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Disrupted Bodies: The Effect of Infertility on Racialized Identities

by

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DISSERTATION

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Dedication

This body of work is dedicated to the memory of my father, Stephan Joseph Szkupinski, who always encouraged me.

Acknowledgments

This work would not have been possible without the support of friends and colleagues over the years, especially that of Sono Aibe, Art Almeida, Olivia Armas, Martha (Saenz) Buchanan, Yesenia Cardona, Dr. Kathy Coll, Veronica Falcinella, Dr. Alicia Gamez, Dr. Irene Gonzalez, Ruben Garcia, Adam Gould, Jeffrey Gray, Helen Lara-Cea, Dr. Sandra Lee, David Lewis, Eddie Limon, Jane McDonald, Mary Mendoza, Noelia Mendoza Salgado, Dr. Hector Mireles, Jennifer Price, Nancy Price, Patrick Roddie, Dr. Caridad Souza, Dr. Winona Stevenson, James Dean Steger and Bob Swarm.

Gay Becker has served as my intellectual mentor, and has guided my development as a scholar and researcher, generously giving of her time and insights.

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To those who graciously allowed themselves to be interviewed about a topic which was often painful for them, and opened their thoughts and lives to me, my sincerest thanks.

A special note of gratitude *a mi familia* and Daniel Cutrara for unending love and encouragement.

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Abstract

Disrupted Bodies: The Effect of Infertility on Racialized Identities

Seline Szkupinski Quiroga

While infertility has been shown to have significant impact on gender identity, not as much is known about the effect of the disruption generated by infertility on other aspects of identity. As well, the subjective infertility experiences of men and women who are not racialized White has not been explored. This study confronts both knowledge gaps. This dissertation is based on a series of in-depth interviews conducted over the course of a year with 43 individuals in the San Francisco Bay Area. The interviewees were members of a heterosexual couple struggling with infertility, and at least one member of the couple was Asian American, African American, Native American or Latino. The narratives collected in the interviews were analyzed using grounded theory techniques. The framework for interpreting the data drew upon concepts of stratified reproduction, racialization, interactionist perspectives on identity and narrative theory. It was found that the disruption of infertility is shaped by interlocking hierarchies of gender, racialized status and class. Infertility is experienced as a disruption of the racialized and gendered body. As well, it is experienced as a disruption to cultural systems of belief about the immutable nature of 'race,' the system of racial hierarchy, and one's relation to this system. The meaning placed on that disruption is mediated by one's relation to collective histories of constrained reproduction. In coming to a resolution of infertility, there is an accompanying transformation of subjectivity which allows one to envision alternatives to the models insisted upon by dominant interpretations of nature, biology and 'race'. This transformation confirms that racialized and ethnic identities are malleable.

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Chapter One: Researching Identity, Reproduction and 'Race'

Since the rise of reproductive technologies, feminist anthropologists and other scholars have rightly debated what these technologies mean for the future of society, for the future of the family and it's shifting meanings, and for women themselves. Writing in 1990, Browner and Sargent pointed out that of the volumes written about reproductive technologies, there were few studies that relied on firsthand data on what users think and feel about the methods currently employed to treat infertility (Browner and Sargent 1990). Since then, a number of excellent studies have been written on the new reproductive technologies which depend on qualitative methodology to reveal the subjective experience of those in Western industrialized countries who interact with these technologies (Greil 1991; Rapp 1991; Sandelowski 1993; Becker and Nachtigall 1994; Ragoné 1994; Franklin 1997; Cussins 1998; Becker 2000). However, very few of these studies include people of color, and in those that do, these individuals are not the focus of the study.

The vast majority of research on conceptive reproductive technologies has been conducted with White upper to upper middle class women and men. This is consistent both with existing patterns of utilization of these technologies, and the persistent relegation of people of color to the margins (Baca Zinn 1994). Consequently, the discussion is left somewhat lacking -- only a partial perspective is offered as the experiences of people of color and low income infertile people are ignored; they are not reflected either in statistics or in qualitative research (Gerson 1989). The studies of reproductive technologies produced in Europe and in the United States have failed to fully incorporate considerations of the subjectivity of people of color. Women of color, those most affected by reproductive hazards and infertility, are not included in discussions of those women likely to use reproductive technologies. The focus is on White upper class couples so that they appear to be the primary casualty of infertility (Gerson 1989).

Research Questions

As the bulk of the research on infertility in the United States has been on the experience of upper to middle class Euro-Americans, I was curious as to what is the experience of people of color and low income couples. Did their experience differ from that documented in the literature? If so, how? Was their sense of identity affected differently from those who were not members of marginalized groups?

This study documents the experience of a group of infertile couples who are not the typical consumers of reproductive technologies. The men and women interviewed for this study, from a variety of socio-economic backgrounds, have a variety of infertility factors, but a commonality that they all share is that they are members of groups racialized as non-White or "Other" in the United States, or they are married to someone who is a member of such a group. Because these men and women are products of American culture, in some respects, their experiences will resonate with what is found in the literature. However, I assert that because of their unique social position created by the intersections of class, race, gender and culture, in addition to a history of oppression and restraints placed on their reproductive capabilities, their approach to infertility and its effect on who they are will differ. Infertility and the disruption it generates shows us that identity is malleable, and that the disruption of infertility is shaped by interlocking hierarchies of gender, racialized status and class, and mediated by one's relation to a collective history of constrained reproduction.

There are sectors of the United States population about whom scholars have only partial knowledge; the holistic vision of anthropology has failed them. Just considering racialized subject position and class, some of these "invisible" communities are middle class African Americans, urban Natives, multiracial families, American-born Asians, and working class Whites. There are varying reasons as to why these communities are invisible to researchers. Perhaps some of it has to do with not yet breaking free of traditional ways of constructing analytical categories, or relying on established categories uncritically. American anthropologists studying their own culture are not immune to being influenced by existing portrayals that erase or render invisible people and things that do not fit into hegemonic ideological constructs.

My own work is a significant contribution to bringing invisible sectors to light, because it is an ethnographic account of the experience of infertility that represents some of the racial, ethnic, class, spiritual and bodily diversity of the experience. I believe it is important to uncover how people view themselves; it is a subversive way of examining those labels such as "privileged," or in the case of women of color "most vulnerable to abuses," "victim," etc. I aspire to present a complex portrait of people of color, mindful of two prevailing tendencies that often occur: People of color are compared to the norm (of Whites) and the differences noted are somehow seen to be intrinsic to people of color and not as a result of the social forces impinging on them. Or, going to the other extreme, so much attention is paid to the social forces that people of color themselves almost are invisible. They end up being defined "primarily in terms of their object status (the way in which they are

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which they are affected or not affected by certain institutions and systems)" (Mohanty 1991b, p. 57). This work aims to go beyond merely adding people of color to the analysis, but have them be at the center (Nakano Glenn 1987; Spelman 1988) which will require rethinking existing theory. Finally, I did this research because I am committed to documenting the experiences of people of color, and because by looking at the gaps in current knowledge, a different light is thrown upon a much contested subject.

The Semantics of Writing about 'Race'

As a researcher who identifies at some level with the respondents of this study, particular aspects of naming troubled me. The word choice involving terms for identifying groups is quite complicated. In this work, one term I will use to refer to African Americans, Native Americans, Latinos and Asian Americans collectively is racial ethnic. I did not want to just use ethnic as a collective identifier since in popular discourse, ethnicity is often structured into equivalence with notions of 'race'. I am using the term racial ethnic so as to pay attention to the realities of racial formation without ignoring the cultural specificity of ethnicity. My use of this term is not a conflation of ethnicity and race; the usage of this term is with the understanding that the social category of 'race' is a construction whose content can change over time, and differs from 'ethnic group' only in sociocultural meaning. I recognize, for example, that African American, as other identifiers, is a politically and culturally constructed category, not dictated by Nature but by historical formations of hegemony. However, as Wolf points out, "the privileging of cultural differences diverts analytical attention from the issues of structural constraint and structural power that makes the experiences, social location, and social relati

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Racial formation is the process by which social, economic and political forces determine the content and importance of racial categories (Omi and Winant 1994). Crucial to this formulation is the treatment of race as a central axis of social relations that cannot be subsumed under or reduced to a broader concept such as ethnicity as race is an ideological vehicle to define some groups as subordinate. In common usage, racial ethnic has come to be understood as referring to peoples who are not members of the dominant group, who are not 'White'. Waters suggests that while for White Americans ethnic identity is largely optional, for Black, Asian and Hispanic Americans it is generally neither optional nor inconsequential (Waters 1990). In the United States, the majority of individuals in the dominant power group are racialized White and are called, among other things, Euro-Americans.

My use of the term racial ethnic for individuals socially regarded as non-White does not imply that Whites don't have ethnicity. Indeed, the disavowal of white ethnicity naturalizes White as a reference point, reinforcing its hegemonic nature (Frankenberg 1993). Wildman and Davis argue that privilege is conflated with whiteness, thus erasing race in our society for some since the characteristics and attributes of those who are privileged group members are described as societal norms (Wildman and Davis 1995). White is the term that I will use to designate those respondents of Euro-American descent who enjoy, consciously or not, the privilege of being affiliated with the social group in power. In this work, I will insist, contrary to anthropological convention, in capitalizing the denomination of White to remind myself and readers of the artificial constructed nature of this category. The salience of racial difference still holds true in our society because of the social and political contexts in which racial difference has been constructed. Race as a socially constructed category of identity is linked to relations of power. The meaning of race changes over time. This does not minimize the social and political reality of race, but insists that the reality is social, political and therefore subject to change rather than inherent and static.

In the past, the term ‘minority’ was often used by scholars and policy makers to delineate those who were lower on the racial hierarchy but it is a misleading term as numerically, people who are non-White are often the majority depending on geographic location and demographic composition. I will use the term ‘racialization’ to refer to individuals who are seen as belonging to a particular group. Racialization is a term used as a way of overcoming some of the difficulties presented by the concept of race. Racialization usually refers to those processes where by 'race' as a supposedly real phenomenon is introduced into description of the world, and is then drawn upon to explain that world (Kirton 2000). Using racialization is "an attempt to move further from any idea that races exist, and instead to switch attention to the processes through which ideas about race originate and develop historically” (Kirton 2000, p. 4) Small notes that the use of the term racialization is based on acknowledging that “social structures, social ideologies have historically become imbued with ‘racial’ meaning, that such meanings are contingent and contested, and that they are shaped by a multitude of other variables, economic, political and religious” (Small 1994, p. 36). As I use the term in this research, racialization most often refers to the process in which “meanings are attributed to certain patterns of physical variation” (Kelly 1998, p. 28).

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The most common term I use to refer to African Americans, Native Americans, Latinos and Asian Americans, and to differentiate this grouping from Euro-Americans is 'people of color'.[1] This sociopolitical term is fairly recent and came into usage partly because of a felt need to find something that would encompass the diverse experiences of people marginalized because of their racialized status, as well as refer to a common context of struggle against exploitative structures and systems (Mohanty 1991a). African Americans, Native Americans, Latinos and Asian Americans are all groups that have been racialized in the United States as Other and have a history of oppression and marginalization in relation to what is regarded as the dominant mainstream.[2]

I acknowledge that using the phrase people of color is problematic because it may be taken to mean a coherent group when in fact it includes men and women of extremely diverse racial and ethnic backgrounds who are not closely related to each other genetically or culturally (Rosser 1994). In some ways, it glosses over the immense diversity and differentiation of the historical and cultural experiences of subjects, and perpetuates an artificial binary of 'people of color' and 'Whites', with non-Whites being defined always in opposition to Whites (Bonnet 1996), essentializing both constructions. As well, racialized identity and skin tone do not "correspond to the color symbolism used to depict race in the United States" (Weston 1991, p. 16). There are also some who object to the use of people of color on the grounds that it is merely a reconfiguration of the term 'colored' which has pejorative historical roots. It was used in the United States to refer to

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[1] See Alarcon, "The Theoretical Subject(s) of *This Bridge Called My Back* and Anglo-American Feminism" and Sandoval, *Methodology of the Oppressed*, for insightful discussions of this term.

[2] Earlier in American history, individuals of Jewish, Italian and Irish origins were also considered to be Other but I am also taking into account the contemporary situation of structural integration. See Ignatiev, *How the Irish Became White*, and Sacks "How Did Jews Become White Folks?".

a person who was non-White in the era before the Civil Rights movement and was also used as an identifier in apartheid South Africa. However, despite these problems, people of color is a term commonly used and accepted by most of the respondents in this study, and racial naming is a part of a community's collective struggle to claim or rearticulate identity (Frankenberg 1993).

In this dissertation, I am primarily concerned with identity. I take an anthropological approach to uncovering how the identity of people of color is affected when confronting infertility by relying on people's narratives of their experiences. In first approaching this topic of infertility and people of color, I was influenced by theoretical discussions from the field of anthropology, especially feminist anthropology's engagement with reproduction and medical anthropology's concern with the social aspects of health and illness and the disruption that illness creates. As I began my preliminary analysis, I looked to various theoretical perspectives of identity to help me interpret my respondents' stories.

Identity

My interest in identity stems partly from my own experience as a woman of color embracing different social identities at different life stages and under varying circumstances, with accompanying changes in my subjective sense of self. Current theories of identity and self across disciplines emphasize its fluid nature as compared to past theories which conceptualized identity as static. Anthropology has long been concerned with notions of the self and personhood (Becker 1997), and its current theoretical formulations of identity also account for fluidity as well as multiplicity (Ewing 1990; Clifford 1994). Identity is seen as changing in response to occurrences in the social environment and life stage (Kim 1981; Helms 1993), and as discursively constructed in historically specific social contexts (Hall 1996); they are complex and plural; and they shift over time (Grossberg 1996). Social identities encompass a sense of belonging to social groups based on such characteristics as gender, ethnicity, race, social class, sexual orientation, and religion. It can include qualities a person sees as part of the self as well as acceptance of external identifiers (Freedman and Lips 1993).

Important for this project is the stance that identities are constituted within a system of social relations and require the reciprocal recognition of others. This relational perspective has developed from Mead's concept of the self which asserts that individual selves are the products of social interaction and not the logical or biological preconditions of that interaction (Mead 1974). However, this theory, associated with symbolic interactionism, has been updated to reflect contemporary ideas that the self is always becoming (Berger 1963). When applied to ethnic identity, this updated symbolic interactionist stance has emphasized ethnicity as flexible, constructed and constantly redefined in relation to social and structural processes (Nagel 1994). Other disciplinary fields have been concerned with identity as well. When theorizing identity, the interdisciplinary field of cultural studies, places emphasis on diversity -- there not being one definition of an identity -- and contingency – the subject taking up positions which are momentary and changing in different social context and relations. Stuart Hall, a leading theorist of the field, conceptualizes identity as a process rather than a "state" or "developmental attainment" so it is an exercise in becoming rather than being, and ever incomplete (Hall 1990). As well, identity can be an exercise in positioning, based on partial identifications and attachments to subject positions determined by discourse rather than being consistent and enduring (Hall 1996). Identities are diverse and changing and can be reconfigured through narrative at different points in time and space. Individuals live within a large number of different 'fields' (families, peer groups, work groups) and while one's sense of self may remain fairly constant, one may position one's self differently in each field.

Of importance to this dissertation is that for Hall, influenced by the Gramscian notion of hegemony, questions of identity are always related to questions of power and the relation of social structure and subjectivity in historical context. As well, he explicitly links identity to ideas about race, class and ethnicity based in classificatory systems. For example, Hall sees ethnic identity as constantly emerging, as formulated through discourse and interaction in a community of peers and "Others," and as a "quest to give authenticity to one's experience" (Hall 1991). He views identities as strongly contested and oppositional. The marking of difference is crucial to the construction of identity positions, and difference is reproduced through symbolic systems. The marking of difference is the basis of culture because things -- and people -- are given meaning in culture by being assigned to different positions within a classification system. The ways in which culture sets boundaries and marks out difference are crucial to understanding of identities. Difference is what marks out one identity from another and establishes distinctions, often in the form of oppositions. The marking of difference is thus a key component in any system of classification.

Anthropology and Reproduction

Since its beginnings, anthropology has concerned itself with reproduction (referring to biological processes of conception and birth) of human beings, via its placement of kinship at the center of social analysis. Kinship, as traditionally studied by anthropologists, was based on a reproductive model: sexual relations, transmitting genes, giving birth are the biological processes believed to be the basis for relations between spouses, siblings, parents, and children, and the basis for other social kin relations. Social and cultural meanings could be attached to these processes but they are seen as derivative and less significant, since the biological defines the system to which the social is attached, and thus logically is precedent (Schneider 1984). Critiques by feminist anthropologists problematized this reliance on the biological and generated attempts to retheorize kinship and gender (Collier and Yanagisako 1987; Yanagisako and Delaney 1995).

Initially, medical anthropology took reproduction out of the kinship system framework and studied how reproductive processes were organized both within and cross-culturally, bridging biological and cultural domains (Browner and Sargent 1990). More recently, medical anthropology has engaged with feminist anthropology's tendency to examine reproduction from a socially and politically engaged perspective. In this vein, contemporary anthropological studies of reproduction go beyond the "mere biological" (Weiner 1978, cited in Franklin and Ragoné 1998, p. 3) to pay attention to nuances such as their subjects' constituted subjectivities, the relation between corporeal body and the body politic, agency and cultural production and transformation, accommodation and opposition to dominant discourses, and a consciousness of the permeable boundary between scholarship and social action (Ginsburg and Rapp 1995). As well, they draw upon the lens provided by the field of science and technology studies to further defamiliarize the subject of reproduction (Franklin 1998).

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Of particular usefulness for the current research project is Colen's theory of stratified reproduction. Based on her work with child care workers who were themselves denied care for their own children, Colen theorized that "physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces" (Colen 1995, p. 78). Colen goes on to point out that reproductive labor and fertility are differentially experienced, valued and rewarded according to inequalities of access to material and social resources.

Colen's theory provides an effectual way for medical anthropologists and others to interrogate non-normative and stigmatized reproduction, illuminating associated cultural norms, struggles, and transformations (Rapp 2001). In this study, I use stratified reproduction in conjunction with considering the histories of constrained reproduction to contextualize the experiences of infertile people of color. By constrained reproduction, I am referring to the constraints placed on people of color's ability to perform physical and social reproductive tasks by social policies, institutional arrangements and ideological constructions (Collins 1999); the specific contours of this history for Native Americans, African Americans, Asian Americans, and Latinos in the United States will be reviewed in Chapter Three. Considering infertility as both a biomedical condition and a social condition, the subjective experience of infertility will be strongly influenced by social expectations, and cultural beliefs about reproduction and fertility (Becker 2000). As well, the history of constrained reproduction which people of color possess will also influence their interpretations of infertility.

Narrative and Disruption

The use of narrative as anthropological data is a way to understand experience within a cultural setting through examination of a cultural form. Narrative goes beyond the recounting of experience. As Good points out, narrative as a cultural form requires that events be presented in a meaningful and coherent order, as well as projecting to the future so as to organize desires and strategies with an eye to imagined ends (Good 1994). As an anthropologist, one must listen to people's stories with an awareness of not only the content of their story but also the structure.

The person constructing an autobiographical narrative engages in a process of selecting, plotting and interpretation of events to make meaning of their lives to both themselves and to their listener (Cornell 2000). In this, narrative can serve as a metatheoretical framework for self and identity (McAdams and Ochberg 1988; McAdams 1993). For this reason, the anthropologist is not looking for objective truth but the truth of the narrative, which will reveal how a person makes meaning. The narrative cannot equal the experience (Good 1994). As the researcher listens to a narrative of a particular experience, they're being removed from that experience; and in the researcher's recounting of that recounting, the reader is further removed from the actual experience. As the researcher, my interpretation cannot equal the experience so I have tried, to the best of my ability, to be faithful and respectful to the narratives.

Another element of theoretical importance is positioning. Positioning is the discursive process whereby selves are located in conversations and narratives as observably and subjectively coherent participants. There can be interactive positioning in which what one person says positions another, and there can be reflexive positioning in

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which one positions oneself. The concept of “positioning” as a term articulates a fluid and dynamic sense of the multiple 'selves' or 'identities' one has, and also how these “are called forth” and/or actively constructed, in conversations between people or in other discursive contexts (to paraphrase Althusser on the notion of being 'hailed' by certain ideological positions (Davies and Harre 1990). Narrative can allow the researcher to acknowledge multiple identities. The person talking to me may be racialized in a particular way and they may embrace the corresponding racial identity but they’re also located in a specific class position, and have a particular sexual orientation. These multiple identities will color and shape the content of their narrative as well, although all that is readily heard is how their racialized status affects their experience. The contradictions one experiences between the constitution of various selves actually provides the dynamic for understanding, through the unfolding of narrative, in which we may be constituted in one position or another, in one narrative or another within a story, or perhaps stand in multiple positions or negotiate new ones by “refusing” the ones that have been articulated by posing alternatives (Davies and Harre 1990).

Like everyone, infertile individuals construct an autobiographical narrative understanding of who they are on the basis of values and roles they find in their cultural and social contexts. As well, their story will be based on their experience of multiple disruptions. A key concept for framing this study is that of disruption. Here I am influenced by Becker’s work on how people make sense of disrupted lives through narrative and metaphor (Becker 1997) as well as Bruner’s argument that individuals turn to narrative as a means of making sense of situations of breakdown or deviation from expectations. In search of meaning, they narrate the unexpected, creating a sense of order through the imposed order of narrative (Bruner 1990). Narrative can be a particularly useful tool individuals use to find meaning during a period of disruption.

Infertility is a disruptive event on a number of different levels. Phenomenologically, it disrupts one's sense of their body as functioning in an orderly fashion, it disrupts one's sense that life unfolds in an orderly fashion, and it disrupts one's biography and ultimately sense of self (Becker 1997). The disruption of the body caused by infertility is similar to that generated by other illnesses. When the body functions as expected, it is often ignored. It is when there is illness that a disorderly body is recognized and efforts are made to control the body and return it to an orderly state.

Infertility, in addition to being a condition in which the body does not function normally, also prevents the occurrence of an expected life event for most married couples – the birth of a child. Anthropologists taking a life course perspective acknowledge that at each phase of human life, specific cultural meanings are assigned to life events and the identities that accompany them. Becker points out that when expected life events do not occur, people experience internal chaos (Becker 1997). As well, the fact that infertility adversely affects biological reproduction which is considered to be part of the natural order of things (Schiebinger 1993) is disruptive to the individual's sense of the physical/natural world as being ordered.

In listening to the narratives and stories of my respondents, I was also influenced by insights from critical race theory (Delgado Bernal 2001). Critical race theory fore grounds race and racism, and conducts research that focuses on racialized, gendered, and classed experiences; these experiences are sources of data. Analyses informed by critical race theory challenges models in which the discourses on race, gender, class are separate.

The stories that are told are referred to as "counterstories" because they are in contrast to "majoritarian stories," the stories of those with privilege in which the privilege is naturalized and thus invisible (Delgado and Stefancic 1993). Counterstories are those at the margin, which are not often told. Because of the scarcity of voices of people of color in the literature on infertility, I believe that this tenet of critical race theory is useful to my own project.

Overview of the Dissertation

In the following chapters, I return to these theoretical notions of identity and 'race' and discuss them in further detail in relation to the experiences recounted in the narratives of my respondents. Chapter Two describes the recruitment strategy and methodology used in data collection, specifies the particulars of the analytic process, and provides a demographic description of the sample. Chapter Three describes the context of infertility in the contemporary United States through a discussion of the medicalization of infertility. Special attention is paid to the interconnection between medical discourse, collaboration and popular media, the marketing of technology, and surveillance. The implications of medicalization for people of color is considered, followed by a brief historical review of constrained reproduction of Native Americans, African Americans, Asian Americans, and Latinos in the United States. Chapter Four considers infertile individuals negotiating multiple identities both within and outside the medical context. Particular attention is paid to the interplay between one's sense of self grounded in social identities shaped by race, class and gender and the disruptive experience of infertility. Chapter Five examines the interactions around disclosure and support as a way of uncovering the identity challenges that infertility generates. After a consideration of the role of the support organization Resolve, the rest of the chapter discusses identity within a marital and familial context, as well as the social worlds of friends and religion. Chapter Six examines how 'race' is implicated in the resolution of infertility. After a brief review of American kinship ideology and some points of intersection with racial ideologies, I specifically analyze the accounts of couples considering and employing donor insemination and adoption with regards to secrecy, meanings of genetics and appearance, and racialization. Chapter Seven summarizes the major findings of the research and discusses the theoretical implications of these findings.

Chapter Two: Setting, Methodology and Sample Description

This research was part of a larger study on gender and the disruption of the life course conducted by Dr. Gay Becker.[3] The geographic site for this study was California's San Francisco Bay Area. The Bay Area has a higher cost of living than the rest of the state but the median household income is higher as well; for the state of California in 1993, it was $34,100 but in the 5 county area, it was $44,000 (Institute of Industrial Relations n.d.). However the Bay Area also had the widest gap between poor and affluent (Perry and Stuchinsky 1995). At the time of data collection, there were a half dozen established infertility centers in addition to two major university-based centers of reproductive science research located in the Bay Area.

Recruitment Into the Study

General Recruitment

People were initially recruited into the study in two ways: through invitations to participate extended at meetings and conferences of the local chapters of Resolve (a national support group for infertility); and through informational flyers included in new client packets of private infertility practices. Over time, these efforts were refined and expanded to include flyers provided to reproductive health clinics serving low-income individuals, and physicians with a significant proportion of people of color in their client base. Using the vehicle of their newsletters, invitations to participate were given to the

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[3] National Institute of Aging, National Institute of Health, Bethesda MD, Research Grant AG08973: Gender and the Disruption of Life Course Structure, Principal Investigator: Gay Becker, Ph.D.

general memberships of groups organized around other related disease entities (endometriosis), and adoption related services. A variety of flyers were developed with wording focusing on different aspects of the infertility experience such as in vitro fertilization, secrecy around decisions, adoption, surrogacy, and the catch all phrase of "difficulty conceiving".

Recruitment of People of Color

Resolve proved to be a fruitful organization with which to work for recruiting participants – almost 40% of respondents heard about the study through Resolve. However, the Resolve group in Northern California is not particularly diverse. As my own research interest was in the experience of couples not represented in the literature and with a history of constrained reproduction, different methods of recruitment were also used. In an attempt to target such couples, I established contacts with networks of service agencies targeting Native Americans and Latinos, attended community health fairs, powwows and other cultural events at which I let my interests be known, and relied on word of mouth and personal contacts. Recruitment flyers were translated into Spanish, a toll free number was set up with a bilingual message, and advertisements were placed in ethnic newspapers.

Having been active in immigrant rights organizations, I was somewhat familiar with existing social service networks in San Francisco. Using this as my starting point, I compiled lists of social service organizations serving ethnic communities. In establishing contact and explaining my interests, I found that agencies serving Native Americans tried to take a holistic approach to providing services even though their funding base may have required them to provide health services or rehabilitation services, or education services.

The administration of these agencies almost always included Native Americans in their composition, and it seemed as if they were conversant with their counterparts across agencies, areas of specialization and region, as well as non-professionals. In contrast, the services for Latinos were not as integrated, and the administration appeared to be more separated from community.

As I was doing fieldwork in my own backyard, there was a conscious effort to talk about my research interests as much as possible. One respondent came to me because of a chance remark of mine at a friend's family celebration; she relayed to me that a mutual acquaintance had struggled with infertility. I asked my friend to tell our mutual acquaintance about the interviews I was conducting, and if he was interested in participating to contact me. After a few rounds of telephone messages received and left, I was able to schedule an interview.

The Bay Area, being a final destination for the Relocation Program in the 1950s, has an established and active Native American community. There are a number of pan-Indian powwows held throughout the year. I had attended powwows with friends in the past so I was familiar with the basic setup and organization of the events. I contacted powwow organizers and requested a table on which to display flyers. I was granted access to all that I requested, although some asked for exhibitor fees. At these, I tried to secure a bit of space on the informational table of a receptive organization focused on health. During the powwows, very few people inquired about the study but, as I was later told by a Native respondent, "people knew who I was."

Within the Latino communities at large, my recruitment efforts took place mostly at health fairs. At these events, usually held in a community center with accompanying entertainment, I was given a table and used a bilingual banner. People did approach me to ask questions about infertility and inquire about the study, but no one agreed to participate. In one attempt, I spoke on a Spanish-language radio program about infertility. It was a call in show, and after a brief interview by the host, I received numerous calls by women wanting information about infertility, and wanting clarification of things that they had heard although ultimately, none agreed to participate in the study.

Recruitment of people of color and low-income individuals into the study occurred at a much slower pace than that of Whites, adding to the overall period of data collection. Ultimately, the manner in which people came into the study broke down as follows:

- 42% of respondents heard about the study through Resolve or a support group
- 23% heard about the study from an informational flyer in a new patient packet of a private physician or clinic
- 19% heard about the study through an adoption related service
- 16% heard about the study by word of mouth

I note that the people who responded to invitations to participate in the study constitute a self-selected sample, and so may not be representative of others who are experiencing infertility.

Difficulties Encountered with Recruitment

When I explained the study and my particular interest in finding non-White couples who were willing to be interviewed about their infertility, I was told more than once by medical professionals that they did not see "those kind of people" in their office, or that infertility wasn't a problem in those communities.

The first Native American respondent I interviewed was a personal acquaintance of mine. In interviewing this Native American woman, more than once she asked me to turn off the tape recorder and she explicitly referred to a historically exploitative and contentious relationship between anthropologists and Native Americans. She told me about a friend of hers – also Native -- who was also experiencing infertility, but the referral to her friend wasn't a matter of a simple phone call. I was invited first to share a casual fast food meal with her friend so he could get to know me, although she advised me not to let him know that I was an anthropologist until our second meeting. At that time, I told him about the study and he agreed to participate.

Also referring to history, an African-American man who was interviewed stated his reasons why he didn't think more African-Americans were interested in participating in the study.

Franklin: I think the reason is a lot of fear. If you start to give out too much information, people will know too much about you to hurt you. And you know that is in our history.

Later in the interview, he continued in this vein, emphasizing that it was a private matter, not anybody else's business, and alluded to chemical warfare that was being done without anyone's knowledge. His oblique reference speaks of the enduring suspicion that is a legacy of historical abuses by the medical and scientific community. The most infamous case is the Tuskeegee experiment which studied the effects of untreated syphilis in a group of 300 African American men over a period of forty years without their informed consent.[4] Pacific Islanders are familiar with the case of Bikini Island islanders whose atoll was used as a nuclear explosion site. After the nuclear clean up, inhabitants

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[4] A history of this infamous experiment can be found in Jones, *Bad Blood: The Tuskeegee Syphillis Experiment.*

returned despite high amounts of contamination in local vegetation. Yu asserts that the military kept good records, in an alleged "natural experiment" of the effects of exposure under the guise of humanitarian medical follow ups (Yu 1994). Incidents such as these are often cited as a reason why people of color do not participate in research, along with distrust of a White dominated healthcare system, and being ill-informed about research efforts. However, Freedman suggests that these can be overcome, noting that if researchers seem willing to have direct contact with subjects, and if people of color judge the research relevant to their medical concerns, they are more likely to participate (Freedman 1998).

I was reminded of this by Raquel, a Chinese-American respondent, who explicitly said a reason for her and her husband participating was so that an Asian perspective could be given. In their own search for information after diagnosis, they could not find anything specific for or by Asian Americans. Raquel offered to introduce me to her Chinese-American gynecologist, believing that her patient base had proportionately more Asians. At the same time, she warned me that most Asians wouldn't talk about their experience of infertility to a stranger. In this respect, she considered herself and her husband anomalies.

Researching an issue about which there is stigma (Goffman 1963) and secrecy may require more time to develop trust and rapport. I felt that my time spent in recruitment and at community events was helpful in establishing myself as someone trustworthy. After the four year period of active data collection had ended, I still occasionally was contacted by people who had heard about my interests.

Data Collection

All data presented in this project were collected between 1991 and 1995. The main source of data is interviews conducted while a member of Dr. Gay Becker's research team. I also attended annual Resolve conferences and symposia; spoke to physicians, infertility specialists, and reproductive endocrinologists; conducted formal interview with physicians; and was an observer ("lurker") of Internet newsgroup discussions alt.infertility and alt.adoption, and participant in an infertility topic in an online health forum from 1993 through 1995. I paid close attention to media coverage of infertility and reproductive technologies by videotaping television specials and talk shows, tape recording radio programs, watching commercial films released during this time period which dealt with topics of reproduction and parenthood,[5] and closely following national magazine stories and articles in two major daily newspapers to gain an additional cultural reading of the experience of infertility. In addition, my research interests were widely known and I benefited from many informal conversations with both fertile and infertile members of a variety of identity groups whose shared insights influenced my interpretations. The lines between "the field" and my own life were constantly blurred, similar to Rapp's account of the bleeding of methodology into everyday life (Rapp 1999).

The research protocol for heterosexual couples experiencing infertility was a series of interviews over the course of a year. The first interview was as a couple, the second individually with each member of the couple using a modified life history

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[5] Of particular relevance due to their portrayal of individuals confronting reproductive technologies were Richard Benjamin's Made in America (1993), Ivan Reitman's Junior (1994), and Henry Jaglom's Baby Fever (1994). An independent documentary, Kathy High's Underexposed: The Temple of the Fetus (1992) was also useful.

approach, and the third again as a couple. Ideally, couples were first interviewed soon after an initial diagnosis which allowed me to detect changes over time. People were interviewed both as a couple and individually because infertility has a powerful impact on the couple as a unit, plus this protocol allowed me to specifically look at the influence of gender and ethnicity on the infertility experience.

Each open-ended interview, conducted in the participant's home, lasted anywhere from one to seven hours, with most averaging about two hours. At the first visit, I explained the study, assured confidentiality, answered any questions and obtained a signed consent form and permission to tape-record before interviewing. Because I was committed to capturing the subjects' understandings and experiences in their own terms, throughout the interviews I encouraged subjects to raise issues they felt were relevant to their own lives and to the study. Dr. Becker also allowed me to modify the interview schedule as I saw fit, adding questions that more closely probed ethnic and racial identity, and omitting questions that I deemed insensitive. I often incorporated emergent themes into subsequent interviews as questions. Thus, while the core interview schedule remained stable over time, specific issues, terms, and concerns that emerged throughout the interview process continuously informed the research. This practice was informed by discussions of "theoretical sampling" in grounded theory methodology (Strauss and Corbin 1990).

In the larger research project, there was an attempt to match interviewer and interviewee by racialized status to help with rapport, so I did not conduct any of the interviews with African Americans. Of the interviews analyzed for this study, I personally conducted a third of them. With the respondents I interviewed, a casual friendship often developed and I was invited to birthday parties, baptisms, and sent birth announcements. I matched most respondents in terms of age but not in life stage as I was unmarried and still a student. At times I was asked if I was myself infertile, if I planned on having children, was in a relationship, etc. Personally, I was made keenly aware of the decline in a woman's fertility in her thirties and realized that I assumed, as did my respondents before confronting infertility, that I was fertile and in fact, took measures to avoid conceiving.

The tapes were transcribed verbatim by other members of the research team, although I transcribed all Spanish-language interviews. I was then provided with both a hard copy of the transcript, and the file of the transcript. I benefited by being part of the research team under Dr. Becker's direction as there was a forum to discuss individual problems, specific questions, how interviewees responded to specific questions, how to handle ethical quandaries, etc. During the same time period I was conducting interviews with people of color for this dissertation, I also conducted interviews with infertile couples who made up the sample of the larger project. Although none of that data is reported here, the multiple opportunities to hear stories from a variety of perspectives was invaluable in assisting me to become familiar with the experience of infertility overall, in providing me other points of comparison beyond the academic literature, and honing a sensitivity necessary to conduct potentially invasive and emotionally difficult interviews.

Consistent with the ethos of feminist research, my work was driven by a commitment to exploring women's own voices and perspectives in the subject area under study rather than by methods. In this sense, many of the methodological tools that were used in the research did not adhere to the strict regulations that have been the norm in more traditional qualitative research. For example, although I used an ethnographic approach in my research, I did not include traditional fieldwork as part of my data collection. My work more closely corresponds to what has become known as multisited ethnography (Rapp 1999). The ethnographic component to it is that I am studying the infertility experience as a cultural phenomenon. Doing a study based on interviews is not usually the basis for the classic ethnography; I did not experience the daily texture of life by living with a couple undergoing infertility. But as infertility is considered a private affair in our culture, it was in the interviews that I was allowed insights into private hopes and dreams, pains and grief.

Interviews are a method often used in feminist research because they permit the person being interviewed to respond in her own words, at her own pace (Kirby and McKenna 1989). Conducting in-depth interviews furthermore, enables the researcher to capture the subtle complexities of the research participants' perceptions and experiences (Patton 1990). In addition to the words participants chose to tell their stories, I had to pay attention to the emotions expressed at various points in their narrative – their anger, anxiety, frustration or happiness, as these were telling of significant junctures. For this analytical task, I relied on my field notes and sometimes on re-listening to taped interviews.

Analysis

There are different ways – styles if you wish – to analyze qualitative data but an underlying realization is that the researcher's own subjectivities are implicated in the process. As Serrano-Garcia points out, "knowledge produced by scientists is not the objective description of an outside reality but the subjective creation of a social phenomenon" (Serrano-Garcia 1990, p. 182). Through my training as a medical anthropologist and my experience as a qualitative researcher, I have developed an approach which is a mix of systematic steps, inspired by Strauss (Strauss and Corbin 1990), and looser interpretive work.

For this project, I began with iterative readings of the transcripts noting broad concepts and themes (defined as ideas that dominated their stories) expressed. I then built an initial coding schema in order to be able to check impressions and associations systematically. The coded concepts and themes were then reviewed specific to selected focal categories of analysis (such as gender, infertility factor, choices about interventions, class, ethnicity, time of diagnosis, time of interview) with particular attention to commonalties and differences. This series of steps was then repeated on a case by case basis, but this time with a focus on repetition of specific words and phrases, the use of language, and the expression of emotion. I was also paying attention to narrative structure, how the person told their story, what was included and what was left out.

This process is not as mechanistic as it sounds; I find it crucial to ensure trustworthiness, the qualitative equivalent of validity and reliability (Lincoln and Guba 1985). According to Lincoln, the criteria for trustworthiness are credibility, transferability, dependability and confirmability. Credibility refers to establishing the "truth value" or accuracy of the research findings. Transferability is describing the context of the research, referring specifically to the content and process of the research. Dependability entails using various techniques such as triangulation of the research methods, and keeping detailed notes on the research process at every stage to maintain consistency. Confirmability is achieved by using triangulation and the notes as a way of cross-checking and confirming the findings.

Other steps I took included identifying key informants based on their representativeness of range of experience, repeatedly asking questions of the data and seeing if identified concepts remained coherent, and looking for patterns of associations within and across cases and analytical categories. The additional methodological tools used in the data analysis were loosely defined approaches to discourse analysis, narrative analysis, and anti-racist feminist analysis. Translating these approaches to a more technical level of understanding, I analyzed narratives in terms of their internal coherence and contradiction, in relation to each other, and in the context of a broader social history. The interpretive framework used to organize much of what I found relied on a conceptual clarification of the diverse ways in which the participants discussed their ideas about gendered and racialized identity, family and children, medicine and technology.

The Sample

A little more than half of the couples lived in the suburbs surrounding the urban centers of San Francisco, Oakland and San Jose; the remaining couples lived within the city limits of these three cities with the exception of one couple who lived in a semi-rural area. Below, I provide a demographic description of the individuals (N=43) who make up my sample. I review the composition of the sample with regards to age, duration of marriage, ethnic/racial identification and socio-economic status based on data gathered in the first interview and summarize it in Table 1. Providing demographic details in this fashion adheres to the scientific practice of drawing comparisons based on a norm. In this case, the norm is the population profile of infertile respondents in other studies. By separating out these variables and calculating their statistical value in the aggregate, I provide a sketch of the contours of the sample.

However, it should be noted that these calculations are based on categories that are artificially constructed, and there is not a consensus as to their measurement, and the dynamics they signify. Consequently, I want to emphasize that each demographic characteristic shouldn't be considered on its own as providing any real insight into the infertility experiences of these people. Doing so would erase the importance of the intersections of, for example, gender and class location and racialized subjectivity, which shape and give specific meanings to interactions with medical technology, illness experience and lived realities. As well, I note that this sample is not representative of people of color with infertility; however, my purpose is not to generalize my findings to a larger population but to explore the experience and changing meanings of that experience for those I interviewed. A short biography of each couple can be found in Appendix A.

Age

In the context of infertility, age is a significant variable, particularly but not only for women. For women, there is an inverse correlation of fecundity to age; the drop in fecundity appears to increase exponentially after age 35 and is related to the "quality" and quantity of oocytes (Stovall, et al. 1991) For men, the major factors contributing to an age-related decline in fertility are the quality of the ejaculate and the frequency of intercourse (Dunson, et al. 2001). For some men, advancing age is associated with declining testosterone levels, decreased sexual interest and reduced sexual activity. The decreasing frequency of ejaculation adversely affects the ease of conception. Sperm production and sperm motility can also decline with age (Kidd, et al. 2001). In addition, the rates of success for the various technological interventions available differ by age (Minaretzis, et al. 1998; Nuojua-Huttunen, et al. 1999; Williams and Alderman 2001).

The age of the women in this study at the time of the first interview ranged from 27 to 45, with most being around age 36. The age of their male partners ranged from 30 to 67, with most being between 37 and 39. For the most part, respondents were of the same generational cohort and thus held values and outlooks specific to the period in which they were raised (Ryder 1965), although there were individual variations related to other factors.

Two other temporal components relevant to the infertility experience are length of marriage (as this relates to the timing of when couples plan to have children) and amount of time in treatment. For this sample, the average number of years married was a bit under 7 years and the average number of years in treatment was 3.5 years.

Ethnicity

The largest number of respondents (35%) identified as Asian-American, primarily of Chinese descent. These were followed by Whites who, for the most part, did not provide any other identifier. Latinos and African Americans were present in equal numbers, together making up close to a third of the sample, followed by Native Americans (5 %). About three-quarters of the couples were interracial or intercultural. Currently, almost 5% of marriages in the United States are interracial (Kitano and Daniels 1988; Harrison and Bennett 1995).

The data on ethnic and racial identification is based on how people responded to the ethnic background question on the demographic form. In this question, the response categories were already provided, but respondents could write in comments as well. Their answers usually correspond with how they identified themselves in the interviews although the terminology often changed, even within the same interview. For example, an individual referred to the specific country of origin of his parents in describing himself - "Mexican" – at one point and used the group identifier Hispanic at another point. Another woman identified herself as Pacific Islander but usually referred to herself more generically as a woman of color.

The majority of the respondents were born and raised in the United States; an exception was a Chicana who spent a significant portion of her formative years in Mexico. About a fifth were children of immigrants and grew up with a different language than English in the household. Of those who were foreign-born, half were raised in the United States and half immigrated during adulthood. I include these details to point out some of the diversity within the sample.

Table 1: Demographic Characteristics

Demographic variables		**Values**
Gender		
Men		49% (21)
Women		51% (22)
Age[a] of total sample (y)		
Men		37 (30 – 67)
Women		36 (27 – 45)
Duration of Marriage (y)		6.76 (2 – 13)
Ethnic/Racial Identification		
Asian-American		35% (15)
Chinese	47% (7)	
Japanese	27% (4)	
Filipino	13% (2)	
Not specified	13% (2)	
Latino		14% (6)
Mexican	83% (5)	
Chilean	17% (1)	
African-American[b]		14% (6)
Native American		5% (2)
White		32% (13)
Place of Birth		
US		88% (38)
Foreign		12% (5)
Education		
High School/Vocational Training		17.5% (7)
Some College		7.5% (3)
College Graduate		35% (14)
Postbaccalaureate		40% (16)
Occupation Type		
Working Class		26% (11)
Middle Class		55% (23)
Upper Middle Class		19% (8)

a) I've reported the median age of respondents rather than the average since the distribution was very skewed for men.

b) Includes one African-born individual.

Socioeconomic Status

Socioeconomic status is of particular relevance to the infertility experience as mediated by technology in that treatment for infertility is "boutique medicine" and reserved for those who can afford it. While infertility affects men and women of all social classes, the vast majority of those who receive treatment are college-educated and financially secure (Abma, et al. 1997). Furthermore, socioeconomic status can be a crude indicator of factors associated with successfully negotiating the medical system; these factors include the amount of financial resources available, experience and degree of comfort with the medical system, experience interacting with medical professionals, social skills and knowledge. Yen and Moss assert that, with regards to health, educational level is key in that there are "skills and social benefits which come with increasing educational levels [such as]: 1) ability to process certain kinds of information or critical thinking and 2) ability to interact with bureaucracies, institutions, and health practitioners. Social benefits may include: 1) credentials and the economic access they provide, 2) social networks and extension of cultural capital, 3) socialization to adopt health-promoting behaviors; and 4) enhanced expectations for the future leading to helpfulness, planning, self-efficacy, and a sense of control" (Yen and Moss 1999, p. 351). I believe that occupation can, as well, provide some clues as to how familiar the individual is with medical terminology, technical terms, and negotiating bureaucracy.

Traditionally in the social sciences, socioeconomic status has been thought of in terms of access to power, property, and prestige. These theoretical constructs have been operationally defined in terms of education, income, and occupation. On the demographic form, respondents could indicate their annual income, years of education, and their current occupation and I considered this data along with information garnered from the interviews.

I rejected using the Hollingshead Index of Social Position (based on education and occupation) to classify respondents because of the multi-ethnic nature of the sample. There are significant ethnic/racial and gender differences in salaries (even within the same categories of occupation), as well as educational attainment. Rather, I classified respondents' occupations as described below, and report income, education, property ownership, and insurance status. I also note the circumstances in which respondents were raised. As found in other studies, "the edges of the clusters ' middle-class' and working class are fuzzy as they should be for groups formed by complexly overlapping characteristics in a state of constant change" (Martin 1987, p. 5).

Occupation

The occupation of the individuals in the sample ran the gamut from dishwasher to legal secretary to veterinarian. Almost 60% of occupations were within the strata of middle class, while 26% I judged to be working class and 19% upper middle class.

In classifying occupations as working class, middle class or upper middle class, I weighed the nature of the job with respect to autonomy, responsibility, mobility and prestige (Braverman 1974). In my rough calculations, I delineated working class occupations as those which were dependent on hourly wages and/or susceptible to seasonal fluctuations. I placed service workers, clerical workers, and skilled manual laborers in this class, and noted the hazards associated with these positions – exposure to chemicals that cause disease, lack of benefits such as insurance, and long hours (Chavkin 1984). In defining middle class occupations, I realized that there exists a variety of strata within the middle class occupations. The defining characteristic was a steady income, from middle to high, with enough extra to allow for "some amount of luxury and discretionary spending" (Rapp 1982, p. 181). In this category are occupations that are supervisory, salaried administrative, and entrepreneurial. Upper middle class occupations were salaried professionals and executives with high levels of autonomy (and often accompanying stress).

Income

In the majority of households (86%), both members of the couple worked. There were 5 individuals who weren't working; for 3 of them, this was by choice. Not everyone disclosed their annual household income; of the couples who did (N=14), 64% made over the median income for the Bay Area while 21% made less than $30,000. The income range was from under $10,000 to $120,000.

Education

The great majority of individuals in the sample were college educated (75%). This is consistent with national data that reports that 60% of women receiving fertility services have attended college (Abma, et al. 1997).

Property Ownership

An indicator of class position and resources is ownership of property. 27 % of the sample rent their housing and they are almost all located in what I have designated as working class occupations. However, being that the occupational status of each member of a couple may not be the same, this is harder to interpret.

Familial Class Background

Thirty percent of the sample talked about growing up poor or in situations of "striving" in their interviews. I note this because familial class background can effect one's worldview and relationship to finances and financial decision-making. For example, one respondent is presently a professional and makes over $100,000; however, in his life history he recounts being raised in the projects (public housing) and how this influences his idea of contributing towards family, and risk-taking around infertility treatment decisions.

Medical Insurance

With regards to financial and other resources, if an individual has medical insurance and if it covers infertility services is as important as income and knowledge. The cost of utilizing reproductive technologies is high and can add up quickly.

In the sample, the vast majority of respondents (86%) had some type of insurance, be it public or private. This is consistent with national data which reported that, in the same time period, 83% of the total population under age sixty-five had some type of insurance (National Center for Health Statistics 1995). However, it is difficult to assess what percentage had an insurance plan that provided coverage for infertility services because respondents discussed only what concerned them, be it diagnostic tests, fertility drugs or surgery. During the time of data collection, a law was passed in California that required health insurers to offer some type of coverage for infertility diagnostics and treatment (excluding IVF) though the law does not require those insurers to provide the coverage; nor does it force employers to include it in their employee insurance plans. Conceiveably, respondents' coverage plan could have changed from the time of the first interview to the last. Based on answers to the demographic questionnaire at the first interview, I estimate that only three of these couple's insurance coverage for infertility services was more than 50%.

Chapter Three: The Context of Infertility in the United States

This chapter will discuss the socio-cultural and historical contexts in which people of color and low-income couples experience infertility. The first section will consider the contemporary situation in the United States, framed by a discussion of how infertility has been medicalized, and the implications of this medicalization process. The second section will review the current socio-political environment and the history of constraints on the biological and social reproduction of people of color. In this chapter, I use the term people of color to refer to African Americans, Asian Americans, Native Americans and Latinos collectively. I am aware that these diverse racialized groups have unique histories and cultures, and could be further categorized into different ethnic/national origin groups. However, I am choosing to emphasize the common experience of being "Other" in American society, and of having a history of oppression and marginalization in relation to what is regarded as the dominant mainstream. I also realize that African Americans, Asian Americans, Native Americans and Latinos are not the only groups in the United States who have such histories, but I use this designation because they are the main groups represented by the participants in this study.

Medicalization

Medicalization is when a phenomenon formerly conceptualized in social and/or legal terms moves into the biomedical realm (Reissman 1983). When this occurs, the authority of the medical enterprise is extended to areas formerly considered outside its purview or jurisdiction. When a condition is medicalized, it can bring greater power and control to the institution of medicine, but it can also provide for an alternative way of conceptualizing a condition or disease that is morally neutral and less judgmental. It can be a somatic idiom of distress deployed when other avenues of communication prove ineffective (Nichter 1981) or a "means of coping with suffering through construction of a narrative to make sense out of chaotic life events which threaten one's sense of self-integrity" (Cassel 1982, cited by Nichter 1998, p. 328).

In the United States, infertile couples began seeking help from medicine just before the Civil War. Before then, couples who could not conceive did not consult a physician but relied on popular home remedies or adopted informally (Marsh and Ronner 1996). The pathway for the medicalization of infertility has been set, in many aspects, by the medicalization of women's reproductive processes, particularly childbirth (Reissman 1983). The historical rise of medicine's cultural authority and use of biomedical rhetoric in the nineteenth century was key to the process of medicalization, and was manifest in, for example, the replacing of home births with hospital births and the dismissal of midwives as unscientific and proponents of old wives tales (Bogdan 1990; Barker 1998).

In the twentieth century, medicalization occurs within a context of increased prestige and power of the medical professions, coupled with an embracing of technological solutions and a faith in science, rationality and progress (Conrad 1992), so by mid-century, infertility was particularly ripe for medicalization. Post war pronatalism embodying a push to return to normalcy (Marsh and Ronner 1996) coupled with the evolution of the cult of true womanhood (Welter 1966) to the motherhood mandate (Russo 1976), also contributed to the notion that a solution should be found for the plight of the childless. As research funds were made available and medical researchers turned their attention to the human reproductive system (Marsh and Ronner 1996; Clarke 1998), each new heralded discovery sped the medicalization process. The discovery of hormones, and the successful adaptation of techniques previously used in animal husbandry were two important turning points and precursors to the rise of reproductive technologies currently in use.

Medicalization is not always an either/or proposition; it can be viewed as something that can be measured in degrees. By looking at the four modes of medicalization as outlined by Conrad -- medical ideology, collaboration, technology, and medical surveillance (Conrad 1992) -- it is possible to evaluate the current state of infertility's medicalization. Note that each of these modes occurs on three levels: conceptual, institutional and interactional (doctor/patient interaction), and are closely interconnected.

The first mode of medicalization, medical ideology is the conceptualization of a problem using a medical model and employing medical terminology and discourse. The medical model implicitly relies on an analogy of the human body as a machine with various parts (organs) which can malfunction. This model is a result of Cartesian influence on the biological sciences (Synnott 1992). Under the medical model, it is presumed that the physician's task is to correct the malfunction through a process of diagnosis, discovery of causes and symptoms, and the design and administration of interventions. The interventions are aimed at eliminating or minimizing the symptoms of the disease, or the cause of the disease, or the disease itself rather than on prevention and the maintenance of wellness. A specialized lexicon is used to describe the condition, and accepted referents are firmly within the biomedical realm. The dominant biomedical model assumes that all bodies function the same, and that people will have the same symptoms and outcomes across social circumstances (Bird and Rieker 1999) so possible class and racial differences are unexamined. It is believed that there will be various medical interventions that can be used to "fix" the non-working part, but non-medical interventions are disparaged, as are simple remedies. Highly technological solutions are valued, often without regard to their cost. However, if successful, these type of interventions may be accessible to only a small percentage of the population (Sherwin 1994).

When the medical community addresses infertility, they bring their ideology to bear which must read it as a pathological condition; the condition of being unable to produce a biological child is considered a departure from the norm (Becker 2000). Biomedical interventions in the case of infertility generally do not offer a cure or eliminate symptoms but rather bypass the malfunctioning part, as in using donor sperm for male infertility (May 1995). The favored interventions are the use of fertility drugs and other reproductive technologies. Medicine provides the language and terminology with which to talk about the inability to conceive to the point that the medical term of infertility has replaced the term involuntary childlessness in common parlance. In my sample, even couples not receiving biomedical treatment used medical terms to refer to their situation (although not always correctly), and I noted that the vocabulary of those most fully immersed in treatment regimens became more technical over time.

The second mode of medicalization, collaboration, in addition to having medical personnel assist as gatekeepers, institutional agents and technicians, refers to the source of information for the patient. For the most part, knowledge that is valued about a medicalized condition comes from medicine. Experiential knowledge or knowledge that is from sources outside the control of medicine is devalued as "unscientific". However, the medical literature is not the only source of information. As medical literature can often be difficult for laypersons to understand, alternative sources of information are available, though they are deemed more reliable if their original source is from biomedicine.

Infertility and its technological solutions have been increasingly visible in the popular media. Popular media (newspapers, television, books, magazines, etc.) corresponding to the medical discourse's presentation of the condition, also consider infertility to be of medical concern. Popular media, friends and relatives were often cited as sources of information for infertile couples in this study.[6] At the time of data collection, there were a number of television specials and magazine articles that my sample was aware of and made use of. One African American woman readily admitted that her education on what to do when confronted with infertility stemmed from the media.

> Raeshell: Well, any women who, to me, is living in the 1990s or is living in the 80s at the time already knew what a basal body temperature chart was. Cause it's been all over ABC, NBC, CBS and every women's story in every show, to me, anyways.

Another respondent, A Chinese-American man, offered to loan me his copy of a TV special that he had videotaped to help me with my research. The show, aired on a

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[6] One or two mentioned the Internet, but the wealth of information currently available through the World Wide Web had not yet been developed at the time of data collection.

major network, featured a journalist interviewing families struggling with infertility interspersed with "talking heads" of reproductive specialists telling of the latest medical advances.

> Louis: I think that show was the most enlightening. I mean, the way it was scripted was the best drafted show that I had seen ... I look at it as "what are you trying to communicate?" and if you listen to her language and how she describes things, she very much is more apropos than any of the other shows. There were a number of shows that have been on on it. You know, the talk shows have had it on it.

In these examples, it is clear that the media (re)produces, legitimates and perpetuates the medical discourse developed through the imposition of the medical model. Furthermore, it focuses a disproportionate amount of attention on biomedical technology. This may be an example of what Steven Heath refers to as "machine interest," instances where technologies become, in themselves, objects of cultural attention, over and above their specific products (Heath 1980). Heath coined the term to account for the public fascination with early cinema, and the contemporary analog is reproductive technologies which seem to offer unimagined possibilities to play with creating life. This is not a new phenomenon. When scientific work was begun in the mid-1940s on techniques that were the precursor to in vitro fertilization, every step was accompanied by media attention and sensationalism (Marsh and Ronner 1996).

While today media attention may not be as uncritical of technological advances, there is still a very strong undercurrent of acceptance of scientific progress represented by these biomedical interventions. In their reporting, there is an underlying idea congruent with the medical model that the body *is* "fixable" and which pushes them to emphasize the "inevitability of scientific progress and the indefensibility of standing in its way"

(Franklin 1997, p. 328). This idea also reinforces the American tendency to seek one-dimensional solutions to problems (Kirmeyer 1988). In analysis of media portrayals of infertility and reproductive technologies, writers have noted that stories tend to focus on the miraculous, progressive aspects of biomedical intervention (thus normalizing) or the freakish aspects of them (Franklin 1990; Mentor 1998). A glance at a few of the headlines from one of the major newspapers (San Jose Mercury News) during the time of the study displays the continuum between freakish and laudatory. The first headline – Menopausal Pregnancies Find Success, Report Says – emphasizes natural barriers to fertility being overcome through the miracle of modern medicine. The article triumphantly boasts that "Menopause is no longer a barrier to having a baby" because doctors can now claim "remarkable success implanting eggs… in women who stopped ovulating years ago" (Ainsley 1990). The opening paragraph of another report entitled "A Real-Life Riddle of Relationships" reads:

> "When John and Jo-Lynne Seeger's daughter is born in September, her future sister will be her mother. And her birth mother's father will be her adoptive father. And if you find that confusing, digest this: She will have -- altogether -- five parents" (Associated Press 1993)

here emphasizing how biomedical intervention will wreak havoc with kinship relationships as we know them.

What these media accounts also do is provide a primer in *how* to be infertile. There is not a common body of knowledge in American culture as to how to deal with this condition beyond turning to medicine for answers. Unless someone known to them has struggled with infertility and confided the details of their experience, many couples are at a loss as how to proceed beyond what has been revealed in media portrayals. The news accounts, personal interest stories and TV specials reveal what modern American couples do when confronted with infertility. What is consistently communicated is that a genetically related child is an inestimable goal, that using reproductive technology is the way to achieve this goal, and there is a need to persevere even though the odds seem insurmountable. In an "active consumer" analysis, consumers are seen as actively constructing their social identity by making use of available cultural texts. Those using reproductive technologies are therefore more progressive, enlightened, and willing to do whatever it takes to achieve their goal of a biological child.

Placing these directives in the familiar literary trope of a quest makes her experience of infertility more intelligible to Mandy, a White woman married to a Chinese-American man.

She says: ...I live with this fear that sort of everything is too good to be true and I think that our culture reinforces it with our literature and our movies that it would be a boring story if they lived happily ever after, and that is the end of the story and now we are trying to live happily ever after and to make a good story, it is supposed to have these doses of tragedy that you overcome.

The media teach Mandy that she has to overcome obstacles, that good things come to those who persevere (consistent with American cultural values), and that if she endures her personal tragedy (she has suffered three miscarriages), she will be rewarded. The emphasis on perseverance is also concordant with a patient's obligation to do everything in their power to get better (Parsons and Fox 1953).

The third mode of medicalization is technology. Technology bears a special relationship to science and medicine, with technological innovations being embraced as a symbol of progress and modernity (Conrad 1992). The American fascination and embracing of technology is consistent with the belief that "all varieties of human endeavor could be improved upon if they were rationalized and reorganized according to the presumably scientific principles that guided industrial production" (Greil 1991, p. 34).

This is a particularly pertinent point of medicalization for infertility as the medical interventions that are offered are, for the most part, technologies, both more low-tech (such as artificial insemination) and high-tech (such as IVF, the most widely utilized procedures of in vitro fertilization, IVF with intracytoplasmic sperm injection [ICSI], gamete intrafallopian tube transfer [GIFT], and zygote intrafallopian transfer [ZIFT]). Regardless of the level of technology used, only members of the biomedical profession are sanctioned to administer these invasive procedures. The fertility drugs used to stimulate ovulation either alone or in association with these procedures are available only through prescription, and require almost constant monitoring which serves to increase costs associated with these procedures. Social scientists note that the Western female body historically has been especially prone to regulation and surveillance, a form of social control, by medical technology (Reissman 1983).

These interventions are perceived as requiring specialized knowledge to be safely and successfully performed. Even artificial insemination, which can be and is performed outside of the medical arena (Wikler and Wikler 1991), is required to be administered by a physician or someone under a physician's supervision by the majority of states' statutes covering this technology (Andrews 1988). At its simplest, the procedure involves taking semen and inserting it into a woman's vagina by using a syringe or cervical cap. More technology can be applied by having the semen inserted directly into the uterus and/or having the semen prepared beforehand through centrifuging (known as sperm washing) or adding additives to increase motility.

The United States is a capitalist country with a market-oriented economy. Consequently, capitalism affects how infertility is medicalized. This is particularly visible in consideration of how a reproductive market centered on technology has developed, and how the organizing of the delivery of infertility services and reproductive technologies reflects to their embeddedness in a market system.

Under advanced capitalism, health care is a commodity. The health care system was initially based on a free market model in which self-employed private physicians charged a fee for each visit by a patient. Efforts to control the cost of health care have led to the proliferation of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and managed care systems run by managers and not physicians in complex arrangements. Today, physicians are more likely to be employed by HMOs or PPOs under contract to insurance companies. Insurance, either public or private acquired through work, helps many Americans pay their medical costs. Reproductive medicine to enhance fertility is generally not covered by insurance because it is considered to be elective, relevant to only a small proportion of consumers, has low success rates, and is not necessary for health. This idea is currently being challenged under the argument of redefining of infertility as a disability, and is subject to ongoing philosophical and ethical discussion on whether being able to bear children is a right or a privilege.[7]

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[7] On May 5, 1997, a US District court in Chicago ruled that infertility fits the definition of a disability, and thus is subject to the antidiscrimination enforcement under the Americans with Disabilities Act.

The high costs of using technological interventions are infrequently subsidized and are borne largely by the patient. Fertility treatments can be considered a type of "boutique medicine" in which access is governed by ability to pay. From an economic standpoint, there is not an incentive to develop treatment interventions that may be less costly, as the current market creates sufficient demand and is quite lucrative because people are willing to pay "out-of-pocket". A recent industry report estimated that the market for reproductive technology products and procedures is expected to grow at an annual average growth rate of 6.5%; in 1998, the market was $6.5 billion (Business Communications Company 1998).

The cost of the interventions are high for a number of reasons: in addition to the time and expertise of the physicians, to perform these interventions requires employing technicians that have been specially trained and additional support personnel to perform tests and monitoring; the equipment necessary to perform these procedures successfully, such as CO2 incubators and special IVF media, are expensive and in most cases, the research to develop these technologies was not subsidized by tax dollars[8] so investors want to recoup their investment.

The demand for these high tech interventions has increased because, while the overall percentage of infertility has declined (Abma, et al. 1997), the proportion of the population who have delayed childbirth (thus encountering more fertility problems later in the reproductive cycle) are members of the more affluent upper and middle-class who

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[8] U.S. abortion politics have resulted in a decades-long ban on federal funding for human embryo research; thus, most of the science that underlies ART has been done with private money and out of the public eye. See Boonstra "*Human Embryo and Fetal Research: Medical Support and Political Controversy*" and Wertz "*Embryo and Stem Cell Research in the United States: History and Politics.*"

account for the increasing numbers of office visits in the last 30 years (Greil 1991). In addition, there has been an upsurge of professional interest in infertility and an increase in the number of specialists. Privately funded scientific discoveries have set the pace for preferred treatment modalities (Marsh and Ronner 1996), as well as increasing the scientific prestige of the disciplinary field. The number of infertility clinics and centers has been increasing steadily as well.

Many of these centers are free-standing (unaffiliated with a university) for-profit enterprises which have minimal oversight and regulation. With the exception of the 1992 Fertility Clinic Success Rate and Laboratory Certification Act,[9] the United States has not established federal legal regulations for assisted reproductive technology; this field is totally dependent for regulation on state laws and independent regulations established and adopted by associations of medical specialists. Some consequences of an unregulated free market environment for the marketing of reproductive technologies is that providers can command high prices under the economic dictum of what the market will bear, and they can set their own policies for screening. Individual clinics and fertility centers can decide on policies as to who can receive treatment based on both clinical and social characteristics. Clinical characteristics such as age and infertility factor can affect the success rates of treatments. A clinic could reject a couple with a particular reproductive history as being a bad risk, meaning that their acceptance into treatment could ultimately lower the clinics overall success rate. Social characteristics which clinics can (and do) use

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[9] This act was passed after charges that some IVF clinics were advertising misleading success rates. The Act asks that clinics voluntarily report success rates (using standardized definitions) and other data. The Society for Assisted Reproductive Technology (SART), collects that information and sends it to the Centers for Disease Control and Prevention.

as criteria include the ability to pay, being married or in a stable relationship, and sexual orientation (Daniels and Taylor 1993). These type of criteria reflect social concerns and prejudices of the mainstream population as to who is considered to be a proper parent (Shore 1992) and, attendant to the links between medicalization and social control, these clinics could be characterized as gatekeepers and moral guardians because they have the authority to refuse to treat candidates they judge as "unfit" (Mamo 2002).

Another consequence, due perhaps to the lack of regulations, is that the process of routinization (the movement of experimental technologies into normal procedures) for reproductive technologies is accelerated. Routinization creates a moral imperative to use the technology (Koenig 1988) which, in the case of reproductive technologies, is exacerbated by the extraordinary emphasis placed on bearing a genetically related child. The high cost of technological interventions is justified under the compelling argument that when it comes to having "your own child" (and conquering infertility), no cost is too great.

The fourth mode of medicalization, medical surveillance, is the extent to which the condition or event is viewed from a medical perspective. Conrad articulates this as occurring when "certain conditions or behaviors become perceived through a "medical gaze" and that physicians may legitimately lay claim to all activities concerning the condition" (Conrad 1992, p. 216). The current understanding of infertility relies mainly on anatomy, physiology and endocrinology. Thus the context in which to understand infertility, and consider ways to deal with it, is essentially medical. The focus on physiological, specifically endocrinological, characteristics simplifies the infertility experience to a purely physical phenomenon while minimizing the psychological, emotional, social and cultural changes that can affect fertility. This process of bodily reductionism further emphasizes the Cartesian duality of the mind and body so prevalent in Western medicine. The very narrow focus on physical aspects of the condition also serves to remove infertility from its social context. Infertility is medicalized in the sense that it is looked at through the lenses of disease and capitalism. Other social solutions that would result in a non-genetically related child – such as adoption or fostering - are not promoted and are regarded as second or third-class alternatives to consider only after medical solutions have been sought and failed.

The increasing level of surveillance and control of bodies in society is what Foucault refers to as "bio-power" (Foucault 1979). Infertility under the medical gaze requires intensive monitoring of individual bodies, especially female bodies as the bulk of treatment interventions is on women, even in cases of male infertility. Self-monitoring begins with daily temperature-taking so as to create basal body temperature charts, a way of ascertaining ovulation and if ovulatory cycles vary from the norm. It continues with both self-monitoring and monitoring by clinicians as one continues up the technology ladder.

In addition to bodies, what are being ultimately controlled are the reproductive processes. In the treatment of medicalized infertility, reproductive processes are manipulated and altered according to the requirements of the technology. So, in some respects, infertility has also been industrialized as well as medicalized. Industrialization of reproductive processes, according to Clarke, is a way to maintain a high degree of control over reproductive processes through rationalization, standardization, efficiency, planning, specialization, professionalization, commodity and technological development, and profitability (Clarke 1995).

Armstrong puts forth the idea of surveillance medicine which is the twentieth century consolidation of the "reductionist clinical gaze" and its extension beyond the confines of the clinic and the individual body into social spaces and spheres (Armstrong 1995). Any individual who has the potential to be ill (in other words everyone) falls under the purview of surveillance medicine, dissolving the boundary between the sick and the healthy. In this way, surveillance medicine also problematizes normality, and redraws the relationship between symptom, sign and illness. These changes affect the way we think of the body, and how we think about and confront illness. Surveillance medicine could be seen as a convergence of Foucault's view of the body as "something docile, that could be surveilled, used, transformed and improved" with medicalization (Armstrong 1995).

Surveillance at the level of populations for infertility has not begun in earnest except for the reproductive industry identifying potential new markets. It is predicted that the market for a vast array of diagnostics to assess fertility status and potential causes of infertility in men and women will increase concomitantly with the growing market for infertility treatment. More specific tests that determine precisely the cause of infertility and thereby allow the possibility of treating these causes will be emerging into the marketplace (Business Communications Company 1998).

The trajectory of medicalization of infertility is firmly set in place. However, the process of medicalization has differential impacts on groups because of varying social location and relation to modes of medicalization. I would now like to specifically consider some aspects of the medicalization of infertility and people of color.

Medicalization and People of Color

The first area that I will review is medical ideology and the media. Medical ideology, communicated through medical discourse and disseminated with the collaboration of the media, is not neutral. Behind the façade of scientific objectivity, it is reflective of relationships of power. Medical ideology depends on concepts that are both racialized and gendered. In nineteenth century America, medical authority and science were used to bolster political and ideological views in which men - White, middle class men - were considered to be the norm. The health of others - non-Whites, women - was ignored because of indifference and lack of interest (Krieger and Fee 1994). So essentially, the medical model of human functioning is predicated on a male, White, middle-class norm. Those varying from this norm are viewed from a "natural pathology" medical gaze as biomedicalizable objects.

The choice of which health problems are studied and the funding allocated to the research reflect the bias towards those in power, the dominant group – White males (Rosser 1994a). This corresponds with Turner's argument about the continuing dominance of certain classes and interest groups in the decision-making process relating to the development and maintenance of health care systems (Turner 1995a). This bias results in research on conditions specific to non-Whites and females accorded low priority, funding and prestige; however, resources and attention paid to women's health is “directly related to men’s interest in controlling the production of children” (Rosser 1994a, p. 7).

However, a point I want to make is that people do not necessarily receive the information and ideologies communicated through medical discourse passively. Individuals can accommodate, resist, and even recode/reinterpret the meanings found in this discourse. A related point is that people’s relationships to the discourse may be multiply inflected and open. In her historical work on medicalized motherhood, Litt demonstrates that the relationships of women of color to medical discourses are different from those of Protestant, White, native-born middle-class women on whose lives, practices and identities the discourse most seamlessly sits. She argues that "medicalized discourse, despite the openness claim for it by the ideology of popular science, offers an example of guarded boundary that secures a space and establishes its meaning as it reflects and reproduces social divisions" (Litt 2000, p. 107). With this in mind, I contemplate media portrayals of infertility to ascertain what social divisions are being reproduced.

Media Portrayals of the Infertile

As mentioned above, popular media are informal informational channels, and people commonly get all types of information from the media. We must remember that all types of information, including that of a medical and scientific nature, are constructed and “reproduced in the context of particular political, social, and economic conditions and is thus in no way purely objective” (MacPherson 1981, cited by Zamecki 2001). The media will, in its role as collaborator, not only validate medical discourse, but may also perpetuate its underlying ideas such as the medical norm being a White middle-class male. With regards to reproductive matters, the androcentricity of the medical model must be adjusted by necessity, but the uncritical acceptance of other attributes persists. So when I consider media portrayals of the infertile, beyond what I have noted above, it is logical to expect that they will be White and affluent. People of color and low-income individuals are rarely visible in depictions of infertility and of those who use reproductive technology. The media present a unitary portrait of infertile couples that is racialized White. For example, the subjects of the newspaper accounts and the TV specials noted earlier did not include any people of color.

When Jocelyn and Gerard discovered that they were infertile, there was an initial rejection of the label because of its association with a particular racial and economic group. They had read about infertility but they conceptualized the condition as something that happened to people unlike themselves – she is Pacific Islander and he is Black – despite the fact that they were both past their mid-thirties.

Jocelyn: I also thought it was strange for us to have -- to have that kind of problem. You know, I just felt like people in my family don't have infertility problems. They can't relate to it. In fact, you know people in my family might be accused of trying to you know –

Gerard: Populate the world! (laughter)

Jocelyn: -- yeah. And so, it's really hard to put yourself in this category which I think is, you know predominantly White –

Gerard: Upper class, middle –

Jocelyn: -- American that you read about.

Overall, the portrayals are indicative of raced and classed prescriptions regarding who can use and who are empowered to engage in technological practices. The appropriate consumer of reproductive technologies is one who matches the attributes of people who have historically been judged to be a fit parent – preferably one who is White, is economically stable and adheres to middle-class standards of behavior (Collins 1999).

Within the US cultural context, the ideals of self-control and self-discipline are evident in the discourse (Sacks 1996) of who is deserving of access to these technologies. In 1994, it came to the media's attention that some states had fertility drugs on the list of Medicaid-approved medications, provoking a storm of controversy and pointed comments by conservatives. In eleven states, Medicaid then provided funding for two commonly used fertility drugs, and in three states, for reversal of tubal ligations and vasectomies (Beck 1994). Although Medicaid recipients can include people making less than a living wage, or who are between jobs, the outcry was framed in terms of welfare mothers using government money to try and get pregnant, thus creating more welfare babies. The subtext is that of who is deserving of becoming a parent, with socioeconomic stability based on middle-class referents being one of the criteria of both fitness and worthiness. I myself was told by a medical office staff member, when researching the demographic makeup of an infertility clinic's client base, that "if they can't afford the treatments, they can't afford to have a baby." The emphasis here on material and economic resources carries the implication that raising a child in less then "comfortable" circumstances was unfair to the child.

There were a few exceptions to the standard raced portrayal of infertility. A notable one was Connie Chung, a very visible news anchor for one of the major television networks. When Ms. Chung, a Chinese American woman, announced that she would be cutting back her schedule so she could accommodate infertility treatments, her decision was highly publicized. It was also debated in women's magazines (1991a), served as fodder for the tabloids, and even parodied in a song (with racist overtones)(WWOR 1990).

From 1989 to 1995, every year or so, an article about infertility would appear in magazines targeting the African American market such as *Essence* and *Ebony*. The stories focused on how infertility affected the African American family, and did not seem as overtly laudatory of technology, though care was taken to mention the few Black owned sperm banks and Black reproductive endocrinologists in the United States (Spedalle 1989; Burns 1990; 1991b; Abdullah 1991; Southgate 1994; Burns 1995).

I couldn't find any articles about infertility in media targeting English-speaking Asians or Latinos, and at the time of data collection, I was not aware of any Spanish language media (TV, radio, newspapers, and magazines) that discussed infertility. A marital advice columnist in one Spanish-language magazine had the opportunity to bring up the topic due to the nature of the question asked, but did not. A married couple in their thirties wrote in seeking advice because the man wanted to have children and the woman still wanted to wait. Although the columnist reviewed the pros and cons of having children, she neglected to mention infertility as a potential difficulty if a woman delayed childbearing (Falicov 1996). When I was a guest on a Spanish language radio talk show during recruitment, the women who called in were hungry for knowledge. They were vaguely familiar with a few procedures, for example artificial insemination, but did not differentiate between insemination with donor sperm and insemination with husband sperm. They asked me if supposed aphrodisiacs such as eating oysters would help with fertility and seemed to have just a rudimentary knowledge of the more complex aspects of the reproductive cycle.

There was such a dearth of information available about infertility, or of models of how other people of color dealt with infertility, that couples in my sample grasped at whatever they found available. In her interview, Jocelyn referred to a foreign language film about a Chinese infertile couple which depicts the stigma and shame attached to being unable to reproduce, and the importance of family.

> Jocelyn: ...I don't know if you ever saw that movie Eat a Cup of Tea?...It's a Wayne Wang movie. And it's about an infertile couple and how they go about it ... Actually, if you don't have any Asian couples in your study, I think that sort of gives you some insight just in terms of how the Asian population looks at family, and how shameful it is not to, you know, to be able to conceive, and you know I think ... it actually, even though it's somewhat of a light comedy ... It's a very definitely a serious topic. You know, some grain of truth to it.

The next area I would like to contemplate is the market and technology, with a few side comments on the relationship of 'race' and technology. As mentioned earlier, interventions featuring biomedical technology are favored by the medical establishment as a result of their mechanistic view of the human organism and engineering approach to health. For the medical consumer, high tech medicine usually represents progress and is a symbol of quality medicine. However, the adoption of high tech interventions significantly raises the cost of treatment. In a system in which health care is a commodity, quality medical care is premised on the ability to pay. While some level of medical care must be given to all in order to maintain a viable workforce, technological innovations which enhance fertility are reserved for those who have economic assets.

There are both economic and philosophical assumptions underlying this stance. Donchin argues that this distribution of medical resources should be considered as a way of perpetuating the capitalist system by maintaining inequality of wealth, services and rights (Donchin 1993). In this scenario, the poor shouldn't have children as their contribution to society will be less than that of a child born to wealthy parents. This perspective reflects a marginal productivity theory of income according to which a person's position in the income distribution largely reflects that person's contribution to society. Wealthy persons "deserve" better housing, education, justice, and health care than do persons of lesser means because it is their reward for their superior social contribution. As there is a higher proportion of people of color found within the lower economic strata of American society (U.S. Bureau of the Census 1997), the implications of this position for people of color are clear.

If we look at how the market for reproductive technologies has emerged in the United States, we notice that when treatment was not reliant on high tech interventions, access to low income couples was made available, although there were geographic limitations. During the period between World War I and World War II, access to fertility services was limited to the large metropolitan cities in which specialists were located. However during this period, there was also an increase in the number of free or low-cost infertility clinics (Marsh and Ronner 1996). With the rise of more invasive technological interventions and a changing biomedical landscape, this option disappeared. As Marsh and Ronner point out, "For the first time since infertility treatment became available … those without substantial financial resources are excluded from advanced therapies … since the 1970s, it has been left up to individual researchers and practitioners to decide what techniques are acceptable and appropriate, to set their own standards for determining success, and to charge whatever fees they either believe fair or think the traffic will bear" (Marsh and Ronner 1996, p.253).

Infertility services have undergone a particular type of industrialization in which the technologies have not been made available to the mass market but are a type of medical luxury good. Despite the accessibility of services to a smaller segment of the population, there has been an expansion and commercialization of reproductive technologies. The end product of assisted reproductive technologies is highly valued by individual consumers because it represents a fulfilled aspiration - genetic offspring. But I would also add that on a societal level, the end product of a baby is more highly valued when that baby has the attributes of those who retain economic power and social prestige. Race and class are implicated here in that a paramount value in Western society as it pertains to infertile women consists of being able to reproduce the right kind of babies – White babies who will have the middle class upbringing believed to enable them to become productive members of society (Collins 1999).

The access to and distribution of reproductive technologies in a market economy requires us to take a closer look at the ideology of choice which is upheld as a benefit of living in a capitalist society. According to López (1997), the "ideology of choice" is based on the assumption that people have options, that we live in a "free" society and have infinite alternatives from which to choose. The focus is on individual agents making choices from an array of options presented as accessible and viable. This focus on the individual obscures the fact that choices are shaped by larger institutional structures and ideological messages. In her work on women's decision making about sterilization, López concluded that reproductive decisions are based on a lack of options circumscribed by a myriad of personal, social and historical forces that operate simultaneously to shape and constrain fertility options. Moreover, it is not simply a matter of the alternatives individuals have available to them but also the perceptions or knowledge individuals have about the various alternatives that are available to them (López 1997).

The way infertility is currently treated and reproductive technologies are deployed can be considered "consumer eugenics." Hilary Rose originally coined this term in her analysis of how genetic testing is presented to potential users (Rose 1994). Under the guise of offering greater reproductive choices, in practice the options available and to whom they are available actually enables the reproductive capabilities of a select group of people deemed more valuable. This resonates with Adele Clarke's observation that contemporary moves to eugenics will look less like (Huxley's) Brave New World's state control and more like niche marketing and consumer choice (Clarke 1995 cited in Mentor 1998, p. 83).

While technology itself can be neutral, it is inevitably embedded in social, cultural and political frameworks which lend meaning to the technology. Writers in the sociology, history and philosophy of technology have demonstrated how artifacts and technical systems transform and become transformed by the social structures and cultural practices in which they are embedded (Bijker 1995; Sclove 1995). Rosen and Rappert make a point which I think is relevant to reproductive technologies; they argue that it is through the design and deployment of technology that it comes to reflect "only certain interests and constituencies, whilst others experience technology as something outside their control, as something which reinforces social exclusion and marginalization" (Rosen and

Rappert 1999, p. 19). This is certainly true for reproductive technologies in the way that they are marketed and presented to the consumer.

The gendering and racializing of technologies are the products of barely visible processes by which certain characteristics are assigned - culturally, institutionally and materially - to particular artifacts. A variety of means exist by which technologies are marked racially, in ways which can both include and exclude particular groups (Martín 2000). Accompanying this process of racializing is the sanctioning of particular types of users.

Technology, when referred to today, is not used with the root meaning use of tools but has taken on the veneer of science, of progress, of high modernity. This contrasts with the attributes associated with people of color – the primitive, the savage, and nature. The association of people of color with nature can be traced back to contact, colonization, and the age of Enlightenment in the eighteenth and nineteenth centuries (Mies 1994). While paralleling the development of the notion that women were closer to nature than men (Ortner 1974), it took a different turn in trying to provide scientific justification for the subjugation of colonized peoples. As part of scientific racism, Social Darwinism developed by Spencer in the second half of the nineteenth century posited that "survival of the fittest" was the selective mechanism by which "superior" societies evolved from lower ones (Harris 1968). Asian, African, and other Native peoples in the colonies were judged to be on a lower stage in the evolutionary process, and thus more primitive.

While we have, as a society, largely rejected these views, traces still persist in ideas of who is an appropriate user of technology. In recruitment for this study, I encountered the opinion that people of color were not as amenable to the use of technology. The starkest example was that of a physician who flatly told me that Native Americans would not use reproductive technologies. He did not offer any supporting facts (or even anecdotes) to support his statement. I attributed his comment to the widespread stereotypical (and romanticized) belief that Natives are closer to nature (Berkhofer 1978). While it is true that most indigenous cosmologies and philosophies teach a different relationship to nature and the physical world than that of the "West", this does not mean that Natives will reject technologies indiscriminately. Rather, I would assert that the manner in which they incorporate technologies into their lives and bodies is perhaps more conscious, critical, and reflective.

The Epidemiological Paradox of Infertility

I would now like to turn my attention to the surveillance mode of medicalization by examining the epidemiological paradox of infertility. The paradox I refer to is that the profile of those afflicted does not match the profile of those receiving treatment.

Epidemiology studies the distribution of disease within a population by quantifying disease, measuring how often it occurs and to whom. Epidemiologic surveillance refers to the dynamic, close, and continued watchfulness over the distribution and trends of disease occurrence. Ostensibly, this data is used by the field of public health to better plan where resources should be directed for both treatment and prevention. From a social control perspective, this need for constant measurement provides a rationale for monitoring a population. Key to this enterprise is precisely defining disease so you have something measurable and can determine what can be judged to be a case. The medical establishment, broadly conceived, maintains the power to define the diagnostic criteria for a disease. Another way of looking at this power is the ability to determine who or what is “deviant”. When an entity is defined as something which differs from the biological norm, it can gain a social definition as well which is based on other than diagnostic criteria. This is apparent when one realizes that the social definition of reproductive dysfunction as either a problem that needs attention or a non-issue, applies to certain groups of people differently, depending on class, race, ethnicity, marital status and sexual orientation. Rosser makes the case that “women of color have become the target for particular aspects of women’s health research...issues of social concern or social problems” (Rosser 1994b, p.98). For example, Black teenage pregnancy is considered a problem even though the frequency of pregnancy among Black teens has declined (Collins 1994 cited by Rosser 1994b, p. 91) Similarly, substance abuse during pregnancy has been identified as a problem even though researchers for the most part rely on public clinic samples which are not representative of the population as a whole (Litt and McNeil 1997).

The definition of medical infertility used in the United States is applied to heterosexual couples with wives 15 to 44 years of age who have 12 or more months of intercourse without contraception and don’t become pregnant.[10] "Impaired fecundity” means that a woman reports that it is difficult or impossible to conceive a baby or difficult or impossible to carry it to term (Mosher et al, 1990). The former is claimed as an objective measure and the latter is deemed a subjective one. In common usage,

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[10] Excluded in this definition and rates are single women and lesbians.

infertility encompasses impaired fecundity. Using this definition, one American couple out of 10 currently experiences trouble getting pregnant.[11] Wagner and Stephenson point out that fertility is a continuum that changes over the lifetime, not an absolute state (Wagner and Stephenson 1993).

There are claims that the rate of infertility in the United States is as high as 20 percent but usually no information is given as to where this number comes from, what age range it is including, and whether it is referring to an incidence rate, indicating the probability that individuals will become infertile during a specified period, or a prevalence rate which provides the number of infertile individuals in the population at a definite point in time. As has been reiterated elsewhere (Faludi 1992; May 1995), we as a nation are not experiencing an epidemic of infertility. In fact, the rates have remained fairly consistent (Office of Technology Assessment 1988; Chandra and Stephen 1999). However, the number of childless women aged 25 to 44 years of age has increased. This is not due to an epidemic of infertility, but rather because of delayed childbearing into ages where a woman's and her similarly aged partner's fertility is more likely to decline. Because the tendency to delay childbearing is more pronounced among those with greater education and educational attainment, the trend toward an increasing proportion of cases of primary infertility is occurring primarily among the White middle class (Greil 1991).

Overall, infertility is more likely to be found among minority and working-class populations (Hirsch and Mosher 1987). Before 1995, there were no national statistics on infertility status for other than African American and White married women. The

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[11] This estimation is based on the results of the National Survey of Family Growth which is designed to provide information on childbearing, factors affecting childbearing (such as contraception, sterilization and

incidence of infertility for people of color was really unknown; however it had been argued by myself and others that women of color could be expected to have higher rates than White women based on extrapolating from a number of factors: differential rates of sexually transmitted diseases (STDs), pelvic inflammatory disease (PID), use of intrauterine devices (IUDs), and exposure to environmental hazards.

The relationship between STDs, pelvic inflammatory disease and infertility has been apparent since the last century (Brandt, 1985). Together, STDs and PID cause about 20% of infertility, usually through scarring a woman's Fallopian tubes not allowing the passage of sperm or ova. For some time during the "sexual revolution" of the 1960s and '70s, physicians did see higher incidence of infertility caused by tubal blockages left by untreated venereal diseases such as gonorrhea and chlamydia. But this trend seems to have reversed since the appearance of AIDS has encouraged the adoption of barrier methods of contraception, which prevent most venereal diseases. There is a higher incidence of both STDs and PID among African-Americans than among non-Latino Whites (Aral et al, 1985). Gonorrhea and chlamydia together account for the majority of reported cases of PID (Rice and Schachter 1991). Unlike gonorrhea, the reporting of chlamydia infections is not mandatory so estimates of incidence are based on surrogate measures. Consequently, no data exists on the frequency of chlamydia infections in different populations, though we know that African-Americans account for a large percentage of the reported gonorrhea cases (Moran et al., 1989).

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infertility), and related aspects of maternal and infant health on a population level.

Intrauterine devices, especially the Dalkon shield, have been shown to be associated with infertility through increasing the likelihood of PID (Cramer et al, 1985). Groups who have higher than average use of IUDs are African-American, Latino, formerly married, less educated and low income women (Mosher et al, 1990a). Historically they have been targeted end-users of "imposable" means of contraception such as IUDs, Depo-Provera and Norplant (Clarke 2000).

Finally, people of color are more likely to be in positions in which there is exposure to hazardous chemicals and environmental hazards because of labor market segregation that follows racial and ethnic lines. For example, agricultural work, which is highly stratified in the United States, has been associated with infertility (Fuortes, et al. 1997). As well, African Americans and Latinos have been shown to have greater residential exposure to toxic wastes due to environmental racism (Lillie-Blanton, et al. 1994).

The 1995 cycle of the National Survey of Family Growth collected information on infertility status from Asian, Native American and Latina women , as well as African American and White women. The results were as anticipated: taking impaired fecundity and infertility together, the highest rates were found among "Other" (comprised of Asian, Pacific Islander, Alaskan Native and American Indian women), followed by African American, Latina and White women (Abma, et al. 1997). These demographic facts of the extent and causes of infertility are ignored in favor of a construction that emphasizes White women of the upper middle classes who have postponed childbearing until their thirties (Marsh and Ronner 1996).

It is estimated that less than 2/3 of heterosexual couples experiencing difficulties conceiving seek medical help, and those who do seek treatment for infertility are not representative of couples who are infertile (Kalmuss 1987; Templeton, et al. 1991; Wilcox and Mosher 1993). Those who seek help tend to be well-educated, older and with a higher-than-average income (Templeton, et al. 1991). In reporting these findings from the literature, I use the same phrase and concept found in the literature – help-seeking. However, I have misgivings about the term "seek treatment" because it implies that some people don't seek treatment by choice. This obscures the micropolitics of access to services and endorses the rhetoric of choice discussed earlier. Among the people supposedly not "seeking help" are those who would like to get treatment but are perhaps constrained by their economic situation, by lack of knowledge, and difficult access. This group may also include those who have truly made a choice not to get treatment from Western biomedicine – possibly because of religious reasons, or mistrust of the medical system.

Infertility Services

I would like to consider some of the data from the 1995 National Survey on Family Growth cited above as it also includes information on what infertility services were received and by whom. The spectrum of services accounted for ranges from asking medical personnel for advice to having diagnostic tests performed up through receiving interventions of assisted reproductive technologies such as IVF. Services received from practitioners of non-Western medicine such as herbalists, acupuncturists or other healers are not included.

At each step along the continuum of services, the numbers of women who receive them drop; but among those women who are less-educated, low-income and non-White the decline is sharper. For example, referring to Table 2, while 7% of White women, 5%

Table 2: Percent of women aged 15-44 who have ever received fertility services, by selected characteristics, United States 1995[12]

	Any Services[1]	Advice	Tests on man or Woman	Ovulation Drugs	Surgery or treatment for blocked tubes	Assisted reproductive technology[2]
Education at interview[3]						
No high school diploma or GED	14.9	3.3	2.0	1.2	0.7	0.2
High school diploma or GED	20.0	7.8	4.9	3.9	2.0	1.1
Some college, no bachelor's degree	19.4	7.8	5.6	3.3	2.0	1.2
Bachelor's degree or higher	18.0	10.3	7.1	5.3	1.9	2.2
Poverty level income at interview						
0-149 percent	16.6	4.8	2.1	1.5	0.9	0.2
0-99 percent	14.2	4.0	1.7	0.9	0.5	0.1
150-299 percent	17.9	6.3	3.9	3.1	1.4	0.6
300 percent or higher	20.0	10.3	7.6	5.3	2.5	2.2
Race and Hispanic origin						
Hispanic	13.4	4.9	2.4	1.7	0.9	0.2
Non-Hispanic white	16.3	7.2	4.9	3.5	1.6	1.2
Non-Hispanic black	13.0	3.8	2.2	1.4	0.9	0.3
Non-Hispanic other[4]	12.3	5.0	3.9	2.9	1.9	1.4

[1] Includes services to help get pregnant as well as to help prevent miscarriage

[2] Includes artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and other techniques not shown separately

[3] Limited to women 22-44 years of age at interview

[4] Asian, Pacific Islander, Alaskan Native and American Indian

NOTE: Percents do not add to total ever receiving 'any services' because some women reported more than one service

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[12] Information in table derived from Table 55 in Abma, J., A. Chandra, W. Mosher, L. Peterson and L. Piccinino, Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey on Family Growth. vol. 23, no. 19: National Center for Health Statistics, 1997.

of Latinas, and 4% of African-American women receive advice, it is 5% of White women, and only 2% of Latinas and African American women who undergo diagnostic testing. These racial/ethnic differences are not wholly accounted for by socio-economic status. These particular services – advice and diagnostic testing – are at the less invasive end of the spectrum and are supposed to be available through low-income reproductive health clinics which receive federal funds under the terms of Title X of the Public Health Service Act (Department of Health and Human Services 2001). However, as not all clinics have the personnel or laboratory facilities available to offer these services, there may be long waits or pre-authorization required to access these services. Henshaw and Orr estimate that Medicaid reimbursement for fertility services is available to no more than one third of the women who request these services (Henshaw and T. Orr 1987).

What is clear from the epidemiologic data is that those population groups with the highest rates of infertility are those least likely to receive treatment. The reason for this is not simple but is a result from the combination and interaction of factors alluded to above: the nature of the emergence of reproductive technologies as the favored intervention for infertility, the characteristics of a for-profit health system, the invisibility of people of color, and the persistence of stratified reproduction. This configuration has changed little from the mid 1950s where the focus on the educated White middle class also ignored the plight of the poor and people of color, who had the highest rates of childlessness, owing to poverty and poor healthcare (May 1995; Marsh and Ronner 1996).

Becker asserts that the current system of delivery of reproductive technologies maintains the status quo in that it works in favor of White middle class heterosexual couples (Becker 2000). Low income people are not a viable market for high-priced technologies, and people of color are too far away from the mainstream norm. No effort is made to market technologies to them, plus the technologies currently promoted are more appropriate for the segment of the population that has delayed their childbearing. Becker cites Angela Davis in noting that "anchoring these technologies to the profit schemes of their producers and distributors results in a commodification of motherhood, a process that complicates and deepens power relations based on class and race" (Davis, 1993 cited in Becker 2000, p. 237).

The invisibility of low income and people of color in both medical and media portrayals of infertility and reproductive technologies bolsters the perception that infertility is not a problem for them, and if it is, that technological intervention is not for them. It could be true as Rosen and Rappert imply, that when people experience technology as something outside their control, they are disempowered to use it (Rosen and Rappert 1999).

Stratified Reproduction

I would like to spend some time discussing stratified reproduction, as it is key to my interpretative framework for this project, and provides an entry point into the historical review later in this chapter. The theory is more fully detailed in Chapter One, but the main point is that some categories of people are empowered to nurture and reproduce while others are disempowered (Ginsburg and Rapp 1995), that some women's fertility is valued and that of other women is devalued. I contend that in the contemporary United States, the reproduction of low-income and people of color is not valued and the reproduction of low income racialized individuals is actively discouraged. Elaine Tyler May, in her history of childlessness, supports this notion in her summary statement that: "… institutional practices [medical, legal and social service] either support or hinder … efforts to achieve reproductive self-determination. Generally speaking, those who are White and affluent have found public institutions to be helpful if their goal was to have children, but hostile if they wished to remain childless. The poor and non-White have been less likely to gain access to infertility treatment and more likely to face involuntary sterilization" (May 1995, p. 9).

To differing degrees, the participants in this study were attuned to the attitude that they and their desired children were less valued, and this affected the meaning placed on their quest for a child. At the time I conducted the research (1992-1996), the socio-political environment in which my respondents were negotiating their infertility was hostile to people of color and low-income individuals. There were multiple ongoing policy debates and cultural commentaries about welfare reform, immigration, affirmative action, youth crime, and family values which implicitly and explicitly communicated that some people were not wanted as full United States citizens with reproductive rights.

The subtext for many of these debates was who was an appropriate reproducer. This was particularly evident in the rhetoric of welfare reform and immigration. The rhetoric about welfare recipients reinforced notions of parental fitness which view the poor and some ethnic minorities in particular as unfit parents. This perspective informs a pronatalist ideology which touts motherhood as "the quintessential compulsory female experience" (Herman 1988, p. 152), unless, of course, one happens to be an immigrant, or a recipient of welfare. Nsiah-Jefferson and Hall argue that the underlying theme of many federally funded health programs is that it is the duty of the poor to have "fewer children who might possibly need governmental services" (Nsiah-Jefferson and Hall 1989, p. 103). With welfare reform came the revisioning of the poor, single mother as the obstacle to social progress in the Black community (Davis 1993), the source of "overbreeding" so as to reap additional AFDC (Aid to Families with Dependent Children) benefits, unworthy mothers (Roberts 1997a), and in one of the more extreme rhetorical flourishes, as a "national security issue" (Hartmann 1998, p. 113).

The debates in California were particularly acrimonious in reaction, perhaps, to the state's changing demographics. In the 1990s, the state underwent a demographic shift in which the percentage of Whites decreased while the percentage of Latinos and Asians increased (State of California and Department of Finance 2001). Historically, when there have been sharp fluctuations in demographics (usually caused by increased immigration), there has been a corresponding resurgence of nativism and xenophobia. The changing demographics of the United States, led by California, was seen as a threat to national identity as evidenced by then presidential candidate Pat Buchanan's 1994 alarmist statement that "A non-White majority is envisioned if today's immigration continues," (Buchanan 1994) and the 1995 publication of Peter Brimelow's *Alien Nation* which denounced America's immigration policies. Immigrant women were seen as particularly dangerous as they could potentially give birth to non-White citizen children. The rhetoric used by anti-immigration groups such as Negative Population Growth, the Federation for

American Immigration Reform, and the California Coalition for Immigration Reform all emphasized the threat of immigrant women reproducing.

In California, a legislative response was the passage of Proposition 187 in 1994 which denied social services, including prenatal care and education, to undocumented immigrants. As part of the campaign to pass 187, the high fertility rate of Latinas was stressed and the statistic that "Two out of three babies delivered at Los Angeles county hospitals were born to undocumented women" was widely publicized (Roberts 1997b, p. 209). A prior proposal in 1992 by California Representative Elton Gallegly for a constitutional amendment which would deny citizenship to children born in the United States to undocumented parents, however, was unsuccessful. Pease Chock examined Congressional testimony on immigration reform and points out how expressed concerns over the fertility of immigrant women's fertility and production of babies (and thus citizens) equates natural processes of reproduction with subversion (Pease Chock 1996).

Constrained Reproduction

The acrimony against people of color reproducing that surfaced in the early 1990s has deep historical roots. I want to uncover these roots by briefly reviewing the history of constrained reproduction of Native Americans, African Americans, Asian Americans, and Latinos in the United States. By constrained reproduction, I am referring to the constraints placed on people of color's ability to perform physical and social reproductive tasks by social policies, institutional arrangements and ideological constructions (Collins 1999). This review will focus on policies that were formulated to target specific groups, and policies which, while not group specific, had greater import for people of color and working class poor individuals.

Turner points out that regulatory processes of the body occur at various levels: at the individual level of a system of interpretation (phenomenology of sickness), at the level of social values and historical processes, and at the level of macro-societal processes (Turner 1995b). In the previous discussion of medicalization, I touched on social values and macro-societal processes, and here I hope to articulate some of the historical processes in preparation for the ensuing ethnographic exploration of the individual experience of infertility.

The eugenics movement in the United States flourished between 1900 and 1930. In 1903, Theodore Roosevelt placed reproduction at the center of the national reform agenda when he pronounced that Americans were committing “race suicide” referring to the declining birthrates of White middle class as compared to rising birthrates of immigrants. His proclamation paved the way for a widespread eugenics movement that “resulted in political, institutional, medical and legislative measures that encouraged some Americans to become parents but prevented others from doing so” (May 1995, p. 62). In 1904, the Laboratory for Experimental Evolution was founded at Cold Spring Harbor; in 1907, came the Eugenics Records Office. The aim of these was to increase the reproduction of “superior” races as well as to reduce the breeding of “inferior” ones. In the climate prevailing in the USA before and after World War I, positive eugenics meant greater reproduction of the White Anglo-Saxons and negative eugenics meant a reduction in reproduction of the “inferior” races, mainly of Blacks and immigrants (Mies 1994).

Advocates of compulsory sterilization believed that preventing the “unfit” from reproducing would be the most efficient and cost-effective way to solve social problems, and in 1927 compulsory sterilization laws were ruled constitutional by the Supreme Court (Marsh and Ronner 1996). Originally used for those determined to be feeble-minded living in institutions, compulsory sterilization laws post World War II began to be used to curb the reproduction of “poor women of color on public assistance”, opening the way for the sterilization abuse mentioned above. Concerns about the raising costs of welfare provided a rationale for attacks on the fertility of Black, Hispanic and Native American women (Reilly 1991) and as of 1982, twenty-four percent of African-American women, thirty-five percent of Puerto Rican women, and forty-two percent of Native American women (DeFine 1997) were sterilized. In the early 1970s, an estimated 100,000 to 150,000 low-income individuals were annually subjected to sterilization under federally funded programs.

A form of constrained reproduction which is often overlooked is the passage of English only laws which forbid the use of languages other than English in various arenas. Such legislation was part of Americanization efforts of the early twentieth century, and affected Japanese, Korean, and Chinese Americans, as well as Spanish and German speakers. Crawford argues that the painful experience of immigrant parents in Americanization programs has served to discourage them from teaching their children ancestral tongues (Crawford 1995). This may affect social reproduction embodied in the passing on of cultural identities through language (Fishman 1991).

Native Americans

The earliest policies in the United States were directed against Native Americans. After the American Revolution, there were almost continuous military campaigns waged against Native Americans in order to acquire their land or allow passage. Following the War of 1812, the policy was to move Native Americans (usually by force) onto set apart lands (reservations) so as to make room for White settler expansion. For many tribes, the reservations would not support their way of life and cultural traditions (Jaimes 1992). The Indian Wars of 1860-1890 constituted a period of bloody, violent subjugation of native peoples by military force, including massacres of women and children exemplified by Sand Creek, Marias and Wounded Knee.

In 1887, the policy of blood quantum was established under the provision of the Dawes General Allotment Act. If an individual could prove that they had one-half or more degree of Indian blood, they were entitled to receive an allotment of land. By government definition, if a person has less than one/32nd "pure" Native blood, then they cannot call themselves Native American (Churchill 1995). By this federal definition, a woman's children could lose their claim to their heritage, dependent on with whom she reproduces. To receive benefits under treaty law, natives must also be enrolled members of federally recognized tribes (Metcalf 1997).

In 1870, federally funded Indian boarding schools were established at some sites at which attendance was mandatory for selected groups. Some Native American children were taken from their parents, often forcibly, and placed in off-reservation boarding schools with the goal of assimilation through deracination (May 1995). The motto of the first official school, the Carlisle Indian Industrial School, was "Kill the Indian to save the man" (Adams 1995). At the boarding schools children were forbidden to speak their native languages, forced to shed familiar clothing for uniforms, cut their hair, subjected to harsh discipline, and kept from seeing their families (Coleman 1993; Childs 1998). In short, the boarding schools served as a means of disrupting the generational transmission of cultural values (Adams 1995). The schools lasted until the mid-1930s (although a few lasted longer), when the policy in some sites moved to placing Native American children with White foster families by state courts and public child welfare agencies (Jones 1997). By the 1960s, in some states with large populations of Natives (South Dakota, North Dakota, Washington, Wisconsin, Arizona, Minnesota, Oklahoma), 35% of Native children were being removed from their homes and culture by being placed with non-Native families (Mannes 1995, p. 267).

Throughout the 1970s there were incidents of coerced sterilization of Native women by the Indian Health Service. The period most well documented is 1973 to 1976 due to investigations started by an HIS physician who was approached by a 26-year-old American Indian woman who desired a "womb transplant." She had been sterilized when she was 20 at the Indian Health Service hospital in Claremont, Oklahoma; in the period studied, there were approximately 34, 000 women sterilized, 4-6 percent of the child-bearing population. The actual numbers could be higher as the study limited itself to just four service areas (DeFine 1997). Documentation can also be found in a study by the Public Health Service (Temkin-Greener, et al. 1981) and others (Hunter and al. 1984; Reilly 1991; Jarrell 1992; DeFine 1997; England n.d.). As early as 1986, the IHS administered Depo-Provera -- without informed consent and prior to FDA approval -- to

Native American women, including many who were mentally retarded (Native American Women's Health Education Resource Center n.d.).

African Americans

For African Americans, their history of reproductive constraints begins with their arrival into the United States as slaves with no reproductive autonomy. African slave women and their status as property intersected with their race in claims of their being "animalistically hypersexual" (Weitz 1998). During slavery, slaveowners encouraged fertility among enslaved women to increase the labor force, as any children born to a slave woman would also be slaves (Davis 1981).

After slavery was abolished in 1865, miscegenation laws were passed prohibiting marriages between African Americans and Whites. In all, 30 states passed anti-miscegenation laws that largely stayed on the books until the advent of the civil rights movement. The post Civil War period also saw a dramatic increase in the number of African American men who were lynched for various infractions.

The eugenics movement in the United States was also an impetus for the sterilization of African American women in the later half of the twentieth century. Sterilization operations were so common in the South that they were known as "Mississippi appendectomies" (Rodriguez-Trias 1982, p. 150).[13] Davis (1983) describes several cases in which Black teenagers were sterilized through various government agencies, including Department of Health, Education and Welfare-funded birth control

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[13] See also Clarke "Subtle Sterilization Abuse: A Reproductive Rights Perspective".

clinics. Reproduction is now regulated less directly and less personally than it was during slavery and Reconstruction. However, as Mullings contends, the structure of the households of African American women seeking welfare benefits has come under increasing bureaucratic mechanism and regulation (Mullings 1995).

Latinos

The history of reproductive constraints for Latinos centers on sterilization abuse with the use of federal funds (MALDEF: Chicana Rights Project 1975; Del Castillo 1980; Gordon 1990). As part of a far-reaching program to industrialize Puerto Rico in the first half of the twentieth century known as Operation Bootstrap, Puerto Rican women were specifically targeted in campaigns to encourage contraception and coerce sterilization of women of child-bearing age (Ramirez de Arellano and Scheipp 1983). This particular program has a continuing legacy found among Puerto Rican women, who still have the highest percentage of tubal ligations in the country (Stroup-Benham and Treviño 1991; López 1997), as many select tubal ligations as their chosen form of contraception.

Latinas continued to be a target of sterilization abuse even after the demise of Operation Bootstrap. Dreifus (1977) documents how some medical residents developed their surgical skills by performing tubal legations on Latina women who were uninformed or misinformed of the operation they were undergoing. Eleven Chicanas were sterilized either without consent or consent obtained under duress in Los Angeles between 1971 and 1974 (Velez-Ibañez 1980).

Asian Americans

The constraints placed on Asian Americans differ from that of the aforementioned groups in that they have depended almost entirely on immigration legislation designed to prevent male Asian immigrants from producing heirs in the United States (Hing 1993). As far as I know, they were not targets of the sterilization campaigns to which African American, Native American and Latinas were subject. The first immigration laws were directed at the Chinese, who had immigrated to the United States and were increasingly visible. In 1875, the Page Law was passed to prohibit the importation of "Oriental" contract laborers, prostitutes and criminals. Women were so strictly screened under the law that it excluded many Chinese wives as well as prostitutes (Chan 1994). In 1880, after large numbers of Chinese men migrated to California in search of work, the state legislature passed a law prohibiting issuance of a marriage license to any White person who wanted to marry a "Mongolian" (the term then used by the California legislature to characterize people of Chinese descent). In 1905, the California legislature expanded the state's anti-miscegenation law, similarly declaring "illegal and void" all marriages between Whites and "Mongolians" (Chin and Karthikeyan 2002).

In 1882, the first Exclusion Act was passed, aimed specifically at the Chinese. Provisions of the Act suspended immigration of Chinese laborers to the United States for ten years, provided for deportation of Chinese illegally in the United States, and most importantly, barred Chinese from becoming citizens. In the decades that followed, the exclusion policy was reaffirmed and gradually extended to other "Asiatics." In the 1917 Immigration Law , men with wives in India were prohibited from bringing their wives to the United States. In 1921, Japan barred the emigration of picture brides to the United States in the "Ladies' Agreement." The 1922 Cable Act took away the citizenship of any female U. S. citizen who married an "alien" ineligible for U. S. citizenship. (At this time, no Asian was entitled to become a naturalized citizen.) If a European American woman divorced, she could regain her citizenship status. However, if a U.S.-born Asian woman divorced an Asian man, she would not regain her citizenship (Chan 1994).

This has been a very brief review of various histories that may or may not be common knowledge to a general audience. However, I include the highlights here as the men and women I interviewed were familiar, for the most part, with the history of their own group. These histories were an element of their narratives and the knowledge of these histories impacted the meanings they placed on reproduction and generativity.

Chapter Four: The Experience of Infertility and Identity

Jocelyn: …My family have always had children. I mean, lots of kids in the family in my extended family, so when I went to family functions, yeah, we didn't have kids, but…that didn't sort of bother me. I remember one time my aunt introducing me to some other relatives in Hawaii, and she would say, "Oh, this is so and so, she has five kids. This is so and so, she has two kids. And this is Jocelyn-no-kids-yet." It was like in the same sentence! That was like my middle and last name, "This is Jocelyn-no-kids-yet." And so ... (laughter) ... I remember thinking that was really really weird – how you get defined in my family by how many children you have. But it didn't bother me. I mean, I didn't have people ... there were a few people who said, "Jocelyn, are you guys going to have kids?" And I would say, "Oh, yeah. Eventually, one of these days. We're working on it."

An interactionist perspective on identity is one which considers the set of identities or positions and ways of living life that is "mediated" or created in social interaction with other people living their lives. These positions are multiple, and could be considered different aspects of the self. The parameters of the self are usually culturally mandated, and are inextricably integrated into society. Moreover, the performance of these multiple identities is situated in social settings and historical times. In short, identities are constituted, in interaction with others in the process of making their lives. (Barvosa-Carter 2002). In this chapter, I pay particular attention to infertile individuals negotiating multiple identities in a broader social world of family and friends, and thus use the lens of interaction to illuminate identity. I chose Jocelyn's quote to open this chapter because it reflects her reality of simultaneously being, among other things, an Asian American/Pacific Islander woman, a woman with a partner, a niece, a female junior member of an extended family which values fertility and in fact uses the number of children a woman has as an identifying trait, a legitimate target of questions about her and her partner's fertility plans, and the receiver of implicit expectations of normality defined by fertility. As well, in her aunt's referring to her as "Jocelyn-no-kids-yet," Jocelyn is being defined by how she differs, by what she lacks – children – in opposition to other female family members who have produced tangible symbols of familial continuity.

As noted earlier, an underlying analytical assumption of this work is that the experience of infertility is a life disruption (Becker 2000), a circumstance where things have not gone according to life's plan and the American cultural blueprint. Consequently, infertility wreaks havoc with one's sense of control, one's sense of what is to be expected, and ultimately one's sense of self (Bury 1982). I am particularly interested in the effect on social identity and subjectivity. By this I mean the interplay between one's sense of self grounded in social identities and the reconfiguration of these catalyzed by the life disruption that is infertility. The disruption in an individual's biography caused by infertility has profound consequences for identity, particularly in relation to family and social life, as it causes a shift in both cultural identities and social relationships. Identity work is the way respondents interpret the marked social identity of 'infertile' and manage to reconcile it with other identities (Fornäs 1995; Schwalbe and Mason-Schrock 1996). This local production and elaboration of identity intersects with history, generation and life-course stage, and is part of an on-going process of making meaning of one's personal experience of infertility.

The literature has documented ways that the infertility experience has affected the gendered self, particularly for women (Seibel and Taymor 1982; Greil, et al. 1988; Spelman 1988; Daniels 1989; Abbey, et al. 1991; Nachtigall, et al. 1992; Greil 1997).

This line of inquiry is understandable since gender is so closely tied to reproductive expectations. Not as much attention has been paid to other aspects of the self, which is unfortunate.[14] Accepting the fact of the multiplicity of identities and seives should lead one to consider the 'the mantra of race, class and gender' (Mercer 1992 cited in Grossberg 1996, p. 90). As Nakano Glenn points out, race, gender and class are "inextricably intertwined ... each develops in the context of the other; they cannot be separated" (Nakano Glenn 1987). It is inadequate to analytically isolate just one aspect of the self that is affected because the nature of the issue is all encompassing and complex, and because an individual's identity is interconnected and fluid. But at the same time, this complexity and fluidity makes a more integrative analysis very difficult. The challenge is to uncover the connections or articulations between the identities, (or fragments if you will). I will be considering ethnicity, gender and class but with an eye to how they are interwoven. I recount views on ethnic identity in relation to reproduction and the disruption caused by infertility, and try to show their interlinkage with how people talk about gender. I will follow up with a closer look at where class is revealed as that is the aspect of the self which is most analytically invisible.

Interwoven Strands

As part of the interview for this research, everyone was asked how infertility affected them as a man or a woman. When I was talking to Raquel, a Chinese American woman in her mid-thirties who had been trying to conceive for four years, her response to

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[14] For recent works that examine the experience of social infertility among lesbians, see Tober, *Romancing the Sperm: Sexuality, Technology and Alternative American Families*, and Mamo, *Sexuality, Reproduction, and Biomedical Negotiations: An Analysis of Achieving Pregnancy in the Absence of Heterosexuality*.

this question struck me as unusual in that she denied that infertility had any real effect on her as a woman.

> Raquel: ...I was thinking, well you know some of these videos that we've watched on infertility and stuff. And they would say, "I felt so unwomanly because I couldn't conceive." I never, ever – I never felt like that. Yeah, I didn't relate to that at all. And then, in fact, Louis said that he didn't even relate to it. Like he didn't feel less masculine because he couldn't conceive...It never occurred to me, you know as being ... I guess it is part of being a woman and yet it doesn't affect my feeling of it.

I probed deeper and rephrased the question by explicitly asking her if infertility had any effect on her as a Chinese American woman. She answered with an emphatic yes and spent the next several minutes elaborating on how.

> Raquel: ...the answer is a resounding yes. Because children are so important in Chinese families that at every family gathering that we have, everyone is always bugging us about, "When's your turn? It's about time. Hurry up." So I think probably if we weren't able to have children, I probably would have let the word leak out a little more so that people wouldn't bug us. But it would have been okay.

When I interviewed Raquel's husband Louis later that afternoon, I asked him how infertility affected him as a man. Louis had been identified as having a low sperm count, and he referred to this in his response but he then went on to relate his personal burden of infertility to being Chinese American.

> Louis: ...I didn't, I didn't feel any different. I just felt that [I had] what I thought was tough luck. But I mean, what was I gonna do? That was not the type of thing that – I mean I could only have the problem and address it. But I didn't find a lot of men that I could talk to about it. And again, it didn't have any side effects. There was no psychological impediments that I was – I was sad that it would happen, that it happened with the person that I wanted to have a family with and there was a good possibility that I would have to come to grips with the inability to have my own children. Which was a very very difficult thing for me to think about...Maybe partly because...there's so much emphasis on Chinese people having families. Chinese males being able to produce offspring, males in particular, is that it's sort of worked in my head in some sort of manner ... But the Chinese

> it's sort of worked in my head in some sort of manner ... But the Chinese stuff that was going on was really the family, the large family, of being able to enjoy a large family. And the fact that not having any family, that could be denied, was playing a heavy factor in my head for a period of time.

What is apparent from both Raquel and Louis' responses is that the challenge to their racial ethnic identity – their Chinese Americanness – was not being able to fulfill that which they saw as important within Chinese culture – having children, and having a large family. While neither identified the ability to procreate as being crucial to their gender identity, their personal history and relational bonds to a Chinese American community with a particular ideology about family which emphasized the importance of fertility became momentous with the disruption of infertility.

Raquel did not come from a large family as did Louis but both shared with me a history in which the ideal of family loomed large. Raquel's father was a paper son,[15] who went back to China to find a wife. After marrying, he sponsored his wife's parents and six siblings to emigrate and in Raquel's words: "provided them with jobs, homes, taught them how to drive. You know, the whole bit. Put them on their way."

Louis was raised in an inner-city low-income housing project, and is the youngest of nine children from an arranged marriage. As he tells it, his father's goal in life was

> ...to bring over all of his relatives who were part of his village. In Chinese style, all the people in part of the village are like your relatives even though they are not blood relatives ... My father had spent a substantial amount of time and money in bringing over a lot of these villager people to come to the U.S...My father did this out of the goodness of his heart but it was not without the rest of the family suffering, particularly my oldest

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[15] Paper son refers to a male Chinese immigrant who bought false papers identifying himself as a child of an American citizen, taking advantage of the loophole in the Chinese Exclusion Act that any Chinese who could prove citizenship through paternal lineage would not be denied entry to the United States. See Hing *Making and Remaking Asian America Through Immigration Policy, 1850-1990.*

> brother who, as the oldest son of a Chinese family was forced to take over a surrogate father role.

The model of family given to both Raquel and Louis is one in which individual sacrifices are expected to be made for the good of the larger entity of 'family', and kinship obligations are preeminent; this is explicitly identified as Chinese.

> Raquel: You know, Chinese families in general, or ours anyway, are very close. I'm very close with all of my aunts, all of my, not all of my cousins but the majority of my cousins. And just the need for the understanding that you take care of each other...that the sense of family is very important to us and that you take care of your family...it's just that sense of, the Chinese sense of you don't talk to old people loud, you take care of them and they stay an integral part of the family.

Louis continues the example set by his father by employing family members in his current business, and providing financial support for those kin in need. Louis is a lawyer and he relates his conscious choosing of a lucrative profession to his perception of family and familial obligations. In doing so, he begins to illuminate one nexus of his racialized self with his classed self.

> Louis: I did that, not because I felt that was a great [career], but because I had to go and make money to help my family. There wasn't a 'let's stop and go and visit Europe'. There was no way that was going to happen. Go get a job and go make some money...I was required to always put my nose to the grind[stone] and do things that probably would be distasteful to others or at least some of my colleagues. I mean, I could stand a level of abuse at law firms that probably no one would ever believe that you can endure, working longest hours. And the education was fine, but, just the level of abuse and you're never really, as well as I could assimilate in that world, you're never really, you're never really there.

Louis clarified his oblique comment on never really being 'there' by recounting that he had hit a glass ceiling within his law firm as a Chinese American male. He did not dwell on the discrimination he experienced, but presented it as a normal feature of his life. His remarks about the extraordinary amount of work he took on at the law firm resonated with the aphorism I have heard repeated by both women and other members of groups targeted by discrimination: "You have to work twice as hard to be considered half as good." Louis clearly differentiated himself from his work colleagues in this regard. He notes the 'abuse' he endured, simultaneously acknowledging it as a symptom of discrimination while both minimizing it as a necessary condition of fulfilling his responsibility as a Chinese American male and deflecting it as something he was able to endure due to his personality traits of being competitive and ambitious. Later in the interview, when reflecting on how infertility has affected him, Louis returned to these themes.

> Louis: ...uh I've always been a competitive ambitious person. What infertility did was make me stop that. And part of the reason of being competitive in ambition was to achieve a goal for a family. It wasn't for myself. Because interestingly enough, no matter how much financial success I have, I never utilize it to my own benefit. It's utilized for that large mass of people that I described to you beforehand. Or to my wife or to my nieces or to my nephews. My largesse is quite amazing to me in that regard. Because I never sought to get things for myself. Uh, the material things or my needs were always secondary to others. That's just the way I've been taught I suppose. So it's always that, umm, before I satisfy any of my non-essential needs that I make sure that my family's essential needs are taken care of. Of course, when you have so many of you, it's virtually impossible to ever get to your non-essential needs then, right? So that's just the theme that's been consistent in my life. And it's not that my family ever asks. I just give.

The act of giving, and of giving to those who could claim kinship obligation is one way Louis performs being Chinese American. Another way prescribed by notions of Chinese Americanness that he and Raquel communicated, would be to have many offspring but, because of male factor infertility, Louis cannot perform this aspect of his identity. He can fulfill his culturally mandated obligations to extended family but he cannot create his immediate family. In order to succeed in a hostile racialized environment, he has had to employ a strategy of being hyper-ambitious and hyper-aggressive but at the time of the interview, this class-based strategy had not met with success in trying to conceive. This failure disrupts Louis's sense of what being Chinese American means and forces him to rethink his performance, his personal experiences and his identity.

A similar interweaving of ethnicity, social relations and history was noted in Diana's explanation of how infertility had affected her, but also evident is Diana's strong sense of failure related to gender ideals. Diana, a woman in her mid-thirties of Mexican and Puerto Rican descent, has a child from a previous marriage and has suffered multiple miscarriages in the six years prior to my interviewing her.

> Diana: It makes me feel half woman. It makes me feel that this card was not dealt right. This is not the way it's supposed to be. A woman is supposed, and I know that this is a very chauvinistic way of saying it, but a woman is supposed to be able to bear and succeed in it. This is really unfair....because I can't have any more children and that bothers me. That really bothers me. That part of me feels I'm not fulfilling my role...because of all my miscarriages that I feel that I failed. I've failed as a woman. That I wasn't able to reproduce. I wasn't able to succeed in this one avenue that I'm supposed to succeed in and that's what bothers me.

Diana goes on, implying that her failure isn't just as a woman, but also in not living up to ethnic norms.

> Hispanic heritage and culture are children. It's almost like you've been put on this planet to have children; you multiply and we come from such a loving family. You've got the family values instilled in you and you're just supposed to have kids. I mean, that's how I looked at it, and where I grew up in the Mission, everybody had kids. The maximum I think, was four in each family - three to four. But then I knew some of my grandmother's friends; I think one lady had 22 kids, another lady had 10, and another lady had 8, so, I mean, it was just the norm. It was just the norm - you have kids.

When Diana talks about herself as a woman, she refers to herself as both an individual subject, and as a member of a community with particular values which influence the way that she views her infertility. Unlike Raquel, her sense of falling short is not expressed mainly in one domain of social identity, but falls across two core identities that are inextricably linked – that of being Hispanic and that of being a woman.

Diana's husband, Kevin, was raised as a Mormon and was also taught an ideology of family and gender roles that is closely associated to enacting a particular identity.[16] Diana points to this as being somewhat analogous to her own history.

> Diana: ...he comes from a family where you're supposed to have lots of kids. Let's just say for a non-Hispanic family. I think that they would view it to have kids, but not as deep, maybe, as I do, you know, the way I was brought up.

Kevin, however, left the Mormon Church when he entered college and consciously put aside the doctrine under which he was raised. When I interviewed him, he obliquely referred to his upbringing but felt that he had left it behind. His social world did not include contact with Mormons except for his siblings, and he pointedly remarked on their different world views.

> Kevin: I think they're different. Certainly, my sisters are. My youngest sister has five kids and she believes very strongly in family, in big family and kids. My other sister I know feels the same way. She had two kids and then ran into problems, but I know she would like to have more. My brother has two kids and I think he's probably happy where he is...I never thought about having children myself... I had always thought about being with somebody and that to me is what was important. The sense of, I don't know. At a loss for words here, but the sense of procreating and carrying on the family name is not that much of a motivating thing for me.

While I am not equating ethnic identity and religious identity, I do note that both are reflective of cultures which have proscribed roles and norms about social entities such as family and gender. However, while one can choose to leave a faith community and

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[16] An official proclamation of the Mormon Church is that God's commandment to multiply and replenish the earth remains in force (Proclamation on The Family from The First Presidency and Council of the Twelve Apostles of The Church of Jesus Christ of Latter-day Saints, September 23, 1995). Mormon culture is considered to be pro-natalist with traditional gender roles.

reject a religious identity, the same is not possible with ethnicity as long as one exists in a milieu where one is marked as Other.

When women talked about the connection between their ethnic identity and the ability to have children, they generally did so more explicitly than did men. I interpret this as an indicator that there was a good degree of congruence between their identity as women and their identity as a person of color, as well as their adherence to a variation of the mainstream ideology of motherhood (Davis 1981). The way that they learned what being Chinese American or Latina meant included ideologies about family, fertility and gender roles. The threat to their gender identity that infertility posed was also experienced, though in a different form, as a challenge to their subjective sense of being a person of color.

Louis was the most articulate about the disruption in his sense of ethnic identity when confronted with the possibility of not having children of his own. Even though the difficulty he and Raquel experienced in conceiving was attributable to male factor, Louis did not feel his masculinity was compromised. Other men of color referred to the relationship between their ethnic/racial identity and having children but not in such an individualistic manner. Rather, they discussed this more abstractly, and often in the context of community obligations. This could be because an ideology of fatherhood is not as well-developed or salient as that of motherhood. However, there does exist a stereotype of men of color, especially African American males, who father children as a sign of masculinity. This oft-repeated belief that being a man means having kids by multiple partners was not expressed by my African American respondents and in fact was actively rejected. Franklin is a Black man in his early thirties. In their first year of marriage, his wife had an ectopic pregnancy and lost a Fallopian tube. Franklin expressed his ideal of manhood in terms of personal qualities which benefited his community and his partner, rather than being able to reproduce, thus refuting the stereotype of the African American male.

> Franklin: ...I know that it doesn't make you a man to see how many pairs of feminine underwear you have hanging off the wall. That is not being a man. Being a man is being with the woman that you said you love and being responsible, so I don't want that stereotype that the Black man has. I don't want that for myself. I am a man, not an animal...I want to clarify this, children have nothing to do with my manhood. My manhood comes from being not self-righteous, but an upstanding citizen, faithful to my wife, tolerant, patient and loving and understanding to the woman that I care about.

Raeshell, an African American woman, and her husband were considering adoption after rejecting using donor semen and encounters with biomedicine left them frustrated. She was hesitant about adoption and in discussing her pondering about the issue, she drew upon a belief found in communities with histories of oppression that the work of reproduction and parenting is work done for the good of the community, not solely benefiting a particular man, woman or couple (Nakano Glenn 1986; Nakano Glenn, et al. 1994).

> Raeshell: But, most especially as a person of color, looking at the way my people are socially now, I think I have a responsibility to some of those homeless children out there and I think that I can convince myself mentally to overcome my own problem and focus on some other problems out through the world and still be able to offer parenting and love to a child. It may not be my own biological child, but I would still be doing the good to the universe. I would still be doing the same things for another child that I would have done for my own. And, to think of the final analysis, if there is someone up there watching us, I think that's all that's gonna matter.

Exactly how 'the good of the community' is defined can vary widely by individuals dependent on their own level of identification with a particular history, and their awareness of larger sociocultural concerns, but the altruism is not directed at an abstract undifferentiated humanity but at a specific entity with perceived shared attributes – their 'community.' Raeshell and Franklin's motives could be interpreted as merely benevolent if it were not for this explicit reference to community, suggesting a link between reproduction and political strategy. The ability to have children was seen as having political significance, particularly against a backdrop of historical devaluation. Charlene, a Blackfoot[17] woman, articulated this association. She expressed her desire for parenthood as stemming from both familial expectations and an awareness of her people's history and current situation.

Charlene: Culturally ... I'm from a family of five children and it was really important to have grandchildren, for my folks to have grandchildren ... with genocide being a big issue in Indian populations, this is the way that girls can repopulate.

Along with repopulating, Charlene perceived an obligation to passing along qualities that would benefit her community:

Charlene: Our race is a very oppressed race and has been for 500 years. Working in the women's treatment facility, I saw two distinct categories of women. One was very much a victim. One was very much a survivor ... I feel like I'm a survivor and I think it's really important to pass on that survivor instinct, that survivor quality of a race, and it's really important that my children see the traditional values as a way of life rather than social values or American [values].

Charlene views biological reproduction as a way of increasing the sheer numbers of people recognized as Native by the United States government, yet she juxtaposes this

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[17] Charlene's roots are in Montana and she is an enrolled member of the Blackfeet Nation. Blackfoot is used to refer to the bands now situated in Canada, and Blackfeet is used for the Piegans in the United States. However, Charlene refers to herself as Blackfoot and I will do the same.

with social reproduction – the passing on of values and teaching of a way of life – which is essential to the survival of Native culture. Both repopulating and the passing along of values to children are gendered strategies of survival which reflect the sociocultural concerns of contemporary Native peoples (Collins 1994). Children and families are theorized by feminists of color (Thornton Dill 1994; Mullings 1995) to be an important part of a strategy of both cultural and economic survival and empowerment, and Charlene's stance provides confirmation of this.

Blood quantum is the government imposed method of determining Indianness based on the amount of 'pure' Indian blood one has. This criteria is rooted in biological notions of heredity and genetics. It contrasts with earlier tribal definitions of membership which relied not only on lineage, but also on knowledge of history, customs and lifeways of a people. The Blackfeet Nation is a federally recognized tribe which offers its members the benefits of treaty rights. Charlene is aware of both modes of being considered Indian and while she is uncomfortable with blood quantum, she recognizes it as a political tool that can be used by Natives to their advantage by increasing the percentage Indian blood of each generation. This is one reason that marrying and reproducing with an Indian man was important to Charlene.

Charlene: ...it was really important for me to marry a Blackfoot male. I don't know. I think it was because, it was important for my mother to leave the reservation, that it was important for me to go back there and marry, and that's what I did.

> That's really, the country, everything, the people, that's where I belonged. And I was taken from it or it was taken from me, in terms of growing up. And it's always been very important to me, you know, and especially in terms of my children, to have that piece of who I am, to be really prominent in a way that was not given to me as a child. And virtually taken away.
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> Because there was a lot of confusion. Well, am I Mexican? My last name is Portuguese. Am I Portuguese? You know, I don't have any Portuguese

> as far as I know. It's just a Portuguese name. There's an interesting story there, but...
> Yeah, I don't know. I wonder if isn't just in spite of my mother, but that was really important. But, I do think that there was a lot of this who I am, and this is important for me to give to my children too. So the men that I had long term relationships were not Blackfoot males. And the man that I married was and that helped to give my children an identity too. And when I married, that was to procreate.

Charlene's sense of the importance of fertility, of procreation is related to her identity as a Native woman, a Blackfoot woman and the responsibility she has as a survivor. Being a survivor is a theme which is often found in Indian narratives (Cornell 2000), and one which could be gleaned from how Charlene told her story. She - like Raquel and Diana - interlaced ethnicity identity, social relations, gender and history. As I talked with her more, the complexity of how Charlene negotiates her identities - a gendered subjectivity, Indianness, and political strategist - in a matrix of history and social roles was impressive. She talks of questioning who she was as a result of being uprooted from her people, placed in a limbo of confusion and connects this to her infertility.

> Charlene: ...the point of being a woman is to have children. I think that that's what life's values have given me. My family life's values have given me is the point of being a woman is to have children and I think at the time of being infertile and having been married that, you know, well, what's the point? What's the point in even being married if you're not going to have children? That's a sign of womanhood. So infertile, being infertile is purgatory or something, you know? Womanhood purgatory. (laughter) As I understand purgatory. Christian concept from way, way, way back.

Charlene links and interprets the disruptions to her identities caused by infertility in ways that allow her to maintain the central trope of survivor, as one who has endured loss and overcome obstacles, ultimately reinforcing her subjective sense of herself as a Native woman who holds a traditional view of appropriate womanhood.

Making Class Visible

While expressly identifying themselves as being a particular gender and belonging to a specific ethnic or racial group, most of my respondents did not claim a class affiliation expressed as a class identity. It has been shown that most Americans, despite their actual income, standard of living and economic resources, believe themselves to be middle class, if pressed to categorize themselves (Miller 1995). This is because the reality of the class system in the United States, while a crucial shaper of life experiences and chances, is camouflaged by the American myths of equality and meritocracy and cultural silences about social class.

If You Work Hard Enough...

The American cultural myth of meritocracy is the idea that if one works hard enough, one will be rewarded. It has its roots in the Protestant work ethic that thrift and industry are the key to material success. The myth holds that if one is able to succeed in America, it is because of one's own hard work, lending credence to the idea that the system itself is fair. Conversely, those who do poorly in life have only themselves to blame. This idea has moved beyond just material success and is applied to other areas of life as well. It is closely related to the cultural ideal of persistence: if one gives up, or if one doesn't keep trying, then this is seen as failure (and a moral failing as well) (Becker 1997; Becker 2000).

These ideals permeate the ethos of the middle-class as well as the working class, and seem to be particularly strong among immigrants. I noted that respondents whose parents were immigrants freely used sayings which reflect these ideals. Raquel's parents were immigrants from China, and this historical fact figured prominently in her narrative.

Raquel: Work hard and you'll get whatever you want....Not even setting, not even setting goals. My father's always said, "America's a good country. You work hard you can get whatever you want." So I think I've always taken that theme, what ever you set your mind to you can do...my mother says to me, recently she said, "You know, nothing that you ever do comes easy."

Larry, a Japanese American man in his late thirties and his wife Donna, a White woman in her mid-thirties, have been unable to conceive due to a low sperm count associated with treatment for chronic kidney disease and her endometriosis. They have been persistent in pursuing treatment, enduring over fifteen insemination attempts, and they believe that their persistence and determination will eventually result in a child.

Larry: There's things you want and you're going to get it somehow. There's always a way to get it. You work hard enough and there's always a way...There's a lot of hard working and joy, stuff like that. But the things that you strive for you finally get; they're all well worth getting. I imagine there's people out there who say, well, "Okay, well, we won't get it. We'll just go on to something else." We can't do that.

Donna: I always think that we're very hard workers. We have a lot, but we work very hard for what we've had. We haven't come from families with a lot of money. We always had to work through high school and all that kind of stuff, and we don't mind working hard and I just sort of took this [getting pregnant] on as another project or a challenge or something.

It is telling that they use the phrase 'work hard' to refer to their endeavors to conceive, and refer to their shared history of accomplishments as support for their claims that they will not give up. Considered from the perspective of the myth of meritocracy and the ideal of persistence (Becker 1997), Larry and Donna are doing what is expected of them by American cultural standards. They supplement this with class-based proof of prior obstacles overcome. In this, they are vaguely similar to Charlene's account yet Larry and Donna's narrative does not draw upon notions of ethnic survival and tenacity, but on an undifferentiated, and to a large degree classless, American persona familiar from popular representations. Raquel, a child of Chinese immigrants, also utilizes the trope of persistence but hers has a temporal quality not as apparent in Larry and Donna's comments.

> Raquel: ...On paper I look like I'm quite successful and that I've done everything that I want to do. But it's always been a very rocky road getting there. You know, I had a tough time being an undergrad, trying to make the grades to you know, be able to get accepted into grad school. I had a tough time getting into grad school, had tough time my first year in grad school you know, just trying to get settled in academic life and everything. I had a tough time passing the board. But I'd managed to do it but it hasn't been easy. You know, getting married was easy. But then you know, having a child is something that I wanted, you know, it was also difficult. I guess you know, the theme of my life is that I can get done whatever I want to get done but it takes a while (laughs).

Respondents did not talk explicitly or at length about their class position. Rather, class usually entered their narratives subtly, perhaps as an opaque or invisible force which limited their performance of other identities, or as a shading when they described their gendered responsibilities. Kevin, a White factory manager, talked to me about his not providing enough support to his wife, Diana, as she went through medical treatment.

> Kevin: ...I wasn't supportive or supportive as I should have been, you know? I certainly wasn't always able to make appointments. I guess a lot of husbands are able to go to the doctor when their wife has various appointments for physical or discussions and I wasn't always able to do that. Part of it has to do with the work ethic that I have. I don't know if it's me or what. A lot of men, I think a lot of men aren't able to leave work, you know, as freely as a lot of these rich guys that can do that. I certainly couldn't. I'm not in a position where I can come and go as I please yet. I left when it was critical and when I can tell it was very important to her, but there are times that I know that she wanted me there that I wasn't there, and there were times that she wanted me there that I wasn't there probably because I didn't want to be there either. You know, I'm not going to blame it on work exclusively. I think I tried to this last time, I felt more part of it. But I'm sure she holds some resentment towards me for a lot of the times in the past where I didn't support her the way she perceived a lot of husbands did or do.

Kevin refers to his work ethic, and not having the freedom to come and go as he pleases or attend appointments with his wife – all coded references to his position as an employee, as not having control over the terms of his labor. While he acknowledges that he also failed appointments out of a lack of desire, the blame is equally divided between that and the constraints put on him by the microprocesses of capitalism.

Access Stories

One area in which issues of class came up less subtly for my respondents was when they talked to me about getting access to biomedical interventions for infertility, and the choices they felt forced to make. This is an obvious site for class concerns to arise as reproductive technologies are expensive. For example, at the time of data collection, couples routinely estimated the cost of IVF as $10,000 a cycle including the expense of the fertility drugs and surgical procedure; a month's supply of Pergonal (a drug used to stimulate hyperovulation) cost up to $1,500; and microsurgery to repair Fallopian tubes could cost $8,000.

However, in listening to the narratives of my respondents, particularly those which could be termed 'access stories' from those with limited options, it was apparent that they were talking to me about more than just economics. The experience of gaining access and taking action was intertwined with their experience as gendered and racialized individuals. For respondents, even those with scarce economic resources, class was not much of a presence in their stories but was held separate from themselves and appeared most often when alluding to control. The sense of loss of control is a common experience of infertility (McCormick 1980; Cook 1987). Women in treatment experience the feeling that they have lost control over their body (Greil 1991; Becker 2000). This sense of loss of control can extend to other areas of life, and is reflected when class enters the narrative. Their strategizing to gain access to biomedicine and their experience of biomedicine was performed across a field of power which required economic capital, social capital, cultural capital, and symbolic capital for success (Jenkins 1992).

Two couples in the study had an income of under ten thousand dollars a year and no or minimal health insurance. These two couples are very different from each other culturally but they are both located in marginalized positions in the social hierarchy. Both live in economically depressed areas with a high rate of crime and must struggle with economics, and institutional racism. Amalia and Hilario are recent immigrants from Mexico; they are monolingual and don't have legal documentation which further limits their options. They are both employed but in very low-wage occupations so they are dependent on the public health care system for their care. These attributes all coincide to constrain their ability to acquire and comprehend knowledge[18] about current technological interventions, and to strategize about gaining access to these interventions. They, not surprisingly, were the most uninformed about the various procedures and options open to them. (At the time they left the study, they were still trying to secure a diagnosis). Calandra and Franklin are African American and in financial straits because of disability and unemployment at the time of the study. As well, they share a past history of drug use. Calandra talks about why she hasn't undergone tubal surgery.

> Calandra: So I went through them [clinic] to see what was going on with my tubes and everything and I had a bunch of tests then and that is how I found out that I had scar tissue in my tubes, and that one of my tubes was crooked and so that is one that is removed… And they told me if you get pregnant

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[18] Although the clinic provided handouts in Spanish explaining various procedures, the information had limited usefulness for Amalia and Hilario as the language used was quite technical. It appeared as if the the information had been taken from materials geared towards health professionals.

> that you have a large chance of getting it in your tubes... And so, they were talking about some kind of surgery they could have done on me to correct that and I never went through [it]... And I didn't want to go through the surgery because they said it wasn't a hundred percent chance that the surgery would work. So I didn't want to pay this money and I don't remember how much money it was at the time, but I would have had to pay this money.

At the point that Calandra had to decide about the surgical option of repairing her Fallopian tube, the chances of success were not absolute. That uncertainty, together with having to pay for the surgery out-of-pocket discouraged her from pursuing this option. Unfortunately, Calandra subsequently suffered an ectopic pregnancy.

> Calandra: Not being in control. That is one area of my life where I have no control. And just not knowing if it going to get stuck in the other tube. Not knowing if I will ever conceive or will I have to go through these other ways of trying to have children. But for the most part because I am looking at all these other things that are in front of me. I don't focus on that so much...But I used to and it was just that neediness that I was talking about before. And now, I don't need a child. I want a child. So it is a difference. But I know that I am going to be a parent, I don't know how or when. But I know that I will. And I think too, that part of my denial is that we don't have the insurance to go through all that stuff.

For Calandra, her sense of lack of control is exacerbated by economics. She starts off talking about the physical aspects of her infertility, of the uncertainty if her body will behave the way it is supposed to. She has had to rethink her life because of the infertility. She has changed from thinking of a child as a need to a desire, being more consciously willful. But even with these changes, this attempt to come to terms with her infertility and make it manageable, there is still the reality that she cannot get treatment because of her economic situation. Seeking medical treatment represents taking control of the situation, and taking action (Becker 2000). The telling phrase at the end of Calandra's response - *we don't have the insurance to go through all that stuff* – and her strategy of denial points the way to the interconnectedness of class, history, experience and making meaning. Her inability to get biomedical treatment, to take the action which is presented by the media and the medical establishment as the thing to do, is another form of lack of control. Yet this lack of control is directly related to a loss of reproductive self-determination. Because the history of people of color has included so many incidents where they were not afforded the dignity of self-determination, this sense of loss is particularly sharp.

While Franklin and Calandra could be said to be actively seeking a resolution to the infertility, their manner of seeking differed substantially from that of the other couples in the study – they didn't have the resources to pay for technological intervention so they looked elsewhere. Hilario and Amalia didn't want to seek alternative treatment because they wanted to take a 'scientific' approach but they recognize the limited options open to them as well.

Hilario: ...we haven't resorted to home remedies, nothing like that.

Amalia: They told me that there was a tea and I told him, or rather a woman told me who has been here a while, she told me about a tea, but I really didn't... She told me that it won't hurt me. Told me to take it. That it wouldn't harm me, even though it wouldn't hurt me, even then, I didn't buy it.

Hilario: Yes, you use recipes that have, at best, some plant in that tea and then it doesn't work... We haven't paid much attention... if you get a massage, drink this tea, do this or that... We're basing it more on the scientific you could say.... But I believe we are going to have to resort to those if this continues...

The situation to which Hilario alludes is that of not receiving any satisfactory answers as to why Amalia isn't getting pregnant, despite they're following the clinic's suggestions. For both couples, the lack of economic resources was not an obstacle to being a parent, but in obstacle to *becoming* a parent because they could neither afford the diagnostic tests nor could they afford treatment.

Couples with minimal insurance coverage manipulated and relied on their knowledge of health care bureaucracy, medical insurance billing policies, and personal relationships with medical personnel to secure access to treatment and thus feel more in control. One couple spoke of an informal network they had set up to share unused or 'left-over' fertility drugs. Wendy, a White woman married to Lorn, a Native man, explained how she was able to get her insurance company to pay for her surgery under the mantle of therapeutic care.

> Wendy: When it came down to getting my tubes fixed, the insurance company said, "No, we're not going to pay for this. You're doing this for infertility reasons." So I switched to another insurance company ... My doctor sent a letter and the way they worded it, they had it done where I had ... scarring in my uterus and my tubes and that I was in intense pain, that things were going to have to be done because I couldn't live this way. And the insurance company signed a statement saying that they would cover that. So it came down, sure enough that they had to pay for it.
>
> Lorn: Wendy ran the office and knew a lot about insurance and was able to get the correct insurance that we needed to go through all the processes that we needed ... So, Wendy's kind of an insurance expert in that end.... And our boss was very supportive of our efforts in trying to have a child. We were able to pull things off that normally people don't have the opportunity to do.

In order for Wendy to exert pressure to obtain the care she wants, more than just familiarity with one's biology is needed. Wendy also needed knowledge of medical procedures and institutional knowledge of who is responsible for what decisions. This is an example of what Lazarus terms social knowledge (Lazarus 1994). In contrast, Charlene's experience was quite different. She received her gynecological consult from a physician employed by the Indian Health Service. Charlene talked to me about her first visit to the doctor when she didn't conceive after marriage.

This was the fact, I was early married. I had some concerns about the fact that I could possibly not conceive, and his [the doctor's] reception was quite good. That would be, like, by late summer in determining my ovulation. And he said, "Wow! You're ovulating. I can't imagine why you're not conceiving in this short period of time. Let's go ahead and do the hysterogram." So, he scheduled the hysterogram.

We had to go 100 miles over the mountains to a clinic, because that was not a service that was available in our town. There was no technology to speak of. The other thing that you'll find interesting is that this was an Indian Health Service Hospital.

The clinic was an Indian Health Service Hospital, but they contract services with this clinic 100 miles away. So it was totally supported by IHS funds.

As I recall, the question came up, "Do you have other children?" And when he [her husband] said, "Yeah." It was kind of, "Oh, well, then it's not you." I think that was the implication. And given the fact that these were all male doctors in this clinic, in retrospect, they weren't the nurturing types. It was almost like a factory. And you know, it's kind of like that in Indian Health Service contracts that they get their money. That's all they're interested in.

I could see that was happening and they said, the technician, because it's not a doc who does it, it's a technician, said, "Oh, no problem here." You know, which is not what you want to hear. You want to hear that there's something going on and you want to know what it is. You don't have a clue. And you don't know what's going on really. It looks like the dye is going through and you can't tell really. ... And it was painful. It resulted in cramping and then, "Okay, honey, get dressed. Here's a pad. Because this blue stuff will leak out of you, and you don't want it to stain your clothing." And that was kind of it. You know, "Go ahead and go get dressed." And I mean, you know, spread eagle on this thing, so it wasn't a very pleasant experience. And then we met, my husband and I met in the doctor's office, in the gynecologist office. The results were clear to him, you know, "you don't have a problem. There's no blockage."

It showed virtually nothing. That there was no tubal blockage at all. And, of course, I was extremely upset in hearing that. Because how could that be if there was no conception, you know? What else was going to happen? What else was going on? Did this mean that I was, in fact, infertile forever and so on. And it was really crappy experience, because I didn't feel like there was a lot of support from my spouse either.

We felt terrible. You know, this is not the answer. This is not what you want to hear. It was kind of like in and out. No support. No suggestions for what could have happen at that point. "There's nothing wrong with you. Your husband has previous children; there's nothing wrong with him."

> I had no idea what to do next. I had absolutely no idea. Because I wasn't familiar enough with what could happen next, or even the fact that there could be something else wrong with other parts of my body. You know, it was all in my head or something.

Charlene told me her story with some residual anger. She implied that her treatment was perfunctory both because she was a Native and she was a woman. She implicates the "all male doctors" and the fact that the clinic contracted with the Indian Health Service, and so was overly concerned with "getting their money", for the lack of sensitivity she experienced. Her bewilderment at being told that there was nothing wrong when she couldn't conceive is palpable in her narrative. As discussed earlier, for Charlene, repopulating was an important cultural obligation. The disruption she experienced in her identities was exacerbated by this medical encounter, which was resultant from her living on the reservation and thus being eligible for IHS care. This confluence of identities and constraints of options because of those identities was an irony she was quite aware of.

Stories of Family

Another place where class came through clearly in my respondent's narratives is when I asked them to tell me about growing up and what their ideas about family were. In their recounting, changes in class status represented by moving to a new neighborhood or changes in the amount of free time a parent had figures significantly. Jay, a second generation Hispanic in his early thirties, remembers:

> My dad worked for Bechtel Corporation, Engineering Construction, the world's largest engineering construction firm, for 33 years. He worked in a variety of different positions. He has an MBA from Golden Gate University in San Francisco. He's trained as a bean counter in accounting, but his last position, for example, was in facilities management, managing all the real estate property that Bechtel owns throughout the world, so he had a very good career, but hit the glass ceiling due to the minority, their lack of minorities up

> into middle upper management and so he never really got past that glass ceiling. Unfortunately, it's still that way today at Bechtel. My mom worked, I think for a couple years during the marriage, but after I was born she continued to remain at home. She did some part time work and so forth. It was some lean years with our family. We were kind of a lower middle class for a while and my mom is really good at budgeting and making the paycheck work and she was very thrifty and has allowed us to move up to where we are now. So we're real fortunate in that regard and my mom was there for us to, you know, led us around to trumpet classes, cub scouts and everything when we practiced and so forth. The same for my sister and all sorts of activities.

Although mothers of families of color have traditionally participated in wage labor, this is not reflected in popular accounts and mythologies of American family life. In these accounts, reflecting both a middle-class perspective and an unrealistic idealized view, mothers stayed at home and took care of the children while the present father brought home a living wage. Those respondents whose mothers worked full time were quite aware of how their families were atypical, sometimes as a result of school experiences. Janice, a Japanese American woman in her late thirties, recalls:

> ...when I was growing up, my mom worked full time. She left early in the morning. In fact, she took us, when we were still sleeping to my aunt's house, her sister's house, where we slept the rest of the morning till it was [time to] go. Then we took the bus to school, cause she had to go into...work, so, um, then when I'm home from school, oh, it's one of these latchkey kids, back then they didn't call them that, and my dad was a milk man, so he started early too, but he came home early, so he was the first one I saw, and saw my mom later on, but I remember that.
> [W]hen we moved to California, then she worked two part time jobs as a waitress, so she worked at night too. So the PTA meetings or whatever, the open house for school, they never came, because my dad didn't like to go out by himself. He is kind of shy...He was all uncomfortable and my mom was working, so there it went. And then, at school I don't think they should do this, they don't mean to, but they always ask, "So, whose parents are coming to the PTA?" you know from outside, and some kids raise their hand. I could never raise my hand, you know, and I see all the hands and oh, I just felt so bad.

Likewise Diana, a Latina, was upset that her mother couldn't participate in school activities or perform those tasks set out as what a mother was supposed to do. For Diana, it led her to think about what she would do and not do when she became a parent.

Diana: I'm not saying my mother was a bad mother, but she was a single mother and I didn't understand that. I didn't like the fact that when I came home she wasn't there. I didn't like the fact that she couldn't go to my school functions or she couldn't go to, get off work to go to parent/teacher night or if I was sick that she wouldn't come and get me and that type of thing, and those things bothered me. And I thought, that's not the way I'm going to raise my kid.

Raquel, a Chinese American woman, recounted her childhood experiences of being a latchkey child with both parents working as both an anomaly in the community in which she grew up, and an example of learning responsibility and the importance of living up to familial expectations.

Raquel: ...during my childhood [my father] was always at work and he would come home for dinner, we would have dinner together and that was it. And so I really didn't know him that well, I don't think. So my mother was the main parent and her ideas of parenting, and she was working also and very long hours because during that time we were very poor. And so I think that umm basically parenting was like, "You kids have a lot of responsibility. You kids take care of yourself and stay out of trouble. This is what I expect of you and that's it." Not that she didn't take time with us but not like the moms in Iowa where it's very middle class and all the moms are home baking cookies and you know, I was a latchkey kid. I went home for lunch by myself, I came home from school by myself and I was expected to do certain things and everybody else's mom was like baking cookies for them when they got home. My mom would be all, "I'll be home in four hours." (laughs) "Call me when you get home." I learned to use the telephone when I was very young.

Gerard, a Black man in his late thirties, also notes his childhood household configuration, a consequence of both parents working, and credits it for endowing him with his present sense of family and how things are done. He also notes the differences he noticed as a child from those families around him.

> Gerard: ...we always had a real strong sense of family and I was probably one of the few young Black kids in my neighborhood whose father was in the household. Um, my father was like a late Baptist preacher, in addition to working to railroad....Plus, you add to the fact that we had recently moved to, you know, from the ghetto, but we lived a real middle-class existence. You know, I had two parents who worked, you know, in my family, for instance, there wasn't a whole differentiation between men and women and housework and child care, um, you know, I cooked, my father cooked. My father did a lot of the housework, so and I mean that's what goes on in this household. I probably do most of the cooking.

Diana's mother, a single mother who worked full-time, emphasized sharing with kin partly due to economic necessity as there was little extra money for leisure items. Diana relates the positive emotional consequences of this economic strategy to her sense of what family is, her ethnicity and her own desires to have more children.

> Diana: Well, when I grew up, I was born in the Mission and I lived with my grandparents, and my father figure was my grandfather. I don't know. It was great. I had my cousins and my aunt and uncle next door, so I had kids to play with. I lived in the neighborhood where there was lots of kids and lots of adults...whenever I had anything I would have to share with everybody else and I didn't mind it. I mean, here's an example: I got a bike and my mom says, "What are you going to do with this bike?" I said, "I'm going to ride it." She says, "No." She says, "You aren't going to ride it, but you're going to share." I thought, "Oh, okay." And I did. But everybody who came over I said, "Go ahead." And I guess you just learn to share with everybody. I think that's why I had wanted four kids. Because I wanted that little family. You know, make everything nice and comfortable and cozy.

I have tried to illuminate some of the ways in which different aspects of the self are disrupted by infertility, how they are interwoven, and how their expression and meaning is mediated through social interaction and social history. In the following chapter, I continue my examination of identity by considering the seeking and receiving of support – emotional and instrumental – and conceptualizing this process as a site of identity work, which allows me to note the varieties of interactions that produce an identity.

Chapter Five: Making Sense of Infertility

Jocelyn: … It felt like we were really all alone.

Gerard: You know, this is probably the most personal thing in your life. Who are you going to talk to about it?

Jocelyn and Gerard are a couple of color in their mid-thirties; Jocelyn is of Asian descent and Gerard is African American. They have been trying for 5 years to have a child. During that time, they saw four different infertility specialists, and were able to receive advice and information from either the physicians or their office staff. However, Gerard's earnest question isn't referring to this informational support but rather to talking to people as part of a process of making sense of infertility and attempting to reconcile this identity with other, sometimes conflicting, identities. In this chapter, I conceptualize disclosure, and the seeking and receiving of support – emotional, informational, and instrumental – within social networks as sites of identity work, which allows me to note the varieties of interactions that can help produce and transform an identity.

Disclosing Infertility

When couples experience difficulty conceiving, they are faced with a multitude of decisions. Because couples are part of social networks, both as a couple and as individuals, a key decision is who to tell, and how much to tell. In discussions of disclosure – who knows, who doesn't – the disruption infertility causes in social relationships and identities is revealed. Couples negotiate their identities as infertile simultaneously with the disturbance that their new identities cause in their social worlds.

The couples in this study vary in their approaches and attitudes about divulging their infertility. There is a tension between wanting to reveal their struggle in hopes of getting support and wanting to keep control over the knowledge at a time when having control seems to be increasingly illusory. Also, a preference to be secretive or keep things private could change as individuals journey through the medical system and find things even more uncertain, and change yet again when embarking on a new course of treatment or strategy to resolve infertility. Nachtigall, Becker and Wozny suggest that unwillingness to disclose could be related to the stigma associated with male infertility (Nachtigall, et al. 1992). I did not find any clear association between a couple's attributes such as infertility factor, ethnicity, class, type of intervention and a tendency to either secrecy or openness about their situation, although who was told may have been influenced by these attributes. With only two exceptions, all couples told their immediate families. Most told their friends, though I noted that couples involved with Resolve tended to differentiate between fertile and infertile friends. Casual acquaintances and co-workers were told on a conditional basis, if for example, medical treatments required a change in work scheduling or when the couple was looking to adopt and hoped that it would increase their chances of finding a birth mother if more people knew. In this willingness to disclose, the couples I interviewed differed markedly from the White women interviewed by Whiteford and Gonzalez in their study. They found that women refrained from telling and suffered in silence (Whiteford and Gonzalez 1995).

In recounting the reaction of casual acquaintances or strangers to the fact that they didn't have children, respondents generally characterized the reactions negatively, as intrusive, insensitive and stemming from ignorance. Roberta and her husband Jay have been married two years. Roberta, a White woman in her early thirties, and Jay, a Hispanic man also in his early thirties, are in a period of transition. They both started new jobs and moved into a new house in the year before their interview, and they are vulnerable to the questions that their new neighbors and co-workers ask, although they have developed a tactic for responding to inquiries they see, in Jay's opinion, as an invasion of privacy.

> Roberta: Well, I think the person that's commented more on that to me is our next door neighbor. We just get along real well with them...And we're getting along better but the woman, she's kind of funny. And the other day she said something like, "Well, are you EVER going to start a family?" Just those little comments and you know, its like, "Its none of your business!" There's a nice way to make nice comments and be a little understanding versus people who just make these flip little remarks... You have to realize too that they don't know. They don't have that....
>
> Jay: Right...just the comments from people. "Oh, when are you guys going to have kids? How long have you been married?" and that whole ticket. And that's just kind of frustrating. We've become used to that. The first few months it wasn't a lot of fun, but now you just get used to it. We know what to say.

Roberta and Jay's experience is typical in that the people my respondents encounter are not sensitive about the emotional aspects of infertility, nor do they see it as something that happens to people they know. Americans may be familiar with infertility in terms of advanced procedures and celebrity 'miracle babies' presented by the media, but not as a condition affecting their neighbors and colleagues. Respondents also told of the inability of people to whom they had disclosed to openly address the reality of what they were going through. Sandra, a Jewish American woman, and her husband Steve, a Chinese American man, have been trying to conceive without biomedical intervention for two years. They decided to tell their friends and co-workers about their infertility at the time they started to consider adoption in hopes of getting a lead to an adoptable baby. Sandra compares the response she has received to the response that people with AIDS receive.

> Sandra: ...it's amazing that some people, when you really tell them, they go "Oh." You can just see they have no idea what it means. No idea at all. What could that possibly feel like? What could that possibly mean? When these are well-meaning people! These are people who know you and love you. They have no idea. It's like people know about AIDS now in our society and [if] somebody tells them that they have HIV, that elicits a certain response from them where they can be supportive, you know, and help. I mean, there are other things, but, you know, infertility is very unspoken.

When Sandra refers to infertility as "unspoken", she is alluding to her perception that infertility, despite the media fascination with reproductive technologies, has not yet reached the public consciousness with the same degree of complexity that AIDS has, and does not evoke a similar empathy. One reason for Sandra's opinion may be that media portrayals and popular cultural knowledge do not encompass the entire spectrum of the infertility experience. As related in Chapter Two, the media highlights success stories and medical breakthroughs. Much of the emotional cost and physical toll on individuals is left hidden, as are the failed interventions. Also, Americans are uncomfortable discussing sexual matters straightforwardly, and though infertility is not a sexual issue per se, the link between sex and reproduction is implicitly present. Adriana, an Italian American woman in her late thirties, catalogs some of the reactions and difficulties she sees arising from discussing infertility with people.

> Adriana: When you start talking about infertility, people react like you're talking about sex and we're not talking about sexuality here. We're talking about infertility....and then you have the extreme where people will arbitrarily give you advice without any appreciation for the facts...They don't understand what has led up to where you're at. So, they just make these blanket statements ... I think what really happens is that people have a lot of misconceptions. So, that's one thing. Another thing is just people don't know what to say. And, another thing that happens is people, I do this sometimes, they feel so uncomfortable they want to help, so they try to fix it.

The reasons why couples choose to reveal their fertility problems are varied. When deciding to tell family members, a cited consideration was that it was important for the family to know that the reason the couple didn't have children was not because of a lack of desire. Joe, Adriana's Japanese American husband, took great pains to explain to his mono-lingual mother that the reason they hadn't had children was because of a physical problem.

> Joe: ...we have a language problem. I could only communicate to her in Japanese and I don't speak fluent Japanese. So, I have real problems with finding the vocabulary to describe all of this.... I tried to describe a little bit more that we're going through some more testing and exploratory things and tried to describe the best I could that her [Adriana's] insides were damaged.... But, I just don't know the words for – (laughter) – but, I think she's got the idea that there is a woman problem is why we can't get pregnant. But, she understands that we're trying and the reason we don't have children is not because we choose not to; it's because we can't physically. And, that's as far as it goes.

For Joe and Adriana, it was important for the cause of their childlessness to be a physical ailment so they could still adhere to cultural norms of desiring children – and thus ensure familial continuity – in the eyes of their parents and other family members. By disclosing their infertility, they could deflect possible negative motives attributed for their childlessness.

People also revealed their problems in hopes of getting answers to their questions, and of finding information that could help them make sense of what was occurring. The sharing of information has long been regarded as key to the survival and flourishing of groups often marginalized from the mainstream. Louis' chronicle of seeking information was noteworthy as he also had emphasized, as did his wife Raquel, that Chinese people did not readily discuss matters considered private.

> Louis: I come from a large family where women were treated as equals and all this other stuff, so I don't have a problem with relating to people and just talking about it. So, I did. I mean, I asked everybody. I called up people I had no idea who – But I asked. I called this person, "Would they be willing to talk to me?" I asked. I honestly had fertility issues. There are very few who had.

> And those who've had, did not have this particular problem… It's more like I'm trying to look for knowledge to see if there's anything that I can do. You know, like, should I stop drinking coffee? Am I supposed to have ice at my side at all times? I mean, are there any of a variety of things that I can [do?], because I want to know the answer.

In the sharing of information, there is also the implied nurturing of bonds of solidarity. This is congruent with another reason expressed for telling: the desire to find other people who, regardless of their own fertility status, might understand and thus lessen a couple's feeling that they were alone. All these reasons are related to support.

When the couples who had decided not to reveal their infertility to their families explained why they had made this decision, what was foremost was the felt need to keep control over the information. This need warred with the desire to be honest and open with their family. The potential for losing control over who was told, however, outweighed their discomfort with holding back from sharing. Raeshell, a Black women in her late twenties, has been married for seven years and her parents are starting to put pressure on her and her husband Tom, to give them grandchildren.

Raeshell: My mom, she is very, very intensely waiting on grandchildren and I think that my father has finally gotten the itch for a grandchild. My parents waited; my parents were married four years before I was born and I think they have respected our waiting in getting settled down and you know they really kind of respect our relationship too. But, lately, she has really been into – I mean, "when are you going to have children?" My mom's only sister has four children and three of the four children have children. Well, two of them have children and one is on the way and her sister needles her a lot about it and I think that my mom is really sort of feeling the pressure. My dad had 17 brothers and sisters and the majority of them have grandchildren…

> but everytime we get into a situation where we're talking and kind of sharing and you know, kind of going deep into ourselves, I always feel like there's this great deception, because my mom does not know about [the] one most important thing in my life right now. But, I also know, the realist part in me [that] my mom is not the kind of person that you'll tell a secret. If I tell my mom and tell her not to tell, it will be like announcing [it] over the PA system at an A's game.

Raeshell's husband, Tom, is a Black man in his early thirties. His family has also not been told of the difficulties he and Raeshell have confronted when trying to conceive.

Tom: ...I couldn't tell anybody else. I mean, I can't see myself telling my older brother. Not at all. I mean, I can ask them indirect questions. But never let them know that I am having any type of difficulties. My sister, um, um. (laughter) I love her dearly, but no. She's missing a cog. Um, no. Nope. I can't think of anyone else. But, that's just the pressure that we received from, from our parents when they see us and ask. My sister asks every now and again. My brothers, no. That never comes up...I must admit when the question is asked, "When are you going to become pregnant?", it pulls; it's like something grabs me from the inside and pulls me backwards. It's almost like it pulls me back and makes me sit down and just kind of look up with a puppy dog feeling inside. But, I know it's two emotions working there. One, I'd really love to tell them what's going on and have them understand me completely; and the second is I know I can't. I have to keep this to myself. It's the only way it's going to go.

A little later in the interview Tom adds:

> No, I could not tell my father. He would not understand. He is very simple and clear in his thinking. And, he has this terrible problem. When he begins to speak, there is only one level. Loud! (laughter). And it's just how he feels. You express your emotional side. "What's that? I don't understand that." That does not come into play. My mother, she'll sit back, she'll listen and then she'll introvert. She'll ask a few questions and then introvert and then talk to her sister on the phone and then I know, it's like going on the grapevine, but it's real hush hush. It gets around, but then she'll do in front me is she'll speak Creole to her sister.... But, she'll talk, talk to her sister about it and it would go, and it would [go] through the entire family all the way across the country and information would be out. So, it's to the point of not saying anything.

Raeshell feels the pressure to have children from her parents more intently than Tom because she is the oldest child in her family and her younger sibling is still single. There is an expectation that she will be the one to reproduce attached to her identities as a married woman, and the oldest daughter in a committed heterosexual relationship. Tom's older brother had a child after 8 years of marriage, and Tom and Raeshell are still within this time frame, and so the expectations for Tom as the younger son, while still present, are not as intense.

Both Raeshell and Tom experience a conflict between what their ideal of a family is, one which supports each other including keeping confidences, and the reality that if secrets are revealed, they will be shared across the larger family. At a time when Tom and Raeshell are learning to cope with the pain and disillusionment of infertility, they do not want to deal with the potential betrayal of confidence as well. They prefer to weather the pressure and questioning of their family members and not reveal their infertility status. Instead, Tom and Raeshell are fortunate in that they have close friends predating their marriage – another couple who also has been diagnosed as having impaired fertility. It is this couple to whom they turn for support and advice. In fact, Raeshell credits the information they have shared with her and Tom with placing them on the path to seeking a biomedical resolution. Because this couple has also been subjected to intrusive questioning by Raeshell's mother, there is an understanding of Tom and Raeshell's desire to keep their infertility a secret from their family until they choose to reveal it.

Diana, a Latina, and Kevin, a White man, have told their respective families of their fertility problems, but they have also decided to maintain control over what information they give out about their efforts to carry a child to term and medical interventions. Because Diana has had multiple miscarriages, with accompanying disappointments and grief, Kevin sees this control as a way of protecting Diana from her family's disappointment in her inability to carry a child to term, and thus fulfill the gendered and ethnic expectations of a married daughter.

Kevin: You know, anytime you got pregnant, I didn't want you to tell anybody... Cause then they'd just... You know, there would be all this emotional

> highs and then if something happened, they wouldn't be very supportive, you know? Or just make it worse, you know? I didn't want anybody to know until – I don't know if that's selfish or not. I thought it was for you; I didn't want anybody to know until we were at a point where we felt that it just wouldn't be possible to have a miscarriage.

Along with letting go of control, there may be fear of social consequences of being thought of as inadequate or flawed. Research has shown that those experiencing difficulty conceiving may also struggle with stigma (Miall 1986; Becker 1990; Nachtigall, et al. 1992; Whiteford and Gonzalez 1995). However, this may be more of a felt stigma, reflecting "internalized societal evaluations of their condition", than an enacted stigma that stems from "intentional discrimination against the stigmatized" (Greil 1991, p. 133). In interactions with family members, infertile couples must negotiate their identity of son or daughter which has been altered by their infertility. They may feel that they are not able to fulfill the expectations of reproduction associated with that identity. Also disrupted may be the dynamics of sharing and support normally in place.

Discussions of disclosure with respondents inevitably led to discussions of support and accompanying questions: what did support mean, who did they feel was supportive, why or why not? People used the term support to refer to a variety of things. Support was understood to be emotional understanding, validation of their struggle with infertility, anything which lessened feelings of isolation, the sharing of knowledge or information, the provision of tangible things such as accompaniment to physician's appointments, a sensitivity to their predicament, or a show of sincere concern.

Support Networks as Sites of Identity Work

I will be using the concept of support as a lens through which to examine identity and interaction but I want to note that support in itself is a topic worthy of inquiry. The network of relationships formed by individuals has many functions related to support such as the channeling of the flow of resources, information, and material goods and services (Stack 1974). The giving and receiving of support - instrumental, informational and emotional - takes place within social networks which are also used to mitigate isolation and aid integration into a community (House, et al. 1988). In relation to illness, support networks have been shown to promote adherence to medical regimens, enhance the effectiveness of medical treatment, protect against depression and other psychological problems in the face of adverse life events, and promote the return to normal functioning after severe medical illness (Wortman and Conway 1984). Two important points to remember about networks which provide support is that they require resources of the individuals utilizing them (Borkman 1991), and they influence the performance and enforcement of cultural norms through the type of support given (Cox and Monk 1993). As it is culture which defines the meaning of an event, it is culture which dictates the appropriate source and type of support to be sought (Ulbrich and Bradsher 1993).

Individuals and couples in this study sought support from a number of sources. The most common order given was spouse followed by family, and friends. A few people also mentioned seeking support from a church or other spiritual center. Before proceeding to explore the negotiation of identity mediated by spouse, family, friends and religious institutions, I want to consider Resolve, a national self-help organization focused on infertility, as its role in providing support reflects race, class and gender configurations.

Resolve

Resolve sponsors support groups and other informational services such as a hotline and symposia. As noted in Chapter Two, initial recruitment for this study was through Resolve and then expanded to other venues. Other existing studies have relied on Resolve membership as a way of gaining access to the invisible population of infertile (Greil 1991; Becker 2000) and have documented its importance as a source of support and site of agency for infertile couples. In this study, 60% of the couples interviewed were familiar enough with Resolve as to have received some sort of service from them (such as attendance at a workshop or a seminar), and a little over a third of the couples attended Resolve support groups on a regular basis.

The reasons why people did not participate in Resolve are somewhat ambiguous although their interviews provide some clues. There were some couples who weren't aware of Resolve at all. This is perhaps due to the fact that a main outreach venue for Resolve is physicians' offices and fertility centers. For people who were not actively seeking biomedical treatment, whose access to treatment was limited, or who did not read English (as was the case with Mexican immigrants Hilario and Amalia), exposure to Resolve's outreach efforts was very limited. Another reason may be that couples judged Resolve as inappropriate or not for people like them. Deborah, a White woman in her early thirties, knew about Resolve but did not become involved with a chapter at first. She and her husband Rob, a Black immigrant man from Africa in his late thirties, have been trying to have a child for three years. They first sought a diagnosis and treatment when they lived on the East Coast, and continued their pursuit after moving to the Bay Area. Deborah talks about her initial impression of Resolve.

Deborah: I had heard about them in the background. Sort of like how I heard about A.A. You don't really know it until you need [that] kind of thing. But we never really did anything with Resolve until we moved here. I think I called them once or twice back east and they weren't quite as organized as they are here. I was just picturing that it was going to be a bunch of rich White people sitting around and going on yacht trips and I just thought I don't think we were going to like that too much. It probably wasn't anything like that. It is just what it seemed like it would be. Here it is different.

Deborah's perception of Resolve was both classed and racialized. Although the membership, by definition, would share the experience of infertility with her and her husband, this supposed commonality was not enough to outweigh Deborah's anticipated difference based on class, racial affiliation, and her being in an interracial marriage. While Rob and Deborah did eventually attend support group meetings and judged them to be helpful, a sense of difference persisted. Rob commented that every time they went to Resolve, all he saw was "White, middle-class, affluent people. Where are the other people?" In other words, where were the people like him?

Becker has shown that Resolve is an example of a middle-class approach to seeking help (Becker 2000). I assert that Resolve is also a racialized approach. For some of the couples who did not attend Resolve meetings, the idea of going to a support group was dismissed out of hand as not fitting in with how they saw themselves as people of color. Support groups were conceptualized as sharing personal information with strangers. Strangers could be individuals who were not family members or people who, while they may have been undergoing a similar experience, were in no way accountable for what they did with the information. While they may not have been referring to Resolve specifically, their sense of where boundaries of privacy lay were communicated clearly and often attributed to ethnic and racial practices. At the same time that Louis and Raquel, a Chinese American couple, acknowledged that support groups were difficult to find, they also made a judgment about the plausibility of Asians talking about infertility with people other than family.

Louis: But, again, with Asians, because so much of their life is centered around family, really, I don't really find a whole group of people, [a] support group available to discuss this matter with.

Raquel: And not only that, Asians don't discuss things like this.

Gerard spoke about the tendency for "Black folks" to be secretive about their private lives, while Franklin alluded to historical abuses in which information was used against the African American community. Gerard did talk to other African American men about infertility whereas Franklin depended solely on his wife Calandra for support – she spoke to girlfriends – and was adamant about maintaining his privacy.

Franklin: ...as far as support I really haven't talked to anybody about it. The only support I have is my wife. And I think that it is nobody else's business if we can't have children.

As well, attending support groups did not always fit with gendered notions of what was needed. Women were more open to receiving support in a formalized fashion while men preferred to gain support from an informal talk with a trusted friend or colleague. Men related their discomfort to talking about emotional issues with strangers to their personalities rather than learned ways of relating. The response of Kevin, a White man in his late thirties, exemplifies this.

Kevin: ...as far as the real emotional stuff goes, I'm not as into it perhaps as a lot of husbands might be. I really don't know because I don't have any friends that are like that. I don't know what men, how some men respond or I suppose there are groups and what not, but I have never been a part of one. All of the friends I had have never had problems like this. It's something that you have a real hard time talking about. At work, you just can't talk about it at work. We have one friend, well, we found out that one person that we knew in my office was going through similar things, so we both talked to her about that,

> and that's kind of nice having somebody that is going through similar situations, which seems to be very hard to find people like that unless you actively seek out support groups. I know she's done that and I haven't. A lot just because that's the way I am. I keep a lot of it inside myself.

While Kevin has decided not to seek out support groups as has his wife Diana, he does acknowledge that it is helpful to have someone to talk to who is experiencing infertility. Kevin, as well as Louis, Gerard and other men, wanted the support and validation that sharing with a person with a similar experience brings,[19] but they did not want to gain this by means of a support group. However, they also realized that finding and interacting with other persons struggling with infertility was difficult. Resolve could provide a venue for meeting other men and women struggling with infertility, but only a proportion of my sample sought this benefit. Those that did spoke of the relief that they felt in realizing that they were not the only ones having difficulties conceiving. Cynthia, a White woman in her early thirties, and Cal, a Chinese American man in his late thirties, have been trying to conceive for 5 years. They didn't become involved with Resolve when they first confronted difficulties but only after years of treatment when Cynthia viewed a television show which featured the organization. They tell of their reaction to their first Resolve gathering.

> Cal: It was interesting - our first time with the symposium...
>
> Cynthia: It was like 100, 150 people. I walked in and went...
>
> Cal: My God!
>
> Cynthia: All these people have the same problem.
>
> Cal: Gee, they're just like us.

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[19] Thoits, ("Social Support as Coping Assistance") asserts that a primary function of support groups is that the presence of others with similar experiences provides validation for the individual's experience.

Cynthia: Well, yeah, you feel like you're the only one.

Cynthia and Cal felt a release from the sense of aloneness they had been experiencing. Their sense of connection with other symposia attendees was based on a perceived similarity of experience which outweighed any differences noted in racial/ethnic composition or class. They subsequently joined a support group which Cynthia credits with enabling her to "sort through her feelings and stuff." Cal noted that his involvement with the support group has led him to be more open with his feelings about their infertility. The only point that the shared experience of infertility became less salient as a unifying factor was when the support group meetings began to take place in various member's homes; Cynthia said that she felt "weird" because having support group members in her home allowed them to determine her and Cal's class position. Her discomfort with revealing her and Cal's class position points to a possible fracture in the support group's privileging of the commonality of infertility when confronted with difference.

Becker suggests that involvement with Resolve could have a significant influence on how couples conceptualize infertility (Becker 2000). One way that Resolve could influence their conceptualization that I noted was that couples were provided with a model of how to manage their infertility. The model put forth stressed being informed, taking an activist consumer approach to remain in control of medical treatment, and ultimately resolving infertility by having a child, though not necessarily a biological child (Becker 2000). While acknowledging the pain of infertility and the underlying American cultural ideals that infertility violated, Resolve does not contribute to the stigmatizing of infertility, but encourages couples to fashion an identity which is empowered. Through their extensive discussion of the differential gender effects of infertility, Resolve also furnishes a primer on how to integrate the infertile identity with that of other social identities, primarily that of spouse. Couples who attended meetings and support groups spoke about how they had learned to deal with their spouse at the same time they were dealing with infertility; men particularly credited Resolve with teaching them how to be supportive to their wives. Cynthia and Cal's discovery in this regard was typical.

Cynthia: ...And I found out what he was doing was what other men were doing too and that they think they are supporting you, but they're not saying the words that maybe you want to hear.

Cal: We're just not saying the right stuff.

The model that Resolve provides for framing communication difficulties between spouses is intentionally gendered, but it is also invisibly classed and racialized White in that other modes of miscommunication are not considered. Of the couples involved with Resolve, there were a few in which the man's involvement was minimal and done as a symbolic gesture of support for his wife rather than for its own merits. In one case, only the wife, a White woman, attended support groups while her spouse, a Chinese American man, preferred not to go, stating that he was raised to "not reveal emotions to others." Overall, men were more engaged by the information services that Resolve provided rather than the emotional support cited by their wives, consistent with gendered ideals of how best to confront a problem. Couples who were involved with Resolve spoke of it as a positive experience. There was some mild criticism, as noted above by Rob, on the homogeneity of the membership and a few were disappointed with the dynamics of the support groups which often fell apart when other members became pregnant.

A quarter of the couples interviewed used Resolve as a source of information rather than emotional support. Women appreciated the knowledge gained from seminars and workshops as it helped to develop a sense of control over what was happening with their bodies (Cohen 1988). Mark, a White man in his late thirties, and his wife Joyce, a Chinese American woman in her mid-forties, had success in conceiving after Joyce's tubal ligation was reversed, but she was unable to carry a baby to term. Being very aware of the passage of time, and the narrowing window of opportunity, Mark and Joyce have been very selective about their involvement with Resolve, choosing to only attend a conference and an informational meeting about adoption, and to receive their newsletter. They found that Resolve informational services provided a forum in which to explore their options and consider the future implications of their choices.

> Mark: ...we get their newsletters and I scan them. I haven't derived a lot of benefit from them per se, but going for a day session and forcing us, by being there, sort of to focus onto some of these things and to hear other people and how they dealt with, is a very useful process in thinking through the issues for ourselves because it forces you to hear how somebody else has dealt with or hear what their views are and not necessarily agree with them but you have to react to them...

Because of their attendance at Resolve sponsored meetings, Joyce and Mark were able to get answers to questions that those in their social world were unable to answer. They received informational support from Resolve but they looked to family members for emotional support, even though their family had no experience of infertility. In this, Joyce and Mark were typical of most couples interviewed in that they did not depend on Resolve as the sole or even the main source of support, but relied on varying configurations of spouse, friends and family. Those couples who were not involved with Resolve or any other formalized support groups sought to receive the benefits Resolve members received

- emotional support, validation, lessening of sense of isolation, information, sense of control - from other sources as well.

Spouse

Infertility is an issue that affects both members of the couple individually, the couple as a unit, and their marriage. While the contemporary model of marriage in the United States stresses companionship, conceptual models which assume the primary purpose of marriage is to have a legal union in which to procreate, and to provide a stable environment in which to raise children persist, particularly in religious and traditional ethnic communities. Under these conditions, the social identities of husband and wife are challenged as couples are unable to make the transition to father and mother.

Another, more subtle challenge to the spousal identity stems from expectations of support and unity in a marriage. This reflects the Western ideal of romantic marriage in which the wife and husband are supposed to help each other, but in particular ways. Notions of support and caretaking are gendered and evident in traditional roles within marriage. Traditionally, the woman provides emotional succor to the man and the man gives economic support to the woman (Rapp 1982). This delegation of roles is associated with the belief that there are two spheres of social life - the public sphere in which men predominate and the domestic sphere which is the responsibility of women (Yanagisako 1987). While this belief has been continually challenged, particularly with the participation of women in the wage labor market, women are still considered to be more responsible for doing the emotional work of relationships. Consequently, women generally construe support primarily as emotional support – talking about an issue, offering validation - while men interpret it as receiving or giving something tangible such as physical presence or information. While a conventionally gendered notion of support was found to be operating among the couples interviewed, I also found that there was some flexibility with men bringing up examples of emotional support they had received from their wives, and women preferring instrumental support more than emotional support from their spouses. When asked how he tried to support his wife Roberta, Jay, a Mexican American man, responded as follows.

> Jay: Well, I try to go to as many [appointments] as I can because I think it gives the doctor - especially the male doctors - a sense of "this isn't some whiny professional woman here." Just a little bit better respect and to just put your money where your mouth is. I mean, if you're taking time off work it shows the doc that you're serious and I think it really provides some moral support for her.

In a separate interview, Roberta, a White woman, confirmed that these were things that she found helpful, particularly as they were symbolic of dealing with the infertility jointly.

> Roberta: Oh, going to the visits. Reading the things. Taking a real active interest. Quizzing the doctors. He makes up his own set of questions when we go. For a while, we were on shaky ground a little bit. When it got into his testing, he didn't want to do some of it, and once he got through one of them then it was kind of no big deal and he was very involved and didn't mind going for all the testing, but that was hard in the beginning. I just think being part of the process. It's not like it's just my process, it's his too and so that definitely helps.

Gerard, a Black man, when asked how his wife Jocelyn, of Pacific Islander descent, had been supportive in confronting their infertility, phrased his response in terms of survival and working together using the metaphor of pushing a wheel.

> Gerard: Just words of encouragement. We have a really good marriage. I mean, we're in love still. And so, you know, Jocelyn's always been my best friend, and so just the fact that I know my wife still loves [me] and that you know, we'd survived whether or not we had a child...that's consistent with my idea of being tough and ... you just don't let anything beat you down. I mean, and

> also, like you said, a large part of that is the fact that Jocelyn is real supportive. You know, if Jocelyn had been less than supportive, then God knows what would have happened. I don't know. I mean, it was always like there were two shoulders on the wheel, instead of one. Two shoulders help it push forward. One shoulder makes the wheel go around in circles.

The perception that both members of the couple were working together to confront infertility was key to feeling supported in all couples, regardless of the type of support received. This notion of unity is consistent with American cultural ideals of marriage, and is further emphasized in situations of infertility because the desired pregnancy and child are supposed to be common goals and endeavors of both husband and wife. There is also a belief that weathering a crisis should strengthen a relationship. This is a belief that is consistent across class lines (Rubin 1976) although the actual dynamics of how crisis is handled can differ by both class and gender. For people of color, the ability to endure and overcome obstacles is recognized as necessary for survival. This ability is conceptualized as both an individual trait, and as an attribute of the collective. If partners in a marriage can demonstrate this quality, it is considered to be a hallmark of a good relationship.

When couples are undergoing treatment for infertility, the desire for a sense of unity is particularly acute. The standard biomedical approach is to treat the couple for infertility, yet the majority of biomedical interventions happen on just one body – that of the woman, regardless of who is diagnosed with a problem. Husbands and partners, in keeping with the couple approach, are encouraged to participate in treatment by providing instrumental services such as giving injections of hormones in preparation for in vitro fertilization. This type of prescribed support is not always valued as in Raquel's case. Her husband's attempts to support her in this manner were rebuffed, as she viewed his lack of skill as potentially harmful. However, what Raquel, a Chinese American woman, counts as supportive is Louis accompanying her *when she asked him to*. She confesses that in actuality his presence was at times more of a hindrance since he did not have a grasp of the technicalities of the medical procedures that she, as a practicing veterinarian, did.

> Raquel: ...he hasn't been that active in the treatment. Most of it is my fault because I couldn't ... I've seen him handle a syringe and I couldn't, I couldn't imagine him coming at me with a needle. And because I handle syringes every single day, I did all the injections myself and you know, uh he would sometimes go in for the monitoring. He would always, if I asked him to, he would always accompany me... For the retrievals, he was there. For the transfers, he was there, and he always came in for the consultations. But I just found it more of a bother. You know, I could get the whole process done much quicker without him there.

Those who did not feel supported or who were dissatisfied with the amount of support received from their spouse were exclusively wives. In these cases, the women wanted their husbands not so much to talk to them but to take action, voicing a desire for their husbands to take on a conventional gendered role. For example, Kevin, a White factory manager in his late thirties, was not always able to take time off from his job to go with Diana to her appointments. Diana, a Latina woman in her mid-thirties, told me that she felt unsupported when Kevin did not accompany her to appointments, both because she thought it was "embarrassing" and because she had to confront the physicians by herself. While Diana acknowledged that Kevin was there – both physically and emotionally – when she suffered a miscarriage, she found it difficult that he did not take as active role as she did in confronting infertility. She is frustrated with what she sees as Kevin's passive approach epitomized by his unwillingness to "fight with the doctors."

> Diana: I wish that he was more supportive and being there; that whenever I had to go for an insemination or if I had to go for a test that he would be right there

> by my side. Because that's one thing that I would yell at him and say, "Well, it's embarrassing for me to go to the doctors and you not be there with me, and me be by myself." And I said, "That really bothers me." And he said, "Well, I did what I was supposed to do, so I guess I was there." And I said, "But you weren't. There's a difference between you holding my hand and being there, being there and then not being there."
>
> Well, when I've had my miscarriages, he's been there. He doesn't say much, but the most difficult...would be that – because he's not a fighter like I am. And I will research until I get my answer and I won't stop until I get my answer and that's not Kevin. He puts me out there. He goes, "There's the lion. She'll go for it" and I am. I'm one of those. And that bothers me...Because I'd rather have him fight with the doctors than me fight with the doctors, you know? I think that since I've done my part and I've said what I had to say, now I've put it on his lap and say, "Say something"...

Diana feels unsupported at times because she perceives an imbalance in performing the work she sees as necessary to resolve their infertility. She wants Kevin to take a more active role, and interprets his reluctance as a difference in their individual commitment to the goal of having a child.[20] Kevin, on his part, admits that he doesn't think having a child is as important to a marriage as Diana does.

In the couple interview, Calandra, a Black woman, expressed some dissatisfaction with the support she was receiving from her husband, and like Diana, phrased it with regards to Franklin's inaction.

Calandra: I have talked to my girlfriends about it and stuff. Sometimes I get, I feel really sad you know. And then there are times when I just give up on the idea. I give up on the idea [of having children].

> And when Franklin and I talk about it, it is just like we talk about it, no action is put behind it. We don't actually go out into the world and try and create something. So that is a problem for me too.

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[20] For all the women who talked about a definite lack of support from their spouses, there was some evidence that their husbands weren't as invested in having a child because of, for example, the presence of children from a previous marriage.

In the solo interview, she returned to and expounded on this dissatisfaction, discussing the gender ideal she wants Franklin to fulfill and what is her strategy to accomplish this.

> Calandra: Franklin is supportive and I know that, I think what is really helpful too is that I know that he will make a wonderful father. And I think that is the biggest thing [that has helped me].
>
> I see him starting to take more initiative on things. But it has been a slow process. Because I have to kind of take less charge in the relationship in order for him to take more charge because I am real sure of myself and what I want and he hasn't come from that place.
>
> And so I have had to allow him the room to grow and change and be the man in the relationship because basically I did make all the decisions because I know what I want and so I am learning how to just sit back and let him take the lead and it has been a process because I have slow down.
>
> But he wouldn't feel like the man that I want him to feel like because he would feel oh she is doing all this and I am less because of all that stuff so, I have had to really help him. Not stroke his ego, but he has been like bashed so much, from his family, society and he does it to himself and so as his significant other, I feel like it is my job to lift him up and encourage him and stroke him and also be firm when I need to be. But it has been a process and I am seeing that he is starting to take more initiative in the decision making and all this.

Like Diana, Calandra wants her spouse to be more active and perform in conventional gender mode. However, Calandra's desires are also shaped by expectations of what a Black man should do. Both are, I believe, responding to the disruption that infertility causes in both gender and spousal identities. With the uncertainty spawned by the possibility that their partners weren't as committed to having a child, they sought to reassure themselves by relying on prescribed gender relations at the same time that they were subverting their own expected performance of womanly passivity.

Family

Families are considered the primary group that a person relates to emotionally (Ablon and Ames 1988), and they have been shown to be a valuable resource and source of support during times of crisis. As well, family and interactions with them during a time of crisis can be a source of stress. When couples of color turn to their families to make sense of infertility, they are also seeking support in a fashion which has been determined culturally, historically and structurally. Among marginalized cultures historically lacking power or status in society, particular support sources (e.g., extended family, spiritual support) have developed through experience and cultural tradition as resources for dealing with crisis (Golding and Baezconde-Garbanati 1990), particularly when other, more institutionalized avenues of support are inaccessible.

The respondents in this study talked extensively about how family members other than their partners either positively or negatively helped them deal with their infertility. In most cases, the type of support received from families was described as differing qualitatively from that provided by support groups and spouse. Family members were not expected to provide information or emotional support in the form of discussion. What was perceived as support from families was showing concern and interest in while not being overly intrusive, and being sensitive to possibly upsetting familial situations such as baby showers. What was most helpful to couples was acceptance where members of the couple were not made to feel that they were "letting their family down" by not being able to reproduce. Jay contrasted the support he and his wife Roberta felt from his Mexican American family, from that of Roberta's White family.

Jay: In regarding grandchildren, my parents have just been extremely supportive, in terms of – They certainly, they have never ever put any kind of overt or subtle pressure on us for grandchildren and so forth. Either why or how many or when. Never. I think my mom has, my dad too, have a sense of what it's like to go through a sense of loss. Infertility in and of itself is a sense of loss. Because you have, hopefully it's regained, but it's a loss. I mean, not being able to reproduce from one generation to the next and that's a loss. But, you know, my parents have been extremely supportive

> of us. My mom was feeling particularly bad. I think some of it's Catholic guilt like all of us Catholics have. But very supportive and my mom and Roberta, for the last couple of months, have had some pretty deep conversations about it. Because one, Roberta's mother doesn't live here and emotionally they are just very distant. I mean, her mother has just no emotional feelings and is just unwilling to talk. I think they are there, but she can't deal with this and it's very frustrating to Roberta and in some ways my mom is like her second mom.

For Roberta and Jay, as for most couples, the fact that they are unable to have children has disrupted the larger family, and affected relationship dynamics between parents and children, and in-laws. The inability of Roberta's biological mother to discuss with her daughter the pain and loss of infertility has deepened the gulf between them. The fact that Roberta and her mother-in-law had some "pretty deep conversations" about the loss of infertility is unusual because, for the most part, couples did not expect their families – particularly those of another generation, and even more those who were immigrants – to understand what they're going through. However, Jay's mother experienced a miscarriage and both Jay and Roberta mentioned this as one basis of understanding. Roberta has turned to her mother-in-law for support, and found some validation in the shared, albeit cross-ethnic and cross-generational, experience of loss. In the process, Roberta is also redefining her identity as family member, and seeking an affirmation of her identity as an adult child despite her failure to complete a life passage viewed as culturally significant.

The inability of family members to understand and discuss infertility was pervasive, and the reasons were varied. Many times the families of respondents didn't understand the complexity of the infertility experience because of lack of knowledge about infertility, beliefs about the naturalness of fertility, and lack of experience with infertility; they were unable to discuss the impact of infertility because of cultural mores against discussing private matters, not wanting to intrude, and communication obstacles. The experience of Delia, a Chinese American woman in her late thirties, is typical. She recounts the following exchange between herself and her mother at the office of Delia's infertility specialist.

> Delia: I had gone to his office with my mother that day, because Eugene was working, and I came out of his office and I just started to cry and my mother said, "What's the matter?" And I said, "He says the next thing we've got to got to try, if we want to try again, is in vitro fertilization." And mother didn't know. She never knew anything about any of this stuff and she's been very nice and very supportive, but it's not something she can totally relate to because she never had this problem. And she said, "Well, what's the matter with that?" And I said, "Well, that's like the court of last resort."

It is significant that Delia characterizes her mother as supportive even though she is unable to give her guidance, or discuss her options with her. In this matter, Delia is the expert and she must educate her mother about the medical interventions she and her husband Eugene are considering. Delia's mother accompanying her to the appointment with the specialist when her husband was unable to do so is valued as an indicator of support, and is sufficient. In this, Delia is similar to other couples who have different expectations of support from family members, and a different standard of what is helpful. Raquel, also a Chinese American woman, in talking about the support received from her family, explicitly lays out the different type of support each one is able to provide.

> Raquel: My sister that I'm close to here in the Bay Area - she was terrific of course and has been through every step of the process with me. She agrees this is, like, a hell of a way to have a baby. (laughter)...my sister and I we didn't believe that it would ever come to this; come to in-vitro. But, now, I mean, she is terrific. She has been really really helpful.
> And my mom and dad are —He's a little Chinese guy. He don't want to hear about this stuff, right? So, he's like, you know, he is sympathetic, but he is not going to engage in lengthy conversations about it. It's like, I do it more as, you know, I want him to know what's going on, but I don't expect him to really have anything to say about it. So, it's more knowledge just for him to

> know…I mean, he's supportive. He told me, "Oh, don't worry. Everything is going to work out." But, as far as contributing any knowledge other than just familial support, I don't expect that of him and I don't expect him to, like, ask me questions about it or anything like that. That's just not his style, right?
> And my mother is also, you know, she will – if I sit down with her and talk to her about it, she'll talk to me about it, but – For example, this time she knew that I was undergoing the egg retrieval and everything and then they went to Hawaii to go visit my other sister. She would not call me to say, "Well, did you get fertilization?" She would wait for me to call her whether, if I chose to do so or not. So she respects my privacy a great deal which I appreciate.
> They've been very supportive and very understanding, but they're not overly inquisitive which to me – I mean, this is just such an undignified process. At least to me, my privacy affords me some dignity.

In addition to conveying a sense of the differential expectations she holds, Raquel's description illustrates some of the gender and generational differences encountered. Raquel's mother and father offer support in a more traditional gendered manner while her sister, a member of the same generation, extends both emotional and instrumental support. Generational refers not just to the age difference between Raquel and her parents but also the difference in experience of an American born and educated Chinese American woman from that of her parents, immigrants from mainland China at a time of xenophobia. In how the different members of her family confront infertility, these axes of identity are thrown into sharp relief.

Raquel's husband Louis took the same stance as Raquel with regards to having differential expectations of his siblings. He looked to his family for emotional support, not expecting informational or instrumental support. Raquel and Louis, like most couples, took their family's shortcomings in stride, made excuses on their behalf, and they then turned to other members of their social group for additional support.

Louis: They have been supportive to the extent that they could be supportive. It's a very unusual issue for them because all of them married in their 20s, so if there were any male factor going on from an inherited point of view, my

> brothers would not have experienced it, because they had their children relatively quickly. My sisters all been married in their 20s in the same circumstances.
> One doesn't know how this occurs. They know, virtually, it's sort of hard to be completely open simply because you get – They're not scientific in any way. All are educated, but they're not, they won't, you know, they won't give you any useful suggestions.

While Louis does not expect to receive any useful suggestions from his siblings, he did take heed when his mother-in-law suggested that they try Chinese medicine and arranged a consultation with an herbalist.

Louis: ...we would drink this very – not distasteful – but unusual tasting herbal soup...it took a long time and a lot of effort. You went to an herbalist and you got all this medicine – It's very expensive. You know, you drink it. You drink it three nights in a row....Your mother – Your aunt made the – Or your cousin made the first batch of soup and we drunk that. And then your mother came here and we drunk the second batch of soup.

I initially found this surprising as throughout his interview, Louis emphasized the scientific approach that he and Raquel were taking to resolve their infertility. As Louis continued to talk about his family values and what steps he took to honor these values, I realized that Louis was acting as a proper Chinese son-in-law and showing his respect for his elder, his mother-in-law, by accepting her offer of support. Her offer of support is instrumental as well as being imbued with meaning relevant to a particular cultural sphere, just as the prayers offered up on Jay and Roberta's behalf by Jay's parents are.

When couples received support from relatives that was ineffectual or were the recipients of comments that were insensitive, they often attributed a positive intention on behalf of the family member. The offending party was often excused on the basis of not knowing enough about infertility. They rarely confronted the offender, but rather remained silent and sought consolation elsewhere. A few individuals felt that such a situation was an added burden which intensified their feelings of isolation and separation, particularly if they perceived an element of blame being invoked. Diana, of Mexican and Puerto-Rican descent, spoke of such an attitude, as did Roberta, a White woman married to a Latino.

> Diana: My family is really hard about it. They couldn't understand. They say, "Oh, it's because you're so thin or you're not eating enough or maybe you're not taking vitamins or maybe because you're stressed out because of work," you know, there's always something. And my mom, you know, she kept saying, "Well, what is it? What are you doing wrong?" And I said, "I'm not doing anything wrong," you know? And they started ignoring me.

> Roberta: [Jay's brother] got married a year ago and we've been close to them as a couple and see them for dinner...And we've talked to them a little bit about it because they are thinking about kids. It's kind of different because he's the obvious breadwinner and she's either going to stay home and all those kinds of things whereas with us, its obvious I'm not going to stop my career and that's going to continue...You can't say its not but its just a little different when we talk to them. I always get the feeling like they're making some judgments about the fact that, "well, if you're trying this hard you should really stay home." Its like, that's probably not reality, so – But your family is still supportive. They know. And most of the time people just don't ask. I think we probably talk to [our friends] more about it because they sometimes say, "well, we know you're trying this month."

Regardless of what type of support was received, for almost every couple, it was important to go through the process of seeking support from family members. Their looking for support is consistent with cultural ideals of turning to family in times of crisis. This process of seeking, receiving and giving support served as a way to implicitly evaluate on the part of both the couple and the family members what disruption in familial identities had been provoked by the infertility. For some, it was a mechanism to reinforce aspects of the identity as a son or a daughter (or son-in-law, daughter-in-law).

Family members as well have to renegotiate their identity and their relationship to the couple. They are experiencing a disruption and a loss (Conway and Valentine 1988).

Diana talks poignantly about her grandmother who is saddened by both Diana's inability to carry a child to term and her own inability to 'help' as an *abuela* should.

Diana: She is very sad. Especially – I saw her a couple of weeks ago and she strokes me and she talks to me and then she'll come up later and she'll say, "Well, what were you eating and what were you doing?" and things like that. She'll just say, "It must be him." I'll say, "Well, *abuela*, there is nothing that they can do." And she says it bothers her. She says she knows I hurt, but there's nothing she can do. She can't help me. That's how grandmothers are. They try to help their kids. She says, "I can't help, can I?" And I say, "No." It's nothing she can do.

Of particular difficulty to negotiate, especially for women, is when other family members become pregnant or give birth. Bierkens found that childless couples experience continual discomfort as other family members have children (Bierkens 1975). The discomfort increases when family members do not talk with childless couples about the impact of the new addition to the family. There are often accompanying celebratory rituals – baby showers, christenings – at which attendance is normally expected. Beatriz, a woman in her early thirties of Latino descent, talks about how she had to struggle to fulfill the tasks associated with her familial identity when members of her extended family became pregnant.

Beatriz: Five of my cousins had babies in one year. That was real hard. My sister, her boys are older so that wasn't a problem for me. Just babies and pregnancies. It was real difficult. Like I said, his sister lives two doors down and his mom lives right here. So I had to watch her while she was pregnant and she'd walk back and forth all the time. I just kept it out. I even helped out with the baby shower...It was hard. Now that his brother and our other sister-in-law, his brother's wife [are pregnant], I'm having trouble with that. And I don't want her to feel bad but I'm forcing myself to be around her.

Italian American Adriana and her sister took a proactive stance when confronted with a similar situation. Because they recognized in each other a significant source of support, neither wanted to endanger that aspect of their relationship by the disruption of infertility so they chose to turn to a person outside the family for help.

> Adriana: ...My younger sister and I, when she found out she was pregnant with her second child, she and I went to a therapy session together. To figure out a strategy, so that I get my feelings being infertile and seeing her pregnant, but she, also gets her feelings and she doesn't have to feel guilty. And, we really love each other and it's like we're too important in each other's life to become estranged. We depend on each other too much for support, so we just did some strategizing with the therapist. The therapist helped us to define, you know our feelings and our jealousies and you know, all of that.

Adriana and her sister provide an example of a more conscious reworking of identity, in this case that of sibling.

Friends

The interaction with friends when seeking support can further influence the infertile couple's reactions and interpretation of their infertility and hence their construction of an infertile identity. They may contrast themselves with friends who are fertile so that the identity constructed is in opposition to another. This is most clearly evident when couples differentiated between friends who are fertile and those who are infertile. This manifested in two ways: discussion of the emotional effect some participants felt when friends conceived or had children, and pointing out the quality of the support received.

The most common reactions respondents had when someone from their social circle conceived or had a baby was pain and sadness, anger and resentment, mixed with guilt for feeling that way. Raeshell, a Black woman, tells of one of her best female friends who she considers an important part of her support network.

Raeshell: One of my very best friends was having trouble getting pregnant with her ex-husband and a year and a half after they split up, she and her new significant other got pregnant. So, I, you know had to be a part of that and I think I was probably a really shitty friend – excuse my language – for about eight months, you know until the day of her shower, because I really resented it and really was angry. Here this woman is coming out of a divorce. Her divorce isn't even final. You know, why can she get pregnant at the worst time in her life and here I am ready and waiting with open arms and I can't do it?

The fact that a friend could, seemingly without effort, enter the world of parenthood, stands in stark contrast to the difficulties that Raeshell and her husband Tom are having. Even though Raeshell knows that this friend had trouble in the past, she still characterizes herself as the one who 'can't do it', the one who is deficient.

While perhaps not felt as intensely as for infertile women, men also expressed difficulty sorting through their conflicting emotions. Lorn, a Native man, has been trying with his wife Wendy, a White woman, to have a child for 5 years.

Lorn: My best friend, they just had a little boy the day before yesterday. I called him to congratulate him last night. And I feel, that kind of depresses me a little bit. I'm happy for him, but at the same time I'm kind of... It depresses me a little bit.

Some respondents, but not all, believe that the only ones who truly understand infertility are those who are also experiencing it. I found that this belief affected who they chose to turn to for support. Those who were involved with Resolve tended to be more definitive about the difference that existed between the fertile and the infertile with regard to support. Sandra, a Jewish American woman, and her husband Steve, a Chinese man, have been attending a support group run by Resolve.

Sandra: I have a few friends that I feel are genuinely really supportive, maybe two, and the rest of them don't understand it. And it's easy for them to say, "Okay. Well, you're having trouble conceiving and I understand that you want to adopt and that is great," but you can tell that they don't, there's not a real connection there, and they're not understanding it on a heart level of

> what it really means. And I don't think that people who've not had trouble conceiving can do that, which is why I felt that our Resolve friends would be important to us.

In contrast, Lorn and his wife Wendy feel that they can receive support from friends who have children.

> Lorn: We had a lot of support…We don't see a counselor or anything like that, although we have talked about it now and then. But most of our support just comes from our friends and family…The people in the clinic were very enthusiastic. All our friends were behind us. We have a lot of friends with children, our age group, and everybody was praying for us and behind us, you know? And then when this [referring to failed IVF] happened, everybody just...They all supported us. They helped us cope with words of encouragement and sympathy and all that kind of stuff…And so we left it in God's hands. If this is going to happen, it's going to happen, but we're not going to worry about it anymore.

Religion

Wendy and Lorn were one of the few couples who referred to their own spiritual and religious beliefs when talking about support. A few others mentioned, in passing, a pastor who they found supportive or a prayer that was offered on their behalf. Those who did talk about religion in greater depth in my sample tended to identify as Catholic. Those who were Catholic had to find a way to reconcile their infertility with the Church's emphasis on procreation and, to some, contradictory disapproval of reproductive technologies. As has been shown is true of most American Catholics, infertile couples disregarded religious teachings on medical intervention and did what they thought was right and ethical for them. However, individuals within a couple did not always make the same decision as to whether they would continue performing those actions which defined them as a practicing Catholic. Beatriz, a Hispanic woman, and her husband Ted, an Asian man, both had strong opinions about the Catholic Church's censure of reproductive technologies.

Ted opines: I don't go with that belief. I think it's kind of wrong that they say that. That you can't use any medical means to conceive a child. Whoever said what you can do and what you can't do!?!

Ted, however, continues to go to church because he feels it gives him "strength" and "a positive attitude" with which to deal with their infertility. For his wife Beatriz, the negative interpretations associated with the Church outweighed any positive, supportive elements that continued involvement would bring.

Beatriz: I mean I was hearing so many negative things from the church about "you're not supposed to have any treatment." If you can't have your own children, then you're supposed to accept it as God's will and if you want children, you have to adopt. And to me that was just like "how dare you?"... and eventually I just turned away from the Church. I don't get anything out of it except frustration.

Adriana, an Italian American woman, and Joe, a Japanese American man, found that the Catholic Church they attended contributed to their feeling of isolation because of the emphasis on children. Adriana was subjected to a number of insensitive comments from fellow members of her women's group while Joe found that the men's group was de facto for fathers.

Joe: ...invariably church means family. And, they all have children. All, but, you know it's centered around children for men – And for men, you know for me to be involved, it's usually the Father's Group or I forgot what they call it, but it's to do with helping children.

Despite these rebuffs, Adriana and Joe did not turn away from their religion. They decided to look for a Catholic church that was not affiliated with a parish school so the emphasis on children would be minimized. In this, they were attempting to refashion their identities as Catholics in ways that were consistent with their reality of infertility.

The refashioning of a Catholic identity which Adriana and Joe undertook was a result of inconsistencies experienced in their identities when seeking support from the

Church as an infertile couple. This, as well as the other accounts in this chapter, reveals that making sense of infertility is done within social contexts. Couples seek support from a variety of sources - spouse, family, friends, religion - and constantly evaluate what are the costs and benefits of receiving support from any particular source. The seeking and receiving of support is a process in which infertile couples' multiple identities are sometimes at odds and must be renegotiated. While a particular network may not always have the capability to provide desired support, the interaction around seeking could validate identities seemingly in conflict with infertile identities when raced and gendered expectations and behaviors are de-emphasized. Classed expectations are revealed when support is sought from unfamiliar sources.

Chapter Six: 'Race' and Resolution

> Rob: Do we want an image of us? Even having a biological child is not necessarily going to look like us. We are both from very different backgrounds. So we had to sit down and consider that the child didn't necessary have to be from us. And we could create a family and we could do it our way instead of paying the doctor fees. And to top it all, we didn't think that we have [the] funds actually to go through all the high tech procedures like IVF, you name it. We just felt it wasn't for us.

In the previous chapters, I used the lenses of race, gender and class to shed light on the experiences of people of color as they dealt with infertility, and negotiated their multiple identities in various social worlds. In this chapter, I examine how 'race' is implicated in the experience and resolution of infertility for the couples interviewed. In this respect, resolution refers to both the internal reconciliation of identities disrupted by infertility, and the final outcome of the specific pathways couples took to achieve their desired goal of parenthood.

As we have seen repeatedly, infertility is a life disruption. Infertility also disrupts cultural systems of belief, most visibly about the role of biology and nature in kinship (Becker 2000). Less visible is the disruption of beliefs about the immutable nature of 'race,' the system of racial hierarchy, and one's relation to this system. In coming to a resolution of infertility, there must be an accompanying transformation of subjectivity which allows one to envision alternatives to the models insisted upon by dominant interpretations of nature, biology and race.

In the Western world, when people talk about having a biological child, they are referring to a child which shares the genetic makeup of both parents. There is an implicit equation between genetics and biology. It has been shown that in American culture, biology equals nature so the biological is seen as what is natural (Yanagisako and Delaney 1995). And yet with infertility, the favored configuration of resolution is that in the attempt to have a child that is genetically related – biological – one must resort to means that are considered to be somewhat unnatural because they require a manipulation of biology. The use of technology confounds natural notions of conception, and thus is one of the first conundrums infertile couples seeking assistance from biomedicine must confront. They move to new conceptualizations from an initial belief that having a biological child means conceiving and bearing a child that shares both their genes.

As couples further explore solutions offered to them from the realm of reproductive technologies, they must also find a way to mitigate the increasing distance from folk understandings of how a child is brought into being, as well as into membership of a family. The lines of difference are often drawn on the basis of shared genetic material; in vitro and artificial insemination are placed in the same broad category as donor egg and donor insemination even though there is not equilateral genetic contribution. Couples do not make the distinction between partial sharing and full contribution unless they are specifically considering those options. Unless going the route of surrogacy (which only one couple did), the woman of the couple could become pregnant and give birth – material practices which mimic the 'natural' way to bring children into a family – regardless of the biological manipulations required and the genetic material used. As Becker has observed, opinions about the importance of genetic relatedness and the meaning of parenthood can change over time (Becker 2000).

This chapter will specifically analyze the accounts of couples considering and employing donor insemination and adoption as a means of resolution. This focused analysis will reveal how supposedly set categories of meaning can shift and withstand reinterpretations. For most infertile couples, their condition forces them to interrogate themselves as to why they want children. But of necessity, those couples choosing donor insemination or adoption also need to consider what the lack of genetic connection will mean. Pursuing donor insemination and adoption especially requires a rethinking of genetics, heredity, family and identity,[21] often in relation to appearance.

The Means of Resolution

The means of resolution used by couples interviewed in this study are biomedical intervention (IVF, AID, AIH, fertility drugs), adoption (both international and domestic), and working towards gaining access to these. The interventions preceding resolution are laid out in Table 3 below, followed by the detailing of infertility resolution status at the end of the study in Table 4 of all the couples who participated. Although in this chapter I will use the term option to refer to the choices that infertile couples felt they had open to them, I must point out that this term blurs the differing social and economic circumstance of each couple and presents the illusion that they all had the same array of choices from which to choose. Some possibilities were not as feasible as others due to external factors such as the cost of medical intervention or the particular nature of a medical problem. Individual members of a couple, or both, could have strongly held cultural beliefs about

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[21] Gestational surrogacy and donor egg also provoke rethinkings of these concepts but will not be considered here as these were not options chosen by the couples interviewed with the exception of one. See Ragoné "Of Likeness and Difference: How Race Is Being Transfigured by Gestational Surrogacy" and Goslinga-Roy "Body Boundaries, Fiction of the Female Self: An Ethnographic Perspective on Power, Feminism, and the Reproductive Technologies."

kinship and family which could lead them to 'rule out' suggested solutions to their infertility. These 'internal' factors could change however, as part of the process of resolution. For example, most couples either explicitly rejected or greeted the idea of remaining childless with little enthusiasm when it was brought up during the interviews. By the end of the period of the study, however, three couples had decided to stop pursuing medical treatment and were seriously considering being 'childfree' and what that would mean. Only one of these couples had gone as far as IVF. In vitro fertilization was tried by five other couples, none of them resulting in a pregnancy. Of these five, one had adopted and two others were in the process of doing so; one conceived without intervention and had a baby, and the other couple conceived after the end of the study.

Table 3: Treatment Decisions

Women's[a] Treatment Profile			Values	
Years in treatment[b] at first interview				
Range			6 months – 8 years	
Percent using Biomedical Intervention[c]				77% (17)
Fertility Drugs Alone			23% (4)	
Laparoscopy (non diagnostic)			12% (2)	
Tubal Surgery			29% (5)	
Inseminations			59% (10)	
Donor	30% (3)			
Average number of attempts		9		
Husband	70% (7)			
Average number of attempts		1		
In Vitro Fertilization			35% (6)	
One Attempt	33% (2)			
Two/three attempts	33% (2)			
Four attempts	33% (2)			
Surrogacy			6% (1)	
Donor Egg			–	
Not receiving Biomedical Treatment				23% (4)
Reasons				
Financial Constraints			50% (2)	
Personal Choice			25% (1)	
Lack of Knowledge			25% (1)	

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[a] I didn't make a similar table for men because there were only two men who had any sort of intervention - varicocele surgery, and taking immunosuppresant drugs.

[b] Including diagnostic procedures

[c] Percentages total to more than 100 because almost half of the women (47%) used multiple interventions.

Table 4: Status at End of Study

Infertility Resolution	Value	
Adoption (%)		32% (7)
Domestic	70% (5)	
International	30% (2)	
Biological Child		23% (5)
With intervention	3	
Without intervention	2	
Still trying[a]		23% (5)
Childfree		13.5% (3)
Unknown[b]		8.5% (2)

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[a] Defined as still actively trying to have a child. In these cases, either through adoption or continuing medical treatment

[b] Couple dropped out of study.

Ideologies of Kinship and Race

Because reproductive technologies pose a challenge to ideologies believed to be rooted in nature/biology, I will briefly review the American kinship system and some points of intersection with racial ideologies. According to Schneider, the two distinct features of the American kinship system are the shared biogenetic substance (blood) and diffuse enduring solidarity (Schneider 1980). Together they comprise an integrated set of symbols that derive from the master symbol of sexual intercourse, which is formulated as both a biological entity and a natural act in American culture. The child that is produced as a result of this entity and act will then be a symbol of the fusion or unity of the couple. It is important to understand that these biological elements are symbols and that their referents are not biology as a natural process – in other words, the way Americans understand kinship is also a folk theory of biological reproduction. For Americans, regardless of class or racial background, kinship is rooted in biology via blood and genetics (rather than the shared cultural symbols as anthropologists understand it).

In popular conceptions, blood and genetics are almost interchangeable, though they are not the same. Blood is the symbolic icon for genetic inheritance, and hence kinship obligations. Genetics have become increasingly important in American culture to the point of what Nelkin calls genetic essentialism, the equation "of human beings, in all their social, historical and moral complexity, with their genes" (Nelkin and Lindee 1995). Marks asserts that this belief goes hand in hand with a hereditarian bias common to highly stratified societies (Marks 1995, cited in Gailey 2000, p. 18). Genes will determine what you will become, with those traits considered essential to success such as intelligence and personality assumed to be inherited, as well as those traits associated with failure. Genes also determine with whom you bond, with the biogenetic tie between parent and child believed to provoke the emotional and social bonds which will develop.

At this point, biogenetic ties are central to our cultural model of parenthood and kinship and identity, though this may change. With the advent of reproductive technologies, Strathern (1995) muses, the understandings of procreation (process of conception and birth) and reproduction (both biological and social) could diverge, effecting how personal 'identity' is formulated. This argument hinges on biogenetic knowledge. Knowing what genes you have could preclude knowing where the genes came from, so identity (genetic) may or may not be located with reference to a specific other person. Strathern uses identity in a particular way, referring to knowing what characteristics you have and who you got them from. She refers to how genetics are understood, suggesting that even though "persons are related to persons through ties of substance and physical bonding, even where such ties are not instigated through procreation ... [it is] likely that the substantial and bodily part of the person" will be regarded as constituted in genetic makeup; however, exactly what does not depend on a reproductive tie with the parent (Strathern 1995, p. 359).

Heredity is usually understood simply as the genetic transmission of characteristics from parent to offspring, with the difference between phenotype and genotype obscured. In popular understandings of heredity, a particular emphasis is placed on physical appearance as a marker of relatedness (Rapp 1995). Individuals are categorized into races on the basis of physical characteristics such as skin color, facial characteristics and type of hair texture, remnants of nineteenth century classificatory systems. Such characteristics have since been shown to have a minimal relationship with any other heritable characteristics, yet they persist as being considered hallmarks of racial affiliations. Although anthropologists and others have argued that 'race' is a social construction (Smedley 1993; American Anthropological Association Working Group 1997; Banton 1998), the ideology still persists that 'race' is rooted in biology. An affiliated notion, though disproved in practice as history shows, is that 'race' is immutable i.e. races are pure, separate, and permanent identities. 'Race' as a concept was developed in association with colonialism, and was part of the ideology of inherent inferiority used to justify the conquering and enslavement of non-Europeans. Today, the racialized terrain of contemporary society - the racial state - necessitates the maintenance of ideologies that justify the systems of racial classification and the structures and organizations based on such classifications. According to Lugones, all members of society are interpellated as subjects within the ideologies of the racial state (Lugones 1990).

Spickard delineates the main points of American racial ideology as follows: "Everyone has a race, and only one. The races are biologically and characterologically separate one from another, and they are at least potentially in conflict with one another; Race has something to do with blood (today we might say genes), and something to do with skin color, and something to do with the geographical origins of one's ancestors" (Spickard 1992). Spickard also points out that American racial practice with regards to categorizing individuals into races is not consistent. For example, the one drop rule historically pertained to African Americans; simply stated, if there is the slightest trace of African ancestry (i.e. one drop), then the person is considered to be Black by social convention (Stampp 1989). This is also known as the "one black ancestor rule," some courts have called it the "traceable amount rule," and anthropologists call it the "hypo-descent rule," meaning that racially mixed persons are assigned the status of the subordinate group (Davis 1991). In contrast, the Native American gene pool is seen as being continually diluted until it disappears. By government definition, if a person has less than one/32nd "pure" Native blood, then they cannot call themselves Native American. The fact that the criteria used to determine racial categorization differs according to the group under consideration reveals that social factors influence the categorization of 'race' more than biology.

Donor Insemination

Keeping American kinship and racial ideologies in mind, in this section I am going to discuss how couples who were either considering donor insemination (DI or AID for artificial insemination – donor) or who used donor semen talk about secrecy, genetic relatedness, and appearance. By focusing on these aspects, I will be able to address how the issue of 'race' is present in their narratives.

Overall, donor kinship does not correspond to the American model of family. The use of a donor in reproduction disrupts the "coherence of natural ground for bilateral linear descent" because it does not preserve the genetic i.e. natural basis of kinship (Cussins 1998). Donor egg and donor insemination are similar in that a child resulting from the use of these procedures will share genetic material with only one of its parents. However, because gametes are also cultural icons which are imbued with gendered meanings, cultural attitudes about using donor gametes are different depending on whether the gamete received is sperm or an ovum. Haimes asserts that while semen donation is sexualized and associated with deviancy, ovum donation is more likely to be seen as asexual and altruistic (Haimes 1993). Becker argues that, due to the patriarchal concern with paternity, donor insemination challenges ideals of manhood, fatherhood and genetic continuity (Becker 2000). Donor egg also challenges how gender is enacted but a women receiving a donated egg can normalize through pregnancy, something which does not happen for men with donor insemination. As well, donor insemination is more often anonymous while donor egg usually is not.

For the couples in this study who were diagnosed with male factor infertility, donor insemination was one option contemplated. The concerns most frequently mentioned by the couples considering donor insemination were secrecy and genetic relatedness. These issues are similar to those found in other studies (Nachtigall, et al. 1998; Becker 2000). Hilario and Amalia, a couple in their early thirties recently immigrated from Mexico, were the only ones who brought up the issue of impropriety – Amalia was concerned that the Catholic Church would view donor insemination as adultery, even though donor insemination does not involve sexual intercourse.[22] Both however, did not see donor insemination as immoral and were willing to entertain the notion as long as none of their family members knew about it.

Secrecy

The secrecy around donor insemination has been shown to be associated with the stigma that exists around male infertility (Nachtigall, et al. 1992). From the time that donor insemination began to be used, anonymity in gamete donation was encouraged to

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[22] The Catholic Church officially disapproves of donor insemination on the grounds that, among other things, it encourages adultery by creating an environment wherein insemination of a wife by the sperm of another man is considered morally acceptable. See Congregation for the Doctrine of the Faith.

protect the couple from this stigma, as well as to protect the donor from legal obligation to the offspring (Marsh and Ronner 1996). Couples referred to this aspect of donor insemination through discussing whether they would disclose the circumstances of their child's conception. Nori, who has undergone six inseminations with donor sperm, has not yet come to an agreement with her husband Edward as to what they will do.

> Nori: Well, the reason I want everybody to think that it is our children is that it might affect our child later. You know? I mean, what do people think of that? A child not knowing at all where the other half of genes came from?
>
> Edward: Honey, I think only a small-minded person would attach any real significance to that.

Nori invokes what other people would think as a reason for not disclosing, alluding to the fact that with the use of an anonymous donor, the child would not know half of its genetic origins which goes against the popular view of kinship. She insinuates that this lack of knowledge would be viewed as abnormal. Becker argues that this emphasis on secrecy serves to perpetuate the dominance of the biological model (Becker 2000). In recent years, there has been a move to lift the veil of secrecy about donor insemination.[23] One argument that has been used is that children have a right to know their genetic history; closely related to this view is the attitude popularized by groups such as the adoptee rights organization Bastard Nation that individuals who do not know their origins will be 'incomplete' (Baran and Pannor 1993). Another argument is that keeping family secrets can be detrimental to overall family functioning.

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[23] Legislation passed in Sweden (1985), Austria (1992) and (Victoria) Australia requires that a donor's identity be readily available to children who inquire. At time of writing, the Netherlands, and Britain are considering relaxing restrictions on donor anonymity. See Blank, "Regulation of Donor Insemination".

Donna has thought about the implications of donor insemination quite a bit. She underwent multiple inseminations before she and her husband Larry finally turned to adoption. She compares the awkwardness she felt with regards to disclosure in each situation.

> Donna: I had a lot of anxiety about AID. That made me... It almost seemed to me you should really keep it a secret or – how on earth do you explain? – it's so – I think it's easier to explain to a child that he's adopted than to say they're sperm from somebody else. That's just my, off the top of my head, that's... So I would almost tend to not want to tell anybody if it was AID, just because... Then they say keeping those secrets is a horrible thing, but... I don't advocate keeping adoption a secret at all, because I think it's painful, but the other thing is just too bizarre. How do you — "Well, you see, we bought this little sample and it's supposed to look like your daddy, but it really isn't," that's too bizarre.

Donna leaves much unspoken with the assumption that her interviewer will understand the strangeness of having to admit to a child that he or she does not share the genetic makeup of both its parents. She characterizes it as "bizarre" and so should be kept hidden, while adoption should not be kept a secret.

Genetic Continuity

In cases of male factor infertility, couples weigh the possibility of having a child with a genetic connection to only the woman against the possibility of having a child with a genetic connection to neither of the couple (adoption). The use of donor sperm enables a woman to experience pregnancy so there is both a bodily and biogenetic connection to the child. However, her husband will have only a social and legal connection to the child. This configuration does not fit with what is considered to be the normal way of having a biological child. In the following exchange, Raquel and Louis, a Chinese American couple, discuss their consideration of options, with genetic relatedness being key.

Raquel: I think probably the question of things that we would consider first before adoption would probably be sperm donation. And the reason why is because at least then half the gene pool is known as mine. Adoption, neither of the gene pool is mine...then my sister brought up a good issue. She said, "People probably don't think it's a big deal because they probably think all Chinese people look alike anyway." (laughter)

Louis: Yeah, but we know that's not true. We know that we can tell the difference when we're out on the street.

Raquel: I know. (laughter) But, you know what I mean; as bad, quote, unquote as bad as his gene pool is, I would still want my child to have his genes, you know? I mean, that was the whole purpose of this - of having children together - so that we could create something together, so I have a difficult time...I don't think you think about the alternatives until you're really forced to think about them and at this point I refuse to be forced to think about them. Adoption, at this point has not been discussed in a positive way at any rate. Sperm donation has probably been discussed probably in a neutral, as opposed to what was a negative light at one point. But, you know, just the ramifications of would he really feel like it was his child? Would his family think that this was Louis's nephews' cousin? Would I feel like it was his child?

Louis: Actually, sperm donation, I mean, I guess Raquel's point is, again, is scientific as long as it's theirs, genetically half. And any gene has got to be better than mine...I'm just teasing...originally I was annoyed by that, you know, the thought [of sperm donation].... Sperm donor just didn't seem like a – I mean, I just worry about the variance of dealing with other people's genes and it's such an unusual experience ... So again, I'll be a trail blazing Asian and I really don't feel like have to do that any longer, because I don't think there are very many Asian donors running around.
So sperm donation, I mean, again, on the scientific basis, recently, I have heard genetic – Of course, I'm not sure how that means when you mix both and you get this other person anyway so...I think, now I think it will be less so because, in retrospect, [if there's] a part of her in a child then that would be okay.
Then, at least, I know that they'll have a part of her, that is – And it'll have my social influence which I think is fine, because that's all they need. I mean, they don't need my genes necessarily, but they need other aspects that I could provide them.

In Raquel and Louis's musings, their grappling with ideologies of kinship and their probable departure from normative practices is revealed. Although Raquel doesn't want to think about their options until forced to, she and Louis have evidently developed a ranking of what interventions seem doable and why. In privileging donor insemination over adoption, Raquel and Louis focus on the fact that at least half of the genetic contribution will be from Raquel, "a part of her" and therefore "known" as opposed to the genes of an anonymous donor. The phenotype and profile of a donor would be provided but their genes are considered to be unknown as there is no social relationship in place. Strathern points out that in American kinship, a relationship is crucial to ideas of continuity and reproduction. Reproduction, the replication of the self and the symbolic representation of a bond, "cannot occur in the absence of a certain kind of knowledge – that is, knowledge about the identity of others" (Strathern 1995, p. 354). Even though the expression of the gene combination of Raquel and Louis would also be unknown, this uncertainty is acceptable as it is mediated by the intimate social relationship Raquel and Louis have. Unknown genes stand for unknown health habits, gestures, personality quirks, etc. – all things that are revealed in the context of a romantic relationship. The significance of romance and love intercedes in another way as well; in the cultural belief that a child should be an embodied symbol of the love a couple share. As Schneider pointed out, a child that is produced (through sexual intercourse) will then be a symbol of the fusion or unity of the couple (Schneider 1980), and as Raquel asserts, the point of having children is creating something new that is a fusion of the two.

Raquel is also concerned with how Louis's extended family members would view bringing a child into the family who did not have any of Louis's genes. She includes herself and Louis in her questioning if the child would truly 'feel' like it was Louis's child if he had no biogenetic connection to it. Louis, while not commenting directly on if the child will feel like his, assures Raquel that what he has to give, his "social influence" presumably through the social relationship of parenting, will be sufficient. In this way, Louis must confront the "cultural expectation that men uphold the patriarchal status quo through their biological contribution to the creation of a child" (Becker 2000, p. 134), and he does so by emphasizing the social bonds to be formed in the absence of, rather than in correspondence with, biogenetic ties. With donor insemination, the links between genetic and social parenting fatherhood (as well as between sexuality and reproduction) are loosened in a radical way so care must be taken to establish affective links to compensate. However, Louis also refers to the strangeness of the experience, alluding to both the experience of depending on another person to assure conception and the unusualness of being an Asian male considering having his wife conceive through donor insemination. The race consciousness of Raquel and Louis provides a subtext to their deliberations which surfaces in joking that others - meaning non Chinese - wouldn't be able to tell if a child was adopted (assuming that any child they adopted would match them racially) and noting that finding an Asian sperm donor would be difficult; one implication is that both of these are non-issues for Whites.

Concerns about bonding and unknown genes are also expressed by Elena, a Chicana in her late thirties. Elena and Peter, a Jewish man in his late forties, have a little girl who was conceived prior to Peter's chemotherapy which effectively rendered him sterile. Elena and Peter managed to store only three samples of Peter's semen before he underwent treatment. This, as well as having their savings wiped out by medical costs, limits their options for having a biological child which is related to both of them.

> Elena: Gaby [their daughter] wants another child. I want another child for her. She wishes on a star, she wishes for a little brother or a little sister and then she talks about having a baby in her *panza*...I don't want to wait till I'm forty to have another kid. There's going to be a big difference between Gaby and the new baby and that kinda defeats the whole purpose.

> Particularly if the other child will definitely not be Peter's. That kinda puts it in a whole other place for me.
> If I knew for sure it was going to be Peter's – let's say they thawed out one of those vials and that's what they used for the in vitro and they put it in...[and] for some reason it didn't work out or I spontaneously abort or whatever. If there was still another vial left of Peter's and we already had been that successful so far, I would want to do it again. If we had to use both of Peter's sperm [samples] and then [I] lost it, it'd be different. I might not want to. How about you?

Peter: I have absolutely no idea. I'd be so drained I don't know what I'd do. I'm sure that's what everybody else says too. What do you do if you don't conceive?

Elena is willing to undergo multiple cycles of IVF if it means that the child will have Peter's genetic contribution. She initially rejects IVF with donor sperm because Peter's contribution would be missing. However as, she continues laying out how she sees their options, she moves away from adoption and back towards donor, drawing on the ideology of genetic relatedness as being foundational to family relations.

Elena: Adoption is not something I really relish. I think if we didn't have any children at all, I might consider it but the fact that we already have one between the two of us just seems weird. I wouldn't want them to be that different. I would be afraid that I would treat them real differently. I'd be afraid that Gaby would treat it differently also. I feel like it's too much of a risk – a total stranger, totally unknown genes, totally unknown background, totally unknown habits or whatever. It's not even necessary when I'm fine. Half of us is okay, why not use it? I'm able to carry it and everything then why not if we're going to want another one that's ours then why not let me make it? And if that's the case, then just do donor. I'd much sooner do donor than adopt. Adopting is like when you don't have any other choice.

Peter: I agree. I think donor would be much more reasonable.

Elena: He's totally comfortable with the idea of adoption. I'm not as comfortable. I don't know if it's a cultural thing. If we were to adopt, I certainly wouldn't want to adopt a Korean child. If we were going to do any ethnic group, it would be Mexican.

Again bonding is an issue as with Raquel and Louis, as well as the desire to 'know' genes. The total lack of genetic connection in adoption is not seen as natural, and plausible cause for a child to be 'treated differently' by its sibling. The strangeness or unnaturalness of using a donor is not brought up and instead the ability of Elena to 'make' a child, carry a child and establish both a biogenetic and biological bond with a child is emphasized.

If Peter and Elena were to adopt, she declares that the child will be from Mexico (where Elena was educated). Even though genes will continue to be unknown, a child adopted from Mexico will, in Elena's eyes, be representative of a culture that Elena knows, and that could be the basis for bonds to form. In expressing a preference for a Mexican child over a Korean child, discussion of race is subverted; a Korean child would be from a different culture but would also have visible differences in physical appearance from adoptive parents.

Appearance and 'Race'

Appearance is critical as it relates to couples' concerns with both secrecy and genetics. When a sperm donor is used, there is usually a concerted effort on matching the physical characteristics of the donor such as hair, skin, and eye color to that of the partner whose genetic material will be substituted – the male partner and potential social parent. The goal of this matching is threefold: 1) to increase the probability that the phenotypic expression will be similar as if the social parent contributed alleles, 2) in so doing, mimic the physical attributes of what Americans perceive as a biological family, and 3) maintain secrecy about the use of a donor by ensuring any resulting child could 'pass' as a genetic child. In this way, appearance is related to secrecy in that couples want to choose a donor whose physical attributes match those of the father.

Appearance as a topic of concern and as a manifest symbol of relatedness came up quite often in the interviews. For example, when couples talked about the desire of having a child that is genetically related to them, they wanted to be able to see that relatedness in the physical appearance of the child. The question of 'will this child look like me?' is important, as is its unspoken counterpart, 'will there be visual confirmation that we are genetically related?' Implicit in these queries is the assumption that a biological child will share the same racial phenotype, or in the case of interracial/intercultural marriages, will look like a 'blending' of the parents' phenotypes. Discussions about respondents' concerns with appearance often opened the door to talking about race, as Raeshell's narrative demonstrates.

Raeshell and Tom had been married 4 years before they consciously started trying to have a child. Raeshell had been off the pill for 3 years and they hadn't had any "accidents" so they decided to seek a medical opinion from their HMO as to why they weren't getting pregnant. After a semen analysis, Tom and Raeshell were told that only 15% of Tom's sperm were normal, possibly due to Tom's exposure to chemical agents at his job. After a long process of introspection, Tom and Raeshell decided to look into donor insemination. Raeshell was angered by her interaction with the first physician they consulted.

Raeshell: I called and ...I told him that I was referred to him and why I was referred to him and then I told him...that we were considering artificial with a fresh donor...we talked briefly and he asked me whether or not I had any questions. Well, I just said, "Well, how do you try to match the physical characteristics of the husband?" And he says, "Well, you know unless your husband has any real distinguishing features, usually it's not difficult to do that." And I said, "Well, I think my husband's most distinguishing feature is the fact that he's Black." I said, "Short of that, I think he's a pretty average looking man." And he goes, "Oh, I don't have any Black donors in the program." I said, "Okay."

> And, immediately in my mind I kind of moved past it. I said, "Okay, well, I'll take anything in, you know, in the color range." I said, "If you have, you know Hispanic, Puerto Rican, you have somebody, I mean, a tangent."
> I mean, those are all people with African descent over history and time; hey, I'm not going to be too flipped out or too choosy about it. I'm open. It's only sperm. And the baby is gonna be half Black or something because it's going to be my baby, right? So, I didn't trip off of it. And he says to me, "Oh, no, I do not think that would be appropriate at all."

Immediately noticeable in Raeshell's narrative is the clash of ideas about 'race.' To Raeshell, the consumer of reproductive technologies, race is fluid while for the doctor – race is 'hard.' Perhaps his primary clinical experience has been with treating patients racialized as Whites where such fluidity is not likely to be apparent. As Raeshell puts it: "*... immediately in my mind I kind of moved past it.*" She constructs her own identity as a Black woman realizing that there is no purity, that there are peoples with African descent who are NOT classified as Black by societal categories.

She goes on to say: *"And the baby is gonna be half Black or something because it's going to be my baby, right?"* Raeshell is referring to the fact that even if she uses donor sperm, the baby will be 50% genetically related to her, so it will be hers regardless of the racial identity of the sperm donor. Raeshell is Black and so any child she has, regardless of appearance or genetic makeup, will be considered to be Black by others (a relational view of identity) and furthermore will be raised as Black by her and her husband.

Raeshell, as an African American woman seeking to become pregnant, brought with her a collective history of constrained reproduction and involuntary sterilizations and a more recent history of demonizing of African American women as being 'welfare queens' so the very meaning of achieving pregnancy differed from that of Dr. P's other patients. In addition, he has been enculturated into a professional field in which classification is a hallmark and the boundaries of such categories are usually rigid. Race as a biological entity has been disproved, questioned and is not believed to exist as a genetic phenomenon, yet clinicians still adhere to using systems of classification based on historical notions of race (Miles 1989), and has been discussed elsewhere, bodies are a site of racialization (hooks 1991; Kelly 1998)

Becker's comments on matching further illuminates Raeshell and Tom's experience. Becker points out that matching is a way to deal with the cultural ideology of biological parenthood by adhering to the cultural expectation that children resemble their parents; in addition, it can serve to help maintain confidentiality, contribute to a sense of control, and make the process more acceptable (Becker 2000). In discussions around donor insemination, the degree of choice afforded to a couple was instrumental to their sense of control over the process. The experience of Raeshell and Tom illustrates this, as well as how ideas of choice and matching are influenced by sometimes clashing racialized notions.

Because there are not many Black semen donors available, Raeshell was counseled by another physician, Dr. S., to "don't try to have too much control over this" which angers her. Because of the conflict between her view and the first physicians' view of who is an appropriate donor, Raeshell has been feeling that she does not have control and this additional comment exacerbates the sentiment.

> Raeshell: And when I started thinking about what Dr. S. said, I started feeling the same thing that I felt Dr. P was trying to say to me was that you really don't have a choice, you know....And so, that's been kind of eating away at me lately. Because I feel like – I am sure of what I don't want my donor to look like. But who can judge those features better than me? No one, right. Or who can judge them better than me? No one or Tom.

Int: Why? Am I correct in assuming you don't want a White donor?

Raeshell: No, that's not the problem at all. I would take a fair skinned donor over a dark-skinned Black male, but what I am getting from the medical side is that they don't feel that that's appropriate. As long as, there's any Black male available that person as a donor is preferential to any other donor out there, and I don't feel that way.

Raeshell wants the donor to look as much as possible as her husband Tom who is light-skinned. She is frustrated with the point of view espoused by her physicians that does not seem to acknowledge the wide variation in skin tone that exists among the group identified as Black. Her bitter appraisal of their attitude that "*any Black male available*" will be an appropriate donor regardless of physical attributes, makes reference to the historical sign of prejudice encapsulated in the phrases "can't tell them apart" or "they all look alike." (This was mentioned by Raquel above as well). This phenomenon, known as "cross-race recognition deficit" in the field of psychology, is explained by some as stemming from the tendency to code for race rather than other identifying characteristics (Caroo 1987; Levin 2000).[24] In other words, a person who can't tell people of another racialized group apart is seeing them only as member of a racialized group and not as an individual. Raeshell interprets the supposed interchangeability of Raeshell's husband with any other Black male (donor) as reflective of this objectifying and depersonalizing stance which angers her, and contributes to her feeling of not being in control. As well, it suggests that different standards of matching hold for African Americans in which the conceptual category of 'race' takes precedence over actual physical attributes.

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[24] Anther hypothesized reason for the inability to recognize cross-racially from the discipline of psychology is that humans acquire "perceptual expertise" for characteristics of their own kind. See Chiroro and Valentine, "An Investigation of the Contact Hypothesis of the Own-Race Bias in Face Recognition".

While Raeshell's husband, according to her, admits that it would be nice if they could have what they want in a child, he also claims that he doesn't really care about appearance because the baby will "be a part" of Raeshell who he loves. Tom places importance on the fact that a baby conceived with donor sperm will still have the genetic contribution of the woman he loves. The American cultural value, according to Schneider, is that "blood is thicker than water" (Schneider 1984, p. 84). There is a culturally grounded fear of not being able to make a real connection with someone with whom one is not genetically connected. Tom, in response, focuses on the shared genetic material with Raeshell as reason enough for forming a bond with a child.

Tom: – she was asking me, "Will you love this child?... Even though you do know that it is not your biological child?" And I said, "Yeah." And, she asked me why. And I said, "Because 50% of it is you. And, personally I don't care who the other 50% is. I know that is a little living being that I am going to love. No ifs, ands, buts, maybes about it."... and Raeshell would quiz me in the morning, in the afternoon, and at night to make sure my mind had not changed.

Raeshell is concerned about her husband's ability to bond with a child that does not have his genetic material. On her own part, Raeshell did not express concerns about being able to bond with a child that would not be the cultural symbol of unity expected because she would have both a bodily and biogenetic connection to the child. However, for Raeshell, a primary issue of having a child by donor insemination is appearance. The appearance of the child is important not only because of the issue of matching and wanting to emulate a family who conceived 'normally', but also because of her own experience of being a dark-skinned woman and her voiced desire to make sure that her child has a different experience.

Raeshell: ...Because I just don't, you know, it's so much bigger than you and I. That sounds really corny, but it's really true. It's what I feel. It's

> something that it's very... I lived all of my life as a very dark-skinned Black person. And I have to say to you, I cannot tell you how much more difficult my life has been because of that. If I can't have the child within the [parameters] that [I] choose, who happens to be very opposite my persuasion –

Int: You say you would like to have a child with light skin?

Raeshell: Yes. Absolutely. Because I want my child to get [the] best. A very trivial, very mundane thing in this world...I know what my life is like. And I know what my life with [Tom] is like, you know. I know what it's like to travel to a different country. I mean, responses and – just, I mean, the treatment in the world. I mean, I just can't, it's so different. It is so different. You know those stereotypes? You know, how intelligent you are, no matter how well you [do]. No matter what your dreams are, you are – I can't tell you the number of times people have said to me, "Gee, how did you catch Tom?" And I say, "Damn. Why [couldn't he] catch me, you know? What do you mean?" That is such put-down. That is so condescending, you know. People do it all the time. People do it all of the time.

While shaped by the colorism[25] which exists within the African American community, and her gendered experience of discrimination, Raeshell's experience of confronting the issue of donor insemination is also influenced by the fact that her reproductive self determination is compromised, a fact made more significant by a collective history of constrained reproduction. Ultimately, she draws on the principle of matching to justify her desire for a light-skinned child, and places it within the accepted trope of having a child who looks like a parent, though there is no guarantee what a child's phenotype will be.

Raeshell: ...I don't want a jet-black child, who, in my eyes, will clearly bring no reflection of my husband. He [the doctor] said, "Your looks are so

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[25] Colorism, or to use Zora Neal Hurston's term "being color struck" , refers to the practice of preferential treatment being given to African Americans who have lighter skin color. The attitude can also extend to those who have physical features similar to those associated with Euro-Americans. The roots of colorism in the United States are in the status hierarchies based on shadings during slavery. For a general discussion, see Wilson, Russell, and Hall *The Color Complex: The Politics of Skin Color among African Americans.* For how manifestations of colorism is gendered, seeFeatherston *Skin Deep: Women Writing on Color, Culture, and Identity.*

> dissimilar it won't matter."...But, he's White. He doesn't have any sensitivity to that, you know?

As an African American woman considering donor insemination, Raeshell must confront varied challenges: clinicians who are insensitive to the nuances of race and appearance, her own desire to gain control over her reproduction, and internalized ideologies about the value of light skin. As well, infertile couples of color who use or who are considering using donor sperm must negotiate the multiple ideological intersections of race, biology, and gender which exist and are emphasized by this procedure.

Adoption[26]

Each step along the way to resolution requires rethinking and renegotiating cultural beliefs and ideologies. If an intervention fails, couples must decide whether to continue and pursue another course of action. Options which were once undesirable may appear more feasible and more acceptable as a result of the shift in thinking and perception yet may require another round of grappling with beliefs and ideologies. At the same time that reproductive technologies reinforce the allure of biological parenthood, infertility also forces couples to consider alternative configurations in which biology is not privileged and the social aspects of parenting and kinship are preeminent. Adoption, unlike IVF and other reproductive technologies, does not uphold American cultural values about the family, kinship and the proper relationship between parents and child (Modell 1989).

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[26] In addition to the sample described in Chapter Two, this section relies on the analysis of intervew data of three couples self-identified as White who adopted a child belonging to another racialized group.

While adoption was historically the manner in which infertile couples were able to parent, it is now seen as the last resort to turn to after other interventions have been tried. While this is true of the couples interviewed for this study, I also noted that the couples were, almost without exception, more willing to consider adoption than either surrogacy or childlessness. Their willingness to consider adoption usually increased if they did not achieve parenthood through IVF or artificial insemination after several years of trying. The objections to surrogacy were usually phrased in terms of ethical concerns and economics, and the one couple who did try surrogacy decided not to try again, with the woman expressing discomfort with 'forcing' another woman to give up a child gestated in her body and the man expressed disappointment that he would not have a biological child.

Reproductive technologies, even when used with donor gametes, hold out the hope to infertile couples of having a child which, in some aspects, falls within the parameters of 'normal' biological reproduction and the subsequent formation of biogenetically-based kinship ties. Therefore, their coming to the point of resolution at which these norms can be set aside may take longer than it did in the past. For these couples who ultimately choose adoption, the genetic aspect of kinship loses its primacy and the social aspects of parenting come to the fore. Steve, a Chinese American man, and his wife Sandra, a Jewish woman, adopted a child internationally.

Steve: ...this is what family values are. Adoption is all about family values. because you have to look inside and ask yourself what your family values are, and it's not just something that involves, you know, copulating and having a child that looks like you. You know you really do have to think about what do family values mean to you.

However, coming to reject American kinship ideology through an embracing of social parenting represented by adoption is not a smooth or unproblematic process. Even with the choice to pursue adoption, the need to make decisions persists. It is not enough to want to parent and to realize that a non-biological child will fulfill that need. Prospective adoptive parents must think about what kind of child they want - a baby or a toddler, what race and what gender - and make overt choices about from where such a child will come - foreign or domestic, open or closed. There are also choices that revolve around trying to match physical characteristics of the adoptive child with those of the adoptive parents. This is justified in terms of the importance of not wanting to stand out, of looking alike, of looking like a family that is biologically related. This is reflective of biologism, of looking to what is considered 'natural' in the context of a biologically related family and using that as a model for what should be in an adoptive family. This plethora of foundational decisions will structure what sort of adoption experience couples have, as well as force them to interrogate themselves yet again as to why they want children. However, the additional layer of determining what kind of children they want and why implicit in decisions about donor is made explicit in adoption. This both denaturalizes the process and further reveals conceptions of what makes a 'real' family, and what constitutes being a parent.

Adoption, whether public or private, can also be an option which is chosen based on financial practicalities when the economics of adoption is contrasted with the economics of treatment. Some couples can afford to pursue both, but for other couples such as Lorn and Wendy, choosing one route to resolution precludes the other. At the time of my final interview with them, they had decided to stop pursuing treatment so they could save money to buy a house. They felt home ownership would make them appear more stable and thus more attractive potential adoptive parents.

The uncertain outcome of medical interventions is traded for the supposed certainty of adoption. Couples who decide to put their energies toward acquiring a child through adoption rather than trying another cycle of IVF or another intervention often talk about it in terms of a guaranteed return. As they see it with a practical eye, at the end of the investment of time, money, and psychic energy into adoption there will be a child whereas there is no such certainty when one embarks on the pathway of IVF or other reproductive technologies. However, this belief is often shaken once they enter the process of adoption and learn of the possibility of a birth mother reclaiming her child, and the institutional definitions of who is considered to be an appropriate parent. Nori and Edward, after struggling with the issues of using donor sperm, decided on adoption. They had ruled out a domestic private adoption which Nori viewed as "buying a baby" and researched the steps of international adoption only to find that they "didn't qualify."

Nori: ...we got all the papers, everything. All the criteria required from various countries around the world and we didn't qualify for any of them...First of all—

Edward: Age.

Nori: Age difference and we both have histories of divorce...You can't have more than 35 years between you and the child. You have to have been married for five years. In certain countries you have to be the same nationality. You can't have any history of divorce on either side.

Edward: And this is to adopt a child with a 55% chance of it having some serious disease.

Nori: The only thing we qualified for was older kids. The teenagers with two or more handicaps...We didn't qualify at all.

In fact Nori and Edward did qualify, but not for a child they felt they could parent, or perhaps desired to parent. The children to whom they had access - older children,

children who were ill or disabled - were available for adoption because they were deemed as 'inferior goods.' Children who are non-White, older, disabled[27] are less in demand, reflecting a hierarchy of physical attributes and desirability. It also reflects the commodification of children which is a result of the strong market environment which has developed around adoption. While all adoptive parents must confront contradictions found in the practice of adoption, the positioning of people of color within a system of stratification affects their worldview and attitude towards this hierarchy. As a Latino man stated with a touch of cynicism: "...there are mixed babies out there that are obviously easier to get than your typical blonde hair, blue-eyed baby." The language this man uses in regards to babies demonstrates an awareness of both the 'commodification of life' (Katz Rothman 1988) and the social devaluation of children of color. Couples referred to the fact that White babies are scarce, using the language of the market place, as a reason that they would try for an international adoption.

> Sandra: ...we first made the determination that we wanted to do a foreign adoption rather than a domestic adoption ... I don't have any desire to put myself in the market for White babies now, so hard. I mean all these people just - it doesn't appeal to me at all...

When couples began the process of considering having a child that was not genetically related to them, appearance once again came up consistently. In years past, the standard US practice in adoptions was to try and match the physical characteristics of the child to the adoptive parents. While this is slowly changing, matching is still popular. Mark, a White man, and Joyce, a Chinese American woman, are considering adoption after

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[27] While couples in this study were willing to adopt a child who was not of the same racialized group as they were, none were willing to parent a child with mental or physical disabilities and none discussed the possibility at any length.

13 years of marriage and several miscarriages; their expressed preference at this point is for a child that is "ethnically related" to both of them; in other words, a child that is 'mixed'.

Mark: Joyce is not uncomfortable with a purely Caucasian child either. Which is not necessarily a preference of mine. I think that I have a lot of history with Asia and Joyce is Asian and that doesn't bother me. It seems right if the child is partially Asian. The humorous thing to me is that unless the child is purely Caucasian – well, I don't know if this is right but I've thought this way – if the child is purely Caucasian then it would probably look more like it was more directly related to me. If the child has any Asian blood, it will look more like Joyce. It's sort of like she wins on that or something, but it's not really an issue because we've talked before about [it], and this was months ago. You said you'd be more comfortable with an Asian child so that if you were pushing it in a baby carriage... if you had a Caucasian child....

Joyce: Oh no, somebody else brought it up that I would be mistaken for being a nanny.

Mark: Oh yeah, particularly here in San Francisco.

Mark's comments point to the complex politics of appearance in contemporary America, a racial state in which difference is located in the body and physical features can be imbued with racialized, classed and biological meanings. If the child had the racialized physical attributes of Mark, then it would look like the child was "more directly related" to him, which would correspond with what is expected of biological parenthood. On the other hand, Joyce would be mistaken for the child's caretaker. On racially stratified terrain, an Asian woman with a Caucasian baby would not be assumed to be the baby's mother, firstly because mothers and children are supposed to look similar and secondly, because domestic workers and nannies are expected to be women of color.

If the child had "any Asian blood," assumed by Mark to be manifested by physical features racialized as Asian regardless of the percent admixture, then the child would look more like Joyce, marking her as the mother and shutting him out from the mimicry of genetic relatedness. He, however, would not be taken for the child's caretaker if he were to be alone with the child, for as a White male, his body is not marked as Joyce's is.

Although the scenario Joyce and Mark bring up is hypothetical, it does suggest some of the issues for couples who adopt children who don't look like them. The most common configuration in which this occurs is what is known as transracial or crosscultural adoption.[28]

Transracial Adoption

Transracial adoption in the United States is almost exclusively seen as the adoption of a Black child into a White family or a racially mixed child into a White family. Other configurations, such as incidents of White children being adopted into mixed/interracial families or a racially mixed child being adopted into an interracial family whose 'race' does not match that of the child are assumed not to exist. Transracial adoption has been the target of harsh criticism. In 1972, the National Association of Black Social Workers passed a resolution characterizing transracial adoption as "cultural genocide," claiming that Black children raised in White households lost their heritage and were harmed because their White parents are unable to teach them the skills necessary to survive in a racist society (Law 1993; Howe 1995). At that time, White couples who adopted children of color usually took a colorblind approach which de-emphasized or ignored the significance of 'race.' For the next twenty years, controversy railed around the appropriateness of placing children of color in White families on the one hand, and the languishing of children in foster care because of strictures against transracial adoption on the other. In 1995, during the course of data collection, the Multi-Ethnic Child

Placement Act was signed which prohibits all organizations receiving federal funding from "delaying or denying" the placement of a child on the basis of race, color, and national origin though racial, ethnic, and cultural background can be considered. White couples are required by the law to undergo extensive "multicultural training" before attempting to adopt minority children, which is an alternative to the colorblind approach.

Even without training, most parents who adopt transracially are mindful that they and their children will be subject to increased scrutiny because of the lack of shared physical features. One immediate consequence of the difference in appearance is the inability to keep the child's origins a secret. Felicia, the White adoptive mother of a Latina baby, is conscious of the reaction evoked by her child's non-resemblance to her and her husband Frank.

> Felicia: I am a bit envious of the adoptive families that we know of where the children blend in. Like they have Latino children and they're not Latino but they have the darker hair and skin ... The adoptive father looks like he could be the birth father.

With the conscious choice of adopting a child who will not have the appearance of the adoptive parents, those physical attributes that are markers of race and ethnicity such as skin color and hair texture gain increased significance. In making choices about who they're willing and able to parent, White couples may try to minimize the differences between themselves and their adopted children by ranking a continuum of attributes as desirable which adheres to the racial hierarchy of light being better than dark, straight hair better than kinky or Asian better than Black. Adoptive parents don't expect that facial features such as the shape of the nose or chin will match, so they look to eye color, skin tone, and hair color as being significant in having the child blend. If a

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[28] The term transracial itself is problematic as it reifies the existence of separate races, but I will use it in

child 'blends,' meaning that the adoptive parents and the adopted child are similar in appearance, then the family is closer to what is believed to be the biological norm and its legitimacy will not be questioned by the casual observer. One adoptive mother admitted that a hope was that 'looking alike' would ensure a degree of family cohesiveness. Perhaps she also hoped that the absence of outside scrutiny would allow the family's bonds to develop without outside pressures and questions about their belonging together. 'Blending in' would allow for more privacy when they appear as a family in public, or as Nicole, the woman of a White couple who adopted a baby of Vietnamese descent puts it, more anonymity.

> Nicole: Sometimes I think I feel a little bit sad about the loss of anonymity. You know you can be anonymous when the child looks like you.

Her husband Holden agrees, and refers to the boundaries of politeness that 'normality' enforces.

> Holden: ...when you're in a public place most people won't... if you're with a child who looks like you, most people won't walk up to you and ask who the father is.

Although their baby doesn't 'blend' with them, Nicole reveals that she thinks that because her daughter is attractive and not too "ethnic looking," people will overlook the physical differences that exist.

> Nicole: ...she's very attractive and it has made, I think, our transition into being a multiracial family a lot easier ... if she were very ethnic looking, you know, I mean, if she were at one of the extremes, in terms of facial features or hair or whatever, perhaps we'd get more looks or questions or judgmental kind of comments ... she's beautiful, people are taken with her so much [they] tend not to think about the differences.

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this section as it is convention in both academic and popular usage.

Beyond the loss of control over disclosing a child's origins, the envy and sadness expressed by these couples could also be related to the families further being reminded that they are unconventional after experiencing the stigma of infertility. With other choices of having a child, the condition of infertility can be kept secret whereas with transracial adoption, family formation by other than biological means is on display. Although this can serve to undermine biologism, it is also a source of discomfort. For Nicole's husband, however, the inability to keep adoption a secret because of differences in appearance has its positive aspects, as it could promote honesty and openness within the family about the choices made.

> Holden: ...as the child is growing up, because they don't look like you, of course you deal with the adoption issue from day one ... you can't hide it. And because the parent can't hide it, the parent is more comfortable because there's no sense in being uncomfortable about it because it's right there in front of your face.

Holden refers to how the fact of parents and children not resembling each other physically or racially will naturally bring up the issue of adoption within the family. The related issue which may not be brought up naturally is that of race, as Americans do not easily or naturally talk about it.

Even though Americans find race a 'touchy' subject to discuss, the United States is a race-conscious society. Even the process of considering transracial adoption has an effect on racial awareness, meaning and subjectivity. When parents and children do not share physical characteristics that mark them as being members of the same 'race,' a consequence is that race becomes an issue because racialized boundaries of family and relatedness have been breached. These racialized boundaries and positioning which are important in relation to particular discourses and identities are usually hidden or out of focus. With transracial adoption, these boundaries suddenly sharpen and as an individual, the parent has to deal with his or her own sense of being a racialized being, their own relation to 'race' as experienced in the United States, and the dynamics of racial hierarchy. The implications of this confrontation will differ for Whites from that of people of color.

'Race' and ethnicity are not foregrounded for Whites most of the time, while the opposite is true for members of racial and ethnic 'minority' groups in the United States. White as a race is invisible for White is the norm. The experience of transracial adoption brings race to the fore, as well as rendering the invisibility of "whiteness" visible. Prospective adoptive parents are compelled to think about race and ethnicity in new ways for the addition of a child of another 'race' to their family will change their relation to the racial hierarchy in the United States. Charlie and Dinah are a Jewish American couple; one of Dinah's Fallopian tubes is damaged and she was told she had a 50% chance of conceiving naturally. Partly because of financial concerns, she and her husband Charlie decided to adopt. Charlie eloquently describes his reactions when presented with the prospect of adopting an African American child.

> Charlie: ...I think the thing that I'm primarily concerned about is: 'Am I inviting race to be a kind of dominating issue in my life? For the rest of my life by doing this?' And the specter of that in some ways is not very appealing ... I was asking a lot of very plain mental questions about who I was in relation to Black people and how I really felt. I was having to look at what prejudice there was even within myself. And I began to see the entire process as an enlarging experience actually.

As a White man, 'race' has not been a dominant issue in his life up to now but with a Black child he will have to confront race - his own and that of his child - daily. His relation to race as a concept somewhere 'out there' which doesn't affect him will change drastically, as he will now have a child who is racialized in a quite visible way. Charlie reviews the nature of his relationships with people of color, noting that up to that point his relationship to Blacks had been one of inequality.

> Charlie: ...basically I grew up in New York which is not... well. I consider New York to be a fairly prejudiced society. And I had never had had relationships with Black people. But they were always people who were primarily in subservient positions to us. I mean we had a maid the whole time I was growing up. She was Black, I was close to her but... it's not the same as...

Intertwined with Charlie's experiences with African Americans is the acknowledgment that they were not of the same economic status as himself. He goes on to recount that even when he worked with "all Blacks" in a shipping room of one of his father's businesses, he did not consider his co-workers his peers. He, being the boss's son, had a different relationship to the means of production than his coworkers, and in addition he was White. The memories Charlie chooses to share as he ponders the implications of this adoption reveals that he is acutely aware of the status differentials reflected in the nature of his relationships with the Other. It is clear that Charlie's knowledge of African Americans was as an entity apart from himself; they did not share the same social space he did. Yet now these threads of race, class and family will potentially come together in a new pattern. Charlie's set notions of race, class and family will be overturned with acceptance of a child presumed to be different becoming part of Charlie's family through adoption.

Charlie's wife Dinah also considers her relationship to non-Whites but in a more abstract fashion.

> Dinah: ...as far as race, for some reason I've never really had a big block about race. Like different races or having them be part of me ... I don't have a lot of baggage about being prejudiced. But on the other hand, I didn't have

> anything thrown in my face to be prejudiced about really. My parents were really open and there weren't a lot of prejudices expressed but also I didn't live with a lot of diversity either ... I had my own things about being like, prejudices about Blacks and other races when I start to think about it but to where I wouldn't want to have a child in my life that was Black or Mexican or Indian or whatever –it never seemed to be a problem for me.

She does not foresee any major changes in the way she relates to race because her focus is elsewhere. In her interview she does not reflect much on the racial component of becoming an adoptive mother, but rather on the change from being a woman unable to have children to becoming a mother and being able to parent. In this Dinah was similar to other women in the study who consistently placed parenting before other concerns. (Charlie and Dinah adopted an African American child).

For individuals who are themselves people of color or their partner is, similar issues arise but racial awareness is more integrated into their comments as they have dealt with racial and ethnic concerns before, both individually and as a couple. Janice, a Japanese American woman, underwent premature menopause. Together with her husband Neal who is White, they adopted a mixed race child. Their daughter is racialized Black based on her appearance. Janice and Neal discuss parenting a child of another race; note that Janice's impressions are filtered through her own experience of being a Japanese American woman.

> Janice: I thought it would be difficult, because there is so much discrimination against Blacks. I, myself, being Japanese, I felt it myself and I felt, "Oh, man, it's going to feel worse for her." In having to be a parent to someone that's discriminated [against] so much, you know I didn't want – And I couldn't figure out how not to be angry at people when they are, if they are mean or when they say hurtful things, you know? I just pictured being angry and always fighting, fighting, fighting back and I didn't want to do that. I haven't thought about that as being a problem lately. I don't know. Sometimes I feel myself, sometimes in a crowd and I feel like, "Oh gee, we're the only two minority women around," you know? And I feel more together with her in that way...I guess because we're also two females too.

> I feel more of that bond in common; but politically we're, our work has always been towards equal rights for people in general, people of color. I guess it won't be as awful of a thing as I thought it would be, much of a problem. I think living here too, I haven't run up against anything. Maybe because she is so young.

> Neal: Yeah. I don't want her to be hurt by discrimination. Make sure she feels good about herself...Although she's a different race than we are. She's somehow different from other kids. It doesn't seem like – Seems there is so much diversity...

Because Janice is a woman of color, she is aware of how racialization will affect her child's life experience in a manner that Neal is not. He agrees with Janice that he doesn't want their daughter to "be hurt by discrimination" hoping that making sure his daughter has high self-esteem will protect her. This was the only comment that Neal had on the subject of race whereas Janice ruminated on her own position in the racial hierarchy (which will change because of her daughter's appearance).

> Janice: ...I feel like I'm in a peculiar situation because in some ways I'm treated like as if I'm a White person, which I'm not. I never had the rights and privileges of a White person, but I'm not the kind of minority person. I'm not a minority person either because I'm not a Black person, so I'm not a minority person either, so it's kind of weird.

Both Charlie and Dinah and Neal and Janice are pondering the changing meanings of race and their relation to it as a result of their adoption of a 'Black' child, though to different degrees. However, the fact that Janice and Neal are confronting race in a context in which race is already salient creates a different dynamic and meaning to their resolution.

Transracial Adoption, Family and Community

In choosing adoption as a pathway to resolution of infertility, couples must also consider the larger family circle for the effects of forming a multi-racial family goes beyond the triad of parents and child. Acceptance of the adopted child by immediate and extended family members is often complicated by the fact of transracialness. Couples who adopt transracially expressed concern that parents who are asked to grandparent a child who shares no genetic ties with their offspring and are visibly different in appearance would not be accepting, particularly if they had expressed discriminatory sentiments against different racial/ethnic group members in the past. Family members may not have the opportunity to confront changing racial ideologies on their own terms but may feel that it is being forced upon them. Referring to acceptance of their daughter by her mother-in-law, Nicole says:

> ...I think that if they have a feeling about her being Chinese they keep that from us. Because you know I have the sense that she has opinions about it but she doesn't say them to us. Just because there's no point, and ... his father I think that if he has opinions about it, he just doesn't say them ... Because his mother has made comments against Chinese people before we adopted or anything ... in fact, she moved out of the community because she felt there were too many Asians in it.

Deborah and her husband Rob, whose quote opened this chapter, have been married for eight years. Their marriage is both an intercultural and interracial union, and they are in the process of adopting a Black child. Deborah, talking about her mother:

> I think that she has a lot of unresolved feeling about the race issue. We have talked to her and explained to her that her grandchild would be Black and she will ask questions like "Will it speak Black English?" And you have a lot of consciousness raising to do...

In referring to consciousness-raising, Deborah is pointing out the error of her mother's thinking that because a child is Black that it will innately speak Black English, ignoring the role that parenting and upbringing will have on aspects of culture such as language patterns. In this case, it is particularly ironic as the adoptive father is African and speaks English with an accent very unlike American Black English. However, Deborah frames this reaction as a race issue even though Deborah's parents had to adjust when she wed Rob. Yet while that adjustment most likely encompassed the possibility of having a grandchild with African American features, now they are being presented with the possibility of a child that is racialized Black and has no genetic tie to them.

For a few couples, the reactions of family members (a potential source of support) were so negative that they negated pursuing transracial adoption, even if they themselves had originally decided to do so. Similar family reactions have been documented with regards to adoption in general, which Becker attributes to the power of the cultural ideology of biological parenthood; even if couples themselves are ready to adopt, family members can derail their plans (Becker and Nachtigall 1994). Paul and Becky, a White couple who have been married six years, were considering transracial adoption. Paul's account of how his family influenced his decision illustrates the quandary when 'race' enters the equation, both with regards to family and acceptance, and other concerns.

Paul: ...the whole idea of adopting a baby of another race or a mixed race. All that stuff came rushing to the surface in me. Personally, I felt like I didn't have a problem with it at all, as far as I felt. But what really stumbled me, I think, and made me pause was the possible reactions of, especially my parents. But also my brother and sister and the extended family. My dad is 87 and my mom is 77, so they're in a totally different generation. Almost two generations ahead of me. And in fact, I think it was last summer that my folks were here, and I kind of screwed up my courage and asked them point blank one day how they felt ... I'm not sure if I asked how they felt about a White couple adopting babies of other races or whether I worded it "How would [they] feel if we did it?" I can't remember exactly how I phrased it. I think maybe it was "How do you feel about White couples [parenting children] of other races?" (because I have a cousin that has done that with several children) and my dad, I can't remember his exact words but he came out with a fairly negative reaction. And of course I immediately stored that away and thought maybe this will lead to rough waters if we pursue this. You know, when I talked to Becky later, she had a good perspective and she said "This is our lives, we have to make our decisions on what we feel is right. And quite frankly, your folks aren't going to be around for very much longer." So that doesn't have to totally

> rule our decision in the matter. But to me I still realized that it was a pretty significant factor in the whole thing and it was just enough of my own insecurities to kind of turn up the volume of my insecurity a little more. Because I have a real struggle with wanting approval from other people. And the thing is, I'm a very performance-oriented person. So that certainly triggered off a lot of buttons to think that my folks would reject their grandchild and that really made me sad.
> The other thing that kind of scared me was I have a sister-in-law whose very proper and closed and everything she does has to be just right. And I felt like without even thinking about it too much, I felt like that kind of action of adoption a child of another race would certainly not enter in her framework of what's proper and what's right. And she has two children and I thought I would really be very sad if that attitude would get down into her kids. And then this baby being cousins and there would be something there with the children, I thought that would be really bad. And then the other thing that Becky may have talked to you about, I think one other thing that came up was our feelings of maybe an inadequacy on affirming that child's race in terms of befriending people - adults - that were Black or Chinese or whatever the race would be so that the child could assimilate some of their culture. And we heard about these meetings about parents that get into that very much and will have a Chinese birthday party for their Chinese child and invite all of the Chinese people in the neighborhood and Becky and I thought "That is a little overwhelming to us."
> So there's a lot of issues that came up in that whole thing that we kind of looked at each one of them and said "This is not really a very probable option for us at this point."

While Paul and his wife thought through the implications of straying from the American cultural norm, they had to move beyond their individual subjectivities to consider both family and friends. They ultimately felt that they could not reinterpret the dual ideologies of race and biological parenthood without support from those around them, so they retreated from the racial front.

In negotiating ideologies and feelings of belonging on racialized terrain, the acceptance of family members can be key. Donna and her Japanese American husband Larry have adopted a White child. Donna, who is White, feels a strong bond with Darren although there is no genetic tie. She has found that her love for her child ‘erases’ the visible differences between him and her husband.

Donna: Adoption, it's been sort of hard for me and I find it's nice when people say Darren looks like me, even though Larry and him look perfectly fine together, 'cause I see Larry in Darren and I don't notice a difference, but I know there's a difference. And I wonder whether there's something wrong in the way that I think about this, because I'll talk to some of my friends and they'll act like I'm crazy.

But what is of concern to her is how a White child will fit in with its Japanese relatives. Donna talks about his family's acceptance of their child which is both genetically and racially distinct.

Donna: I place too much importance, I guess, on Larry's family liking Darren. Now whether that's because ... Well, it obviously has to be, I think, because he's adopted or he's not half Japanese or half whatever, but for some reason I think it makes great brownie points when his aunts like Darren or when he performs well at a dinner or he doesn't make us look ridiculous by misbehaving or whatever ... And now the biggest thing lately has been he'll eat any kind of Japanese food you put in front of him, which is so bizarre because it took me a long time to acquire a taste for some of that stuff. And his aunt, it meant a lot for some reason when his aunt said, "Darren is eating that stuff? I guess he just doesn't know he's [not] Japanese yet." And I just thought that was such flattery. I really thought, gee, we really must be accepted. It must be okay. But, on the second hand, you know, why should that matter? But, yeah, I guess it does. That they think it's okay that we've done this. They're sort of old school."

Donna is gratified to recount Larry's family looking beyond the appearance of Darren and focusing on his behavior, in this case his enjoyment of Japanese food which his aunt jokingly points to as a result of him not realizing that he is White. For Donna, this sign of acceptance for Darren as an individual beyond his phenotype is heartening. Despite his appearance and biological ancestry which are explicitly commented on by his aunt, Darren is implicitly being acknowledged as Japanese by a Japanese relative because of his behavior, pointing to the possibility that ethnic identity does not have to be associated with genetic ancestry.

Another area of social life where racial mis-matching is questioned is within the community. Couples who had adopted transracially talked about how it was important to find a residential community where their reinterpretations would not be constantly challenged. Couples in which both members were White characterized such communities as those that were already diversified.

Nicole: ... I guess I was hesitant to tell people about our situation, because I know they wouldn't understand it and it would be very difficult for them to understand it and I didn't want to take the time out to educate them about it either. So, yeah, I think it's real difficult. We're thinking of moving out of this area. One of our big issues has to be what is the community going to be like that we're moving to, because we don't want move into a community that's going to be very intolerant.

Holden: ...That's the other issue though is that I think some of the places where we can live is one of the things that's going to be hard for me.

Nicole: We're not going to be able to live in the Deep South.

Holden: ...We can't go live in Birmingham, Alabama.

Nicole: We could but it would be a real hard life on Olivia, so I don't think we'd do it. People are real limited to metropolitan areas and fairly urbanized areas –

Holden: – with a large immigrant population I guess.

Holden: ...You can't just live anywhere with a multi-racial family. You just can't move to Skokie.

While their concern for their family's quality of life is understandable, there is also an assumption by Nicole and Holden that the presence of people of color will translate into increased tolerance for multiracial families. This view was not shared by people of color who adopted transracially as they experienced confrontations from a variety of sources

Janice: ...one time I was riding BART and this lady from China or something. She saw me with Sue [baby] and she says, "Why did you marry a Black man?" And I said, "I didn't marry a Black man. I married a White man and she's adopted." And she goes, "Adopted, oh."....It's [a] very stereotypical Chinese or even Japanese way of speaking, it's like, "Why don't you make your own

> baby?" You know like that. And I said, "Oh, we can't. Nothing happens." She said, "Oh, well, then it's okay."
> [Here] I don't have too many encounters like that, but it's like people still think – And it's hard for me to think because here I am married to a White man and I'm Japanese, you know? That why can't different races be together, you know, as a family? That it's not abnormal or something...it's not wrong so –

To answer Janice's plaintive question of why can't different races be together as a family in the negative, one would draw on the ideologies of 'race' – that they should remain separate - and kinship – that blood is thicker than water and biology - real families resemble each other. This points out the subversiveness of transracial adoption as a resolution of infertility. Anthropologist Kath Weston argues that the traditional nuclear family exhibits a "tendency to create ties primarily with people they perceive to be 'like' them, using one criterion or another to gauge similarity" (Weston 1991, p. 206). If we read 'likeness' as corresponding to 'racial' similarity, then transracial adoption, as well as donor insemination, can reconfigure biological, kinship and racial ideologies. People of color who use these methods bring their own grappling with these ideologies to bear on the meaning of family and generativity. The politics of appearance plays a key role in shaping how individuals and couples will come to terms with difference. Larry, the Japanese American man who adopted a White baby, has come to his own resolution, both materially and conceptually.

Int: So, how have you managed to adjust to a child that is neither of your genes or of your race?

Larry: Because from the very beginning they had told me that I'll never have a child...Sometimes ... There was a few times when [I] thought, "Well, gee, it would be nice to have a child that resembled me." But after I thought about it, you know, a kid is a kid. You raise [it] and hopefully they become nice kids.

In this chapter, we have seen that the process of resolving infertility leads people to confront issues of race, class, gender and ultimately identity. However, there are differences when these issues are confronted as part of the process of resolution than when they arise as positions from which infertility is experienced. The resolution of infertility challenges couples – vis-à-vis their understanding of themselves (identity and subjectivity) as racial ethnic individuals and gendered beings in relationship to themselves, one another, their family, friends, co-workers and racial ethnic group. For many of them, they experience a transformation as they confront one challenge after another. At each step of the way they may confront an obstacle. To overcome the obstacle, they have to change their understanding of what it would mean for them to have a child – the "natural way" or not fully related – and must choose to either continue the process of seeking to have a child, or to end the process and accept themselves as childless. The experience of infertility has the potential to be transformative when an individual's desire for generativity and resolution transcends the constraints placed upon them by ideology. In this, new interpretations of content and meaning are legitimated, but at the same time existing structures are not discredited.

Chapter Seven: Beyond Gender
The Intersection of Hierarchies and History

In this research, I found that the infertility narratives of Native Americans, African Americans, Asian Americans, and Latinos and their partners show that identity is malleable, and that the disruption of infertility is shaped by interlocking hierarchies of gender, racialized status and class, and mediated by one's relation to a collective history of constrained reproduction.

As the experience of infertility is multi-faceted, I considered respondents as they positioned themselves in their narratives as a patient, as a member of a family, and as a member of a community with a particular history of constrained reproduction. Having the opportunity to hear people's stories over time allowed me to see how people tried to make sense of the disruption that infertility caused. Infertility was experienced as a disruption of the body, of the pattern of the life course, of systems of meaning, and of social identities.

The backdrop against which infertile couples experience these disruptions is that of techno-medicine operating in a capitalist racial state. The phenomenon of infertility in the United States has been highly medicalized. Using biomedical interventions which rely on technology to preserve genetic continuity is the favored course of treatment. These interventions, developed and implemented within a for-profit health care market, are costly and not attainable to everyone who desires them. In this regard, the current biomedical approach to infertility, with its focus on high-tech treatment rather than prevention, bolsters a system of stratified reproduction. One's economic and social resources, in conjunction with one's position in the racial hierarchy and institutional

mechanisms, determines the type of access one has to assisted reproductive technologies and the way in which reproductive decisions are intimately linked to social identities (Cohen 1999). Regardless of whether couples are consumers of these reproductive technologies, their experience of infertility is mediated by technology to the degree that this is the prevailing discourse of treatment, both from the biomedical and popular perspective. As well, infertile couples are forced to engage with the ideological underpinnings which privilege biological parenthood.

Interlocking Hierarchies

Colen's theory of stratified reproduction tells us that reproductive tasks are accomplished differentially due to the hierarchical nature of contemporary society (Colen 1995). In this work, three such hierarchies operating are those of racialized status, gender, and class. Each is a hierarchy based on difference in which power relations are embedded. One is not primary to the other, but they are mutually constituted (Boris and Janssens 1999). Individuals experience these hierarchies as interlocking because each hierarchy corresponds to different aspects of the self which are interconnected. To consider only one hierarchy isn't adequate (Nakano Glenn 1985; Higgenbotham 1992); the hierarchies of racialized status, gender, and class, along with other sites of marginalization such as sexual orientation and language facility, should be considered as an interactive matrix and examined as a complex to give us a more sophisticated perspective on reproduction as a process within social structures.

Using Colen's theory as a lens to view infertility shows how some women's fertility is encouraged as that of others is discouraged as a result of positionality with regards to hierarchies and sites of power. The position one occupies within the matrix of hierarchies affects reproductive decisions and options, as well as interpretations of reproductive experiences. The consideration of racialized status simultaneously with gender presents a different perspective on the meanings placed on fertility and reproduction when the intersection with the collective memory of a history of reproductive constraint is included as well.

Memory usually refers to an individual relation to the past, a relation to an actual experience that is significant enough to inform and color the subjectivity of the rememberer (Burgoyne 1999). History, on the other hand, is traditionally conceived as impersonal, the realm of public events that have occurred outside the archive of personal experience. Landsberg argues that history must become like memory in order to inform subjectivity, as part of the process of becoming politically aware (Landsberg 1997). In effect, she is arguing that history, often regarded as impersonal, must become personally significant in order to effect change. This concept is useful to discern how an individual's understanding of their group's collective history of constrained reproduction can shape their interpretation of their own infertility. The disruption to biography caused by infertility is thus not just experienced at the individual level, but on the collective level of racial and ethnic identity as well.

Another reason history is important, as Hall informs us, is that "identities are the names we give to the different ways we are positioned by, and position ourselves in, the narratives of the past"(Hall 1997, cited by Burroughs and Spickard 2000, p. 251). As social researchers, paying attention to the history of our respondents as well as how they relate to this history can enrich our analysis. Paying attention to and centering narrative analysis on the overlapping of social history and individual experience, collective

positionality and personal choice can reflect the intertwined and negotiated workings of structure and agency (Rapp 1998).

Reworking Identities

As has been shown in the literature, infertility has an effect on how gender is performed. Men and women try to adhere to gender norms regarding reproduction, but when they repeatedly meet with failure they undertake a redefining of gender which will encompass their experience of infertility (Becker 1997; Becker 2000). I found that infertility also had an effect on other aspects of identity, which became apparent when I looked at interrelational aspects present in respondents' narratives. Reproduction is important not just to gendered identities but to racialized ones as well. For my respondents, fertility and the ability to procreate was an assumed component of not only gender identity but one's identity as a person of color.

The concept of family held by most Americans is uncritically linked to fertility, the ability to have biological offspring, with the presumption that genetic kinship is the natural form of family. While most Americans subscribe to this concept of family, not all incorporate it into their racialized and ethnic identities, though the construction of racial and ethnic categories reflects a society's shared social meanings. It has been documented that family is a particularly strong orientation and cultural value for people of color (Collins 1987; Keefe and Padilla 1987; Williams 1990; Joe and Miller 1994). Families and children are also symbolic of people of color's survival and resistance to oppression (Collins 1994; Thornton Dill 1994). The people of color interviewed for this study subscribed to this concept of family as an important cultural value laden with symbolic meanings of survival and resistance. Furthermore, they associated this concept of family with biological parenthood, merging the two into an integral component of an ethnic and racialized identity.

This conceptualization of self was threatened by infertility and provoked a process of introspection and repositioning. In this, I found that respondents' sense of ethnic and racial identity was malleable and subjective. Individuals had to reformulate a sense of self which allowed for the seemingly discordant juxtaposition of infertility and race ethnicity without discarding the value placed on family or diminishing the symbolic meaning. This required a reworking of ethnic and racialized identity similar to what Becker has documented with regards to performing gender (Becker 2000). The issues of order and relations to power intertwined with the identity of people of color had to be negotiated, as well as disassociating the concept of family from biology. In these reworkings, the disruption generated by infertility was ultimately transformative of one's sense of self and a crucial step in the process of resolution.

In the narratives told by Native Americans, African Americans, Asian Americans, and Latinos, race was always a subtext. It came to the fore at varying levels, in different contexts and in response to interactions which primed that particular aspect of the self (Stephan and Stephan 2000). Most commonly, 'race' surfaced most strongly when respondents recounted situations of racism and discrimination. The hyperawareness of race and ethnicity occurred when one was placed in juxtaposition with others and when the priority of other social identities, such as patient and spouse, subsided momentarily into the background. This corresponds to the fact that discrimination has historically been a central force in the construction of identity for Native Americans, African Americans, Asian Americans, and Latinos (Pierce 2000). However, race also surfaced unexpectedly when respondents told of the importance of having a child.

For people of color, the desire for generativity located in parenting is related to one's sense of self as a gendered person who is a member of a racial ethnic community with a particular history and values. Women were more articulate than men about the link between ethnic identity and fertility, and individuals with a strong sense of connectedness to an ethnic community were more likely to conceptualize reproduction as part of a political strategy. One's personal history and relational bonds to a community of color with particular ideology about family, survival, empowerment etc. which emphasizes the importance of fertility becomes momentous with the disruption of infertility.

For individuals in this study, their gender and ethnic racial identity was initially presumed to be fixed. Most did not have any reason to analyze the content of these identities and how they intersected with fertility until they met with the challenge posed by infertility. An exception were those individuals in interracial and intercultural relationships who pondered what the implications of marriage to someone from another racial ethnic group would mean both to their family and their own sense of self (Stephan and Stephan 1989). An important part of this consideration was grappling with the possibility of raising children of a mixed cultural heritage. In those cases, both interaction (Collins 1990) and the prospect of achieving a life goal influenced how identity was experienced. However, this aspect of deliberation was based on the assumption of fertility.

As people move through infertility, from diagnosis to resolution, their identities are challenged and they must re-examine who and what they are as individuals and as a couple in relationship to a broader collective. For people of color, this process is mediated by their history of constrained reproduction, their social location as targets of discrimination, and the devaluing of their fertility. In this context, making sense of infertility requires a rethinking of cultural ideologies both mainstream and those associated with marginalized subject positions.

Differences Found

Infertile couples of color do not have models of how to deal with infertility. What is presented by media and biomedicine is based on the experience of White middle-class individuals with assumed financial and social resources. For couples struggling with infertility, it has been characterized as a source of stigma and shame (Miall 1986; Whiteford and Gonzalez 1995). Research on infertility of non-White women in China and Egypt (Handwerker 1995; Inhorn 1996) and journalistic accounts of infertility in Zimbabwe (Matetakufa 1998) has found that, in those contexts, infertile women are stigmatized to the point that they are publicly scorned. In what is perhaps a simplistic conflation of non-White women in an international context with that of women of color in the United States, it has been conjectured that women of color will suffer intense stigma and be alienated from their communities if they are unable to reproduce. I did not find this to be the case. While women of color did personally struggle with feelings of inadequacy and loss of self-esteem, they were met with sympathy and attempts at consolation and understanding by both family and community members (although these attempts were often clumsy and ill informed).

The stigma accompanying infertility has been cited as one possible reason why there is an unwillingness to disclose infertility, particularly in cases of male infertility which is even more stigmatizing than female infertility (Nachtigall, et al. 1992). Contrary to findings from other studies, my respondents were willing to disclose their infertility status to others as long as they could maintain control over the information. I found that hesitation to disclose was related to perceptions of power relations and the potential for abuse for some respondents. They were concerned if information about their infertility status could be used to harm them personally or their racial ethnic community in some way. The suspicions they held reflect the structural position communities of color have held in relation to the medical community, particularly with regards to experimentation (Rapp 1998). This nuancing of disclosure would have been obscured by relying solely on stigma as an explanatory factor if the respondents' knowledge of historical experiences had not been probed.

The willingness to disclose to others outside their immediate family was related to the need to garner informational resources which were assumed to be scarce in their communities and among family. The willingness to disclose to family was spurred by the need to receive emotional support and assurance that the couple was not seen as shirking their culturally defined familial obligations. The respondents in this study sought help in making sense of infertility through support mainly from individuals within their same social world. While some individuals and couples went outside their kin and friendship support networks and used formalized support groups, they confessed an ambiguous relationship with formalized support groups, which were sometimes seen as inappropriate and viewed with suspicion.

As discussed in Chapters Four and Six, couples' decisions about what pathway to resolution to pursue were determined by economics, and the degree to which they adhered to cultural discourses about biological parenthood and genetic continuity. While respondents did not claim a strong class affiliation, I found that their class position was significant in shaping their encounter with the biomedical system. The sense of loss of control which accompanies the bodily disruption of infertility was found to be exacerbated by economic constraints which effectively undermined reproductive self-determination. For those couples who were unable to pay for the expenses associated with biomedical intervention, they engaged in active strategizing to gain access to biomedicine while consciously preparing for desired parenthood. They were less likely to take a consumerist stance towards biomedicine, both demanding and expecting less than their more financially comfortable counterparts. For those couples who had the financial means to pursue biomedical intervention but still had to struggle to acquire sufficient resources for treatment, strategizing centered on getting the most services for their health care dollar.

While couples made decisions about treatment jointly, there was a difference in the way men and women approached the material economics of treatment. Key to women's considerations was the expense of trying, of taking a chance while men considered both the cost of trying and the additional cost of raising a child if an intervention was successful. There was not a similar gender difference found with regards to consideration of emotional and physical costs associated with certain avenues of resolution, although both genders felt that the burden in these areas fell heavier on women.

The choice of resolution was determined as well by the outcome of an ongoing process of confrontation and negotiation with cultural discourses about biological

parenthood and the importance of kinship based on genetic continuity. If couples pursued biological parenthood without success, I found that they were more likely to de-emphasize genetic continuity and the quality of 'known' genes to emphasize social aspects of parenting. Resolution of infertility utilizing donor insemination or transracial adoption also required confronting racial and biological ideologies. The conflict was expressed most commonly in concern over appearance and secrecy. In a racial state, concerns over appearance stood in for concerns about race, belonging, and naturalness.

I found that the notions of 'race' were challenged but in a different way from that of ethnic and gendered identities. The difference was most visible in the narratives of Whites considering transracial adoption. For Whites considering transracial adoption, they confronted a disruption of beliefs about the immutable nature of race, the system of racial hierarchy, and one's relation to this system. Their narratives concerning the intersection of their desire to parent, of generativity, with their White racial identity revealed an engagement with the reality of privilege which had not always been conscious or visible.

Beyond Gender

This work offers an implicit critique of research frameworks which privilege gender and do not fully consider other identity formations. When one pays attention to how certain identity categories are privileged and others are obscured, it generates a subtler, more complex and more complete picture of how identity can be transformed encompassing historical character and formative context (Moya 2000).

Hegemonic cultural forces normalize the subject of infertility as a White middle-class heterosexual woman. Baca Zinn, writing about feminist theorizing on the family, notes that "although Western feminist thought takes great care to underscore race and class differences, it still marginalizes racial ethnic families as special 'cultural' cases" (Baca Zinn 1994, p. 305). In other words, while the experiences of men and women of color are relegated to the margins, White women and their experiences remain the norm. What are the consequences of normalization of the White bourgeois subject? We must ask ourselves what is missing from the portrait painted when the subject is always racialized White, when the subject is constructed as an object of biomedicalization, and when the subject is feminized?

The intersection of racial ideologies with other systems of classification based on difference are not visible when the subject is homogenous. As well, this reinforces binary thinking of White and Other. As defined by Kolbert, reproductive rights encompasses the "ability to choose whether, when, how, and with whom one will have children"(Kolbert 1988, p. 8). With regards to reproductive rights, much has been written on women of color as victim, and as the target of coercion (Katz Rothman 1989; Wajcman 1991; Callahan and Roberts 1995; Roberts 1997). This is important and necessary work, particularly as women of color and low-income women have been shown to be targets of coercive and punitive reproductive legislation. However, these writings all assume uncritically the fertility of women of color. This representation in both academic and popular literature of women of color as fertile perpetuates the construction of an essentialized identity which has political and social implications. Studies of infertility among those other than the normative subject could encourage a nuancing of the notion of reproductive rights.

The majority of contemporary inquiries into infertility has been done on people in treatment. Medicalizing means that only people who receive treatment are considered. A consequence of this is that the varieties of classed experience are hidden as only those who have financial and social resources are able to access treatment. This disallows an examination of the microsociology of access and an analysis of structural constraints operating in concert with ideologies of difference. As well, room for theorizing about men and women's agency and resistance to constraints placed on their reproduction is constricted. Another consequence of a medicalized subject is that the experiences of individuals who reject and resist biomedical interventions are erased, leaving us with only a partial perspective on responses to infertility.

That the subject of infertility studies is feminized is not surprising as the majority of biomedical interventions for infertility – both male and female - occur in and on women's bodies. Though men suffer from infertility as well, infertility is conceptualized as a women's problem, prompting comparisons with earlier thinking which 'naturally' relegated reproduction and children to the domestic sphere. An analysis which includes gender should consider the effects of infertility on both men and women as does the work of Greil and Becker (Greil 1991; Becker 2000). There is room for studies in the gaps of patriarchy, studies of men who are constrained from 'reproducing' either biologically or socially. For example, research on gay men who use surrogacy or reside in those states where they are not allowed to adopt would tackle questions of alternative ways of confronting generativity.

Feminist anthropology contends that the domestic sphere, into which reproduction usually falls, does not stand in opposition to the politico-jural sphere but rather these spheres are cultural constructions which are interconnected (Rapp 1979; Yanagisako 1979). Any analysis of reproduction must be historicized and contextualized. Reproductive decisions are often the most personal of decisions but they cannot be removed from the political context in which men and women live their lives (Herman 1988).

Building on this contention, I note that even the most intimate issue such as infertility is mediated by location in history and implicated in larger, broader collective experiences. Infertility is not just about gender, biology and kinship, but is about collective history, identity and relations of power as well. This point is made most clearly when one foregrounds the narratives of people of color.

APPENDIX A: Biographical Sketches

Ages and length of marriage are based on responses at first interview. Racial and ethnic identifiers are respondents' choice of terminology.

Raquel (35) and Louis (39) have been married for 5 years. Raquel, a veterinarian, is a Chinese American woman from the Midwest. Louis is a Chinese American lawyer originally from the East Coast. Both Raquel and Louis are children of immigrants. Louis has a low sperm count.

Charlene (36) was divorced at the time of her interview. She is Indian (Blackfoot) and a health educator. She spent summers growing up on a reservation. Her infertility was unexplained.

Adriana and Joe have been married for 9 years, and run a computer business together. Adriana (39) is an Italian American and a practicing Catholic. Joe (44) was born in Japan to Japanese parents and immigrated to the United States when he was a child. Adriana has damaged Fallopian tubes.

Sandra and Steve have been married for 5 years. Sandra (32) is Jewish and works as a secretary. Steve (32) is a first-generation Chinese American and a lawyer. Their infertility is unexplained.

Deborah and Rob have been married for 8 years. Deborah (32) is White and a legal secretary. She gave up a child for adoption before meeting Rob. Rob (37) is from Liberia and an accountant. Their infertility is unexplained.

Diana and Kevin have been married for 7 years. Diana (36) is a Hispanic woman raised in San Francisco and a medical assistant. She has a teen-aged son from a previous marriage. Kevin (39) was raised Mormon and is a factory manager. Their infertility is unexplained.

Alita and Edmund have been married 10 years. Alita (35) is an American-born Filipina, and works in a bank. Edmund (36) is an American-born Filipino and a manager. Alita has blocked Fallopian tubes.

Cynthia and Cal have been married for 7 years. Cynthia (33) is White. Cal (37) is a Chinese American originally from Hawaii. They run a general contracting business together. Their infertility is unexplained and complicated by endometriosis.

Wendy and Lorn have been married 5 years. Wendy (31) is White and an agricultural inspector. Lorn (38) is Indian and a welder. Lorn has two adult step-children from a previous marriage. Wendy's Fallopian tubes are damaged.

Calandra and Franklin have been married for 3 years. Calandra (31) is Black, being retrained from construction and on disability. Franklin (31) is of African descent and a carpenter, underemployed at the time of the interview. Calandra has problems with her Fallopian tubes.

Raeshell and Tom have been married for 7 years. Raeshell (27) is Black, and works in sales & marketing. Tom (32) is Black, works as a chemical technician and teaches high school. Tom's sperm count is low.

Joyce and Mark have been married for 13 years. Joyce (45) is Chinese American and a part-time interior designer. Mark (38) is Caucasian, and executive director of a non-profit. Joyce has an adult daughter, and has had a tubal ligation.

Roberta and Jay have been married for 2 years. Roberta (33) is White and a hospital administrator originally from a rural area on the East Coast. Jay (31) is a second-generation Hispanic and administrator. Roberta has endometriosis.

Donna and Larry have been married for 11 years. Donna (35) is White, and works part-time as a computer artist. Larry (39) is Japanese and has a chronic illness requiring dialysis; he works in maintenance. They have both male and female factor infertility.

Janice and Neal have been married for 4 years. Janice (38) is Japanese American and takes care of children part-time. Neal (39) is White and a nursery technician. Janice underwent premature menopause.

Amalia and Hilario have been married for 2 years. Amalia (28) is Mexican and does child-care. Hilario (30) is Mexican and works as a dishwasher. They are mono-lingual Spanish speakers and immigrated to the United States a year ago. They have not received a diagnosis for their infertility.

Nori and Edward have been married for 3 years. Nori (36) is Japanese-born and a pharmacist. This is her second marriage. Edward (67) is White and is retired. He has 5 children from a previous marriage, and had a vasectomy.

Jocelyn and Gerard have been married for 9 years. Jocelyn (41) is a woman of color (of Guamanian descent) and works as a sales manager. Gerard (37) is a Black investment banker. Jocelyn has ovulatory problems.

Delia and Eugene have been married 12 years. Delia (37) is second generation Chinese American and a lawyer though she is currently unemployed. Eugene (45) is also a lawyer and White. He has 2 teen-aged children from a previous marriage that live with them. Delia's Fallopian tubes are damaged.

Beatriz and Ted have been married for 7 years. Beatriz (33) is Hispanic (her mother is from South America), and a student. Ted (33) is Asian and works in construction. Ted's sperm has low motility.

Mandy and Will have been married for 10 years. Mandy (36) is White and a filmmaker. Will (37) is Chinese American and works in marketing. Their infertility is unexplained.

Elena and Peter have been partners for 3 years. Elena (37) is a Chicana raised in Mexico, and works as a counselor. Peter (48) is a Jewish attorney. They have a child predating Peter's chemotherapy, and Peter has a child from a previous marriage. Peter's chemotherapy rendered him sterile.

Sub-sample

Dinah (38) is Jewish and a nurse. Charlie (43) is also Jewish and a director of development. They have been married for 3 years. Dinah has a damaged Fallopian tube. They adopted a Black child from the United States.

Nicole (27) is White and a preschool teacher. Holden (28) is White and works in agricultural planning. They have been married for 4 years. Holden has a low sperm count. They adopted a Vietnamese child from the United States.

Felicia (38) is White and a nutritionist. Frank (44) is White and is an electrical engineer. They have been married for 4 years. One of Felicia's Fallopian tubes is blocked. They adopted a Mexican baby from the United States.

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