forcible separation (once it was slavery, later disproportionate imprisonment).

Childless or Childfree?

Many researchers' stories about infertility and the new reproductive technologies begin in the 1960s and 1970s (e.g., Becker 2000, Franklin 1997, Harwood 2007, Mundy 2007). The widespread availability of birth control and abortion, the Women's Movement and the sexual revolution all undeniably opened up opportunities for women and improved women's procreative control. To have children or not became a real choice. "Childfree living," was a viable option, one promoted by some feminists, by lesbians on the heels of the 1969 Stonewall Rebellion (see Stacey 1996), and by environmental activists worried about the population boom. Women could pursue other life interests and careers instead of being burdened with the task of

raising children. Infertile women and those who were involuntarily childless were virtually indistinguishable from those who freely "chose" to live their lives without ever having become mothers, and, thus, childlessness was less likely to be seen as pathological. Divorce was more common and women married later. Women could be single—or lesbian—and face less discrimination and harassment. They could support themselves and they could become mothers; all that was need was a willing male friend and/or a turkey baster. Alternatively, these women could make a withdrawal from one of the new sperm banks who had perfected the cryopreservation of semen (the first one opened in Iowa in 1965), though many of them served only married women, with their husbands' permission (in 2006, the California Cryobank, citing implied financial responsibility and parental rights under the marriage contract, would not release sperm to me without a "permission" form signed by my husband).

By 1970, hormonal drugs—namely Pergonal and Clomid—that could induce ovulation and promote pregnancy in previously infertile women had been introduced, and not coincidentally, the first advertisements for fertility drugs and services began to appear in *Fertility and Sterility*. Doctors could offer more to help women become pregnant. In 1978, Louise Brown, the first "test-tube baby," created via *in vitro* fertilization (IVF) was born in England, thus opening the floodgates for the infertility industry. Clinics proliferated and men began to re-gain dominance as specialists in a field that had become preferred terrain for the large, post-Women's Movement influx of women doctors. Concomitantly, ongoing battles for equality expanded gender roles for women and fewer and fewer women stayed home and more went to work.

But the availability of treatment and the opening of career paths were not as significant for poor women and women of color who had always worked and who could not afford the expensive treatments (nor were they encouraged to use them; this discourse is reflected in the ads

for fertility aids in *Fertility and Sterility*, for example, which depicted only well-off white women). In fact, the 1965 Moynihan Report, officially titled *The Negro Family: The Case for National Action*, reflected and produced white attitudes and governmental policies regarding black families, lamenting the "high" fertility rate of African American women and maintaining that "at the center of the tangle of pathology is the weakness of the family structure" (31). Black women, and most women of color for that matter, were consistently charged with being irresponsible, profligate, and prolific mothers. The children of poor women were removed by the state and placed into foster care or adoptive homes in an attempt to break the "cycle of poverty;" besides women and communities losing their children, the children themselves reportedly suffered loss of identity and heritage (Patton 2000). The National Association of Black Social Workers, alarmed at the rate at which black children were being taken and placed in white homes, strenuously objected in their *Position Statement on Trans-racial Adoption* disseminated in 1972. They called for more African American adoptive families and greater respect for informal adoption among kin and community members. And in 1978, the Indian Child Welfare Act (ICWA), which re-instituted tribal authority of all adoptions of Native American children, was enacted into federal law to stop the habitual removal of the youngest tribe members to white adoptive families. The coming Reagan-Bush years (1980-1992) saw sweeping changes to the cultural landscape that effectively altered how infertile and childless women from a wide swath of class and race backgrounds experienced their non-mother status, but the stereotypes remained.

Welfare Queens, Working Moms, and the "Desperate" Infertile

The 1980s, called the "me decade" for a reason, saw a sharp rise in consumerism and the pursuit of individual satisfaction. Fertility clinics offered a service for the well-to-do consumer/prospective mother who was seen as wanting a child to better her enjoyment of life. As life got better for the middle class than it had been in the energy-crisis seventies, the poor suffered more than ever. Ronald Reagan's attacks on welfare portrayed poor black women in particular as "welfare queens" who drove Cadillacs while sponging off the state and having more resource-greedy, delinquent children for the purpose of fleecing hard working Americans (Zucchino 1997). Crack cocaine ravaged many poor communities and led to a mythology of "crack babies"—helpless, cocaine-addicted, and condemned infants who should be removed from their criminal mothers (some women were imprisoned for using drugs while pregnant). Poor women—assumed to be dangerously overfecund—could not get help for infertility via state health programs but they could get sterilized for free and this is still the case.

Ironically, the abortion debate involved vehement opposition to women's rights to end unwanted pregnancies. This fight facilitated the rise of the Christian Right and the "Moral Majority," evangelical Christians who espoused traditional "family values" that they equated with male-headed households that included a wife, who was the antithesis of the strident, bra-burning feminist and who—as a devoted mother—conformed to the collectively-imagined 1950s ideal, and their drug-sex-and-rock 'n roll abstaining children. At the same time, invoking both the promise of science and the grace of God, media stories abounded of "medical miracles" in which "desperate" infertile or childless women could suddenly become mothers via IVF and

related procedures or, perhaps via surrogacy. This media fascination helped to usher in a new era of pronatalism.

The flipside of the cheerleading for these medical advancements—a distinctive technophilia and interest in progress permeated public attitudes throughout the Cold War—was a moralistic distaste for women who had been career-building when they should have been family-building. The “mommy wars” between those women who selflessly dedicated themselves to conventional domesticity (“opting out” of the “rat race”) and those “supermoms” who juggled career and motherhood, all while staying fit and happy, were largely a media fiction (Hays 1998). However, the ideological work was done; feelings of guilt and insufficiency plagued middle class mothers whether they worked outside the home or not. For their part, the fertility industry and its consumers successfully mainstreamed the procedures by cleverly casting these technologies in the language of “choice” but they erased the choice to be threateningly childless, instead championing the choice to occupy maternal roles as expected. Marsh and Ronner (1996) suggest that the use of private funding streams instead of federal grants in developing IVF and the like shielded these technological interventions from moral reprisals until well after its spread in usage. I would add that the because the patients were predominantly white middle class and professional women—usually married in the early, more selective years of NRT—further protected it from the kind of criticism that might lead to restrictive policies. There were kinks though.

The Baby M case, in which Mary Beth Whitehead, a surrogate mother, refused to give up the child she was contracted to bear, unleashed a ferocious backlash. Some advocated for the maternal bond created in pregnancy. Others, once again revealing class tensions about good and bad mothers, found her less worthy as a parent (and untrustworthy since she reneged on her

contract) than the wealthier couple who hired her to have “their” baby. Many commentators privileged the husband’s genetic tie (he provided the sperm) over that of the surrogate (her eggs were used). That the childless woman, Elizabeth Sterns, who hired the surrogate had not been shown to be infertile (she had been told that pregnancy could exacerbate her multiple sclerosis symptoms) was a sticking point for those who thought she should have tried to get pregnant first. As May (1995) points out, the common thread in the arguments on all sides of the Baby M discussion was distrust of women’s ability to make sound procreative decisions.

With the arrival of AIDS and the ensuing rush to assign blame, African American women’s fertility problems were more likely to be attributed to sexually transmitted infections than to endometriosis (Nsiah-Jefferson and Hall 1989). Lies originating in the days of slavery about black women’s sexually promiscuity and inherent pollution led to biased medical diagnoses and prevented doctors from providing adequate treatment. Endometriosis, in which endometrial tissue exists in other internal organs besides the lining of the uterus, is a leading cause of infertility and there are a number of therapies to correct it, but the damage can be irreversible if left untreated. Throughout the 20th century, African American women had higher rates of infertility than white women (Marsh and Ronner 1996); this pattern resulted not only from inadequate health care and misdiagnoses but also from structural conditions in poor communities that fostered nutritional deficiencies, drug and alcohol abuse, environmental hazards at home and at work, unsafe working conditions, and the use of IUDs, particularly by Medicaid recipients (Nsiah-Jefferson and Hall 1989). Women of color, including African American women, Native Americans, Asian and Pacific Islanders, and Latinas were also subjected to unnecessary hysterectomies and coerced sterilization (Corea 1985, Mullings 1984, Silliman et al. 2004).

Many of these groups began organizing in the 1960s and 1970s for reproductive justice, but the anti-abortion movement and the racist stereotyping of women of color in the mid-1980s triggered more activism (Silliman et al. 2004). Infertile and childless Native American women had to cope with their personal feelings about motherhood and femininity as well as with community concerns about the survival of their people owing to acculturation projects, adopting out of their children, and sterilization due to frequent botched medical procedures at the free clinics (Silliman et al. 2004). Class differences among women of color made for different experiences as well. The communal child-rearing among African Americans was curtailed among the black middle-class with its eventual integration into predominantly white communities—or into exclusively black middle class enclaves—moves that fostered greater privatization among those upwardly mobile families (May 1995). Middle class black women might have sought out adoption or fertility treatment if they encountered infertility or found themselves involuntarily childless, but they did so (and continue to do so) in very small numbers.

Soccer Moms, The Infertile Woman, Lesbian Mommies, and Hyper-fertile Latinas

The 1990s and the first decade of the new millennium brought about a number of legislative changes and landmark legal cases that further codified the definitions of good mothers and bad mothers, definitions that drew primarily from existing stereotypes and race and class prejudices. The fertility clinics, exposed in the 1980s for providing misleading statistics—some clinics accomplished no “successful” pregnancies—backed the federal Fertility Clinic Success Rate and Certification Act of 1992, which charged the Centers for Disease Control (CDC) in Atlanta with compiling statistics on IVF from the approximately 483 fertility clinics in existence

nationwide (not all clinics send in their reports, however). The move was part regulation, part marketing strategy (Spar 2006). The image of infertile and childless women as consumers solidified. As a demographic, women of childbearing age—the ideal being the (white) middle class "soccer moms"—had political power as swing voters and buying power for the host of products (including family vans and SUVs) geared toward babies and children that flooded the cash-rich, dot-com-boom market.

Medically assisted conception continued to increase with the advent of newer, more refined technologies. Testing of cryopreserved semen extended from HIV monitoring to routine pre-screening for a host of genetic diseases and anomalies. By 2009, the NRT options included not only IVF facilitated by ovulation drugs but also egg donation, embryo donation, GIFT (gamete intrafallopian transfer), ZIFT (zygote intrafallopian transfer, ICSI (intracytoplasmic sperm injection), and TESE (testicular sperm extraction). The latter is a significant development in an historical sense in that it involves surgery on men (as well as on the women who have the resulting *in vitro* fertilized embryo implanted in them) for the purposes of restoring fertility. The advent and apparent popularity of this procedure that requires testicular surgery underscores the continuing importance placed on genetic kin. Donated sperm would be easier, cheaper, and less risky to obtain but the damage to men's masculine self-concept in having to undergo such a procedure is outweighed by the need to biologically father (i.e., provide half of the genetic make-up for) one's "own" child. When I called around to area clinics in search of one that would permit me to use a donated embryo without having submitted to numerous IVF cycles myself, two doctors extolled the virtues of the brand-new TESE procedures and attempted to convince me to go that route. I demurred but I also newly appreciated just how meaningful genetic

parenthood remains in American culture and how value-added, medicalized services reify that preference.

The new technologies in general up the stakes for infertile and childless women and men. The mere availability of options compels women to try treatments (Franklin 1997) even when they may be ambivalent about motherhood in the first place (Mundy 2007) and increases pronatalist social pressures on childless lesbians (Agigian 2004). The rampant medicalization of procreation (Greil 1991) and the industrialization of "reproduction," as Adele Clarke (1998) describes it, or "Infertility, Inc." as Laura Mamo (2007) prefers, helped build the current, rather monolithic image of the "Infertile Woman." The image of the wretched barren woman who loses God's favor remains but in the contemporary version she is medicalized, consumer-oriented, and driven as well as pitiable and accursed.

A society-wide loosening of moral strictures about what constitutes legitimate motherhood, medical ethics committees' recommendations, and a need for more customers opened NRT and run-of-the-mill assisted conception techniques (i.e., insemination) to more single women and lesbians. A lesbian baby boom (AKA "gayby boom") began in the 1990s. No longer did women choose between life outside the proverbial closet or motherhood; gay women assumed they could have both. Fertility clinics offered anonymity, safety measures (i.e., semen screened for infectious disease), and other services (e.g., choice in donors, legal safeguards, and even sex selection in a few cases). For these reasons, fewer lesbians restrict their procreative attempts to the low-tech techniques of home insemination. Laura Mamo (2007) has shown that many lesbians employ hybrid (or "mesotech") strategies that employ both the high-tech medicalized fixes and the low-tech do-it-yourself techniques. Lesbians are now more able to take advantage of procreative technologies while also enjoying the benefits of their outsider sexual

identity status. These benefits may include a special sense of community and belonging, heightened credibility in a social justice milieu, and consequently, some freedom from traditional norms and mores. Nevertheless, the prevalent cultural discourse that gays and lesbians are unfit as parents remains. Many believe that the parents' queerness will stigmatize their children for life. And gay and bisexual men are portrayed by homophobes as particularly "decadent, selfish, and above all, nonprocreative" (Lewin 1993:16). Political rhetoric depicts them as unworthy of parenthood yet also worthless to society for eschewing reproduction. The alternative—building families with children—that took hold in the 1990s can also be oppressive (Agigian 2004). A number of actors and social forces constructed the "normal gay," who pursues goals like marriage and parenthood that parallel the norms of straight society (Seidman 2002) and this pro-family movement in the queer community has gained momentum (Stacey 1996). Gay and lesbian parenting may be viewed as resisting the system of gender organization, though it may also reify elements of gender ideology. Equating womanhood with maternity and manhood with paternity requires gay parents to cultivate available cultural symbols and discourses. Despite these limitations, many gays and lesbians strategically modify the dominant social scripts to pursue and construct satisfying lives.

Racism did not fade away in the decades since the ethnic and racial pride movements of the 1970s and its imprint can be seen in health disparities, including infertility. In virtually every measure of health and well being, African Americans, Native Americans, and the poor come out on the bottom (Lillie-Blanton and Hubman 2001). Latinas have the greatest morbidity of any ethnic or racial group in the country (Centers for Disease Control and Prevention 2004). Women of color, especially African Americans, Native Americans, and Latinas, have the highest infertility rates (Greil 2009, Nsiah-Jefferson 1989) and children from these communities are

most likely to be forcibly removed and placed with (white) adoptive families and foster homes (Child Welfare Gateway 2008). African American women and Latinas rarely relinquish their children voluntarily (Jacobson 2008). Women of color are more likely to be infertile, less likely to seek and receive treatment for infertility or for the medical conditions that cause it. They are less likely to be adoptive parents. All of these factors play into the global and domestic system of "stratified reproduction" first theorized by Faye Ginsburg and Rayna Rapp (1995) and later expanded by Culley et al. (2009) and Inhorn, ed. (2009[2007]).

Opposition from the National Association of Black Social Workers (NABSW) notwithstanding, new adoption laws in the form of the Multiethnic Placement Act of 1994 and its revision in 1996 put a stop to the use of race as a factor in foster care or adoptive placements for any agency receiving federal funds. Members of the NABSW were worried about the inherent power imbalance in an adoption system in which the children (who were, by turns, commodified and pathologized) are racial minorities and the adopters are white. In response to the legislative changes, agencies stepped up their recruitment efforts to attract more adoptive families of color but whites still comprise 90 percent of prospective adoptive families. In addition, international adoptions, overwhelmingly undertaken by white couples, increased by 150 percent since the early 1990s (Bureau of Consular Affairs 2008). Owing to the growing stigma of infant relinquishment, greater acceptance of single motherhood, and continued use of birth control and abortion, fewer white babies became available (Melosh 2002, Mundy 2007) and an international market in adoption proliferated (Jacobson 2008). Incidentally, domestic adoption and foster care are on the rise in China (Handwerker 2002) and the country, which contributed more adopted children to the U.S. than any other country in the past couple of decades, instituted new adoption rules that went to effect in 2007—rules that bar singles and, by extension, gay and lesbian

couples, and restrict adoption by body mass index, income, able-bodiedness, and length of marriage. The result is a morphing adoption scene in America.

The image of hyper-fertile Latinas—again that entrenched xenophobia—culminated in voter approval of California's Proposition 187 that denied social services, including education and health care, to the children of undocumented immigrants. Politicians and their supporters claimed that Mexican women were entering the state in alarming numbers in order to give birth in the United States and ensure citizenship for their children and access to public coffers to support those children. Federal courts found the law unconstitutional but the sentiment remains. Two of the Latina participants of this study complained about such women and their children's ill-gotten citizenship. And, in the summer of 2009, state lawmakers introduced another bill to once again deprive so-called "anchor babies" from state support.

Adoption laws, healthcare disparities, and an enduring ideology that differentiates between "good" mothers (read: white, middle class) and "bad" mothers (read: poor, racial/ethnic minorities) impact the experiences and shape the discourses of childless and infertile women. Identifying and understanding these effects—borne of an ignominious history—is a primary aim of this dissertation.

Cultural Dupes, Earth Mamas, and the Childfree: Feminist Research and Philosophies of Infertility and Childlessness

Medical studies comprise the bulk of the research on infertility, followed by psychological research on the emotional crisis of infertility and then by public health work that aims to reduce barriers to quality treatment.

For their part, feminist studies of infertility and childlessness usually begin by questioning patriarchy and gender ideologies. Ever since Simone de Beauvoir (1952) famously contested the truism that motherhood is women's calling in life, feminists have debated what, then, lies at the core of womanhood. Childless and infertile women embody the perennial feminist problem of defining women as somehow different from men without reducing women to reproductive systems or to intrinsically maternal psyches (Rich 1976, Chodorow 1978, Friedan 1981). This paradox gives many feminists pause as they try to theorize women's emancipation from all institutional and ideological subjugation while also honoring the legitimacy of mothering (distinct from the patriarchy-serving role of "motherhood"), childfree living, and the pursuit of motherhood by the involuntary childless and infertile.

Several feminist scholars (e.g., Rothman 1982, Oakley 1984, Martin 1987, Ginsburg 1989, Corea 1985), whose work Thompson (2002) attaches to second wave feminism, recognized the profound impact of involuntary childlessness on women's lives. These scholars debated whether technological fixes increased procreative options and women's control over their bodies or whether they threatened to exacerbate gender strictures and patriarchal control. One camp of second wave feminists hailed the arrival of new aids to family planning and even predicted a utopia in which pregnancy and childbirth could be removed from the woman's body, taking place in a laboratory and thus freeing women from those procreative chores (i.e., Firestone 1970). Many lauded the potential for women to have children later in life or even without a partner. Some in this group (e.g., Hartsock 1983, Ruddick 1989)—those who promoted a *matriarchal* future— appeared to idealize motherhood and construct it as the ultimate expression of womanhood (i.e., "Earth mamas"), albeit in a way that rejected patriarchal conventions and parenting norms (Thompson 2002). However, other second wave feminists

vehemently opposed the notion that motherhood was essential to femininity and fulfillment (Lasker and Borg 1989, Rich 1976). Childfree living could free women from society's constraints. These scholars were dubious about procreative technologies, which they saw as potential instruments for greater patriarchal control in terms of the ideology of compulsory motherhood and of direct manipulation of women's bodies (Mies 1987, Klein and Rowland 1986, Rapp 1987, Rothman 2000 [1989], Solomon 1989, Sandelowski 1991). A few influential writers went so far as to assert that women were duped into their interest in NRTs (Crowe 1985) or that their biased upbringing obliged them psychologically to pursue motherhood and to enact mothering (Chodorow 1978). Barbara Katz Rothman (1984) worried that the new choice to use quality control measures in high tech procreation might lead to the *de facto* loss of choice not to use them. Rayna Rapp's (1999) study of amniocentesis, an invasive post-implantation diagnostic tool that is now routine, confirmed that this fear had become a reality.

Concomitant with third wave feminism—perhaps precipitously so—was renewed appreciation for multiple procreative experiences and for women's procreative agency. Structural changes coincided with a shift in the mainstream discourse from "the best interest of the child" in determining who could use NRTs and adoption to a reproductive choice model that valued privacy (Thompson 2002). At the same time, however, concern grew about the "ideological wedge" being driven between pregnant women and their fetuses with the proliferation of prenatal testing and fetal surgery as well as continued attacks on abortion rights and arrests of drug-using pregnant women (Casper 1998, Morgan and Michaels, eds. 1999, Rapp 1999, Thompson 2002). Feminists (e.g., Rothman 2000 [1989]) reasserted the importance of focusing on women's well-being and self-determination in all procreative matters from abortion and birth control to infertility treatment, adoption, and the right to be childfree. There was growing recognition of

women's power in reproductive rights movements and other feminist/anti-racist campaigns that included reproductive rights (Nelson 2003). Historians (May 1995, Marsh and Ronner 1996) traced the history of childlessness in America, providing the context that could explain the divergence in experiences between groups of women. It became clear that women had always defied convention and exercised a modicum of procreative control and that infertility, childlessness, and that motherhood could mean different things to different women.

Of course, the reality of "stratified reproduction,' (Ginsburg and Rapp 1995) meant that structural inequalities severely constrained procreative "choices" for women at or near the bottom rungs of the social hierarchy (see also Dworkin 1983, Roberts 1997). When studying procreative technologies—which Marilyn Strathern (1992) called an "artifice of culture"—it is vital to ask "who *uses* them and who gets *used* by them" (Klawiter 1990:84). Even before the first successes with frozen embryos and surrogate mothers, Angela Y. Davis (1981) presciently described a dystopia in which some women (probably poor minorities, she thought) would be classified as "breeders," making babies for the benefit of the elite. Her predictions have come true both in America and within the global system of cores and peripheries. As Helene Ragone (2000) reports, 30 percent of gestational carriers (i.e., "surrogate mothers") are black women carrying the genetic progeny of white couples. Ragone explains that the symbolic distance manufactured by race difference aids in the construction of these women as mere incubators, as not-related to the fetus that their bodies nurture, nor to the baby they deliver into existence. They are the modern-day equivalent to the wet nurse whose job was classified as another kind of manual labor. In addition, today, in India, poor women earn the equivalent of several years' salary acting as commercial surrogates for Westerners' frozen embryos that they "hand back"

after birth (Associated Press December 30, 2007). This practice adds a global economic dimension to the stratified commodification of (dis)embodied motherhood.

In her widely read book, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, legal scholar and public intellectual Dorothy Roberts (1997) analyzed court decisions that borrow from oppressive ideologies of reproduction. Legal victories for women that increase access to birth control, abortion, adoption, and new reproductive technologies, further subjugate women of color and others on the margins of society. Poor and minority women often have limited "choice" due to structural inequality (e.g., inadequate living conditions, dead-end jobs, and substandard healthcare), discrimination, and well-founded suspicion of the medical and legal establishments. The increase in choice for the more privileged group negatively reinforces race and class inequality. By placing greater and greater value on the creation of white babies—whether "naturally," through international adoption, or with technological assistance—we expressly devalue black babies. Moreover, essentialist attitudes about genetics privilege the creation of white babies and white families while casting families of color as inherently inferior. Researchers (i.e., Twine 2000, Gailey 2000, Ragone 2000, Rothman 2000, and Duster 2003) note this ideological trend among all parties in transracial adoption, interracial surrogacy, and interracial families.

Any procreative decision is racialized. This fact is rarely acknowledged. White Americans cannot procreate or adopt without encountering race politics and a eugenicist past. Race impacts life opportunities at every turn and becomes a major component in choosing a romantic partner. It is present in our decisions to adopt this child or that child, to have a child with a partner of a particular race, and to choose sperm from a man (or eggs from a woman) of one race or another. Race makes a difference, as Dorothy Roberts (1997) and Barbara Katz

Rothman (2004) argue, in whether a woman is valued or devalued as a mother or her children considered "precious" or a burden on society. Domestic or Third World adoption, or going to a sperm *bank* to choose a child from a *catalog*, all clearly commodified processes, are also, undeniably, racialized practices.

Class is an interrelated matter. Only women with the means and the social support can take advantage of many of the procreative options. They are likely to believe in genetic relationships, sometimes privileging that bond over the social parent-child relationship (Rothman 2004). This investment in genetic essentialism is not surprising since privileging genetic ties benefits them as successful whites in American society. Implicit in this way of thinking is the notion that poor or working class families, particularly racial/ethnic minorities, cannot give their children adequate opportunities, good genes, or the opportunities that good genes produce.

Feminist scholars also criticize the medicalization of procreation (Rothman 2000 [1989], Simonds et al. 2007), the simultaneous commodification and personification of embryos and fetuses (Morgan 2006), and the false promises of "embodied progress" (Franklin 1997). Anthropologists, influenced by Donna Haraway's (1991) proclamation that "we are all cyborgs now," began to accept that the "new world order" is permanent and to theorize the ways in which machine-human interdependence changes procreative experiences and related feminist politics (see Davis-Floyd and Dumit, eds. 1998). More feminist studies of infertility "refused to read ARTs as simply signing and sealing preexisting oppressive social orders" (Thompson 2005:70). There is room for marginalized groups to disrupt the social order (and challenge state oppression) by participating—on their own terms—in the very arenas that try to exclude them (Haraway 1991). Lesbian insemination has been frequently cited as one such example (Agigian 2004, Mamo 2007) and single motherhood-by-choice has been another (Klett-Davies 2007).

Shelley Park (2006) re-imagines adoption as a queer model of mothering, given the priority of biological and genetic kinship ties in American culture. She argues that heterosexual use of ART and adoption "queer" reproduction and help to normalize those avenues toward parenthood for gays and lesbians. Nevertheless, race and class inequalities predetermine who gets to use ARTs and/or go the adoption route and who gets excluded. Feminists problematize adoption's lopsided propensity to exploit the dire circumstances of one group of women to ameliorate the infertility of more privileged women (Brakman and Scholz 2006, Roberts 1997, Rothman 2004).

Yet, concerned about knee-jerk rejection of all things technological (read as inherently patriarchal), Sandelowski and de Lacey (2002) warn infertility researchers to think phenomenologically, by which they mean to strive to understand women's real experiences in critiquing the social impact of ARTs. These authors want feminist researchers who study infertility to recognize the intentionality of women's actions and in their meaning-making. Similarly, Brakman and Scholz (2006), who argue for a more broadly defined "embodied maternity" that respects the physicality of mothering in the absence of genetic ties or pregnancy, point out that the complexity of adoption stories belies numerous assumptions about women's motivations for adopting or for placing a child for adoption. As Adrienne Rich (1976) famously noted, motherhood is also a personal experience, not just a social institution. So too are infertility and childlessness. Understanding those personal experiences, then, may suggest ways in which oppressive institutions can be challenged, disrupted, and rebuilt.

Maternal Bodies and the Social Body: Empirical Studies of Infertility and Childlessness

Several ethnographic studies of infertility seek to explain that experience. A number of anthropologists (see Inhorn and van Balen, eds. 2002 and Inhorn, ed. 2009[2007]) demonstrate ways, cross-culturally, in which the infertile body becomes the site for negotiating the tensions of the social body, especially regarding nationalism, gender identity, religion, and marital norms. Infertility and childlessness occur everywhere and the social responses to these phenomena match the local historical, cultural, social, and political contexts. It is beyond the scope of this discussion to describe all of the international research, but I will mention a few notable studies that offer especially useful insights. For example, Lisa Handwerker (2002) indicates that the particularities of Chinese history and the cultural preference for male heirs have culminated into an obligation by infertile Chinese women to use procreative technologies in the pursuit of superior babies. Her work illustrates that feminist worries about a future of "designer babies" in America is not at all farfetched. Marcia Inhorn (2000) examines the infertility experiences of poor women in Egypt, experiences that exemplify the danger of compulsory motherhood for women who have no other life options outside of conventional norms (Inhorn 2000). Whereas wealthier Egyptian women facing infertility can find alternative societal roles, poorer ones are outcast. In an attempt to avoid that fate, impoverished women seek treatments—from both charlatans and medical professionals—that turn out to be life threatening and financially ruinous. Inhorn's is a cautionary tale; pronatalism and patriarchy combined with uneven access to safe and effective treatment can be disastrous. Catherine Riessman's (2002) work uses a symbolic interactionist perspective to delineate the ways in which infertile women in fiercely pronatalist India dialogically form positive identities in their later years in spite of their non-normative

social status. They avoid self-blame and emphasize the perpetual progress and plurality of their identities. Instead of being overcome by “bodily disruption” (Becker 2000), “spoiled identity” (Greil 1991, after Goffman 1964), or “role readjustment” (Matthews and Matthews 1986)—all conditions that require grappling with their inability to comply with the most basic cultural mandate for women and then to grudgingly re-situate themselves into a secondary role—the Indian women take a more self-accepting, philosophical approach that occasionally “reaches beyond” existing narratives of motherhood. Riessman also points out the need for research into infertility across the life course, an area I explore in this dissertation project and recommend—echoing Riessman—as an area requiring further examination.

The work of Sarah Franklin (1997), Gay Becker (2000), Gail Letherby (2002), Andrew L. Greil (1991), Judith Lasker and Susan Borg (1994), Margaret Sandelowski (date), Seline Szkupinski-Quiroga (2002, 2007) and Karey Harwood (2007) comprise the bulk of the ethnographies among infertile and childless women in Western societies. All but one (Letherby 2002) are book-length treatments and all are written by self-identified feminist sociologists and anthropologists. These works also share a certain recruitment etiology. The knowledge that they generate from in-depth interviews come from two primary sources: fertility clinics (in the U.K. and U.S.) and the RESOLVE organization. The latter is a national support group and information clearinghouse that originated in Boston in 1974. Researchers contacted members through newsletters and attendance at support group or informational meetings.

Thus, virtually all of the respondents, and most of what is known or understood about “infertile” women and couples come from a fairly homogenous pool that funnels in members who have an interest in medically assisted procreation. RESOLVE, imagined to be “a bunch of rich white people sitting around and going on yacht trips” by one of Szkupinski-Quiroga’s

(2002) informants, attracts those with the cultural capital, support group mentality, free time, mainstream identity and master statuses, and consumerist motivation that befit this kind of gathering. As Becker (2000) and her former graduate student Szkupinski-Quiroga (2002) point out, involvement with RESOLVE colors the experience of infertility; it trains people to set aside the stigma associated with infertility, to cope with their feelings (especially by providing emotional support to their [presumed heterosexual] "spouses"), and to approach treatment as informed consumers.

RESOLVE simultaneously contributes to the medicalization and psychologization (van Balen 2002) of childlessness, as do the fertility clinics, of course. The various interview schedules listed in the appendices of these (across-the-board) well-written and thoughtful ethnographies present another striking similarity. It is no wonder that these authors come up with consistent results. Largely in response to these scholars' calls for further research that includes women from different segments of society, part of this dissertation project involves interviews with women who did not interact with RESOLVE and who did not visit fertility clinics. (In the next chapter, I discuss how I found this comparison group and what happened when I attempted to ask them the kinds of questions these other researchers asked of their respondents.) Besides recommending innovative research directions, the existing ethnographies also offer fascinating, diverse theoretical perspectives with which to understand infertility and childlessness in the Western world.

Andrew L. Greil's (1991) *Not Yet Pregnant* represents one of the earliest, in-depth, qualitative investigations of infertility. He interviewed 22 married, heterosexual, white couples in the mid-1980s. Most were members of the RESOLVE support groups and all were currently seeking medical treatment for infertility. Greil, a sociologist, provides a broad cross-cultural

survey of infertility and childlessness, and draws on Erving Goffman's (1964) concepts of "stigma" and Barbara Katz Rothman's (1982, 2000[1989]) feminist theories of motherhood and mothering to understand infertile couples' meaning constructions surrounding medical treatment, social pressures to become parents, partnership strain, and personal identity. For his respondents, infertility is a liminal, status-less state of being that they describe as "not yet pregnant." The differences between men's mere disappointment at infertility and women's devastation reflect the deeply gendered meanings of parenthood. In a departure from feminist critiques of patriarchal doctor Frankensteins who push the new reproductive technologies, Greil finds that women—whose class status tends to be equal to or greater than that of the doctors—"demand" the (ever riskier) treatments. Greil urges scholars to take infertility seriously as a major life crisis that causes inordinate suffering, as a social problem worthy of study, particularly due to the need to inform public policies that increase treatment quality and access.

If women had agency, they could redesign their lives in response to infertility. Such is Gay Becker's (2000) conclusion in her influential study on "bodily disruption" in *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. Becker, a medical anthropologist, explores the identity transformations that occur among the 300 plus infertile couples who she and her graduate students interviewed. Following the initial disappointment and then a liminal period, these predominantly white, middle class and professional couples craft novel social scripts that give them more agency. They find the power to reject socially predetermined plots of gender and infertility as they make their way through the fertility "journey." Social expectations strongly influence their subjective experience with infertility, but do not completely define that experience.

Gayle Letherby's (2002) work also challenges the assumption that infertility and involuntary childlessness always results in a negative experience. In her study, which solicited letters from RESOLVE participants, mostly white, middle class and professional women, she found great variation in infertile women's experiences with "identity disruption." Letherby noted that many women saw their experience as an opportunity to grow and change in positive ways. These women did not reflect the stereotype of desperate, damaged, and easily manipulated by treatment providers. In addition, Letherby contributes a Foucauldian framework that recognizes how changing discourses shift the source of social power. She sees the current vacuum in the public discourse of infertility and involuntary childlessness as an opportunity to tap into new regimes of truth that benefit women, rather than patriarchal and capitalistic interests.

In their classic, *In Search of Parenthood* (1994), Judith Lasker and Susan Borg analyze interviews with over 200 infertile men and women as well as a number of experts. These authors focus on how uncontested use of reproductive technologies ripples outward to affect many groups. They consider the disapproval of, support from, and impact on friends and family, children born of high-tech intervention, donors and surrogates, and the infertile couple. Lasker and Borg also consider the social consequences of the growing prestige and power enjoyed by the providers of assisted reproduction. These authors caution against increased patriarchal controls of the procreative process that they see inherent in the commercialization and medicalization of reproduction.

Seline Szkupinski-Quiroga's (2002) soon-to-be-published dissertation is the only qualitative work I know of that addresses race and infertility. She analyzed the interviews of 35 couples in which at least one member of the couple was a person of color (15 Asians, four African-born, three African American, one Native American, five Latino). These 28 individuals

of color represent fewer than five percent of the participants in Gay Becker's larger research project discussed above. Szkupinski-Quiroga focuses on how infertility intersects with not only gender identity but with a racialized gender identity. The politics of race and reproduction outlined by feminist historians and black feminist scholars provide the backdrop for her analysis which builds on the theory of stratified reproduction (Ginsburg and Rapp 1995).

British feminist Sarah Franklin (1997) writes and presents extensively on the new procreative technologies. Her book *Embodied Progress: A Cultural Account of Assisted Conception* (1997) emphasizes the ways in which assisted conception obscures and disputes the "facts of life" and challenges local knowledge about kinship. Her interviews with 22 white, middle class women in their mid-thirties to mid-forties who were currently seeking IVF treatment also shows that medicalized reproduction synthesizes iconographic images of "desperate" infertile women and their "miracle babies" with the hope of technology, a pairing that "embodies progress." As part of the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINNRAGE), Franklin takes an activist stance that is suspicious of medicalized procreative technologies.

Karey Harwood's (2007) slant originates from what she calls "Christian-feminist" ethics, a perspective that she only vaguely defines, presumably relying on the reader to know what she means. In any case, Harwood values women's needs for "generativity" but criticizes the consumerist and "never enough" (Sandelowski 1991) or "treadmill" quality of reproductive technologies. Again, gleaning participants from a RESOLVE chapter, this time in Atlanta, Georgia, she takes field notes in meetings and interviews a handful of willing respondents (n=9). Harwood decides that the RESOLVE organization helps construct infertility treatment (and the support group) as a ritual that gives weight and meaning to the struggle and also helps women

cope with infertility but does not prevent them from “destructive overconsumption of ART” (157).

A final, more obscure, interview study, by British social worker James Monach (1993) provides a twist on all of the foregoing ethnographic literature. He studied exclusively *working class* patients at a public fertility clinic in England. Though decidedly therapeutic in his analysis, Monach wants the medical establishment to cease victim-blaming (i.e., unexplained infertility is due to “stress” rather than the limitations of medical knowledge) and foster more realistic expectations for ART and the adoption option. Few adoptable children are available and the home studies effectively shut out the working classes from that route to parenthood. Like Greil, Monach uses the concept of “spoiled identity” to explain the distress experienced by his respondents.

I discuss here the most relevant social science articles gleaned from the comparatively few in circulation on infertility and childlessness (an artifact of ongoing academic discrimination against these topics). First, Matthews and Matthews (1986) offer a theoretical framework for understanding the “transition to nonparenthood” as reality reconstruction, identity transformation, and role readjustments necessary to get past the stigma and pain of infertility. In spite of rapid technological and social changes, this theory holds up to some degree in studies of white, middle-class married couples but completely falls apart when lesbian and single women’s prospects for motherhood are considered or when one takes into account the historical constructions of mothers and childlessness among the working class, poor, and racial minorities. Another article, by Israeli nursing scholar Daphna Birenbaum-Carmeli (2002), makes a global comparison of the impacts of discrimination and the social implications of IVF for women who are poor, racial minorities, single, and/or lesbian. She concludes that the disciplinary power of

IVF on infertile women is still under contention and calls on scholars to take part in this struggle for ideological control. Similarly, feminist psychologists Miriam Ulrich and Ann Weatherall (2000), who analyzed 19 infertile women's reasons for wanting children (summarized as instinct, a relationship stage, and social expectation) and their feelings of guilt and failure surrounding infertility, insist that broader definitions of motherhood are needed.

Decrying the wholesale medicalization of women's procreative functions, Sarah Earle and Gayle Letherby (2007) extend Wendy Simonds' (2002) work on the coercive power of the "time" concept. Their research compares the preoccupations of pregnant women and infertile women with trying to get pregnant in time and at the right time, concepts that re-route control and procreative self-determination away from them. Maggie Kirkman's (2008) interviews with 21 women who received donated eggs or embryos highlights ways in which these practices can simultaneously affirm and contest dominant discourses. The pursuit of motherhood reifies that role as a prime factor of womanhood but the privileging of these women's nurturing relationships with their children over genetic ties upsets the master kinship epistemology. I suspect, though, that the biologic notions attached to maternal bonding through pregnancy, childbirth, and breastfeeding (sometimes) supersede genetic connections in the popular imagination. Egg donors (who usually have lower class status) are generally not thought to be the "real mothers" of the children gestated in another's womb unless they are also the "intended" or "contracted" mothers (in which case they have higher class status) in a surrogacy scenario. Prevailing medicalized discourses strive to cast egg donors as analogous to sperm donors (the much greater medical involvement, level of health risk, and time demands of egg donation make it impossible to honestly equate these). For these reasons, I doubt Kirkman's assertion that her respondents offer a promising site of resistance. Rosemary Gillespie's (2000) work with a score

of voluntarily childless women, on the other hand, found that despite the “disbelief, disregard, and [accusations of] deviance” that they put up with in their social interactions, these women deflect discursive attacks on their femininity. Though they compensated mainly by aligning themselves with other repressive stereotypes of femininity (e.g., via appearance norms or the selfless nurturing of pets), they remained unapologetic for their childlessness.

Current social research continues to paint a grim picture of the infertility experience and access to treatment. McQuillan et al. (2009) demonstrate a negative association between lifetime infertility and life satisfaction among a random sample of 580 midwestern women. Katherine Johnson (2009) argues that barriers and subtle discrimination by fertility clinics slow full-scale participation in these procedures by lesbians and single women. Preliminary results of a study of Latino couples getting infertility treatment in San Francisco suggest that men and women in this cultural subgroup both describe the experience as detrimental to their self-identities (Inhorn et al. 2009). This finding, which does not conform to the gender division of the emotional pain of infertility seen in studies of white couples, substantiates the hypothesis that social status influences the psychosocial impact of infertility. In recent work, Greil et al. (2009) conduct a quantitative investigation to account for distinctions in helpseeking behavior between racial groups. African Americans and Latinos, being more inclined to have procreative difficulties, and counterintuitively (to those who take an ahistorical, astructural view), are less likely to pursue treatment. Greil et al. delineate the individual cues (e.g., interest in parenthood) and social cues (e.g., family encouragement) that contribute to this disinterest in assisted procreation. Sociological researchers (Abbey et al. 1992) applied structural equation modeling in a study of 185 white, middle-class, married infertile couples recruited from infertility specialists and self-help groups. The authors examined the interactions of self-esteem, perceived internal control,

and interpersonal conflict on the amount of infertility-related stress reported by the husbands and wives, concluding that infertility negatively affected life quality more so for the women than the men. This finding has become so common that it has taken on the characteristics of a stereotype.

Two new edited volumes, *Reproductive Disruptions: Gender, Technology, and Biopolitics in the New Millenium* (2009[2007]), edited by Marica Inhorn, and *Marginalized Reproduction: Ethnicity, Infertility, and Reproductive Technologies* (2009), edited by Lorraine Culley, Nicky Hudson, and Floor Van Roolj, present the latest theoretical currents in the study of infertility and childlessness. The former book provides an overview of the primary messages in over 150 ethnographies on women's health and connects these messages to fresh thinking about "reproductive disruptions," a term that Rapp and Ginsburg (2001) use to describe threats to the "standard linear narrative of conception, birth, and the progress of the next generation" (Inhorn 2009 [2007]:ix). The authors—mostly anthropologists reprising their earlier empirical studies—cross-cut the life course in considering issues of childbearing (Bledsoe and Scherrer 2009 [2007]), pregnancy loss (Layne 2009 [2007]), prenatal diagnoses (Browner 2009 [2007], Rapp and Ginsburg 2009 [2007]), adoption (Grotevant 2009 [2007]), contraception (Sargent 2009 [2007]), infertility and ARTs (Inhorn 2009 [2007]), and women's "post-reproductive" life (Lock 2009 [2007]). These works investigate the boundaries of "normal" procreation as it is produced and reproduced within particular cultural systems. The other volume, *Marginalized Reproduction* (2009), represents the first published book to address ethnicity and infertility. The authors, of disparate disciplines and critical perspectives, share "a concern for exposing the hegemony of the dominant perspective of infertility as a concern of Western elites…coupled with a strong plea for providers of infertility services to carefully navigate the difficult terrain of taking into account the broader social and cultural context of the infertile patient" (5). Lorraine Culley (2009)

exposes the misguidance of researchers and medical professionals who blame the differentials in access to fertility treatment and adoption on intragroup "cultural" factors when, in fact, structural disparities and discursive power are at work. The tensions of acculturation, religion, and Western biomedicine are other primary components of the analyses in chapters on non-Western migrants to Western countries who find they must negotiate "impaired fertility" in unfamiliar contexts. A final chapter by Marcia Inhorn, Rosario Ceballo, and Robert Natchigall offers a sweeping glimpse into these authors' current research into the infertility of Arab Americans in Michigan, Latinos in the San Francisco Bay Area, and African Americans in Detroit, Michigan. Their interviews with mostly low-income, married couples recruited from infertility clinics indicate that the demoralizing, gender-disruptive impacts of diagnoses parallel those of white, middle-class couples except that there is the added frustration of an inability to pay for medications and NRTs. The authors write, "unwanted childlessness leaves a void for most Latina women that nothing else can fill" (189). African American women are said to "cope through religiosity and spirituality" when faced with infertility (188). And the mostly unassimilated Arab Americans, who, as Muslims are prohibited from using donor gametes or adopting, were frustrated at their inability to afford IVF.

None of these studies have been able to include the majority of infertile and involuntarily childless women who do not seek treatment. Most qualitative and quantitative studies focus on a narrow group: white, middle class, married women, whose traits are shared by the collectively imagined ideal mother and the "desperate" infertile woman. This dissertation attempts to broaden the range of voices and hence reveal the complexities of power relations and the potential for counternarratives.

Besides attending to the historical context, drawing on the feminist debates described above, and contextualizing my results with previous research findings, I borrow from several theoretical traditions to interpret infertility and childlessness. Marxian critical theory (after Davis 1981, Gramsci 1971, Lukacs 1922, Marcuse 1964) provides one lens for understanding the relations of power in procreative politics, particularly the macro-level influences. Throughout the dissertation, I play close attention to structural issues of class and race and the impact of these on the respondents' experiences. Symbolic interactionist approaches (after Blumer 1969, Mead 1962, Goffman 1967) illuminate women's negotiations of the available narratives in their social interactions. The emphasis on the centrality of language that symbolic interactionism promotes offers an opportunity to build an explanatory model via my interpretation of the interview transcripts. In other words, this theoretical tradition undergirds the method I use for the analytical phase of this research. I also attempt to heed Sandelowski's and de Lacey's (1992) call to consider phenomenology, to piece together the ways in which *a priori* social assumptions inform the construction of common-sense knowledge (after Husserl 1936, Heidegger 1929, and Schutz 1967). Basic ideas about motherhood, femininity, and womanhood have a tendency to be essentialist and deterministic. Recognizing that this phenomenon structures the study participants' beliefs and interactions is equally important to an awareness of the inter-class, inter-gender, inter-race power dynamics that also shape beliefs and interactions. Focused study on the interactions themselves is enhanced by attending to these angles.

To account for the very real overlap between kinds of knowledge—that is between scientific knowledge and everyday understandings—I pair Foucauldian (1977, 1979, Rabinow, ed. 1984) concepts of discourse, medicalization, discipline, and biopower with black feminist thought (Collins 1983, 1991; hooks 1999[1990]) which privileges experiential knowledge and

intersectionality—various social statuses like race, gender, age, and sexual identity cumulatively and individually affect social life. Although I cannot help but be sensitized to these aforementioned perspectives, I attempt to build new theory to add to and adjust the pre-existing scaffolding. That is, I endeavor to go beyond the descriptive and confirmatory, attempting instead to enter the realm of the explanatory. For instance, I explore the social processes (i.e., relative notions of *identity sufficiency, decisive efficacy, role applicability,* and *normalizability*) in the context of motherhood/otherhood) that underlie some ways of re-defining women: as the "ambivalent childless" and as the "pragmatic infertile." The following chapter outlines the methodology necessary to complete this objective.

CHAPTER 3: RESEARCHING WOMEN

"All research of 'the other' is imperialism," insisted a classmate in my graduate qualitative methodology course. This remark sent my thoughts into a tailspin. *He's right! What have I gotten myself into? How can I in good conscience conduct work that benefits me but exploits others? Who am I to say that what I produce is going to inform better social policies or have any measurable positive effect whatsoever on people's lives?* Feminist sociologists and anthropologists share these concerns, and for over 30 years, they have tried to address them by developing methodologies that seek to minimize the inherent inequality between researcher and subject. Images of white-coated "experts" peering over their clipboards at people-cum-specimens smacks of patriarchy and class privilege, two institutions that feminists want to destroy. Even the term "subject" is notoriously problematic in its linguistic polarity with "master," truly an imperialistic relationship.

Sociologists—who occupy relatively prestigious, educated, middle-class social positions—often study the underclass and usually concern themselves with disempowered populations. In face-to-face interviews and ethnographic interactions, the social distance between the groups can be nearly impossible to hide. Symbolic cues like clothing, language, university or agency affiliation, and lifestyle mark the class differences. Researchers have long realized this and noted the impact of social distance on the quality and validity of the resulting data (Spradley 1979). While it is possible to sidestep this problem by choosing projects that involve participants with equal or higher social status or confining analyses to archival data or census statistics, there remains a need to "give voice" to more marginalized groups (Harding 1987, Gorelick 1996, Reinharz 1992, DeVault 2004). Of course, researchers arguably lack the power to give voice to

the presumed voiceless—they are a bit delusional and self-important if they think their research studies represent the only conduit for expression or social change. Their work does offer, however, analytical insight, contextualized findings, and, yes, the weight of institutional authority, to real-world social phenomena. Interpreting the words and experiences of subordinated groups is essential to this task.

Assuming that these contributions are worthwhile, sociology provides valuable methodological and theoretical tools for understanding people's lives, for recognizing social disparities, and for offering well-reasoned solutions to social problems. Salient components of methods are the formulation of research questions, recruitment, sampling, data collection, and analysis. It is not enough to ask the right questions or to view data through a feminist lens; the process of obtaining that data needs to be sensitive to feminist values as well (Cannon, Higginbotham, and Leung 1991).

Sociologists differ on what constitutes feminist methodology (Acker et al. 1983 Gorelick 1996, Harding 1987, Reinharz 1992, Thompson 2002b) but they consistently agree that it does not refer to a prescribed set of methods (e.g., Clegg 1985, DeVault 2004, Gottfried 1996). Instead the blanket term "methodology" refers to the way researchers conceive of and practice a variety of methods (Ramazanoglu and Holland 2002). Marjorie DeVault (1996:31-34) recommends several strategies to enhance a feminist approach, including bringing women in as researchers and as subjects, minimizing harm and social distance, and working toward positive social change. Others (e.g., Fonow and Cook 1991, Oakley 1981) focus on the emancipatory power of the research process itself. In approaching this project, I expected my interference in respondents' lives to be totally innocuous—I strived for harmlessness—but I doubted there would be any liberating potential to the interviews. I was wrong on both counts.

Recruiting a Nonexistent Population

The robust literature on feminist methodologies in social research somehow misses recruitment as a situation needing special sensitivity. Based on my experience with a project in which the research team encountered practical and ethical difficulties in recruiting (Wilson, Sterk, and Elifson 2003), I knew going into this one that the process called for a thoughtful, feminist approach, and that finding participants would pose the biggest challenge to completion.

First, I was attempting to locate a hidden, stigmatized population. Women who are infertile do not look any different from other women. I could not spot them on the street. If infertility were my only criteria, I could find participants through fertility clinics and the RESOLVE support group as other researchers have done (Becker 2000, Greil 1991, Franklin 1997, Harwood 2007, Lasker and Borg 1994, Letherby 2002, Monach 1994, Sandelowski 1994, Szkupinski-Quiroga 2002). But all of those projects, as mentioned in the last chapter, rely on the observations and experiences of a narrowly-defined population of women, who approximate the ideal in the psychological and medical literature, in advertising for infertility products and services, and in the popular imagination. The aforementioned sociologists and anthropologists generally concur that their data would be richer if they had been able to include women and couples from a broader swath of society. Following their recommendations, I wanted to talk with women from other social groups and with women who were not in treatment.

Qualitative research does not call for a representative sample. Rather, the impetus for choosing respondents based on their gender, race, sexual identity, age, marital status, and other social factors is to tap into the widest range of experiences feasible, all for the purposes of theory-building (Goodwin and Horowitz 2002). Convenience sampling, though never ideal, is

appropriate to this exploratory study, especially so given that infertility researchers have long been stymied on *how* to stratify (i.e., broaden) their study populations (Becker 2000, Greil 1991, Letherby 2002).

I obtained approval from Georgia State University's Internal Review Board (IRB) for the study and for recruitment flyers. I posted flyers on public bulletin boards, focusing on low-income neighborhoods in an effort to find poor and working class women to interview. My colleagues, peers, and professors each received flyers in their mailboxes with a plea from me to share them with anyone they thought might be willing to be interviewed. I gave them to students, too, but I never received any calls from the flyers. These impersonal solicitations were ignored probably for several reasons. The average American encounters several such advertisements daily and often tunes them out, infertility is personal health information and not thought to be the business of strangers, Georgia State University was not recognizable to any Californians who saw it on the flyer, and "infertility" turns out to be meaningless to many women who might be medically-designated as such.

I interviewed two experts who work at fertility clinics and tried to elicit tips from them in finding respondents; they were at a loss since few of their patients fit my criteria. I wanted to talk with women who did *not* fit into the standard, idealized image of infertile women (i.e., white, middle-class, and married). When attending a work-related training near Oakland, California, a San Francisco Bay Area city known for its large African American community, I met many poor and working class African American women and told them about my project. One woman, I will call her Patricia, knows several women "who can't have kids" and she promised to put me in contact with them. While I was in the area, I attended three orientation meetings held by Black Adoptions, a private adoption agency. I reasoned that these meetings might draw infertile

African American women, plus I was interested in adopting a child and I wanted to gather information on that. The agency director granted me express permission to go to the meetings, to make an announcement about my project, and to individually approach attendees. After finding success with this tack, I attended similar meetings in two other communities, one predominantly white and the other Latino.

The sample snowballed from there. All 25 of my respondents were found through personal contact with me or by word-of-mouth. Several were referred by Patricia; I paid her five dollars for each. This constitutes a tiny finder's fee but Patricia, who was woefully underemployed, appreciated the incentive as an easy way to make a few dollars. Before reaching into her vast social network—she was a longtime area resident and nontraditional student (in her mid-forties) at two local community colleges—she grilled me on my research objectives. She was initially wary about any studies of black women, given the terrible history of exploitative research and her questioning seemed designed to determine if I had any racist goals in mind. For example, she asked me if I thought black women "had too many kids." I satisfied Patricia by indicating my political leanings, emphasizing my willingness to "learn" from others, and, finally, by helping her with a complaint she had about a college program (I had some clout in that arena). I was keenly aware that my self-presentation was vital to gaining access (Fontana and Frey 2000). As Claire Sterk (2000) recommends, I established trust (and a reason for her to reciprocate) by doing a favor for a gatekeeper.

Not only was this active recruitment perhaps the only way to find participants in a timely manner, it is probably the most "feminist" or woman-centered approach in that it relies on establishing personal trust via individual interactions (even if once removed) rather than relying on the public confidence that is reflected on the researcher from his or her institution's

reputation. These two scenarios likely engender unique sets of expectations on the part of the prospective respondent, and probably attract different types of people. The former would ideally be seen as a collective endeavor while the latter may well be interesting to some as a way to do something important, to “contribute” to science—a frequently mentioned “benefit” to participation in interview studies (e.g., Lasker and Borg 1994, Harwood 2007, Kirkman 2008, Sterk-Elifson 1993).

In keeping with a feminist methodology, I held to these strategies: 1) chatting casually with potential informants like a friend might (to mask social distance), 2) including unlikely candidates in these conversations (to prevent individuals from feeling singled out), 3) answering and soliciting questions and insights about my project (to foster a collaborative attitude), 4) emphasizing (truthfully) that they would be helping me out and downplaying the monetary “gift”/compensation for the interview (to make it clear who was really benefitting), 5) refraining from “pushiness” while still attempting to get a solid commitment (to avoid subtle coercion), and 6) encouraging them to suggest the venue (to maximize their comfort). Marjorie DeVault (1996) notes that feminist methods are fairly indistinguishable from pure and simple “good” qualitative research. She argues that the intent on the part of the researcher and a willingness to cede control as much as possible are the hallmarks of a feminist approach. In the same vein, Cotterill (1992) stresses the ethics of pursuing interviews and lines of questioning in less aggressive ways. It is better—more sensitive to others—to let go of the idea of interviewing a particular person or of understanding an aspect of their experience that they do not wish to talk about than to push them into it.

Recruitment for this study posed a few ethical dilemmas. I am not by nature gregarious with strangers, nor do I engage in much small talk with anyone. To set prospective interviewees

at ease, I acted friendlier—it felt to me like flirtation—than I ordinarily would have. I never felt able to balance in my mind the risk/benefit equation in which any emotional risks to respondents would be outweighed by the benefits of the research to society (see LaRossa et al. 1981). Instead, I sometimes felt that I was hustling for research subjects. I later discovered many of the women I interviewed were lonely and that loneliness may have contributed to their interest in taking part in the interview. They appreciated the attention, and whether or not that benefit superseded the fact that I was unwittingly taking advantage of them by offering (token) friendship for a time, I cannot say for sure.

Another major challenge of recruitment was the word—indeed the concept—"infertility" itself. Everyone knew what it was, but only a few of the respondents truly identified as such. I tried asking around for women who "wanted kids but couldn't have them," even going so far as to get IRB approval to replace "infertility" on my flyer and consent form to "want(ed) children." After conducting a few hard-won interviews, it began to dawn on me that women were so ambivalent about whether they wanted children or not, so disinvested with medicalization and its terminology, and so pragmatic and unclear about their current fertility status, that a concept that signified desperation, devastation, and a single-minded drive to have children simply did not resonate with them. This finding that first emerged in recruitment obstacles was fleshed out in the interviews and eventually became the defining result of this project.

I had to find study participants and if there were no "infertile" women from marginalized groups then I had to expand that criterion. I began looking for women who did not have children as well as infertile women. By choosing not to specify whether or not the childlessness was voluntary or involuntary, I figured, I could find more participants. This stratagem worked, though seven referrals fell through when the women declined to be interviewed. From what I

could tell, doing the interview was too inconvenient for most of these women, and too painful for one (an elderly neighbor recommended by another respondent). All of the women I met face-to-face and asked for an interview ended up participating. Table 1 provides a demographic summary of my study sample. All names used in this dissertation are pseudonyms, a few chosen by the respondents themselves; I attempt to preserve the ethnic origin suggested by their actual names. All of the women listed as infertile are either medically or personally identified as such, but that identification occurs along a spectrum and none are "definitely" infertile. For women with no knowledge of their fertility, I indicate either their childlessness, their menopausal status, or both. I include occupation as an imperfect proxy for class; the benefit of using occupation is that the category taps into common notions of prestige. Though I inquired about related statuses like income and educational attainment in order to more fully gauge class status, there were limitations in their utility. For example, one respondent (Hannah Jacobsen), a part-time teacher, earns the least amount of money of nearly all of the other respondents, but she has a doctoral degree. Serena Lopez, a laboratory technician, has the highest income yet she lacks a college education. The differences in educational requirements as well as the autonomy intrinsic to teaching as contrasted with the layers of supervision assumed to exist for a laboratory technician play into our shared ideas about occupational prestige and the related idea of social class. Education is another problematic marker for class among the women in this study sample. Emily Reilly, for instance, holds a bachelor's degree from a California university but she manages a fast food restaurant, not an occupation that brings with it prestige or income. I attempt a classification nonetheless. Most (n=15) of the participants could be considered "working class." There are 10 participants who I assign the descriptor "middle class" on the basis of education and

job prestige and these include: a project manager for a bank, three teachers, a life coach, a therapist, a guidance counselor, two fertility counselors, and a civil engineer.

For sexual identity, I use the term “queer” to describe participants who identify as neither straight nor lesbian but who have had serious romantic relationships with both men and women. The race/ethnicity descriptions also reflect their self-reports; two (Zara Senai and Azra Alic) are naturalized citizens and the rest are U.S.-born. “Secondary infertility” means that the woman has at least one child, wants or wanted more, but cannot have them biologically for medical reasons.

Interviewing Interlocutors

Qualitative interviewers need to establish rapport in order to elicit better, more in-depth interviews. I attempted to make the interview appear like a conversation, or “coffee-klatch” between two woman friends. My initial goal—guided by feminist principles— was to set the respondent at ease and to make the interview a pleasant experience. To reduce social distance I presented myself, less as researcher, but more as a woman and as a student. One researcher (Murray 2003) uses Goffman’s (1961) concepts of “front stage” and “back stage” to describe how she traversed her multiple identities in the field. Like her, I cannot deny that an element of stage managing was at work. I wanted the participants to view me as a friend, an equal, or even as a bit below them in status as I took on the role of “learner” (see Wax 1960) and guest, and I wanted them to become the authority and the hostess-entertainer. But my obscured role as the one controlling the interview and the later interpretations made my actions somewhat insincere. However, it is important to give my respondents credit for recognizing this tension and for their

intentional role-playing as both amiable acquaintance/host and as subject. In adition, most of them seemed genuinely pleased that I valued their experiences and opinions.

Setting the Stage for a Good Conversation

Ostensibly to show my appreciation and, latently, to firm our respective roles in the interview, I gave a small hostess gift to each respondent as many women do when invited as a guest to a friends' home. Depending on the venue and what I knew of the individual, I brought flowers, a bottle of wine, gourmet coffee drinks, baskets of strawberries, and, in one case, a pack of cat-themed playing cards for a respondent who told me she was "obsessed with cats." I also bought lunch on a few occasions, particularly for those with low incomes. Because I wanted to avoid highlighting our class and income differences, I suggested that the university grant I had received would cover the cost, an explanation that was well-received.

The interview setting is undeniably relevant to the outcome of the interview. In their discussion of the ethical dilemmas of qualitative research with families, LaRossa et al. (1981) note that the "home ambience" fosters the perceptual conflation of the researcher with a friend, probably opening the door to more intimate disclosures. Feminist methodology suggests that removal from institutional settings yields better, more humanistic one-on-one interactions. Padfield and Procter (1996) reveal that woman-to-woman interviews are also more likely to garner more detailed responses and volunteered elaborations than those interview dyads that are not gender matched. Thus, a woman interviewing another woman in one of their homes is perhaps one of the most likely ways to gain insights into personal and private experiences; it is also a setting ripe for the production of an emotionally exploitative relationship (Stacey 1988).

Fourteen of the interviews took place at the home or office of the respondent. These were places where they were most comfortable. Except in cases where I brought drinks, they always offered me something before we settled in for our "conversation." These women were also in charge of where we sat in relation to one another. In most cases we sat on the floor or on couches, and in two instances we spoke quietly while infants napped in a nearby room. One woman, Annette Kramer, is a psychotherapist. She sat in a large, tall office chair and I sat on the couch, literally and metaphorically. There was no doubt in this case who had authority and who did not. Though I posed the questions, she often as not, gave terse answers followed by a comment on the quality of the question. Ralph LaRossa (1989:231) writes, "good informants…do not constantly analyze their responses as an outsider would." Annette Kramer, on the other hand, retained her accustomed role as the powerful diagnostician and interpreter of others' thoughts and feelings and that dynamic began with the setting (her office) and seating arrangement. We were on her territory. A similar outcome resulted from my interview of one of the infertility clinic experts; she provided rehearsed answers and often ignored the content of my questions. Once again, I found myself seated on a low couch—where I later sat as a patient—looking up at her in her high office chair. She perceived me less as a researcher and more like a reporter/prospective patient and the interview went accordingly.

Two interviews happened at my home. In these situations, we talked in the living room over tea and cookies from a local bakery, as I tried to make them feel as comfortable and special, like honored guests. One of these women, a friend of a friend of a friend, was similar to me in terms of class status and education and, coincidentally happened to live in the neighborhood, all of which apparently helped her feel quite at ease if her forthrightness is any indication. The other was an acquaintance who had been to my house before. Any imbalance to the relationship may

have been largely mitigated by familiarity with the surroundings. On the other hand, the three interviews that took place in my office posed a greater challenge. First, all three women were low-level staff at the large college where I work as an instructor, a higher level position in terms of pay, autonomy, and prestige. They chose to come to my office because of its convenience and because they could come during their work day. That they were being paid for their time and, at the same time, they were able to break up the routine or monotony of a typical day, were two factors in favor of a positive experience. I was acquainted slightly with only one of them, so I worked hard to downplay any social distance. I provided tea, coffee drinks, and desserts to simulate a tableau of friends chatting over a treat. Still, my desk was between us, symbolizing my relative position of authority.

I conducted three interviews in my car. This was the least comfortable interview setting because we were forced to look straight ahead much of the time. However, we were in close proximity to one another and that seemed to enhance the intimacy of our conversations. We sipped our coffees and nibbled on pastries as we talked. Finally, three interviews took place on neutral territory including an empty courtyard at a public library, a private room in a restaurant chosen by the respondent, and a study room at a college library. The first two of these were less than ideal because there was a great deal of empty space around us. It did not feel like a natural environment for friends to get together, but it did preserve our privacy. The study room was a good place for the interview except for the fact that the respondent was a student and, even though I taught at another school, I was a teacher. My casual dress probably helped equalize us to some degree (I noted that the instructors at that school dress in business attire). In fact, for all of the interviews and for the outreach efforts, I dressed like a student might, in jeans, t-shirts, and sneakers, a look that fit with my presentational aims.

Listening and Learning as Feminist Praxis

Some feminist sociologists (e.g., Collins 1991, Mies 1991, Oakley 1981, Stanley and Wise 1983) prefer qualitative research for its constructivist bent. Others find plenty of room for feminist methodologies using quantitative methods too (e.g., DeVault 1996, Letherby 2003, Reinharz 1992). Nevertheless, qualitative methods like in-depth interviewing attempt to extract—while also inductively constructing—social *meanings*, which are notoriously hard to capture or elicit in close-ended surveys. The idea is that women, especially those with multiple marginalities, have "epistemic privilege" (Harding 1991) or experience-based insights that may diverge significantly from dominant narratives. Respondents' ontologies send the research into new directions, and, in effect, the respondents are interlocutors, the co-authors of created knowledge.

Nevertheless, there are ethical pitfalls intrinsic to intimate, face-to-face interviews such as increased potential for exploitative relationships (Cannon, Higginbotham, and Leung 1991), intrusion on privacy (there is confidentiality but no anonymity), and the discomfort associated with certain personal topics (Riessman 1987). These concerns were foremost in my mind when I began the interviews. Moreover, I was worried about balancing authenticity with my research goals. In other words, how could I show my respect and appreciation for their time, frankness, and confidence without also manipulating them into giving me all of that? For example, when I feigned ignorance about topics that arose, was I being disingenuous in order to get them to explain their thinking in more detail or acting like any good listener by letting them vent their feelings and ideas?

I conducted one interview per respondent and most interviews lasted between an hour and a half and two hours. It was necessary to cut two interviews short (to about an hour each)

when the participants (mentioned above) were unforthcoming; and a couple of interviews went on for three hours. Nearly all of the respondents talked off tape to a significant degree. They visibly relaxed when the tapes stopped and often provided back stories to accompany previous responses. I frequently obtained their permission to turn the tape back on or to take notes, as these off-the-cuff remarks were invariably informative. Clearly, the knowledge that they were being recorded influenced their answers. It is not that they were avoiding saying certain things "on the record," rather, I suspect that they restrained themselves in an effort to stay on topic; they were trying to be accommodating.

Prior to starting each interview, I spent some time chatting with the interviewee, going over the consent form, and explaining that I hoped we could have a "conversation." I encouraged each woman to take breaks, change the subject, refuse to answer uncomfortable questions, ask me questions, and let go of any concerns about what I wanted them to talk about. Pointing out my interview schedule, I typically said that I might look at it some but that we did not need to cover all the questions on it; it was just there to jog my memory if needed. Indeed, I rarely looked at it because it would sometimes cause the respondent to stop talking and to look at the questions, too. However, I approached the interviews knowing what I wanted to ask about. Previous research findings and the gaps in these inspired many of the questions (Appendix 1) and I could remember them easily.

At first, the questions fell flat. Asking things like, "How did you first discover your infertility?" and "How do others react when they find out about your infertility?" meant nothing to women for whom "infertility" was a "yuppie disease," not relevant to them. As with the flyers, I tried substituting "want(ed) children" only to discover that the women were too ambivalent about that idea as well. At this point, I allowed for a more free-flowing type of interview, only

loosely following the structure of the prepared interview instrument. This move was necessary to begin to understand where these women were coming from and how they constructed their (in)fertility and/or childlessness. Allowing respondents to reflect on questions at their own pace and to meander around the main ideas not only aligns with feminist objectives toward a friendlier research process, it is also good qualitative practice. One cannot do away with an interview structure altogether, but as long as the questions touch on topics of "conceptual equivalence"—the inquiries elicit respondents' ideas about the same general subject matter—the resulting transcripts will be comparable and sufficiently analyzable (LaRossa 1989).

My efforts to convert the interviews into some kind of conversation-interview hybrid were in vain. Instead of strictly relegating my part to asking questions and probes, head nodding and mm-hmming, I occasionally remarked on my own experience. This practice was inspired by Patricia Hill Collins' (1991) call on researchers to recognize that black women, for example, tend to strongly value dialogue. The comments I made were carefully selected so as not to sound like I was passing judgment or wanting the interview to go in a different direction. I talked not because I could not refrain from interjecting my own thoughts, but because I thought it would engender a dialogue more like that between friends. I wanted to reciprocate by sharing personal information like girlfriends are wont to do. This strategy failed.

The women being interviewed either listened politely—but not encouragingly—then launched back into their story, or else they talked over me. None of them asked me questions during the interview. They were invested in the interview as an interview, not as something akin to friendship. Similarly, Elizabeth Bott (1971[1957]) discusses how her research teams' attempts at less-structured, more casual and friendly interviews with couples made the respondents "anxious," causing her to abandon that technique. Like Bott, I had underestimated the power of

the implied dynamic of an interview (see Weiss 1994:65). As Fontana and Frey (2000) say, we are an interview society and the respective roles were already "known" and assumed by the participants in this study. I constantly learned from the interviews about the effectiveness of my approach; sometimes the participants gave outright evaluations (e.g., "those questions really make you think," "I never considered that before," "what a good question," and "that doesn't apply to me," "what does *that* mean?") and, occasionally, their passing comments on the interview gave me pause. For instance, after each interview, I prompted the respondent to ask me any questions she might have. Few had any, but one asked, "Do *you* want kids?" All along, I had been probing for her thoughts on motherhood and her perceptions of why people have children. She exclaimed smugly, upon hearing me answer in the affirmative, "I *knew* it!"

This interchange revealed that I had tipped my hand both more *and* less than I thought I had: 1) I wrongly assumed that all of my respondents were aware of my infertile, childless status as well as my regretful feelings about it, and 2) my questions evidently revealed a pronatalist bias. This respondent represented the only militantly childfree woman in the study population, perhaps leading her to be more sensitive to any inherent assumptions in my interview questions. These sorts of interchanges enhanced my reflexivity and encouraged me to continually refine the methodology.

LaRossa et al. (1981) mention that qualitative family research—often done in respondents' homes over the course of multiple visits—resembles therapy. They express concern that confusion over the researcher's role might lull participants into divulging more personal information than they otherwise would have. My interviewees frequently commented that the session felt like therapy. All but two (including one of the experts) were brought to tears—often by surprise—in recalling aspects of their lives or in trying to answer questions about their

feelings. In these cases, I attempted to strike a balance between allowing space for them to vent their feelings and moving on to less difficult topics. Although their crying—which caused me to cry as well—often made me feel like Barbara Walters (i.e., like I had encouraged the emotion), I did not have any interest in delving deeper. I did not want to insinuate myself into painful matters, in part because many times the sore topics were only tangentially related (e.g., failed romantic relationships, deceased or estranged family members, health problems) to the key research questions and in part because it was not appropriate for me to probe their wounds.

One woman, Azra Alic, who was pursuing IVF treatment at the time of the interview, revealed raw feelings about her infertility. She was especially tearful and, when I asked her if she wanted to stop the interview, she adamantly refused, insisting that it was good for her to talk about it. That interview was emotionally taxing for me as well because I was also trying to get pregnant and I was exploring IVF as an option. I left feeling like the interview had worsened her pain. Nevertheless, Azra and many of the other women I talked with mentioned to me that they had never thought about many of the topics I asked about. I questioned them, for instance, about why women want to have children and why they did or did not want them. Having children is widely considered to be the natural order of things and to be asked to explore any motivations behind it can be bemusing and seem rather exigent. Psychologist Maggie Kirkman (2001:523) reported that that the infertile Australian women she interviewed chafed at the suggestion that they should "justify their desire to become mothers." Although I was not requiring women to "justify" their situations, my questions did spark a little bit of surprise and a great deal of introspective musing as women considered their infertility and childlessness in new ways. Several of them emphasized that they have chosen not to think about or dwell on that status and, for a few, it seemed they were thinking and talking about it for the first time. This reflection

likely helped women understand themselves and connect their experiences with wider social phenomena, but it may also have damaged the protective psychological mechanisms they had in place.

When the interviews ended, some of the women asked me about the research or a bit about myself but they generally kept this conversation short, conveying their expectation that our time together was over. When a respondent had been especially emotional or revealing, I felt closer to her. I thought we might hug our farewells. But this did not happen. As a rule, the respondents' manner and body language indicated that the intimacy was over, thank you very much, as they resumed their ordinary demeanor. Virtually all of the respondents told me that they enjoyed the interview—even when I thought the interview had gone poorly—some going so far as to thank me for the "free therapy." They typically indicated that I could call them if I needed clarification and that it was their pleasure to help me with my project. Despite my concerns about exploitation and my lame attempts at simulating friendship, it appears that I usually achieved my general goal of ensuring that the process did little harm to the participants. In an attempt to make up for any unevenness in the relationship, I offered some respondents a small thank-you gift ($20 Target gift card or cash, depending on their economic circumstances) at the end of the interview. I knew better than to try to give this gift to the middle class respondents; it would be awkward. Still, although many of the working class and poor women I interviewed appreciated the gesture, some were embarrassed and refused the gift. It was difficult to gauge respondents' perceptions of the interview as an impingement on their time at one end of the spectrum or as an opportunity to be heard on the other end, or as a favor to a friend somewhere in the middle. Their reactions to the gift—which I made sure to mention during recruitment—depended on how they conceived of and experienced the interview.

I did not predict the inordinate benefits that came to me. Throughout my time in the field, I was undergoing fertility treatment and struggling with depression over my childlessness. Like many other researchers in this area (e.g., Becker 2000, Greil 1991, Letherby 1997), my own encounter with this (sometimes) alienating, stigmatizing experience guided me to the research topic. The interviews, while perhaps unintentionally therapeutic for my respondents, were decidedly therapeutic for *me.* The various ways these women's coped with their childlessness and infertility, the practical advice they proffered about fertility treatments and adoption, and the genuine happiness of those living childfree lives, provided me with myriad tools for handling my own problem. In contrast to the advice or support I could have gotten from a therapist or friend, my respondent-interlocutors offered multiple streams of wisdom, borne of quite different life stories and perspectives. Because I implemented a feminist method in which I stepped outside the conventional role of knowing researcher and exposed myself as another woman with experiences and vulnerabilities, response effects are probably different than usual. For one, the participants may have been more willing to open up to me and they may have focused more on their feelings than on concrete experiences. Also, perhaps, as Gayle Letherby (1997) argues, respondents who feel supported in the research process, in turn gain the strength and motivation to support others, including the researcher.

Interpreting Conceptions

Nancy Naples (2003) argues that the insider/outsider debate often obscures the power differences between researcher and researched. In this project, I was an insider as a woman and as a member of a childless, infertile couple but that did not erase my privileged statuses in terms

of class, race, perceived sexual identity, and marital status. I would be privy to some experiential insight perhaps and I could commiserate with other childless women about our stigmatization, desires, and so forth yet my role as researcher automatically places me in a position of power. As Catherine Riessman (1987) puts it, “gender is not enough” to equalize the relationship. This imbalance affects the interview dynamics but is even more conspicuous during the analysis and interpretation stage of the research. I have the authorial license to interpret respondents’ words and gestures, to read between the lines and interpret their meanings, and to use their ideas to weave the tale of my choosing (Van Mannen 1988). But if a feminist methodology is at all achievable, it must reveal the guts, the micropolitics of face-to-face research. Liz Stanley and Sue Wise (1993) attack the “myth of hygienic research,” the misguided belief that rigorous methods yield objective data. Even the hard sciences yield little more than “situated knowledge,” not incontrovertible facts (Haraway 1988). The subjectivity of the researcher inserts itself every step of the way beginning with selecting a topic of study and the designing the research. Yet nowhere is this reality more evident than in the interpretive stage. Instead of hiding behind formalized academic language about sampling technique and integrative models, the feminist researcher needs to be forthright about what is produced and how. Stanley (1991) calls this production “accountable knowledge.” The interpretations are not any less valid for their transparency; instead, they are arguably *more* valid since the epistemological context is evident.

Grounded theory method (GTM) as first described by Barney Glaser and Anselm Strauss (see Glaser and Strauss 1967, Glaser 1978, Strauss 1987, Strauss and Corbin 1998) is one of the handiest and most popular methods for analyzing textual materials like the interview transcripts I studied. I use a version of GTM as interpreted by LaRossa (2005) and Clarke (2005). Data collection and analysis were concurrent as much as was feasible (Lofland and Lofland 1995).

This process allowed me to integrate emergent questions that I had not considered until talking to respondents. I used the constant comparison method and followed the process of open coding, axial coding, and selective coding described by Strauss and Corbin (1998). I read each transcription in its entirety then coded the text into general categories using microanalysis, or line-by-line analysis. I then defined the dimensions of these categories with special attention to the many variations. This approach helped me identify interconnections between saturated categories and subcategories that I explored using analytical tools like diagrams, memos, and triangulation. The diagrams I drew charted the interactions and causalities of the social processes at hand. I drafted a number of memos throughout the research process in order to constantly make connections between the interviewees' words and emerging theoretical ideas. As I compared the many categories and variables to one another during the axial coding phase—and all of these phases happened synchronically—I paid close attention to the influences of power and politics. Not only did I ask when, where, why, to whom, and how certain phenomena occur, I also attempted to incorporate the processes that made the categories relate. Within the relevant historical, social, and cultural contexts, I thought about the respondents' various strategies, tactics, positionings, manipulations, and maneuverings in their accounts. GTM co-inventor Barney Glaser's (1978:76, 78) "six C's" of "causes, contexts, contingencies, consequences, covariances, and conditions" came to the fore during this analytical work. Following LaRossa's (2005) suggestion to think of the emergent/researcher-created categories as "variables," I made linkages *between* the theoretically saturated ideas. I selected the core variables "ambivalent childless" and "pragmatic infertile" because these ideas challenge existing assumptions about childless and infertility and because they interact strongly with all of the other primary categories (and their subcategories).

To couch all of this into lay terminology, I read, and re-read the transcripts, picking out ideas that seemed most important to the respondents and, along the way, I figured out the interrelationships between these ideas. To encourage theory-building over theory-testing—and at the risk of re-inventing the wheel—I did this work without (re)consulting the extant literature until *after* I dimensionalized the concepts and drew many of the connections between them during axial coding. My previous intimacy with the literature and my theoretical sensibilities, however, undoubtedly guided my choices. Specifically, I focused on the liberatory possibilities within marginalized women's experiences.

In his classic *The Sociological Imagination* (1959:216), C. Wright Mills tells sociologists, "You must learn to use your life experience in your intellectual work: continually to examine it and interpret it." In compliance with this mandate, I wish to make apparent that my own experiences with infertility treatment inform my analysis (and, of course, my choice of topic and lines of questioning). Feminists (e.g., Rich 1976, Rothman 1986, Reinharz 1992) have long argued for increased visibility of the self in scholarly writing. Owning one's subjectivities invites the reader to indeed pay attention to the woman or man behind the curtain. The institutional power of science (prone to be an extension of patriarchy) is taken down a notch in favor of increased validity and accessibility. Since the 1980s poststructural, postmodern turn in social research, social science has been called to task for its historic inability to account for the fluidity of experience and identity as well as the fluidity and subjectivity of scholarly interpretation. In writing about motherhood and infertility, in particular, two emotional subjects integral to identity and social perceptions, the researcher's experiential perspective and empathy is perhaps just as important as her academic knowledge (see Ettore 2005). Examining one's own life and social interactions—treating the researcher-self as a subject—also levels the distinction between

researcher and researched (it is only fair to expose oneself to equal scrutiny), and, ideally, offers the depth of a case study.

Autoethnography is not synonymous with autobiography; instead of merely relaying experience, the former emphasizes the meaning of experience (Bochner 2000, Ellis 2004, Richardson 2003) within its sociocultural context. Feminist work like this is also critical and political, with an emancipatory bent (Ettore 2005). Still, autoethnography entails substantial risks. For me, it was at times painful and embarrassing to write about myself or to include unedited passages from my journal (no pseudonym to protect my identity), and, as Gayle Letherby (2003) points out, it includes the stories of my loved ones, an ethically-fraught aspect of research not covered in IRB approval procedures.

But, in addition to providing insight into apropos social phenomena, the personal history illuminates my motives as an interpreter of social action. Reflections are relevant chiefly because they never represent a private, subjective act; they are always immersed in social life. Yet, research about women (especially feminist research—thought to be overly biased—and studies of women's bodies—associated with the natural, not the social) already resides lower on the scholarly totem pole, and the seeming free-for-all that ensues when scientific objectivity is contested provokes criticism and disdain from those invested in a more positivistic view of sociology or from those feminists who fear that their work will not be taken seriously (see Letherby 2003 for an extended discussion of this tension). Detractors characterize autoethnography and first person academic writing as prone to poetic license, to fictionalization (see Kelly et al. 1994), ignoring many feminist researchers' commitment to what Max Weber labeled *Verstehen*, theoretical generalizations or understandings that are compared to and confirmed by human experiences (Ettore 2005, Murray 2003). Feminist methodologies and

methods like autoethnography effectively introduce a newer kind of rigor by carefully naming and considering the biases intrinsic to any research endeavor.

Another benefit to self-reflexiveness illuminated by this particular study is its power in grounding my criticisms of the fertility world. The study participants' experiences differed from my own and called into question accepted common and academic knowledge about infertility and involuntary childlessness. Because I was able to relate to the women described in earlier ethnographies (and, to a lesser degree, to the public caricature of the infertile woman), I remained cognizant of the need to validate those experiences even while I deconstructed them and documented competing discourses.

Several ethnographies on infertile women, statistics from the Centers for Disease Control and from several sources compiled by Mundy (2007) and Spar (2006), field notes, and the other interviews eventually provided opportunities to triangulate, or confirm my provisional findings. Selective coding involves identifying a core category or categories that will help refine and integrate the theory. I returned to the transcripts to sample and test my assumptions and findings, ultimately yielding the core variables of "ambivalent childlessness" and "the pragmatic infertile"—two interrelated ideas that other researchers have yet to explore. By the time I coded the first 20 transcripts, I began to reach theoretical saturation, at least for the concepts I chose to highlight. I could predict interviewees' responses. I interviewed a few more women, looking for those who might offer distinctive points of view, and I was able to find a few more variations to more fully describe the main ideas. Margarete Sandelowski (1995:183) notes that theoretical saturation is not contingent on sample size but on the quality of the information gathered and the ability of the researcher to generate useful concepts to enhance "a new and richly textured understanding of experience." Not until I began diagramming the results did I realize that the 25

infertile and childless women and two experts (one of whom also fits the former category) shared sufficient information to allow me to construct an adequate theory, one that also suggests a number of future directions for research on infertility, childlessness, and motherhood.

The interpretation of respondents' meanings posed another ethical dilemma and opportunity to be reflexive and to test my feminist mettle. Sometimes what the respondents meant to project was subject to a different reading on my part. I tried to incorporate their manifest meanings alongside my translations and sociological interpretations. Harwood (2007), for instance, casts the infertile women that she studies as overly consumerist, ideological dupes. Although I found evidence among my respondents that substantiates these findings (up to a point), I was wary of privileging my broader, contextualized view and political biases in ways that dismissed women's feelings, ideas, and observations. Their lives and thoughts are not so easily explained. Feminist research aims not to merely tell others' stories, but to detect ways of redressing inequalities and oppression.

To this end, I tried to honor the respondents' experiential knowledge and agency—requisites for gaining a valid feminist understanding (Collins 1991)—even while I critiqued the dominant ideologies, institutions, and discourses that constrain them. This way the respondents and I collaborate—we do what Hesse-Biber and Leavy (2004:4) call "knowledge building together." I strived to "reduce dualisms" in my analysis (Sprague and Zimmerman 1993, Williams and Bendelow 1996), trading explicatory neatness for a more authentic—but messier—description of respondents' lived experience.

By abiding by reflexivity and a feminist methodology, I intend a more nuanced, fuller understanding of infertility and childlessness that is line with a feminist paradigm.

Table 1. Participant characteristics.

Identifier	**Age**	**Race/ethnicity**	**Sexual Identity**	**Marital status**	**Occupation**	**Fertility/Motherhood Status**
Carol P.	50s	White	Straight	Married	Fertility counselor	n/a—expert
Robin Smith	40s	White	Lesbian	Partnered	Fertility counselor	IVF patient
Dianne Jacobsen	50s	White	Straight	Single	Life coach	Infertile/adoptive mother
LaWanda Jackson	40s	Black	Straight	Single	Nursing assistant	Infertile/childless
Jessie Silva	40s	Portugese	Queer	Single	Hairstylist	Infertile/adoptive mother
Penny Ortiz	50s	Latina	Straight	Single	Guidance counselor	Postmenopausal/childless
Annie Adoyo	30s	Kenyan	Straight	Single	Student	Childless
Talia Stein	40s	Israeli	Straight	Single	Home health care aide	Childless
Annette Kramer	50s	White	Lesbian	Partnered	Nurse	Childless
Hannah Johanson	30s	White	Queer	Married	College instructor	Infertile/adoptive mother
Geanie Owusu	30s	Ghanaian	Straight	Single	Project manager	Childless
Zara Senai	40s	Somalian	Straight	Married	Laboratory technician	Infertile/childless
Karen Tabb	50s	White	Straight	Single	Teacher	Postmenopausal/childless
Jennifer West	40s	Latina/White	Straight	Married	Civil engineer	Infertile/adoptive mother
Lana Marks	50s	White	Lesbian	Partnered	Therapist	Childless
Serena Lopez	30s	Latina	Straight	Married	Laboratory technician	Secondary infertility
Jamilah Washington	19	Black	Straight	Single	Student	Childless
Nicole Lambert	20s	Black	Straight	Single	Student	Childless
Lourdes Garcia	50s	Latina	Unsure	Single	Administrative assistant	Childless
Shana Jones	20s	Black	Straight	Single	Student	Childless
Aikiko Moto	40s	Japanese	Straight	Married	College instructor	Secondary infertility
Emily Reilly	30s	White	Straight	Single	Fast food manager	Childless
Azra Alic	30s	Bosnian	Straight	Partnered	Apartment manager	IVF patient
Lupe Jimenez	40s	Latina	Straight	Married	Pharmacy technician	Secondary infertility
Iris Hernandez	50s	Latina	Straight	Partnered	Administrative assistant	Infertile/childless
Mary Benson	50s	Black	Straight	Married	Cook	Infertile/childless

CHAPTER 4: MOTHERHOOD FROM THE MARGINS

> A woman who can bear children is held in higher esteem than a woman who cannot. The culture is, or used to be, very harsh on people who could not bear children. Because once you're married, your job is to have kids. It's just that you're a baby-making machine. So if you cannot have them, it's like, "What is wrong with you?"—*Annie Adoyo, 30, second generation African immigrant, single, student*

Women can be single, childless, professionals, artists, healers, nuns, and workers, but they are also mothers *a priori*, imbued by society with a maternal femininity. In their book *Pregnant Pictures*, Matthews and Wexler (2000:2) posit, "Most women must deal at some point in their lives with the possibility, impossibility, or fact of becoming pregnant." This understatement—for I would argue that virtually all women encounter these facts several times in their lives—goes for motherhood as well. As Adrienne Rich (1976:250) writes, "The 'childless woman' and the 'mother' are a false polarity, which has served the institutions both of motherhood and heterosexuality." Precisely how infertile and childless women construct motherhood and nonmotherhood within the constraints of available discourses varies according to their positions in the social hierarchy and their individual circumstances.

Most of the 25 women I interviewed for this study do not fit within what Dorothy Smith (1993) calls the Standard North American Family (SNAF), an ideological code akin to DNA that defines family, the basic unit that forms society. The SNAF family consists of a household that includes a (masculine) father who does most of the earning, a (feminine) mother/housewife, and

their (biological) children. Beyond the reduced code of SNAF, the ideal family variant (or dominant "allele" to continue Smith's DNA analogy) is presumed white and middle class. The participants in this study represent a cross-section of women who are childless and/or "infertile"—designated as less essentially feminine—who also belong to social groups that mainstream society portrays as dubious candidates for motherhood anyway: women of color, poor women, lesbians, and single women.

I further describe them based on their reasons for childlessness. Again, feminist poet and scholar Adrienne Rich (1976:250-251) offers insight:

> There are women (like Ruth Benedict) who have tried to have children and could not. The causes may range from a husband's unacknowledged infertility to signals of refusal sent out from her cerebral cortex. A woman may have looked at the lives of women with children and have felt that, given the circumstances of motherhood, she must remain childless if she is to pursue any other hopes or aims . . . A young girl may have lived in horror of her mothers child-worn existence and told herself, once and for all, *No, not for me.* A lesbian may have gone through abortions in early relationships with men, love children, yet still feel her life too insecure to take on the grilling of an adoption or the responsibility of an artificial pregnancy. A woman who has chosen celibacy may feel her decision entails a life without children. Ironically, it is precisely the institution of motherhood, which in an era of birth control, has influence women against becoming mothers. It is simply too hypocritical, too exploitative of mothers and children, too oppressive.

The study interviews reflect a similar range of motivations and circumstances. Two (Lana Marks and Annette Kramer) are *childfree-by-choice*, both college-educated lesbians in their fifties who display second-wave feminist sensibilities: they see motherhood as a trap designed to subjugate women. The three young, low-income, urban African American women (Jamilah Washington, Nicole Lambert, and Shana Jones) are childless due to an *intentional delay*. They differ from their older sisters and aunts as well as their peers and cognates by putting off pregnancy—and serious romantic relationships—in order to pursue education and get a foothold on a career. These young women depart from the expectations others have for them and instead embrace mainstream values about the proper life course trajectory, a plan they are able to follow, they say, thanks to material support from their families and "God's will." A few women (Annie Adoyo, Gloria Owusu, and Emily Reilly)—the "*(n)ever readies*" still hope to become pregnant should the perfect conditions present themselves. They are all three single, self-supporting women over 30 and with one recent exception (Emily), they have relatively little involvement in any children's lives.

Childlessness *just happened* for quite a few of the women (Mary Benson, Iris Hernandez, Lourdes Garcia, LaWanda Jackson, Penny Ortiz, Talia Stein, and Karen Tabb). Other life events intervened and diverted their attention. Two of these women are pre- or peri-menopausal and they have not yet ruled out pregnancy—and both are exploring adoption—but they differ from the "never readies" in that they appear to be on the cusp of identifying as nonmothers. The *infertile-identified* includes women who unsuccessfully tried to get pregnant and then pursued medical help. This interface with the medical industrial complex—with doctors, nurses, specialists, laboratory technicians, pharmacists, and counselors—medicalized them. That is to say, the experience probably altered their perspectives, leading them to more closely identify

with the term/diagnosis/status/role of “infertile.” Among these infertile-identified women, all of whom are married or engaged, include those who never birthed a child (Jessie Silva, Hannah Johanson, Azra Alic, Jennifer West, Zara Senai, and Dianne Jacobsen) and those who had one and then were told (or “realized”) that they could not or should not have any more (Serena Lopez, Aikiko Moto, and Lupe Jimenez). It is significant that none of these women are absolutely, 100 percent certain that they cannot, or could not pre-menopause, become pregnant and bear children. That is, they mention that they have or had either a “window of opportunity” or some “chance” (possibility) to achieve pregnancy. Four adopted a child (and two of these are currently fostering an additional child with the hope that it will lead to adoption), three say that they have accepted that they will only have one, and one (Azra) is still pursuing medical help (i.e., IVF). Finally, one woman, Robin Smith, a counselor for a fertility clinic can be described as *de facto infertile*. Robin, like many other lesbians and like some single women, was seeking, at the time of the interview, “alternative insemination,” in Amy Agigian’s (2004) usage, and taking fertility drugs to improve the probability of success (she has since given birth twice). These women’s procreative capacity is rendered invisible by the medical definition of infertility (e.g., 12 months’ intercourse without pregnancy) that assumes a SNAF-like norm wherein a male romantic partner (i.e., not a mere donor) will provide the sperm. My first intent in introducing these women and their “types” is to illustrate the diversity of the women who participated in this project. Throughout the ensuing discussion, indeed, for the rest of the chapters, I frequently consider how the accounts of infertility and childlessness differ between these groups.

The interviews confirm many of the already-familiar social meanings of motherhood but they also show how these meanings impact their lives, revealing some extradiscursive facets of their lived experience as women with multiple consciousnesses. Infertility is to fertility as

pathologized, marginalized blackness is to normative, hegemonic whiteness. Frantz Fanon's (1967) prediction that the "view from the periphery" might provide the insight needed to instigate positive changes and imagine liberating alternatives is relevant here. To the lower strata of race and fertility hierarchies, add minority sexuality and marital statuses and there we have a wide range of standpoints from which to break apart a monolithic idea of motherhood/nonmotherhood.

In this chapter I outline respondents' constructions of womanhood and femininity as these concepts relate to motherhood and its alternative, "otherhood." In the next chapters, I illustrate how these women's self-placement within this conceptualization correlates with their *decisive efficacy* about becoming mothers, their responses to the motherhood mandate—their *role applicability*, and the likelihood that they will pursue assisted reproduction or adoption—their *normalizability*. All of this underpins a broader discussion about femininities and power relations that vary for different groups of women, according to their intersecting status locations within society's hierarchical systems.

Real Moms, Bad Mothers, and Other-than-Mothers

When asked to think abstractly about what it means to "be a woman," the respondents—across lines of race, class, age, sexuality, marital status—usually talk about one's capacity for motherhood, whether or not she was a mother herself:

> Although of course not all women are mothers, most have the potential to be. And that makes us very different from men, just having that. Most people I see tend to

be closer to their mothers than their fathers. Even if the relationship can be difficult, there's a different bond. Like me with Louis. It's almost hard to compare it; I can't imagine him being closer to anyone than his mother. So part of being a woman is being a mother.—*Aikiko Moto, 43, Japanese American, married, teacher*

Women have that responsibility in terms of bearing children. It's not something you can pass off to the men. I also feel that in general in our society, women have a bit of elevation or respect because they are capable of that. Especially these days, with the sperm bank, I think men realize, I hope, that women don't need them as much perhaps—*Emily Reilly, 30, white, single, fast food restaurant manager*

I think it's a beautiful thing to be a woman because we are the ones that give life. We're the ones that give life, carry life. We're like a miracle within, I think. And, I think being a woman is a gift as well as a miracle. And, I'd rather be a woman, than a man [laugh].

Kristin Wilson: Why?

Just because we are able to do that. Maybe not so much in my case. But at least our body, the way we are built, we are supposed to be able to do this. So, I think

> that in most is what to me is being a woman. Now that I'm older, I see it that way.—*Lupe Jimenez, 41, Latina, married, electronics technician*

These passages reflect the paradigm of the maternal body as fundamental to the social body. Aikiko emphasizes the maternal bond as the basic social relationship, Emily views the maternal body as an agent of liberation, and Lupe's comments show that merely the *potentiality* to "give life," iteratively essentializes women as mothers. Lupe's personal experience challenges the very definition that she gives, a paradox that exposes the tyranny and insufficiency of the motherhood-equals-woman discourse. Humans cannot exist without mothers nor can society function. However, this loftiness, this supposedly innate value is exactly why a feminine body that is nonmaternal can cause loss of feminine identity:

> I found out [the infertility diagnosis] through this specialist in San Francisco and he was an older man and it was just horrible. It was just this older man saying, "Well you can never have any children" . . . And of course I'm 16. I'm like [makes a blank face], "Okay." Like no questions; I just like, boom, totally shut down. Completely shut down. Went totally into survival mode . . . because the whole—you know. It's like I just didn't feel—it's different steps, you know—and then I didn't feel like a woman.—*Jessie Silva, 42, white, queer, hairstylist*

> Without my uterus, even though I went through a lot [pain and medical procedures], I wouldn't feel like I'm a woman. So I'd rather keep it. That why I

> left it [contrary to medical advice].—*Zara Senai, 45, African immigrant, married, laboratory technician*

Each of these women negotiate a new, strained relationship with her disruptive, disorderly, unruly maternal body while they also negotiate with the men who control—and attempt to normalize—those bodies with surgery and medicine; Jessie, as a powerless teenager, "shuts down," refusing to interact as expected, whereas Zara insists on keeping her uterus, an organ that is both problematic (prone to cysts in her case) and the keystone to her embodied womanhood. Jessie repeats throughout her interview that taking pills to bring on menstruation made her feel "less of a woman." She finally stops her daily doses after a couple of decades perhaps not coincidentally at just about the same time that she re-defines womanhood with the help of self-help seminars and a pagan-inspired "women's circle" that she attends each full moon. The healing was possible, and necessary, but it was slow owing to the pervasive suppositions that conflate womanhood and motherhood. Still, many women oppose this narrative:

> I have the utmost respect for single parents you know but I think some women really feel like they just have to have a baby because they're a woman, and I just said, "You know what? Whatever you feel, but that is not right."—*Penny Ortiz, 52, Latina, single, guidance counselor*

> I think for a woman sometimes it is to the peak to be a female and be a woman once you give birth to a child. Personally, it is not the way I think . . . They say

> [incredulously], "You don't have kids?" It's like I should have a kid to be a woman. And I don't see it that way myself. I always was afraid in my life of two things: that I will be a prostitute or a drug addict. Those things were a panic for me. And why? I don't know. But I would say, "How miserable will my life be if I get pregnant? My dad will kick me out of the house. I will be on the streets with a child with me." Those things were in my mind. And maybe that is why I always thought to have a child would be a big responsibility for me, that I was not capable. But recently when I said I am not married and I don't have kids, people suddenly look at me and say, "You're 56 and never got married? You are 56 and never had kids?" But I see it like they are questioning my sexuality.—*Lourdes Garcia, 56, Latina, single, office assistant*

Both Penny and Lourdes are outspoken, friendly women in their postmenopausal fifties, childless, single, and satisfied with their lives. They belong to the group for whom nonmotherhood "just happened." Their critiques of the motherhood mandate help them to resolve any lingering doubts and to strengthen their identities as fully complete women despite their childlessness. These two women, as Latinas whose mothers modeled social expectations by having many children, already distinguish themselves by having careers and—for Lourdes—by wearing pants and by not wearing make-up. This pants-wearing metaphor has long been used to make fun of wives who assert themselves—and the hen-pecked husbands who allow it. Lourdes constructs her pants-wearing as an expression of her freedom from a patriarchal family and culture and as a symbol of her questioned sexuality. She notes that others conflate her sex, gender, and sexuality, all contested by her failure to marry and procreate. People apparently

cannot comprehend her body and her identity given her childlessness. Yet she is self-accepting and defiantly a woman.

Like Lourdes, these women locate themselves and other women along a continuum that connects femininity, motherhood, and womanhood. I propose a way to visualize their constructions as a series of concentric circles with the "real mom" at the center, a woman who performs her "natural" role by being nurturing, self-sacrificing, and loving. By virtue of their feminine praxis, women with biological children as well as those with formally or informally adopted children may fit this description. Following the nucleus, is an outer ring corresponding to a secondary type of mother, the "nominal mother" who may have not planned her pregnancy and who lacks the means or emotional resources to care properly for her children but who is still seen as feminine and womanly to the extent that she fulfilled her biological destiny. This (straw) woman—whose shortcomings help to define the "real moms" by contrast— fails to hear her calling and does not fully inhabit motherhood. The nominal mother is analogous to the "bad mother." The next ring signifies the "godmother auntie," a woman who does not achieve womanhood from having children herself, but who is not childless. She exercises maternality in her intimate involvement in the lives of their nieces and nephews or godchildren for whom she provides advice, financial support, and childcare. Finally, we can imagine the outer ring, on the periphery of all the others, as the "less involved nonmother," a woman who self-reports anti-motherly traits like selfishness or an intolerance for children and does not have children in her life to any substantial degree. These categories are not exclusive ones and an individual woman may self-identify—or may label others—differently depending on the temporal and social context.

In an absurd contradiction, motherhood is seen as honorable and central to womanhood, while the day-to-day work involved—the *mothering*—garners little respect or material support from society. The women I interviewed expressed a spectrum of views on motherhood, some *hypothetical*, based on an idealized vision of mothers versus those views that are *experiential*, based on the woman's own lived experience as a mother.

Real Moms

I either asked directly or probed each respondent for her views on what makes someone a "mother," a question frequently interpreted by the woman to mean *What makes someone a* good *mother?* Some women offered, in a rote manner, little more than predictable lists of virtues such as "patient," "listener," "loving," "forgiving," "selfless," and "comforting," and others told me that the mother is the core or glue of the household or family. A few respondents called up more specific—if hypothetical—images that essentialize mothers—and themselves—as feminine nurturers:

> I had always pictured that I would be a mother and I even pictured myself making big bowls of bread from scratch with the yeast and rolling it out, and making big bowls of soup. So I always pictured myself as a mother with kids. *–Diane, 58, white, divorced, life coach*

This mythos that the peak of motherhood is baking for or with one's adoring children belies the toil involved in raising children, renders invisible the social supports necessary, and holds up an unattainable ideal of femininity. This is not to say that women do not enjoy baking

or cooking with their children but, rather, that this is a superficial image of mothers. Several respondents measure a "good" mother by her ability to produce quality children—by whatever means:

> Being a mother means unconditional love, nurturance, protection, and guidance and teaching. If you're a good mother. How to be a decent human being and grow up with ethics and morals, and just raise somebody phenomenal who could contribute to society maybe, or just be a nice person contributing to society, making the earth a nice place.—*Talia Stein, 41, white, single, home healthcare aide*

> Children are like animals. They will do whatever they can get away with. And if you don't enforce that line, they will overstep whatever boundaries you think you've set . . . Communication [is also important to being a good mother]. I think my mom was a great mom. We were definitely disciplined. We knew those boundaries were there. I got spanked a few times. I know some people don't believe in spanking but I am not entirely against spanking, because like I said, little children are like little dogs, and they need a little smack.—*Annie Adoyo, 30, second generation African immigrant, single, student*

> You sort of have to give them everything: love and support and kindness and encouragement. And yet not be overprotective or pushy or anything like that. I think you have to find a good balance between being really supportive and loving,

> but also firm. I think my friends and my sister-in-law are incredible mothers. All my friends have been really good. I can see that my friends' kids have confidence in themselves but none of them are bratty or act out. It's sort of a balancing act between being really there for them but allowing them to be independent at the same time.—*Karen Tabb, 49, white, single, teacher*

Beginning with choosing a partner or sperm donor, motherhood is something of a eugenic enterprise. The social reproduction of "good values" is an extension of this emphasis on quality. For Talia, Annie, and Karen, a mother's task is to preternaturally draw on her intrinsic motherliness—to nurture and to guide—in perfect balance. The flipside to this valorized task of dedicated, purposeful, self-denying childrearing, called "intensive" or "extensive" mothering by Hays (1998) and Blum (1999), respectively, is the longstanding tradition in Western society of blaming mothers for their children's flaws and crimes (see Ladd-Taylor and Umansky, eds. 1998, May 1995, Chodorow 1978). The three women quoted above are all childless and have yet to confront the reality of this ideal mothering. However, just the social knowledge that mothering is supposed to entail a full immersion—a baptism and reawakening as wholly different women who "give everything"—affects their plans for pursuing that role.

In their definitions of "mother," some of the women emphasized the hypothetical practicalities involved in mothering, using phrases like "financially stable," "provider," "orderly," and "organized," to describe what being a mother means. These respondents equate motherhood with work, both inside the home and outside of it (due to the financial demands of having children). Their views range from seeing motherhood and its attendant responsibilities as

difficult-but-laudable and indicative of maturity and goodness to a bad choice revealing of meager personal integrity:

> I always thought of having children as a way to completely give up your own needs, and your own goals, and direction in life . . . it's way too much work to be a mother . . . I saw my mother as kind of a slave really. She worked constantly raising kids.—*Lana Marks, 52, white, lesbian, nurse*

> It means a huge commitment to somebody. A huge responsibility for somebody else. And I'm in awe of people that take it on consciously. Because it seems very complex to take on today, if you want to do it differently than it was done to you.—*Annette Kramer, 56, white, lesbian, family therapist*

> I can honestly say she's [teenaged cousin] trying . . . She goes to work. Picks her son up from daycare. Comes home. She cooks, cleans. A real mother. Her life is gone. Well, not gone, but she can't do half the things she wants to do because of her son. She never says he's a burden, but she says sometimes she gets frustrated and tired to where she can't take it.—*Jamilah Washington, 19, African American, single, student*

> One, let me start off by saying, it's a blessing to be a mother. I believe it takes someone who has a lot in them: patience, love. To see after someone else and put them before yourself, put their needs before your needs, and their wants. It's a

> pretty big task. But I really think it means that there is someone that obviously is going to need you . . . it's the mother's job to provide for them. So I think to be a mother and what it means to be a mother is probably the most—I don't know what the word is. But it's a job. It's a really big task. And it never ends really . . . . I don't think it's possible to be a mother and not be warm-hearted and take responsibility. I don't even know the word for that. But I don't think it's possible to be a mother and not do those things. Because if you're not doing any of those things, what purpose are you serving?—*Nicole Lambert, 20, African American, single, student*

Lana's view of motherhood as drudgery and limiting contrasts with Jamilah's subtle admiration of her cousin's earned designation as a "real mother" and Ann's "awe" of intentional mothers who will strive to do it better than their own mothers. For Lana, motherhood is not a role any self-actualized woman would want. Both Lana and Ann are "childree-by-choice," and middle-class lesbians who came of age during "women's liberation"—long before the so-called "gayby boom"—when conventional roles for women were being rejected. Neither has had children in their lives much since adulthood, perhaps because they cast off wholesale these roles and embraced an "alternative lifestyle" but probably also because they were aware of the unwarranted distrust society has had for gay adults in relation to children. They see motherhood as an unattractive experience, one that is not something they would miss. By contrast, Jamilah and Nicole, who represent a group of women who enact an "intentional delay," hail from poor communities in Oakland, California, and recognize motherhood as an acceptable reality of adulthood, a phase they are not yet ready to enter. Though both young women repeatedly point

out that their peers have all had children already—and thereby have already entered adulthood, a pattern famously documented by sociologist Elijah Anderson (1999) among other inner-city African American adolescent girls—their primary definition of motherhood as work steers them away from taking it on too soon. A more experiential take on both the emotional aspects and the mundane practicalities of motherhood comes, quite expectedly, from the mothers, all of whom identified as "infertile" at some point in their lives, and, thus have ample impetus to ponder these meanings:

> Kristin Wilson: What does it mean to be a mother?
>
> Well, wow! I think as a mother, I would say I'm amazed at how much I love Jade [her adopted daughter]. I mean, I knew I would, but the actual emotional experience of it is incredible. It's overwhelming. The nature of feelings I have for Jade is different from the love I have for other people . . . . there is a protective, nurturing quality to the love I have for Jade that I haven't felt before to the same degree . . . . it's hard to say how much of my emotional experience is related to wanting a child, deciding to get married and settle down with Gabriel, and part of that being tied up with the collective dream of having children, or the mutual dream of having children, and then thinking we couldn't have children, and then wondering how we would have children, applying to adopt and waiting for a long, long time.*–Hannah Johanson, 39, white, queer, married, teacher*

It's a big responsibility. Let me tell you. I cannot sleep in anymore because he will wake up at 6 o'clock in the morning and either ask me for a bottle or ask me to watch *Sesame Street* at 6 o'clock in the morning . . . he wakes up really early and is a big responsibility. It means that I have somebody to take care of and that I have somebody that might be able to take care of me when I grow old.—*Serena Lopez, 39, Latina, married, pharmacy technician*

Lots of different things. Motherhood is, for me, more difficult than anything else I've done in my life . . . Being a mom is 24 hours a day, seven days a week. There are very few breaks. You don't get paid for it. In many ways society doesn't reward you for it. You get the spit-ups and diarrhea and everything else! But there are also the joys of it. There's no monetary value to that. I think Louis has enhanced our life considerably. We were a very happy couple before, but Louis has really brought us several notches above in terms of happiness . . . It means a lot of things. Once Louis was born, I felt like my life was complete.—*Aikiko Moto, 43, Japanese-American, married, teacher*

It's wonderful. Our baby is—she's so sweet. It's a lot different than I thought it would be. It's more all consuming of your life than you think it's going to be. You kind of think it's going to be this thing like on the side. It's really like it becomes your life and suddenly other things are not that important. Like at my work, I was trying really hard to like get promoted, move up the ladder and all this stuff and now suddenly I don't really care. I just want to do my time, do my hours as early

> in the morning as possible, leave as soon as I can so I can get home with the baby.—*Jennifer West, 46, white, married, engineer*

If probed on the difficulties of motherhood or on the emotional rewards, respectively, Hannah and Serena would probably echo Aikiko's balanced analysis of motherhood. But, when just asked what it means to be a mother, their initial reactions are revealing. Class differences between the two may partly explain their differing descriptions of motherhood. Whereas Hannah, who has the luxury of a relatively high-status career with adjustable hours and a husband who shares more equally in the childcare, marvels at the emotional rewards of motherhood, Serena, who seems to have a more conventional marriage wherein she works the "second shift" and bears the lion's share of childcare duties, fixates on the responsibility involved. Motherhood for Serena is toil and sacrifice (and old-age insurance); for Hannah it is achievement and personal happiness. Jennifer, who once doggedly competed for promotions in a male-dominated profession, feels indifferent now, transforming her identity (temporarily?) by refocusing her energies to her newly adopted baby. Their experiences, though perhaps a little surprising to them in their magnitude (e.g., universal shock at the amount of laundry), are expected and largely defined by social class.

Mothering for all of these women for whom motherhood came about difficultly means subsuming themselves within the "generalized other." Their actions are partly motivated by what they think is expected of them, not some inborn "maternal instinct," thought to be awakened in some women only by having children. The genuine joy of mothering, articulated by many of these women, cannot be denied but neither can it be denied that material conditions and the presence or absence of adequate social support shape the mothering experience. It can be more

adult responsibility and less warm and fuzzy bonding depending on where a woman is situated in this stratified society. This truth that is so clear to the young black women—those participants among the ones who intentionally delayed childbearing—is obscured in society's fantasy of motherhood, an image held by some infertile and childless women. As pitiable and in need of repair, infertile and childless women are thought to "desperately" want to be mothers, specifically the kind of mothers who for whom childcare "becomes [one's] life." But an acknowledgment of the disparities in women's economic and social situations is not usually part of that narrative. It is in this sense that infertility can be seen as a "yuppie disease."

Not only are there very different day-to-day realities between groups of mothers on the basis of structural factors, there are also unique histories and attitudes. Australian sociologist Christine Everingham (1994) argues persuasively that mothering—as socially constructed, not driven by innate responses—involves women asserting their own needs and interests (e.g., affection, status). They are themselves agentic "subjects;" they do not just learn to respond to babies' cues in culturally appropriate ways, they participate in what Habermas (1984) calls "communicative action," a dialectical conversation enabled by "intersubjective social relations." They *negotiate* their needs with the perceived needs of their children and not every action is instrumental in intent. Women like Hannah, Serena, and Jennifer, who pursue motherhood in the face of multiple obstacles, exercise their agency in service of their own needs and interests. They do not become mothers only because it is expected of them. We must also discard that tenacious trope—still promoted in the medical and psychological literature—that instinct drives women. They balance their own desires—desires that are not entirely socially determined (but also not instinct-driven) as appropriate to their social positions. Tellingly, some of the women I interviewed brought up the concept of ownership in defining what it is to be a mother:

> Joy, love, those are the best word I can describe it with. The happiness that I have with my son. The happiness is so fulfilling, so fulfilling. When I think of my son, I just smile. I just have to see his face in my mind and he makes me so happy. Even though, I mean, all kids have their days, but just knowing that he's mine, it makes me feel like I have won.—*Lupe Jimenez, 41, Latina, married, electronics technician*

> I guess to feel completed in life and, yes, this baby is making me really, really happy in every way. Sometimes I can't stand him but, yes, children make me, he makes me happy, so I believe in having somebody that belongs to me. This baby belongs to me. It's really nice.—*Serena Lopez, 39, Latina, married, pharmacy technician*

Lupe, who suffered a couple of miscarriages first, then went through a difficult pregnancy before birthing a one-pound-15-ounce premature son, feels as if she has won (a prize). Serena, a mother with secondary infertility and only hypothetically considering adoption, speaks of motherhood as a completed life goal and expresses some characteristic (for her) ambivalence about her satisfaction with motherhood (e.g., "Sometimes I can't stand him…"), she chooses to emphasize ownership of her baby. It is noteworthy that she uses the term "belong" here, a word that means not only ownership but also implies fitting in and can also indicate the natural order of things. All meanings apply. The baby and Serena belong together as mother and child, belong to one another in the primary human relationship, and the baby belongs to Serena—like Lupe's

belongs to her—as in their personal property. It is revealing, incidentally, that Serena does not use the term “us” to include her husband as a co-owner. The children are extensions first and foremost of the mothers, entities whose purpose is to make their mothers “happy” and “fulfilled” (and to make their fathers “proud”); they are not quite full persons in their own right. Both of these women describe an initial period of terrible disappointment at their secondary infertility and they indicate a redoubling of their attentions on their singleton children, a situation that may increase possessiveness. It is common, nonetheless, to refer to one’s “own” children suggesting that ownership is an integral characteristic of the relationship. Having one’s “own” children is preferable to adoption or to other close relationships with children, for example.

In a capitalist society in which property ownership symbolizes individual autonomy (e.g., Stay off my property!), the ownership of children implies that rearing them is a private venture, not a public one. Of course, there is considerable tension surrounding this attitude with doctors, teachers, neighbors, social workers, law enforcement, and relatives all claiming some responsibility in seeing to it that children are raised in accordance with societal values. This surveillance more significantly affects poor women and women of color who are more likely to lose children to the system. Maybe Lupe and Serena, both women who have witnessed—albeit at a distance— children being taken by the state, feel the need to establish the permanence of their mother-child relationship; stressing ownership carries out this rhetorical task.

Another description of a good mother—what I term a “real mom,”—that emerged in several of the interviews, was “being there”:

> What makes a good mom is being there for their kids. Being for them in whatever they want. Since my parents are divorced, my mom was always for me and my

> brother. Even today, we are both of us grown and we have our own families and she is always there for us, you know. [sigh] . . . Being a good mom is not easy, but it's a job for life. And we'll be kids all the time even when I'm 50 and my mom's 70; I'll be a kid for my mom. I want to be my mom really; I want to be like my mother. She was divorced when she was 30 years old; she was never remarried. She never really wanted to meet anyone else, which is not good. She concentrated on me and my brother to be where we are right now. If my mom wasn't like that, we wouldn't be here . . . . I mean 80 percent of the time, if the kids are coming from a family or loving mom, those kids are most likely to have their own family [reflect that].—*Azra Alic, 30, Bosnian immigrant, engaged, apartment manager*

> I'm not that close to my mom. We don't have that perfect mother-daughter relationship. We do talk and she help me out and things like that but we don't have that special bond like that. But I'm going to have that with my child. I've learned from things of my parents' past. One thing you don't do is favoritism your children. If you do, keep that to yourself. And you know always be there for you child and so like that.—*LaWanda Jackson, 42, African American, single, nursing assistant, 41*

"Being there" connotes a permanent, lifetime commitment in which women prioritize above all else their role as mothers. These ideal mothers dedicate themselves physically and emotionally to their children, and as Azra indicates, ensure the social reproduction of family-

oriented values. Mothers or nonmothers, middle class or working class, black or white, women who fit all these categories emphasize being there. Obviously, a mother's success or failure at "being there" is subjective. Its meaning can vary from lending a sympathetic ear to sacrificing one's romantic life to supporting a child long past adulthood. The thesis of Sharon Hays' *The Cultural Contradictions of Motherhood* (1998) is that good mothers "must" be "intensive mothers" (i.e., dedicated to "being there" for her "sacred" children) whether or not they work outside the home. Infertile and childless women most definitely grasp this directive and, depending in part on their social status and individual circumstances, they may imagine this life as gratifying, terrifying, or some combination of the two extremes. The working class women and women of color see ideal mothering as providing direction, discipline, basic necessities, love, and permanence; the white, middle-class model of mothering seems to them neurotic and overbearing. Although their precise understandings of "real moms" differs, one fact is certain: the focus on mothers accomplished at "being there" contrasts sharply with those other mothers constructed as hapless, unready, and unavailable.

Nominal Mothers

Mothers, given the responsibility for the production and progression of modern society, cannot escape the incessant public scrutiny on her work. Infertile and childless women chime in as well. To wit, many of my respondents volunteered parables about hypothetical and particular bad mothers:

> One of my nieces was with her mom in Sacramento and I went to pick her up and on the way home she just poured her heart out and I thought, "uhhh." And I knew

she had a tough life but just little tiny things that she would say about her mother. She said, “you know my mother used to call me a bitch since I was three years’ old? She said “I can remember that. She still calls me a bitch.” And I said, “You know that is so sad to me because a mother shouldn’t even be using that kind of language to her children. A mother shows love. A mother shows respect. A mother—because that’s how you learn.—*Penny Ortiz, 52, Latina, single, guidance counselor*

[Following a story about a friend who had a baby to (unsuccessfully) “keep a man”] . . . I don’t want to say lesson, because I don’t want to say, “You having a baby is your punishment.” But that was a lesson, something she had to learn. You’re being selfish because you’re only thinking about this man. You don’t think about bringing a life into the world! And you have to take care of that baby whether he is in your life or not . . . I hope she’s taking care of the baby. I really do. Sometimes you have a baby and you don’t even care about it . . . It’s kind of like, “I have you, but what good are you now?” And then you drop the baby off on family members, and that’s not fair to the baby! The baby didn’t ask to be here and the baby doesn’t deserve that kind of treatment.—*Nicole Lambert, 20, African American, single, student*

Without the mothers, the kids would be screwed. You know, you have a messed-up mother who doesn’t care about their kids; their kids are all messed up later on. For example, my cousin. My uncle is a millionaire but got married to this woman

> who is a diehard alcoholic. And she died of cirrhosis of the liver. She was only 48 . . . And my cousin Roxanne is very messed up. She does drugs, and she's back doing drugs, now they want to take the kids away and lock her up…it's just a mess. She's just addicted to drugs. She has this lifestyle now; it's a trendy thing in Long Island, where couples are having sex with other couples, and leaving the kids with a babysitter. And she does that kind of thing.—*Talia Stein, 41, white, single, home healthcare aide*

> It's kind of rough out there. A lot of these girls . . . is having sex. Ain't nobody told them like they going to have a little baby, like "you're going to have my child." They just having sex, ain't even thinking about the consequences. About the baby coming. You know, so the most of the time the children are in the system because they're parents are on drugs. That's the main thing . . . [Their] parent was probably on drugs or they didn't have love or they was on alcohol or someone molested them or somebody did something to them. That's a cycle that goes on. You have to break that cycle. It goes on until someone broke it.—*LaWanda Jackson, 41, African American, single, nurse's assistant*

These comments reflect societal fears about negative social reproduction, or those cycles of poverty or bad-living that produce women who have children, but who do not behave like "real moms" Molly Ladd-Taylor and Lauri Umansky (1998:2) explain:

> Some mothers are not good mothers. No one can deny that. There are women who neglect their children, abuse them, or fail to provide them with proper psychological nurturance. But throughout the twentieth century, the label of "bad" mother has been applied to far more women than those whose actions would warrant the names. By virtue of race, class, age, marital status, sexual orientation, and numerous other factors, millions of American mothers have been deemed substandard.

Mother-blaming accomplishes many nefarious goals. It provides societal scapegoats, allows others to define themselves more favorably against their opposite, serves an allegorical function, boosts divisive political rhetoric, represses women, maintains existing social hierarchies, and ensures social reproduction. Infertile and childless women of all backgrounds grapple with this concept of the nominal mother, who represents an inferior kind of woman who, despite her immorality, is still assigned higher status than them thanks to a technicality. The sexual minorities (especially the lesbians), women of color, and single women among my respondents occupy categories that would automatically make them "bad mothers" in the eyes of many. Thus, these women (like Nicole, Talia, and LaWanda, all childless women quoted above) have to preemptively intervene in this discourse to deflect the future label of "bad" or nominal mothers from themselves. A general attitude lingers that childlessness indicates punishment for gender role transgressions. Just as in the Protestant ethic, wherein those "called" by God can be identified by others in their receipt of many "blessings," so too are mothers assumed to be God's chosen. It is this context in which the infertile and childless women point their fingers the other

way, toward those women who—through some cosmic mistake became mothers—but who do not deserve that status.

Occasionally nominal mothers came up when a woman wanted to point out the unfairness of her own difficulty in having children:

> I hated anybody that had more than two children; I mean I hated them. I would despise anybody that had more than two children. I hated the fact that women that didn't deserve children would have them . . . I felt I was treated so unfairly in life because I knew I could be a great mother to other children. And that's why it hurt because I just felt that I could do it. My husband and I are financially okay and we would be great parents and why weren't we blessed? What did we do in our past? I felt that we were being punished. What did we do in our past that this was happening to us?—*Lupe Jimenez, 41, Latina, married, electronics technician*

In this way of thinking, why should those who refuse to heed the "being there" prescription, who, for lack of character or maturity are financially unstable, be rewarded while the truly deserving are inexplicably "punished?" Lupe tells me also that she began to lose her religious faith precisely because of this dilemma. Some of the mothers in this study contrasted their reasons for having a child with some of the more "selfish" reasons they imagined others to have:

> Some people would like to have children because it's a way of continuing the species, one of them. Pass on what they've learned. I think kids are lots of fun and they bring a lot more love to your family and your home. I think some people do it for more selfish reasons, and I think some do it without thinking about it, unfortunately. So there could be parents who are parents, but it's more like they are biologically based rather than doing the actual work.—*Aikiko Moto, 43, Japanese American, married, teacher*

Aikiko, who (consciously) talks more generally of "parents," rather than just of mothers, emphasizes that these so-called parents—who *could* exist, but who are not real people she knows—refuse to do the "actual work" of parenting, the work being essential to the definition of parent. It is telling that she uses the term "parent." As with the word "mother," it functions as either a noun or a verb. One who biologically reproduces yet does not do the work is called a "parent" or a "mother" but others—like Aikiko—lacking a word to describe these less-than parents must content themselves with knowing that these reproducers are not "really" parents. The term "sperm donor," in American slang usage now means any uninvolved or estranged father, not just one who donated to a sperm bank. These men may *father* (definition: to contribute male gametes) a child but they do not *parent*. There does not appear to be an analogous term for a mother who does not mother, as its meaning is oversaturated.

Although society general perceives "bad" mothers through the lens of prejudice, i.e., mothers who are racial or ethnic minorities, teenagers, impoverished, single, and sexual minorities, sometimes "bad" mothers can occupy privileged social strata:

> I have this girlfriend who spent over $100,000 trying to get pregnant. She'd fly from Palm Beach through Atlanta over to Alabama to get artificially inseminated every month. When she came to Atlanta, she'd try another technique; she'd stay at the Ritz. What she wanted to do is—she had a doctorate; she had a law degree, everything she wanted, she'd always had and this she couldn't get. So she was willing to go bust out anything . . . . But she ended up marrying. She ended up going to MENSA, a guy in the MENSA society for years. He was the biggest drag in the world. He had no personality at all. But she wanted to be with him so they would have smart kids. Then she decided to go with a jock. Go with a jock so the kid—I went through four marriages with her and she had already been married before and she was after that elusive thing. But she wouldn't have known what to do with a baby, with a child. She just wanted to get pregnant and have that baby.—*Dianne Jacobsen, 56, white, single, life coach*

Dianne, an infertile-identified adoptive mother, taps into critiques of consumerism, eugenics, careerism, and instrumentalism. Her friend exemplifies the calculating businesswoman for whom children are highly commodified and represent nothing more than the opportunity to put another feather in her cap. In contrast to Dianne, who subsists on a limited budget, this wealthy woman seeks bragging rights instead of a mutual, loving relationship.

The notion of nominal mothers helps childless and infertile women situate themselves in a comfortable place within the schema of motherliness/femininity. Their infertility or childlessness places them outside of standard notions of womanliness and, by placing some mothers in a spectrum as inferior to others, they dissociate being a woman from being a mother,

a classification that can range from merely giving birth and—in un-mammalian fashion, returning immediately to one's own self-interested pursuits—to all-consuming devotion. They typically emulate or admire the real moms on their pedestals—even if they cannot envision themselves in that role—and, regardless of their own status as mothers, godmother aunties, or less-involved nonmothers, they place themselves above the nominal mothers.

Nominal mothers are thought to be too selfish to fully immerse themselves in motherhood. These fallen women's perceived lack of planning and assumed lesser emotional investment are unforgivable in the eyes of many of the women interviewed for this study. The working class women and the women of color tend to point more to the cycle of poverty and the perpetual immaturity of the mothers as the most unfortunate outcomes of nominal motherhood whereas the white and/or middle class women lament the dearth of "wantedness" and the injustice of easy fertility for the unappreciative and less deserving. In concert with political pundits and everyday bigotry, they demonize and blame a faceless bunch of women for societal ills, but the irony is that the stereotypes are usually culled from prejudices about the very groups to which many of my respondents belong: the poor, working class, African American, Latina, immigrant, and lesbian communities. This fact merely increases their need to distance themselves from these unacceptable mothers.

Godmother Aunties

> I love those two kids. I don't know what love means when you have your own child, how could I love more someone else? I mean, *really* love those kids and they love me and I'm their aunt and I—I just don't know how much I can love

someone else when I have a lot of love for those two kids.—*Azra Alic, Bosnian immigrant, 30, engaged, apartment manager*

Azra, the only woman pursuing IVF and one of the most emotionally invested in having her "own" children (at the time of the interview), describes the deep love of what I call a "godmother auntie." The label refers to the voluntary role taken on by women with close relationships with others' children. The godmother auntie can be distinguished from an "aunt," a mere title imposed from the cultural kinship system, or "godparent," sometimes an insubstantial, ritual designation. Godmother aunties also differ from aunts who raise their sibling's or friend's children as I would categorize these as "adoptive" mothers.

Fully half of my respondents call themselves aunties and/or godmothers. They animatedly, and proudly, describe the godmother auntie as one who loves unconditionally, who keeps alive family traditions, who purchases tickets to special events, who finances vacations and "extras," who provides guidance, who joyfully babysits, who teaches about volunteerism and other moral values, who listens without judgment, who provides an escape from abusive parents, and who generally "spoils" the children. But her role and status differ from those of real or nominal mothers. Though she may feel an abiding love for the children, she is always at some remove from them and from that perfect feminine status enjoyed by the "real moms." Stepmothers may fit into this role or they may more closely fit the role of "real moms" depending on the intensity, quality, and extent of their relationships with their stepchildren. Some of the women detail their long-term—even intergenerational—roles as especially involved godmother aunties:

My niece, the 26-year-old, she's my goddaughter. When she was 18, she got pregnant and she said I was such a good godmother to her that she wanted me to be the godmother of her daughter . . . And, I love those babies. I love them so much. And it's nice because when they see me they—there is so much love . . . they are jumping on me and I love it. "Give me more hugs, more kisses, you know I love it." [speaking animatedly]. I'm the only one when I leave that my nieces and my nephews come to kiss me . . . So there is just a real special bond with all of them. I guess when they were little, I didn't have any kids and so I always used to pick them up and take them to ToysRus and take them to the movies. And it was like rent-a-kid. And I loved being with them. I absolutely love being with all my nieces and nephews. And, they wanted to go and tell their secrets to [me] and they would talk to me before they would talk to their parents. Like, "How do you think I should talk to mom about this?" and so forth. I would always try to direct them in the right way as if someone was going to direct my son in that way.—*Lupe Jimenez, 41, Latina, married, electronics technician*

I think it was God's calling for me not to be a mom, you know. I love being an auntie. And you know how people say, "Oh yeah because you can just take them all day and then dump them back with their parents?" I never think that . . . And I have some traditions that I do with nieces and nephews. And they wait for me to do them . . . I remember one of my little nephews came over and he said, "Auntie—he's looking around; he's been there for a while and they would just come over. . . . —Auntie, do you have any little children?" And I said, "No." And

> then the other one said, "Well, why not?" And I said, "If I did, I wouldn't get to spend all my money on you guys. I wouldn't be able to take you out on vacations. I wouldn't get to buy you some new shoes." "Oh" he says, "I like that." He's the older one. So they, I think, grew up thinking that big women have little children. Isn't that weird? I thought that when he said that to me. And then that I mean the aunt is just like freedom. I would've never—I don't know what I would've done with my own children. Would they have traveled like my nieces and nephews? Would they get what I've given these kids? I don't know, I don't know what it would be like. But I have felt free to do [for them].—*Penny Ortiz, 52, Latina, single, guidance counselor*

The godmother auntie connotes "a special bond" as well as "freedom." This role enables women to love, nurture, and enjoy children—and to provide for them in selfless ways—but, at the same time, the giving does not require "giving up" much. Penny has the "freedom" to provide financially and emotionally for her nieces and nephews, the freedom to limit what she provides, and the freedom to do what she wants to with her life. This role does not completely satisfy Lupe but it does Penny, suggesting that a social theory of "infertility" or nonmotherhood must account not just for blithe "childfree living" but also decidedly "child-ed" "otherhood" roles. Jamilah further explains how godmother auntie can be *enough*:

> I wouldn't say that everyone should [have a child]. I know of people that are satisfied. Like my best friend, her little sister, her godmother, she's satisfied with just being a godmother. She can get them what she wants. She takes care of them

> just like she was their mother. Helps them, supports them in school. She asks their mom, "What do they need so I can help them with that?" or "Send them down to me." Things like that. Matter of fact, they find comfort in her more than their own mother. "Oh, I want Godmother. I want Godmother." She comes to them. She don't feel that. She doesn't feel that. She'll tell me, "If I'm supposed to have kids, God will give me kids in time. But for now I'm content with what I have." She's almost 40. She's content. She says she don't have no wants right now as far as children. She says she's selfish. She don't want to give. And she know if they're her children, it's like she has to. I mean, her godchildren—she does for them. But it's not the State telling her she has to, or society is not saying, "Oh, you have to provide for your godchildren." Because I know lots of godmothers who don't do anything.—*Jamilah Washington, 19, African American, single, student*

Being a godmother auntie involves nurturing, an activity ascribed to the "nature" of women. But these godmother aunties relate an experience that, to some extent, strains against discursive control. Although they enact the nurturing expected of women, they also do this nurturing much on their own terms. What they offer to children is not mandated by the state or by strict social convention, as Jamilah notes. Some aunts are distant relatives and some godmothers are just old friends of the children's parents. Those women who turn it into something special choose to each and every time they interact with the children. Being childless, as the above stories reveal, opens up an opportunity for women to enact a satisfying role that enhances their lives and the lives of the children they know. Based on these women's

experiences, it does not appear that occupying the godmother auntie role is always a concession, resulting from a frustrated desire for motherhood.

Nevertheless, since society exalts motherhood, some women who cherish and enjoy themselves as godmother aunties, do not find it an adequate replacement:

> [My nieces and nephews] love me. Go over there and I can't even get them off my back. They call me Lalatiti. Lalatiti . . . that's like my little nickname. They love me and ask [using child's voice], "Lalatiti, when you coming over?" . . . They LOVE me. I'm a good auntie and I'm fun. I'm fun. One of my little nieces go..."Lalatiti, do you have a car? Do you have a car seat?" "Yes, I have a car seat." "Put it in back in my car so you can go with me." I said [as to a child], "You can't go with me." "Whyyyyyy?" She surprised me when she asked me that, you know. And I said, "One day I'm gonna have a child," and she say, "Noooo. I don't want you to have one. I want to be the only one." But it's a good feeling, you know, when—children know good people. Children are attracted to me.—LaWanda Jackson, 42, African American, single, nursing assistant

> For a long time it was okay not to have kids, but then it was—after a while—it would be kind of cool if we had some kids to do this with too. So we'd go borrow the nieces and nephews for a while to do it with them. But then it was like . . . But it was never like enough. It's like we wanted to bring them home. You had to go by what the parents wanted. Just when it got fun, it was over.—Jennifer West, 46, white, married, engineer

> My mom tells me all the time, my auntie used to keep me because she wanted to have a baby. But my auntie was into school so she wanted to focus on herself first, and then think about having children.—Jamilah Washington, 19, African American, single, student

The intent in these comments is to demonstrate that these women are "natural," capable, (apprentice) nurturers. The godmother auntie relationship/status/role latently provides proof that the women are deserving of children, that they *should* be mothers, evidenced by the fact that children—who "know good people,"—love them. The godmother auntie role holds their place, as with Jamilah's auntie, in the motherhood/nonmotherhood structure, and within the accompanying hierarchy of femininity. Childlessness "just happened" for LaWanda, Jennifer is "infertile-identified," and Jamilah is in the midst of an "intentional delay." All three are good, motherly women, as they have shown themselves to be, and they will eventually—with luck or with God's help, they believe—find their way into the role that they hold in highest esteem: real moms.

Women "settle" for this role even if they later revise its meaning as meant-to-be rather than the default in the face of infertility and/or involuntary childlessness. This role also comes with a twist; the godmother aunties are in some ways better than real moms and they certainly feel they are better than nominal mothers. And yet. They still view themselves as less-than as women because they do not have children "of their own." In the Latina and African American communities, the auntie and the godmother are roles with deep historical roots in cultures of communal familism. Thus, for the women with these origins, the status is recognizable and the

duties are already partially defined. These roles exist among mainstream, middle class whites, too, but they are less common and more likely to be superficial labels. Nonetheless, for all of these groups there is a large measure of freedom encoded in this status. They can fully inhabit the role for a time or forever. It can be an outlet for their need to nurture, to feel connected, to take responsibility for children, to practice mothering skills, and to be recognized as feminine women. Some turn the godmother auntie role into a master identity—occasionally pointing to length and depth of service as proof of their dedication and integration into a larger family—whereas others use it as temporary stop on the way to motherhood.

Less-involved Nonmothers

About a third of the women with whom I talked were childless and described themselves as less involved in children's lives when compared to the mothers and the godmother aunties. Among the less-involved nonmothers are a few different types: those who decline motherhood, those for whom childlessness "just happened," and those who may still have children at some indistinct point in the future when they meet their personal, somewhat vague standards of "readiness." Some declare their disinterest or allude to their self-perceived deficiencies as mother material:

> One thing is for sure: God is no fool. God would not give me a baby, I don't believe, not right now. Because I don't have that much patience. And I have nieces and nephews like I told you, and they're little. I can watch them and the minute they wrack my nerves, good-bye!—*Nicole Lambert, 20, African American, single, student*

It's way too much work to be a mother. I was never interested in being a mother. That thought never crossed my mind . . . I think kids are okay . . . when I have kids that I like [around], I enjoy kids. And it's nice when they leave.—*Lana Marks, 52, white, lesbian, nurse*

In my early years, actually I thought to have children placed a big, big responsibility. Maybe that's why I never thought about it, to have children, because I thought I was not capable; I didn't have the intellectual ability or the education to educate a kid…Actually some of my friends at this point have adopted kids. Some of them actually, that's the advice they give me, "Why don't you adopt a kid?" but I'm of the idea that I don't feel capable of giving the attention and all of what a child requires. I like to be independent. I like to be free. I like to do whatever it pleases me to do.—*Lourdes Garcia, 56, Latina, single, office assistant*

I was almost 30, maybe it was later, and I do remember my mom saying, "If you do want to have kids, you'd better get married soon." And I though, oh my god, she's right. Because I love them so much but what scares me is they're so consuming. You have to be looking after them or be ready to be looking after them every minute. So that scared me but I'm also very drawn to them and like them.—*Karen Tabb, 49, white, single, teacher*

Lana, a woman I describe as “childfree-by-choice” is alone among the study participants in her utter lack of ambivalence about her childlessness, yet even she employs the common trope about the joy of having children around….for a little while. She enjoys her time with them, and unlike the godmother aunties, she also looks forward to giving them back. The less involved nonmothers often portray themselves—mostly without apology—as selfish in not wanting to devote every second of their lives to children. This counternarrative of fulfillment outside the maternal sphere is possible post women’s lib but it does carry a social cost:

> It’s natural instinct to want your own . . . People who don’t want children [in another voice]: “I don’t want no kids. I don’t want no children.” It might be experience they may have went through or they might just be selfish. . . . It’s up to them. I’m not there to question them, “Why don’t you want no children?” So it’s like they own little reason. . . . some people say, “I’m too selfish.” I was really hurt when they say “I’m too selfish. I’m not ready to settle down. I want to do this and do that. I be like, “Can I have your eggs then? Give me your womb.”—
> *LaWanda Jackson, 42, African American, single, nursing assistant*

LaWanda’s judgments illustrate several widely accepted ideas about voluntary childlessness. She implies that women who do not want children are unnatural, selfish, immature, wasteful, and ungrateful (for their potentially functioning eggs and womb). The less-involved nonmothers, whether voluntarily childless or not, turn these accusations in on themselves. Like those people that LaWanda quotes who say, “I’m too selfish,” my respondents inventory their own nonmaternal traits. Conversely, they also echo one another in frequent

mentions of their freedom. Without children, they can pursue advanced education, travel, stay out all night, whatever they want to do. They concede their selfishness but enjoy their liberation all the same.

But accusations of selfishness abound in these interviews and this blanket term obscures more complex motivations and phenomena. The women accused nominal mothers of selfishness for their supposed inattentiveness to their children. On some level, the selfish label reflects the envious feelings of those who cannot have children so easily. The less-involved nonmothers who abstain from motherhood or delay it are not only selfishly independent but also *unselfish*, they say, since they refuse to have children that they would not sufficiently "want" or dote upon.

The sentiment of having "always wanted" children crops up repeatedly in the interviews. Several of the infertile-identified and adoptive respondents say this about themselves or about women they know. To have "always wanted" children indicates some predestination and a naturally-inclination toward motherhood; those who have not "always wanted" children are automatically assumed to have always been less suited for it. The phrase "always wanted" can also serve as an explanation for the "desperation" of women who try too hard to have a baby, a feeling attributed to others—not themselves. They suggest women who have always wanted children just cannot let go of the goal of having them, regardless of the obstacles and costs. Some of the less-involved nonmothers seem to think their ambivalence about motherhood further proves their maternal shortcomings. It may also entail a bit of self-protection, wherein women who cannot come by motherhood easily reflect on their motivations and re-remember that they never really wanted children anyway.

Though they have no children and some may be nominal aunts at best, most still find significant ways to contribute to children. I can offer many examples: Monica makes baby

clothes in her spare time for friends' and neighbors' children; Talia's job involves full-time care of a 14-year-old severely disabled boy; Karen, who had children's drawings all over her living room floor leftover from a recent young friend's visit, received a call from a neighbor during our interview asking her to babysit for two small children while the mother ran to the grocery store; Gloria, who began considering adoption because her house was "too empty," cared for her adolescent brother until he recently moved out on his own. In addition, several of the less-involved nonmothers bore considerable responsibility in the care for younger family members at some point in their lives, sometimes during their own childhood:

> I am from a family of 11 kids . . . there's a lot of them [nieces and nephews] because I have so many siblings. But my older sister had kids young. She got married at 18. So I took care of those kids when I was 12, 13, 14. So I was babysitting for them. I was sent over to help my sister when she had her second baby.—*Annette Kramer, 54, white, lesbian, family therapist*

> There were six of us, so I had five siblings . . . I did a lot of babysitting growing up . . . It was awful. It was awful . . . I was trying to grow up and be a kid, grow up and survive, and then I had these other kids to take care of.—*Lana Marks, 52, white, lesbian, nurse*

It is possible that on some level these women feel that they already did their time raising children (see Gregory 2007). Indeed, some of the older, adoptive mothers I talked with who recalled similar responsibilities indicate that they delayed childbearing because they needed the

opportunity to be free, sometimes inadvertently passing up their fertile years. A need or desire for the autonomy they did not have growing up, then, may also partly explain some women's choice to be childless. In any case, they may be less involved with children now but they have not always been that way. This fact underscores the fluidity of these categories in individual women's lives.

Some of the less-involved nonmothers specify how they may sustain a feminine, nurturing identity through praxis that does not involve mothering:

> There's just a lot of children out there who need somebody to listen because they don't get that at home. I'm not saying I would be the perfect person. I'm not saying I would have all the solution to the children's problems. When I think about being a nurturer, I think I don't need to have my own; I could maybe get into a line of work where all I ever do is deal with children who have issues and try to play my part in trying to make their lives a little easier.—*Annie Adoyo, 30, second generation African immigrant, single, student*

> Back home, we have about two, three, five kids that we are sending to school. We support them. So that makes us feel good, better.—*Zara Senai, 45, African immigrant, married, laboratory technician*

Annie imagines a job with children as an alternative to having them herself and Zara, who expresses much sadness at her infertility, tells me of her and her husband's choice to buy books, send money, and provide the financing for her brother-in-law to build a house in the city

back in Ethiopia so that her nieces and nephews can go to a better school. The social stigma (or, more to the point, the resulting negative effect on self-esteem) attached to childlessness may be allayed among my respondents by their devotion to the care of pets, partners, friends, or elderly parents and by their working in professions seen as altruistic and requiring mothering-like talents like nursing, counseling, and teaching. Maggie Kirkman (2008) found that childless women reassert one aspect of their femininity (i.e., caring/nurturing) by pointing to these kinds of proof of their "maternal instincts" or stereotypically feminine qualities. To be clear, I do not propose that all women who opt out of motherhood must find other outlets for their "motherly" qualities—qualities that are no more "natural" to women than to men. Their behavior likely stems from their socialization as girls, their need to identify as gendered women or to project that image, and the career tracks most open to women.

The less-involved nonmothers who are singles and lesbians live what second-wave feminism envisioned as the emancipatory ideal: freedom from the private patriarchy of heterosexual marriage-with-children. A couple of them (i.e., Lana and Annette, the "childfree-by-choice") concur with this vision but there are several other takes on this status of the less-involved nonmother. Besides jokingly or seriously casting themselves as inadequately maternal, some of these women point out, as I have said, that they have already fulfilled their duty by raising siblings and/or remind me of their other feminine qualities. These tactics may be read as defensiveness in a pronatalist, gender-stratified social context or as internalized gender imperatives, but they may also be read as substantial life options in and of themselves. For several women in this category of "less-involved nonmothers," childlessness "just happened" as result of the vagaries of life events. They embrace the status a bit less comfortably, choosing instead to "not think about it." The younger women, of course, often view themselves as only

temporarily less-involved nonmothers. For them, it is an appropriate and acceptable life stage between childhood and adulthood. But for the postmenopausal women who have been less-involved nonmothers for decades of adult life, it is a permanent situation. Some claim no regrets and others acknowledge intermittent disappointment in the turn their lives have taken. But all recognize that their lives nonmothers challenge expectations and they find they must defend and explain themselves to others. They find ways to explain within the available discourse that they are nonmaternal but feminine (I discuss these ways in Chapter 6), and then go about living complete, rewarding lives in which they contribute to society. They do not have to be viewed as stymied by childlessness or stumped by infertility nor even the kind of women for whom "childfree" is a badge of honor, an indicator of their feminist bona fides. Taking their claims of happiness at face value, their lives advocate a broader discourse about what womanhood means.

Virtually all of the women in this study parrot commonly held ideas about "good" mothers and "bad" mothers, which are often little more than judgments resting on assumptions about class, race, sexual identity, and, to a lesser degree, age. Old notions about women as mothers, originating from specific historical junctures persist even as the ideal (i.e., the Standard North American Family as described by Dorothy Smith [1993]) becomes ever more unattainable, or, really, *untenable*. When asked about the meaning of "mother," the women who I spoke with craft answers that accomplish these rhetorical tasks: 1) reifying motherhood as the quintessential embodiment of femininity and mature womanhood, 2) resetting the hierarchy of mothers that Ginsburg and Rapp (1995) term "stratified reproduction," and 3) locating themselves in a comparatively comfortable place in a taxonomy of women. They report these conceptualizations of women as common knowledge; after all, it represents an overwhelmingly hegemonic conception of women in American society. However, the fact that this dutifully built narrative

peripheralizes infertile and childless women shows the power of these assumptions and makes their resistance to the processes of normalization (seen more in their actions than in their rhetoric) appear all the more agentic, even courageous.

Importantly, however, gendered *identity sufficiency* evident in their otherhood constructs varies and this variation conditions *decisive efficacy*, *role applicability*, and *normalizability* in the context of motherhood, all in dialectical ways that I describe in the following chapters. Some of the women create and embody admirable godmother aunties and authentic, self-aware less-involved nonmothers whereas others see the former as a temporary substitute or testing ground for real motherhood and the latter as indicative of immaturity or selfishness, of inadequacy as prospective mothers and as women. The following chapter shows how respondents' marked indecisiveness about motherhood increases alongside increased experiential knowledge that they are "enough" as women in sufficient otherhood roles.

CHAPTER 5: INDECISIONS

> People want children to be able to continue their bloodline. Psychologically, it gives you some sense of fulfillment. As human beings, you go to school, you grow up, you get a job, and you start a family. And you retire, and you go senile, and then you die. Finding a partner and starting a family is supposed to fulfill you.—*Gloria Owusu, 38, African American, single, project manager*

Gloria succinctly—if a bit cynically—outlines the standard life course in this society. But when it comes to the part about "starting a family," the women I talked with all found themselves off that course to one degree or another, at times intentionally and at times accidentally.

Prior to beginning this study, I naively assumed that many women made a definite decision to have children or not. Clouded by my own struggle with involuntary childlessness, in effect, "courtesy infertility" (see Miall 1986) due to my partner's sterility and, eventually, my own age-related subfertility, I thought that women who, like me, did not have children, would know whether or not they wanted them. Thus, I diligently crafted questions and probes for my interview schedule that were designed to explore how these decisions were made: who influenced the respondents, what kinds of reactions their decisions provoked, what advantages and disadvantages they considered, what feelings surrounded their decisions. I quickly discovered that instead of offering clarity, many of the respondents would hesitate, hedge, and waver in their answers. Some displayed greater ease in telling me first why "other people" want children, only later explaining their own reasons for wanting them or not. A few talk about having "always wanted" children, but at times, even these same women contemplate the negative

consequences of having children, harbor doubts about their capabilities as prospective mothers, and defer to what many describe as God's unique plan for them.

This chapter explores the tension between the goal of identity-construction within a rubric that has idealized motherhood at its core and the women's indecisions about their own fertility and motherhood. This unwillingness to commit to a decisive plan (and perhaps this kind of planning is a "yuppie" construction just as infertility is oft seen as a "yuppie disease") stems from the complexity involved in attaining *readiness* for motherhood and a steadfast belief that motherhood is not wholly an achievement; rather it is a *mystical ascription.* Comparing my interlocutors' understandings of what motivates other women to become mothers alongside *their* personal motivations and prerequisites for motherhood is instructive. For instance, the women I interviewed are fully capable of making motherhood a basic, essential function, the key to life fulfillment, for (other) women even while approaching the role a bit more cautiously themselves. As always, these constructions and explanations differ qualitatively by the respondents' social backgrounds. There is also significant interplay between the types—"*de facto* infertile," "infertile-identified," "intentionally delayed," "childfree-by-choice," "never readies," and "just happeneds"—introduced in Chapter 4, "Motherhood from the Margins," and their positionings along a continuum of *decisive efficacy* about motherhood. In this last phrase, "decisive" refers to how definite the respondents are about choosing or not choosing motherhood or nonmotherhood and "efficacy" represents their beliefs and attitudes that they themselves can make motherhood happen or not happen. For many, their statuses are ascribed and their own actions do not account for their childlessness or, alternatively, for their fortune or "blessing" as mothers.

Motherhood Motivations

Imagining procreation/reproduction as homologous to capitalism, the "exchange value" of maternal bodies involves making babies. The "use value" of maternal bodies would be, most obviously, motherhood as status-enhancer as well as mothering as emotional contentment. Nonmothers may lack "exchange value" as reproducers but their "use value" extends to greater upward mobility and career enhancement, opportunities to be other-than-mothers (e.g., godmother aunties) and the enjoyment of other pursuits like traveling, hobbies, friendships, and other relationships.

My talks with respondents about why people have children and why they as individuals want(ed) or do not (or did not) want to have children, bear out the analogy above. Their answers, which vary from general, philosophical musings to practical benefits and drawbacks of having children, also further illuminate shared ideas about femininity/womanhood. Having children, something preferably planned, provides the opportunity to fulfill personal, biological, societal, or divine expectations, to ensure social reproduction, and to enter adulthood:

> I think some people have children because it is the way. It is life created. You are a woman, you have to get married and have kids and have a family—*Lourdes Garcia, 56, Latina, single, office assistant*

> Just culturally, everyone has children. Children are like air. Having children is like air. So everyone has children. Even though I'm not someone who does what everyone does, I just get so much joy. Aside from everything, I get so much joy

> from children. Peace. Grounding. That's what my niece gives me. I know that it will just be a blessing.—*Gloria Owusu, 38, African American, single, project manager*

> [People want children] for lots of reasons, I suppose. Carry on the family line/tradition; don't think about it—just sort of do it. It just sort of happens. And then some people, that's their *role* [original emphasis]. It seems like that's what they are called to do.—*Annette Kramer, 54, white, lesbian, family therapist*

The women in this study understand having children as a basic fact and facet of life even if it is not their experience. Most people—not them—do not pause very long to consider their reasons for procreating. Gloria, one of the women for whom childlessness "just happened," still hopes to be "blessed" with a child in order to gain peace and grounding in her life and she acknowledges that having children is also culturally prescribed. Annette, who is "childfree-by-choice," reintroduces the two types of mothers discussed above: the real moms for whom motherhood is a role and calling and the (nominal) mothers who "just sort of do it." Infertile women, lesbians, and singles do not usually have children as the result of a moment of passion, nor by charting their ovulation while choosing the color-scheme of the nursery. Their motherhood, if it is to happen at all, entails intention and clearing many hurdles along the way. This view sensitizes these women to careful consideration of motherhood, an attitude that they expect all "good" mothers, or "real moms," to take on.

The mothering instinct, the motherhood calling, and/or the need for the bodily experience of pregnancy and childbirth came up repeatedly as reasons why women might go to the trouble of pursuing motherhood:

> I just feel like I am blessed with more than some people have, it terms of being able to get an education and being able to work and support myself. I'm just at that age where many of my friends have settled down . . . are married and have children and whatever else. And I love my cats, you know, but they're not children. It's not like you're nurturing anything to learn to become independent. And I guess it's my mothering instinct, or whatever it is, is alive, kinda sorta. I just thought maybe it would be nice to have a child. Right now I am just open to exploring what my options are. I am not opposed to being a single mom. There are lots of single moms out there. Ideally, I would have a partner, but I know I could do it on my own.—*Annie Adoyo, 30, second generation African immigrant, single, student*

> I want to experience pregnancy. And it's just a natural thing that women go through and just to experience carrying a child inside of me. And the childbirth, I've heard about that! But just to experience what it's like to carry somebody inside of you. I just think it's amazing. I really want to experience it.—*Nicole Lambert, 20, African American, single, student*

You get to experience the birth of having that baby [sic]. It's important to me but it's not *that* important to me. If I could have a child without the pain and just pray over the baby that God will heal that baby with whatever it had, and He will heal it, you know, so when down the road with schizophrenia or any kind of trouble diseases with that. That's the only thing. It would save you time and you would have that baby without hurts or anything. And you know you have the experience of being pregnant or breastfeeding to bond with that baby. Cause you know when you breastfeed that's a bondage.—*LaWanda Jackson, 42, African American, single, nursing assistant*

A lot of people are in love and they want to have a family and having children is obviously an expression of their love and they want to be partners raising kids together. And I think a lot of people feel that after a point in their lives, they are not enough for themselves anymore and they need someone else to put their energy into and kids require a lot of energy so that would be a good way to redirect that. And I think a lot of people also have a lot of things about themselves they don't know and they look at childhood and childrearing as a way to make themselves grow and to find out new things about themselves and their capabilities. And of course they want to perpetuate themselves, I think leave somebody behind, because nobody's immortal . . . I think I have a lot of love to give, and I'd love to give it to somebody. I'd love to leave a little posterity behind. See my eyes in some other individual. I'd love to have that experience of pregnancy.—*Emily Reilly, 30, white, single, fast food manager*

Several respondents indicate that pregnancy is the embodiment of womanhood. It is a tightly woven symbolic, physiological, and social experience. Many women assume it will happen to them and they want it to happen, and when it does not, they have to cope with the perceived loss of femininity. But there are options. Annie hedges that her mothering instinct has "kinda, sorta come alive" leaving the logical door open for a different outcome. LaWanda, who wants to adopt, tells me that birthing her child is important but not "that important," indicating that she is sad to let get of the bonding opportunity but, at the same time, as feminine experiences go, raising a child trumps birthing one. In fact, the adoptive mothers—generally busy with the daily responsibilities of childcare—barely lament the lost opportunity to carry their child(ren) and choose to expend little or no energy on regret. All four of them, though, all "infertile-identified" to varying degrees, attempted to get pregnant, certainly the first resort, but then, upon difficulty, finally decided to go with the "sure thing:" adopt a child rather than step onto the "infertility treadmill," (Harwood 2007) in pursuit of that "elusive embryo" (Becker 2000). However, Emily, a new foster mother, still wants to experience pregnancy (she is looking into sperm banks); she emphasizes a social preoccupation with "collecting experiences." To her, motherhood enables personal growth. This narrative paints motherhood as a journey to full womanhood:

> The reason why I want a child is—Well, now having one, I can grow in ways that I never thought imaginable and it makes me want to be the best person I can be having her. And she's the greatest teacher yet.—*Jessie Silva, 42, white, queer, hairstylist*

I think a lot of the reason why people want children is to feel wanted, to feel that somebody needs me. To encourage them. If I have a baby, I have to go on for my child. I can't not work. I can't not continue on. I know that if I give up, then I'm not setting a good example for the child. And a lot of times it isn't planned. It's something that I think should be thought out before it happens . . . I have a close friend and she has a baby. And the baby's father is in prison. But she didn't plan on having a baby. But when she found she was pregnant it was too late for an abortion…and we don't believe in abortions anyway . . . I look at her as an example of what life would be like for me if I had a child. It's hard . . . She's raising the baby alone . . . but the baby . . . encourages her to keep going on. She is up at the crack of dawn going to work. She struggles just so she can make the money so that someone is there to watch the baby.—*Nicole Lambert, 20, African American, single, student*

We wanted children because we wanted to help bring up children as happy individuals who can contribute to the world. We wanted to share some of the things that we really love about living in this world with young individuals entering life. We wanted to share our knowledge, share our happiness, and also share our desire to be kind to other people, make the world a better place in various ways. So we wanted children I guess because we want to share the experience of things, and because we thought our own happiness would be increased a great deal if we could share these things not with just adult friends,

> but with young individuals, with young children, whose lives we could help influence, who we could help bring up to be happy and to care about . . . I was very happy growing up and had a good home life and remember my childhood years as having been very happy ones, and so I wanted to share some of that.—*Hannah Johanson, 39, white, queer, married, teacher*

One grows as a person—as a woman—*through* the nurturing of a child. Nicole, who sees having a baby as motivating women to persevere, is not ready to grow up; being forced to grow up is the main consequence of motherhood in her view. When she is "ready," she will pursue it. These women are not preoccupied with the goal of a baby or of the status of "mother," but with the process of mothering and the benefits of that process to themselves. I interpret this as a fairly emancipated perspective. These women are not in it (potentially) to fit in or to acquire a baby or to fulfill a directive of social reproduction; rather, they want the *experience* for its own sake (*cf.* Ginsburg 1989).

Having children also, according to the women I talked with, cures loneliness, theoretically brings one emotionally closer to a spouse, provides insurance in old age, is simply the result of a biological drive to reproduce, or is expected by God:

> A lot of people, they want children to start families. But as for young people, I think they are missing something. Like maybe the lack of love of a father or a loved one like that. I have a lot of friends who have children because they feel that something is missing in their lives. They think a child will be able to replace that. Like my friend that I went to middle school with. Her dad was a part-time

dad. He was there, and then he wasn't there . . . When she got to high school, she didn't which way to go—hang out with the bad crew or do her work. Now I see her at the department store where she works. She says it's really hard on her. She don't regret having her son. But at the same time, she thinks she shouldn't have done it. She just did it because she was missing something—*Jamilah Washington, 19, African American, single, student*

I want a child because I was talking about how lonely I am [tape paused]. We were talking about how lonely I am and everything so it's like recently it's like God—I just been seeing if I want to adopt a child. Um, just a few weeks ago, I see on TV, um, *Calling All Angels* and then about two weeks ago at my church, my pastor was like, "you know a lot of children need to be adopted." And I was like, "Okay, God, I hear you." Because I was talking about all how lonely I am and waiting for that special husband to come along so I fittin' to say, "Okay, I hear you," and then that's how I ended up at the adoption agency. I feel that I could love a child; I have a lot of love to give. I'm patient, I'm experienced too. I work with children. I'm a nurse's assistant, so I work with children in pediatrics like that. And I handle like 12 babies, change their diaper and feeding them and rocking them and doing things like that in between other things that I do. And I'm the oldest of four girls so you know I have a lot of experience dealing with children.—*LaWanda Jackson, 42, African American, single, nursing assistant*

> [People want children] because they want to have something in their life—it makes your life full I guess. I started thinking about like how would it be if we get old and we don't have any kids and also like how would it be if something happened to [her husband]? And he's my family. He's all I have and I didn't have any kids with him. I just felt like I'd be really lonely if I didn't have children. There's so many things that I'm into doing that I love sharing with children . . . Like baking Christmas cookies each year, going to get the tree, making a big deal out of the holidays, and swimming in the tropics.—*Jennifer West, 46, white, married, engineer*

> I think that people want children because they want to give and nurture, probably in the same way that some people want to give and nurture their pets, but also because they want their genetic or DNA—to be sort of immortal. To be allowed to be immortal and continue.—*Lana Marks, 52, white, lesbian, nurse*

For Jamilah and others, the phrase "have a family" is synonymous with having children of one's own. Couplehood is inadequate for women like Jennifer—who I describe as "infertile-identified," for example, who wants to carry on traditions and share her favorite pastimes with children in particular. But her real fear is not baking too many cookies; it is loneliness in old age. A few of the single women, like LaWanda, complain about their loneliness and point out that their own children would keep them company, and would presumably help them in their old age. To be sure, the absence of someone to care for them in their old age is the only regret several

respondents (i.e., both of those who are “childfree-by-choice” and a couple of those for whom childlessness “just happened”) have about their childlessness (often offered in jest).

LaWanda also indicates that God is telling her to adopt children; He is calling her personally. By contrast, Jamilah’s friend has a child in a misguided attempt to fill a missing part of her life. This mistake carries lasting consequences and, to Jamilah, it serves as a cautionary tale and justification for her own intentional delay regarding motherhood.

To explain why some women do not have children, the respondents generated a much shorter list, one that mostly just adds negative dimensions to the themes explored above. Some women metaphorically shrugged, saying that motherhood was not a “calling” for everyone. They have fewer narratives available to them to explain this deviance. However, several insisted that one’s life may already be “full” without children or that some women lack the patience or commitment necessary (as discussed above regarding the “less-involved nonmothers”), or that they themselves were not yet—or ever—“ready.”

Readiness

Readiness for motherhood was a recurring theme in the discussions of fertility and infertility, childlessness and transitions into motherhood. Readiness is a highly ambiguous concept that can change over time. It can mean being prepared in a practical way, having the correct social status (e.g., married, employed), being emotionally and psychologically willing, or being primed biologically for motherhood.

Elizabeth Gregory’s (2007) recent book *Ready*, based on interviews with apparently white, middle class women entering motherhood in their late thirties and beyond, champions the

decision to delay childbearing, arguing that women who wait until they are "ready" for motherhood, tend to be wealthier, more stable and satisfied in their careers and partnerships, and more emotionally mature. The author considers how adoption and advanced reproductive technologies can offer older women (i.e., 35 years' and up), singles, and lesbians the opportunity to become mothers when they are good and ready, after they have established themselves, sowed their wild oats, and had their adventures. My more diverse study participants agree with this notion of readiness up to a point. Consider this example from one of Gregory's interviews with a lawyer and single mother named Andrea who adopted when she was 44 years' old:

> You've gotten to travel, you've gotten to do stuff that's just for you, you've gotten to have the outrageous car, the outrageous handbag that cost too much money, take the most wonderful trips, not have to worry about getting a sitter. And so for me, at this point in time in my life, it's all good . . . I'm happy, and I think that their happiness depends largely on your happiness. And if you aren't capable of taking care of yourself, and you aren't having a satisfying life, they are not having a satisfying life. And I think that in my twenties, I would have felt like I was missing something. (Gregory 2007:260)

Andrea's veiled indictment of mothers less well off than her and the symbolic cues that let others know that she engages in higher status modes of mothering, underscore how class locations and other status disparities foster very different standards of readiness.

Finding Mr. Right

The focus on "finding Mr. Right" depends on factors like 1) age (there is either "still time" or the time has passed), 2) sexual identity and relationship status (primary romantic relationships with women or with men deemed unsuitable for fatherhood dampen the possibility of motherhood), 3) self-concept and its relation to romantic goals (degrees of emotional and material preparedness for pairing with a potential reproductive partner), and 4) race and class community conventions (the acceptability of families that do not approximate the SNAF ideal).

> We didn't talk too much about the whole sperm donor thing, and that has been a big issue for me. Is it morally right to bring a child into this world who's going to only have a single parent? They'll always have those issues of "Who's my dad?" And it's kind of giving up the dream of Mr. Right and two and a half kids and the white picket fence. It's not a total nail in the coffin, but it certainly makes it is more difficult to meet a man when you have a kid fathered by somebody else, even if that man is not in your life.— *Emily Reilly, 30, white, single, fast food restaurant manager*

Emily's moral quandary reflects a patriarchal legacy that includes the theory of the human stain, in which men suspect their progeny are not their own if their bride is less-than-virginal, geneticism, as in the primacy of genetic ties in forming kinships, legitimacy, and the necessity of a "father figure" for healthy child development. She wants to have children anyway, but she risks "giving up the [SNAF] dream" if she goes it alone. A woman can wait indefinitely

for a partner or she can enter motherhood which may make her less attractive. For this reason, many women delay making a decision, leaving events up to fate.

Many—but not all—of the women interviewed, including two of the lesbians (who, when partnered with men in their younger days, considered getting pregnant), focus on the need for an appropriate male partner with whom to have children. Marriage, most seem to reason, implies that children are intended. The converse, singlehood, does not always mean that children are not part of the plan, but the status does complicate things considerably in instrumental, material, and ideological ways. Several of the interviewees tell of their frustration in not meeting eligible men in time to satisfy their biological clocks. Annie, for example, in commiserating with me over our shared childlessness, remarks that I am way ahead of her because at least I am married. This is a common outlook:

> I always loved kids, even when I was little. I always babysat and worked at the daycare center at church. I had strong attachments to kids and assumed I would have kids. In my twenties I moved out here with a boyfriend and it didn't work out. If had found the right relationship and gotten married, I think I would have kids. But I wouldn't want to do it by myself…And then since then I've had boyfriends that I really liked, but nobody where I thought, "We would be good together; we should get married." I don't know why. Sometimes I forget that happened and I think, "Oh my God, how weird!" Because I'm very family-oriented and I love kids. But I didn't want to take that on. I've known a lot of single moms and I know how hard that is . . . I think I did want kids but I didn't feel like I could just go out and make it happen . . . I felt like I needed to find the

> right relationship. I felt more pressure to find the right relationship than to have a kid because I knew I wasn't going to have a kid without the right relationship.—*Karen Tabb, 49, white, single, teacher*

Karen iterates the idea that woman should be married before considering having children. She's had several boyfriends but none were quite right for marriage and children, a fact that she finds surprising given her interest in children but one that she chooses not to "dwell on." Her reason for not having children boils down to not having ever met the right man with whom to have them; this is why her childlessness "just happened." Particularly the younger women, but also some of the older ones, insist that a man is unnecessary and that the lack of a partner will not prevent them from having children through adoption or a sperm bank, though most indicate that "it would be nice" to have a co-parent to share in the love and the responsibilities. Some of the women expected to have children with a particular partner, only to be disappointed to discover that he no longer wanted children or that he was unsuited for fatherhood:

> The last long-ish term relationship, when I met him, he had children. And I asked him if he would have any more children. He said we would. And based on that, I had a two-and-a-half or three-year relationship with him. It was then that he said he didn't want to have children . . . that was an absolute deal-breaker.—*Gloria Owusu, 38, African American, single, project manager*

> I had a little window of opportunity where I could have been artificially inseminated and able to hold a child and I had tried to talk to him a little about

that . . . but he was in denial about it. And he wasn't ready—he wasn't ready to have children at all. He wasn't ready to go there . . . he just wasn't ready to like dig deep and like grow. He just wanted to stay in that place like when we first met—*Jessie Silva, 42, white, queer, hairstylist*

I got married and I waited a long time because I was in school. And I had relationships before I was in a long relationship and thought, "This is it. I'm ready to have a baby." And that wasn't the case. That's not what my boyfriend wanted . . . [13 years' later] I met my future husband [coughs] he was just, you know, "Oh this will be great. I think it will be so great together. We can have a family." And you know, I thought, "Wow this is what I really always wanted." So we were engaged and I think along the way . . . I started seeing red flags . . . I remember us being up at the landing on the stairs and looking down and he goes, "just imagine. One of these days they're going to be looking down. We're going to be downstairs getting ready for Christmas and looking up and telling the kids, "Get to bed or Santa Claus isn't going to get—So I thought, "Wow, what a vision for him to say that," so it turns out, I forget what holiday it was, but we were all at the house and my nephew was two, I remember, and I remember he wanted to play with my husband. He kept going to my husband. And my husband kind of shook him away. And I thought, "Oh no, that is not okay." In my heart, I was thinking, "Oh my God, how could you do that to a baby, to my nephew?" And I thought, "You want to have children?" Anyway it was wrong to me anyhow . . . I mean I would just love to have a baby, I that would be . . . but I'm not just going to go

> have a baby. I'm not just going to find somebody and be like, "You look nice; would you be the father of my child?" [laughing] I mean it had to be real, it had to be relationship that was going to last, like have a father and have a family, and what have you.—*Penny Ortiz, 52, Latina, single, guidance counselor*

In the above interview excerpts, Penny remembers being "ready to have a baby" in her twenties. This "readiness" stems from feeling secure in her romantic relationship. But this boyfriend was not "ready" (or not interested). Later, she sadly accepts that her husband, despite his keen interest in having children, is not father material. Thus, she never becomes ready to have a child with him, and never does have a baby. Her experience belies the frequent supposition that it is women who decide whether or not to have a child and to enter motherhood. Many would look at Penny's life—noting her master's degree, career ambitions, her blithe, spur-of-the-moment travel expeditions, her frequent fun evenings out with friends—and dismiss her as another of those *feminists* (a word some spit more than they enunciate) who selfishly indulged herself instead of settling down and becoming a mother as socially expected. As a society, we generally forget men's role in delayed childbearing, ignoring their influence—by refusal to pursue having children or by not measuring up as "father material" in the eyes of their partners. And certainly men's delayed parenthood is much less pathologized than that of women.

Gloria, in contrast to Penny who stuck it out for a time, swiftly ditches her relationship when it becomes clear that the man does not want to have children with her. In my conversations with her, she sounds resigned to having children without a partner and she expresses mild concern that her "marketability" will diminish should she adopt on her own. Unlike some women, Gloria feels "ready" even without the male partner. This divergence is partly the result

of changing societal norms as regards the standard life course well as individual differences between women. Jessie Silva, whose husband seemed like he would never be ready, breaks off the relationship and later begins a long term partnership with a woman:

> It was always my journey. And I was thinking about it when I was married, too. It was something that I deep down always wanted so I was looking for a partner to have that with. Because I thought I had to do it with somebody else. I didn't think I could do it alone. That wasn't what I thought that I could do. So when I got into my relationship with [her] I knew that our relationship wasn't going to go that way. And she wasn't ready. I just said, "This is what I'm doing . . . I'm 34 and I'm going to adopt and it's going to take me a while and this is what I'm going to do."

As evident with Jessie's comments, having a partner is not solely about getting pregnant or about building a Standard North American Family. It is also about having another adult with whom to share the work of parenting, and presumably with whom to share the joys and intimacy. Several of the women for whom childlessness "just happened," never achieve sufficient readiness because they do not think they "could do it alone." But Jessie, who first thought she needed to become pregnant with her husband, then she thought she merely needed a life partner to be "ready" for motherhood, and then she finally recognizes that she can mother without either, evolves in her thinking. Conservative initiatives, like George W. Bush's Marriage Initiative and anti gay marriage bills, notwithstanding, more and more families are female-headed. This increase in acceptable family types allows women like Jessie to go against the grain with less

stigma—and with a small measure of structural support. She receives some financial assistance, for example, from the state and federal governments for adopting a “special needs” (i.e., an ethnic minority, “drug-exposed”) child. Women like Penny prefer alternatives to motherhood, given all the difficulties attached to single motherhood.

A qualitative interview project by Martina Klett-Davies (2007) on “lone motherhood” among welfare recipients in England and Germany develops several categories of single mothers: pioneers, copers, strugglers, and borderliners. Single motherhood is a feminist project for the pioneers, a temporary, improvable state for copers, an overwhelming trap for the strugglers, and a mix of these for the borderliners. It is important to note that state-dependence (or any other status) does not preclude single motherhood from being an emancipatory experience. As Klett-Davies points out, it is easy to imagine a wealthy mother who stays in an unsatisfying marriage because of financial considerations as well as to imagine a poorer woman who feels the freedom of controlling her own meager spending. Klett-Davies’ typology can be applied to childless and infertile women’s predictions about their potential motherhood. There are those, like Jessie Silva, who declare their womanhood despite the “bodily disruption” of infertility and resolutely chart a course toward motherhood without a partner. More common among the study participants were those women who are reminiscent of the “copers.”

Gloria Owusu and Emily Reilly, by example, were testing the water as regards insemination and adoption—looking at the catalogs and getting certified as foster parents—when I met with them. Both worry some about their chances of finding romantic partners after acquiring children, but they seem to think that as long as the possibility was there, they might just forge ahead into single motherhood. The prospective strugglers include women like Penny Ortiz and Karen Tabb and Lourdes Garcia, all women in their fifties (or almost) for whom

nonmotherhood “just happened,” do not think they would have been able to “handle” the financial and emotional demands of single motherhood. These women, raised before the Women’s Movement, also allude to—in varying degrees—their concern about the legitimacy of children born out of wedlock and about the moral correctness of single motherhood. But the possibilities for women have changed in recent decades, concomitant with growing numbers of single mothers across the Western industrialized world (Duncan and Pfau-Effinger 2000). The youngest women in this study, the three African American women under 26, predict single motherhood as a “struggle” if it were to happen right now. Nevertheless, provided they reach certain goals toward self-sufficiency, they welcome it.

Located in late modernity, betwixt and between Gemeinschaft and Gesellschaft, the women in this study must parley their own inclinations and choices about motherhood through the scrim of traditional notions of family and women’s place in society. To say that women like Karen or Penny are “voluntarily” childless occludes the fact that any choice they make is subject to social regulation and discursive constraints. Women are expected to have children and they are expected to get married. But these expectations are not an either/or proposition nor are they mutually dependent. For women who want children, finding Mr. Right can be the only way out of this bind, wherein they can have children in comfortable, socially-approved SNAF fashion. Those nervy singles, lesbians (who may also be “infertile”) that decide to make the effort to get pregnant and raise a child outside the institution of heterosexual marriage, make the decision to fulfill one mandate and forgo the other, but to do this they also have to decide *when* this is going to happen.

Finding the Right Time

I did talk to [my mother] about possibly adopting a child. She's like, "You need to finish your education first. Wait until the time is right." But when is the time ever right? It's always something. I've learned that. It's always something.—*Annie Adoyo, 30, second generation African immigrant, single, student*

I just wasn't ready for it at that time. I wasn't ready for marriage either. I wasn't ready then to raise his kids and have more kids. I just wasn't ready for kids at that time. I mean, I loved picking up my nieces and nephews for the day; but I took them back afterwards [laugh]. All my friends in high school had children before we graduated high school. I was the only one that did not have a child in high school, so.

Why not?

For one, I seen what my sister went through being sixteen. Actually, [laughing] I didn't lose my virginity until I was out of high school because I was just so scared of being pregnant. And, I think about it now and I think God, I should have done it [laugh]; maybe I would have had more kids. I was just, kind of a little wild too, you know, being young. And, I wasn't ready to settle down. So my girlfriends in high school were having their babies and dropping out and I was into having fun and going out and partying and having a good time.— *Lupe Jimenez, 41, Latina, married, electronics technician*

Not only do women feel they need to find the right partner, they also must find just the right time to have children. The right time is, of course, an undefined objective, one influenced by others' opinions, by personal ambitions, by practical goals, and by age. As Lupe's comments show, laments about timing often occur in hindsight. She wishes she had had sex in high school (the search for Mr. Right be damned) because she may have had more children and consequently she would now feel more successful as a mother and as a woman.

Readiness is not an exclusively personal experience or state-of-being, as alluded to in the above discussion of men's part in the decision-making. Many people in the lives of my respondents, especially their mothers, employers, friends, and partners, express their opinions about when they think the women are ready for motherhood. The women I talked with noted their mothers' warnings about their decreasing fertility over time, for example. They also bristle at—yet still mull over—other people's suggestions about timing:

> I can't believe she said that yesterday. I told [the director of the adoption agency] that I was between jobs and she was like, "Why don't you take the application back and, when you get a job, come back." I am like, "take my application now before I change my mind." I should have something going on . . . So you know, keep it. I don't want to take it back. I been meditating about this. I been thinking about—I been setting my mind to this and I'm ready.—*LaWanda Jackson, 42, African American, single, nursing assistant*

> Most of my friends have children already. And many of them had them young—18, 19, 20. And everybody says, "Annie, you should have a child." And I'm like, "I'm not ready to have a child." This is what I thought. I means, sometimes I think, what will I do with a child? I can barely take care of myself. And then sometimes I feel like maybe having a child would help me direct my purpose in life, try to focus my efforts on something specific.—*Annie Adoyo, 30, second generation African immigrant, single, student*

> All the people would say, "It's time. Your clock is ticking." It's like society says, my coworkers said, "You should start having children now." I'm like, "Leave me alone." See society is expecting me to have children at a certain age. Now I'm close to 35 and I'm not having any children and some other professional will tell me, "Hey, you should start having children because the older you get the more difficult it gets."—*Serena Lopez, 39, Latina, married, pharmacy technician*

The adoption director dismisses LaWanda's interest in adopting since she does not meet the unofficial requirement of gainful employment. Despite the fact that LaWanda feels "ready," an outsider tells her she cannot become a mother at that time, at least not through that avenue. Her prospects for motherhood are beholden to a bureaucrat's assessment of her readiness. Readiness is not the personal choice Gregory (2007) and others make it out to be. Annie is told that she is ready when she thinks she is not. She equivocates on this, seeming to take their remarks under advisement. She may not be financially stable—or, in her particular case, as healthy as she ideally could be—but Annie thinks that having a child might motivate her to get

on track, to help her grow up and embrace her adult responsibilities. She is ready for motherhood for the same reason that some young adults enter the military—to be forced to grow up. In fact, several of the African American women, younger and older, make this claim that motherhood "makes a woman out of you."

Other women feel they must meet a number of personal and professional goals (hypothetically) *before* having children:

> I want a daughter, I really do. But I don't want a baby now . . . I don't have the finances to be able to take care of a baby. And when I do have her, I want to be able to spoil her. You hear a lot of people say that. And I don't just mean financially. I want to be at her school when she has a field trip. Of course I want her to be well taken care of. I just want to be as ready as possible. I want to have a baby. Not in the near, near, near future, but after I've gotten a degree. After I'm settled into what Nicole wants to do. Which is be a mortician . . . after I'm established, around 26, 27. But once I get there, I don't want to be old. I want to enjoy her childhood.—*Nicole Lambert, 20, African American, single, student*

> I was going to school and this is my second marriage. I didn't have any children even though we tried during my first marriage. So my second one, you know, we waited a little bit until we were stable in our relationship and we bought a house and we decided we've been living together for so long, why don't we start getting pregnant? I was getting old and I wanted to have a child.—*Serena Lopez, 39, Latina, married, pharmacy technician*

> I think I always wanted to be a mom but had like put it off for a long time. I grew up in a really big family. I'm one of eight children and I have six brothers and one sister. And one of my brother is 11 years younger than me and my sister is 16 years younger than me. So in a way, when my brother was born, I felt like he was my new baby. I remember him coming home from the hospital and it's like, "Oh okay." And my mom was so busy because she had so many other kids that I think that being the only girl at the time, I kind of naturally took on that responsibility. And even to the point where he slept in my room with me until he was two or three years old. So I think I realized from taking care of him how much responsibility children were, so when I was first sexually active, I knew I didn't want any kids right away. Because I knew I just wasn't ready; there were so many more things that I wanted to do.—*Jennifer West, 46, white, married, engineer*

Both Nicole and Jennifer need time to do what they "want to do" including getting an education, establishing a satisfying career, and, for the one who can afford it, having adventures (i.e., Jennifer surfed in many countries). For Serena, the goal was to solidify her new marriage and buy a house in preparation for children. These women, who occupy differing race and class statuses, need to fulfill certain expectations to be ready to schedule motherhood into their lives. Motherhood, then, as a life stage, necessitates clearing the calendar as it were because, as Nicole indicates, they wish to "spoil," i.e., "be there," for their future children. Because they anticipate conforming to an "intensive mothering" ideal (Hays 1998), and, of course, because they need to earn a living, some delay childbearing past their most fertile years. Media stories, pundits, and

common stereotypes promote the idea that delayed childbearing is selfish. These women argue just the opposite, that delayed childbearing is more *selfless* and responsible.

Women must constantly negotiate a suite of new choices, but compared to the traditional ideal, their decisions often make them feel like they are coming up short. Jennifer, for example, feels like she lost the opportunity to birth a child because she simply waited too long, always thinking that there was "still time." She stands out as one of the few participants in this project who approximate the "careerist" stereotype—that woman who (ill advisedly) pursues the glory of a high-powered career and then is (stupidly) crestfallen when she finally decides too late to fulfill the motherhood mandate. This allegory, shot through with *schadenfreude* at women who apparently do not know their place, or alternatively, at snobby women who cannot appreciate their privileges, does not resonate with most of my interview population. They are hardworking and goal-oriented, but not particularly "career track," professionals; most have working class occupations and modest lifestyles and they must work to live (not that they do not enjoy their work). That tired discourse that modern women are to blame because they sacrifice their fertility for their careers may lack explanatory power but, nonetheless, it still weighs on the consciences of infertile and childless women.

Some women offer the perspective that having a child is one of their goals in life, something else to strive for:

> I think that, for me, that's on my list of things to do in my life is have a baby. I feel like there's this emphasis on experiences in society and that's one experience I want to have, being pregnant.—*Emily Reilly, 30, white, single, fast food manager*

> I've never seen children and yearned, "I want my own." I just enjoyed seeing them. But I have not got to the point where I see a child and think, "I wish that was me," no. But I think just society, and because of all the people I know, I'm the last one who hasn't married and had kids, so I think about that, but I've been one to follow the crowd and keep up with the Joneses anyway. I just think for me, personally, it's time to make that initial step [toward having children].—*Gloria Owusu, 38, African American, single, project manager*

Emily later tells me that riding a motorcycle is also on that list. Her concept of having a baby is, in part, checking off an item on life's to-do list. Gloria, too, does not "yearn" for a child, does not identify as "desperate" at all, but instead matter-of-factly recognizes that she has reached the pre-determined time she set years ago for becoming a mother, something she is especially ready for now that her younger brother has moved out, leaving her with nobody to nurture. Both women are single and both desire pregnancy but, in keeping with their purposefulness, have another option—adoption—lined up as well. Emily and Gloria differ from the "Infertile Woman" supposedly motivated by a single-minded drive to conceive in that they talk casually, almost flippantly at times, of having a child as something they plan to do alongside all of their other pursuits. Maybe this attitude stems from a psychological defense mechanism in which they do not want to come off as wanting a child too much, or perhaps they do not wish to test fate. Even if true, that is not the whole story. Ticking off motherhood from a list is not just a metaphor for an instrumental, consumerism but an acknowledgment and anticipation of

motherhood as a *process* that engenders existential human connection. They want the life-enriching experience but that aspiration does not define them.

Age Talk

Age is a social construct. The end of the childbearing years occurs along a spectrum, according to the social and cultural context. In a logical parallel, as sociologists Jaber Gubrium and James Holstein (2003) point out in an edited volume on aging, the concept of "old age" is a permeable one, with different meanings according to one's communities and biographies. Of course, there are relevant, related biological factors that mark someone as "old," or as past their "fertile years," but these too occur along a continuum.

Statistically speaking, about 75 percent of women "trying to conceive" are fertile at age 30, 66 percent at age 35, 44 percent at age 40, and 13 percent at age 45 (Leridon 2004). Since the advent of NRT, not only do women rather routinely achieve pregnancies via egg or embryo donation well into their late 40s, there are several cases of women giving birth in their 50s and 60s that have gained notoriety and extensive public commentary (see the Wikipedia entry for "older mothers"). Now that technology has gotten involved, nature can no longer implement a definitive limit to a woman's ability to gestate and bear children. A new discourse, in light of these possibilities, is under construction. For example, anthropologist Margaret Lock (2009 [2007]) concludes from her research with aging Japanese women that aging out of fertility does not have to be the "disruption," an embodied betrayal of one's femaleness or womanhood that most people predict and assume to be a natural part of life.

The women I talked with intimate that a woman can be too young or too old to become a mother. But they differ on what age range is appropriate. The poorer, younger African American

women (i.e., Nicole, Jamilah, and Shana) and several of the Latinas suggest the early to mid-twenties as the best age for having children. Robin Smith, one of the experts I interviewed for this study, marvels at the youth of the few women of color who come to her clinic for insemination; they tend to be around age 25, already worrying about aging out of their prime. Her white clients are usually well beyond their mid-thirties, many into their late 40s. Among my respondents, the older African American women and all of the white women suggested 30 as the ideal age to begin having children. By that time, they loosely imply, women should be settled in terms of relationships, financial stability, and their career path. Since their epistemological standpoints, vary by race and age, it makes sense to examine the national birth rates of these cohorts. The American Community Survey (U.S. Census Bureau 2008) provides the following statistics:

Table 2. Births per 1,000 in the last 12 months by age and race (U.S. Census Bureau 2008)

	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**
White	16.7	48.6	42.5	29.7	11.4	2.5
Black	30.1	53.1	30.6	17.2	2.9	0
Hispanic	45.6	59.5	31.4	30	6.6	6
Asian	10.3	16.3	43.3	33.9	31.2	0

In comparison to black women and white women, Asian women have exceptionally low birthrates overall and Hispanic women have particularly high ones. Looking more closely at the age at first birth between black women and white women, though, it becomes evident that black women are decreasingly likely to have their first child as they approach 30 and beyond. Interestingly, the highest current fertility (i.e., not cumulative numbers of children) by any category (e.g., income, educational attainment, race, age) occurred among women with graduate or professional degrees who had 67 births per 1,000!

These patterns have several implications for childless and infertile women. First, because they wait to find a partner and/or to achieve stability, they tend to get serious about birthing (or adopting) a child much later than their peers who have children more easily, without as much forethought. Second, that black teenagers have twice as many births as white teenagers bears out in the experience of the young African American women in this study who feel like social oddities—expressing to me their pride and autonomy as well as their defensiveness and a little bit of concern—as nonmothers at the youthful ages of 19, 20, and 25. Third, the fact that highly educated women were the most likely to become mothers in 2006 speaks to the social milieu in which women routinely control their reproduction with birth control, abortion, and the intentional timing of "conception" and many make decisions to enter motherhood only after completing their education. It is not just that women are having children later—women always have had children into their 40s—it is that some are having children for the first time later in life. The ideal life course for women, particularly in terms of entering motherhood, is changing and medical interventions or simply knowing that they are available if needed, enters into the decision-making. Just like other American women, many infertile and childless women spend their years between puberty and menopause avoiding pregnancy or pursuing pregnancy, contingent in part on their proximity to a small—but moveable—age window. Race and class background influence the age parameters and as individual women age, some—but certainly not all—adjust upward their notion of the ideal time to become mothers.

The medical and census-taking definition of childbearing age is 15-44, though of course there are plenty of exceptions. The more restrictive social definitions that my respondents refer to involve a mainstream disdain for teenage motherhood and a vague aversion to pregnancy among women over 35. Beginning at age 35, women who become pregnant are almost

universally labeled “high risk” (see Simonds et al. 2007) and pressured to submit to umpteen invasive diagnostic tests (Rapp 1999). Even at age 30, women who visit infertility clinics, begin to not only hear about their decreasing chances of a “healthy” or “successful” pregnancy, but also get slapped with incrementally higher fees with each birthday. Accordingly, age constrains women’s ability to accomplish “readiness” for childbearing (and childrearing more generally). The question for women becomes: Can I satisfy other aspects of “readiness” like finding a suitable partner, becoming financially stable, and preparing myself emotionally and psychologically in “time” to get pregnant—or to adopt before I am “too old” for childrearing? This question is at the forefront of some of their minds, but for others, it is very abstract. Consider the passages below, which roughly correspond to chronological life course stages as they relate to motherhood:

> I can still have kids but it can take a long time and I don’t have that much time. I’m 30 now so it’s five years since my first surgery. I don’t want to be 40 and still—you know what I mean? So they are suggesting IVF.—*Azra Alic, 30, Bosnian immigrant, engaged, apartment manager*

> I just remember when I was 26, nothing was happening, no relationships to speak of, I had said that when I am 35, if I am not married, I will have my own by whatever means. I then started thinking seriously about it.—*Gloria Owusu, 38, African American, single, project manager*

And actually, I never felt in a hurry to get married either. I always thought, oh yeah, down the line, later on. I talk to some women who are like, “I really want to get married,” or “I really want to have a kid.” But I never felt that way. I just assumed it would happen . . . I was almost 30, maybe later, and I do remember my mom saying, “If you do want to have kids, you better get married soon.”—*Karen Tabb, 49, white, single, teacher*

So I went to my gynecologist, who said that there was a pretty slim chance of my getting pregnant, because by the time I went, I think I was in my late thirties, maybe 37 or 38. And so I went and my gynecologist said, “It’s not looking too great” . . . so they did all these tests, and my uterus was loaded with fibroids—*Dianne Jacobsen, 56, white, single, life coach*

We did try. We tried a lot more times. To this day, my mom will still tell me to try again. I’m going to be 42 years’ old [laughs]. I’m done! [laughing]— *Lupe Jimenez, 41, Latina, married, electronics technician*

You see all the excitement of a new baby and all that. But it doesn’t give me any ideas of wanting to be in her place [laugh]. Besides that, I’m past my time, you know.—*Iris Hernandez, 54, Latina, office assistant*

Some of these women hear the proverbial biological clock ticking and others are too busy to listen, but all relate their awareness of the impact of time and age on their fertility/infertility or

status as mothers/nonmothers. Nicole, quoted further above, has no reason to doubt her fertility and she envisions her late twenties as the best age to enter motherhood. Azra, a few years older and already encountering problems with her reproductive system, worries about time as she accelerates her involvement with medically assisted conception. Beginning at age 25, she tries surgery, then an hysterosalpingogram (HSG) to examine and clear her fallopian tubes, then takes Clomid, an ovulation drug, and then tries injectible fertility drugs before starting IVF. She relates a sense of urgency now, owing to fears that she may not be able to get pregnant and carry to term. Azra insists on waiting to marry her fiancé until she can prove her fertility. She says she does not want to "waste his time" or limit his opportunity for fatherhood, something she says he does not even realize may eventually become more important to him than she is. She is doubly unhappy about her infertility because, to her, it *may* (she is not consistent about this) also spell the end of her relationship—and her identity as a woman. Gloria, as noted earlier, plans for the contingency that she will not find the right partner in "time" and sets an age by when she will make a withdrawal from the sperm bank or adopt a child (domestically). By contrast, Karen reports having been untroubled by time, even though her mother warned her that it was running out. She, like many others I talked with, thought there would be time "later on" to pursue motherhood. For Dianne, time ran out early. Her mother reminded her that menopause tends to start early in her family but Dianne was still caught unawares upon the discovery that her body would not cooperate once she was "ready" to get pregnant. Lupe attempted to have a second child and experienced only debilitating miscarriages. She has let go of any hope or intention to have more, but her mother still thinks that Lupe has "time" left in which to try for another. (Mothers' advice is a leitmotif in these interviews and it is nearly always about advising daughters on their readiness for motherhood. For their part, the daughters very often deliberately

exclude their judgmental, worrying, or confused mothers from full knowledge of their goals surrounding motherhood or childfree living.) Finally, Iris, chuckling like at the seemingly ridiculous idea that she would still want to become a mother, reminds me that she is "past [her] time," that she is on the other side of menopause, and is no longer interested in pregnancy or adoption.

These snippets from several infertile and childless women's lives highlight the theme of time that shadows women's childbearing years and beyond. Sociologist Elisabeth Ettore (2002) describes reproduction as a structured social practice that covers a wide expanse of time and space. Thinking about motherhood probably begins for most women in girlhood as they see their own mothers at work and as they play house and play with dolls, rehearsing their prescribed destiny. It does not end at the age of 44, whether or not women have had children. And assumptions about motherhood and nonmotherhood impact women's lives in many environments: within families, at work, among friends, in interactions with strangers. But the actual span of time when a woman can enter motherhood is rather small if one takes into account the myriad personal, biological, social cues for readiness that must first appear.

A vague sense that there must be "still time"—when indeed there was not—influenced the childlessness or age-related infertility, or secondary infertility of many:

> I felt like I still had lots of time. This other kind of thing kind of happened to where I always felt like—and I think it was because of the generation I grew up in—I always felt like there was still time. I think because I remember being young and I remember seeing—who was it? Adrienne Barbeau? Someone on a magazine cover having had a baby when she was 50. I think our society was like at that time

> making women feel like have your career now, there's all these miracles that can happen for you later. You can wait. And you'll still be okay. No one ever told me that at 36, your fertility takes a nosedive.—*Jennifer West, 46, white, married, engineer*

> I say well, I still want to have a child. There are women in their forties having – Like my sister-in-law when she was 39. The day before her fortieth birthday she had my niece, and her sister tried for like six months and she was 41, and had a healthy boy. So you hear stories about Holly Hunter, how she had twins, and she's 47.—*Talia Stein, 41, white, single, home healthcare aide*

Knowledge of celebrities giving birth later in life persuade some women that this practice is the new norm, even desirable, or, at least, is relatively free of negative consequences. They all know about the "miracles" of assisted conception and the attendant technologies, something few of them pursue. Nullifying an hypothesis of mine, these women do not seem to experience a sense of relative deprivation; many do not mention the cost prohibitions; they do not decry the policies that discourage singles and lesbians from accessing services; they do not point out that surrogacy arrangements might be difficult to find and arrange for women of color or for working class women; they do not seem to feel left out of that scene at all. If they want or wanted to become mothers badly enough, they suggest, they will find or would have found their way through the medical (or adoption) bureaucracies (about which many know relatively little) or they would informally adopt a relative's child (two mentioned this solution). They indicate that they are insufficiently motivated. Greil et al. (2009) name motivation to become mothers as one

of the factors for infertility helpseeking but the term may not be fully operationalized. What motivates women to plow through the thickets of NRT and adoption bureaucracies? Material and ideological barriers aside, and time constraints notwithstanding, my respondents take their time in coming to any decisions about motherhood. Some of the women point to examples within their own families, of aunts, older sisters, mothers, and grandmothers, who gave birth into their forties. Several take a pragmatic view of their childlessness, choosing to extol the many benefits of childfree living, but not giving those benefits as the *reason* for their childlessness. With all of these possibilities in the backs of their minds, it is easy to elide the creeping passage of time. Their experiences are at odds with those of respondent Robin Smith's infertility patients (in a nod to the consumerist conception of infertile women [pun intended] she calls them "clients"):

> There are some couples where [the male partner] does not have a infertility diagnosis, and most of those couples have tried six to seven months, mainly because in those situations—at this time—the woman trying to get pregnant is over 35. The general standard rule of thumb in the fertility world is if the woman's under 35, try for about a year, and then get a fertility assessment. If she's over 35, then seek assessment from a specialist after about six months. So most of those couples, the woman is 35 or older; they waited six months and saw a fertility specialist or us and are now pursuing donor insemination.

They race against time, ratcheting up their treatments, increasing frequency, degree of invasiveness, and levels of medical expertise as they age, all in pursuit of pregnancy before it is "too late." This description conflates the medical definition of infertility with the actions of the

infertility clients. The reason many of my respondents differ from these women may be simply be due to the fact that they avoid(ed), limited, or delayed medicalization, whether intentionally or not, and remain(ed) focused on more pressing aspects of their lives.

It is a well worn criticism of contemporary society that women must somehow complete their education and mount fulfilling, self-supporting careers while also fitting in pregnancy, childbirth, and childrearing. Virtually all of the women I talked with—women who are either childless, infertile, or both—constantly mention the virtuous "real moms" who mother with all they have. The respondents' childless or infertile status partially results from an acceptance of this unattainable ideal. They await "readiness" for motherhood, sometimes indefinitely as they hope to find the right partner, to achieve their other goals, to encounter the right time, and to reach—but not pass—the prime age. As a society we expect women to work out these problems on their own (and, to a lesser degree, with their partners), instead of calling on society to support mothers or even calling into question individualistic cultural models that shun communal living and adopt isolating, neolocal residence patterns. The existing system promotes infertility and childlessness by not supporting women's childbearing earlier in their lives, effectively shutting some women out of motherhood. Rather than blaming society or personal failure, my respondents, who tend to find their infertility/childlessness to be mostly a positive outcome, commonly attribute their condition to chance or "God's will" or "God's plan" for them.

Mystical Ascriptions

"Mystical ascriptions" is the broad category that encompasses all the overlapping ways in which the respondents attribute the occurrence of motherhood or nonmotherhood to forces

beyond their control, supernatural influences that may or may not be affected by women's behavior. Rather unexpectedly, more than two thirds of the women I interviewed brought up the supernatural in accounting for their infertility and/or childlessness, not as merely a coping mechanism but as a driving force. Motherhood to them is primarily an ascribed role, not an achieved one. This view emerges as the exact opposite of the (exaggerated) single-minded pursuit by infertile women to get pregnant, even if it means submitting to dangerous, improbable, morally questionable, or intrusive treatments. Aspects of this stereotype are fed by media hype, political hyperbole, NRT critics, and—to a lesser degree—by research interviews with women recruited from the fertility clinics or from RESOLVE. Respondents like these have already been fairly medicalized and their hopes are continually stoked by talk of medical "miracles" that are just around the corner, i.e., the "never enough quality" of ART treatment (Sandelowski 1991). In addition, these women generally conform to the specific marketing demographic, i.e., middle-class, white, married women, targeted by the commodifiers of infertility. There is a multi-billion dollar per year financial interest in women pursuing motherhood at all costs. This pursuit, this focus on *achieving* motherhood, places the power in the hands of unfeeling technogods (who perform the medical miracles) instead of—from the perspective of many of my respondents—in God's loving hands (or, for some of the women, the benevolent, omniscient, animistic "universe"):

> I mean I'm sure if God put [a baby] in my life, I'd do it, but what I think of the choice, I think God has made me an auntie for a reason. I say that repeatedly. He's—there's really a plan. I never really know what the plan is because He's got it, but the plan was: you're an auntie because you got plenty to do with all your

> nieces ad nephews and you know friends' babies and what have you . . . So I think I just accepted the fact that God did not want to bless me with children but bless me as an auntie and then move on.—*Penny Ortiz, 52, Latina, single, guidance counselor*

Penny, for whom childlessness "just happened," and like many of the women who talked about God or other supernatural powers, accepts her childlessness with the comforting realization that there is a greater plan than any one she could have predicted or designed herself. It is not enough for her to say that she was preoccupied with other satisfying life pursuits; the dominant discourse does not sufficiently legitimate that path to fulfillment for women. She was meant to be the one free to provide additional support to others' children (and, as she details later, to care for her elderly parents). In this way of thinking, some women attempt to manipulate the grand design, sometimes concluding that individuals do not hold that kind of power:

> They all knew we were trying to get pregnant; they were rooting for us. And the whole time I felt like so restless; I wanted to get pregnant so bad while we were down there and I remember when we left, one of the boys said to us [whispering], "I just know next time we see you, you're going to have a little brown fuzzy headed little girl." Like I almost started crying the way he said it. And then it's so weird because I came back and I was so restless. I went through the IUI, it was like I was trying everything in my powers that I knew how to do because I wasn't really ready to take that step for IVF. And I was doing everything I could. I took that next step further on the fost-adopt and even the next step further on to

> adoption. And the whole time—I started thinking about it after we got [our adopted daughter]—that's when she was conceived . . . while we were down there in Costa Rica. So it was like the whole time I was just so restless, maybe I knew my baby was coming.—*Jennifer West, 46, white, married, engineer*

> God really does have a plan because now I can look back and go, "Ohh. This is what He was doing. Hey, good planning, God!" It would've been nice if He would've warned me. But I just think it's God's plan. And He knows when you're ready for it and when you're not and if you should, if you can't. I think of one of my girlfriends from high school who wanted—she had her daughter—and she wanted another baby so bad and she had so many miscarriages and she finally had her baby. And he was born with this very, very rare disease and I can't remember what they call it, but the little guy had so many things wrong with him. And she would forever have to take care of that little guy. I mean, I don't know how long they live, supposedly they don't live very long . . . and often I thought that she wanted so badly to have this baby and she finally got to have him but it wasn't God's plan. He didn't want her to have a baby."—*Penny Ortiz, 52, Latina, single, guidance counselor*

Jennifer recalls a child's prophecy and her own eerie restlessness, indications of the supernatural at work. She was just passing the time by trying some low-tech assisted conception methods and taking incremental steps toward adoption (a process she did not complete until *after* the placement); meanwhile, her adopted-daughter-to-be had already been conceived and was

ostensibly waiting to become Jennifer's baby. From the vantage point of happy motherhood, she is able to look back and (re)construct events as proof that her infertility, her unsuccessful attempts at pregnancy, her eventual adoption were preordained by an all-knowing force, one that she unconsciously detected as evident in her otherwise-unexplained restlessness. She does not report desperation or frustration so much as a state of flux. Unlike Penny, Jennifer is not overtly religious. But assigning power to another plane elevates her experience, something that she may need as evidenced by the choice words she offers about fertility clinics and the adoption bureaucracy. Rather than a path that has to be metaphorically bushwhacked and endured, her journey's twists and turns provide opportunity for self-realization and inspiration. Penny's God has more complex motivations. You have to be careful what you wish for. Trying too hard to circumvent His will, His eternal plan, instead of accepting—even embracing—your fate like Penny does can result in devastating consequences. The woman in Penny's story who could not accept her secondary infertility finally got the baby she wanted "so bad[ly]"…along with a large, punitive dose of heartbreak.

Magical Motherhood

For others, letting go of control, putting one's faith in God's plan, or drawing on magical forces is the most likely route to motherhood (or, at the very least, it cannot hurt):

> You want to hear a miracle? One of our friends in church, her husband was trying to have a baby for five years. And I just talked to her and told her that God and Jesus said that whatever you ask in his name, you shall receive. Once you have faith. I prayed over her and I said to her, "Raise your hands to the Lord Jesus and

say ‘thank you Lord Jesus for giving me my baby right now.’” The faith in things in things we haven’t seen yet. A few months later she got pregnant. She has a little girl now. Her name is Aakalijah. She’s five months.—*LaWanda Jackson, 42, African American, single, nursing assistant*

If you focus on your intent and eliminate the word “want,” let that go, but visualize you being pregnant, being a mother, it’ll manifest itself.—*Talia Stein, 41, white, single, home healthcare aide*

My co-workers—the majority of them right now are curious about what me and my partner’s process is. I met my partner at where we work and she still is working there, so we have very separate jobs there, but they are curious and inquisitive and give you the, are-you-pregnant-look and come and feel the belly: “Is there anything going on there?” “Not yet; we’re working on it.” There’s all this “we’re praying for your ovaries” energy. Not many of our clients necessarily come from a Christian background, but they’re channeling whatever their belief system is and we’ll take it. I’m not real picky about which energy it is we’re tapping into. We’ll take whatever you got!—*Robin Smith, 42, white, lesbian, fertility counselor*

LaWanda, an evangelical, encourages an acquaintance’s faith and the woman gets pregnant. For some women, trust in fate or in God must precede the fulfillment of wishes. The ubiquitous—and, frankly, irritating—advice to women trying to get pregnant to “just relax” is an

homologous assumption from the secular world. Both ideas subtly blame women for their own infertility and scorn desperation. Harkening back to Puritan ideology, wanting something too much leads to curses and jinxes since people have failed to have enough faith. By contrast, Robin uses the supernatural casually, conceiving of it as yet another possibly helpful option among so many. Her clinic promotes the use of a dizzying array of herbs and tonics, diets, acupuncture, massage, yoga, and meditation along with more prosaic correctives like fertility drugs, HSGs, and other medical procedures. She points out that acupuncture, massage, yoga, and meditation help clients relax to improve fertilization odds (that old warning again), relax to get through invasive and taxing process of fertility treatment (again and again), and to harness supernatural energies. Another, more latent function, may be to deflect responsibility for the effectiveness of treatment by hinting that "success" or "failure" is ultimately up to the supernatural, not to the individual doctors and fertility clinics.

Magic can also stand in for "holism" in the notoriously alienating world of fertility treatment. At one clinic, I witnessed routinized summoning of supernatural powers. After a brief IUI procedure in which the (tardy) doctor barely glanced at me before inserting the syringe (and allowing my partner to perform the symbolic and practical act of "pushing the plunger") the counselor, in an equally indifferent manner, then grabbed two rattles that she described as "fertility idols" and shook them over my body for "good luck." We tolerated this ritual 14 times for seven unsuccessful cycles.

For several respondents the supernatural is more meaningful and allows control to shift away from doctors and other authorities in ways that are liberating for women:

> Right when I said adoption was a choice, it actually felt more right to me than birthing a child . . . when I opened up my heart and opened up my eyes, that felt more like, "yeah, that's me" . . . I have [my adopted daughter] now and it's like, the love for her and the connection between is like, like I can't even imagine. There's no separateness between us. It's like I don't know if we've experienced each other in a different life, but it's like when I met her, it's like, "Oh, of course it's you. Who else would it be? Of course you're my daughter. Of course it's you. Here you are. Thanks for coming."—*Jessie Silva, 42, white, queer, hairstylist*

It is a common feeling among adoptive parents that their child is exactly the right one for them, a feeling attributed here to having met in a past life. Jessie tells me that once she "let go" of any residual anger at her medical encounters, at the frustrating adoption process, and at the unfairness of her infertility, and "opened her heart," her daughter preternaturally perceived this and became "willing" to come into her life. Had I interviewed her—or any of my other respondents—before they made peace with their situations, I may have reached very different conclusions. But based on this narrative that I am privy to, women like Jessie place the bulk of their faith in higher powers instead of with medical and adoption-system authorities. She says she never feared losing her daughter (who she first fostered) to birth-family reunification because, even though the social workers tried to "scare" her, she tapped into her own spirituality and "just *knew*" that she and the child "belonged together." Loss of control is one of the most often-cited negative impacts of assisted conception (Becker 2000). Respondents like Jessie, while taking back some of this control herself (i.e., "opening her heart") and giving a significant measure of control over to the universe, she symbolically wrests it away from those same doctors

who are told by advertisers that “you are their only hope” (Wilson and Simonds 2006). Nicole’s comments further exemplifies this way of thinking:

> If I experience something like the doctor telling me I won’t ever be able to have a baby, I’ll take that and throw it out the window. Honestly. Just because of past situations and the people they’ve seen? Maybe God is saying now is not the time for you to have a baby. But that’s not to say that you won’t ever be able to. I believe that if it’s in His will for me to have a child, then I don’t care what the doctor says. I don’t care how many degrees they have. If it’s in God’s will for me, then I will have a child, but in his time. . . . My prayer wouldn’t be, “Oh God, give me a baby.” Honestly. It would be, “Okay, I see it’s not happening now in your time” . . . once you realize that you don’t have control over things you say, “Okay, well it’s out of my hands. I’ve tried everything there is.”
>
> Kristin Wilson: What would you try?
>
> As far as having a baby, adoption is always an option. But if that’s not what I want to do, I wouldn’t do that. I could take in a relative, but you usually want to have your own. But once you see that the only thing bringing fulfillment is being able to carry a baby that you and someone else created, once you see that that’s not happening, you say, “Okay, I’m going to hold off. And basically leave it in God’s hands.”

Nicole's rhetoric does not always stay consistent but her position that God knows more than doctors reverberates throughout this collection of interviews. Relinquishing control over to God is preferable to giving over to doctors. This attitude should not be read as overly traditional nor as psychological protectionism. Instead, it is a way for women to own their life trajectories in spite of the vicissitudes of their bodies and their life opportunities.

Some of the respondents—instead of waiting patiently for God's blessing or calling on the supernatural to hurry up and make them mothers (as Robin does)—indicate that God called or may call them:

> So you know, when it came in three [suggestions that she adopt], I was like, "Okay, God, I hear you." And it was like five years ago [the preacher] had mentioned it cause I had wrote it back of my Bible. And the time when I heard it two weeks ago and I'm like, "Okay, God, I hear you." So I'm looking in the Yellow Pages, looking through the book and the Holy Ghost was like, "It's in the back of your Bible." I looked; there it was. I called the lady and here I was [at an adoption orientation meeting.]—*LaWanda Jackson, 42, African American, single, nursing assistant*

LaWanda, for example, decides to look into adoption when she keeps hearing mention of it, encountering messages that she interprets as being hailed directly by God to do her duty and take in a needy child. She thinks she is now "really ready," particularly because she is lonely and she longs for the companionship and an opportunity to create the kind of "special bond" between mother-daughter that she never experienced with her own mother. Like many of the women who

feel called to motherhood, she knows that she will be a good mother and God apparently knows that too and will soon "bless" her with a child.

Holy Paternalism

The colonial concept of "blessing" turns up frequently in women's discussions about having children. One is blessed or not blessed by God with children (AKA "blessings"). God blesses those who are "ready" to become mothers, whether they recognize the readiness or not, and does not bless those who are not ready or not deserving, whether or not they know why. Like the conventional model father, kind and benevolent, yet quick to mete out stern discipline when necessary, so goes the supernatural influence on motherhood:

> I just have to thank God that I don't have no kids, that I don't have to go through that struggle—*Jamilah Washington, 19, African American, single, student*

> But the way it is right now, I am blessed I do not have kids. Because the situation, I see children are suffering so much.—*Lourdes Garcia, 56, Latina, single, office assistant*

> I would consider adoption but I would first want to experience pregnancy and everything like that. But I can say, it's a blessing. And you don't have visuals, a camcorder, but this mole on my hand, my mother has the same mole! The exact same mole in the exact same place. You can ask her if you don't believe me. It is such a miracle. It's like, what are the chances of me having this and my mother

having the exact same mole and she adopted me? None of her other children have it. So we say that this is our mark from God who says, “Nicole, this is your mother. This is your child.” I don’t think anything happens by chance. I believe God has allowed a time or preordained a time. And so I believe this was meant to happen. So yeah my mother was of an age [48] when she adopted me. —*Nicole Lambert, 20, African American, single, student*

And she had a previous abortion that she did not regret at the time. But when you have trouble getting pregnant, you could look back at that and go, “ What if that was my one chance, and God’s got some way of—” And she didn’t have a belief in her god being one that punishes. But she almost changed her faith-base to give it that.—*Robin Smith, 42, white, lesbian, fertility counselor*

I said, “What bad luck we have.” I tried this, it did not work. I tried this, it did not work. And sometimes I believe, it’s spiritual too, some kind of power that did not want me to have any kids. So I said what I think is I’d rather live like this. I don’t want. If I bring somebody to my life [i.e., adopt], maybe something—I get scared that something will happen to that kid or something like that.—*Zara Senai, 45, African immigrant, married, laboratory technician*

Where Jamilah is not-yet-blessed because she is not ready—and actually she is thankful that God agrees—and Lourdes, too, is relieved to be blessed to not have children as she feels incapable in the midst of a decaying society, and Nicole recognizes that her mother adopted her

right on time, according to God's plan (proven by a miraculous mark on their bodies), others like Robin Smith's client and Zara are not "blessed"; they are cursed. Robin's client and, certainly other women as well, may feel punished with infertility because they had abortions when they were not ready to become mothers but when God intended it. Karey Harwood (2007) wonders if undergoing ART is not an ascetic expression or absolution for known or unknown past sins; they brought their infertility on themselves and must suffer to undo it. The daily injections are modern-day flagellations (and, owing to hot flashes, Clomid makes an apt hairshirt). Nicole comments at one point, "God wouldn't give me anything I can't handle," referring to any accidental pregnancies—and children—that she might have (she claims at times that she doesn't "believe in" abortion, though she vacillates on this issue). Zara, like many others, wonders what she did to deserve such "bad luck." In the quote above, Zara talks about her fear that the curse may be contagious to those who are close to her. She suffered the pain of many fibroids in her uterus—an organ she refuses to have removed from her body believing it's the essence of her womanhood—and unwittingly doomed her husband to worrying about her health and to fatherlessness. At his behest, they attempted to adopt a little boy, a boy they received a photograph of prior to the adoption, but, sadly, the boy died of pneumonia before they met him. After this emotional blow, she decided that she better not try to become a mother against the will of some spiritual "power" lest she transfer her curse to other potential children. For her, this spiritual power is dangerous and maybe not benevolent at all.

Women do sometimes turn to the supernatural to help them cope with infertility or childlessness:

> One day I just snapped out of it because I had a co-worker and her daughter— . . . it was basically all about me and why me—and what it was that she had found out that her daughter couldn't bear her own children. She had either, was born without a uterus or her uterus was somehow deformed or something and she was only 19 years' old . . . So that was a sad case to help me; for some reason it was put in my life so I could see, so I could stop feeling that way. I wasn't the same person anymore. I'm usually a really happy person. And I wasn't anymore; I wasn't. I was very miserable.—*Lupe Jimenez, 41, Latina, married, electronics technician*

Another's relatively worse condition, in comparison to Lupe's secondary infertility, helped her feel grateful that she already had a son. She, and a few others, credit a single, fated moment to this enlightenment. Hannah, the most irreligious of all the women with whom I spoke, says that she does not believe in the occult but still allowed a medium to do some "feeling work" with her after her infertility diagnosis. Though the channeling does not bring a specific message, the psychic claims that an ancestor was attempting to contact her. Upon consultation with her mother, they decide that it must be a maiden aunt from Hungary who never had any children. Despite the fact that she denies believing in the supernatural aspects of this encounter, Hannah reflects on that aunt's life and commitment to progressive political work, finding it a helpful inspiration as she worked to accept her infertility.

Chance

Chance signifies probability (as in odds), opportunity, and happenstance. Chalking up life's events to chance can be a more secular way of diffusing the power that influences who becomes a mother and when, and who does not or cannot. This concept regularly surfaced in the interviews:

> [The doctor] said I might have a chance to still get a tubal pregnancy so you know the opportunity still be there but the hole—there is still a little hole. Plus that was back then; they didn't have all this high tech stuff they have today. But I just lay there and boom. But yeah so I tried then and I am like, okay, there's some hope; you can still have a chance to have a baby. But then it was like when I was trying, it didn't happen.—*LaWanda Jackson, 42, African American, single, nursing assistant*

> So [the doctor] said with my own egg, there is almost no chance at all.—*Jennifer West, 46, white, married, engineer*

> And finally he said, "I think we have to remove those fibroids." It's like about nine of them now. And they said, "Okay, you have a fifty-fifty chance that maybe you will get pregnant, maybe you'll get scars. It's going to be hard.—*Zara Senai, 45, African immigrant, married, laboratory technician*

> You pay for [ART] and stick yourself with needles all the time. For that baby, you're taking chances. It's like playing Russian roulette.—*LaWanda Jackson, 42, African American, single, nursing assistant*

> I started going to church more often, trying to get involved in all the things. But at the same time like, "God, this divorce happened when I'm old and maybe I'll never get married again, maybe I'll never—last chance to have children." Right, I'm not going to go meet a guy and get pregnant right away. So last chance to have children.—*Serena Lopez, 39, Latina, married, pharmacy technician*

In LaWanda's first comment excerpted above, she uses the word "chance" twice: once to mean that she might have another ectopic pregnancy (therefore she feels that she should think twice before getting pregnant again) and once to mean that there is still a possibility that she may yet birth a baby (therefore she refuses to give up her dream of finding another husband with whom to start a family). She explains that since she is aware that there is a medically-defined "chance," then she can now leave it up to God to decide whether to "bless" her with a successful pregnancy. In the second quote, LaWanda shares her dubious view of ART, suggesting that women who do it are taking unwise risks, that they are endangering their health to get a baby. For women like Dianne and Zara, doctors' use of "chance(s)" equates to calling the odds on their fertility potential. In many cases, they stop short of trying every treatment available to them mainly because they believe their "chances" of success to be so small. Following fibroid surgery, Dianne has a "little window of opportunity" in which she could get pregnant before getting more fibroids and/or reaching menopause. She does not want to take the drugs involved. Some

women—perhaps more set on biological motherhood (and there are myriad reasons for this preference) and/or perhaps more accepting of medicalization—may have chosen to interpret the doctors' proclamations about "chances" to mean that there is still hope and these are the women likely to select from the extensive menu of amazing and new and improved—but improbable—fertility procedures in hopes of a miracle. In fact, incredible anecdotal success stories keep the fertility industry afloat and further encourage more experimentation in reproductive medicine.

Zara reports being given a "fifty-fifty" chance to "maybe get pregnant." The meanings of these kinds of odds are obscured by their prevalent, inconsistent, colloquial, and incorrect use and by patient misunderstanding. Rayna Rapp (1999) noted similar problems with doctor-patient statistical discussions around prenatal test results. Statistical probabilities inform the recommendations of fertility doctors and the relative costs of treatment. To some extent, when "chances" are too low, the fertility clinics and doctors may discourage the women from further treatment by charging more, by refusing treatment, or by talking them out of it. However, at other times, the financial rewards, the patients' demands, or the opportunity to produce a "miracle" may prove to be too great for the clinics to turn away too many patients. Much has been made of the ethics of fertility clinics and advertising success rates (e.g., Thompson 2005, Spar 2006). The Fertility Clinic Success Rate and Certification Act of 1992 may have helped clean up the available statistics, but clinics may still improve their apparent success rates by recruiting younger patients (some, like Azra and me, who may have been steered to IVF too early), by encouraging the use of donor eggs from younger women, by limiting access to older women or women with certain kinds of hard-to-treat fertility problems, and by highlighting pregnancy rates instead of live birth rates (also failing to note that IVF increases the likelihood of miscarriage). The CDC (2009) recently found that fertility doctors and their laboratory staffs are

improving success rates as they gain more experience and as they practice with finer (and costlier) techniques such as intracytoplasmic sperm injection (ICSI) wherein the most robust, quality-controlled, genetically-screened eggs are chosen and then individually injected with individual sperm cells that are also cherry-picked. A trend in the past 10 years is to transfer fewer embryos, but these embryos are the best available and the most likely to implant in the uterus (i.e., lead to pregnancy). CDC data gathered in 2006, lists the success rates by type of cycle, number of embryos transferred, women over 40, types of treatment used, and many other factors. It does not list an overall "success rate" but the 2003 report does. Compare that to the success rates published for 2005 by the Zouves Fertility Center, a well-regarded clinic in the San Francisco Bay area where three of my respondents (and I) had a consultation (only one person, Azra, continued with treatment).

Table 3: IVF pregnancy rates by age: nationwide and at Zouves Fertility Center.

Age of patient	**CDC success rates**	**Zouves success rates**
<35 years	37.3%	51%
35-37 years	30.2%	51%
38-40 years	20.2%	43%
41-42 years	11.0%	13%
>42 years	4%	9%

The reason for the discrepancy in success rates is unclear. Zouves publishes this statement: "We believe our experience, cutting edge technology, both medical and technological, and personalized care will optimize your *chances* of success." They pair the wishy-washy term "believe" with the statistical-sounding word "chances," chances that are an improvement on those offered by other clinics or perhaps on nature.

Biologists characterize human reproduction as “inefficient” and influenced by innumerable “behavioral” factors like timing of intercourse, penis withdrawal patterns, washing, and environmental conditions (e.g., Tingen et al. 2004). The idea that there is a 20-30 percent chance of pregnancy in any given “exposure” during sex appears to be accepted dogma. My experience with infertility specialists reveals additional insight into the numbers game in the fertility world where statistical confusion reigns. The fertility specialists who I saw in Atlanta did not provide any numbers. Instead they said that “most women” get pregnant within six cycles of IUI and “almost all” get pregnant within 12. In California, my doctor told me that I had a three to five percent chance of getting pregnant with each attempt at ICI (intracervical insemination) done at home and “double that” chance with IUI (intrauterine insemination) in his office. I wrote his statistics down and scoured the medical literature for some reference to back it up. I had no luck. Incidentally, I got pregnant twice, both times with the at-home ICI. He referred me to an IVF clinic after the first miscarriage, telling me that I would “probably” get pregnant “right away.” The origin of the probabilities given to my respondents and to me is mysterious and probably arbitrary, the rough guess of a doctor. “Chance,” when used by doctors, signifies not just scientific probability but also the relative amount of hope remaining. When there is a chance, there is hope. The quantifiable concept of chance transubstantiates into the metaphysical concept of hope. Miracles can happen, they might happen, and one must put their faith in God’s will, in luck, medical miracles, or a combination of all three. Hannah is given excellent odds for getting pregnant with IVF but she is not willing to take that bet:

> We started looking at IVF and you know, with my case, what I was quoted in terms of the chances of getting pregnant didn’t sound good enough to me –

> Do you know what they are?
>
> They were probably relatively high, I think 25 percent. But given our limited resources, they didn't seem good enough to put all of our money there. And with me it would have been pretty complicated.

Though Hannah's quoted chances were as high as nature is supposed to be—and thus, rather suspect—she cannot leave her opportunity for motherhood up to chance. She expresses concern at the complexity involved but she also refuses to put her faith (and her money) into a process that is not guaranteed. Adoption, she decides, is a better use of funds because the "chances" of a take-home baby are much higher. Jacobson (2008) writes on the management of relative risk by adoptive mothers who must weigh overlapping financial, emotional, and social costs in choosing adoption over ART or childlessness.

Penny Ortiz likens "chance," to serendipity. Her childlessness gives her the "chance" to fill an important niche, that of a godmother auntie and a caretaker. This usage is consistent with her belief in God's master plan. This meaning underscores the belief by many respondents that motherhood is ascribed in spite of dominant narratives that emphasize it as an achievement (Ginsburg 1989). But Penny is not just stuck in a traditional belief system, a throwback from the past. This concept of "chance" allows a positive spin on childlessness. It is opportunity knocking at the door.

Although my respondent Mary Benson, another woman for whom childlessness *just happened* does not employ the word, chance is insinuated in her comment to the effect that

"whatever happens, happens." She indicates that she leaves pregnancy up to chance or happenstance. She does not seek medical advice or try any remedies when she does not get pregnant after "doing it all the time." Mary and her husband give it a chance by forgoing birth control for six months. She then closes the window when pregnancy does not happen, quickly deciding that she does not want children anyway. Two months later, by chance (that fickle phenomenon), they lose the condom during sex and her period is late. She worries that she is pregnant and then is relieved to find out she is not because now she is certain that she does not want to be a mother. Mary does not mention God or any other supernatural forces, but she still symbolically restricts her own power to decide whether or not to become a mother. Chance, then, is yet another route to "indecisions" about motherhood among my respondents. Greil's (1991) explains that one way that people make sense of their situation in the case of infertility is through "theodicies," attributing this undesirable condition to punishing supernatural forces. While, some of my respondents do indicate that they feel like they are being punished for something, many more construct positive meanings from assigned decisions about motherhood to another realm.

In a classic article, anthropologist George Gmelch (1992) points out that indigenous Trobriand Island fishermen and professional baseball players tend to rely on magic, on good luck charms and rituals, when they enter situations for which they have little control. Whether heading out to the open sea or pitching to a switch hitter, these men cannot accurately anticipate the outcome so they call on the supernatural to help them. Pregnancy is similarly unpredictable. Women try magical thinking, potions, charms, and rituals to prevent pregnancy and to achieve it. On one level, they believe that God/the universe/chance controls the situation, influences readiness and timing, and delivers karmic justice. But they do not rely on magic alone. The women I talked with control their fertility in the sense that they have abortions, they use birth

control, and they dabble in medical treatments to promote pregnancy. Because getting pregnant is an especially uncontrollable event in the lives of involuntarily childless women, constructing pregnancy and motherhood as ascribed statuses, as God's blessing, or as chance provides a comforting view.

Women do not "decide" to be mothers; "nature" (or an omniscient, omnipotent power) does and that is explanation enough. In *The Social Construction of Reality*," Berger and Luckmann (1966:89-92) define "reification" as this idea that many roles (e.g., motherhood or nonmotherhood in the case at hand) are "products of the nature of things." As such, it is only a "mandate of natural law" that most women will become mothers but that a few will not. Consequently, accepting this "reality" is part of being enough as women without necessarily having to become mothers.

The talk of mystical ascriptions among the respondents is internally inconsistent and contradictory within single interviews. Some situations are magically meant-to-be or even subject to influence (through positive thinking, trust in the universe, or "good vibes") yet God or fate or chance ultimately decides who will or will not become a mother and by which route. Doctors can prescribe appropriate medications and perform procedures or adoption agencies can search for a child to match with a family, but mystical and random forces account for so much of the outcome. Women cannot determine this outcome; they themselves do not "decide" to become mothers or not, although their "good" or "bad" actions (e.g., previous abortion, dedicated hard work, being a good person) can influence the universe/God/chance in their favor or against them. They are supposed to have "always wanted" children like real moms are said to do but they must balance this permanent intent with the degree of wantedness. That is they cannot want too badly

(or try too hard) lest they jinx their "chances" or irritate God by revealing an inability to trust in a master plan.

My respondents ponder many worthwhile reasons for becoming mothers, yet to become a (good) mother, many believe they need: to be with the best partner, to find just the right time at the right age under the right circumstances, to follow God's plan or to be lucky, to harness the supernatural to their benefit, and to have a chance. This perfect storm of readiness and divine influence gathers on its own to a large extent, outside the immediate control of women *and* beyond the control of medical practitioners and adoption gatekeepers.

Why do the women I interviewed differ in their self-constructions and in their experiences from those infertile or involuntarily childless women portrayed everywhere else? It is not just that my respondents' epistemological standpoints as lesbians, women of color, single, and working class exempt them from the social imperative to become mothers. It is not just that they buy into the myth of the ideal nuclear family and the archetypal mother who epitomizes womanhood and femininity and thus refuse to challenge those ideals. It is not just that their narratives are traditional, reminiscent of the religiosity that preceded modernity. Most of them are not devout Catholics or Christian fundamentalists who demonize abortion and assisted conception, believing "spilling seed" to be a crime. Even the ones whose rhetoric is very religious use birth control, refuse to have children when they find themselves with the wrong husbands, and get divorces. They are empowered women, present in a post-Women's Movement society; women with jobs and careers, friends, and aspirations beyond motherhood. They exercise control over their fertility (though maybe not their infertility) and expect satisfying romantic relationships. In the following chapter, I further interrogate the roots of my

respondents' distinctiveness from women who do let IVF "take over" and become a "way of life" (Franklin 1997).

CHAPTER 6: CONCEIVING COMPLEXITIES

"If we are to recognize and respect choice, we have to respect these choices as well: the choice to accept infertility and the choice to fight it." (Rothman 2000 [1989]: 95)

It is typical for us as humans to look back on our lives and identify moments when we made choices that led to our present circumstances. We tailor our stories to fit existing, socially agreed-upon narratives (Goffman 1963). Our memories are faulty and suggestible, prone to taking on new import as our lives and our self-concepts change. The meanings are subjective and shifting, suited to our psychological, emotional, and relational purposes. And, conveniently for the sociologist, these meanings highlight emergent discursive strategies, revealing how people make sense of their experience and how they subvert oppressive ideologies. Infertile, childless, or both, the women I interviewed relate their stories in ways that are ambiguous, inconsistent, and seemingly contradictory. Some "always wanted" children but "maybe never really wanted them anyway." Some identify as "infertile" but tell me that there is still a "chance" they could get pregnant and have a baby. Some "don't dwell" on their childlessness; instead they declare themselves fulfilled, all the while weeping for the lost opportunity to have grandchildren someday. Their feelings are complex. Their "decisions," as shown in the previous chapter, are not firm ones. Their plans and their memories change even as they relate them to me. These disorderly patterns may seem like so much noise but they are significant and, upon consideration, they make perfect sense.

Women's studies scholar Charis Thompson (2005:55) writes, "…involuntary childlessness is recognized as being one of the greatest forms of unhappiness and loss an adult

woman might have to endure." But the childless and infertile women I talked with do not radiate unhappiness or sit around mourning their loss. They come by their childlessness incrementally and often unselfconsciously; they are never "really" infertile, and they accept these almost-statuses pragmatically. Other life events like illness, injury, death of loved ones, divorce and other relationship terminations, job loss, and poverty elicit stronger, more long-lasting emotional reactions for many. Undoubtedly, the essentialization of women as mothers intensifies suffering among those who cannot easily become mothers, but women who are otherwise marginalized contend with multiple kinds of oppression throughout their lives and the pressure to mother takes on a different character for them.

This chapter explores the myriad ways in which these women either realize or ignore their childlessness and/or infertility, cope with and deny that experience and identity, and convey regret and acceptance at the same time. This palpable, *dynamic ambivalence* originates in part from women's subjective sense of *role applicability*—the degree to which they think that the motherhood mandate applies to them. They fully recognize and value that mandate and many would happily become mothers given the right conditions—and, thus, the Goffmanesque terms "role embracement" or "role identification" are not the most apt descriptors—but even as their narratives support the mandate, their actions do not. They are unwilling to commit to being either voluntarily childless nor involuntarily childless. This rejection of both the motherhood mandate and a childfree identity interacts with the women's gendered *identity sufficiency* vis-à-vis their motherhood/otherhood taxonomy and with their (in)decisions about motherhood and nonmotherhood. These infertile and childless women do not avoid treatment just because they lack access to it, as typically claimed, but for other, interrelated reasons that have to do with their understandings of femininity, womanhood, and motherhood.

Their deviance as nonmothers or infertile notwithstanding, as women they must constantly contend with societal models of the maternal body and ideologies of motherhood. And as single, poor, working class, racial/ethnic minorities, and sexual minorities, specifically, they also have to navigate around negative ideas about their bodies, their moral fitness, and their motivations.

Dynamic Ambivalence

I just wanted [children] in the past five years. I didn't definitely want no children. Not desperately want them.—*LaWanda Jackson, 42, African American, single, nursing assistant*

Most of the women I interviewed could hardly be characterized as desperate and unfulfilled. In fact, like LaWanda in the line quoted above, several of the women make the outright claim that are not desperate, "desperate" clearly being the default trait in our shared image of infertile women. Even if many of the women in this study express sadness, disappointment, or wistfulness at times, they generally describe these feelings as either short-lived or rather diffuse. They are aware of the medical "miracles" and high-tech possibilities out there but they set limits on what they are willing to try. These women are fully capable of analyzing the relative costs and benefits of assisted conception, adoption, and childfree living. Aside from the fact that infertility can be seen as a "middle class disease," with certain women funneled into treatment, having been favored by the medical establishment and targeted by industry advertising, the availability of options is apparently common knowledge. Much is made in the public health literature about "access" to fertility treatment. My findings suggest that lack

of access (i.e., appropriate medical care and adequate insurance) is in fact not the main reason why socially marginalized women are less likely to pursue NRT. As mentioned in the previous chapter, they tend not to worry as much about the financial costs or social barriers to treatment/adoption (e.g., proscriptions against single motherhood; religious objections to assisted conception) as one might expect. Instead, they are wary of the emotional, physical, and practical tolls exacted by infertility treatment, by the adoption process, and by motherhood. And in many cases, other life events intervene to supersede questions of procreation and motherhood.

Transcending Realizations

Along a spectrum that includes sudden realizations, to gradual or multiple ones, to asserting that they are not-really-infertile, the women I interviewed indicate that perceptions of fertility vary within one's lifetime, even within the conventionally defined fertile years (ages 15-44). They discover in different ways that motherhood will not just happen for them and their reactions vary accordingly. Many of the women come to acknowledge their infertility or the permanence of their childlessness only in gradual and intermittent ways. For example, those women for whom childlessness "just happened" cannot pinpoint when they realized that they were always going to be nonmothers. They do not see themselves as "infertile" or "involuntarily childless." Those labels are reserved for someone else not like them—those women who feel more strongly about it, who are invested in the motherhood mandate, who are certain they want only to become "real moms."

Two outliers in a sample of participants who do not "suffer" because of infertility, are two immigrant women, Azra Alic from Bosnia and Zara Senai from Eritrea. Even though they represent the most "infertile-identified" of the women I talked with, they still discursively

transcend that label upon learning of their infertility. Azra, the only respondent pursuing NRT (in the form of IVF), points out, “I wasn’t thinking about kids at that time, you know.” She is not worried about her fertility potential when she first realizes that there could be a problem. She is 25 and not yet interested in becoming a mother. Her focus is on the abdominal pain she has and the need for surgical intervention. Her concern soon grows, however; and by the time I talk with her about it, she is beginning IVF, feeling depressed and emotionally raw, and sullenly planning her future as a childless old maid. Only Azra and Zara, among my respondents, convey deep, unresolved emotional pain in their interviews. These two women have much in common. Both endured large ovarian cysts and multiple surgeries and both harbor doubt that their partners will still want them, despite reassurances of love and loyalty from the men. Zara keeps her uterus because, as she says, quoting her husband, “…maybe someday these people—they do a lot of research—something will come up; don’t give up.” These two women cherish their godmother auntie roles but see that as a second-best alternative to “real” motherhood. It took Azra a while to first realize that her fertility was in danger and that it was something that she cared about. Now she is accepting medical treatment beyond her comfort level, leading me to wonder if she is getting a little bit “desperate.” However, she adamantly denies being “stressed,” and indeed gets annoyed when doctors insinuate that she is. Both Azra and Zara clearly state that they know that there is more to life than motherhood and that they will eventually come to grips with that fact. They just have not done so yet.

Well? Do You Want ‘Em, or Not?

Several of the women vacillated between wanting children and not wanting children, reacting in part to medical assertions regarding their fertility. They demonstrate their

ambivalence by weighing the benefits and drawbacks of having children or not having them, by "wanting and not wanting" children at different points in their lives and even at various times throughout the interview. This pattern held true for the younger women who intentionally delayed childbearing as well as for the women who have given up on the idea of having children or having additional children. By not making a clear distinction, the women allow for mystical ascriptions but they also leave open the possibility that they can will change their minds and that there are other ways to be, besides being a mother:

> I think at one point [I wanted children] and then I found out I couldn't so I was in denial about it so it was more like, "Oh I don't want then anyway." And then I really opened up in my twenties.—*Jessie Silva, 42, white, queer, hair stylist*

> Never been pregnant that I know of. Yeah. So I'll tell you, part of my life I thought maybe I could never get pregnant. I think that the first two sexual experiences I ever had, I was not on the pill. And then I got on the pill. And I thought, "Gee maybe I could never have children anyway." But I never, you know. Cause a lot of times first time young people—You know? So not that I know of, no. Yeah. [trailing off—I thought it sounded wistful]
>
> Kristin Wilson: Do you have any feelings about that?
>
> Not, um, well, the story that comes to mind is my periods are getting further and further away. I thought I was pregnant from a boyfriend at age 40 and I went to

> my doctor. I think I was starting to have hot flashes, too. And I went to my gynecologist and I said, "You know, I think I need something because—" I-I really thought I was pregnant and he said, "No that's just your start of your peri-menopausal or whatever." And I go to say, "You mean I can't have children?" [disbelieving] And it was weird because I think I had already said, "It's okay if you don't have children." But as soon as he said I can't it was like, "What do you mean I *can't*?" And then he said, "Well did you want to?" And I go, "Well, no not really because I'm not with anyone in my life that I could have the child with." And to me, I connected have a partner, have a baby. And then he had to drop my insurance. I had to go to another doctor. When he said that, I remember having a feeling of, "Oh this is so—um what's the word—this is so—you can't have children anymore because you're in menopause.—*Penny Ortiz, 52, Latina, single, guidance counselor*

Jessie and Penny both experience a bit of a shock when their doctors proclaim them infertile. Whereas Jessie's first reaction is to dismiss the idea of motherhood in a way that she later describes as sour grapes, Penny thinks she is fine with the idea of childlessness until she realizes the finality suggested by the doctor's statement. The threats to their self-concepts as women, to their assumption of fertility, to the options they thought they had about motherhood are serious but not determinative. As with any life-changing information, there are long-term pros and cons to consider and several possible directions to go. These women do not collapse upon hearing of their infertility but neither do they take in stride.

For other women, the realization sneaks up on them:

> We finally got a house and then I had a new job and then it was like I had way too much responsibility. I guess I started trying then but I wasn't that serious. So probably around when I was 38 I got more serious about trying. Suddenly I realized, maybe I'm not fertile anymore . . . And I had spent so much effort for so many years trying not to get pregnant, that I didn't really think about anything else. I can't remember. There was so many times when we would like go on vacation and I forgot to take my pills and made sure I called my doctor. I'd go to all these special lengths to try and make sure I had my birth control pills because I was so worried I was going to get pregnant. I always think about this story this person told about this guy who used to shave his head. He shaved his head for like 20 years and he finally decided he wanted to grow his hair out and he found out he was bald. So I think that's me. I tried so hard for so long to not be pregnant because I was so afraid of how my life was going to be or how it was going to work out that I didn't realize that maybe I wasn't even fertile.—*Jennifer West, 46, white, married, engineer*

Many women recount the disorientation they felt when trying to get pregnant after many years of trying to prevent it. The fear of infertility supplants the fear of pregnancy. Jennifer remarks on the irony of this phenomenon. She "didn't really think about anything else," never considering that she might not ever have children someday. For her, the realization came too late. She partly blames the media for her predicament, maintaining that her generation was brainwashed into delaying childbearing by stories of procreative "miracles" and older celebrity

mothers on magazine covers. Once faced with the option of trying for a miracle, she realizes that she is unwilling to go through the medical ordeal. Jennifer ends up adopting an infant, a decision that she and her spouse come to incrementally, much more slowly, by comparison, than the other members of their cohort in the mandatory adoption training classes.

Some women come to the realization that they will never be mothers when they discover that they will never meet their own criteria of readiness:

> The guy was a gentleman, I can tell you. I knew him for a while. He was a co-worker. And he maybe had more feelings for me than I had for him. And after that actually, I said, well if this is what it is to be married or have sex with someone, this is not what I want in my life. I didn't enjoy it.—*Lourdes Garcia, 56, Latina, single, administrative assistant*

In Lourdes' case, this realization happened somewhat suddenly. At the age of 40, she has her first and only sexual encounter and it is a disappointment. As a result, she comes to understand that if she does not have a relationship, a criterion she links to her Mexican cultural background, then she will not have children. She talks about a close friend who adopted on her own, so Lourdes has personal knowledge of motherhood without a sexual relationship, but she cannot reconcile herself to the lack of partner with whom to raise children. She knows that single women can adopt but she still feels like it is wrong somehow.

As is common, exceptions are illustrative. One woman, Hannah Johanson, who in fact did have a sudden realization of her "infertility"—actually an almost-status rather than an overdetermined one—is certain in wanting children, and she acts decisively and efficaciously.

She approximates the white, middle class, married infertile woman of lore though her queer sexual identity (masked by her SNAF-seeming lifestyle) and her current male partner's questionable fertility status has meant that she did not always assume that she would have children in the conventional way.

Reflexive Realizations

Another kind of realization is one that disentangles fertility from motherhood:

> I actually had a note, like a note card around a couple places, just to remind--…I realized that on a note card I had written "mother." I had not written "pregnant" and that was a real turn-around for me to realize, wait: my goal is to be a mother . . . Well I thought "mother" meant going through all this stuff. But in the end what I realized after I ran across that card, after I found out that my fallopian tubes were closed, is that mother means you want to be a mother, not that you want to get pregnant.—*Dianne Jacobsen, 56, white, single, life coach*

Over the course of perhaps several months, Dianne ponders her apparent infertility. She gets medical treatment for fibroids. She tries to be nice to her husband when she is close to ovulation so that he will cooperate in her attempts to become pregnant. She stands on her head after sex to encourage sperm to swim into the fallopian tubes. She eventually finds out that her fallopian tubes are closed, signaling the end of her fertility. She writes herself reminder notes about her "goal." (Dianne fervently believes in self-help methods; she gives motivational speeches and hires herself out as a "life coach.") And then she realizes that her ultimate objective

is motherhood, not pregnancy. She wastes no time, signing up for adoption classes and a home study, exercises that she enjoys for the self-examination they require. Finally, Dianne gets a call via her social connections about an available baby born thousands of miles away. She immediately flies out, takes the baby home, and soon thereafter divorces her husband, remaining single throughout the baby's childhood. In the stories provided by most of the adoptive mothers in my study group, realization led to action.

In contrast, some of the other women develop a wait-and-see attitude, not "realizing," not naming their "infertility"—not out of superstition or the blush of finality on the word, but out of deeper, certain non-identification with it:

> I personally don't know the reason why I don't have any children. I did want a child. I at one point was really trying very hard to get pregnant with a man that I live with now, that I've been with since 1991. And uh we were not able to. And he ended up having to go through some prostate surgery so that meant that he was going to be sterile. And but before that, before that, before the surgery, we were trying really hard and we really wanted a child.
>
> Kristin Wilson: What kinds of things did you try?
>
> Uh, well we tried getting pregnant but the thing is when they suggested, when the doctor suggested that um you know like saving the sperm and stuff because of him getting so many infections, we didn't know if that was going to be the right

kind of thing. And then so we kind of cancelled that.—*Iris Hernandez, 54, Latina, office assistant*

Iris never receives a diagnosis about her fertility, though her boyfriend becomes sterile. She did not go so far as saving sperm for later insemination, for reasons that are unclear but may be related to moral doubts. She does not "know the reason" for her inability to get pregnant before he had prostate surgery. Later, she goes on to say that they "thought about" adoption but it just did not "materialize." There is no clear explanation for that either even though she notes ample opportunity when she worked as clerk in a public maternity ward where infants were abandoned on several occasions.

The women participate discursively in the "regime of truth" that is hyper-medicalization, though not typically as co-conspirators. Medicine labels all pregnancies as "high-risk" (Rothman 2000, 2007) just as it portrays all types of infertility as treatable. There are no hopeless cases. Medicine can always offer some "chance" of a "miracle" thanks to the alphabet soup of available technologies: e.g., IUI, ICI, HSG, IVF, GIFT, ZIFT, ICSI, and TESE. Failing those, there are always surrogacy arrangements—an option I found to be shockingly routinized as if it were a mundane transaction—in which people can even make use of their own gametes, preserving a genetic connection. It can be irrelevant to think of oneself as "infertile" when it is always hypothetically possible to remedy the situation if the desire is great enough. Infertility seems more a temporary condition, rather than a firm diagnosis or an identity. In actuality, infertility is always already a liminal state of being because women can never really know how fertile they were when using birth control or avoiding pregnancy in other ways and they can never really know how fertile they are or will be in the future since they can never truly exhaust all possible

treatments. Therefore, some women who are infertile-identified are “infertile” with caveats. Fertility fluctuates. These women apply the brakes themselves for personal and emotional reasons as well as for financial reasons:

> Some of it was the infertility bit, and I think within a couple of months I was sort of reconciled to being infertile. And I should say it’s not absolutely certain that I’m infertile. So part of the problem with this vague POF [premature ovulation failure] diagnosis is we don’t know what it means. My ovaries aren’t functioning properly, but since we don’t know why, we don’t know if they might start functioning again or what for the rest of my life, for the rest of my body. I think about five percent, or five to 10 percent (I’ve seen different statistics) with POF eventually become pregnant. Sometimes twenty years after the diagnosis. So in saying I’m infertile, I’m just going with the statistical probability. And that’s again not something my doctor told me, but something I had to find out on my own. I think I began finding myself reconciled the more I found out about other options. So the more I began to see that we could have children other ways, the less important it became to me to be able to bear children myself. And I think the main difficulty in thinking about how to have children other ways was financial. And that was for a time very hard. So part of the difficulty I have being infertile was when we started looking at how much IVF would cost. We started looking at IVF and you know, with my case, what I was quoted in terms of the chances of getting pregnant didn’t sound good enough to me.—*Hannah Johanson, 39, white, queer, married, teacher*

> I had a weak cervix. And, after the miscarriage that I had, for the pregnancy that I took so hard, they said that if I wanted to try again that they would tie my cervix. That is something that they do for women that have this problem. But, I took that one so hard and then the other [miscarriages] as well that I didn't want to do it anymore. I didn't want the chance of going through all that emotion again— *Lupe Jimenez, 41, Latina, married, electronics technician*

In Hannah's case, discouraged by the doctors' apparent lack of knowledge regarding her diagnosis, she casts a more critical eye on the medical establishment. She re-examines her (largely unconscious) acceptance of biologism and acknowledges that she *could* have biological, genetic children but that given the circumstances, she prefers not to. She takes the power into her own hands by making adoption a deliberate choice, not merely the default option. And she can "accept" the label of infertility, in other words become resigned to it, once she sees other options for achieving motherhood.

Lupe chooses to re-focus her attentions on her existing child and to let go of the idea of producing a sibling for him. Her doctors suggest a new way to prevent her miscarriages but she has had enough of the emotional turmoil and medical hoop-jumping. She wants to "be happy" again and wants to sustain a healthy relationship with her son (who at the age of six, noting her sadness, reportedly reassures her, "It's okay if I don't have a brother or sister.") Again, she could have more children; she is not "really" infertile. The language used—that she has a "weak" cervix—implies that she is somehow to blame for this lack of strength (see Martin 1987). But in

spite of this insinuation, and in spite of pressure from her doctors, her husband, and her mother (who always asks her to “try again”), Lupe refuses.

Many of the women interviewed, particularly some of the older, postmenopausal women for whom childlessness “just happened” enact “reflexive realizations” in that they ponder their (in)decisions over their lifetime and allow for ambiguity and that wait-and-see attitude about the unfolding of life events. They do not see infertility as a fixed status. Neither is there a sense of inevitability to childlessness (in spite of their simultaneously conception of it as ascribed).

There are aspects of human biological reproduction that are unknown and, some suggest, are unknowable, even by medical science. This missing knowledge helps fertility to retain its mystery, leaving the door open for mystical influences as discussed in the previous chapter. It also leaves room for interpretation. Most women of childbearing age (an age that is creeping upward) see themselves as fertile or, at the very least, possibly fertile. “Infertility” still sometimes signifies “barrenness” in popular usage. It suggests finality, a fixed status, even, arguably, an aspect of identity. The women I interviewed reject that label even while they explore alternate paths to motherhood or embrace their childlessness. The CDC term “impaired fecundity” makes it sound fixable and impermanent; fecundity can be repaired by medical mechanics. Fertility is always potentially there (or was there at one time). The realization that one is infertile occurs along a continuum that extends to the denial of infertility. It is a process. And this process can occur multiple times, in different ways each time, contingent on women’s fluctuating biology, changing social circumstances, and temporally-situated psychological and emotional states.

Because a clear transition does not necessarily happen, the “reality reconstructions,” “identity transformations,” and “role readjustments” (Matthews and Matthews 1986) and the

"redesigning the life plan" (Becker 2000) that some infertile women and couples go through (particularly after repeated failed IVF attempts) are masked by the complexity of these women's experiences. The "transition to nonparenthood" is less tangible because their goals are fuzzier in the first place. Their realizations of infertility are often in flux (even, seemingly incongruously, long after menopause) and so too are the mechanisms for coping with it.

Coping and Regret

Thankfully, my partner and I now have two healthy and happy sons that we were able to adopt. I go about my everyday business of writing this dissertation, caring for the children, managing a household, and keeping up with social, professional, and familial obligations, thinking little about my own "devastation" from infertility. But I felt differently in the summer of 2006 when I finally—after six years' of trying—realized that my fertility pursuit was over and that we would try to adopt. Here is an excerpt from journal entry jotted down immediately after talking with the clinic nurse over the phone:

> Today 7/21/06 I had the nurse consultation with the Zouves clinic. She detailed the procedures for precycle testing in which I would have to be tested for hormone levels, immune responses, psychological counseling (because we are using donor sperm), and genetic counseling and tests (even though we are using pre-screened donor sperm). The medications will total into the thousands, the counseling fees are not listed on their lists of fees (which already total about 30k), and there are required shots daily for about four months. Some shots are twice daily, etc. I feel that I can't do it because if it doesn't work it will be torture for

nothing (but more torture in an emotional sense), will require lots of time off work in my untenured position, and will max out our credit . . .

Now I feel upset, maybe even devastated (at least within the hour of the phone call) that I will not experience a pregnancy and birth. I cried. Called Dan. He is pretty supportive but still likes to blame himself and make it seem that that is the real problem, not my loss of fertility or frustration with these medical processes. IVF is not indicated, only in the sense that IUI hasn't worked for so long. That miscarriage was not about the method (ICI/IUI vs. IVF) but about proper medical monitoring. Perhaps I just need a good doctor. Maybe I should return to FWHC [Feminist Women's Health Center] in Atlanta where the quality of care was so much better? I am pretty damned sure IVF is out of the question. One thing that makes me feel better even though I am sad about the idea that I may well not get to experience a pregnancy is that I may still get to breastfeed. I need to look into how that is done for foster/adoptive moms. I also feel better thinking about adopting a child who needs us. I think I can handle losing one I fostered if I believe it's in the child's best interest. That's a good discursive strategy by the county adoption workers/fost-adopt system. Media stories and people's anecdotes propagate a needless fear about foster care. I want to be a mother. The physical experience is a small and perhaps forgettable part of that in the scheme of my lifetime or my child's lifetime. I am beginning to feel less scared of adoption and less loss about IVF and the imagined pregnancy (not even the baby, in fact. It's the pregnancy I am mourning).

In this passage, I work through my thoughts in an attempt to cope with the loss, coming to the conclusion that adoption will heal me, or correct the "handicap" of infertility (Rothman 2000 [1989]:95), especially if I still get to "embody" motherhood through breastfeeding (I *was* able to breastfeed the second child). The coping stories among my respondents echo my own in some key ways: expressions of sadness or regret, questions of blame, frustration at loss of power via doctors' ineptitude, critiques of medicalization and "society," glorification of the pregnancy experience, and, of course, resolution through some other plan (or, for some, through giving up planning altogether). It may be overreaching to use the term "cope." For so many, it is a gradual, irresolute process, a phenomenon that goes hand-in-hand with indefinite, ephemeral realizations. Still, my conversations with these women yielded some patterns, patterns comprised of components that vary in intensity. Generally speaking, the childless women find good reasons to be that way even while they express mild to moderate longing or regret. Of course, they emerge at discrete points in the coping process due to diachronic variation: those premenopausal women still hold out children as a future possibility and the older women expect no change.

The women who became mothers through adoption or whose infertility followed the birth of at least one child recall their feelings from a manifestly different standpoint. They *are* mothers, they live it everyday; "mother" is their master status. It cannot be separated from the whole of their being, making it all but impossible to (re)imagine the alternative. Their recollections of suffering must be understood as partly the result of their investment in their current identity and partly a reflection of this cohort's particularly strong desire and drive to become mothers regardless of the obstacles.

Not Meeting Expectations

Even the women who tend toward and identification with voluntary childlessness must contend with their choice within a society that, in spite of the strides toward liberation of gendered strictures, still ties womanhood to motherhood:

Kristin Wilson: Did you ever want children?

That's a good question because I'm not sure. I thought I did. But in retrospect, I think it was more just doing what my older sisters did and what my mother did . . . I remember thinking that I would at least go to college and get a degree and then I'd have kids…I decided somewhere along the line to not. I mean it really—I don't think it was ever really conscious. It was conscious when I thought I was going to have kids at 19 or 20 because I was with a guy that wanted kids and we were talking about all these kids. But then that fell apart and then I never really thought about it...We'd have a bunch of kids because he liked kids and I liked kids. So it was pretty flip. It wasn't in any depth at all . . . The only thing I think about is who's going to take care of me when I'm 85. Now that I work with seniors, I wish I'd had kids! I don't really think about it. I kid around with you that I wish I had kids—*Annette Kramer, 54, white, lesbian, family therapist*

Annette's comments mirror those of the other post menopausal childless women. They downplay their regret, a feeling typically tied to the need for care in old age rather than to their identity or to loneliness or to missing the experience of pregnancy or motherhood. In this

passage, Annette cannot pinpoint a time when she decided not to have children, nor was her earlier plan to have them ever serious. This indecisiveness about motherhood and the levity evident in Annette's joking that she wishes she had kids, indicate a minimum of regret. Like Annette, the older women I talked with by and large appear content with their lives and their choices; they often say that they "don't dwell" on their childlessness. This is not to suggest that they are unaware of their departure from the norm. For example, Annette recounts a recent uncomfortable incident wherein others were apparently "judging" her because she did not have children (she was certain they would have been positively shocked that she was also a lesbian). A similar event was related to me by Karen. She concludes, "When I think about it I think it's strange, and people must think I'm a little odd." She knows that people expect women to be mothers and they are surprised that she does not have children; she is a little surprised herself:

> By the time I was 40 I just said it looks like it's not going to happen. But it is weird to me. I've been thinking of it the last few years because it seems like I should have them in a way. I love my nieces and nephews and my friends' kids but it feels strange like I could have also have had the life with the family. I don't sit around regretting it but sometimes I think that's weird. It's weird that I didn't have them— *Karen Tabb, 49, white, single, teacher*

Again the coping mechanism is to not "sit around regretting" one's childlessness. Only in the last few years does Karen begin to wish she had not waited for the "right" relationship, that she should have had children on her own, something she did not do because it seemed like too much to handle. It is not until she is nearly 50, long after she accepts her childlessness, that she

needs to “cope.” During our interview, Karen begins to cry when thinking about what could have been. This emotional response stuns her as she never had explored her latent feelings about her childlessness. At the end of the interview, she thanks me for the “free therapy” and later e-mails me again to express gratitude for the cathartic experience. Obviously, talking over one’s feelings, the very basis of Western psychotherapy, is yet another route to acceptance.

The women who are still within the presumed childbearing years experience pressure to meet social expectations by becoming mothers and they also predict how they will feel in the future if they remain nonmothers at other points along the standard lifecourse. For the lesbians I interviewed, they do not feel it is expected within their social circles to become mothers, but they note that they had to out themselves to explain their childlessness to strangers. Younger lesbians and queer women are arguably more beholden to the newer, broader motherhood mandate that now includes them in the wake of the “gayby boom” (Agigian 2004, Mamo 2007). The older, single, straight women indicate others’ surprise that they never had children. Although their singlehood is the main reason for their childlessness, their reported encounters indicate that their not having children causes greater dissonance than their not having a spousal partner. This is true even among the Latinas, for whom marriage and children must come in that order; these incompatible convictions appear to foster more internal tension for these groups of childless women. Not meeting expectations does not only refer to social prescriptions but also to personal goals. Some of the women lead satisfying lives in the present but they wonder if they should or should have had children because that is what they once thought they wanted, or else they wonder if they will later wish they had become mothers.

Altering the Lifecourse

The speed at which women arrive at resolution depends on their age and life course stage, social status (e.g., married or single, poor or middle class), drive to become mothers, degree of medicalization, and idiosyncratic events. Sadness or regret may last a month or a year or may crop up here and there throughout one's lifetime. Mary, for example, never minded her childlessness one whit, firmly concluding within a six month period in her twenties that pregnancy was just was "not going to happen" and that she did not want children anyway. Then, at the age of 48, she attended a spate of baby showers for her friends' expected grandchildren:

> We go, "Oh, okay, let's have kids," and we tried but we didn't have any. And then I don't want any kids right now. We were free. We could do what we wanted. So then we were fine. And then about a year ago, I started freaking out. Like, "Oh why didn't I have kids?" Oh yeah. I was going through it for a couple of months. Every time somebody would ask, "What was the one thing you most regretted in life?" And I'd go, "Not having kids." And I'd burst into tears. But now I'm like okay again [laughs].
>
> Kristin Wilson: What brought that on, do you think?
>
> All my friends were having grandkids now. And I'm like, I'm the only one that doesn't have any kids at all. They'd go, "Oh, do you want to go to a baby shower?" I went to many baby showers and then I started thinking one day and I got in that rut and I cried about it every time someone asked me. I'd start crying

> and they'd go, "What did we do? Why is she crying?" Especially the men. They don't know how to handle that…And then I was thinking, I don't have any kids. I won't have any grandkids. And, but then now I see my friends and they have teen kids and they struggling now because, "Oh I've got to send him to college and I can't afford to do this." And then I'm thinking, "I'm lucky because I don't have to provide for that."—*Mary Benson, 48, African American, cook*

Mary goes almost a quarter of a century without worrying about her childlessness and then it hits her. One way she had coped was by not thinking about it. Upon the realization that no children means no grandchildren, the mourning is acute but brief. She soon remembers that she enjoys fewer responsibilities and now she laughs about her earlier histrionics. Her experience illustrates several things: 1) the meaning of childlessness changes throughout the life course, 2) feelings change yet the interview responses, produced at a moment in time, cannot capture the full complexity of the experience, and 3) people constantly renegotiate their feelings and identities with each new encounter. Put together, these insights challenge discursive truisms about childlessness and infertility. Childless women do not fit the tropes: they are not insouciant devotees of childfree-living and they are not desperate, anomic old maids.

There are, of course, class-, race-, fertility status-, and age-based variations in the definitions of and strict adherence to the standard lifecourse. The younger women, who put off motherhood to ensure their readiness, end up becoming mothers later than expected and in different ways than they had assumed. Among the African American women in their 20s, this means watching their friends and age mates within their families raise their children during their youth, but being left out of that cohort. They miss the advantages of the attendant support

networks, for example. The African American women in their 30s note that everyone has "already raised their kids." For the single middle class women—both African American and white—in this study, putting off childbearing due to lack of a partner can mean looking into adoption and sperm banks and sacrificing the dream of ever finding Mr. Right. (He will not be interested in a woman who already has children that are not his.) Most of the postmenopausal women refuse to consider becoming mothers at this point because they are past the traditional age, no matter that adoption might be available to them (a couple of them ponder the possibility of foster care, though). Among these, the Latinas and African American women—whether married or not—are especially isnsitent that they are "too old" to become mothers or to try for additional children. But some of the white women see the cut-off age a bit later, and indeed, one adopted a child in her mid-40s and another is thinking about doing so.

Within their complicated lives and their marginalized social status(es), infertile and childless women make sense of their situations in several different ways. In addition to not dwelling on the fact that they do not have children (or cannot have more)–and the word "dwelling" insinuates that there is some inherent pain associated with the status—the women I interviewed also find psychological comfort by: blaming their partners and ex-partners, identifying personality shortcomings, finding ways to be other-than-mothers like occupying the role of godmother auntie or working in a children-centered profession [similar to Matthews and Matthews (1986) "role readjustment"], deferring to God's plan, denying infertility (i.e., taking on the wait-and-see or you-never-know stance), pursuing other life goals, using assisted conception, and applying for adoption. Some enjoy identity sufficiency and due to their related lack of decisive efficacy about motherhood, they hear, but do not always follow the motherhood mandate.

Intersecting Strategies

Although I analytically separated some of the ways that infertile and childless women may explain themselves in changeable, ambivalent ways, as one might expect, most of the women employ multiple strategies:

> I thought I was never going to get pregnant. Sometimes I was okay about it. Oh, good, my husband doesn't want to have children. But, sometimes I was kind of sad. Because my husband was in his own world and I was basically alone. I could do whatever I want, but then you know there was some point that you said, "Oh, look at those children in the park and they're playing, oh I wish I could have one."
>
> Kristin Wilson: Why did you think you wanted one, because they were cute?
>
> They were cute and I wanted to be able to play with them. Now, it's like, "Oh God, you want me to play with you with your cars and your train? Oh, I'm so tired. All right, let's play."—*Serena Lopez, 39, Latina, married, pharmacy technician*

I met Serena and her two-year-old, slightly developmentally-delayed son in an empty courtyard at a library near San Jose, California. Her fertility history reveals how women can both reconcile and regret their infertility many times. She says that "sometimes [she] was okay about it" when she could not get pregnant with her first husband. She enjoys traveling and the freedom

to do what she wants. Toward the end of their marriage—indeed the cause of its demise—he decides that he cannot in good conscience add to a society run aground. His work with "juvenile delinquents" leads to this conclusion, thereby causing Serena to request a divorce because at an undefined point, she begins yearning for children like those she observes at the park. While single, she becomes very close to a friend for whom she acts as childbirth coach and, later, frequent babysitter.

After some time, she takes up with a man who is already a father and they talk about having children together someday. She feels pressure from her boss, her friends and acquaintances, and her mother to "hurry up" before she ages out of her fertility, but she resists this pressure saying she is not "ready," as she wants to finish school and buy a house. Finally, she tries to get pregnant to no avail for over a year and so then seeks medical help. She takes Clomid and does get pregnant, but ends up with pre-eclampsia, other complications, and a premature baby born weighing barely over one pound. She is saddened by her secondary infertility—really a decision not to "risk" complications again—but also implies that one child is quite enough for her. However, she and her new husband discuss adoption frequently, but she worries about the potential "fairness" of bringing an adopted child into a family with a biological one who might receive preferential treatment.

Serena reconciles her changing situation as needed. She tries every tack, by turns: appreciating a childfree lifestyle while honoring her then-husband's preference, pursuing other life goals, becoming a godmother auntie, using "assisted conception," considering adoption, and asserting that she could not handle two children anyway (particularly in light of her son's special needs). Coping and regret are ever-present, nebulous, and malleable. There is a necessary tension

between the two phenomena that results from and accommodates the complexity of these women's lives.

Take into account the following comments from two women using NRTs, only one of whom is critical of medicalization:

> If I'm not to have kids, what can I do? I'm not the only one you know. It's hard but—you know…I think I'm ready to have kids. And I was ready a long time. And my partner is ready and-and that's what everybody's suggesting. Everywhere I went, I had a few opinions on everything. Everything seems okay, everything seems to be working, but there is something wrong inside since I'm not getting pregnant. And they're saying, whatever it is, IVF—you do the IVF process, you will skip it . . . So everyone is suggesting actually IVF . . . . I mean if I have to adopt my kids, that would be—I'd love them the same but still I would like to have my own kids. I don't know how to explain that.—*Azra Alic, 30, Eastern European immigrant, engaged, apartment manager*

> We're open to adoption but we can't really get too open to it. My partner and I talk about it not a lot, but enough. She says, "I'd be really open to adoption." And I feel as the one trying to get pregnant, a little more reserved about opening up to it too much. I feel like if I were open to it, I'd be telling my body something. No, I want you to work for it! There's something psychological. Maybe if I was more open, my body would feel less pressure. I feel like I don't know what that's about.

> It's all these questions. This maddening thing.—*Robin Smith, 42, white, lesbian, fertility counselor*

Adoption is on the table for Azra though she prefers to have her "own" while Robin cannot let herself ponder that option when she is still trying to get pregnant, lest she jinx her chances. Paradoxically, infertility and childlessness are never fully reconciled though in a way they are always being reconciled. Azra and Robin, while in the process of intensifying their attempts to get pregnant (Robin needs assisted conception because she is a lesbian but she begins taking fertility drugs because of her presumed age-related subfertility), try on assorted narratives. For instance, Azra thinks perhaps she could leave it up to fate like so many other women must do and she contends that adoption could work for her and—elsewhere in the interview—she notes satisfaction in being a godmother auntie and, all the while, she maintains her commitment to getting pregnant even if she has to resort to IVF, a process she abhors. Like Sarah Franklin's (1997) study participants at a U.K. fertility clinic, Azra feels "compelled to try" IVF to remedy her childlessness. She may be able to get pregnant without Clomid and IVF but she submits to treatment since she feels time is running out for her. By bringing up adoption and other possibilities Azra prepares for "reality reconstruction" (Matthews and Matthews 1986). Incidentally, this theory works here, I assert, because Azra is fully medicalized and (begrudgingly) invested in motherhood at just about any cost.

I interviewed women at many points along the life course and at various stages of coping with infertility and/or childlessness. Coping for the women who are not yet ready to have children is about coming up with a future plan that balances all of their other needs with the desire to be mothers. Some are in the midst of accepting that there may be a problem. Others

have comfortably reconciled their situation. Close examination of the words of this latter group reveals lingering ambivalence, however. For example, Penny says, “Maybe it was a blessing that I didn’t have children because what did he get to do for his daughter?” She alludes to her ex-husband’s discovery of a daughter late in his life. Following his divorce with Penny, he became involved with her friend who got pregnant and then put their daughter up for adoption. When the girl reached adulthood, she located the father and he ended up giving her away at her wedding, thus beginning a lasting, warm relationship. Penny rapturously tells this touching story that illustrates how her childlessness was meant-to-be in the universal scheme of things. Yet, she prefaces the conclusion with the indefinite word “maybe.” Hedge words and phrases like “maybe,” “I guess,” “probably,” and “sort of,” litter the speech of even the most contented of the respondents. This practice indicates a little uncertainty and shows again that coping with a status outside of the norm for women must be continually negotiated.

On the other hand, there are discursive ways to get past even very negative feelings about infertility and childlessness:

> Probably my ovaries only stopped working in my thirties, a few months before I was diagnosed. It’s really hard to know. Maybe around 30, maybe 32, maybe closer to 34 when I was diagnosed. And again, this didn’t last very long, but at first I was very, very mad at myself for having waited because I may well have been fertile prior to my thirties. And I talked with Adriana [a female partner with whom she seriously considered having children when they were both in their twenties] about a lot of these things, that if I had children instead of waiting and making other life decisions, that if I’d tried having biological children earlier, the

infertility part wouldn't matter. Again, pretty quickly that was a non-issue.—

Hannah Johanson, 39, white, queer, married, teacher

Hannah recalls her relatively quickly dismissed but strongly felt self-blame at the decision to put off childbearing. She ultimately settles these regrets in two complementary ways: emotionally and intellectually through feminist introspection and, practically by successfully adopting a child and achieving her preeminent goal of motherhood. Basically, she uses what amounts to the "sociological imagination" to connect her experience to wider societal patterns such as those that force the nonchoice between higher education and career pursuits and motherhood during the most fertile years. Hannah, who happened to be in training to become a therapist during this time, also analyzes her feelings and methodically separates her health concerns from her assumptions about femininity and motherhood from her mind-set about aging prematurely (due to "early menopause"). Adopting a daughter from China, a course that unleashed a rollercoaster ride of emotion, eventually transformed Hannah's daily experience from hopeful and anxious to busy and fulfilled.

Not everyone has such tools for reconciling their circumstances. But the women I interviewed, who come from many walks of life, tend to find equilibrium between their acceptance and their regret regardless of where they are in their "journey." This capability comes from their multiple, transcendent realizations and flexible coping strategies, their "dynamic ambivalence" in effect, and also to extradiscursive phenomena. On the whole, their dispositions on infertility, motherhood, and childlessness are situated within their multiple marginalized statuses variously as single women, as women of color, as poor or working class, as lesbians, and as childless, infertile, or both. As oblique recipients of hegemonies like the motherhood mandate

and the technophilia surrounding assisted conception, they are less likely to receive any promised benefits and so they are less likely to passively receive any encoded messages about how they should lead their lives. As this role applicability decreases (and ambivalence heightens), their decisive efficacy decreases. Concomitantly, their gendered identity sufficiency is likely to be high, whatever their position in the spectrum of womanhood as defined by mother/other status. To this end, the women in this study, who commonly classify themselves as “not fitting in,” filter social knowledge through their particular experience, then resist and disrupt those normalizing discourses that are the stuff of assisted conception and adoption, practices that attempt to re-feminize childless and infertile women. They make their own meanings.

CHAPTER 7: DEFYING NORMALIZATION

For whatever reasons, most of the women who participated in this project, for the most part, do not become lured by the siren call of technology as a fix for childlessness and infertility. They hear it, to be sure; indeed, the existence of NRT impacts them considerably. For example, the implied *freedom to* use it allows them to "settle down" on their own timetable but NRT's existence may also imply that they cannot fully escape it—there are discursive limits on their *freedom from* it—and the motherhood mandate that it supports. (Just ask Azra Alic and the hundreds of thousands of women who use it every year.) This is not to say that women cannot be simultaneously grateful for and critical of the technology.

Foucault's (in Rabinow 1984) concept of disciplinary power explains how one can be fully cognizant of being manipulated, but still conform to expectations nonetheless because they know that it is "good for them." But what encourages women to reject NRT even while the fertility industry concertedly promotes its use, increasingly in ways that are prophylactic and in ways that beckon to singles and lesbians? The major public criticisms of NRT including debates about the personhood of embryos, the unknown health consequences on the women under treatment and the Franken-baby effect, as well as feminist attacks on medicalization, compulsory motherhood, and the false promises of technology, do not fully explain my respondents' resistance. What besides insufficient insurance and liquidity and overt and subtle discriminatory barriers to treatment makes singles, lesbians, and women of color avoid or limit their use of these technologies?

Certainly painful histories of mistreatment, experimentation, and distrust between marginalized women—especially women of color—and the medical establishment play a part.

Historical legacies and recalcitrant contemporary discourses that sentimentalize motherhood for middle class married white women but not for others represent other significant social factors. The women I interviewed are bent on self-determination in many aspects of their lives but they do not always imagine the emancipatory potential some feminists attach to insemination, NRT, and adoption by lesbians and single women, for example. Rather, they explain how they defy normalization—the foremost purpose of medically assisted conception and adoption is to redress the handicap of childlessness—by telling me that they do not "fit in," by showing me that they use medicine to their advantage when they need to or want to in agentic and consumerist ways, and by illustrating their respective ways of making adoption either meaningful or unacceptable.

This chapter offers an answer for how and why socially marginalized infertile and childlessness do not seek to change those statuses via the institutions—the fertility industry and the adoption bureaucracy—that exist to normalize nonmothers by making them mothers. Near the end of this discussion, I explore how these behaviors help to explain "ambivalent childlessness" and its inextricable counterpart "pragmatic infertility."

Normalization and Normalizability

The process of normalization in this context involves helping women reach the ideal of the Standard North American Family (SNAF) by becoming "real moms," the height of womanhood and femininity in the culture. Nonmothers are deviants. But they vary in their normalizability. Voluntarily childless women borrow from a counterdiscourse that actively rejects SNAF and narrow definitions of women but the consequences of this resistance can be suspicion, accusation, and other types of social rejection. Involuntarily childless women, at the

other pole, need the normalization processes to mask their deviance as infertile or as single or as lesbian. Motherhood, for them, is a new master status that comes with many social benefits. They may also long for the affective advantages of motherhood, the deep emotional relationships. But nonmothers and infertile women who fit in neither binary category (and an individual woman can belong to any of these categories at different times and in different contexts), but instead fall in between along a spectrum of ambivalence, do not deny wholesale the promises of NRTs and adoption. Neither do they embrace them, chase after them, or lament their inability to afford them. Their narrative discourse sometimes suggests approval of these procedures, these ways to motherhood, but their actions—avoidance of and resistance to these normalizing processes—belie their words. I posit that this trend relates back to their low role applicability. These women do not always think that the motherhood mandate applies to them, thus, enabling greater ambivalence about motherhood. Having children will not fully "normalize" them since they will retain many other oppressed social locations. By contrast, white, married, middle class, heteronormative women who happen to be childless are more convincingly normalizable; all that they are missing on the road to idealized womanhood is motherhood (although they may harbor lasting feelings of shame or inadequacy). Moreover, the respondents' decreased decisive efficacy suggests that their tenuous notions of "readiness" for motherhood and their belief in something similar to fate coincides with their disinterest in intervening in their own futures, particularly when it comes to something as basic-yet-permanent as motherhood. They are, in this case, less normalizable. If their gendered identity sufficiency is concomitantly high—that is, they are satisfied in their positions along the periphery of the motherhood/womanhood schema—then their inclination toward normalization is further diminished.

Not Fitting In

Many of the women in this study assert that they do not fit into their families or into society. Certainly most people feel this anomie at times, a byproduct of modernity as Durkheim (1897) laments. But my respondents not only find themselves marginalized on the basis of social statuses, they also claim to be individually "different" in that they "don't follow the crowd," they are "shy" or "reserved," and that they display fierce "independence" as if these characteristics explain their childlessness or infertility:

> All of my older sisters are married. But being the little one, I am the travel person in the family, the one who has more curiosity about life and adventure. And just being different in that way, and I was the first one to have a job outside my father's business. I think being more independent and aggressive in life—*Lourdes Garcia, 56, Latina, single, office assistant*

This discourse of difference shapes these women's personal mythologies and allows them women to disregard some cultural prescriptions about how women should be. The norms apply to other people, not to them since they are genuinely different. They say they have always been different—and difference can come in many forms from shyness to not conforming to appearance standards to a preference for nonconformity. Presumably, those women who do not fit in or who wish to fit in might negotiate infertility and/or childlessness in divergent ways, perhaps, in the latter case, by feeling irreparably "damaged," "distraught," or "desperate" enough

to try any remedy. In societies where nonconformity is negatively sanctioned more severely (e.g., Bosnia and Eritrea, the homelands of two of the study participants) infertility and childlessness may be more problematic (see Inhorn and Van Balen, eds. 2002).

Being Too Independent

Separate from the idea of not fitting in, but very closely related to it, is the notion of "being too independent." Although independence can be a kind of not fitting in, it is also a stance or declaration about these women's abilities to make life choices for themselves as well as a personality trait that makes one less feminine and thus less suitable for motherhood. This attitude, really a point of pride in a society that values independence writ large, is most prevalent among the older lesbians I interviewed:

> Kristin Wilson: Why do you feel the way you do about not having kids?
>
> I think it goes back to being independent early on. Being one of eleven, you really had to take care of yourself. So there was that early independence that led me to hold my own ideas independently. Sometimes too independently, actually!—*Annette Kramer, 54, white, lesbian, family therapist*
>
> I've been different from the beginning from everybody else, and everybody knows it. Everybody knows that I'm different. And my mother told me this story: I was four years' old and she and my father were in the kitchen shouting at one

> another. Well, probably my father was shouting at my mother. And my mother started crying and my dad left and stormed out. She said I looked up at her and said, "Mom, no man is ever going to treat me like that." So I always associated being with a man and being married as being trapped in a horrible relationship. I thought her life must be a living hell.—*Lana Marks, 52, white, lesbian, nurse*

Annette and Lana credit early family experiences with pushing them toward self-reliance and unconventional paths in life. They describe themselves as "free" and "fulfilled" without children. Today each these two women associate mainly with other childless lesbian couples. Both of them marvel a bit about the current lesbian "gayby boom," something that they describe as an acceptable—but confounding—life choice. One could argue that they embrace a masculinist model of women's liberation in that their focus is on their careers and they have female partners. They are less involved non-mothers and they see motherhood as too limiting, too conventional. Caring for children is a "role" other kinds of (slightly duped) women take on. Lana wonders why they do not just get a dog to satisfy their needs to nurture.

They also tend to see themselves as antithetical to men, as reflective of a femininity that does not require them to be mothers. This is not the case for all the lesbians/sexual minorities I interviewed. Lourdes, for instance, who brought up her sexuality at the end of the interview when I failed to ask about it, tells me that some people question her sexuality, tying her childlessness to suspected lesbianism. She specifically blames her childlessness on her independent spirit, characterizing herself as perhaps overly masculine. Lourdes outwardly rejects the idea that to be a woman is to be a mother but she seems to hang on to some inward critiques

about her own femininity as a childless, single woman, disinterested in men and thus prohibited from motherhood.

Feeling Less a Woman

Other women feel left out and less feminine due to their infertility:

> I don't think you ever get over the sadness because there's so much that comes with not—I think it's all head stuff. Not feeling like a woman. I think I was just feeling so imbalanced all the time and I mean like my periods not starting and now I haven't had a period since I was 30 years' old. So I haven't had a period in almost eight years. I stopped. I just—and my story just didn't connect with all of the people I met. So feeling just really alone.—*Jessie Silva, 42, white, queer, hair stylist*

Unlike, Lourdes, Jessie does not conflate femininity with sexuality. She finally, somewhat magically, becomes a mother, and, in her view, fulfills her feminine destiny and resolves her loneliness. The medical literature lists adoption as a way to cure infertility, at once a social disorder and a biomedically-defined (if ill-defined) pathology. In Jessie's case, adoption remedies her infertility but also dramatically reifies her femininity since she now enacts motherhood. In the sense that her story "just didn't connect" with others, she did not fit in. This not fitting in, in fact, does not stop her and maybe even obliges her to act, to adopt a child without a partner.

Jessie's self-esteem problems compel her to work on herself. This kind of introspection, influenced by not fitting in, was common among my respondents. Colorism was a frequent theme brought up by the African American women. Being either too dark-skinned or too light-skinned led to merciless teasing, loneliness, lack of confidence, and mistrust of men. These experiences partially account, they say, for their childlessness.

LaWanda's story is particularly traumatic. Her mother sent her to live in a foster home and kept her other four children. LaWanda thinks that her mother disliked her because of her light skin which "favored" her father's. She spends years searching for self-esteem through several failed marriages.

Now she wants a child in part because she feels more self-assured, in part because she thinks it is her Christian duty, and in part because she wants the reflected admiration she imagines will come with motherhood. The stories of Nicole and Shana are remarkably similar to one another. Both indicate that they delayed childbearing to "get themselves right" by amassing self-respect and maturity through work and education in order to heal their emotional wounds. They talk about how they will mother a child (always assumed to be a daughter) with skin like or different from theirs, insisting that they will love them and inculcate them with the self-esteem needed to confront daily slights and judgments based on colorism. They are wary of the attentions of men right now, and although they expect to get married and have children "someday," they think informal—and perhaps formal—adoption might work for them should they not find the right relationship. Being marked as different by their peers impacts their self-defined readiness for motherhood.

For a variety of reasons ranging from low self-esteem to the conflation of fertility with femininity, some of the respondents report feeling inadequately feminine. Part of this thinking

involves the belief that only fully-fledged women can be “real moms” but, in a bit of a catch-22, one must already be a mother to be a complete woman. To attempt to reach this balance, several women are working toward improving their self-regard in order to ensure readiness for motherhood and also to attract the mystical ascription of motherhood. The women who have given up on motherhood, of course, did not talk like this. Instead, they proclaimed, sometimes defensively, that they are real women despite their childlessness.

Defending Difference

Several of the young African American women I spoke with endorse a mainstream (white) discourse, a position that they have to defend:

> The school I came from, most of the girls there have kids or are pregnant now. [My best friend] and I was just talking about that the night before last. Saying how when we see people we used to go to high school with, they’ll be like, “Where your baby at?” And it’s like, “I don’t have any children.” “Oh, you ain’t got no baby daddy?” “No.” “You ain’t got no boyfriend?” “That’s none of your business if I do. I’m just telling you I don’t have children, I don’t have no kids, I’m not responsible for no one but myself.”—*Jamilah Washington, 19, African American, single, student*

> They have an attitude. They look down on me because they feel I feel that I’m better than them. And I don’t. I just didn’t have a baby. I don’t look down on you

> because you had a baby. It was the decision you made. It was something you did. And I don't think you should look down on me because I'm succeeding and prospering in life and doing well, and that's not to say you can't either.—*Nicole Lambert, 20, African American, single, student*

They are young and unattached and these interviews reflect their thinking at a point in time. Should love or other life events intervene, they may change their minds quickly as they have a counterdiscourse available to them that equates adulthood with motherhood and presumes that 25 is "old" for becoming a mother. Within their community and their families, motherhood is an acceptable, supported role even for teenagers.

Some of the older women can satisfactorily explain their childlessness by outing themselves as lesbians, but others—who do not feel the least bit pitiable—have to tolerate misdirected pity and inevitable suspicion by those they encounter. The women who adopt also have to defend their choice, usually by constructing it as preferable and preordained, even if they once attempted to enter motherhood more conventionally via pregnancy and childbirth.

Having Special Insights

Several of the study participants refer to having special insights that allow them greater reflexivity and a capacity to cope more effortlessly with the "disruption" of infertility and/or childlessness. Many of the women I talked with attribute their resilience and perspective to loneliness, being a "spiritual seeker" or having been treated for depression and other neuroses:

> I have social anxiety disorder or whatever you call it. I start to freak out, have panic attacks in big crowds. So I have to limit myself to just being with two or three people. I like to be in control, but that's not the most important thing. I would rather have a peaceful group than a group that has a lot of dissent but I'm in control.—*Annie Adoyo, 30, second generation African immigrant, single, student*

Annie wants to make her way in the world on her own terms. She admits to having some previous problems with handling her finances and functioning on a day-to-day basis. But through counseling and mood-enhancing pharmaceuticals, she has arrived at self-acceptance. Motherhood is a duty or vocation that she feels called to perform despite the fact that she is single and underemployed. She is unconcerned about finding the right partner or the right time—an unusual attitude among my respondents.

Another respondent, Talia, who is Jewish by birth, dabbles in Christianity (she had a large portrait of Jesus above her bed in her studio apartment), Buddhism, and New Age mysticism, all traditions she draws on extensively in trying to get her body "ready" for pregnancy even though she does not have a partner. She plans to use a sperm bank soon since she is approaching her mid-forties. Emily thinks having a child will give her something constructive to do and prevent her from wallowing in her loneliness or watching too much television, previous habits that instigated her to request a prescription for antidepressants and to get involved in foster care. These women's lives illustrate ways of not fitting in to the mainstream. They are all looking for a route to happiness, something that the motherhood is supposed to bring.

Yet their intrinsic difference provides them with somewhat off-kilter points of view by which to examine the inherent promises of that narrative. They do not fit societal expectations and so maybe the expected ways of doing things will not work for them. The motherhood discourse motivates them yet, at the same time, constrains them. They want certain benefits like the bonding, nurturing experience and mutual relationship, the status, and the engendered femininity, but they cannot entirely conform to the ideal. Although I suspect that these orientations are dialectically interrelated with their childlessness or infertility, their different perspectives permit them to forge different paths in life, to deftly cope with and defend their multiple marginalizations, and to ignore, subvert, or renegotiate mainstream values. They have another kind of "epistemic privilege" (Collins 1991) to add to their others. These women suggest that other women, who have not encountered multiple oppressions and who live comfortably within the mainstream world, cannot deal with the threats to their feminine identity and roles as efficaciously, and, therefore, they are more inclined to take part in social efforts to re-normalize them through assisted reproduction or adoption.

For their part, the respondents with "special insights" sometimes consider assisted conception and adoption to address their infertility or childlessness but they are apt to use them in unintended, potentially liberating ways.

Medical Interventions

Women intervene in the application of medical technologies just as the technologies intervene in women's lives, in their experiences with infertility, and in their conceptions of motherhood and femininity.

The new reproductive technologies are publicly and privately contested. The infertility industry and the women (and men) whom they serve collaborate and compete in assigning meanings to these processes. Although Miall (1994) portrays the pursuit of ARTs as irrational, it now appears deviant in some circles for childless women to *not* pursue them (Mamo 2007, Spar 2006). Wider society, too, stokes the debate. That "miracle" babies are attainable—with medical help—is common knowledge, a fact clearly evident in the respondent comments already presented. On the negative side, politicians, headline-writers, and talk shows guests have found a new springboard for demonizing women for the same old bad behavior such as shirking their duty as potential mothers in favor of careerism, having abnormal numbers of children who then require state support (see all the 2009 media coverage on Nadya Suleman, the so-called "Octomom," a single, unemployed woman with 14 children from assisted conception), making babies outside of marriage to a man, and attempting to control their own procreation.

This last "sin" includes the production of excess embryos during IVF treatment, a practice akin to abortion in the eyes of the religious right, and, albeit more subtly, even to IVF patients who form emotional attachments to their embryos and blastocysts. It matters not that critics' accusations about the technologies are inherently contradictory; they achieve the same tired result—that women cannot be trusted with their own bodies. Still, feminists (e.g., Haraway 1991, Rapp 1999, Rich 1976, Rothman 2000[1989], Thompson 1995) concede the emancipatory possibilities of reproductive technologies even while they critique the added surveillance and eugenicism that these medicalized, value-added methods engender. Women who step onto the "infertility treadmill" (Hardaway 2007) must race, cognitively, to make sense of what is oft-described as a grueling physical and emotional ordeal. Women borrow—but are not entirely convinced by—the discourses offered to them by their medical practitioners through counseling,

brochures, advertising, and in miracle stories and advice articles like those found in the mass-circulation infertility magazine *Conceive*.

But what about the ordinary, everyday infertile and childless women who choose to forgo assisted conception, or who try some elements of it, stopping short of IVF and other more advanced treatments? Or who use IVF grudgingly, not buying into the rhetoric about the amazing advancements of modern medicine? What discourses influence them and how do the meanings vary according to the women's age, marital status, sexual identity, race and ethnic backgrounds? The women in this study are undoubtedly aware of the public conversations about infertility treatments. Their lived reality affords distinct interpretive standpoints from which to actively intervene in the making of medical meanings.

CDC and NSFG statistics from 2002 indicate that of the approximately 12 percent of women visiting a doctor for "infertility," just five percent of these resort to IVF treatment. Others find success with techniques like insemination, fibroid surgery, laparascopy, insemination, ovulation charting, and fertility drugs, or else they abandon any further attempts. Trends show IVF usage increasing; between 1992 and 2002 it more than doubled. Yet there are any number of reasons why women might not want to use IVF, or any of the other assorted assisted conception technologies. Financial obstacles loom large, prompting public health advocates, feminists among them, to push for greater access particularly through mandatory insurance coverage. Religious objections to the use of donor gametes and to the production of excess embryos deter some. In spite of industry efforts to normalize and even glorify high-tech infertility treatment, some women fear the unknown consequences of these medical interventions. Some fear the known and suspected consequences like cancer, early menopause, low birth-weight babies, and passing on their infertility (and related health problems) to the offspring.

Questioning the Experts

Class and race differences—as well as the personal and social histories associated with these social statuses—influence respondents' levels of comfort and facility with doctors' authority and with medicalization, in what Thompson (2005) calls "biomedical citizenship" and Mamo (2007) calls "cultural health capital." Some do not like doctors and medicine, perhaps due not understanding them or to not trusting them:

> He basically said, he basically—and this was a urologist—he basically said, suggested doing something about saving the sperm, freezing the sperm, but I don't think anything was very clear. Nothing was really uh—I got the feeling that um, if we did that, how you know I didn't know how the results would affect the child. It wasn't very clear and I think that maybe I didn't really, maybe we didn't really, when we saw that there were some obstacles, we just didn't pursue it you know.—*Iris Hernandez, 54, Latina, office assistant*

Iris, bemused by the doctor's suggestion to freeze her partner's sperm, worries about defects in a resulting child. Because matters were not "very clear" and there were confusing "obstacles," they let it go, deciding not to preserve their potential for fertility. Doctors note that infertile patients are much more "motivated" than cancer patients to save gametes for later use (Mundy 2007). Moreover, Rapp (1999) explains in her study of amniocentesis that less-privileged women with limited science education—a group comprised disproportionately of poor women of color—tend to "get off the conveyor belt" of medical surveillance early on. They fear what they do not understand, commonly misinterpreting medical jargon and the ubiquitous

double-talk about statistical probabilities. Whereas I suspect that overriding Iris' interest in having a baby were concerns over her partner's prostate cancer, the reported interaction with the doctor reveals a ideological chasm between the promises of assisted conception and belief in those promises. Saving sperm, to the doctor, is a simple procedure as is the subsequent insemination. It happens every day and requires no medication, no surgery, and, truth be told, no special medical knowledge. Refracted through the lens available to Iris, however, it becomes one with those mysterious, cutting-edge, almost sci-fi, techno-medical experiments. She does not want to know and so she does not pursue it.

Some of the women rail against the insensitivity of the doctors, who frustrate them in their inability to understand that the knowledge they share, the findings they impart, have real-world ramifications with the potential to destroy life plans and challenge the core of their patients' identity:

> [The doctor] told me over the phone that I was in fact in menopause. She used the term menopause although medically that's not correct, and told me that that meant I was infertile, and then said good-bye! So I was basically told over the phone. She did nothing to prepare me; it was just a call on the phone. I was utterly devastated . . . . I think what was going through my head was that we couldn't have children. And we'd made a lot of decisions, we'd done a lot of planning, we'd talked a lot about how our lives would be with children. That was something that Gabriel and I had very much been expecting and wanting. And I couldn't get past that . . . for some reason it had never entered my head to think that I wouldn't be able to get pregnant myself and carry a child. So it was really hard to get past

> that. I don't know why I couldn't begin to think about other options, but for awhile I really couldn't. It just felt like we wouldn't have children. And part of that is actually part of the phrasing . . . people will say, "You can't have children." And that's sort of something that people will talk about if they're talking about POF [premature ovulation failure]. . . What in fact is meant in my case is that I was infertile and could not bear a child in the traditional way biologically. But I think hearing people talk about it, just hearing that phrase "You can't have children," I think that is indicative of a biological bias in our society with respect to how we think about having children, and is also something that can make it very hard for someone who cannot have children biologically or who is infertile, and yet can have children lots of other ways, but it makes it feel like you can't, kind of increasing the sense that you'll have a future without children.—*Hannah Johanson, 39, white, queer, married, teacher*

Exasperated at being told that she "can't have children," a phrase that can mean she cannot give birth and can mean that she is not allowed to have children, Hannah feels resentment at the way the doctor treated her. In nonchalantly dropping a bomb over the telephone, surely influenced by time constraints and competing demands, the doctor—or more precisely the institutional protocol—discounts her humanity. She also feels alienated by her doctors' inability to explain or adequately treat her premature ovulation failure (POF), a condition with health ramifications beyond compromised fertility. The science is lacking and the doctors available to her are not sufficiently knowledgeable on the topic. Hannah, whose class status and educational attainment enhance her "cultural health capital," seriously researches and considers the medical

options but ultimately decides that those choices will not work in her particular case. She dislikes her doctors' bedside manner so to speak and she shakes her head at their incompetence but she does not dismiss medical and scientific knowledge *per se*. In fact, she participates in experimental treatment in another state in hopes of advancing the cause for herself and others.

Others, particularly the poor and working class women and the women of color, question medical authority fundamentally:

> In terms of kids, I was pretty much thinking the same, that I don't want kids. Probably not until maybe about 25, 30 at the most. Only because at a certain age you cannot bear kids. But my grandmother had my mother when she was like 42, 42. So, she had, my grandmother had my mother during the change of life . . . So I guess with medical saying that is that after a certain age, like 35, it's going to be harder for you to bear kids. But, being that my grandmother had her in her early forties, sometime I kind of think it's possible, and one of my cousin's friends just also had a baby and she's 42. So like, I'm starting to wonder, are the really saying, is medical saying, is it really true? Or is it just because they were fortunate enough to have kids at that age?—*Shana Jones, 25, African American, single, student*

Shana, for example, has heard that women's fertility diminishes at age 35. But evidence she sees around her challenges that "fact." Shana's skepticism highlights the competing epistemologies of science and experiential understanding. For women like Shana, medical knowledge is convincing only if it squares with what she already knows or can see evidence for

in her personal experience. She does not passively receive scientific conclusions as truth although it does influence her plan to have children by age 30 “at most.” At 25, she is already at the age that she thought she would be having children. But she is single and underemployed, still living with her mother, under her mother’s rules. She cannot envision having a child in these circumstances. She wonders about the possibility of fertility in the early forties, thereby doubting medical advice and implying a modification to her procreative plans.

In addition to the epistemological divide, several of the women I spoke with impart suspicion on doctors’ motivations in offering assisted conception, especially NRTs:

> Yeah, [I would consider IVF] if I had the money and a partner. It’s very expensive. And I don’t know why they make it so difficult for women who want to have babies. I can see a couple thousand. But to throw ten, twenty thousand dollars to do that is just mad! Can’t these doctors have compassion? . . . They want to be rich. How technical could the procedure be? It’s not like open heart surgery or taking out a gall bladder. And then they’re taking the sperm and whatever they do with the equipment. I think it’s kind of ——*Talia Stein, 41, white, single, home healthcare aide*

> And then when I went to my new doctor, she asked me, “Have you ever been pregnant? Do you want to be pregnant?” and whatever. She went on this high horse thing about, “if you ever want to get pregnant, just let me know.” She says, “I have fabulous doctors I can send you.” She goes, “Matter of fact, I’m pregnant now.” I mean she went off. And I thought how disrespectful. I just felt like this is

> not what I'm here for. I'm here for my annual pap, not to be sold a child. It was weird. That's how I saw her communicating with me.—*Penny Ortiz, 52, Latina, single, guidance counselor*

Both women portray the doctors as greedy, motivated by money. Whereas Talia, a nurse with no health insurance, fumes at the high cost given the relative simplicity of the procedures, Penny chafes at her doctor's proselytizing about high-tech fertility treatments. Whether they see the doctors withholding treatment from women who want it or pushing it on women who do not, the doctors appear self-interested and "disrespectful" or uncompassionate about women's needs. The much-maligned financial cost of IVF and related treatments excludes women like Talia while potentially making those who can afford it feel like they are getting a better product. Women like Penny, who is content in her childlessness—her identity sufficiency is high—and would not have a child out of wedlock in any case, may perceive doctors' unsolicited communication about assisted conception as both presumptuous and reminiscent of a high-pressure sales pitch. To them, medicine is not what purports to be. It is neither the manifestation of scientific progress nor healing art.

The women in this study, for the most part, are not targeted and not fooled by industry advertising that portrays assisted conception as an improvement over nature. They adhere to the hegemonic discourse in which SNAF families produce children through heterosexual intercourse as an "expression of their love." Iris Hernandez illustrates this view when she says, "When you have a marriage and you have a father and a mother for that child. I think that's beautiful." Hers is a conventional view, one that many of the Latina respondents espoused.

"Stratified reproduction" (Ginsburg and Rapp 1997) describes society's preference for the social reproduction and procreation of the white, married, middle-class followed by others according to rankings along the axes of class, race, marital status, sexuality and so forth. But reproduction is also stratified in another way. Following, in order, what my interviewee Shana Jones calls "natural childbirth" (the conventional method of getting pregnant), would be pregnancy achieved with the help of: surgery or fertility drugs, insemination using the partner's sperm, IVF with the couple's gametes, IVF with only one member's gametes, donor insemination, IVF with donor gametes/embryos, surrogacy with the couple's gametes, surrogacy with one member's gametes, and, finally, surrogacy with donor gametes. (There are, in fact, even finer distinctions, such as the use of a family member's gametes or a friend's womb.) Adoption, though not always a last resort (e.g., even some proven fertile women adopt), occupies a lower stratum. Childlessness, of course, carries the least status. Most of the women I interviewed are uninterested, for various reasons, in IVF and related ART. Therefore, they have less impetus to examine the nuances of each successive step in assisted conception. Even as they see "having your own" as ideal, in choosing childlessness or adoption and skipping most medical options, they challenge, through their praxis, dominant notions of marital love, womanhood, genetic kinship, and biologism.

The ART (of) Horror Stories

By relating cautionary tales about infertility and medicalization, the respondents explain why they abstain from (further) assisted conception techniques:

I woke up in the middle of the night in severe pain and I knew what was happening because I was timing and I was basically having contractions [sigh]. So my husband again had to take me to the hospital. And my doctor was irate because I was in there in the waiting room and for some reason the registered nurses thought I had a botched abortion and he knew me and he was on call that night so once he seen how severe my pain was he was irate that they let met sit there for so long. Because I was sitting there for approximately four hours before they even took me in. And, as soon as he took me in, he pumped me full of medicine and they ended up doing the D and C [dilation and curettage] at that time, removing the baby.— *Lupe Jimenez, 41, Latina, married, electronics technician*

My sister went through all of that. And I said, I'm not going to do that. I saw what it did to her. Not only just emotionally, but she went through – I'm trying to think how many – artificial, in vitro, multiple times. It was just like, I don't think I'll do that. Emotional. She would get hugely bloated ovaries when she was taking shots. The disappointment when it didn't work. She would be devastated. She's two years older than I am. I got married before she did. I think she would prefer that it didn't happen that way. And then I had a child before she did. She actually has twins. But in some ways, I feel that she didn't bond with [my son] because she was on these meds and she wasn't supposed to hold anything heavy, so she would like not hold him! It'd be like, you have to be that careful with your body when you're going through treatments—that you can't hold a baby. Or it makes you

> upset to hold a baby. So I didn't want to go on that roller coaster. And financially, we're not in the same place my sister is. She's quite well-off. So they can do that. It was probably seven in vitros that they did. Yeah. Yeah. And artificials and everything else. And I don't do well with the pelvic exams. They're usually very painful, they're uncomfortable. I don't want people doing that.—*Aikiko Moto, 43, Japanese American, married, teacher*

Lupe's traumatic miscarriage, which finally convinces her to stop "trying," is even more horrible given her mistreatment at the hospital. Though she credits her doctor with saving her from the nasty nurses who seem to punish her for a "botched abortion," the general tone of her account is negative (i.e., "they pumped me full of medicine"). Aikiko's story contains both her rationale for declining IVF and several warnings. To her, IVF means emotional pain, physical consequences like "bloated ovaries," relationship problems, and intrusive violations from strangers. Both of these women can be described as having secondary infertility, although either one *could* birth another baby if she were committed to really "trying." Besides not wanting to experience any more pain, physical and emotional, they are unwilling to subject themselves to more ill treatment. An individual doctor may be a heroic savior but the overall experience is alienating and painful. A certain feeling of powerlessness permeates these stories. Besides stopping treatment—and this can be a challenge in and of itself due to familial pressure, personal aspirations, medicalized discourses, and social role assignments—some women intervene in their medical treatments.

Taking Control

Instead of letting medicine be done *to* them, some women have medical treatment done *for* them, on their own terms:

> Well, realistically, I'm 40. And I went to this famous intuitive psychic. She's a medical intuitive, and from what people say she's pretty accurate. I said, "What do you see for me down there?" She says, "Well, you're healthy down there. You can get pregnant. That's not the problem. The problem is that you have a higher chance of getting a Down's syndrome baby." And I was like, "Oh, gee," you know. But from what this lady said, we're born with so many eggs, and what happens is you get 3000 or something like that. You still have a lot when you're older but some of them are dormant, and have to open up or something like that she explained to me.—*Talia Stein, 41, white, single, home healthcare aide*

Talia gets her medical advice from a psychic instead of doctor. Her preference is partly explained by the fact that she lacks health care insurance, but she also does it because she puts more stock in the spiritual side of life than in science, despite the fact that she has medical training. She decides to take herbs to help "open up" her dormant eggs. However, she does not have a clear idea about where the sperm will come from. She considers a sperm bank, "hooking up" with someone from Craigslist, and getting pregnant by her new boyfriend without his knowledge. Failing these possibilities, she may adopt. Pairing medical-scientific "knowledge" about oocyte depletion—heretofore thought an inexorable decline but now understood to be more complex—with psychic forces (four respondents mentioned visiting psychics specifically

to understand their infertility) and decidedly unscientific herbal preparations is one way to undermine medical authority while taking advantage of its benefits (while also individualizing and spiritualizing one's path to motherhood).

Sometimes women, especially those whose positions in social hierarchies allow them the wherewithal and relatively more social power, take control within highly medicalized contexts like surgery:

> They removed 28 fibroids from my uterus which was a record! And they were infertility specialists. So my whole uterus was kind of shredded after that. But *I really empowered them* [my emphasis] before the surgery. When they came in to talk with me before the surgery I said, "Just remember that the reason we're going through this is that I want to get pregnant. It's not that the fibroids hurt. We wouldn't even be going through this surgery if I weren't trying to get pregnant. So if at all possible, if you could save my uterus, and everything else, that would be a really good thing." So they saved the uterus.—*Dianne Jacobsen, 56, white, single, life coach*

Interestingly, Dianne says *she* empowered *them*. She feels the need to counsel the surgeons when they come in planning to counsel her. Her comments indicate that she does not entirely trust the doctors to act in her best interest, to honor her desire to preserve her fertility; thus, she gives them the "power" to make decisions that follow her wishes instead of merely abiding by the standard, more conservative surgical practice of removing any and all potentially offending tissues. She is not complacent and tractable, probably not an ideal patient from the

doctors' points of view. To her at least, the authority is hers, not theirs, as it is her body being operated on for the fulfillment of her desire to become a mother. And the doctors do her bidding as directed.

A degree away from this empowered patient is the patient as full-fledged consumer. Without a doubt, the so-called "baby trade" is a booming business, a venture whose profit motives subjects it to ethical inquiry and generates plenty of criticism (Spar 2006). Numerous articles in *Fertility and Sterility*, for example, cover pointers for entrepreneurial doctors and clinics who want to grow their infertility enterprises. In this discourse, the doctors provide the expert service and the patients behave as discriminating consumers (see Wilson and Simonds 2006). The women in this study, though not fully immersed nor invested in the medicalized world of fertility treatment, still cast themselves hypothetically as prospective buyers. Much in the way that regular people idly dream of purchasing the million-dollar homes in those free real estate magazines found in the newspaper stands, some women browse sperm donor catalogs:

> And I found out a lot of information online. They have donor profiles listed right there online. It's kind of like shopping for your sperm; it's kind of weird.
>
> Kristin Wilson: Tell me about your donor, since you already have him picked out.
>
> He has blue eyes, which is a big thing. The other thing is, he has a negative blood type, and a lot of the donors that they have there have positive blood types, and I'm O-neg, so I figure that helps make things easier, since you do get to pick. And he doesn't have any red flags. Some of the donors have red flags, as far as in their

> medical histories. He's a young college student, as a lot of them are. He wrote a little bit about why he's doing that, and I liked the reasons that he said. He's very kind-hearted.—*Emily Reilly, 30, white, single, fast food restaurant manager*

> I talk to my friends about it all the time. I say, we'll go up to San Francisco and look through the catalog. You see all these good qualities and everything that the men have – seven feet tall [laughs], or blue eyes, whatever it is. But everyone has an ugly relative. So just because you are reading all this doesn't guarantee you anything. And it's just pretty much like having your own kid. I mean, you've seen really good-looking parents out there with not so good-looking kids. And I hate to say that, but I've seen some ugly kids. And you've seen some parents out there who are really – and again, beauty is in the eye of the beholder—*Annie Adoyo, 30, second generation African immigrant, single, student*

Either one of these women might actually pursue donor insemination but they are not yet committed to doing so. For now, they hold it out as a possibility in case they do not find a suitable partner by the time they are "ready." They shop with a discerning eye, one tinged with eugenic fantasies, yet in identifying the irony of a "weird" process that carries no "guarantee," these women reveal their misgivings. This low-tech version of assisted conception has not been entirely normalized which means that fertility industry still has ideological work to do. But maybe not much work as one of my students wrote (earnestly) in a class poll, "If I found out I was sterile and could not have kids, I would order one online…" Already the browse-able online sperm catalogs are set up to suggest how the customer might discriminate among the products

(Moore 2008). The catalogs first group the donors by race—California Cryobank, the sperm bank I used many times, lists “White” first (and, in symbolic constancy, the color-coded vials arrive with white caps)—eye color, hair color, height, complexion, and ethnic background. With California Cyrobank and Xytex Corporation, by example, one can then examine the donors’ personal and family medical history, read the psychological profiles and lists of hobbies, peruse their (self-reported?) test scores and GPAs, and learn of the presence or absence of moles and freckles.

The term “discrimination”—here a double entendre—comes to mind. In the Bourdieuian sense, the shopper’s “taste” in sperm donors is indicative of their class-race “distinction” in “designer babies.” The women in this study are perhaps not the ones to whom these catalogs specifically cater—sociologist Katherine Johnson (2009) shows how single women are subtly discouraged—but they are by no means immune to the allure. Practically speaking, they want to become mothers, and without partners, sperm banks provide a necessary product. In addition, their (imagined) use of sperm banks is decidedly liberating for the simple fact that these women are intending to have babies intentionally outside of the SNAF norm. This low-tech method of fertilization is something that these women seek out on their own, expecting the industry to serve them. They may browse the online catalogs from a comfortable, anonymous distance, but once they decide to purchase, they will find out just how much the process differs from ordering books on amazon.com. For insemination is obstinately medicalized and surveilled despite the fact that it involves no more expertise than it takes to insert a tampon or diaphragm. Turkey baster insemination places control in the hands of women, who act in private. Discursive strategies that make insemination sound perilous (e.g., due to fears of HIV transmission) and better-controlled in a medical environment (e.g., due to better statistical “chances” with doctor-

performed IUI than at-home ICI), coincide with a consumer-based desire to have the best. And having the best is a big deal in an age preoccupied with "perfect babies" (Landsman 2009). This shopper's attitude toward assisted conception emerged among respondents' discussions of high-tech procedures too:

> Because I want twins in my life. That's what I want. That's what I want, twins. And then, see, before my sister had had twins I was telling everybody, "I'm about to go to the doctor and stuff like that and have them give me some twins," right? And come to find out twins run in our family. Plus when you get older it's a high risk of you having twins. Yeah. Yeah. And so it's like uh, uh it's beautiful. It's a beautiful thing watching them grow.—*LaWanda Jackson, 42, African American, single, nursing assistant*

LaWanda is apparently under the impression that one can order up twins through medically assisted conception. IVF twins appear to her to be intentional but they are more the *de facto* result of: IVF procedures in which doctors insert multiple embryos, the older age of women who undergo IVF and who are more likely to release two eggs per cycle instead of the typical one, and for reasons that elude medical science, IVF embryos that are more likely to split. LaWanda does not see multiples as a medical risk but as a desirable product available for a cost. But like any savvy consumer, once she realizes that she can get them for free (due to her age and a familial propensity), she decides not to waste her money. The consumer-business dynamic is less a function of freedom to choose, though, and more about creating needs and reducing human lives and human experiences to commodities.

Paradoxically, babies created through NRTs are more likely to be born prematurely, potentially leading to many health problems. The ideological construction of “superbabies” in the wake of IVF and its ilk obscures the reality that these babies, in actuality, sometimes embody the reverse. They may be sickly, developmentally delayed, and they may be predisposed to genetically-inherited conditions that cause infertility. Long term effects of NRTs is still unknown scientifically. The “eugenic logic of IVF” (Steinberg 1997) helps to sell it. Leaving the growth of the infertility industry solely up to market forces encourages the use of oppressive discourses (e.g., the motherhood mandate, stratified reproduction, eugenics) and questionable technologies and discourages healthy debates about whether the various technologies are good for the women whose bodies undergo treatment and for the children that those treatments create.

Defining infertility as a disability may help produce social policies that make treatment more available to individuals who want it as Rothman (2000[1989]) maintains, but what other impacts will it have under capitalist, patriarchal, stratified, technophilic medicalization? Will voluntary childless women be subject to greater stigma since their “disability” could be treated and removed? Will added availability of medically assisted conception to women of color and poor women be also extended to single women, celibates, and lesbians who require the same treatments to remedy their involuntary childlessness? How will infertility, impaired fecundity, and involuntary childlessness be adequately distinguished among as separate conditions when the end result is the same range of experiences? Will more miscarriages, multiples (and concomitant premature births), and long-term health consequences be on the way and will society accommodate and support these children’s needs and the needs of their parents? Will there be tiers of treatment for women on public assistance, women receiving employer-paid insurance benefits, and wealthy women who can pay out-of-pocket for value-added options like

Ivy League donors and college-educated surrogates, a system that would surely reinforce the existing tiers of race and class privilege and the social judgments attached to mothers from different strata?

None of these questions are fanciful and as I try to predict the effects of infertility-as-disability for the infertile and childless women who participated in this study, it seems that some would feel more fettered and other would feel less so. If society values the human experience of mothering (broadly imagined to include the nurturing of fathers and other caregivers), then fertility treatments of all kinds, including adoption, should be supported financially and discursively. This freedom needs to occur outside of pronatalist rhetoric that characterizes nonmothers as lacking positive qualities.

Adopting Discourses

The kind of commercial talk among the respondents' discussions of medically assisted conception, encouraged by medical advertising and popular narrative, evaporates when the respondents consider adoption:

> There are a lot of children who need a family. I would do like my mom did, adopt a baby girl. And I say a girl because that's what I want, but if there was a little boy . . . And it's not like you go to a store and pick and choose, pick and choose, pick and choose. When my mother adopted me, she told me there was a connection. I ran up to her and sat on her lap!—*Nicole Lambert, 20, African American, single, student*

Adoption involves real children, seen as needy and imperfect, never theoretical, fantasy, designer babies made to reflect parents' good taste. As Nicole avers, you do not "pick and choose" a child for adoption—even if it is tempting to compare the process of selection to shopping. The meant-to-be narrative (which I expand on below) must be constantly reasserted to deny the commercialization of this aspect of the baby market.

Four of the respondents are adoptive mothers, five are seriously considering it, three tried and failed to adopt, three considered it but rejected the idea (sometimes because their partners demurred), and five might still adopt in the future. Only a handful of my respondents never really engage with the possibility of adoption. Adoption is important to many of these infertile and childless women, whether or not they ultimately decide to do it. Their views on adoption reflect the diversity of (mostly) mutually exclusive narratives including adoption constructed as: a good deed, an impossible dream, an inferior choice, ethically complicated, or preordained. This array of concepts also represents the different "vocabularies of motives" (Mills 1940) that allow these women to defend their "choices" to adopt or not to adopt, both options that require explanation. The general attitude in contemporary society is that adoption is a way for almost anyone—no matter their marital status, fertility problems, age, sexual-identity, or, to a limited extent, class and race/ethnicity—to become a mother. The institutions associated with adoption employ a host of screening strategies to funnel in "ideal" parents and discourage all others. Despite this disjuncture between the mythology of equal access and the reality of stratified reproduction, more marginalized women still feel the rhetorical pressure, indeed the influence of biopower—to use Foucauldian parlance—to consider adoption and to have convincing reasons for their decisions.

The Good Deed

> And many times the only time somebody will think of adoption is when they've tried to have of their own and can't, and they've exhausted many of the other options or they've just been trying too long and they're tired. Then the heart opens up to, "Maybe I could love someone else's child."—*Annie Adoyo, 30, second generation African immigrant, single, student*

Annie mentions to me several times in her interview that adoption might work for her. At one time she says that she thinks of it as her "duty." In the quote above, she constructs the decision to adopt as not only a last resort for many but also as an awakening of sorts. The people she speaks of exhaust themselves trying other methods to become parents and, only through this trial, they come to realize that their commitment to biological or genetic kinship is impeding their emotional potential. It is evident in Annie's comments that both uphold and cast doubt on biologism and ownership that adoption as a good deed is a complex notion.

Class-based, race-based, and religious subtexts all accompany the narrative of adoption as a good deed. For example, many people tell me that I "did a good thing" in adopting my children or that they are "lucky" that we adopted them. I usually respond that my partner and I are the lucky ones to have such wonderful sons. Others—in particular our social workers—see our adoption as guaranteeing our children's upward mobility and intervening in a cycle of poverty. They are not entirely wrong in this assessment but attributing all the good fortune to the children (a testament to their benevolent social engineering) ignores several other outcomes: the adoption ended our involuntary childlessness and made us parents, the resulting parent-child

relationship is mutually beneficial and satisfying, we adoptive parents reap any future rewards of pride, grandchildren, and care in our old age, and the birthparents are deprived of all of these benefits.

Hannah Jacobsen's daughter is Chinese and Hannah and her partner Gabriel are white. Strangers see their kinship with their child as up for public discussion and in well-meaning but offensive ways, they actively construct the adoption as a good deed:

> Obviously out in society we're encountering lots of questions and comments, which Gabriel and I are still figuring out how to respond to…"They don't like little girls in China, do they?" is pretty bad. And I'm glad Jade doesn't understand that yet.—*Hannah Jacobsen, 39, white, queer, married, teacher*

This "cross-cutting master narrative of race" (Gailey 2000:13) gets used to portray (white) adoptive parents as rescuing children from an inferior cultural upbringing. In this line of thinking, Chinese girls are saved from Chinese misogyny (and poverty and Communism) and black or Latino children adopted by white parents are protégés being taken on by benevolent benefactors (Rothman 2005).

The religious subtext of the good deed model is both prevalent and especially problematic for adoptive parents. Hannah, for example, expresses her annoyance at people who use her "adoption as their political statement" in referring to strangers' approval of what they see as her tacit advocacy of adoption-not-abortion. In my experience with the mandatory, lengthy adoption training program provided by the county—and dictated by the state—several of the prospective adoptive parents in the class were looking to adopt because "children need families."

For the most part, they were not trying to become parents; they already had children by birth. Instead, they conceived of adoption as a way to express their (Christian) faith, particularly as anti-abortionists and as proselytizers. As someone who wanted to adopt in order to enter motherhood, I could not help but view them as "greedy" competitors for the few available children. Indeed, I was particularly jealous and critical of a woman who worked as a volunteer doula at a Catholic home for "unwed," mostly homeless pregnant women; I felt like she was going to talk a young girl out of keeping the baby that she had already been talked out of aborting, catch the baby, and race home with it. But women like these see themselves as morally righteous and media stories and community feeling support this idea of adoption as a good deed. My respondents often admired those who could find it in themselves to adopt but they questioned their own ability to be so selfless and to be tenacious enough to weather the process.

The Impossible Dream

The infamously long waiting lists, the interrogations and the intrusive "home studies," and the notorious failed attempts prevent or slow many women—and it is mostly women taking the lead (Rothman 2000[1989])—from pursuing adoption:

> And the adoption thing, they make it really difficult for you to adopt. It's a money thing. It's pretty sad. Like in Russia, no offense to Russia, I think it's more corrupt. If you have 20 or 30 thousand dollars, you can get a baby. Meanwhile the orphanages are overwhelmed with kids. There are just so many kids that need love and homes, they don't even know what to do with them.—*Talia Stein, 41, white, single, home healthcare aide*

> We even looked into the idea of adoption and later on that kind of didn't materialize. I used to work at a hospital before so I knew that there were a lot of babies that were born that got adopted or the moms didn't want them. And I thought about that but some of the babies that I had, was really uh was sensitive to were the babies that were really sick, that were drug babies or their mother had been an alcoholic or drinking or something that she didn't do right in the pregnancy. And so they were called "drug babies" or whatever and so those, that's the kind of baby that I wanted to adopt because nobody wanted that child. But somewhere along the line, it didn't happen. I think there was just too many obstacles for us.—*Iris Hernandez, 54, Latina, office assistant*

The narrative of adoption as an impossible dream, whether due to a corrupt bureaucracy or merely to a less nefarious obstacle course of requirements (made more rigorous for singles and working class women, and also more legally dicey for lesbians), makes adoption unlikely as the default option for apparent infertility or to involuntary childlessness. Still, there are many families waiting to adopt and many children (but very few healthy infants of any race) waiting to be adopted.

The prevailing preferences for white children, for girls, for newborns, for single children (i.e., not sibling groups), for uncomplicated relinquishments, and for "healthy" (read: able bodied and not drug- or alcohol-exposed) have resulted in a bottleneck in the domestic market. The supply of many foster children without permanent homes cannot feed the demand for particular kinds of children. Transnational adoption opens up another supply stream, but this too, is

becoming more difficult as China tightens its standards for adoptive parents, other countries clamp down on adoption-related corruption, and the long-term health problems of alcohol-exposed and orphanage-raised children receive greater media attention.

The Inferior Choice

Without a doubt, genetic ties and maternal bonding are culturally preferable to adoption. Women are expected to "try" every way they can to have a biological or genetic child before resorting to adoption (Gailey 2000). Adoption, in this discourse, is an option that (other) people have to "settle for" when all else fails. The parents' "ownership" is in question; the kinship ties are thought to be weaker:

> I would love to. But, on the other hand, my husband, he's not as for it as I am. He said he would if I really wanted to, but he just—he said that he—I don't know if he would love the child any less, but then, that's the one reason why I didn't want to go through with it is because I wouldn't want to put a child into a home where one parent didn't love that child unconditionally like their own.—*Lupe Jimenez, 41, Latina, married, electronics technician*

Lupe worries about her husband's ability to adequately love a child that is not "his." Another concern among the secondarily infertile women I interviewed regards their fear that love and affection would be (unconsciously but inexorably) doled out unevenly between the biological/genetic child and the adopted one. And many of the respondents wonder if they themselves can muster up enough affection for an adopted child.

Not only is adoption an inferior choice in the hierarchy of procreative options, many believe that the children are inferior too, that they are damaged in some way, or in many ways:

> It's kind of like, if you want a baby, the chances are you're going to get the drug addict baby and who knows what kind of problems they're going to have. I don't want an older kid because of the issues already. And then I thought maybe I'll go to China or Russia or Poland or whatever. But that's a lot of work.—*Talia Stein, 41, white, single, home healthcare aide*

The overblown crack-baby myth (Roberts 1997), the parallel and incipient meth-baby myth (Shaw and Rosales 2007), and all of the real and imagined effects of *in utero* drug and alcohol exposure feed into the larger social project that constructs adopted children as poor substitutes for hearty and hale biologically-produced, prenatally-monitored, properly nurtured, promising middle-class children.

In order to adopt an infant in the county that I live in, the prospective parents must attend not only the standard adoption training but also specialized training about drug-exposed children. Drug exposure is loosely defined as pre- or post-natal illicit drug use (or abuse of legal drugs) by the birth mother or by those who co-habitate with her. Jennifer West, a respondent who graduated from the same foster parent education program before I did, describes the purpose of the training as "scare tactics" meant to weed out the more cavalier adoptive parents, if such people actually exist. Whereas the trainers emphasize all the known and all the suspected negative health outcomes from drug exposure, they fail to provide accurate information regarding the majority of "drug-exposed" children who do not ever become symptomatic. The

issue is complicated, though, by the dearth of longitudinal data, the question of whether behavioral disorders like attention deficit-hyperactivity disorder (ADHD) are attributable to prenatal drug exposure or postnatal environment (or a genetically-inherited propensity), and insufficient scientific understanding of drug effects. Class and race come in to play as well, of course, with the moral panic about unsuitable prenatal environments directly aimed at poor women and women and color while deflected from higher status women (who may, for example, abuse prescription medications).

In any case, one attitude among infertile and childless women leads to this question: Why should stigmatized women be the ones to take stigmatized babies, some of which require much more care? Women seen as already damaged are asked to adopt babies with more problems than the average mother has to contend with and some of my respondents reject this compromise. They believe that adoptive kinship ties are not strong enough or permanent enough and the perceived deficiencies in the children exacerbate this weakness.

The Ethically Questionable

Another way to approach adoption is to question the ethics behind the process. LaNora Jackson, for example, wonders why a white family would adopt a black child, suggesting that the baby must be some kind of “pet” or “trophy.” Her comments reflect a long and ugly legacy of slave children being treated as such by planter’s wives and daughters (Rothman 2000[1989]).

Other respondents expressed concern about the origins of adoptable children, who they suspect—with good cause—might be “stolen” or “given up” by coerced birthmothers:

> I started researching adoption. I really thought that for a while I was going to do international adoption and adopt from you know Central America cause I love—I'm really connected with, you know, Central America and Mexico and I love to speak Spanish. And then I was just researching more and they were having problems and they had closed down adoption because of—there was some illegal stuff going on. You know, women were being propositioned to sell their babies. So that kind of closed down.—*Jessie Silva, 42, white, queer, hair stylist*

Transnational adoption of children—particularly when the children look much different than their adoptive parents—is a matter for public debate. Conflicts about class, race, national sovereignty, power and influence came to the fore during the 2006 flap surrounding the white American pop star Madonna's adoption of a black child from Malawi, a desperately poor African nation. The celebrity claimed that she fell in love with the child while visiting an orphanage and that his only living parent, his father, could not afford to care for him. Critics say that she used her money and influence to expedite a possibly illegal adoption and they wonder why she did not just give financial assistance to the father so that he could take the child back home with him. Others think she set a bad example by glamorizing international adoption over the adoption of waiting domestic children or, more generally, by glamorizing adoption over charitable giving. The story unfolded in frequent media updates, revealing many nuances and generating statements from Madonna, the child's father, and authorities in Malawi and Great Britain, where Madonna lives. The story as a parable about adoption in general exposes several ethical tensions: saving a child versus stealing a child, mothering versus trophy collection, colorblindness versus ethnic/racial preservation.

Hannah Jacobsen chose China for her adoption for several reasons. She knew that there were orphanages full of children due to the notorious one-child only policy there and an ancient requirement for male heirs, she was worried about getting a child from Eastern Europe because she did know if she had the financial resources to provide for an alcohol-exposed or mistreated child that might later exhibit attachment disorder, and she and her partner Gabriel had been told (mislead, in my view) that they were unlikely to "qualify" or be "chosen" for a domestic adoption since they did not own their own home, they had only been married a few years, and they were not particularly religious. Ethical considerations were also at the forefront of her decision-making. In her understanding, the (mostly) girls placed for adoption in China were not unloved or necessarily unwanted by their mothers, but they were already detached from them and available. Notwithstanding China's oppressive policy, there was less fear on Hannah's part that the mothers were being unduly coerced into giving up their daughters.

Despite the caricature of infertile women as desperate and willing to do "anything" to get a child, my respondents' concerns show that women do care about the ethical and moral correctness of their child's origins, not least because they will one day have to explain their actions to their child(ren).

Adoption Agency

Two groups of women among those I interviewed—the ones most involved with adoption and the young African American women from poor neighborhoods in Oakland, California—related experiences and expectations about adoption that imply room for agentic change, or to use more Foucauldian language, novel discursive strategies with liberatory promise. As one might expect, the women in the interview group who actually did adopt, and the one woman who

was herself adopted, offer a more multifaceted picture of adoption than those who have merely considered it and even those who attempted adoption but failed:

> I felt really angry that I had to do all this to have a child. And here I was this loving, open person with a home and just ready just to give. I was so ready to give but I had to go through this dance. So I was really, really angry and um and frustrated and um felt sorry for myself and um and I just, I changed by focus after—I—that just got tired. I was just like, "I don't want to stay in this place of anger and it's not going to come to me. A child is not going to come in life." Who would want to come into my life when I feel this way? So I um had to change my story around that too and I just thought about the child. I just totally got focused and I was like totally open, ready to receive whatever I'm supposed to have—a boy a girl, you know. Two, an infant. And I'm just going to trust in this process that I'm doing the right thing. So I just like, got rid of that stuff, that negative stuff. I mean it still like came up but I just was like, "That's not my truth." I was just really focused and really busy. I just was like, this is my way. I can't birth a child and this is how I'm going to have a child in my life. And this is what feels really real to me. This feels like who I am. To adopt a child feels more than actually birthing a child—*Jessie Silva, 42, white, queer, hair stylist*

Jessie elevates adoption over birthing a child. She also illustrates how women might cope with the onerous, and seemingly inane requirements of the adoption bureaucracy (attorney-arranged private adoption, by far the priciest path, makes fewer demands of its hyper-privileged

clients). She makes a deliberate effort to re-focus her energy from anger and frustration to openness and a balanced sense of resigned expectation or expectant resignation. She no longer holds tightly to “hope” or to any specified “dream,” instead she just “trusts” that the universe will bring about the connection between her and her adoptive child. This mind-set represents a departure from the kind of hand-wringing worry that some of the adoptive respondents (and I) recall and some of those who consider adoption anticipate.

Breaking free of one’s position as a powerless cog squeaking in the wheel of the adoption bureaucracy, a system seemingly designed to cause anxiety, is a way for women regain their discursive power or perhaps even to enjoy the preparations—like a pregnant woman might—for the arrival of the child. A single-minded drive to acquire a child does not have to define the adoption process and changing this discourse could open up the possibility of adoption to a greater range of women. More adopters, numerically speaking, are not desirable since adoption cannot be a long-term feminist solution to infertility or involuntary childlessness as Rothman (2005) persuades. For poor women to lose their children through state intervention or to feel compelled to “choose” to give them up in the face of economic circumstance and its consequences (e.g., inadequately treated drug addiction) is not the natural order of things; it is the result of a failure on the part of society to equitably distribute resources. No, more white, middle-class adoptive parents are not necessary; there are many. But women from working class backgrounds and women who are ethnic or racial minorities might find adoption a more interesting prospect if the process was affirming instead of alienating. Jessie’s reasoning offers a discursive shift.

Several of the African American women I interviewed comprise the second group to rely on a counterdiscourse:

I might adopt, but one thing is for sure: I don't have to legally adopt someone to take care of them. I've known a lot of children, and a lot of people who take care of children, and they didn't have to go through the court. You can take a child in, take care of them, clothe them, feed the, and they're someone else's child. I could possibly do that.—*Nicole Lambert, 20, African American, single, student*

I don't see a problem with adopting or having a foster child. But before I'd adopt or take a foster child, I would take one of my cousins. I have a lot of cousins. Even one of my cousins who is one or two now, by the time I decide to have a child, he would be seven or eight. I would take him, even though I wouldn't have the baby part.

Kristin Wilson: Is there anybody in your family who has informally taken somebody else in the family?

Yeah, my cousin Ursula, she took as a matter of fact -- The young lady I'm talking about with the baby, she was adopted, but not legally adopted. My cousin took her in. That was her best friend's daughter. My cousin, the one with the baby, she calls my older cousin Mama. But that's not really her mother. But she took her in, let her stay with her, was helping her with the baby until my cousin got it on her own. Now she's doing it on her own at nineteen.—*Jamilah Washington, 19, African American, single, student*

These women refer to the deep tradition among African American women of raising other women's children. No home studies, fingerprinting, surprise inspections, court dates, mandatory training, essays, or interviews required. These women bring up a discourse in which mothering does not command "ownership," "blue-ribbon babies," or perfect blank slates (Gailey 2000), or cutting off birthmothers' rights. LaNora Jackson mentions the concept of a "playmom" who mothers a child not hers when the birthmother is unwilling, unavailable, or otherwise unable to do so. Playmoms, godmother Aunties, and grandmothers "take on" children, loving them and forming everlasting bonds all without state approval or state surveillance. These unofficial relationships work well, according to my respondents, until some official document is needed for school, for medical care, or for other agencies. The informal nature of the arrangements also mean that they are deprived of the governmental assistance and adoption tax credits that formal adoptive parents receive to ease the financial burden. In most of the U.S., efforts are being made to honor so-called kin-adoptions and to place forcibly-removed children with members of their extended families, but in this rule-bound, legal milieu, genetic relationships take precedence over social ones.

I sat in on a county-funded, mandatory "adoption support group" meeting in which a woman sought to have a child removed from a family member's home by challenging the genetic relationship the child presumably had through the (prospective) adoptive father. The woman wanted to stop adoption proceedings when she heard a rumor that the man's mother once "cheated on" her husband, the social father of the child's (now questionable) uncle. Codifying familial relationships and kinships—a continuing legal maneuver in the light of the complex relationships engendered by medically assisted conception—ends up denying integral social

relationships, including not insignificantly, mother-child bonds. The kinds of informal mothering arrangements practiced most often in minority communities represent a mode of resistance to dominant meanings of womanhood, motherhood, infertility, childlessness, and family. The disruption by ART of the historic linearity in kin relationships among the white, middle class may also contribute to new imaginings of relatedness.

Enough is Enough

Motherhood mandate aside, some women find that other aspects of life are good enough to assuage role strain and identity crises; they enjoy identity sufficiency. They do not need to be mothers (or mothers of more than one child) for fulfillment, although this conclusion may be reached only after a woman has traveled some toward coming to terms with her childlessness or infertility:

> A couple of women I know have struggled a lot [with childlessness]. One because it was so entrenched in her family. She's Dutch. She said that's just what they do. She didn't feel—she's an incredible artist—so it took her awhile to realize that it was okay to give up motherhood for art and she could be a good enough person in the world. And she battled it for a long time…you can tell from her paintings.—*Annette Kramer, 54, white, lesbian, family therapist*

> I thought, you know, I don't need a baby to be fulfilled and when I look at my siblings and the responsibility that they have to take on with their children, I

> think, Oh I don't think I have it in me to do it. Please call me, I'll come and support you. I'll sit up with you all night. But I just don't think I could do it.—*Penny Ortiz, 52, Latina, single, guidance counselor*

Annette's friend "battles" her choice to give up motherhood—the motherhood mandate has high role applicability for her—finally settling on the hard-won idea that she could still contribute to society in other ways. Ironically, mainstream narratives from the work sphere may lead some mothers think that they are not contributing enough when they reduce their hours, take maternity and child-rearing leaves, miss work to care for sick children or to take them to appointments, and reduce their career ambitions and dedication to work life. Women end up caught in a double bind whether they have children or not. This is because all women are essentialized as mothers and work means giving up on that imperative.

As the interview results demonstrate, deciding not to have children (or more children) is a flexible process rather than a distinct event. Throughout the conventional fertile years and beyond, women lack certitude, and decisive efficacy, regarding their identity/role/status as mothers or nonmothers and their concomitant ambivalence underscores the discursive complexity of and constraints on women's "choices" in life in Western society.

The actual experiences of marginalized women who arrive at their position as nonmothers or as secondarily infertile, however consciously or unconsciously, illuminate multiple paths to full womanhood. This result does not just come to those who staunchly declare the voluntariness of their childlessness nor does it merely derive from psychological coping strategies. Instead their satisfaction comes from being enough as they are. Should the multiple ways of being a woman that their lives exemplify merge into the larger discourse about

womanhood, then broader options may open up for many more women. Those women who face infertility or childlessness may feel less compelled to pursue NRT to the cutting edge, or perhaps they may feel empowered enough to control more of the process, to demand woman-centered treatment.

Infertile and childless women have already made strides in changing the accepted views of NRT and adoption and minimizing the stigma attached to these. For instance, NRT is no longer governed exclusively by the "best interests of the child" (in which single women, lesbians, and the less well-off were discriminated against) and has instead become not exactly a "right" but a consumer "choice." In the adoption world, advocates insist on meaningful language modification: birthmothers no longer "give up" their children; they "make an adoption plan." The "real" parents are not the biological ones. "Adopted" is a verb that refers to a past event not an adjective describing a person. Children (well, babies, anyway) no longer "languish" in foster care but parental rights are terminated quickly, enabling permanent placements. But when one considers what strata of society benefit from these discursive transformations, it becomes obvious that, once again, middle class whites come out on top to the detriment of more marginalized groups of women.

Procreative freedom has to encompass all women to be any freedom at all. Three decades ago, at the height of the second wave Women's Movement in the United States, Adrienne Rich (1976:280) prescribed the emancipation of motherhood from patriarchy: "It is to release the creation and sustenance of life into the same realm of decision, struggle, surprise, imagination, and conscious intelligence, as any other difficult, but freely chosen work." To be freely chosen, motherhood must be an attractive option among many—for all sorts of women. And those other options need to be freed from the disciplinary power of motherhood as the primary role for

women, as the crux of femininity, and as the axis by which basic social dichotomies like good/bad, nature/culture, and public/private get defined and essentialized. Oddly enough, as queering practices (de-normalizing the normal and consequently expanding the definition of "normal"), NRT and adoption prove the plasticity of all these supposed binaries while simultaneously being used to reinforce them.

The lives of my respondents suggest ways to emancipate the notion of mother as well as that of "nonmother." At the same time that we need greater recognition that life is enough for women who do not have children, it is imperative to support ways for infertile and childless women to become mothers if they want to. While fertility treatments and adoption remain problematic in many ways and need to be critiqued and monitored, they also provide important alternative paths to motherhood and mothering. The less institutionalized ways of mothering, such as through the godmother auntie role or informal adoption need to be respected and supported in definitive, material ways by any society that values the needs of women and children. Moreover, the fact that infertility affects poor women and minorities much more so than women older than 35 years reinforces the importance of focusing on preventing infertility over treating it. In the epigraph at the beginning of Chapter 6, "Conceiving Complexities," Barbara Katz Rothman advises feminists to evenly defend the rights of women to accept their infertility or to fight it. Unraveling the strands of femininity and womanhood from motherhood and destroying the wrong-headed idea that infertility and childlessness are easily describable experiences constitute steps in this direction. Recognizing the depth and range of all of these categories for women across race, class, sexual-identity, age, marital status, and able-bodiedness is another.

Ambivalent Childlessness and the Pragmatic Infertile

It is an impossible task to represent all views in any ethnographic project, but seeking out the widest variety of voices feasible has the potential to pay off in analytical breadth (Woollett 1996). I listened to and dialogued with single women, lesbians, women of color, working class and poor women in addition to the socially amplified voices of white, middle class, married women, and heard something new. Many of these marginalized women were neither voluntarily nor involuntarily childless. They could not say for sure whether they wanted children or not and even several of the happiest childless ones sometimes waxed emotionally about what they may have missed. These women represent the "ambivalent childless," women who may have avoided medicalization for any of a host of reasons, may or may not have gotten involved in adoption, and do not necessarily characterize themselves as "infertile."

Those who do see themselves as "infertile" are quite different from the "desperate" or devastated infertile portrayed in public accounts and documented in ethnographic studies:

> The effect of finding out about the infertility problems for me was that I felt completely useless. I felt like, basically, a piece of garbage. And I thought, "Wait a second, this is not a time for you to feel worthless. This is a time where you really need every ounce of confidence you have." Your feeling of self-worth just plummets when finding this out because everyone always says, "You can have kids. Everyone can have kids. It's the American dream Why can't you?" "Snap your fingers and you're pregnant!" But if it doesn't work for you . . . I don't even have the words. It just really throws you.—(participant cited by Becker 2000: 39)

> It was as if a part of me had died, a part of me was never going to be fulfilled. Grieving to hold a baby. A part of me felt like I was never going to be, a part of me felt like a major disappointment to everybody.—(participant cited by Greil 1991:54)

> We wanted children, and I suppose it's like everybody, you just think it's going to happen..and when it doesn't . . . it's devastating—(participant cited by Franklin 1997:132)

> I got unbearable to live with . . . I was really miserable a lot of the time. You hardly ever saw me with a smile on my face . . . just got really depressed when going through the infertility thing. I used to cry and cry, anything would set me off.—(participant cited by Monach 1994:112)

By comparison, most of the women in the present study have much more muted responses to their infertility or childlessness. Earle and Letherby (2002) note that ambivalence about one's infertility was acceptable before the technological cures came on the scene. And one of Franklin's (1997:182) respondents says that she never felt "desperate" about having a baby until she got involved in IVF treatment, at which point she became so invested in the goal that when it did not work, she felt something was taken away from her. This phenomenon partly accounts for my respondents' acceptance of their childlessness. Rather than the "desperate infertile" (a category that actually describes few infertile women), many of my respondents could

be called the “pragmatic infertile.” Those whom I describe as “infertile-identified” are precisely the ones willing to explore adoption or try some of the medical techniques available (within reason), but many of the others, those who do not accept the infertile label, do not go that far. All of these women seem to recognize that there are numerous trade-offs whether they become mothers (or have more children) or remain nonmothers and either status has its perks; they are ambivalent, indecisive, and willing to attribute their statuses to the vagaries of fate and chance and God’s will. Obviously, the more invested in cultural ideals about femininity a lá motherhood (i.e., the intersecting influences of identity sufficiency and role applicability), the more likely women are to be crushed when they cannot conform. Marginalized women may be already less invested (*cf.* Inhorn et al. 2009). Their ambivalence and pragmatism appear disorderly in a world where routinized, normalizing apparatuses exist to repair infertile and childless women’s transgression as nonmothers. But their attitudes and experiences—which result in less normalizability—offer fresh discursive possibilities. A more encompassing, potentially emancipatory narrative of womanly fulfillment recognizes the capacity for acceptance of infertility and childlessness over resignation, values abstaining from treatment just as it values helpseeking, and advocates extra-institutional mothering (i.e., informal adoption and godmother aunties) as well as conventional motherhood. Through their experiential accounts, the women who participated in this study indicate a broader range of identities, roles, motivations, and, ultimately, new definitions of “normal” for childless women that, if brought into the public discourse, may advantageously impact all women.

CHAPTER 8: FROM MANDATE TO OPTION

Infertility and childlessness are socially constructed, stratified, and steeped in gendered beliefs and power relations, as are, arguably, virtually all social phenomena. As fascinating sites for the continuing medicalization—and component-by-component isolation—of processes once taken for granted as immutable, holistic, and divinely-controlled, the study of procreative matters tracks the inexorable rise of new means for social control. It is not only important to advocate for equitable access to medically assisted reproduction (including NRTs) and adoption but also to question, queer, and disrupt their usage in the interest of true procreative self-determination. Women's discursive and experiential interventions—especially via the margins—provide the tools for "dismantling the master's house" (Lorde 1984), that is, the techniques for re-building mothering and families outside of patriarchy, institutional control, and stifling discourse.

For their part, the simultaneous liberating and oppressing effects of assisted reproduction (and its fall-back cousin: adoption) occur on multiple levels. NRTs and the like liberate infertile and involuntarily childless women from "spoiled identity" (Greil 1991); they can become mothers after all and fill the expected role, yet they must admit their failure and submit to sometimes risky, typically rigorous, heavily surveilled, medicalized and bureaucratized regimes.

Single women and lesbians can become mothers without men partners—but they usually must trade one form of patriarchy for another as doctors, psychologists, social workers, intimates, colleagues, and even casual bystanders scrutinize their fitness for motherhood. At the same time motherhood is opened up to more women, it is reified as the pinnacle of womanhood. Even the happily childfree come to be viewed as closeted infertiles. Amy Agigian (2008) comments that the motherhood mandate now extends to lesbians (and single women, I might

add), pushing them to find life fulfillment in motherhood. Those who do not wish to mother are often treated with disbelief or viewed as slightly pathological when they claim to want a "childfree" life.

Assisted reproduction and adoption help to normalize those women who cannot become mothers in the conventional way. These options that ameliorate infertility or childlessness for some women also, at the same time, queer motherhood in general (see Park 2006). In other words, the assumption of motherhood as sacred, natural, normal—and biological and genetic—gets disrupted. Ideas about the natural order become disordered. Procreative autonomy supplants biological or social determinism. Even potentially fertile women heretofore barred from motherhood because of their social status use medically assisted procreation and adoption in deliberate, defiant ways.

For their part, fertility clinics and providers extol the ethical and business-growing benefits of serving singles and lesbians. Yet predicated on legal risks, a fear of HIV, the value-added quality (read: eugenics) of NRTs, and a cultural turn toward greater medical control of women's bodies, the once-empowering turkey basters are being left to Thanksgiving duties in favor of the expert's syringe (and accompanying fertility medications). Increased choices can lead to increased control in some respects and to the dangers of treatments gone awry (hyperstimulated ovaries and births of multiples are not rare and the increased risk of breast cancer and ovarian cancer—though purposefully downplayed by fertility consultants—is particularly worrisome).

Adoption has the potential to liberate, to create trans-families. Transnational, transracial, multilingual, multicultural, two-mother, two-father, and queer families are more common than ever before (Child Welfare Gateway 2008). Adoption transubstantiates the meaning of families

by transforming its outward look and the family-building experience. Motherhood (and fatherhood) become divorced from biologic and genetic roots, from pregnancy and childbirth, from looking like one's young, even from beginning mothering at the child's infancy. The need to mother transplants the need for following the conventional, linear route to motherhood. The decrease in the stigmatization of adoption is liberating for these women. A childless woman is normalized as a mother (read: a true woman) through adoption at the same time that her actions queer the experience and discourse of motherhood and mothering (Park 2006). But the displacement—some say "trafficking"—of children preferably, for many, involves matching race and the selection of only the youngest, healthiest children for assimilation into a now-"normal" family. Happy families are created, to be sure, but the distinct preference and unsatisfied demand for particular children further oppresses those for whom this type of motherhood is denied—to say nothing of the thousands of children who are bypassed, or, in effect, rejected.

"Stratified reproduction" (Ginsburg and Rapp 1995) notwithstanding, opportunities for unconventional routes to motherhood and mothering are increasing for socially marginalized women (Culley et al. 2009, Greil 2009, Inhorn et al. 2009). Public health advocacy by fertility clinicians and social researchers concerned about disparities in access to fertility treatment, media stories about miracle babies, mandatory insurance coverage pushed through by legislators in some states, and clinics' need for new markets, have all resulted in greater use of these services by women other than the white, middle class married women for whom the procedures were originally intended. Charis Thompson (2002) goes so far as to suggest that barriers no longer exist to any significant degree for single women and lesbians. But as Inhorn et al. (2009) so persuasively show, poor and working class African American, Latino, and Arab American infertile couples (they studied only *married* infertile people) are routinely denied sufficient

insurance, savings, and adequate information to access treatment. Cultural and religious factors also impede some ethnic minorities from making use of donor gametes or from adopting outside their families. The resulting disparities vex social justice-minded researchers in light of the fact that these are the very groups most likely to be medically infertile.

Disrupted Definitions: Re-casting Infertility and Childlessness

The women I interviewed, though varied in their experiences, possess an outlook on infertility and childlessness that departs from the mainstream discourse. First, most of them do not recall a traumatic moment of hearing an infertility diagnosis or recognizing their permanent childlessness (I return in a moment to those who did). Their suffering over their "disrupted reproduction" or the threat to their identity as women is mild compared to that reported in most other ethnographic works. Their stances are decidedly ambivalent be they *de facto* infertile, infertile-identified, childfree-by-choice, or whether childlessness "just happened" or they have intentionally delayed childbearing. As a whole, they are not particularly regretful in retrospect; they emphasize the many positive aspects to not having children or to having only one. Nonetheless, their comments and reasoning demonstrate a familiarity with the master cultural narratives about infertile and childless women and about motherhood and mothering. Like Becky Thompson's (1994) study of African American women with eating disorders, their lived realities do not match the dominant cultural discourse. They display "epistemic privilege" (Collins 1991) in accommodating the narratives even while resisting the inherent constraints. In attempting to explain their situations as infertile or involuntarily childless, many of my respondents pay lip service to the rhetoric of desperation and loss of femininity even while agentically eschewing

treatment (not solely for lack of capital), dismissing adoption, or pursuing (or imagining pursuing) either on their own terms. They resist medical and bureaucratic control but they also note the relevance of assisted reproduction and adoption to their own lives.

Any frustration about lack of access to treatment or insufficient capital to cover adoption takes a backseat to more pragmatic—though amorphous—concerns about their readiness for motherhood, locating a suitable life partner, piously (or matter-of-factly) accepting God's, or the universe's, plan, and coping with other life events. Coupled with distrust of medicalization and adoption, they tend to take on a come-what-may attitude instead of relentlessly pursuing motherhood or falling back on coping mechanisms. The angst of infertility or childlessness is not salient for most of these women although they do have deep feelings about their statuses. The childfree express some sadness at times, and the involuntarily childless or secondarily infertile tend to temper any regret with optimism about their present and future circumstances. Dichotomies are, as ever, highly problematic.

Researchers who study infertility and involuntary childlessness give a great deal of attention to disparities in access to treatment, to the patriarchy inherent in medicalization, and to the emancipatory promises of new family forms. Academic conclusions and policy implications should be tempered by the realization that women's procreative autonomy hinges not on individual choices but on social circumstances and America's unequal history of racism, classism, nationalism, and eugenics in regards to fertility.

As researchers, we ask women when they discovered their infertility, how they coped, and how others reacted (e.g., see appendices of Becker 2000, Greil 1991, Harwood 2007, Szkupinski-Quiroga 2002). My respondents' blank stares at these inquiries gave me pause. It became clear that *my* life crisis was not theirs. The possibility that childlessness or infertility

could be a gradual process with shifting meanings very different from my own, with unexpected potential for quasi-emancipation from predominant strictures of motherhood was an important realization for me. These women's perspectives and lived experiences make it clear that infertility and childlessness do not have to mean "spoiled identity." Motherhood and mothering are not necessarily *chosen* roles and they do not always equate to fulfillment. Analogously, infertility and childlessness are often not chosen, but they do not preclude fulfillment.

Except for those who are in the midst of it treatment or awaiting an adoption, infertility and childlessness is not all-consuming. While it is true that the study participants were the ones who were willing to talk about experiences that are painful to some women, this self-selection bias does not hinder theory-building. Their life experiences underscore the possibility that infertility and childlessness need not be tragic (and that childfree may be a more complex designation as well). Their experiences demand renewed appreciation for ambiguity and ambivalence, practicality and pragmatism.

Theoretical Conceptions

This dissertation contributes new model for explaining why so many infertile and childless women—especially marginalized ones—are ambivalent and pragmatic, not single-minded and desperate. They are consequently less apt to seek treatment or adopt and this trend involves gradations of *identity sufficiency*, *decisive efficacy*, *role applicability*, and *normalizability*. Instead of undergoing an "identity transformation" (Matthews and Matthews 1986), some women—those with high levels of identity sufficiency—keep their existing identities and maintain their personal notions of womanhood. Arguably, those in certain

marginalized positions, such as lesbians and African Americans, belong to communities that recognize and appreciate nonmother identities. Even though some lesbians may not think of themselves as intentionally childfree, as voluntarily childless, enough women within their milieu do and that provides space for acceptable childlessness. Similarly, African Americans have long conceived of a role for the "auntie" or "godmother" who takes in others' children or who merely watches out for them; identity sufficiency exists for the nonmothers in groups like this with more fluid notions of family and responsibility.

Conversely, then, it stands to reason that women whose self-identities as less-involved nonmothers or perhaps as godmother aunties are less sufficient—for reasons that vary importantly along the lines of class, race, sexual-identity, age, marital status, and so on—may indeed need to change their status by becoming mothers. In some contexts, such as pre-Women's Movement America or in societies with more traditional, stricter hegemonies of motherhood as ideal womanhood (e.g., Bosnia and Eritrea), identity sufficiency as nonmothers may be harder to come by. This pattern is borne out in Marcia Inhorn's extensive ethnographic work with Arab Americans (Inhorn et al. 2009) and with Egyptian women (1994, 2003). She also illustrates that class matters a great deal. For example, upper class Egyptian women can sometimes take educational and career tracks to self-satisfaction and social acceptance but the poor women are in danger of permanent loss of identity, social roles, and even opportunities for survival. As a result, the poor women are even more likely than the rich ones to try all manner of fertility treatments, ranging from medically-sound IVF techniques to dangerous snake-oil cures. Arab Americans, Inhorn et al. show, attempt certain kinds of medically assisted reproduction if they can afford it, though religious rules bar the use of donor gametes and prohibit adoption. Clearly, many factors, or variables, influence identity sufficiency and every other aspect of this model.

Race, class, marital status, age, and sexuality are but a few. Religion, able-bodiedness, mental health, culture, and political contexts are also important.

Decisive efficacy forms the second component of this model. As I discussed previously, many researchers (e.g., Becker 2000, Inhorn, ed. 2009 [2007]) emphasize the "disruption" caused by infertility. The participants in this present study often do not describe their experience as disruptive to their lives—and this varies by their reasons for childlessness as well as race, class, age, sexual identity, and marital status. They often make no firm decisions about motherhood/nonmotherhood—holding out for unclear and shifting standards of "readiness,"—and they defer to the forces and will of the supernatural, to God, to chance, to fate. Their decisive efficacy, in this situation, is low, while their identity sufficiency remains high. They do not feel disrupted because their identities and roles are not severely threatened. They behave unlike me and other women, who, when faced with infertility or involuntary childlessness, insist on remedying the problem, taking decisive action, relying on reserves of social, cultural, and medical capital to "make it happen." This last group of women tends toward the other extreme, toward high decisive efficacy, often along with low identity sufficiency.

As Edin and Kefalas (2005) show, in their ethnographic work building on Elijah Anderson's (1999) ideas, poor, young African American women do not, in fact, lack decisiveness in having children without visible means of support. They do not just have children accidentally or ignorantly. Becoming mothers allows them a particular role in society and ensures an emotional, familial connection in the absence of prospects for stable marriages. In the present study, the poor, young African American women as well as the older African American women and the middle class African American women share similar beliefs in God's will and fate but they are "indecisive" about becoming mothers. It appears that there are more options

along the spectrum of motherhood and otherhood within this community as compared to white, middle class, married women, for instance. An important piece of decisive efficacy is the concept of "readiness." What makes a woman feel she is ready for motherhood varies by era. Today, it is increasingly acceptable—and common—to have a child out of wedlock. Marriage or partnership still figures in significantly to notions of readiness but probably less so than before. The flipside is that marriage, for many women, as several respondents noted, indicates the intent to have children. Still, there are other aspects of readiness necessary even within the institution of marriage (e.g., the woman's view of the partner's "maturity," financial stability, home ownership). Some of these standards reflect changes in social understandings about the right environment for children. Prior to the Women's Movement, women had children soon after marriages that happened much earlier in life than they do now. Back then, it seems that decisive efficacy would have had to have been lower; women were less able to intentionally delay childbearing. In a similar way, cross-culturally, women who live in more patriarchal societies with less reproductive freedom and fewer alternatives to the role of motherhood, probably have more decisive efficacy. They need to resolve their childlessness by becoming mothers, and even though they may be quite religious and try religious rituals and cures, they may also be less likely to leave their fate in God's hands if there are medical treatments available. Social worker James Monach (1993) describes how working class (mostly white) British couples most decisively pursue fertility treatments to the end and then try desperately and ineffectually to adopt, suffering greatly along the way, feeling God has cursed them for unknown sins. They are "ready" for parenthood, something they harbor little ambivalence about and they are unwilling to give up. This group exemplifies the opposite route through this explanatory model when contrasted with my respondents (both married and unmarried). It is noteworthy that religiosity is

not the issue at hand. Less religious women may attribute their childlessness to chance or bad luck and not make attempts to become mothers. Very religious women may try hard to have children—using all sorts of medical treatments perhaps—simply because they cannot abide childlessness. Motherhood is too integral to their identity sufficiency and thus they are quite "decisive" and self-efficacious in accessing treatment or adoption.

The third axis of this theoretical model for explaining the range of attitudes about childlessness is role applicability. That is, to what extent does the motherhood mandate hail a woman? My respondents reify the motherhood mandate in their speech but not in their actions. They do not think that it has to apply to them. I use the term "role applicability" to contrast with Matthews' and Matthews'(1986) "role readjustment" and to Goffman's (1963) "role embracement" or "role identification." The respondents do not "readjust" to their roles as nonmothers or as "infertile," so much as they feel ambivalent about them. They can find plenty of reasons to be happy about motherhood or otherhood or else they accept their infertility somewhat in stride. These attitudes come about because they do not think that the mandate to take on the motherhood role applies to them especially. Role embracement or identification references a continuum of how much an individual fully inhabits and appreciates a role they actually have, whereas role applicability denotes the degree to which a person thinks a future role fits them and must define them. The notion of role applicability intertwines with identity sufficiency and decisive efficacy. If a woman has a sufficient identity in the motherhood-otherhood structure, then she need not be decisive about changing that role. On the other hand, a change in one of these variables will ripple through the others. A woman who believes that the role of mother is mandatory to her existence will likely find otherhood insufficient and may be certain enough in her desire for children to become very decisive about it, all the intricacies of

“readiness” be damned. Unreadiness is an explanation (like an excuse or an accounting) often, rather than an absolute hindrance to motherhood.

Lifecourse sociologist, Tanya Koropeckyj-Cox (2003), notes that older, childless women, women from the World War II generation, reveal in their life histories that their childless status becomes central to their identities. More so than childless men from this generation, they see themselves as deviant and they indicate that others demand an accounting for this deviance (Fisher 1991, Koropeckyj-Cox 2003, Houseknecht 1987). They experience great role applicability even though they never actually took on the role. If the role does not apply, as is the case for pre-Third Wave, pre-gayby boom lesbians, or for some single professional woman, women display greater identity sufficiency and—unless they are emphatically childfree-by-choice—they may also reflect diminished decisive efficacy, they are never “ready” for motherhood and God/chance/fate concurs.

The final piece of the model, which is, of course, interconnected with the others, has to do with normalizability. The closer one is to meeting mainstream social standards, the more “normalizable” she is. Women like this are the ones for whom the infertility industry and the adoption bureaucracy were designed and to whom these institutions cater. Fertility clinics and adoption agencies want to expand the range of normal in part to expand their clientele and grow their businesses. Women who are less normalizable will tend to have higher identity sufficiency and lower decisive efficacy and role applicability. They are more likely to ignore treatment options and reject adoption because they are satisfied in who they are, they feel ambivalent about motherhood, and the role is not necessary to their social integration.

Whereas the social consequences of women’s liberation mean that childlessness, singlehood, and lesbianism are more acceptable, and that procreative freedom is greater, the

motherhood mandate increasingly affect these women. The normalizing institutions—which, importantly, are more effective than ever thanks to technological and legal changes—want this, because making mothers is their *raison d' etre*. The rapid changes have created a discursive vacuum that these institutions are all too willing to fill with a broader motherhood mandate (and, not incidentally, a eugenic promise of "quality" with medicalization) that will chip away at identity sufficiency and move more women away from ambivalent childlessness to "involuntary" childlessness. There is another discursive possibility, however. And that is the one the study participants—through their experiential accounts—offer. The vast middle, those childless or infertile women who right now do not seek treatment and do not adopt, give to all women the possibility of ambivalence about childlessness and otherhood as well as pragmatism about infertility. More freedom, more choice can arise out of this discourse that lauds motherhood but does not make it imperative. Instead, an appreciation for other-than-mothers and for women with other life interests is permissible without the stridency and "selfishness" attributed to "militant" childfree-living.

The women I interviewed teach several lessons that further social theory in general. First, researchers' subjectivities, here the "knowledge"—grounded in both personal experience and a robust scholarship—that infertility and involuntary childlessness signify a major life crisis, especially for women, biases expectations, encumbers the formulation of innovative research design, and clouds theoretical insight. I do not advocate positivism as a solution, however. Biases are unavoidable and, as a critical theorist and feminist, I aver that biases are necessary to the study of social inequality if justice is a goal. Nevertheless, the ubiquitous characterization of infertility, and especially of the "Infertile Woman," has taken on a monolithic, one-dimensional, overly simplistic tone. The content summaries on the back of two brand new edited volumes on

infertility begin with these statements: “Reproductive disruptions, such as infertility, pregnancy loss, adoption, and childhood disability, are among the most distressing experiences in people’s lives.” (Inhorn et al. 2009 [2007]) and “Worldwide, over 75 million people are involuntarily childless, a devastating experience for many with significant consequences for the social and psychological well-being of women in particular.” (Culley et al. 2009). Between the covers, these authors and editors, who are established leaders in the field, proffer rich analyses based on thorough and well-funded research—in fact, funded sometimes (i.e., the “Reproductive Disruptions Conference” held at the University of Michigan in 2005 that led to the aforementioned book by the same title) by Serono USA, Organon USA, and Ferring pharmaceuticals, the manufacturers of infertility medications. But these authors start with an emphasis on “distress” and “devastation,” experiences that are not universal to childless and infertile women, as my study reveals. Of course, childlessness and infertility are not always “disruptive” or “involuntary” and these last two words are key. Nonetheless, it does not diminish the importance of disruption and involuntariness to acknowledge the presence of ambivalence and pragmatism among some women. Rather, it enriches and broadens our understanding of the range of women’s experiences and may even suggest better ways to advocate for procreative freedom. The scholars mentioned above recruited their participants mainly from treatment contexts, suggesting again that acculturation into the “fertility world” makes the “Infertile Woman.” This phenomenon, this distinction, may help in the strategic development of policies aimed at rectifying disparities in infertility treatment and adoption.

Second, the diversity of the study participants’ experiences proves the folly of binary thinking; not only is assisted reproduction oppressive for some and liberating for others, it is, at the same time, both liberating and oppressive for individual women. Interactions with social

institutions can be *quasi-emancipatory*. In the case at hand, there are fewer ways to be a woman (reifying the motherhood mandate) but there are more ways to be normal, and, most fascinating, women's praxis re-defines "normal" itself. New beliefs about normal threaten the Standard North American Family while at the same time permitting a greater number of women to approximate SNAF in their own lives. And, as noted above, the discursive vacuum formed by the rapid pace of technology and the lack of regulation of infertility clinics provides an opportunity for women instead of institutions to construct meanings. Women who do not seek treatment and women who are not yet ready to begin their lives as mothers are affected by the emerging discourse just as much as those who are in treatment. They see the options even if they do not want to (or cannot) make use of them. Most of these women have opinions about medically assisted conception and adoption and, thus, their (in)decisions, ideas, and experiences raise questions about womanhood, motherhood, fertility, childlessness, nature, medicalization, surveillance, and disciplinary power. They are neither technophilic nor technophobic, but they contest doctors' power by criticizing medical personnel and regimens, avoiding medicalization, and emphasizing the metaphysical. They do not wholly cooperate with an ideology of consumerism and commodification of motherhood yet they do not cling to traditional, essentialized, "natural" embodied femininity either. Theirs is a mixed approach and this is an important point to remember when researching human-institution interactions, particularly when re-framing basic, essentialist notions of role and identity like those surrounding motherhood and "otherhood." Beyond the tension of structure and agency or the disciplinary power of normalizing discourse, are the materialities of everyday life and everyday people. The interlocking and overlapping forms of oppression suffered by the marginalized are negotiated and agitated by those very oppressed who pick and choose, subvert, and recognize-but-disobey

the existing narratives and counternarratives. Like Azra Alic, the study participant who “tries on” a number of coping strategies, marginalized people—who develop multiple consciousness to survive—are quite capable of borrowing ideologies that compete with one another, and using them strategically, depending on the social situation.

Future Research Directions

This exploratory study points to burgeoning possibilities in research on infertility and childlessness. Dismantling the accepted notion that the infertile are probably involuntarily childless and that the “childfree” are probably pleased by their status or, alternatively, destroyed by it, is a step toward envisioning new research directions. Additional interviews with women from various social positions, with attention to the intersectionality of these statuses, would likely elicit more detail with which to compare and contrast. For example, how do childless African American women, Latinas, white women, and Asian women of diverse ethnic backgrounds make meaning of their circumstances, given their different histories and contemporary positions in the social hierarchy? How do factors like class, sexual identity, marital status, culture, region, age, and able-bodiedness interact with hegemonies and interventions of motherhood and “otherhood?” Inhorn et al. (2009:187) mention that childless Latinas fear that the use of the term “infertile” will curse them and that infertile African Americans see NRTs as a “white thing.” Given these findings, is infertility a “yuppie disease,” applicable only to white, middle and upper class, heteronormative women? Is it then a clandestine identity for some otherwise marginalized women, or do they see at as a privileged status to which they do not have access? Is the meaning of infertility undergoing a change with

new cohorts coming of age after treatment has become more “successful” and routinized? I make suggestions toward answering these questions, but more interviews within each category are called for to expand my findings.

One way to interrogate the commonalities and differences among women would be to conduct focus groups with treatment seekers and nonseekers who could share their rationale and perhaps reveal what makes them head in opposite directions.

Interviewing women who are more militantly childfree alongside ambivalent nonmothers, “accidental” mothers, and intentional mothers may be a way to capture the full range of women’s experience. It might be helpful to examine the motivations and insights of medical workers involved in fertility treatment as well as those of adoption social workers. In what ways does medicalization generate the stereotypes and shape the experiences of the infertile? How does the greater routinization and wider acceptance of NRT and adoption impact beliefs about kinship, eugenics, and the life course among women who use them and women who do not use them? What of the current trends in hyper-intensive mothering based on attachment theory in which women are told that motherhood *par excellence* entails babywearing (into late toddlerhood), co-bathing, co-sleeping, extended breastfeeding, as well as providing playdates, enrichment classes, and appropriate developmental toys? How does this milieu play into the optionality of motherhood across categories?

Quantitative testing of the theoretical concepts I put forward, particularly the idea of “ambivalent childlessness” may elucidate persistent questions about marginalized women’s helpseeking. As Greil et al. (2009) show, unaccounted-for variance remains in explanations for disparate interest in obtaining treatment.

Expense and recruitment challenges aside, longitudinal studies of changing feelings and attitudes about infertility are sorely needed. How do the formerly “infertile” or involuntarily childless (or, for that matter, the once adamantly childfree) feel years later, when their status is resolved or remains unchanged? Do women now “age out” of “barrenness,” the passage of time dulling their memories of pain and frustration or the hopes of their youth seeming less significant? What about women with disabilities whose rights and access to motherhood is de-legitimized due to ableism? How do various cohorts, each with unique sociohistorical experiences, explain their childlessness or infertility as the cultural landscape changes?

I hope that the category-defying experiences and the thoughtful words of the women who participated in my research will help scholars to re-think customary approaches to the study of infertility and childlessness and to problematize the dichotomies of motherhood versus nonmotherhood and involuntary versus voluntary childlessness. My research presents an explanatory model for theorizing women’s decision-making and attitudes about treatment and adoption. I also wish to emphasize the importance of changing the current normalizing discourse. Concerns about access disparities are important but it is equally important to expand what is meant by womanhood and fulfillment. This suggestion is not new but it needs revisiting because normalizing institutions are powerful and notoriously oppressive. It is the task of feminists to chip away at this power and marginalized women—the original feminists—provide the tools.

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