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Healing The Social Body After Assisted Reproduction

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HEALING THE SOCIAL BODY AFTER ASSISTED REPRODUCTION

by

CVETANA CINDY GOLUSIN

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

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2016

MAJOR: ANTHROPOLOGY

Approved By:

Advisor

Date

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DEDICATION

To my family:

To my husband Millard, for all his love and support, for all the dinners I didn't have time to cook, and the time away from home. I couldn't have done it without you.

To my three children, Matthew, Paul, and Natalie, with the hope that one day you will recognize you can accomplish your dreams. To my granddaughter Emma, you have brought me great joy.

And in memory of two special women in my life who gave me strength before, during, and after this journey.

To my mother, Joan Pavlovich:

“I kept my promise,”

and

To my aunt, Jeannette Curmaldi.

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I am indebted to many individuals who supported me on this journey—it was one of epic proportions. I want to thank especially Dr. Andrea Sankar, the chair of my dissertation committee, for her support, guidance, and patience as I worked through my own personal grief while preparing for this dissertation. I would like to extend my deepest appreciation to the members of my dissertation committee, Dr. Mark Luborsky, Dr. Todd Meyers, and Dr. Linda Hunt, for sharing their knowledge and expertise along the way. A heartfelt thank you to all the courageous women who shared their lives with me and entrusted me to tell their stories: I am eternally grateful. To my dear friends, who provided me with continual encouragement and support, I will always be grateful. To my editor, Lauren, for your patience and guidance, draft after draft.

There are no words to truly express my thanks for the love and support from my family. First and foremost, to my husband Millard: Your love and support helped me through many days when completing this journey seemed insurmountable. To my children, Matthew, Paul, and Natalie Flandorfer, for being my inspiration to persevere: Your encouragement and love were endless. Finally, to my granddaughter Emma, I could hardly wait for your arrival. Welcome to this world!

My mother, Joan Pavlovich, had a significant role in the development of this dissertation. Her story inspired me. Her courage, strength, and endurance to overcome the loss of her unborn children, her strong religious faith, and her everlasting love all worked to help me get through some very hard days. I remember her with great love and longing. She passed away the Fall of 2011.

During some of my darkest hours after the death of my mother, my aunt, my mother's sister Jeannette Curmaldi, believed in me, supported me, wiped away many tears, and lovingly pushed me when I thought I could no longer muster the energy to carry on. She never let me forget the promise I made to my mother before her death. While writing this dissertation, my aunt, whom I lovingly referred to as "Teta Jan," passed away on September 27, 2014. With my faith in God, the love of my family, and the memories of two very special women in my life, I accomplished my dream and I kept my promise.

To all of you mentioned and to others too numerous to mention who helped me day after day, I thank God for each and every one of you in my life. I love you all.

PREFACE

My thoughts and questions related to assisted reproduction are relatively recent and required many different directions and thoughtful introspection. I realized that understanding the lives of women who had undergone assisted reproduction could not begin without understanding what it first meant to be infertile. Over the past few years, I have explored the literature in anthropology, psychology, and medicine on topics related to cross-cultural infertility, identity, and biotechnology. The literature renewed my interest in women's health, which I first had in the mid-1970s in my career as a registered nurse. My renewed interest led to a greater awareness of the debates surrounding a multitude of women's issues, including abortion, contraception, and assisted reproduction. I wanted to understand better how assisted reproductive technologies affect women's rights and social structures. As I continued to delve into the literature, I wanted to explore the role assisted reproductive technologies may have in kinship. I have come to see that some of the most difficult questions raised were will be those the women in this study hoped I would be able to answer, about how to understand their experiences and how their experiences shaped who they are today.

A Journey Begins In 1977

At the age of 19, I became a professional registered nurse and began my career in a small community hospital in southeastern Michigan. I spent several weeks working in various wards of the hospital until I accepted a permanent position on a women's gynecology ward. Each day brought new challenges to this novice nurse. On one sunny fall day in October, my morning would begin like all others, listening to the midnight reports of the patients. However, this day would be life changing, not only for me but also for one woman that had also started her day's routine like any other.

Maria¹ was six months pregnant when on her way to work her car was broadsided by a semi-trailer truck. Maria's pelvis had been crushed, rupturing her placenta. She came to my ward postoperatively after repair of her pelvic fractures and a total abdominal hysterectomy. The fetus did not survive. I was totally unprepared to deal with this woman's grief. Her loss was insurmountable. I had received training on death and dying, but I was unable to find any words that would comfort her. On her fifth postoperative day, the physician that had performed the hysterectomy came in to see Maria and attempted to comfort her, telling her she could still be a mother; she could adopt. Thinking back to that time, I remember her turning her head to look at the physician. A few seconds passed until she said, "I lost my child. I can't simply replace him. The child will not be mine. My life is not worth living." During the night, Maria developed a complication from surgery and died. The next day I transferred out of the gynecology ward.

Over the course of my career, I worked in a number of different health care settings as a nurse, first in surgical intensive care units and cardiology intensive care units. Upon completing my master's degree, I ventured into hospital administration and, later, into clinical research. It was during my work overseeing the medical management division of a physician's organization that I began to wonder how people were supposed to fit into neatly packaged diagnostic groups. Diagnosis-Related Groups were introduced into the 1980s to determine how people should be categorized and treated, and the financial value of the care provided by medical professionals and hospitals. The trend then and still today is population management. What happened to individualized care?

After more than two decades of practice working in various areas of medicine, I felt a void. Something was missing. My thoughts and interests turned towards making sense of the

¹ Pseudonyms have been provided for all participants interviewed or mentioned in this dissertation. In addition, locations have also been changed to protect the confidentiality and privacy of the participants.

illness experience and how health care professionals contributed to that experience. It was then I began my studies in anthropology. It was then I also began to see things differently, and thought back to that day on the gynecology ward when I felt helpless, and wondered what the experience of such a profound loss in the death of a child or fetus may mean to a person. Thinking back to that day, I realized I had not even begun to understand her experience, what it meant to her to have lost a child, or her future. I wondered what else I had not seen, what I did not understand, and in what ways the medical professionals had failed her. Do medical professionals play a role in a patient's ability to endure loss or deal with an illness experience? I also wondered how American culture and society shapes the way we experience illness and death.

In 2010, while a doctoral student in anthropology, I was offered an administrative position overseeing primary care clinics. I took the position with the hope of gaining experience in how medical professionals shape the illness experience of their patients. As the administrator of these clinics, part of my responsibility was to analyze various data on population management and to prepare the clinics to become patient-centered medical homes.² The principal means of data collection consisted of extracting clinical information from medical records to submit data to health care insurance carriers based on patient visits that included the diagnoses and the services rendered. In turn, the insurance carriers collected data from all primary care givers and specialists and forwarded a report comparing various data points such as specialty, categories of diagnosis, and cost of care of particular diagnoses. In addition, I received prevention data on a subset of patients who had not had a particular service rendered, such as a woman's annual physical exam that included a pap smear and mammogram. Over the course of that year reviewing data, I began to realize how the data shaped clinical practices: The primary focus of

² Patient-centered medical homes (PCMH) are designed to provide coordinated health care services among specialists with the primary care physician as the lead to improve quality outcomes and reduce health care costs.

the data was on cost control, not on the experiences of the patient or how a patient's day-to-day life was affected by various diagnoses and illnesses.

At the same time, I continued my studies in anthropology and came to the juncture of determining a topic for a pilot study. My interests were directed towards how diagnoses may reshape identity. I sought counsel from several sources, including one most dear to me: my mother. It was a difficult period of time for me. My mother had just been diagnosed with a terminal disease. After she began her treatments, we sat and talked together for hours. I learned of female family members' experiences with infertility and my mother's own experience of miscarriages. During these talks, I came to the realization that I had taken my own fertility for granted: I never wondered why members of my family did not have any children. I also realized no one had talked about it and, if they did, I was not a part of those conversations. I began to think back and wonder how our Serbian culture affects the way we experience infertility. Is infertility talked about or is it hidden? How did our family members affect each other's personal experiences of miscarriages and infertility? Were they supportive for the female members of my family who had suffered a miscarriage?

I later asked another member of my family about her personal experience with infertility. Her response surprised me: "I didn't have any other choice but to deal with it. Not like today, where you can get help. It's a good thing that they have the technology to help women. It's too late for me, but at least other women have a chance." Other women have a chance? Do they really? Or are there barriers? My thoughts moved towards data collection and controlling health care costs and wondering whether these "other American women" my family member referred to had access to this technology. More questions began to surface about the way American medical professionals treat infertility, who has access to assisted reproductive technology, and the way in

which family, cultural values, and society affect women's reproductive futures. I had found my topic.

In a casual conversation with a colleague, I discovered that she had experienced successful IVF and was an activist in her own right. She described an event that occurred in a shopping mall. She observed a young woman in her mid-thirties pushing a stroller with two babies. She saw a woman approach the young woman and overheard her ask if her children were from IVF or if they were "normal." She described how angry she felt at this woman's comments. Because of that incident, she felt it was important to do something, saying, "I want to educate women and society that it's 'normal' to use assisted reproductive technologies." Her use of the word "normal" to describe this event and her IVF experience suggested to me that her word choice in this context was not only a response to her own personal experience of infertility and IVF, but also to American society's expectations of conception and procreation. Her self-described activism to educate other women and society was a means to reshape her own identity. This encounter with my colleague ultimately fueled my quest to understand better how such technologies as IVF within a particular cultural context facilitate, shape, and constrain women's identities, and the types of circumstances that cause some social actors to act but not others.

Over the years, I continued to think about the conversations I had had with my mother, my other family member, and my colleague. I began to scrutinize various interactions, the context of our discussions, the word choices used during those discussions, and American societal and media influences during difficult periods of time in a woman's reproductive years. My mother died the year following her treatments, which led me to further introspection and reflection of my own experiences, both personal and professional. I began to consider the role I may play in the future of anthropology as a result of my own life experiences. Questions

concerning life, both end of life and the creation of life, were foremost in my mind. Do we take life for granted both in its beginnings and its endings? These questions were only the beginning, as I continued to wonder about life, needs, wants and desires, dreams and disappointments, and how all of life's experiences shape who women are, what they will become, and their relationship to their social worlds. All of these thoughts and feelings eventually inspired this dissertation.

In the following chapters, I continue my exploration into the ways that identities and subjectivities are formed, reshaped, and experienced through the ethnographic analysis of data gathered from interviews conducted among women in the United States. Over a period of one year, I interviewed ten women who had had successful IVF and delivered singleton, twin, and triplet births. I examine various components that affected their experience, access to IVF, social and cultural relationships, and personal expectations of conception, pregnancy, and motherhood. The goal of this research was to understand better how women assign meaning to this experience, how the various circumstances in their lives shape their reproductive identity, and how their experiences with IVF influence their present world.

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CHAPTER 1 INTRODUCTION

Dana is late for work, having just left the clinic for the third time this week: another blood draw, another day of waiting for results. She rushes into her office, grabs her file, and walks into a meeting in progress. She can't focus. All she can think about is her blood test: Will she be pregnant this time? Or will this IVF be a failure once again? When the meeting adjourns, she heads for the ladies' room—it is time for her injection. Later that day she will head to the airport to meet with a client in Texas. She hopes she has packed everything she needs for the next two days: meds, injections, syringes, wipes, thermometer... Yes, she believes she has it all.³

Statement of the Problem

The purpose of this study was to understand better how assisted reproductive technologies (ART) affect the lives of women, their relationships, their sense of self, and what it means to have a child with IVF. I focus here on how reproductive technology becomes embodied in their everyday life before, during, and after IVF; and the way these experiences redefine their identity.

The Pilot Study

My interest in understanding the experiences of women who had IVF began in the winter of 2012 when I conducted a pilot study. I interviewed six women initially who had experienced IVF. I wanted to understand and learn several things about their infertility experience. I wanted to know what their treatments entailed, how they made decisions and evaluated the risks of the treatments, and how they learned if their treatment was working or not. They described for me how horrible it was to wait for the phone to ring, wondering whether the implantation had worked and if they were pregnant. Oftentimes

³ This excerpt recounts the story as told by the participant in her first interview.

they would wait by the phone, not sure if they wanted it to ring in case they would have bad news. More times than not, they cried while they waited only to learn they were not pregnant, especially with the first cycle. A few of the women were fortunate to receive good news after the first cycle. Once they were pregnant, their worries did not end. They feared they would have a miscarriage, which a couple of the women had experienced, which meant going back for another cycle or making the decision to stop. Looking back, they described how anxious they were during their pregnancies; always worried that something would go wrong. Some of the women described being anxious that something would happen to their babies during birth or even months afterwards. During the pilot study, I began to see how the women's experience of IVF and their subsequent pregnancies all held different meanings for each of these women. I began to understand how complex the experiences and meanings were for each of these women. I had not anticipated prior to this study how profound the changes would be in their lives, or how deeply infertility and IVF would affect them, how they thought about their life, or their sense of self.

The primary force that drives women to this technology is the belief that without it, they may not be able to become a mother. Prior to the use of ART, women who desired motherhood but were infertile sought folk remedies or played a part in childcare within their family, while others attributed their infertility to God's will (Finkler 1994; Greil et al. 2010). In the post-WWII era, women who were childless sought medical treatment or adoption if they could afford to do so (Marsh and Ronner 1996). As medical treatments for infertility continued to advance, women in the United States sought infertility treatment in the form of medication to regulate menstrual cycles or to improve

the chance of pregnancy. If pregnancy did not occur with medication, the next step was insemination. With the advent of IVF, this procedure was able to bypass previous conditions that prevented pregnancy.

The Medicalization of (In)fertility

In the state of Michigan, coverage for medical treatments for infertility and ART are meager at best and contribute to what anthropologists Faye Ginsburg and Rayna Rapp (1995) call “stratified reproduction.” To this end, one woman’s personal struggle with infertility led her to form the organization Resolve to help other women and couples alleviate the pain of infertility. Founder Barbara Menning’s personal mission initially was to reach the isolated and stigmatized members of the infertility community with the intent to decrease the stigma of infertility and change cultural attitudes. In the early 1980s, Menning took a political stance and began lobbying efforts, education, and gaining media attention to advocate for medical treatment for infertility. In the process, Menning took the position that authorizing a medical definition for infertility would increase the possibility of providing needed medical treatment, taking the stance that infertility is a medical condition. However, this bolstered infertility as a medicalized abnormal condition (Simons 1998).

For many middle-class women, and for the women in this study, health insurance acts as an incentive and means to become successful in IVF, while at the same time supporting the obligation to try to reproduce. Insurance then works to support the ideology of having to try, and the obligation associated with women’s “privileged access” to do all they can to have a biological child (Sandelowski 1991). In 2014, health care coverage underwent tremendous change in the United States to provide affordable

insurance to all. However, the changes that took place had minimal to nonexistent support for infertility treatments for women. Both working middle-class and poor women have access to control their contraception via the federal mandates of the Affordable Care Act. However, treatment for infertility is excluded, which limits access to those that can afford it. The privilege of medical treatment for infertility serves those that have private medical coverage or finances and the flexibility in their work lives to adhere to the strict regimented therapy of IVF. While the Affordable Care Act may provide medical treatment where some did not have access prior to its enactment, it works in some ways to stratify reproduction economically and symbolically, encouraging some women to reproduce. It should be noted, however, that while medical inequities are important, they provide a backdrop to this discussion of ART, and lay outside the scope of this research.

By defining infertility as a condition within a biomedical framework, it becomes a condition with possible solutions. The solution for some women is the medical treatment of ART. This holds social and cultural implications, as anthropologists have explored in ethnic groups (e.g., Paxson 2004) and in the case of adoption (e.g., Becker 2000; Inhorn 2000). If IVF reinforces the biological mandate of motherhood, middle-class American women's use of reproductive technologies reinforces the cultural ideology of biological parenthood, which may distract them from the primary goal of parenthood (Becker 2000; Paxson 2004). For these women, it provides a sense of reproductive agency to repair what nature has done to them—their bodies and their sense of self. Reducing infertility to a physical condition that may be explored and treated also temporalizes the experience as social, economic, and cultural. The desire to conceive a biological child through IVF and

experience pregnancy takes on more than the cultural context within which childlessness began; it represents an overarching search and desire for normalcy.

Thus, the medicalization of infertility functions to identify the abnormal, creating tension that compels the individual to act and makes that action challenging. Women undergoing treatment are caught between choice and obligation, failure and success, order and control, sustaining the work of normalization. Understood this way, reproductive technologies and the process of normalization are cultural categories that frame our understanding of gender roles, parenting, kinship, the embodiment of disease, and how we come to redefine them.

Assisted reproductive technologies, and in vitro fertilization (IVF) in particular, serve to alleviate the burden of infertility women experience, while at the same time creating and perpetuating the distinction between the “normal” and the “abnormal” (Canguilhem 1991:77). As a technology, ART validates the medicalization of infertility, normalizing both infertility and fertility, to make the infertile feel more normal. At the same time, it validates a system that differentiates the infertile, thus reinforcing infertility’s abnormal status. As ART has yet to be viewed as a normal or “natural” way to have children, it is often framed as a choice or, in some cases, an expression of the right to seek medical intervention to have a child—in other words, women exercising their right to reproduce. Women that engage in IVF therefore also engage in webs of relationships—medical, social, and cultural—that reinforce categories of difference and normalcy (Becker 2000).

Reproduction, IVF, and the Role of Biology in Kinship

The social institution of the traditional American family unit—seen as a heterosexual, married couple with biological children who live together connected by “love”—is the past product of a particular space and time. This deep-seated ideology has proven to be hard to denaturalize because of its relationship to biology (Thorne 1992:10). For example, Yanagisako (1977) described cultures in which no language defines family, parents or children, biology, or love; and living arrangements are not organized around biological kinship.

A significant contribution to understanding kinship in the United States stemmed from the work of David Schneider (1969), who regarded biology as the basis of kinship in America. His work has since been questioned and critiqued by Yanagisako and Delaney (1995), namely the assumption of kinship as “natural fact” that categorizes and restricts different groups or societies. Carsten (2004) also brought another perspective in regards to kin relationships surrounding individuals. Lastly, Strathern’s (1992) work has been influential in the area of what is considered “natural” and “cultural” to characterize conception by assisted reproduction in the making of kinship. As such, the significance in the meaning of the biological to a woman who has had IVF invites scrutiny to discover how kinship is interpreted and reframed in a social and cultural context.

For the contemporary American family, IVF reframes the meaning of reproductive choice, reinforcing the value of the biological child. Franklin (2013) explained the rise in alternative family structures, such as donor, same-sex, and other nontraditional family structures, and how ART contributes to the remaking or “re-crafting” of kinship (Franklin 2013:751). The modern or achieved family structure is a

product of technology, and gives the appearance of a new category of fertility behaviors and alternative parenthood structures, thereby comprising a new social norm. A consequence of these technologies is a change in the meaning of biological relatedness and kinship identities. The kinship ties that were once primarily biological or natural are now routinely imagined and celebrated as technologically achieved (Franklin 2013:751).

Indeed, in vitro fertilization has become more familiar, while at the same time women who have had this form of conception view it as an “unpleasant step toward a biological family” (Becker 2000:6). Despite the associated physical and emotional discomfort that IVF procedures entail, infertile women are willing to take risks to have the opportunity to share in the genetic makeup of their offspring (Becker 2000). The point of IVF, as the women in this study have shared, is that IVF provides a much-desired biological connection in the sharing of genetic makeup. As such, the rise of ART has led to debates about parenthood and kinship, changing the way we perceive reproduction (Franklin 2013:297).

The Choice of In Vitro Fertilization

Undergoing infertility treatment with IVF, as a choice, is complex and intimately connected to the notion of control. Women who feel that they have lost control of their reproduction seek medical treatment such as IVF to regain control in their lives. Using Paxson’s (2004) work in Greece as a basis for comparison, Greek women who benefited from IVF described it as “correcting damage that had been done to them by nature.” Here, “by nature” referred to the internal metaphysical forces that denied Greek women conception. In vitro fertilization is seen as a “natural, normal way of reproduction” (Paxson 2004:219) because it not only fulfills a woman’s desire for motherhood; it is

viewed through an ethic of well-being consistent with an ethic of choice. Choosing IVF, for Athenian women, satisfies the goal of motherhood and family expectations of another generation, and services their husband's paternity. In contrast, the sense of taking control of nature described by Sarah Franklin (1997) and Marilyn Strathern (1992) in the United States and Britain, respectively, is the sense that nature needed a "helping hand" to do "what it would have anyway" (Strathern 1992). Given these comparisons, to choose (or not choose) IVF means choosing to either remain childless or to be childless. Infertile women have stated that they did not choose to be infertile, yet are faced with having to choose—that choice transforms their future. Choosing IVF is taking control of nature; this also means living with this choice. For women who feel they have lost control over their reproductive ability, gaining a sense of control means correcting the problem of infertility with IVF. The expectation of control in the late 20th century follows the growth of technology more generally. Examining how the women in this study "imagine" control may tell us how shared cultural values play into whether control is an illusion or part of the notion of normalcy. Taking advantage of a given opportunity, such as IVF, is a process of normalization, a path towards being normal. Reproductive technologies such as IVF therefore reshape how women live their lives and how they experience their bodies.

Reproductive Agency in Middle-Class America

Today, some infertile women view motherhood as a goal to be achieved rather than an idiom of God's will as perceived by their mothers and grandmothers, illuminating contemporary women's reproductive agency (May 1995; Paxson 2004:39). A number of contemporary women consciously make decisions about their futures in the pursuit of an

education or career. Women make decisions on how to control their fertility and what type of contraception they use; they make decisions to remain childless or when to begin a family; they make decisions about family size; and they act to achieve these desired outcomes. Their acts are based on conscious decisions—when and how to have children.

Controlling fertility has also had repercussions for women. There has been a historical trend of blaming women for their inability to conceive. Women's inability to have children is often seen as a result of their choices, a price women pay for delayed childbearing, sexual promiscuity, or having had a previous abortion (Sandelowski 1990). Alternatively, many women think of infertility as something that has been done to them. They did not choose infertility, and for many infertile women who work very hard at trying to conceive and do not become pregnant, they also experience a feeling that they have lost control. This may be the first time, for some middle-class women, to have experienced a loss of control over their lives. Regaining a sense of control of their reproductive capacity means seeking medical treatment to correct the problem, to fix or repair their body (Rapp 2001). By defining infertility as a medical condition, women can be treated without the accompanying stigma, much like we treat cancer (Sontag 1978). If a middle-class, American woman has adopted the view that she can choose her life path, to have children, and to have children with ART—because choice is an idiom of contemporary American life—why then, as I will illustrate in this study, does she encounter cultural criticism when she exercises this choice?

The stories of the American middle-class women in this study show how ART affects their lives, relationships, and sense of self. I trace the elements that frame their decisions when faced with the ethical and moral decisions to become mothers, and how

their decisions reinforce categories of difference and their sense of normalcy. Using Ortner (2006) and Paxson's (2003) concepts of agency as a theoretical framework, I examine the language and discourse the women use to determine the fields of meaning of the events leading up to, during, and after IVF, in order to understand their experience, and the ways in which this experience redefines their identity. As such, I also explore the many webs of relations these women are engaged in (e.g., medical, family, social, and cultural), as well as their values in determining what it means to have a child with IVF. I illuminate how ten American middle-class women engaged in ART to become mothers, how they redefined and justified their reproductive decisions, and how they worked to reshape attitudes that explain everyday life after IVF.

Chapter Summary

More specifically, this research study unpacks the themes of normalcy, kinship, and reproductive agency in the experiences of the women of this study who have had a child with IVF. This dissertation is based on observation, archival research, and ethnographic interviews conducted in Southeastern Michigan, which took place over a one-year period. Chapter 2 details the research methodology and introduces the key participants to contextualize their lives, families, experiences with infertility, and how they came to try IVF as a means to achieve their goal of parenthood.

In Chapter 3, "Pursuing Normalcy," I examine the women's experiences of infertility and pursuit of parenthood through IVF. I explore the notion of normalcy as a continual process, examining the tensions between the overlapping boundaries between abnormality and normalcy. I argue that in electing to use IVF, a woman's status and

identity are negotiated by the use of this technology in relation to gender expectations, and are determined by cultural ideologies of normalcy.

In Chapter 4, “Kinship in the Age of Reproductive Technologies,” I further explore the women’s sense of normalcy within kinship structures, investigating what it means to have a “normal” family, and how this meaning reshapes their sense of self and belonging in their kinship network. I explore the participants’ personal and social values that influence their desire for a normal family in relation to the notion of biological imperative.

In Chapter 5, “The Meaning of Successful IVF,” I discuss the pursuit of normalcy as a drive for success and accomplishment. I examine how women understand success in the form of obligation or entitlement to become a parent. I explore the women’s desire to regain control and drive to restore a sense of order and normalcy in their lives. I compare Paxson’s (2002) work on Greek middle-class women to the American context in a case study that illuminates how the experience of IVF interacts with the women’s definition of success and failure.

Finally, in the Conclusion chapter, I synthesize existing anthropological literature on normalcy in relation to this study’s findings on IVF, agency, and sense of self. Specifically, I further summarize the construction of the “normal self” by exploring the tensions between what is considered normal among the American white middle-class women in this study after successful IVF. I argue that the technology of IVF sustains the normalization process. The ideology of normalcy after the experiences of infertility and, then, assisted conception reshape their sense of self. The paradox of the technology of IVF is that it helps conception and provides a “normal” experience of pregnancy, while at

the same time exacerbating feelings of difference and challenging these women to reshape their identities to “their” normal.

CHAPTER 2 METHODS, CONTEXT, AND PARTICIPANTS

In this dissertation, I approached this research as a practice of construction, an emerging social phenomenon in which assisted reproduction transforms and redefines a woman's identity through stages of infertility to conception, and conception to live birth. I employed various methods of ethnography (e.g., observation, interviewing, and archival research) to reveal how IVF reshapes and redefines a woman's identity after assisted reproduction. I conducted 20 semistructured, in-depth interviews from a nonrandom sample of ten women in Southeastern Michigan who agreed to participate in two face-to-face interviews of one to two hours in length.

In interviews conducted over a period of one year, I asked open-ended questions related to their experiences during and after successful IVF, and prompted the women to tell their stories in their own words. The questions asked were designed to elicit the meaning of the IVF experience during and afterward, and how it affected their everyday life. I probed further to understand how the meaning of that experience is embedded within the constructs of relationships and forces of cultural construction and reconstruction. Additional questions prompted discussions of the perception of IVF in and within their local social worlds in the context of family and kinship. Based on their responses, I also probed to understand the strategies these women used in social contexts, and how these strategies redefined their identities and sense of self.

In this chapter, I provide a description of one encounter that took place in a clinic where I worked two years ago. This account captures my first reaction to the situation at hand, and was the impetus in my decision to focus on women's identity and reproductive technologies in my doctoral research. This section is followed by a general description of

the research setting, the economic and geographical context of the participants, and data collection and analysis methods. In the final section, I provide an overview of the key participants of the study.

Methods

In order to explore the ways in which women negotiate discourses of normalcy/difference and the gendered body in relation to IVF, I conducted 20 semistructured, in-depth interviews with a nonrandom sample of ten women in Southeastern Michigan over a 12-month period. All participants had undergone successful IVF with single, twin, or triplet births at least two years prior to the interview. Initially, I explained the purpose of the interview and that I wanted to learn how they viewed their IVF experience, their desire for parenthood, and how they made decisions about their treatment. At the beginning of the interview, I used close-ended questions to obtain demographic information. I subsequently asked open-ended questions related to the women's experiences during and after IVF, which prompted the women to tell their stories. A number of interviews were conducted in the homes of my informants. One interview was conducted in a local coffee shop, and the rest of the interviews took place in my office.

Ethical Considerations

I obtained approval of my study from Wayne State University's Institutional Review Board. All women volunteered to participate in the study. We mutually agreed upon a time, date, and location to conduct the interview to ensure comfort and privacy. Written consent was obtained prior to the interview, and each participant was informed

that they could decline to answer questions during the interview or decline further participation in the study at any point in time.

Infertility is a highly stigmatized condition cross-culturally, and the treatment for infertility with assisted reproduction continues to be debated in areas of religion, inheritance, law, and medicine. A number of the topics addressed in this study are of a delicate and sensitive nature. Given the factors stated, specific details were omitted and biographical data has been modified out of necessity to maintain participants' privacy. I changed the names of the participants, as well as their demographic and geographical information.

The initial scope of this dissertation study included the participation of reproductive medicine physicians to understand better their role in shaping the IVF experience and women's identities. Due to ethical considerations of medical treatment, the IRB recommended the removal of the physician component of this research. This may be an opportunity for future research as indicated in the Conclusion chapter.

Data Collection

The first encounter

I explained in the preface how an encounter with a colleague, along with learning of a family member's infertility, led to my research questions. The first encounter was an unplanned observation and an unexpected conversation. My commitment to the pilot study and this dissertation had not begun, and my thoughts were in various and emerging stages. The conversation, however brief, was significant. Over the course of my study the word "normal" was used by each of the women I interviewed. Some of the women used the word to describe what they hoped their family would become. Others used it to

describe what they had hoped for in their pregnancy, and for their bodies after assisted reproduction. From that first encounter and throughout the study, the word normal returned time and time again. Being different in the context of reproduction was no longer desirable. I was intrigued how the idea of normalcy shapes, affects, and reinforces patterns of behavior and has multiple meanings as people go through their daily lives.

As I mentioned in the introduction, the use of assisted reproduction in live births continues to increase each year in the United States. Assisted reproduction has transitioned from a private to a public awareness. Internet access has exploded in the last decade to provide the public with an unlimited amount of information on the treatment of infertility and types of assisted reproduction. Searching the word “infertility” on the Internet provided a plethora of data from detailed descriptions defining infertility, to infertility treatment centers locations, to support groups for infertility, blogs, and links to various organizations. Ultimately, the Internet search led me to Resolve founder Barbara Menning. Her personal knowledge and feelings motivated her to help others experiencing infertility to understand their options better. Her mission and vision was to provide information on reproductive technologies, and for those women who failed ART, the information to consider the possibility of adoption.

Beginning my research on reproductive technologies included research on infertility as well. I wanted to examine every aspect of these women’s journeys from discovery of their infertility to medical treatment, along with their social experiences leading up to IVF. To understand everything fully, I needed to educate myself on the various procedures and to learn the inclusion and exclusion criteria from a biomedical perspective. I did so by attending various symposiums on infertility, as well as attending

a local Resolve meeting. My goal here is to portray, from an in-depth perspective, women who have undergone these treatments in the context of contemporary cultural phenomena. First, however, I had to understand the process from beginning to end. The following section describes a Resolve meeting that took place at a local medical center. This account captures some of my initial thoughts about the information that was provided and my reaction to the stories told by a woman who had successful IVF.

The Resolve meeting

The evening meeting was held at a local medical center not far from my home. The meeting took place in one of the medical center's conference rooms, away from any patient care areas. As I entered the room, the registration table had a welcome sign with a sign-in sheet, Resolve pamphlets stacked on the table, and volunteers to greet you. I had registered for the meeting in advance and, upon my arrival, I explained once again my purpose for attending this meeting—my research study—and my desire to learn more about their organization, what they do, and how they support individuals in their quest for a child. I signed in and moved to find a seat. Arranged in the room were long rectangular tables placed in a shape of a U, and against the tables were black mesh armless chairs to seat approximately 50 people. The room was a bit chilly. A large ceiling-to-floor window stretched across the expanse of one wall. Off-white shades were pulled halfway down the window. Against another wall was a long table with a pitcher of water, some cups, and a variety of cookies arranged on a platter. To the right and at the front of the conference room stood a speaker's podium. I found a chair towards the back of the room.

The meeting began with an introduction of the volunteers and the agenda for the evening. The volunteers included medical professionals, representatives from various

agencies, and two women who would share their personal experiences with assisted reproductive procedures, namely IVF. The room was fairly full with approximately fifteen couples and five women attending the meeting. As the speaker began her talk, another volunteer circulated informational handouts and brochures explaining the peer-led support groups' mission, meeting times, and locations. The speaker was introduced, Dr. Thomas Smyth, a reproductive specialist. Dr. Smyth completed his medical training at a well respected medical center on the East Coast. After completing his residency, he moved to Michigan where he has practiced medicine for the past 15 years. He began his lecture with, "I understand your frustrations and disappointments that have brought you here this evening," and then immediately segued into the various procedures and statistics on infertility/treatment. I watched with interest the interactions between the audience and Dr. Smyth as he explained how the success rates for IVF had improved over the years from 20 to 40% for women under the age of 35. He attributed improved pregnancy rates with a procedure called intracytoplasmic sperm injection.⁴

A couple sitting to my right were discussing the odds of success. The couple appeared to be in their mid-thirties, both well dressed. The male was tall, thin, and wore a black leather jacket, a button collared shirt, and blue jeans. The female was an attractive blond, also tall and thin. She appeared to be an executive, wearing a tailored suit and heels. Beside her chair was a large leather purse that could also function as a briefcase. On her left ring finger was a large diamond wedding ring, around her wrist were silver bracelets, and she completed her ensemble with diamond stud earrings. They listened

⁴ Intracytoplasmic sperm injection (ICSI) is a procedure performed in conjunction with IVF in cases where the man has a very low number of normal sperm. Performed in a laboratory, it involves the injection of a single sperm into the cytoplasm of an oocyte. Fertilization occurs in approximately two-thirds of injected eggs; the technique achieves the same pregnancy rate: approximately 20-40% per cycle at the added cost of \$1000-\$2000 per cycle.

intently to the various speakers, whispering back and forth during the lectures. The male shook his head, and then looked down before speaking to the female next to him. He was pessimistic, where the female leaned towards optimism. Essentially, she was conveying to her partner that these odds were not the best but were better than what they were presently experiencing.

Looking around the room, the participants were primarily Caucasians except one Asian couple, concurring with both medical and anthropological literature that attendance to infertility groups and access to reproductive technologies is predominately White middle class. This was same experience encountered during my pilot study: I was unable to recruit any women who were not Caucasian. I found myself wondering how each of the participants was dealing with the information that had been given to them, and what was going through their minds. A female lecturer introduced herself as Leanne (pseudonym), and she quickly brought me back to the meeting at hand. She began with, "I am a success story." Leanne was in her late forties, a physician who worked full-time in a clinic in Southeast Michigan. After completing her residency and opening up an internal medicine practice, she and her husband decided it was time to start a family. Leanne described in detail how she had come to the conclusion that she was infertile and the steps she began to take to cure her problem. She made every attempt to manage things on her own before seeking medical assistance, keeping a detailed diary of her irregular menstrual cycle, what foods she consumed, and the different vitamin supplements she had tried to remedy her infertility. Once diagnosed with polycystic ovarian syndrome

(PCOS),⁵ she immediately felt relief. She was confident with medical intervention her problem would be fixed. However, it was not that simple. Leanne continued to describe her painful journey of medications, procedures, and disappointments. She was worried that she would never get pregnant despite spending the past five years trying various regimens. As she stated, “We decided to try IVF. There wasn’t anything else left,” tears filled her brown eyes and spilled onto her cheeks. She tried to speak several times without success, attempting to regain her composure. She reached for a Kleenex, took a deep breath, and began once again: “I can’t forget the pain, the sadness, even though we have a son.”

I felt very uncomfortable watching her—I felt out of place. I also remember thinking that I had three children and had taken conception for granted not once, but three times. It had never entered my mind that I would have difficulty getting pregnant. Despite some of my family members’ infertility, I had beaten the odds. I found myself wondering how my mother had felt during her miscarriages and how the members of my family dealt with their childlessness in a culture that centered around children and family. On the surface, we shared something in common. Leanne and I were both working mothers, professionals balancing work and family life coming together in one evening so we could learn from each other and maybe help others. Yet, I could only sympathize with her pain. Her losses and struggles appeared quite vivid in her mind as she stood before us that evening describing the “ups and downs” of infertility treatment. Despite her success in having a son, there remained a deep and enduring sorrow.

⁵ Polycystic ovarian syndrome (PCOS) is a genetically inherited syndrome marked by irregular or absent menstrual cycles, excess facial and body hair, and infertility. This syndrome results in either absence or the failure of mature eggs to develop. The treatment utilizes hormones to enhance egg production and IVF.

As I looked around the room, the couples were watching Leanne closely. A few of the women had tears in their eyes, dabbing them with a Kleenex; a couple of the men looked away. One couple had their heads down looking at the floor. As Leanne regained her composure and began to speak, the couples looked up at her once again. At the end of one table sat a woman with short brown hair and glasses. She looked as if she could be in her early forties. She was organizing some pamphlets on the table. When Leanne completed her lecture, she briefly introduced the next speaker, Sheila was a nurse and massage therapist, saying how she too had a successful IVF. Sheila began her story of infertility and her ten-year “rocky road,” as she called it, of IVF. She described how she had failed other forms of medical treatment, then intrauterine inseminations (IUIs),⁴ which led to IVF. Sheila described her IVF cycles to the group and shared with them the stress she and her husband had experienced during that time. She looked around the room, smiled, and said, “IVF helped me to achieve our dream—we have a daughter.” Sheila stated she was here this evening not only to share her story but also to encourage the couples to support one another during this process. Sheila provided examples on how to relieve their stress, and offered her services as a massage therapist to help the couples relax. She described undergoing IVF as one of, if not the most stressful period in her life.

While its goal is to educate individuals, by the nature of its organization and volunteers, Resolve works collectively to change cultural ideologies and practices concerning infertility and difference. Resolve illustrates the ability to bring about change and creative transformation not only at a group level, but also at the individual level, as seen when the speakers described their experiences. These meetings also work to reshape

⁴ Intrauterine insemination (IUI) is a technique of placing the sperm directly into the uterine cavity as the first step in cases of infertility where there is a cervical factor affecting conception, anti-sperm antibodies, or unexplained infertility.

cultural dialogue about difference by talking about the frustrations of infertility. Conducting group meetings allows the individuals to see and hear that they are not alone. Sharing their experiences allows them to deal with what they are feeling, and the potential to develop bonds with other members of the group. Sharing their experiences during these meetings is a powerful tool to restore a sense of normalcy. Resolve's long-term survival is based on the support of its volunteers. As illustrated by their success stories and their emphasis on educating the community, Resolve has collectively influenced change in cultural ideologies about difference. The volunteers' stories illustrated how their experiences and actions were personally transformative. I would later learn that a few of my participants participated in at least one Resolve meeting.

As I drove home from the meeting that evening, and even days later, I wondered how the women who had attended the meeting were able to persevere as they did through the many challenges and disappointments they encountered. I questioned: Where did they get the strength and dedication to pursue the infertility treatments? How were those women able to endure not only the physical discomfort they described, but also the mental anguish? What did it mean to them to be a mother? Put another way, what did it mean to become a mother with IVF? How did the experience of IVF shape who they are today? As I began my interviews and got to know the women I interviewed, the need to figure out and reconfigure their identities surfaced repeatedly. As I listened to their stories, disappointments, and triumphs, I sympathized with them and cheered their victories. Their stories illuminated, both for me and for my informants, the meaning behind their desires to become a mother, fortitude, and their identities. This became a core component of my research.

Data Analysis

Data analysis involved two primary data sources: in-depth, open-ended, audio-recorded interviews and observation. Audio-recorded interviews and related notes were transcribed and reviewed multiple times. Transcripts were then imported into a qualitative software program, Atlas Ti7. Ten separate documents of ethnographic data were coded. A case-by-case analysis was also carried out with a close reading of each case for thought patterns and repetition of words and phrases. Recurrent themes, domains, and phenomena were identified to organize the data and applied to all documents. Data was then analyzed using research domains adapted from practice theory in relation to agency and subjectivity to answer the research question and specific aims.

The process of coding included coding for identity, the context of identity experiences, and any other theoretical concerns or conceptual categories that emerged, including feelings of failure, feeling defective, and attempting to meet family expectations. Each interview was analyzed at least three times for each of the areas and then coded for subdomains. After several reviews, I identified specific contexts containing rich discussions on normalcy, the sense of achievement, identity, and the significance of relatedness. In addition, the use of media technology as a source of gaining knowledge and learning biomedical discourse as a means to assert control over women's bodies and lives during treatment was illuminated during the interviews. Another example of the use of media technology was for support during and after IVF. The analysis thus involved an intense process of review between key scenarios, excerpts, categories, themes, and additional sources of text data. The participants reviewed specific

paragraphs of the interview transcripts in relation to family dynamics and normalcy to verify its accuracy of interpretation.

Context

Michigan's Economy 2007–2009

In the years 2007 to 2009, the United States entered into an economic recession. Michigan's unemployment rate was at an all-time high of 10%, slightly higher than the national average. Subsequently, increasing job loss left women and families without healthcare coverage (www.michigan.gov 2014). For many Michiganders, starting a family was postponed. For those women who were in infertility treatments, they encountered delays as their financial savings rapidly diminished. The middle class struggled to meet the financial burden of this technology, and the technology was made further unreachable for low-income women and women of color. Despite the economic recession, however, this technology continued to expand both in the United States and internationally (Centers for Disease Control and Prevention 2012). As the economy rose, so did the demand for ART.

The Communities

The metropolitan areas of southeastern Michigan surrounding Detroit are largely composed of middle- and upper-middle-class families. According to the 2010 United States Census, one county in particular adjacent to the city of Detroit is listed as one of the top 25 wealthiest counties per capita in the United States. Another county adjacent to the city of Detroit is one of the fastest growing in population. Both counties are predominately Caucasian, with less than 15% of its residents African Americans and the remaining 1% of other races. My informants live within these counties.

The residential areas consist of blocks of single-family homes, both frame and brick construction. Subdivisions of family homes range from comfortable to affluent neighborhoods. As you drive through these neighborhoods, you see well-tended yards to palatial homes and landscapes, swimming pools, and an occasional gated community. Throughout these neighborhoods, sporadically placed are shopping areas and elementary and secondary schools. Closer to major thoroughfares are restaurants, health clinics, infertility clinics, and a medical center. Despite the economic downturn, with loss of industry and jobs in this area, the wealthiest county rallied in comparison to neighboring counties. As I continued to drive through these neighborhoods where my informants live, the splendor of the homes and landscapes made it apparent they were middle- to upper-class families. From this view, they appeared to be unaffected by the economic downturn. The interviews were conducted in different locations at the request of my informants: in the homes of my informants, a local coffee shop, and in my office. As it worked out, the farthest home was located approximately five miles north of my office.

My Field Site

My community was not restricted to a particular institution, medical center, or community but the region of southeastern Michigan. Conveniently, five of my informants lived or worked very close to my office, located half a mile off a major thoroughfare in the county previously described. For the remaining five informants, I traveled to their homes or locations of their choosing. As previously stated, many interviews took place within my office. My office is located in the farthest point of an administrative wing of a medical clinic with its own private entrance. At the opposite end of the entrance sits a large walnut desk, and beneath it is a colorful oriental rug. Behind the desk sits a

credenza with pictures of my family and a crystal desk clock. Above the credenza, hanging on the wall, are framed diplomas. The office is bright with a large window. Framed pictures sit along the windowsill. Eight black leather chairs surround a walnut conference table at the opposite end of the office. The room is quiet, warm, and private. This location provided anonymity and privacy for my informants.

The First Home

The homes of my informants were at opposite ends of the counties but an equal distance from my own home. Once again, I realized how people could take an environment that they drive by everyday for granted, not seeing what may surround them, the location, or the quantity of infertility clinics located on a busy corner or in a strip mall. On one such corner of a very busy thoroughfare, as I approached the intersection, I glanced upward at a tall building that included a bagel shop, a restaurant, a real estate office, and an infertility clinic. Positioned at the very top of the building was a sign publicizing an infertility clinic.

My first interview took place in my informant's home. I was somewhat familiar with the area, but I had never driven through this subdivision. I left early so I could familiarize myself with this residential neighborhood of tree-lined streets. The homes were all brick, ranches and two-story homes with an elementary school in its center. It was an early winter morning, with a light dusting of snow on the ground. As I drove through the neighborhood, I watched the children walking along the sidewalks to school. A crossing guard stood at the corner. As I approached my informant's brick ranch home, a prominent college football team flag flew on the porch rail. The wreath on the front door read *Welcome*. The door opened and a small dog with a piercing bark ran out to

greet me, promptly running around my legs barking and sniffing. I'm sure it was an attempt to defend his territory. I entered the main hallway, passing a living room, then went into the kitchen where the interview would be conducted. My informant was also a gracious hostess, having coffee ready on a cold wintery morning, which I accepted eagerly. The kitchen had dark walnut cupboards and a light countertop, and the stainless steel refrigerator had a multitude of children's drawings and magnets adorning its doors. The wood table for four was located close to the wall in the kitchen, where we would have coffee and begin our interviews. As we both got comfortable and prepared to begin the interview, I glanced over to the family room. Along one wall stood a large bookshelf filled with children's games and books. A large family picture hung over the mantel of the reddish brick fireplace. A brown sofa faced the bookshelf, with a couple of side chairs surrounding a wood coffee table. It was a cozy room. Note: I will more fully describe the homes of my other informants when providing full accounts of the additional interviews.

The Participants

Recruitment and Demographics

As discussed in the prologue, my profession as a registered nurse with extensive work experience in a variety of health care settings allowed me to develop relationships with business and health care professionals. My involvement in various health care-related committees provided me with access to resources including journals and a social network of colleagues. My relationship with these professionals afforded me the opportunity to share my ideas, thoughts, and questions regarding my study and, through networking, obtain referrals for potential informants. These informants were personal

connections of health care professionals; no patients were solicited from these professionals' clinics or any other clinic.

On any given day, my cell phone would ring with a potential informant inquiring about the study who saw my poster in clinics or bulletin boards from colleagues, or were referred by an informant. At that time, I would introduce myself and provide a brief overview of the study to establish their interest. Next, I would ask specific questions to determine if they met the inclusion criteria. A total of 36 women called to inquire about the study, those that did not meet the criteria either had children younger than two years of age, had become pregnant via Clomid⁵ rather than IVF, or were in the process of IVF. None of the women were recruited from clinics or posters, but rather from referrals from colleagues or informants themselves. Occasionally, women would call seeking information about IVF or hoped that I may provide them support during their IVF process. My thoughts centered on the isolation and loneliness these women endured during this distressing stage in their lives. I would suggest local groups and organizations like Resolve if they were interested in attending to learn more about the various options in treatment. The women that qualified for the study were between 25–50 years of age, and had successful IVF with a child at least two years of age. For the women that met the criteria we would set a date to begin.

My first participant, Elise, was a close friend of a colleague of mine who dropped by my office one day to learn about the study and what it entailed. She explained to me that our mutual friend had shared with her the aims of my research study and she wanted to help other women if she could. Over a cup of coffee, I explained to her the purpose, goal, and aims of my study and discussed the inclusion and exclusion criteria. As the

⁵ Clomid or generic clomiphene is a synthetic estrogen used to induce ovulation in women.

topic is sensitive and quite personal in nature, I felt it was important to develop a trusting relationship with her as well as future informants. Describing the study was one way to facilitate that relationship building. A second way I accomplished relationship building was to share some of my own story, for example that I was a nurse, a working mother, and that members of my family had experienced infertility. This discussion allowed the informant the opportunity to get to know me. Placing myself in a vulnerable position and sharing my own small story allowed the informant to develop trust. As a result, my first informant agreed to participate in the study and a formal date was set for the consent process and interview. This method worked well with this informant and, therefore, I subsequently used this method with the remaining nine informants. Based on the approach used with the first informant, she participated in the study and also identified and referred other potential informants, who likewise did the same.

Description of Participants

The study consisted of ten women. Earlier in this chapter, I noted that all ten women who participated in this study were Caucasian and middle class; despite my best efforts and extensive search to include women of color, diverse ethnicities, and a mix of economic classes, I was unsuccessful. My search extended well beyond the two counties I have previously described to no avail. More specifically, while I attempted to recruit from various sources and posted the study in clinics and with colleagues who worked in a variety of settings (i.e., colleges, businesses, and health care institutions where they served diverse ethnic and racial groups), I did not receive any inquiries about the study from non-Caucasian women. At the same time, I posted in clinics to recruit from different economic classes, including federally-qualified clinics to attract low-income women;

again without an inquiry. While I was frustrated with the lack of response, I discovered in my literature search that this experience is not unique.

There has been a dominance of women, in both the research and IVF, who are predominantly (although by no means exclusively) White, middle class, and educated to a degree- or professional-level, as documented by other prominent studies in this field (e.g., Daniluk 1996; Franklin 1997; Sandelowski, 1993). Indeed, in a recent study conducted by the National Survey of Family Growth, 17% of women in the United States between the ages of 25 to 44 sought some type of infertility services, such as advice, testing, ovulatory drugs, or reproductive technology. In all survey years, seeking medical help to get pregnant was highest among older and nulliparous women, non-Hispanic White women, and women with higher levels of education and household income (National Health Statistics Report 2014). While the data suggests an increase in seeking infertility help among this population, their options for assistance focused on lower cost therapies and complexity of treatment. Only 1.7% elected to try artificial insemination or IVF. The study concluded that cost was a major factor associated with not electing any type of reproductive technologies. In Michigan, infertility treatments are considered an option of coverage by the insurance company and are not mandated by the state.

Many of the women in this research study brought up the issue of finances and insurance coverage without any probing on this topic. Financial stressors led to delays in timing of their IVF cycles, borrowing money from family members, and/or remortgaging their homes. Middle-class women are seen as being able to afford IVF cycles without concern, though several of the women in this study or their partners worked more than one job to save for their cycles, and were still making payments years later. One element

of success in IVF is whether the couple can afford the cycles at all. Thus, although these women are drawn from a middle-class economic region of Southeastern Michigan and may not be representative of all American women as a whole, the research nonetheless suggests the social and cultural power that frames a women's experience of ART, and the role the notion of normalcy plays in shaping a women's identity. To unpack this fully requires a much more complex analysis in the decades to come.

In this study, the ages of the women ranged from 30–47 years, and all were married. Seven out of the ten women had master's- or doctoral-level education. Two of the women had an associate degree, and one a specialty certification. All were in the workforce in a variety of fields, including medicine, law, and business. Married and employed, their combined family incomes ranged from \$75,000–\$200,000 annually. After the birth of their children, three women elected to stay home full-time with their children, two returned to work several years later, and the remaining women returned to work after their three month leave of absence and continued to work full-time. According to the participants in this study, additional emotional strain arose out of the financial investment of ART. They believed there was a social perception that most middle-class Americans can comfortably afford reproductive technologies. Half of the women in this study believed they were entitled to medical treatment and viewed treatment as an expectation and right of citizenship; not a burden they should have to bare alone.

A brief overview of the ten participants follows. Elizabeth, Elise, and Dana all had their first child with IVF, after which their second child was conceived without reproductive assistance. Robin was married and had her first three children without IVF. After her first husband's death, she remarried at the age of 40 and wanted a child with her

second husband; she was able to have a single child with IVF. Grace and Carolyn both had children the first time with IVF and then, a couple of years later, wanted another child and had IVF successfully a second time. Carolyn, Susan, Melissa, Jae, and Tanya were mothers of multiples: one had a set of twins, and the remaining four had triplets.

Some of the participants reported the experience of the interview as cathartic, saying they felt relief discussing their reproductive histories. Some revealed stories of abuse, issues that they had never broached with anyone before.

Elizabeth

My first interview was with Elizabeth, 45 years of age, married to John with two children. Elizabeth and John were both accountants, and had married in their early thirties after completing graduate school. Elizabeth worked in a well-known accounting firm. Elizabeth had an irregular menstrual cycle. Diagnosed with PCOD in her mid-twenties, she knew getting pregnant was not going to be easy. Elizabeth began with various medications to regulate her menstrual cycle and very quickly became pregnant. Unfortunately, she had a miscarriage in her first trimester. She quickly progressed to IUI, and after several attempts became pregnant; again this pregnancy resulted in a miscarriage. Disheartened, she stopped all treatment for the next three months. Elizabeth and her husband decided to pursue IVF. The first IVF did not result in conception. The second IVF, the doctor implanted five embryos. After trying for three and a half years, she was able to have her first child with IVF. Eighteen months later Elizabeth became pregnant without any medical intervention and had another child.

Melissa

Melissa was 38 years old, married, and a full-time health care professional. We agreed to meet at my office for the interviews, and began our initial discussion with demographic information. She described her education and present occupation, then her husbands. Melissa's husband, Tim, owned a home repair business and travelled frequently throughout the state. Melissa and her husband built a two-story home in southeastern Michigan shortly after they married. Melissa described the stress and financial pressure she felt because of her husband's business; his monthly income was unpredictable. Melissa felt that she was the stable provider in the family with her salary and the insurance benefits to support her and her husband. Tim's business was doing well when they decided it was time to have children.

Over a period of three years, Melissa was unable to become pregnant despite medication and several failed IUIs. Melissa and Tim decided to try IVF. She described being very hopeful that this would "finally work" but, unfortunately, it did not once but three times. As a health care professional, Melissa felt responsible for finding the cause of her infertility. She spent countless hours researching to discover why she was unable to become pregnant to no avail. Without a diagnosis for her infertility, Melissa felt that her doctors would not find the right treatment. She attributed her infertility to stress, working too many hours, and going to graduate school. On the fourth try with IVF, Melissa became pregnant with triplets.

Melissa felt unprepared to care for three infants alone, and explained how her mother moved into her home for the first few months to help her. Tim was helpful in caring for the infants, but had to get enough time to sleep so he could work since he was

the only income now to support this family that had rapidly gone from two to five. Melissa described how the three infants' nursery was on the second floor of their home, and how they never came down to the first floor until they were six months of age: everything she needed to care for her triplets was upstairs—three cribs, a changing table, even a kitchenette to prepare their bottles. The daily routine was rigorous: “Feeding, burping, changing, getting them to go to sleep; the first one then the second baby and then the third and no sooner were you finished, you had to start all over again. It was exhausting.” Melissa explained how she had to become extremely organized, and the strict regimen she created to help her survive those first couple of years. The financial pressures mounting, she returned to work when the triplets were nine months old. She has continued to work full-time as a health care professional, balancing her career and the demands of eight-year-old triplets.

Dana

It was a sunny spring day and a pleasant drive to my interview with Dana. Dana chose to meet at her home. As I pulled into the driveway, I could see a woman looking through the window. Walking up the stairs of the neatly manicured Shaker-style home, she opened the door to greet me. She gestured toward the couch for me to have a seat. The living room was inviting, warm, and smelled like cinnamon from a candle burning on the coffee table. A few family pictures adorned the mantle of the fireplace. I could see a kitchen island with white cupboards from where I sat; some baked goods sat on the counter. She noticed my glance toward the kitchen and explained she worked part-time from her home baking cakes. She curled up at one end of the couch next to the large front picture window, and I sat at the other end.

Dana was a 48-year-old retired advertising executive. Although Dana knew when she got married that she had endometriosis and may encounter difficulties getting pregnant, she did not believe she would ever be so desperate as to need IVF. Dana's husband, Sean, was a business executive and had a demanding work schedule. Married with two very successful careers, Dana began to fear her time to have children was running out. After two years of not becoming pregnant, Dana and Sean went to see a fertility specialist to discover that Sean had a low sperm count. Dana described how she felt overwhelmed by the news. She knew she had endometriosis and expected to have some difficulty, but now that her husband also had a problem, it would take more "effort" to become pregnant. However, at that point, she still believed she would not need IVF.

For Dana, conception required intense focus and self-education to understand how her body would respond to infertility treatments. Dana took an approach much like she used in her career—to research the problem, prepare a plan, and set deadlines to accomplish her goal. Dana experimented with herbs, vitamins, and diets to become pregnant. She researched fertility regimens on the Internet and placed her husband on special diets that would supposedly increase his sperm count. Dana's personal and professional life course was disrupted by her infertility. Dana became consumed with finding her own cure for her endometriosis and both her and her husband's infertility.

When Dana began her infertility treatments with IUI and then IVF, Dana never stopped searching for a way to have a child without IVF assistance. She continued to take vitamins and try various herbs. After several attempts at IVF, Dana was able to conceive, maintain her pregnancy, and deliver a healthy baby. Two years later, with much determination, Dana conceived without ART and delivered a girl.

Elise

On the day of our interview, Elise, a petite young woman, arrived at my office smartly dressed, bearing a wide grin. Our first ten minutes were spent exchanging pleasantries and talking about people we had both known from our previous place of employment. It was a mutual colleague that had told Elise about my study. Unbeknownst to me, Elise was considering IVF at the time we worked together five years ago. Prior to starting the formal interview process, Elise spontaneously began to tell me that IVF was her only hope of having a child. She knew prior to getting married to David that her chances of getting pregnant without some type of assisted reproduction would be, in her words, “a miracle.” She had minimal expectations of getting pregnant “naturally” but remained hopeful. Elise explained how ill her husband was as a child, the stormy course of his illness, and how the necessary treatment placed him at risk of being sterile. For Elise, IVF was the only choice.

Elise was 30 years of age and now worked part-time in a small accounting firm. Five years prior, Elise and David decided to begin IVF at the suggestion of her physician. The physician was concerned that David’s sperm count and motility would continue to deplete; if they wanted to try to have a child “together” they would need to begin very soon. At his suggestion, they tried IVF the first time and Elise became pregnant. Elise went on to describe the serious complications she experienced in her last trimester of pregnancy: her near-death experience and the multiple surgeries she had to have to control internal bleeding. Fortunately, both Elise and her baby survived the complications.

A couple of years later, Elise hoped to have another child with IVF, however her husband David was opposed to it due to the financial strain and debt they still faced from the first IVF. Elise was very disappointed but understood the financial impact on their household. Elise would not consider adoption and always maintained that if she had another child, it would be a child she shared biologically with her husband. Much to their surprise, two years later Elise became pregnant without any complications and delivered a baby girl.

Caroline

Caroline was in her early forties and a physician. Caroline and her husband, Craig, married when she was in medical school. They lived in a two-story English Tudor home in a beautifully landscaped neighborhood. Our interview took place in her home. The home was open and spacious, as I walked into the entryway, looking straight ahead into the great room, I could see an in-ground swimming pool through the glass door. The pool, surrounded by flowers, shrubs, and a privacy fence, created a wonderful view. The great room had a large sectional couch in front of a marble fireplace. We both sat on the couch, and she began her story with her suspicion she had a fertility problem while she was in residency. She attributed the lack of pregnancy to other factors: extensive work hours and a fluctuating schedule, stress, and her husband's frequent out-of-town business trips. She did not pursue any medical assistance for a few years because she was starting a medical practice. Busy building her practice and somewhat disillusioned with society—the violence, poverty, and in her view, a lack of compassion for those less fortunate in life—Caroline was unsure if she wanted to bring a child into this world. It was not until her husband told her how much he wanted have a child with her—a child that he hoped

would resemble her, a product of their love and union— that Caroline reconsidered postponing a pregnancy any longer. She also was conscious of the fact that she had not taken any measures to prevent pregnancy and had not become pregnant for several years.

After considerable thought, she decided to reach out to a colleague she had known during medical school to discuss her infertility. Being a physician, Caroline wanted to be informed of the statistical averages of the procedures and to participate in her care. She stated she “trusted” the physician but still “needed to know what was going on.” She soon discovered being a patient had a very different perspective than what she had ever imagined. She admitted how emotional she became and how stressful knowing so much about the risks and potential complications affected her emotional well-being.

Caroline had tried Clomid, then IUIs without success. To determine what prevented Caroline from becoming pregnant after two failed IVFs, she had a laparoscopy. Caroline had endometriosis and significant scarring of both fallopian tubes that the surgeon attempted to repair. In vitro fertilization was her only chance of pregnancy. Shortly after the laparoscopy, Caroline and her husband attempted IVF again. Caroline began to experience severe pain that resulted in an ectopic pregnancy and removal of the fallopian tube. After three months, Caroline and Craig decided to try IVF one more time. This time the IVF was successful. At the age of 32, after several IVF procedures, a surgery, an ectopic pregnancy, Caroline had a singleton birth. Caroline would return two years later to the IVF clinic with the hope of having another child. Caroline subsequently had twins.

Susan

Susan was a tall, slender woman in her mid-thirties, and her triplets are five years old. Susan began her story by describing her years of infertility and her inability to become pregnant. As she told her story, tears fell down her cheeks. She lowered her head, and paused in silence. I waited. Susan sat in a leather chair in my office, a cup of coffee on the table. As I waited for her to begin again, she spun the coffee cup around and around. She finally looked up at me. The tears welled in her eyes again. She continued to tell her story. Susan met her husband in high school then later got married after he finished his degree in education. She began to laugh, then explained how they had used contraception for many years so she would not get pregnant—it was “ironic” that they “tried so hard not to get pregnant, and after all that, [she] couldn’t get pregnant anyway.” She bowed her head again and was quiet for a while, then looked up at me and began her story.

Like many of the other women, she began by going to see a fertility specialist to determine why she could not get pregnant. Without a diagnosis, Susan began taking Clomid and was unresponsive. After failed Clomid, she followed with unsuccessful IUIs, which eventually led her to IVF. After her first IVF cycle, within a few days, Susan developed severe abdominal pain and a high fever. She collapsed at home. Susan had a severe infection that developed from the embryo implantation and was hospitalized in the intensive care unit. Susan was critically ill. Her illness began to stabilize after several days of antibiotics while the medical staff monitored her very closely. After one week, alert, pain-free, and without any fever, Susan was told that she was pregnant. Neither Susan nor her husband could believe what they heard—she was finally pregnant. They

could not believe that she was able to maintain her pregnancy during her illness. After that experience, Susan still felt that they would remain childless if she had not maintained the pregnancy. She would not take the chance again after all she had been through. They were amazed and shocked at the news, but an even greater shock was about to occur: Susan was pregnant with triplets.

Susan reached into her purse and handed me a letter. “I just wrote a piece, a show about motherhood that I am auditioning for. I wrote about infertility and the in vitro process. This is for you.” She handed me the paper and I thanked her. Susan’s story was entitled *The Ride*, an interesting title. I quickly read the pages she had handed me and Susan sat in silence, waiting and watching me. I took a deep breath before looking at her. She had described the pain, the sadness, the loneliness, and the need to belong, to have a normal life, and to be accepted like “other” women who had children without IVF.

Jae

I met Jae for the first time in her two-story home in a suburb in southeastern Michigan. I was greeted at the door by two very rambunctious dogs. Jae invited me into the living room and I took a seat in its only chair. Along the wall directly behind me were neatly stacked boxes. Jae explained she was preparing to move to a new home in the upcoming weeks. Jae sat across from me on a long brown microfiber couch under the picture window. Jae’s two dogs jumped up and positioned themselves next to Jae on her couch. Jae had been married to her husband Steve for seven years, a manufacturing executive.

Jae described herself as an independent woman. Growing up in a small rural town, Jae left home to attend a university several hundred miles away. Jae’s goal was to

complete her college education and have a career. Jae became a health care executive managing multimillion-dollar accounts. Jae was 31 years old when she met her husband, and two years later they married. She was quite emphatic that motherhood was very important to her, and that she wanted at least four children. Jae said she told her husband “it was more important for [her] to be a parent than a wife.” She stated that she had always loved children and had many nieces and nephews that she helped to mind. She always “wanted to be a mom.” Her husband also wanted children, but two would have been just fine according to Jae. Jae and her husband agreed on the importance of having children and wanting a family of their own. Jae described her birth family as dysfunctional, and how her father had been the “rock” of the family until he became terminally ill; then the family fell apart. Jae’s siblings were several years older than her and she described herself as an “oops child”; she was “obviously not planned.” Her siblings resented the attention she received and the closeness she had had with their father. Jae’s father died the year she started high school, and her mother did the best she could, according to Jae. Since her father’s death, starting her own family was all Jae could think about.

Shortly after their first wedding anniversary, Jae and her husband decided to “try,” and the first month she became pregnant. It was Christmas time, and she was approximately two months pregnant when she began to bleed. Jae had an ectopic pregnancy and had to have her fallopian tube surgically removed. Jae was very concerned that she was losing significant time in getting pregnant: she was getting older and her life plan was “out of control.” She decided to “speed things up” and try an IUI; after all, “technology is there for a reason.” After several attempts, she was unsuccessful.

Saddened by the failures, she waited for nine months and tried IUI once more. Jae became pregnant for the second time with another ectopic pregnancy, and lost her second and only fallopian tube. At that point Jae realized her only hope of a pregnancy would be IVF. After her unsuccessful IUI, two ectopic pregnancies, then two-failed IVF treatments, Jae did not believe she would ever become pregnant. Disillusioned and depressed, she struggled between adopting a child and trying once again to have a biological child. Without fallopian tubes, her only alternative to have a child that shared her genetic makeup was IVF. She attempted IVF for the third time, and from this IVF implantation conceived triplets.

Tanya

Tanya was a tall slender woman in her late forties and a mother of triplets. Tanya and her husband, Jeff met in college, married after graduation, and began their careers. Tanya earned her doctorate in chemistry and worked full-time for a pharmaceutical company. Both Tanya and Jeff were chemists, and after two years of marriage bought their first home in a suburb of Detroit. Tanya began “trying” to get pregnant a year after they bought their home; she wanted to have everything “in place” to raise a family. Instead, Tanya was unable to become pregnant. She attributed her inability to become pregnant to the stress from her job and her mother’s terminal illness. After failed medical therapy, she gave up the idea that becoming pregnant was going to happen without assistance. It was at that time Tanya and Jeff had their first appointment with the IVF doctor.

After three cycles of IVF, Tanya got pregnant. She said she was so happy to find out she was finally pregnant after five years of disappointments. However, her mother’s

illness left her with mixed emotions, unable to share her joy with her mother, saddened by the fact that her mother could not share in her joy of finally being pregnant. Tanya said she felt guilty for being so happy when at the same time her mother was so ill. Tanya's mother died shortly after she delivered triplets.

Tanya's triplets were very small and were hospitalized for months. Two of the three infants had significant health problems. As the children grew and become stronger, many of their health issues were resolved. By the time the children were ready to go to school, two of the three children were diagnosed as Autistic.

Grace

I was introduced to Grace at a concert I was attending when I ran into a mutual friend. A week later, Grace contacted me and explained that our friend had told her about my research and she was interested in talking to me. She began our phone discussion with, "I am proud that I was able to have a child with IVF. All women should be proud of what they accomplish." We met a week later. Grace was 44 years old, married, and worked full-time as a marketing consultant for a fast food industry chain in Southeastern Michigan. Three years passed without a pregnancy; failed medical treatment and IUIs left Grace and her husband to determine if IVF was the next step. The cost was beyond what they could afford. Both Grace and her husband found second jobs so they could save up for IVF. After 18 months and three cycles later, Grace was pregnant. Grace and her husband would follow this same path three years later to have another child with IVF.

Robin

I was at work when my phone rang and Robin introduced herself. Robin mentioned a mutual colleague had told her about my research, and she was interested in

knowing more about it. We talked briefly on the phone and then set a date to meet in my office. Robin was in her second marriage; her first husband had died and they had three children together who now were young adults. Robin met her second husband a couple of years later. He was much younger than Robin and wanted to have a child. Robin knew that at the age of 43, she would not be able to become pregnant without some type of medical assistance. She made an appointment with a reproductive medicine physician and agreed to start with an IUI because of her age. The IUI failed. The next step was IVF. After two cycles, Robin was pregnant. Since Robin had three children with her first marriage, she knew she was “capable” of getting pregnant. Sadly, at 16 weeks, Robin ran into complications and lost the child. She waited six months and then tried once more. The IVF worked, and Robin was pregnant once again. Robin had an uneventful pregnancy and delivered a little girl.

In summary, all the participants encountered a number of failures in treatment prior to having a child with IVF. Many became disillusioned with their failed treatments, yet persevered until they were able to experience pregnancy and the birth of their children. How their life experiences reshaped their sense of self will be explored in the coming chapters. Some of the women shared their personal family experiences of love and support while others described an unsupportive family life growing up. Their childhood experiences highlight the meaning of creating a family, and their quest for a child now leads us to the next chapter, which examines how pursuing parenthood became, for these women, a quest for normalcy.

CHAPTER 3 PURSUING NORMALCY

Introduction

The middle-class women in this study did not consider the use of ART a “natural” course to have a biological child, but a necessary one. Rather, they viewed a traditional private conception as natural, one without the attendance or knowledge of other parties or technology. Privacy was relinquished for the possibility of what IVF may bring: a child. As such, ART is understood as an acceptable way to exercise what many see as their right to reproduce. In vitro fertilization provides a context in which established norms are changed and the normal/abnormal are identified—here, the fertile/infertile. A rudimentary medical definition of infertility is a condition in which women are unable to become pregnant, conceive a child, or in the focus of this study, have a biological child. Medicine thus differentiates between women who can become pregnant and women who cannot. From a medical perspective, such inability is an abnormality, a condition, or a disease requiring medical intervention.⁸ Here, I define infertility as the experience of involuntary childlessness. I do not deny that there may be an underlying physiological cause to involuntary childlessness; rather I adopt the interpretive stance of Bryon Good (1994), who explained, “disease is not an entity but an explanatory model” (53). In this sense, understanding a woman’s experience of infertility can only be understood as part of a particular cultural context; here a local context of a small group of women in Southeastern Michigan.

Infertility is not just a physical problem: women who are infertile are required to make choices concerning whether to remain childless, consider adoption, or to pursue

⁸ Some of the women in this study were diagnosed with endometriosis and polycystic ovarian disease, as will be further discussed.

IVF. They are caught between failure and success, normal and abnormal. Not only is IVF a technology of reproduction, IVF is a technology of identity and subjectification (Franklin 2013:221) that takes on new meaning when examined within a cultural context. Franklin (2013) suggests that IVF offers a context in which established norms are changed. Embarking on IVF is a means to defy convention, enabling a new form of reproduction to be pursued despite the high risk of failure. In this sense, in this chapter I explore what it means to women who have undergone IVF to have experienced a nontraditional conception. I argue that we cannot understand what it means to a woman to have a biological child or the experience of pregnancy without placing it within the context of reproductive normalcy, and how IVF both reproduces and challenges the norms aligned with it. I approach this chapter in two ways. In the first section, I argue how IVF produces a technologically-mediated way to legitimize the women's form of conception as normal. I discuss how the women disciplined their own bodies to maximize their chances of success. In the second section, I examine the different ways that agency and inter-subjectivity work to reshape women's identity, and how women negotiate notions of normalcy after successful assisted reproduction.

The social sciences have explored ideologies of nature and normalcy in particular times and contexts of human reproduction. While no single meaning can be given to the concept of nature or normalcy, here I suggest the concept of normalcy is a way of thinking, an idea, or an image that functions as a means to determine sameness or difference. Normalcy is associated with a number of domains, including medicine, cultural practices, and identity (Becker 2000; Bourdieu 1977; Reissman 2003). Normalcy is also associated with states of being (e.g., acting normal, being normal, or being seen as

normal). We can further expand on normalcy by examining normal behaviors (i.e., the range of normal as the “good” or “right” way to be), which reveal patterns of thinking, feeling, and acting (Markus and Kitayama 2010).

For many people, bringing a child into the world is considered a normative life event that clearly establishes the parents as full, autonomous individuals (Greil 2010). Parenthood fulfills role expectations associated with full adulthood, a fully functioning cultural person. The norms that are fulfilled by parenthood are embedded in the inherent order of a society. Foucault maintains that “the concept of order and control are ‘fundamental codes of a culture’—those governing schemas of perception, its values, the hierarchy of its practices for every man” (Foucault 2002). In this sense, rules of order and expectations serve as common guidelines or social norms for behavior that are integral to the dynamics of power and control. While differing interpretations of what constitutes normalcy in a given context occur, the same definition of normalcy in relation to fertility is predominately shared among people within the same society (Becker 2000). Here, the women in this study share in the belief that bringing a child into the world is considered a normative life event. I explored the meaning of assisted conception and what it meant to them when they encountered opposing beliefs and values, as they understood the rules and social norms within their local social worlds. As such, I examined the concepts of normalcy and control as a topos shared by this one particular group of middle-class women, aligning Foucault and Becker.

On the concept of norms, Durkheim (1963) took the approach that members in society hold a common set of beliefs including the recognition of shared norms and values. These provide a consensus about the right way to behave to providing stability

and order in society. Durkheim came to see social norms as a way to regulate people's behavior by institutionalizing values, leading them to become internalized. Methodologically, and following Durkheim and Goffman (1964), I aimed to understand the everyday experiences of these women's lives in relation to IVF. I follow Goffman (1964) to focus on how order is constructed on a smaller scale, governed by rules that an individual is largely unaware of in everyday social interactions. As such, I examine how rules and social norms play into the everyday lives of these women during and after IVF in family and social interactions, as well as their personal and professional lives.

As I discussed in the Preface, fertility may be taken for granted. Similar to Becker, whose own life experiences of infertility prompted her work, I recognized that I took my own and members' of my family's fertility for granted. As I continued to explore my own family's experiences with infertility, I began to understand their expectation of parenthood, along with the social rules within our ethnic group. From this point onwards, I wanted to understand how these rules impact women's experiences of infertility.

Berger and Luckmann (1967)'s examination of the social construction of reality also influenced this chapter. The authors argued that social rules are those that are taken for granted; "what everybody knows about their social world" is learned in terms of expected behaviors and conduct, which are "transmitted recipes of knowledge that supply the appropriate rules of conduct in a society" (Berger and Luckmann 1967:65). Socialization and learning, then, is part of the human experience, internalized as subjective reality (Berger and Luckmann 1967:67). It is here that culture becomes encoded on an individual body, and the body becomes a device for the communication of

cultural codes (i.e., dress and gender) that dictate moral standards and normalcy (Bourdieu 1977).

Anthropologists have argued that conceptions of normalcy/difference are embedded within social, moral, and cultural norms (Becker 2000; Ortner 2006). As such, differences in images and ideologies (i.e., beliefs, values, norms, and practices) are characterized by social interactions and in various social environments. For example, living up to the cultural ideology of biological parenthood is equated with normalcy in American culture (Becker 2000). I argue that women that finally succeed in having a biological child after IVF undergo a deliberate transformation of their identity, and in how these women determine what matters the most in their lives. In this chapter, I therefore examine how the women's engagement with their local social worlds affects their sense of self, identity, and agency and what it means in a specific sociocultural context; here within the dynamics of reproductive technologies.

In this chapter, I also draw on the work of Biehl, Good, and Kleinman (2007), and Todorova and Kotzeva (2006) to explore the role of identity and the formation of modes of subjectivity. In their work, they showed the significance of lived experiences, and how the perceptions and subjective states of people intertwine with their local social worlds, particularly within the dynamics of infertility, and spill over into their professional lives. By doing so, we can understand how they endure their circumstances in times of chaos, such as their infertility treatments, to obtain a sense of achievement from conception and then the birth of a child.

The influence of the following anthropologists and sociologists are equally important in the transformation of identity. Identity has been explored at the social and

cultural level in relation to politics and biopower, health and illness, the body and its consumption of technologies, and the effects of perception, and meaning (Bray 2007; Greil et al. 2010; Luborsky 1994; White 2009). A number of factors shape subjectivity, including bodily practice and attentiveness, the use of technologies, and knowledge of the body (Biehl and Moran-Thomas 2009). I draw from their work in several ways, namely to understand the meaning of their lived experiences in the consumption of IVF technology, and how the women in this study perceive the use of technology within their local social worlds. In addition, as the consumption of IVF includes bodily practice and attentiveness, I want to understand how they learn about their body to control, manipulate, and improve their chances of conception and how it shapes their sense of self and identity.

Personal identity, or a subjective sense of self, can be defined as a characteristic that a person believes to be unique and that sets him or her apart from others (Simon 1997), as well as an individual awareness of being physically distinct or separable from the group (Hallowell 1955). The concepts of self and identity have taken several directions in ethnographies, from life stories (McAdams 1988), to role and social identity (Thoits and Virshup 1997), to technologies of self (Danziger 1997; Foucault 1990), self in action (Holland 1997), and identity politics (Whyte 2009). Danziger and Holland suggest cultural practices are conditioned by societal situations, expectations, and events over time (Danziger 1997; Holland 1997).

In a postmodern account, Giddens (1991) argues that individuals can choose who they want to be in a society, a “reflexive account of the self” continuously reworking their identity over their lifetime. The point of identity and subjectivity in relation to

different cultural constructs of time and space illuminate the social phenomena of technologies in everyday lived experiences, as embedded in sociocultural practices. Here, I interpret the work of Giddens in the lives of a discrete group of middle-class American women. I explore the tension between the notion of normalcy and the role of normalcy in women's identity formation after successful IVF, examining the obstacles that women face and the consequent strategies they devise to cope with them. I address a number of broader social and cultural concerns, including the relationship between women's agency and everyday practices in directing their reproductive lives. I examine the role of women's social interactions post-IVF, asking: How do women negotiate instances where they are perceived by family members or friends as not conforming to local social norms? In what ways are their perceptions, subjectivities, actions, and practices shaped by the conflicting notions of normalcy in assisted conception?

Agency, Subjectivity, and the Self

The concept of agency has been underutilized in scholarship on ART. Examining a women's sense of self and identity is important to understand how women redefine normalcy in relation to ART. To understand how ART affects women's perceptions of self while managing the increasing demands of IVF requires a deeper consideration of what happens to a woman before, during, and after IVF; as well as how they overcome various modes of subjective states (i.e., feelings of difference, failure), and how they act on the world even as they are acted upon (Ortner 2006).

In Ortner's (2006) theory of agency and subjectivity, she refers to agency as the basis of subjectivity including specific desires, thoughts, and meanings. I treat agency and subjectivity as partially constituting the self. Here, the self attends to the contexts of

who the women are, what they should be doing, and their relationship with others in response to different life situations. In the context of women who have experienced infertility and assisted reproduction (i.e., IVF), I approach agency much like Ahearn (2001) and Ortner (2002) as women's socioculturally-mediated capacity to act, constituted in part by subjectivities. Ortner more specifically defines subjectivity as an "ensemble of modes of perception, affect, desire, and fear that animate acting subjects" (Ortner 2006:107). Here, the subject or actor is a person "whose action is rule-governed or rule-oriented" (Ahearn 2001:113). The importance of agency, the actor, and subjectivity here is to view the person as a being "who feels and thinks, is reflexive, and who makes and seeks meaning" to make sense of their social worlds and the circumstances that work to shape their subjectivities (Ortner 2006:110). Therefore, to understand the lives of women who experienced infertility and IVF, to make sense of their world is to understand the cultural circumstances that shape their subjectivities.

Building upon Ortner's approach, I propose that intersubjectivity is the "being" that entails a form of action and a component of agency. Experience is "interpersonal communications and engagements, and experience is intersubjective" (Biehl 2007:53). Intersubjectivity thus requires production, action, and practice. Intersubjectivity is constituted in part by historical knowledge, the bringing forth of a consciousness of past experiences, meanings, and subjectivities to be used in the present in decision-making and consequent action. In this dissertation, by using subjectivity and historical knowledge, I combine aspects of the aforementioned definitions and examined the lived experiences of women after IVF, their sense of self and, most importantly, the role of normalcy in their everyday lived experiences.

Researchers studying effects of chronic illness (e.g., Becker 1997; Leventhal et al. 1999; Murphy 1990) have demonstrated when the body is no longer taken for granted as a medium of experience, it can become an obstacle, a problem to overcome. Basic physical acts like walking create a sense of self-division within the individual. This also holds true for women who desire the experience of pregnancy and are faced with the obstacle of infertility. This creates a division between women who are able to conceive and women who are not, creating a sense of self-division and difference. In my research, this form of self-division occurred in two ways: physically and subjectively. Socially, the women stated they isolated themselves from social events and were unable to attend if they knew other pregnant women would be attending. Subjectively, they were aware of their physical difference (infertility). This also played out in the stories of mothers of multiples. In Jae's story, as discussed later in this chapter, she separated herself from her friends that were having children while she was undergoing infertility treatments. Jae described her frustrations, disappointments and, at times, anger towards her friends. Once she conceived with IVF and delivered triplets, she became aware of how different her life was with triplets compared to her friends with singleton births. Jae sought support and friendship with women whose lives were similar to her own, other mothers of multiples. These findings are corroborated by the works of Sokefield (1999) and Whyte (2009), who found individuals, displayed an awareness of similarity and difference between themselves and others, and were separated from a group by their physical distinctiveness.

A Brief Background on the Concept of Normalcy

The concept of statistical norms emerged during the probabilistic revolution of the early 19th century. Both probabilities and the discipline of statistics established the notion

of the norm between the individual body and social systems (Desrosieres 1998). The history of therapeutics in the United States shares many parallels with the history of statistics; indeed the use of statistical tools in medicine have redefined and reorganized categories and concepts of disease. Prior to the 19th century, divine wisdom explained the natural history and evolution of man (Porter 1986). With the advent of statistics and mathematical probability, statistics chartered a new course, creating a sense of power and dynamism in society, a source of progress and newfound authority in medicine (Desrosieres 1998). Historically, the concept of disease categorization began with “prevention and prediction” for health and sanitation purposes (Desroseires 1998). To this end, calculations of average death rates or individuals at risk provided data for possible preventive polices to segments of a population. This form of medical statistics fueled debates in medicine, between the experimental method and the numerical method. The medical community challenged its form of generality and its applicability to treatment to determine prevention, cause, and effect (Desrosieres 1998).

Since the 1880s, numbers have been used to control individuals, knowledge, behaviors, and morality previously governed by the laws of nature (Desrosieres 1998; Porter 1986). Data were gathered for use in population censuses, and to apply subjects to actuarial and demographic data to set rates for life insurance and annuities, which led to the use of statistical averages to determine human variation. No longer were games of chance or degrees of uncertainty a methodology to understand population attributes. Human attributes were measured and plotted out to determine degrees of risk in a society or population. This graphical representation of a population has come to be known as normal distribution or the bell curve, which depicts norms and deviations. As such, the

norm became one of the means by which the body could be disciplined, “subjected, used, transformed, and improved” (Foucault 1979:136). Modern medicine, as such, is a disciplinary system that educates, corrects, and examines the body as something to be measured, compared, and averaged. Those that lay outside the desired value are subjected to reform, categorized, and placed among the distribution of a population as either falling inside or outside of the degree of normalcy (Ewald 1991).

Normalization as a technique or discipline organizes, classifies, and controls abnormality. According to Canguilhem (1991), the normal and abnormal exist not as discrete entities to be observed but as functions that stimulate modification (77). In other words, normalization identifies difference and variance from the norm to develop categories—here, fertile and infertile. We have come to compare our selves to this norm, to standards in which humans are expected to conform as something that individuals have always done (Ewald 1991). These comparisons influence our daily lives, our routines, and our medical care. The women in this study associated the “norm” with their response to infertility treatment (IVF). They compared themselves to “normal” averages, in grading their eggs (ovum) to the “ideal” as “above the norm” or “below the norm.” They categorized themselves as to how well and if they responded to treatment. The norm became one of the means in which they disciplined their bodies (Foucault 1979:136) to “improve their averages” and be “successful.” Such categories altered their cultural and medical assumptions about reproductive health by perpetually distinguishing between the normal and the abnormal.

Womanhood and Gendered Identities

Anthropologists have explored the relationship between the cultural norms of womanhood and how infertility has been categorized as a disease entity first by physicians and then later by infertile women (Inhorn 1994; Paxson 2003). Viewing infertility as a disease identifies a woman who is unable to reproduce biologically as someone who is abnormal (Becker 2000; Martin 1992; Paxson 2003). Becker (2000) examined the cultural forces that shape the experience of being infertile, the quest for parenthood utilizing IVF, and the relationship of reproductive technologies to biology, normalcy, and identity. In a collection of personal accounts from women who experienced IVF, Becker illustrated the ways in which women rework cultural meanings of “nature and nurturance . . . to rework bodily knowledge to create a synchrony between gender identity and cultural ideology of womanhood” (169).

The experience of infertility and the choices women face to try, continue, or quit IVF, emphasized for these women the categories of normal and abnormal, sustaining the normalization process. The quest for normalcy was enacted in their choice of IVF. Those that feel they have lost control of their reproductive capacity attempted to regain that capacity by imagining their future, which meant seeking medical treatment. Susan, for example, saw infertility as a problem, “something that you need expert help [with] that you can’t resolve on your own.” She said, “I just treated it like it was something that you have: diabetes, you go to the doctor. You have cancer, you go to the doctor. You have anything that you can’t resolve on your own, you need a doctor. I always believed I would get pregnant.”

In keeping with the American cultural idea of “choice,” choosing to pursue IVF represents “autonomy, independence, and freedom of will, signifying a woman’s sense of self as having an influence on the process in which they are engaged” (Strathern 1995). Women bare the burden of choice and decision-making. They carry the burden of procreation and what is natural, experiencing tension between a physical conception between a man and woman and the technological experience of conception. In this vein, Strathern (1995) argued that choice is a consumer idiom that enhances the self. To choose to do something about infertility is a more enterprising choice than to choose not to do something (Becker 2000:243).

Several of the women in this study established a network of friends who could provide support and friendship. Jae, for example, felt that her infertility was “done” to her and that she was “cursed,” and that she had lost control over the process and her life. Participating with an Internet group of friends, she shared her feelings. The group was able to help her recognize that her choice to continue IVF was within her control. Later, this same group of women supported each other, particularly the women that became mothers of multiples as well. They found other ways to support each other, arranging play dates, providing tips to reduce the “chaos,” and manage the stress of having triplets in their daily lives. This finding may be unique for this small subset of women in this study, and may not be shared by other women who have experienced IVF. I argue that in electing to use IVF, a woman’s status and identity are negotiated by the use of this technology in relation to gender expectations where achieving motherhood is not enough: gaining membership in the community is also determined by cultural ideologies of normalcy.

Adopting a New Normal: A Daily Routine

One goal of this research was to gain an understanding of the day-to-day experiences of reproductive treatment in the lives of these women. I chose this example as it constructs a field, a space, to understand their personal world, albeit for one day in time and for one woman. However brief this example may seem, it affords an opportunity to understand the women's day-to-day challenges, and how each day redefined their sense of self. Relaying this participant's daily regimen also provides some insight into the time commitment required during IVF therapy and how it alters what is normal in a day. Elizabeth worked full-time in a large accounting firm, and had decided not to share with anyone at work that she was attempting IVF. She began her morning by taking her temperature, followed by oral medications, a quick breakfast, and a drive to the clinic. There, she would begin her routine, answering the nurse's questions, having her blood drawn, and waiting for results later that day or the next. Based on her blood tests, she would need to schedule other morning appointments. Her work schedule required frequent adjustments, and early morning meetings were impossible to accommodate because that timing interfered with her testing.

Once she returned home from work, she needed her daily injection, which was quite painful and caused severe abdominal bloating and discomfort. To lessen her discomfort, her husband would give her the shots. Elizabeth described how they would enter their bedroom, soften the lights, and she would lie on their bed so her husband would give her the injections. He would lie next to her afterward and hold her in his arms for a while. Later, they would anxiously wait to hear what the results of her blood work would show, and based on those results, her routine may change to accommodate more

testing or another embryo transfer. This routine was fairly common for all the women in this study, except for slight differences in the injection administration. Some preferred using humor rather than romance or intimacy, taking turns in administering their medications themselves. This daily routine is filled with unknowns—actions leading up to the hoped for event: conception.

Findings

Over the course of my study, the word “normal” was used by each of the women I interviewed. Some of the women used the term to describe what they hoped their family would become. Others used it to describe what they had hoped for in their pregnancy, or what they hoped that their bodies would become after ART. From that first encounter and throughout the study, the word “normal” returned time and time again. I found it strange the American cultural value of the individual disappeared in the pursuit for a normal birth. In this context, being different, special, or unique was no longer desirable. I was intrigued how one word—normal—shaped and reinforced patterns of behavior in a variety of contexts.

Entitled to Be Normal

The women’s discourse on normalcy was expressed in many ways, such as wanting to be normal, choosing to be normal, and being entitled to be normal. The women described being “robbed” of the experience of a normal pregnancy, having normal children, wanting a normal life, and being seen as normal. All ten of the women’s stories began with conception, even though the question I asked was, “Tell me about what your life is like today after IVF.” Each of the women’s stories began with their history of trying to become a mother. The women described their infertility, IVF

treatments, and successful birth of their child or children as a battle, sharing the strategies they used to try and win this fight to be normal.

An Unconventional Conception

The participants all began their stories of trying to become a mother, followed by descriptions of the months and years of the seemingly never-ending erratic flow of emotions that followed. Disappointments and renewed hopes made infertility treatments both physically and mentally consuming. The women's stories included images of what they believed a "normal life" should be: pursuing an education, establishing careers, getting married, and then starting a family. Each of the participants described an orderly, step-by-step life plan and how they consciously approached each stage of their life; one participant described it as "my action plan." In trying to follow their life plan, which included having a biological child, several of the women expressed anger and sadness that they should have to go to such lengths to become a mother. Others were grateful that IVF was an option for them.

Dana

It was a sunny spring day and a pleasant drive to my interview with Dana. Dana chose to meet at her home. As I pulled into the driveway, I could see a woman looking through the window. Walking up the stairs of the neatly manicured Shaker-style home, she opened the door to greet me. She gestured toward the couch for me to have a seat. The living room was inviting, warm, and smelled like cinnamon from a candle burning on the coffee table. A few family pictures adorned the mantle of the fireplace. I could see a kitchen island with white cupboards from where I sat; some baked goods sat on the counter. She noticed my glance toward the kitchen and explained she worked part-time

from her home baking cakes. Dana was a 48-year-old retired advertising executive. She curled up at one end of the couch next to the large front picture window, and I sat at the other end.

Dana did not believe that she would ever be so desperate as to need IVF. Dana described her scientific approach: she began learning about various medical treatments and options from the Internet, websites, and talking with other women on Internet blogs. She charted her ovulatory cycle, and began experimenting with natural herbs and vitamins to improve her ovulatory cycle in hopes of becoming pregnant. By collecting data, recording her results, and comparing her data with information she found on the Internet of an “average” woman’s ovulatory cycle, she created a process that served as a technique of normalization. The data points became a way of knowing in an objective manner whether she was similar or different to the “other” women she compared herself to from the Internet. She explained:

I was trying to avoid IVF. I was trying to give all the possible intervention of trying naturally to using Clomid, IUI, all the things that lead up to it. The thought of IVF was just daunting. That was something other people did when they were desperate. I never saw myself doing it necessarily. I had a very scientific approach. I was learning everything I could so that I gave everything 100%. I charted and everything like that. I was very dedicated to what I could do on my end.

As Dana continued charting her course of therapy and her response to the various medications she attempted to control her body with, she began to feel more and more “out of control” with each day spent “taunting nature.” She referred to IVF as a “sterile” process—it was not how she had imagined becoming pregnant. Dana’s story attests to the conflict and inner struggle these women face during their infertility treatment concerning

what was yet to come in their future, since nothing of what they had imagined was their reality.

You wonder if, in a very nonscientific way of looking at it, if it is maybe forcing nature's hand, and at some point there is going to be a repercussion for that. It is so bastardized by that point. It is not even remotely how it is supposed to happen. We bastardized conception.

Susan

Susan is a tall, slender woman in her mid-thirties, and her triplets are five years old. Susan began her story by describing her years of infertility and her inability to become pregnant. As she told her story, tears fell down her cheeks. She lowered her head, then silence. I waited. Susan sat in a leather chair in my office, a cup of coffee on the table. As I waited for her to begin again, she spun the coffee cup around and around. She finally looked up at me. The tears welled in her eyes again. She continued to tell her story. Susan met her husband in high school then later got married after he finished his degree in education. She began to laugh, then explained how they had used contraception for many years so she would not get pregnant—it was “ironic” that they “tried so hard not to get pregnant, and after all that, [she] couldn't get pregnant anyway.” She bowed her head again and was quiet for a while, then looked up at me and began her story. Like Dana, Susan also began her story by describing her years of infertility and her inability to become pregnant without IVF. She stated that how her conception occurred—“in the dish”—was not important. Rather, what was important to her was having a child that was biologically related to her and her husband:

Interviewer: Susan, you said if the sperm was different you may have gotten pregnant the natural way. Was conception “in the dish” unnatural?

Susan: Not unnatural, but, like, who doesn't want to have sex? And now we made a baby, the dream or fairytale. It's not unnatural. Maybe the unconventional way,

maybe. If you need to go through all that to get pregnant, there is nothing unnatural about that. But that seems how my life is going. Nothing I planned in my life is going down the path I planned. . . . I wanted to get pregnant; that wasn't ever how I imagined.

Using Susan's words, IVF was an "unconventional way" to achieve conception. She attempted to normalize the process of IVF by having a child that was biologically related to both parents—using their egg and sperm to "control" how they were "perceived socially"—to fit her image of family. Susan described her daily routine of "blogging," and I wondered why it was important for Susan to let her friends and family know that they used "their egg and sperm." I asked Susan to tell me more about it. Susan said she had created a Facebook page because her friends and family wanted to know how things were going with the IVF. When she started blogging, it was to talk with close friends. In a very short time, more and more people wanted to know. At one point, Susan said she had hundreds of people following her blogs. I asked Susan what she would tell people in her blogs:

Susan: Oh, anywhere from what I did in a day, but mostly how I felt that day, whether I had to go for a test, what the results were. Stuff like that. It was crazy—people would ask me personal stuff.

Interviewer: What would you tell them?

S: It depends. I would tell them, most of the time, mostly what I wanted them to know. Like, it was important to me.

I: What was important for them to know?

S: That we were a family like everybody else's, you know, everyone has the same stuff. Their family.

Jae

Similar to Susan, Jae, also a mother of multiples, encountered uncomfortable moments in public settings, which highlighted the issue of normalcy. Jae described how difficult it was running errands, going to doctors appointments, and shopping with triplets—not having enough hands to manage all three. Going to the shopping mall

brought another set of unique challenges. She talked about what would happen when traveling through the mall with her three triplets in a stroller. She described how people would stop, stare, and point toward her—"I felt like a freak show." Once again, Jae felt "different" than other women. She went on to say that this was not the type of attention she wanted in public. As Jae continued, she described how she wanted to return to a normal life and walking around in public was like sending out a red flag: "Look at me—I couldn't get pregnant like other women. Really, who just has triplets naturally?" For Jae, triplets represented her inability to conceive without assistance, reminding her of the time of her infertility, her treatments, and how she felt "defective." Her conception was no longer a private matter, in public she was "seen" as not having had a traditional conception. She stated,

It is not the old-fashioned way, but it is not unnatural. The egg and sperm did come together, just in a Petri dish. I just don't like that word [unnatural]. I think it implies that my kids are aliens or something. They were just conceived a little bit differently. They were just made a little bit different than everyone else.

She became angry, her tone quite strong, and as she continued her voice escalated while telling her story of how she was approached by strangers. She resented the implications that she was defective, and even more so that her children could be defective too. Jae continued:

These are all things that I never thought of until I was in the fertility world. If you ask me if they are "natural," I am NOT going to tell you how my kids were conceived. I don't know, are your kids natural? They are kind of like, "Well, you know what I mean." I don't know what you mean—I think all children are natural.

Understanding that going out in public with the triplets garnered attention, Jae was also reminded that her life was not "normal" nor what she had envisioned, and that her children were a sign that Jae and her life were not like other women. Jae explained

what it entailed “to go out with three babies”: the need to bring three sets of everything from bouncy chairs to car seats, and the difficulty getting them in the car. There were “three of them” but she only had “two hands,” she said stretching both arms out in front of her. She said she missed having a conversation with her friends; she was unable to sit and talk and at the same time try to feed three babies. Jae’s life was no longer predictable. She longed to regain control or a sense of continuity and resemblance of her life before the birth of her children. Yet, her outings often entailed confrontation by strangers.

Jae: I am not a low maintenance friend right now. What did you think I was going to be doing with three infants now? People have this cutesy, romantic notion of multiples. I can’t tell you how many people [will stare]. I am a traveling freak show, or at least I was. Not so much now, because they are getting older. When I would go out with that triple stroller pushing them somewhere, I was a freak show. I would get everything from, “I am jealous, I always wanted to have twins or triplets,” to something like, “You are so lucky.” I was like, “Really? Come over at 3am. You can see how lucky I am.” You get the people who have the romantic vision of how cute it is—they don’t get the work or expense behind it. Then you get the other people, “Oh, I feel sorry for you,” just the rude people. Oh, and then I can’t even tell you the number of times I have been asked point blank, “Are they natural? They aren’t natural, are they?”

Interviewer: What does that mean to you when someone says, “Are they natural?”

J: Annoying. It is almost insulting. I have to remember that people don’t know. I know what I have learned from being infertile. I remember before when someone would get married they would ask, “When are you going to have kids?” [Now] my question would be, “Do you want kids?” I have changed now too.

In the excerpt above, Jae described her outings as a “freak show.” Tension is apparent between how she had imagined motherhood would be, personally and socially, and her reality. Jae’s friends did not understand her chaotic life with triplets. They did not understand her world; therefore they could not support her. No longer able to fulfill the expectations and lifestyle of this circle of friends, Jae sought the friendship and companionship with women who were like her and shared similar day-to-day lifestyles, who understood the experience of raising triplets. Jae sought membership within a

community of other mothers of multiples. Here, she was the “same” as the other mothers. She was not judged, pitied, or expected to live up to or give the time and energy she could barely muster for herself. Rather, she was comforted by the similarities in their day-to-day lives, not the differences she had experienced with her friends with single births. Establishing new friendships and community, normalcy for Jae meant integrating new friends as a family, where everyone gets along and supports one another.

The Role of Biology

Assisted conception with IVF affords one pathway to biological parenthood. The pregnancies they produce are, to some degree, only a semblance of what is viewed commonly as normal, in that the children did not result from “natural” intercourse. In other words, the children are perceived to be simultaneously normal and abnormal. The seven women that openly discussed their IVF shared similar experiences like Jae when confronted by strangers or even family members about their children’s origin. In particular, the mothers of multiples felt that their children’s normalcy was doubted. The remaining three women had singleton births and did not encounter this issue because they had not disclosed publically that their children were assisted conceptions. However, they stated that they did not tell anyone to avoid the “risk” that their children would be considered “abnormal.” I understood this to reflect more about how the mothers of these children felt rather than the children having some health issue or physical disability that would bring attention to these strangers.

The excerpt described below from Jae illuminates the cultural framing of infertility as something that should be treated, and the tension that exists between what is considered normal and whether a condition should be treated:

I don't think it is unnatural and I think that is what bothers me. It is messing with Mother Nature. It is not unnatural. I feel like there are scientists and doctors with wonderful knowledge for a reason. I feel lucky to live in this day and age where this technology is available to me. How lucky are we—otherwise I might not be a parent. I think it is becoming more natural. So what I just can't get pregnant without four or five other people in the room. [laughs]

Jae attempted to justify her conception as taking advantage of scientific knowledge. At the same time, by “messing with Mother Nature,” she was unlike other women. Jae was offended when asked if her children were natural. How she interpreted the word as implying her children were “aliens” reveals that neither she nor her children are perceived as normal, lying somewhere between the boundaries of the normal and the abnormal.

A similar experience also occurred with Caroline. Rather than a stranger, here a family member implied both she and her children were abnormal. She described an event that occurred at a family gathering shortly after having her twins when a relative began to provide advice about her form of conception:

Caroline: That is what makes you mad. You don't know what I have been through, so don't give advice.

Interviewer: So, that made you mad.

C: Yes. We [Caroline and her husband] are pretty open about it. This is why I do it, because I feel I have nothing to hide about it, and secondly, to let people know that this is something that happens a lot more than people realize. It is nothing to be ashamed of, and it is nothing that we should be anything other than supportive of each other about.

I: Who do you mean?

C: I think everyone in general. I have friends who have gone through IVF that haven't told anyone but me. I have been there, in social situations where other people thinking they are being okay just say to you, “Oh, you have twins and they are natural. That is great.” . . . I think that is just a horrible conception in our society that having twins by fertility is easier or not as great, or somehow not as special. Because those children are yours, no matter how they were conceived.

For Caroline, these encounters triggered painful memories of sacrifice, the emotional upheaval of infertility treatments, and the disappointment and loss she and her husband

experienced from an ectopic pregnancy. When a woman confronted Caroline and commented on the twins being natural, she was seeking validation on how the children were conceived. Caroline resisted the implication that her children were “unnatural” and therefore of “lesser value.” Caroline returned to this point several times in our discussion. She wanted me to understand that children born from IVF are “just as good,” in other words, just as valuable as other children born from unassisted conception.

Not A Matter of Choice

All of the women discussed how they had envisioned their future. They described how their lives became consumed with thoughts of infertility and their infertility treatments. Jae described infertility as preparing for and then fighting a battle:

When I started to try and get pregnant, I really didn't prepare my body because I remember thinking when I got married that my husband wanted to wait a year, even though I was in my thirties when we got married. I was like, okay, I will only be 32 and I had it all planned out that I would be 33 when I'd have my first kid and 35 and then 37—it will be perfect. I was going to have a kid every other year. I had it all planned out. I didn't have any reason to think I wouldn't get pregnant.

As Jae and I continued our discussion about how she had planned her life versus what her life was like at the time of the interview, five years after successful IVF, she returned to the period in time when infertility consumed each day of her life:

Interviewer: You said you don't think about infertility anymore, “I am a different person.” How are you different?

Jae: I don't live my life in 28-day intervals anymore for sure. You plan your whole life around your infertility. You have to be at a certain place at a certain time of the month so that you can visit the doctor. I can't schedule a work meeting before 10am that week because I am probably going to have to be going in for ultrasounds. It really is like your life is on hold while you are fighting that battle.

Jae felt that she needed to prepare herself daily for her fight to become pregnant. This battle disrupted her daily habits, affecting her personal and work life. She believed she

had done nothing wrong to deserve this—“I just felt cursed almost”—and that she did not “choose” to become infertile.

She continued our discussion and compared infertility with cosmetic surgery as a matter of choice in life, saying, “Infertility is looked at like cosmetic surgery.” Yet, she did not choose IVF the way some choose cosmetic surgery when, in her mind, they do not need it. She only chose whether she would seek treatment. She further explained:

People equate infertility treatments like they do going to see a cosmetic surgeon. It is not your God-given right to have a tummy tuck and it is not your God-given right to have a baby either. It is not the same.

Jae described infertile women as helpless victims of circumstance borne not of their own choosing or actions. Jae also compared infertility to substance abuse, arguing choosing to take drugs or drink alcohol was an individual’s decision or under their control, where infertility was not. For Jae, infertile women do not have control or choose to become infertile, yet society supports “fixing” substance abuse, but does not support helping the innocent victims of infertility, illustrating a tension between what individuals can and cannot choose to do in life.

Interviewer: How does that make you feel?

Jae: It pisses me off because I didn’t “choose” it. Why is it covered [by insurance] for someone to get a 30-day inpatient treatment for substance abuse when they are the ones who chose to shoot themselves up with heroin? I certainly didn’t choose to have two ectopic pregnancies and having to go the route of IVF and have triplets. There is a reason babies should be born one at a time. I would prefer to have had the good old-fashioned way, one-baby-at-a-time thing. People don’t see it that way. They see it as a luxury and not [a] necessity.

Jae saw having a baby as a necessity to fulfill her life plan. Pregnant with triplets, she described her months of bed rest. I then asked her, now that she had her triplets, what her life was like. Was it what she had hoped for? She replied, “I wanted a normal life.”

Interviewer: Define normal for me? Can you do that?

Jae: Like a normal life?

I: You said, “I wanted a normal life, I am not normal and my pregnancy was not normal.” What is normal?

J: I feel like [laughs] the people who have sailed through life, they get married at 25, they fall into the norm—the expectations, the all-American expectations.

For Jae, I understood the “all-American” expectation was to “get married at the right age, the right time, to have a wonderful loving husband, four children, a couple of dogs and a house.”

Interviewer: Was that your expectation?

Jae: I wanted it to be, but it wasn’t what happened. I am a different person. You plan your whole life around your infertility. It really is like your life is on hold while you are fighting that battle. To me, it [IVF] was the means to the end, and I hoped I wouldn’t have to do it. But I did.

What may happen in life is not what was planned for or chosen—sometimes the totally unexpected happens. Once the women made the choice of IVF, they experienced unexpected consequences. I asked Jae once again to describe her life now. Was it what she had expected? She described herself and her life as “chaos”: “I’m a ‘crazy’ busy person is how I would describe me. On top of managing my three kids, my husband, my job, my dogs, my house—plus I have a mother who is very dependent on me too—I have a lot on my plate.” For Jae, the definition of normal, the “all-American family,” led her to try to oversee, manage, and take control of her and her family’s daily lives. She wanted to be seen as “in control” and not “chaotic.”

For Jae, the years of infertility treatment were a life-changing experience. More often than not, she felt out of control while dealing with her infertility. When she was able, she made decisions during fertility treatments, exerting agency in some situations. Her life after IVF remained “chaotic” and “out of control” again after the birth of multiples, forcing her to rework her life plan and redefine normalcy. These experiences

of losing control and redefining normalcy are similar to Becker's (1997) concept of normalcy, which explained the loss of control that leads people to question their entire life and continuously rework their identity. The concept of control over one's environment, home, work, and body is a key value in the United States. In this example, the need for control is rooted in the American ethic of individualism (Becker 1997; Giddens 1991).

As an executive for a national health insurance carrier, Jae manages a number of contracts for large businesses that have thousands of employees. Her role is to advise, guide, and implement their selected health plans. Jae was worried that would be viewed as "incapable" of managing both her life and her work and had the potential of failure:

The best word that describes me is probably "chaos." I have to laugh because in my job thinking that people may not want to know that I have triplets, I remember really trying to hide it at first. My bosses knew because they knew before they hired me. I didn't want my customers to know.

Jae shared her concern that her life would be "seen as abnormal" to her clients. Once again, she would be considered a "liability," and the "failure" created by her inability to conceive would be diffused to other aspects of her life, including her professional life.

Here, Jae's concept of being "in control" of her life was equated with being "seen as successful" or how she redefined what it meant to be successful and the ways in which success could be achieved both in her professional life and in motherhood. Jae's perception and beliefs of regaining a sense of control conform to the "fundamental codes of American culture" (Foucault 2002). In this sense, Jae's notion of success is similar to the enculturated narratives of success in some American middle-class women: controlling one's life through hard work, persistence, and determination (Schneider and Smith 1973).

Jae continued:

I thought they would think, “She has three young babies, she will be paying attention to other things besides her work.” I thought they were going to think, “This is not good, she is a liability. She is not going to be dedicated to me.” What I tell people is that it is a very big benefit for me. I have such a higher tolerance for chaos than most people—you can’t even imagine. I think that is the key of success to my job. I have a higher tolerance for chaos.

In the excerpt above, Jae attempted to reestablish a sense of order and control in both her personal and professional life. Jae’s feelings of taking control of her reproduction by choosing IVF are complex. Her reactions show that choice is intimately connected to the notion of control. This contrasts with Elise, who felt from the start that IVF was not a matter of choice, but her only option.

Elise, a petite young woman in her early thirties, spontaneously began to tell me that IVF was her only hope of having a child at the onset of our interview. She knew prior to getting married that her chances of getting pregnant without some type of assisted reproduction would be, in her words, “a miracle.” She said she had minimal expectation she would get pregnant “naturally,” but remained hopeful. Elise explained how her husband’s childhood illness affected his sterility. For Elise, IVF was the only choice:

I look at infertility like it is not a choice, someone didn’t ask for that. Is it a disease in the same sense that cancer is a disease? It is still a medical problem that needs assistance. People consider alcoholism and drug addiction a disease and insurance pays for people to go to rehab and everything else multiple times, but they are not willing to help a family that is trying to have a baby because they don’t have a medical condition. Being an alcoholic or being a drug addict is a choice. Eventually it takes over your life and is a disease as well, but initially it was your choice. You made the choice to take those first drugs or take those first sips or to continue to do it. People who have fertility problems didn’t make that choice. Women don’t choose for their ovaries to not work properly or to have blockages with their tubes or whatever the case may be. It is not a choice that people make. Who would want that?

In this comparison of the two medical conditions, infertility and substance abuse, the women wished to shift blame for their infertility as a matter of something they had no

control over. During our meetings, Elise made a point of telling me about her husband's childhood illness and that he was the reason that they had to resort to IVF. At the same time, she made it quite clear that she was "perfectly fine" and went on to tell me that her husband's illness was "out of his control"; he was a child and did nothing to deserve it.

Here, infertility is compared to drug addiction, someone who lacks control, where how one chooses to live life plays into their moral value. The concept of control in these two very different conditions is unequal: there is increased favor in the treatment of a person who demonstrates moral character, whose actions are considered the right way of living, over someone engaging in questionable behavior or the wrong way of living. In the stories that follow, women that have made the decision to pursue medical treatment and IVF hope to regain "being" normal; this means also conforming to "acting" normal.

Social Normalcy

The women in this study who struggled with their infertility were confronted with cultural ideologies surrounding social norms. They have expectations surrounding the preparation of the birth of their child as well as their pregnancy course. The women in this study who were pregnant with multiple births experienced a different pregnancy course in how they looked compared to women with a singleton pregnancy. Complications often set in and they found themselves on complete bed rest. They also experienced premature births and, sometimes, complications after birth, as did their infants. Jae described this feeling of not fitting in:

Jae: I still feel like I missed out on a normal pregnancy too. I was in bed from 22 weeks on. There was no walking around or going to work or being a cute pregnant person. There was just bed rest. While that does bum me out, it doesn't rule me. The end result was that I wanted to be a parent. I just got there a little different than most. [laughs]

Interviewer: You took a different route?

J: Yes.

Susan did not choose to have multiples, nor did she choose what her life would be like. She is not alone. Finally pregnant with triplets, Susan had a party “so people could see I was a little pregnant” (Interview #1). Susan did not hide her infertility nor did she hide her infertility treatments. She spoke openly about trying to get pregnant. Once pregnant, Susan wrote blogs to address the interest of family and friends. Susan recalled a particular event at the party that troubled her:

One of my neighbors came over to me, and people knew we were having trouble getting pregnant. I remember her coming over to me and asking if they were my husband’s. I was just like, “Wow!” It astonished me cause I never thought that people would think they weren’t our babies; his stuff and my stuff put together. It really threw me. If she is thinking that, I wonder how many other people are thinking that. I remember in my next update, how can I address this so everyone knows? It was important to me that everyone knew that they were mine and my husband’s biologically.

In this excerpt, Susan emphasized how important it was to her that people knew their children were theirs biologically. For the first time, Susan introduced the father, her husband, as part of the discussion to legitimize their nontraditional method of conception and to convey their future child’s biological normalcy as well as her own. She continued to explain how she conveyed this in her updates:

So I said, “Steve and I are so excited. I am 16 weeks pregnant, and we can’t wait to see who looks like Dad—will they have his blond hair and blue eyes or my brown hair and brown eyes?” I had to put it out there that they are ours and not donor eggs or sperm. IVF for me plays into it, I guess, in that sense that IVF only happened because we both were able to contribute to making a family.

In the excerpt above, Susan described the importance of her family’s normalcy as she explained how her children resulted from her and her husband’s combined contribution; their eggs and sperm. I wondered why this social recognition was so important to Susan. I

probed further to understand what Susan meant by contributing to making a family. She further explained:

For me, family is an accomplishment. The big thing for me was I didn't just want to be a mom. I wanted 'us' in those kids. I wanted to be a cohesive, biological family. That's what family means to me. I identify with my parents. I want the same for my kids. I want them to identify and see that they are a part of me, and that we are family and there are identifiers there. There is no question: We are all part of each other.

Susan's response evoked her idea of family. She viewed her quest for motherhood as a goal to be achieved. She described her perseverance to attain motherhood and create a family as a personal accomplishment. An integral component of what family meant to Susan and why she chose to try IVF was the opportunity to have a biological child. So, I posed the question once again:

Interviewer: What do you mean by "a biological child"?

Susan: I wanted to have our baby. I think it's the fascination of it—it's a little bit me and a little bit him. It had to be part him and part me. IVF would never have happened if, say, he was sterile or I didn't have eggs. I wouldn't have done it. Even if it's the sperm and egg thing in the dish, it's still us. If the sperm was different, I might have gotten pregnant the natural way.

For Susan, a biological child meant the sharing of genetic substance by using their eggs and sperm so that their children would have physical characteristics like them. Genetics superseded the process of the 'sperm and egg thing' in the dish. For Susan, it was very important to share a physical resemblance with her children. She describes the physical markings and what those markings mean to her. She begins by describing her own physical resemblance with her parents:

I have my Mom's hands, my Mom's feet, her eyes. I have a birthmark, one from my Mom and one from my Dad. And my son has the same birthmark of me and my Dad. My [other] son has a freckle just like mine. [shows me her wrist where the birthmark/freckle is] I love that stuff. I love that connectivity, proof of continuance of generations I guess.

How Susan's conception was achieved did not affect her sense of self as a woman or mother, as this was maintained by achieving "biology." Physical markings, birth marks, and so on in common with parents and grandparents were symbolic proof of a biological link.

I began this account with an excerpt in which Susan described her expectation of IVF. Susan said in the interview, "Once I got pregnant I had expectations [of an uneventful pregnancy], once I knew I had triplets those went out the window." Treatments like IVF may relieve the burden of infertility for many couples, but it also represents substantial risks for multiple births. With multiple births, the risk of complications increases compared to a singleton birth (American College of Obstetrics and Gynecology 2005). Susan's course of pregnancy remained uneventful until her 20th week of gestation. Ordered on full bed rest, Susan made intermittent trips to the hospital for ultrasounds. After her 22nd week, she never left the hospital. Susan described her six-week stay in the hospital:

Susan: My pregnancy was different. For me, what I had to do was be in the hospital. At the time, you think you should be washing the clothes and getting the changing table ready and going through your baby shower stuff, all the fun stuff. I was stuck in the hospital bed, pregnant, scared, by myself. I feel like, at the time and still now, I feel like I missed out a little bit but in reality, in my brain, I knew I was doing the exact thing at the time that I was supposed to be doing for my babies, the normal thing.

Interviewer: What is a normal thing?

S: Pregnancy-wise? When I think normal, from soup to nuts, it is getting pregnant with sex, you know [laughs]. You go to the doctor and get two, maybe three ultrasounds. You have your baby shower and everyone gets to see you. Everyone gets to touch your belly and guess boy or girl. Everyone asks you the name. That's the normal thing. I know people with only one baby have issues and they are on bed rest. For me, I didn't wear hardly any of my maternity clothes because I was on bed rest when I really got big. No one really saw me when I was pregnant. I didn't get to walk around pregnant and get the attention [of] being pregnant. Being pregnant, I didn't get to prepare for the babies. I didn't get to nest for them.

As Susan reflected back on her experience of being pregnant, she identified herself as “different.” She compared her experience to an idea of what a course of pregnancy should be and justified her feelings of her maternal sacrifice by doing what she was “supposed to do for her babies.” Susan continued to describe an image of a pregnant woman preparing for her babies, washing their clothes and setting up the changing table. She thought back to how she felt at the time—and still to this day—like she “missed out a little bit.” Finally pregnant, Susan’s ideology of the course of pregnancy was altered by a multiple gestation. At my prompting, Susan relayed what it meant to her to be on bed rest and not at home preparing for her babies:

I just wanted to be left alone. I didn’t want them [friends and family] hovering over me and I wanted to do things and I couldn’t. Other people were setting up my nursery. Other people were doing what I should be doing. (Interview #1)

I then asked Susan to tell me more about what she meant by what she “should be doing”:

Susan: Realistically, in hindsight, I know what I was doing was for the benefit of my children to keep them in. At the time though, you are so emotional and you are supposed to be getting ready for your babies. Everyone I knew had one baby and they were at home and they got to paint the nursery and they got to set things up. It is the not keeping up with the Joneses, doing the normal thing, what everyone else did when they were pregnant.

Interviewer: What does everyone else do when they were pregnant?

S: We didn’t do the pregnancy pictures with the mom, dad, and the big belly. I guess normal for me, in pregnancy terms, is just that. The progression of “we are pregnant” to “the baby is here. Come to the hospital and hold him or her.” I didn’t even get to hold them. They took them away. That is normal to me I guess.

Susan’s choice to use IVF was an expression of how women attempt to live out gender expectations in an effort to reestablish a sense of normalcy. Instead, being pregnant with triplets eliminated any hope of the pregnancy experience she had envisioned. These same

feelings, as Susan described, were also present with Jae and other participants of multiple births: they felt denied, once again, of a normal experience.

Achieving Normalcy

Throughout my interview with Susan, the word “accomplished” surfaced many times. First, in the context of seeking IVF treatment, she stated, “Whatever I set my mind to, I tend to accomplish. So this was just something to accomplish to a point. I never doubted that fact.” Then, again, when asked what family meant to her, Susan’s first response was about accomplishment:

I don’t know if that would have been the same word if we had not had to go through fertility. It did feel like such an accomplishment, and to have triplets and not just one baby. It felt like that is the first word that popped into my head was “accomplishment,” that we did it. We accomplished something we set out to do.

Susan used the terms “normal” and “natural” interchangeably to imply an altered expectation or image of her conception and pregnancy. By choosing IVF, Susan was attempting to take control to restore what she envisioned as a natural process. Put simply, if something is broken, a person may attempt to fix it. At the same time, being capable of fixing something—here Susan’s infertility—transforms such a state from an inevitability to a choice for normalcy. I began to wonder if this discourse was, in part, a dialectical pattern of processes to normalize the IVF experience. This issue contrasted with other informants, Jae and Dana for instance, who did not believe their conception was normal or natural. Indeed, Dana referred to IVF as “bastardized conception.” I understood Dana’s reference to a “bastardized conception” in a way that she had failed; it did not represent her values, or what she had intended how her conception would be. Dana described her conception as “sterile” and “medicated,” not the “romantic notion you think of.”

All of the informants in this study became defensive when the term “natural” implied abnormal, as in the example when a family member or stranger asked Caroline, “Are your children natural?” In Susan’s discourse, she exposed the tension between what she had expected (the normal/unassisted conception) and her reality. I returned to Susan’s infertility treatment to explore the meaning of nature in relation to her body and her role as a mother:

Interviewer: Susan, can you help me understand what you mean when you use the word “nature”?

Susan: For women, it is—it is what my body was created for and I can’t do it. It was what our bodies are supposed to do. Our bodies are supposed to recreate. Technically our bodies are here for recreation. I never had those inadequacy feelings—I wouldn’t say never—but they weren’t as prominent for me as they were for other women.

I: When talking about your experiences going to the infertility clinic, you said you wanted “to make it as normal as possible.”

S: I just treated it like it was something that you have [to do]. [When] you have cancer, you go to the doctor. I am not going to call infertility a disease. It’s a problem. You have something you can’t resolve on your own; you need a doctor. I just tried to make it so that it wasn’t this big hurdle we couldn’t overcome. We were dealing with not being able to get pregnant and we are going to go to someone to help us get pregnant.

In this excerpt, Susan took the position that medicine and technology were the logical way to resolve a problem. Like Susan, Jae also felt that the purpose of IVF technology and physicians was to provide an opportunity to bring about a solution for her infertility. This illustrates Conrad and Kern’s (1990) theory, where medical treatment provides a way to regain control. For many Americans, medicine is a resource for understanding and correcting problems.

Unlike Jae, Susan did not convey that her body was at fault or incompetent. She went on to say that she tried to maintain a “normal routine.” She went to work, saw her friends, and attempted to maintain the activity that she had prior to her infertility

treatments. Susan's repeated use of the word "normal" and "normal routine" suggests that she felt anything but normal. Susan focused on controlling the situation at hand. Trying to get pregnant meant she needed to assert control over the process and her life to fulfill what she believed she was obligated to do. She compared the threat of infertility to cancer—something frightening and uncontrollable, unsure of her destiny. Her life plan remained out of control, outside the boundaries of what she envisioned her life would be like.

Interviewer: What did it mean to you that IVF was the way for your body to become pregnant?

Susan: I was appreciative. Think about how many people wouldn't be on this earth if IVF wasn't an option. There could be scientists (referring to her children or other children from IVF) that could be curing cancer because of IVF. IVF has been around for about 30 years now. There could be the next president, a six-year-old running around right now.

Susan attempted to justify the existence and purpose of IVF as a service to mankind and used the example of finding the cure for cancer. Susan mentioned at various intervals in the interview her ability to meet challenges, tackle problems to achieve a goal, and persevere. Faced with infertility, Susan took the position that her treatments were the tools to beat this game. Afraid of failure, she attempted to gain control of her body and life by following the medical routines outlined in her therapy. Medical treatment offered Susan the opportunity to put life back on track.

Alternatively, Caroline shared views on people's ignorance to what women and couples go through to have a child. This was made clear in the multiple times people approached her to ask if her children were natural:

Interviewer: How does that affect you and what you communicate to others?

Caroline: I share it because I want anyone who is going through it to know that they are not alone in that difficulty. I know when we went through it, it was

terribly isolating. It was horrible when someone tried to equate that they had a miscarriage, “I know how you feel.” It is not the same. I think even when I talk with women now who are going through it, cause we are all at different phases, we all have different beliefs. We all have different life experiences and expectations, and everything else. When I encounter women going through it, going through anything, I don’t think you can say, “I know how you feel.” But, I will say something like, “I have a better understanding than someone else who hasn’t gone through similar circumstances. No one can know how you feel.”

These comments led me to consider how Caroline’s personal experience of IVF affected her daily practice as a physician. Caroline had several rounds of IVF for her first pregnancy and then again for her second pregnancy, similar to other women interviewed:

Interviewer: You describe your experience as an isolated and difficult time. How were you able to do it again?

Caroline: What I have been through in my life—so many things out of my control. In the end, everything in my life I have made happen. I have chosen it. I decided to do it. I have worked hard and I make it happen. In my life, my determination to leave behind drama and trauma and victimization and all of that, that I refuse to be a victim. I refuse to let that define me. I have always been determined to get beyond that and focus on what I can do and what I will accomplish.

Discussion

Although each of the women was considered a successful IVF, the stories and observations I included in this chapter demonstrate the complexities for the women surrounding what it meant to be normal, to themselves and within their local worlds, during and after IVF. Most of all, the study participants continued to strive for a sense of normalcy. As a result, many study participants made efforts to cope with opposing social norms. Some of the study participants continued to struggle with their own ideologies, values, and beliefs of conception, while other participants devised coping strategies when confronted by other family members and friends with opposing beliefs of conception.

These women faced many challenges that women who have not conceived with IVF do not face in unassisted conception.

Another overarching theme was control. The vignettes described various ways the women in this study attempted to regain a sense of control: control of their bodies during treatment, and control of their lives after IVF, especially for mothers of multiples. Attempting to regain a sense of control also brought hope for one woman in this study. In one example, I illustrated how Dana attempted to regain control of her body in her “scientific experiment.” Her experiment, as she described it, required her to “learn” about various medical treatment regimens to “control” how her body would become more receptive to pregnancy. At the same time, she compared her responses to treatment with other women, categorizing and differentiating her response being “in and around” normal ranges. Dana believed that gaining medical knowledge would help her find a solution to her infertility problem. I understood her actions in this experiment as a way to try to regain a sense of control in her life. For Dana, and many of the women in this study, the loss of control was no longer just about reproduction, it was losing control in everyday life experiences. They felt constrained in their relationships, their abilities in their work, and their schedules. Jae, for example, described her mood and life as “chaotic” and her life as “fighting a battle.” This ongoing loss of control perpetuated her frustration. As Becker (1997) has illustrated, women experience frustration and sadness when the orderly plan of life is disrupted. Similarly, these examples illustrate the women’s frustration when their life plans became out of control and did not follow their expectations.

From a cultural perspective, social norms, rules, and order played a considerable role in the women's sense of self. As the vignettes depict, instead of being constant, agency varies, responding to unique social settings and gatherings. Several of the women resisted being cast as "victims" or being distinguished from other women because they "took a different route" to conception. Some of the women selectively chose when and how to assist other women who shared similar life experiences by going on the Internet and meeting with other mothers of multiples.

Educated and knowledgeable, those women made choices as knowing subjects to redefine their own ideas of who they were, both in symbolic forms in words and in their actions, such as "being supportive" in educating women, and not allowing their infertility to "rule" them. I found Jae's word choice rather interesting, in how it played into following or opposing the rules of social norms. Similarly, Caroline's belief that not following the "norms or rules" (quotation marks indicated by gesture from participant) of society in electing to undergo IVF was "nothing to be ashamed of," so she shared her personal experiences with her patients. Other strategies included educating other women when asked about IVF, lending support, or sharing knowledge or experiences in the workplace to alter perceptions that IVF was abnormal or pathological. On an individual basis, many of the study participants sought friendships with women of similar experiences, such as participating in "moms of multiples" groups. In the examples provided, I illustrate the importance of not underestimating the significance of subjectivity in the transformation of women's identities, when they are confronted by opposing social norms, beliefs, and values.

Efforts to restore normalcy meant reconstructing life stories, reexamining the past in relation to the present, and rethinking the future. Even for the women in this study who had a biological child, the years and experience of infertility left an indelible mark, as seen in the examples of Jae and Susan, who described themselves as “defective” and “different.” Alternatively, feelings of “accomplishment,” “refusing victimization,” and overcoming adversity revealed subjectivities that served as a catalyst for redefining normalcy.

Individual beliefs, values, and subjectivities (i.e., feelings of failure and difference, as well as achievement and accomplishment) played a significant role in recasting the women’s identities as they attempted to live up to social norms, especially when challenged by opposing social beliefs by friends and families in their choice of IVF. Some of the women compared their “right” choices, actions, and behaviors to the “wrong” choices of drug abusers and alcoholics. Contrastingly, drug abuse and alcoholism were seen as consequences from “bad” choices in life, conditions that could have been avoided, and therefore treatment was not an entitlement. I found this comparison interesting, particularly regarding who and why individuals should receive treatment, illustrating their moral values and personal judgment of these individuals’ choices and actions in life did not conform to the “rules of society,” yet, they did not want their choices to be judged.

The theme of normalcy described in these vignettes illustrates the desire of these women to follow social norms, the “contribution to making a family,” and the manner of behavior of a “cohesive biological family” conforming to their values and beliefs within their local world. Notions of normalcy are intertwined with the concepts of order and

control, as seen in the vignettes of these women. Susan, for example, described the importance of “physical characteristics” to validate the genetic makeup of her children to conform to her beliefs and ideas of social expectations. Interestingly, Susan experienced tension when unable to fulfill her ideas of what an expectant mother “should be doing.” Specific practices in preparing for her children, like “preparing her nursery” or “nesting” like her friends and family members, or being “seen in maternity clothes,” were an expression of cultural codes theorized by Bourdieu. The mothers of multiples described missing these practices as being “robbed” of their experiences of preparing for motherhood. Even after their children’s birth, many of the practices are “taken for granted” or “lost memories” because they are exhausted. I understood these moments as feelings of guilt, not meeting expectations of what they felt they were supposed to do as mothers, not following “the rules” within their local worlds. These learned practices follow Berger and Luckmann’s theories of socialization, where activities are learned from past and present generations of women.

Seeking treatment for infertility, for many of the women, was considered the only choice—a “necessity” or the “normal thing to do” to achieve motherhood—and was not seen as optional. While practice theory of agency and subjectivity are treated as mutually constitutive, with the increasing use of IVF, close attention should be directed to how women attribute responsibility, blame, and credit for certain actions that may alter these subjectivities.

Seeking medical intervention offers a way to regain control of the situation. Knowing what caused their infertility provides hope that they can “control their bodies” and, at the same time, be part of the decision making to control their future. In some

cases, unexplained infertility adds to the frustration of not knowing “why I couldn’t get pregnant like other women.” The women in this study described their emotions and used the metaphor of a “roller coaster ride,” experiencing the highs and lows of beginning and the end of cycles. The mothers of multiples (Jae, Susan, and Carolyn) said their lives remained on that roller coaster ride: the ups and downs of their emotions, the fatigue of managing three children, the hope of returning to the imagined “controlled and organized” life of motherhood, yet feeling life was “chaotic” “unorganized” and unable to get life “back on track.” I understood these women to feel that they were not in control of their lives. Unlike mothers of singleton births, they were “different.” They often felt that they were “inept at managing their home life” and feared “failure” at work that this lack of control would seep into their professional lives. I acknowledge that some new mothers—whether of singleton or multiple births—may have similar feelings attributed to new motherhood in general, however these women specifically attributed such feelings to their experience of having multiples, believing singleton mothers did not face such issues.

In this study, the domain of normalcy became a continual process of redefinition. Women that have achieved motherhood with IVF are considered a technological success. Yet these women never completely surrender themselves to the idea of IVF as a “normal” way to achieve parenthood; instead it’s a way to *try* to be normal and, to some degree, regain a sense of normalcy. The mechanism and technology of IVF sustains the tension between the normal and the abnormal. Normalization, for these women, is a contradiction that does not resolve, as Haraway (1991) has stated “about the tension of holding incompatible things together because both or all are necessary and true” (149). Mothers

of triplets illuminate and sustain the tension between the normal and the abnormal, as in the examples of Jae and Susan, who felt on display and part of a “freak show.” This example illustrates similar findings by Rapp (2001) whereby “the hierarchal organization of reproduction supports some women while other women are despised. Technologies such as IVF both accompany and partially produce late modern pathologizations of personhood . . . normality and abnormality as mutually co-constituted” (469).

Social class was also related to different types of categorization and expectations of assisted conception. It is assumed that middle-to-upper-class women can afford or absorb the cost of IVF. Many of the study participants had delayed beginning their family to meet personal and familial expectations of careers, and experienced concerns and added stressors related to meeting the financial demands of IVF with existing financial burdens. All of the study participants were Caucasian middle-to-upper-class women.⁶ Some of the women felt that having a child was their “natural purpose” and what their bodies were “supposed to do” to follow in the footsteps of previous generations. For many of the women, they felt an “obligation to try” and the responsibility that they should take “advantage” of such technology aligned with notions of American individualism and perseverance. In doing so, study participants encountered negative social reactions based on “how” they conceived, and were left to develop strategies to cope with these encounters.

⁶ Utilization of ART services among African American women increased when access to care was improved. A clinically significant reduction in live birth rate and statistically significant increase in spontaneous abortion rate was observed in African American women compared with Caucasian women. Leiomyomas were three times more prevalent in African American women and reduced ART success, regardless of race. The persistence of racial differences in an equal-access-to-care environment might be explained, in part, by the increased prevalence of leiomyomas in African American women. See Feinburg et al.

Although the women's assisted conception and the birth of their children took place several years ago, ambivalence, a sense of difference, and their struggle to achieve a sense of normalcy remained for these women, which reflects the conscious subjectivities of their sense of normalcy and identity. The agency of the women can be seen in the forms of action they took when their normalcy was challenged. As such, women who have tried and succeeded in IVF distinguished themselves in such a way to produce a novel and legitimized form of normalcy.

Conclusion

The American middle-class women who experienced successful IVF in this study wanted to guard against a view of their choice as abnormal, as a means of reproduction that goes against cultural ideologies of normal conception. Those committed to helping others overcome notions of abnormality devoted themselves to educating family and friends to convince them that ART is simply a way to fulfill the desire of motherhood. The women's experiences described in this chapter brings into view the individual and social meanings with which the women invested in agentive practices. An abnormal or infertile identity is a contested domain in which participants struggle to overcome negative social connotations and, at the same time, take control over their reproductive lives.

These encounters also reveal the heterogeneity of membership in a community. As evident in this study, these women are not radically different in that they want to fit in, to belong to a community, and to do so, they must continually renegotiate and redefine what it means to *be* normal. I have argued that a woman's status and identity are in a continuous process of renegotiation and transformation during and after IVF. Although

this process is apparent in the case studies, the women forge emergent ways of being women as they relate to the context of emerging local norms of womanhood. These stories reveal the women's struggle to connect, to regain control in their lives. It also reveals the force of human resilience, and how the women's understanding of a "new" normalcy post-IVF may contribute to a cultural shift in what society more broadly defines as normal in relation to reproduction and fertility.

CHAPTER 4 KINSHIP IN THE AGE OF REPRODUCTIVE TECHNOLOGIES

Introduction

“IVF and kinship are already biologically related. They not only share the same form but serve the same purpose: they are kindred technologies in the making of kin and the kinning of life.” (Franklin 2013:29)

The previous chapter explored the notion of “normalcy” as a continual process of redefinition on the one hand, and of trying to be “normal” on the other. The women’s stories described how, from their discovery of infertility to after having a child with IVF, the women are in a constant state of comparing themselves to others and their normalcy. This chapter is organized around a discussion of norms, to be more precise, the fluctuating, local and regulative domain of normalcy that builds upon the existing literature of ART interfacing with kinship. I explore how the technology of ART works to reinforce the desire and capability for biological parenthood, not to be celebrated as a technological achievement, but rather as a new form of normalcy in the making and remaking of kinship. I emphasize the role agency and normalcy play for the women in this study in their differing values, beliefs, and understandings of the meaning of kinship. I trace the elements that frame the meaning of kinship and how the technology of IVF reinforces the cultural ideology of the biological child and the notion of the American nuclear family. Using Ortner’s (2006) concepts of agency and subjectivity as a theoretical framework, I examine the language and discourse the women use to determine the “fields of meaning” in their local social world and the ways in which this experience reshapes their kinship identity (110).

Conceiving Parenthood

Why do people desire and yearn for parenthood? For some, parenthood is an insurmountable quest when faced with infertility. The answer may seem obvious: the desire for parenthood is the desire to have a child and to have a family. In contemporary America, reproductive technologies such as IVF are one way in which women may have the opportunity to become a parent when faced with infertility. Yet, the invention of ART has created debates concerning the definition of the nature of family and kinship in contemporary life. There is an extensive body of literature that examines issues of infertility, access to various medical treatment regimens such as IVF, the relationship between the science of assisted reproduction and society and, more recently, the impact of ART in reshaping the definition of kinship (Becker 2000; Finkler 2000; Franklin 2013; Inhorn 2008). In more recent literature, ART is another facet in the changing structure of kinship, including providing donor eggs and sperm and the possibilities of surrogacy and motherhood to lesbian and single women who want to experience pregnancy and the “high tech solution to the traditional American goal of creating a family defined in terms of shared (at least in part) biogenetic substance” (Peletz 1995:365; see also Franklin 2013; Ginsburg and Rapp 1995).

Robin

I was attending a conference on reproductive medicine in the spring of 2013 in Florida with my husband, who is a physician in obstetrics and gynecology. At the meeting, I ran into a colleague I had not seen for several years. We exchanged updates on our families, careers, and so on when I discovered she had recently had twins. She then shared with me she had difficulty getting pregnant and tried Clomid. After three months

on Clomid, she was pregnant, which resulted in her having twins. This prompted my discussion and my interest in IVF, along with the details of my study. She mentioned she had a friend who may be willing to participate. From this encounter, I met Robin.

Robin was 43 years old when she had IVF. She was in a second marriage; her first husband had died and they had three children together who now were young adults. Robin's husband was 10 years younger than Robin and he wanted to have a child. Robin knew that at the age of 43, she would not be able to become pregnant without some type of medical assistance. Since Robin had three children with her first marriage, she knew she was "capable" of getting pregnant. She made an appointment with a reproductive medicine physician and agreed to start with an IUI because of her age. The IUI did not result in a pregnancy. So, Robin and her husband decided the next step would be IVF, and after two cycles Robin was pregnant. Sadly, at 16 weeks, Robin ran into complications and had a miscarriage. She waited six months and then tried once more. This cycle resulted in another pregnancy and a birth. I asked Robin to tell me why they chose IVF. She responded:

At my age I knew that it was not going to be easy. I also knew that going through IVF would be very hard for me at this stage of my life. I knew my husband wanted to be a father and have his own child. He was great with my kids, but it isn't the same—you want a child that's yours, your genes. I wanted him to have the chance of being a parent. He is the last male in his family, and I know it would mean a lot to him.

For Robin and her husband, the technology of IVF provided an opportunity for them to have a child that shared in their genetic makeup, the experience of parenthood, and the ability to carry on the family name. Robin's statement reveals themes central to anthropological thinking. What constitutes kinship? Before continuing this discussion,

however, I will briefly trace the evolution of the study of kinship into the era of new reproductive technologies.

A Brief Trajectory of Kinship Studies

Kinship has had a prominent role in anthropological thinking since its beginnings. In the late 20th century, the focus primarily was on theoretical advances and debates about kinship terminology, rules of descent, and postmarital residence. The trajectory of kinship studies then changed to structural functionalism as a guiding paradigm (Peletz 1995). British anthropologists such as Malinowski (1930), along with Fortes (1939) attempted to understand the orderly function of small-scale societies. They saw kinship as constituting the political structure of states providing the basis for social continuity. From the French perspective, Levi-Strauss (1969) was primarily concerned with structure, how societies functioned, what the practices of a particular society were, and the rules in terms of relationships to each other, descent, and marriage (as cited in Carsten 2004). Bourdieu (1977) devoted his attention towards understanding social actors in the context in which they organize themselves, relate to one another, and create order and meaning in their everyday lives. In the 1970s, the study of kinship took a different direction towards social history, legal anthropology, and feminist anthropology. Feminist anthropologists situated gender at the theoretical core of anthropology focusing on the cultural analysis of meaning, pattern and symbols of meaning, and systems of social inequality understood best in historical terms. Contemporary kinship studies focus on the importance of kinship in any context factoring in variables of class, gender, and other understandings of imagined communities that shape local and everyday experiences.

This section shall explore theories of kinship and norms in the context of feminist thought on reproductive technologies and their interfaces with kinship. The revival of kinship may be linked to the works of Marilyn Strathern (1992), Sarah Franklin (2000), Jeanette Edwards (2000), and Donna Haraway (1997) among others. I will discuss some of their contributions to the understanding of kinship as a technology.

Theorizing about nature, Donna Haraway (1997) states that nature (along with race, sex, and kinship) represent the domain of the impure, a realm of cross fertilization that has evolved for hundreds of years, before science and technology, that beings of different orders have always co-evolved, assimilated, and were unregulated by taxonomic systems created by man. This was nature's natural order of things, the capacity to mix orders in her words "organisms as well as for humans, in the doctrine of types and intrinsic purposes...[have]a mixed-up history of living beings, whose long tradition of genetic exchange will be the envy of industry"(1997:61). In this brief excerpt, Haraway suggests that nature has an innate normativity characterized by the principals of kinship of all natural living beings, where one does not take precedence over the other. Haraway calls "kinship" a normative and moral device: "Kinship is a technology for producing a material and semiotic effect of natural relationships of a shared kind (1997:53), she then critiques technoscience as "worldly, materialized, signifying, and [a] significant power. That power is more, less, and other than reduction, resourcing...determinism" (1997:51). Haraway suggests that technoscience's (referring to ART) ability to imitate nature's ways of reproduction, enhance the mixing of orders, and the production of new forms of kinship should be promoted to counter racist ideologies, nature is now a "natural technical order of knowledge" (54) and a product of technoscience. Haraway views

technoscience as a way to assign kinship to beings without categorizing them, or limiting the ways in which they are related to one another. In a pure sense, ART enables new conditions a priori of nature, normalcy, and kinship.

Franklin (2000) conceptualizes kinship somewhat differently than Haraway, she explores how nature is being reconceived in the context of new forms of genealogy as a result of the work of biotechnologies. Franklin (2000) examines nature and technoscience as a new way of reprogramming biology both literal and metaphorically to be understood as a new form of normalcy of nature. In Franklin's view, a technologically assisted type of genealogy is about how to reprogram information contained in the gene from "familiar models of kinship and descent, by demonstrating that patterns of filiation and succession...once fixed by nature can be transcended by technology (2000:224).

Both Haraway and Franklin see what counts as nature has been transformed by different types of intervention into life processes. In Haraway's view technoscience mimics nature's inherent tendency towards hybridity and cross-mixing and is not a new way of producing natural kinds, or forms of kinship. Franklin's post-modern view of nature, is now nature is being controlled from the outside, a modified life, whereby technoscience is about producing different forms of genealogy, not a continuation, but a rupture with pre-inherent nature. Here, the elements of modern biology entail external rules and re-categorization of its elements of nature, which allowed only certain forms of kinship. For Haraway, this operates as a political and racist project of modern biology. This closely resembles what Rabinow (1992) terms "socio-biology" which models society on the basis of the metaphor of nature-social hierarchies-perpetuating natural differences and inequalities based on genetic differences.

Focusing on the social significance of ART we now turn to Marilyn Strathern (1992) and Jeannette Edwards (2000) to explore the impact of ART on the lived experience of kinship. Like Haraway and Franklin, they explore the ontological status of nature into life's processes, but their focus is in how ART informs lay knowledge about kinship in England. According to Edwards (2000), understanding that such knowledge does not suggest a set of moral principles that define how ties between kin are to be established and maintained, rather, unspoken understandings about what constitutes relatedness point to how knowledge about family connections frequently entail a form of normalcy.

In Strathern's (1992) analysis of 19th and 20th century English kinship she suggests a way of theorizing the normative workings of kinship. Central to English understandings of kinship, Strathern points to the concomitant tropes of individuality and diversity. Diversity in the genetic pool was thought to ensure novel combinations in the progeny, "the more rugged the offspring" contributed to a uniqueness of English character, thought to be the result of the slow mixture of races that took place in the early formation of English population (1992:36). In this account, a normative ideal emerges about what 'better nature' and thus 'better English kinship' are. This diversity had the potential to influence culture, and the character of a nation. The more diverse the genetic pool, the degrees of mixture, the better the cultural prospects of novel combinations of people and their resulting uniqueness, or individuality. Those that were not sufficiently "mixed" were deemed not sufficiently "unique" and thus kinship links were graded, chosen, or avoided on the grounds of their ability to cultivate diversity and individuality. This suggests for English kinship, the uniqueness of the person through genetic mixing,

became the foundation for personal individuality and identity. In this sense, genetic mixing was the normatively preferred model of kinship and nation.

With the advent of ART, Strathern saw that the morally praised individuality that had been the result of a slow and progressive mixing of nature manifested an increasing anxiety in the public mind. Thus, Strathern identified a nostalgia, a paradoxical fear that more choice for assisting nature, here ART, would entail less diversity in nature:

“It is now individuality that is under assault from the over-exercise of individual choice, from innovations that reduce variation. More choice seems less choice: with the engineering of genetic stock, the potential for long-term future variation may be reduced rather than enhanced. When diversity appears to depend literally on the vagaries of human individuals, it suddenly seems at risk: variation may not ensue” (Strathern 1992:43).

Strathern understood that the public anxiety of fiddling with nature gave a sense of reduction in human genetic diversity, the potential for donors and surrogacy heightened their fears of a genetic connection of unknown others. Strathern claims “these new images introduce the further idea that a fusion of materials is also a fusion of identities. Persons who pride themselves on individualism, as English do, are right to be suspicious: for the fantasy supposed a creature who is no longer an individual” (1992:180). This fact threatened Western understandings of kinship as a domain concerned with the knowledge of biological connections. In Strathern’s view, the image of the clone was associated with eugenics and the reduction in genetic diversity that created a source of apprehension in English culture that implied ultimately a loss of nature and of the very nature of Western Kinship. She says: Civilization is not so much under threat; Nature very much is” (Strathern 1992:41).

In Strathern’s analysis the English and European publics were attached to normative ideas about what nature *should* be, diverse and individual. The stability of these ideas

were significantly threatened by the possibilities of ART, the image of clones, people born from donors, or surrogacy who might be unaware of their connection.

Jeanette Edwards also focused on the importance on the knowledge of biological connections for modern English kinship. Her ethnography of narratives of conception led her to affirm that “knowing” is central to what constitutes a person in late twentieth-century English kinship. The knowledge about one’s roots implies that one is connected, not knowing ones roots conveys a danger of being unconnected, being denied the chance to know the identity and origin of your roots (Edwards 2000:243). Edwards suggests “knowing ones roots” becomes normative, being connected with others, to be complete as an individual, means one “has” to know. Those who do now know are considered less related as maybe in the case of gamete donors in ART. Knowledge of one’s roots becomes a normative way of establishing relationship.

In *Born and Bred* (2000), Edwards explains that the roots that connect a person to others demarcated by biological substance, egg and sperm, and through sexual intercourse also involve the knowledge of places where one’s family lived, where one grew up, the frequent visits of relatives, and the bonds sustained through care and love: “A persons background—a particular upbringing, childhood experiences, play a part in reproducing persons. Both genes and values perdure; they are passed on to children, and to children’s children” (Edwards 2000:37). The connectedness defined in the excerpt above, speaks of the different forms of the normalcy of kinship in England. For the English, having been born and having been bred often times are connected to one another in a manner that makes their distinction significant to certain types of kinship. In Edwards view, kinship “ is a mode of thought which orders and organizes immediate

social worlds (27)...and elicits notions of persons and places...[that] formulate categories of, for example, tourist, incomer, and migrant (34). If connections are accepted or rejected based on shared nature (substance-egg and sperm), or at times through shared experiences, and then at other times by both nature and culture, they are experiences that work to create, and sustain relationships. Whichever of these combinations of nurture and nature they serve to function, they function as criteria that classify the world, the relationships that an individual establishes with others in such a world.

In Edwards view, knowledge is a constitutive part of kinship, not knowing may lead to a lack of kinship. If one has to know how one is related and one feels compelled to prove that one is actually related to one another (parent and child), then it isn't so much about the fear of nature (as Strathern implies) or the response to the growth and spread of ART, but more the anxiety that the impossibility, or the threat of not knowing, or not having a connection may lead to a lack of a related identity, or a lack of kinship.

For potential parents, the ability to envision their own social and biological connection to the imagined child becomes relational, not only in physical attributes (shared genetic makeup) but also social and cultural ones. The power of knowing one's identity, one's kin is a potent narrative in US culture (Mamo 2005). In the US, "racial/ethnic/geographic identity is a central way in which people come to know oneself, ones family, and other social groups" (247). What remains unspoken is the desire to create a certain type of family. In creating kinship with ART, piecing together issues such as knowing one's biological identity, race, class, and history, one must also consider subjectivities, to understand the cultural significance of what it means to be biologically

related, and what constitutes the white middle class American woman's ideology of a "normal" family.

Kinship: Symbols and Meaning

When people decide to seek IVF as a means of achieving parenthood, they want both to be and to be seen as a "normal." They choose IVF so they do not have to give up the idea of a "biological" child, a child that shares in their biogenetic makeup. Becker (2000) explored how people choose IVF to have a biological child, and how and when they consider alternatives (e.g., donor eggs, adoption) as well as the equation of gender identity with biological function.

In identifying the importance of biological links for Western kinship, Becker and colleagues (2005) employed the term "resemblance talk" to signal how common "chit chat" about parent-offspring resemblance occurred in conversation and to illustrate how "the normative folk model of kinship in the US attaches great significance to genetic or blood relationship" (1301). In the case of heterosexual couples, (as it is in this study) physical resemblance is a highly anticipated result, and expectation for choosing ART to have a child. While ARTs have successfully positioned themselves as the great means to achieve the goal of a biological child for those who can afford the expensive treatment, ART casts doubt on the biological relationship because of the possibilities of donor gametes. Biological parenthood and biogenetic kinship are still the preferred means of family constitution in the U.S., "proof" of a biological connection, and tracing the natural ties is part of every day kinship-making (Strathern 1992).

Kinship in the making is not simply biological, but cultural. Sahlins (2013) defines kinship as the "mutuality of being", kinfolk are members of one another, intrinsic

to each other's identity and existence, in varying degrees and forms such as intersubjective relations of being. In Sahlins's view, kinship relations are "performative or made kinship as well as relations of procreation. Persons participate in each other's existence by a variety of meaningful attributes besides the presumed connections of 'biology' or even common substance" (62). According to Sahlins, relationships by birth are culturally relative and understood differently in different societies according to their "local theory of reproduction" (64). Sahlins quotes Ernest Gellner to reflect on the cultural variability of kinship values:

"Kinship structure *means* the manner in which a pattern of physical relationships is made use of for social purposes...for the selection of members for a group and the ascription of rights, duties, etc." (64).

Here Sahlins point is to consider the structure of kinship based not solely on biology but on other social considerations. Kinship members are inter-subjective relationships both procreative and made (culturally constructed) and its members are treated on a "as if basis" lying somewhere in between the biological and cultural.

In the previous accounts Becker describes the importance of a "genalogical" connection in American couples. Kinship as a cultural system is not under dispute, what will be argued is the social and cultural "as if" kin membership that Sahlins and Gellner mention. Not only the importance of the "genetic" connection is at play here, but the importance in preserving the white middle class. I will argue that white middle class women unknowingly preserve their whiteness, thru their discourse of resemblance talk, a sense of belonging, a sense of obligation to have a family and choose IVF as a means to complete their identity. It is important to understand how ART plays a role in bolstering

biological relatedness but first outlining the origin of the American kinship system begins with a discussion of the works of David Schneider.

Schneider on American Kinship

A seminal anthropologist in the field of American kinship, Schneider (1980) argued that there are two dominant orders that lead to the understanding and definition of kinship: the “order of nature” and “the order of law” (27). The distinctive feature that defines a kin relationship is in the biogenetic sense of a blood relative. Relatives in nature share heredity, and relatives-in-law are bound by laws, customs, and order of conduct. Schneider (1968) argued that the sexual union of two people (sexual procreation) is central to the definition of kinship. Sexual intercourse is a symbol that defines and differentiates members of the family. In American culture, kinship is “biology”: symbolizing the kinds of interpersonal relations of human beings, “they represent something other than what they are over and above, they symbolize diffuse, and enduring solidarity” (116). According to Schneider (1984), the institution of kinship in American society is closely linked to natural human activities (188), in that the social and cultural attributes of kinship are derived from the biological relations of reproduction. This definition of kinship underscores the significance of biology and its symbolic importance in American culture as a constitutive power.

This model has been heavily criticized for its assumption that all Americans share the same social structure, and the view of the biological basis of kinship and gender as natural facts (Strathern 1992). Yanagisako and Collier challenged that Schneider’s theory of “natural facts” does not work in the presence of ART. In a further critique of Schneider, Yanagisako and Collier’s kinship research of Japanese Americans (1987)

illustrated the variation in what defines a person as a relative, and in the construction of sexuality, marriage, and family and household organization, which Schneider largely ignored. Subsequently, in the context of “new biologies,” Franklin (2001) considered kinship and new reproductive technologies like IVF, questioning how “knowledge is produced” and how “identity categories are transformed” (319). In a further critique of Schneider, Franklin (2013) argued that Schneider’s view of biological kinship did not take into account how biological and social practices are constantly remade (286), such as deciding to remain childless, adoption, or the use of ART. Franklin (2013) examined how the interaction between biology and technology reconfigures kinship. She explained that IVF does not replace sexual intercourse, but replicates the hoped-for outcome, making “new assisted conception techniques ‘born’ of the union of reproductive substance and technological innovation” (21). Haraway (1997) also challenged the idea of biology, distinguishing between the body itself and the discourse of the body. Haraway (1997) contended that “establishing identities is kinship work in action,” adding that kinship as a technology produces the material and semiotic effect in that “kinship is about both kinds of membership and kinds of liveliness” (284).

In this chapter, I combine aspects of the aforementioned theories to examine how the women in this study define their kin relationships and the meaning of parenthood. In addition, I examine the emergent subjectivities that arise in their everyday experiences, histories, and local social world. I explore their inter-subjectivities as it involves practices, negotiations, and contestations with others to whom they are connected. Lastly, I examine how they see themselves and how they believe others see them.

Involuntary Childlessness in the United States

Prior to the 19th century, in colonial America the family unit was a changing and flexible household, which included children, step-children, and related dependents. A model household had at least six children, if not more, to meet the demands of rural life in America (May 1995). May (1995) dispelled the notion that infertility or the inability to have children is a recent phenomenon. She argued that the meaning of childlessness has changed with the structure of the family: as the family unit became focused on the married couple, the value of biological children born to that couple increased. In the early- to mid-20th century, the “culture of matrimony” was an established norm, limiting women’s marital and childbearing options. Motherhood was the most exalted role in life, and women who did not meet this norm were considered abnormal (May 1995:69). In the earlier part of the century, women who were unmarried or without children could play respected roles in the family. As time progressed and the development of medical technologies addressed infertility, women unable to produce children continued to be stigmatized (Goffman 1963; Marsh and Ronner 1996).

The decades following World War II brought economic prosperity to the United States, along with a baby boom. The idea of the family centered on personal fulfillment and the success of the country. As birthrates increased, the focal point was on the child (May 1995:135–136). Women who sought medical treatment for infertility markedly increased, even though treatment for infertility at the time was limited, encompassing a variety of therapies without much success. It was not until the mid-1960s, with the development of hormonal drugs to control ovulation followed by the first live birth from IVF in the late 1970s, that the institution of the family took on a new structure. Parallel to

the advancement of reproductive technology were a number of cultural factors, such as the growing women's movement, which questioned gender roles, changing meanings of sex, and changing definitions of the family institution (May 1995).

Notions of Kinship and In Vitro Fertilization

In vitro fertilization changes the way in which kinship is configured. As IVF continues to develop, so does the meaning of kinship. The options and alternatives with reproductive technologies may create many types of families, for example single mothers, gay families, surrogate families, and so on. Since the advent of IVF, conventional views of kinship norms no longer rely on natural biological closeness and the underlying culturally-constructed biological and social categories that previously defined kinship (Franklin 2013). Although the distinction between nature and biogenetic vocabulary differentiates family relationships from biological and technological perspectives, these theories retain an overly deterministic view that ignores the agency of human actors to illuminate important macro and micro level contextual influences in the development of new categories of people, and fail to account for what these categories mean to individuals. I argue that while IVF may assist in conception, its implications reach beyond the petri dish. Reproductive substance symbolizes, for the women in this study, a wide range of sentiments, from a fractured sense of belonging, to the kin group, to positive sentiments expressed in discourses of achievement, accomplishment, and fulfilling cultural ideologies and obligations in the kinship group

Findings

Participants' Notions of Kinship

In interviews with the ten participants, the women discussed the significance and meaning IVF played in the creation of their families. Some of the women stated that the point of IVF was to help them conceive a child who shared in their reproductive substance—the ultimate goal. Many of the women stated it was important to bear a child from their own eggs rather than adopt, use a surrogate, or use donor eggs. All of the women expressed some form of anxiety or tension in how they believed society perceives IVF (i.e., unconventional or second best). Several of the women continued to experience a sense of “difference” after the birth of their child when confronted by strangers or family members. The stories that follow describe the strategies they employed when encountering confrontations in a public setting by strangers challenging the biological legitimacy of their children and their normalcy. Many identified coping by avoidance, while others defended their status or educated people to understand IVF better. Additional strategies to cope during and after IVF included acquiring medical knowledge, forming new relationships, and seeking support through Internet blogs and chat rooms. I begin with Elise’s story, which shows what it means to have a child with assisted conception that shares in her genes and the importance of a generational connection.

Elise

As previously discussed, IVF was Elise’s only hope to get pregnant due to her husband’s fertility issues:

We had tried for a year basically on our own. [The doctors] said, “Don’t wait much longer.” They said there will be a day when he will be completely sterile. If you want a baby bad enough, you are pretty much going to do anything. Having a biological child, for my husband—having a biological child was the ultimate goal

and extremely important to both of us. I knew from Day 1 adoption would never be an option for me. It may sound callous. It is not for me. When they turn 18, they want to seek out their biological parents. That would be devastating to me. For me it would be hard to disconnect.

During this powerful account, Elise began to cry. Elise viewed adoption as a potential threat of losing her child. For Elise, a biological child ensured a permanent relationship. The notion of a biological relationship carries more weight than just permanency here; it carries with it the possibility of sharing in everyday life, an act of nurturing equated with parenthood. The forging of parent-child relationships is manifested through everyday practices, through acts of love and generosity generated over time through consistent and continuous actions. For Elise, ensuring a biological link between child and parent ensured the future relationship, as she described her fears of being unable to “disconnect.” This aligns with Becker and Natchigall (1994) and Bledsoe (2002), who found few infertile couples are willing to consider adoption, holding negative attitude towards adoption and fearing the child would later search for their biological parents.

Although her husband’s childhood illness caused a significant reduction in his sperm count, she hoped that IVF would provide an opportunity for them to have a biological child. This deep yearning to have a child despite the odds indicates her strong desire for a connection. Elise’s strong desire to emulate the image of her mother is associated with how she was raised as a child and the deep affection she has for her mother. For Elise, a sense of security was a shared genetic relationship with her children. She feared a child without this connection “may leave to find their ‘real’ biological parents, [her] life would never be the same, it wouldn’t be what [she] had grow[n] up [with].” It was Elise’s desire and expectation to have the same relationship she has with

her mother with her child, and for her, this could only be accomplished if the child was biologically related.

Elise's story shows her sense of moral obligation for biological continuity as an attempt to live up to cultural expectations of motherhood and generational continuance. Becker (1997) described the notion of continuity and a sense of obligation when an individual in the family has been ill. Although Elise's discourse did not specifically reference her husband's illness, it was a factor for her desire for biological continuity. I understood it as a much deeper need that she was not consciously aware of, or even a sense of devotion to her husband. Here, we are also able to see how Elise's sense of self was defined by fulfilling her role as a wife. Somewhat later in the same interview session, in response to a question about the importance of having a biological child, she responded:

Because we made them. They came from us. My husband and I created them from love. . . . Having a child for my husband was my ultimate goal. Regardless of how it happened, the end result is the same. The reason we did it was the same. So how it went in the middle doesn't matter.

For Elise, the desire to have a child "for my husband" and viewing the child as the "ultimate goal" are symbolic representations in the definition of family. For Elise, the importance of having a biological child meant that the family would maintain its solidarity through their shared substance, egg and sperm, avoiding any threat of losing her child in later years.

In adhering to the medical regimen of IVF, her action was an act of love. It was both a symbol of her identity and a symbol of the love for her husband and their togetherness. It was the desire, the intent to have a child "made from them." Elise's actions thus became a substitute for the conjugal relationship. I found this interesting;

how biology to Elise would guarantee family solidarity in this day and age of divorce, or even children relocating to other parts of the country or world for education or employment. As Elise's story continued, she talked about her desire to have another child, despite the seriousness and risk of her health during her first pregnancy. Women's willingness to take inordinate risks was also found by Douglas (1966), who observed that women would sacrifice their own health and well-being to conceive and bear a child.

Elise described how when her daughter was two years old, she wanted to try IVF again to have another child. She wanted to provide a sibling for her daughter. She described the close relationship she had with her sibling growing up, and how she wanted the same experience for her daughter. Elise returned to the IVF clinic: "We had some frozen embryos left and we decided to go ahead and try with them and it didn't work, they didn't survive the thawing." For Elise, this was "absolutely devastating" and she was "heartbroken" that she would not have another baby, saying, "I never thought I would only have one baby." Elise also described her disappointment when her husband David refused "to go broke to have another baby," saying, "Maybe someday in the future we will reevaluate, but right now we just can't do it." This process would have been expensive. They would have had to start from the beginning with harvesting eggs, which they could not have afforded. They had already borrowed money from Elise's grandmother that they had not been able to pay back. She agreed with her husband's logic and acknowledged the financial burden that it would entail: "In my heart I knew he was right, but it didn't change anything. It didn't make it any easier. I still wanted a baby and that wasn't going to change." As time progressed, Elise felt that she was "finally okay" with the idea she would only have one child, believing that she had to "count [her]

blessings and someday, you never know.” Another year had passed and Elise continued to hope that she would become pregnant. Coming home from a family vacation, Elise noticed that she was having bouts of nausea relieved when she “ate a cracker or something.” She began to suspect she could be pregnant.

So I broke down and took a test. I was so convinced that it was not even possible that I could be pregnant. . . . I had this stupid period tracker on my phone that is supposed to tell you when you are fertile and all this stuff. I bought two tests and the digital ones because I didn’t want any confusion with the lines. I got the digital one that says “pregnant, not pregnant.” Sure enough it was positive. I took a picture of the test. It was one of those half-hysterical, half-laughing times.

Even with her prior history of IVF and the odds against her, Elise continued to monitor her ovulation cycle, hoping for a “miracle” to have another baby, a sibling for her daughter, to share in the same experiences as she had growing up in a loving family.

I asked Elise to describe her experience of becoming pregnant without IVF. Elise began with the details of her first complicated pregnancy (she had a rare hemorrhagic condition), then compared her first to her second pregnancy:

As far as IVF goes, I do wonder a lot now if there is a correlation, some truth to a correlation, between IVF and my complications. I have read a lot, I do a lot of research myself, and there are a lot of doctors and scientists that believe there is a correlation, just given the fact that I did have another pregnancy that was conceived naturally and I had absolutely no complications whatsoever. I think about that. . . . It was meant to be.

Elise attributed the serious complications in her first pregnancy to an assisted conception. Scientific technology was needed for her to become pregnant, but becoming pregnant without assistance to her proved that nature overrode technology. Her conclusion was based on an uncomplicated natural second pregnancy. Elise’s comment that “it was meant to be” correlates with her initial statement that it would take a “miracle” for her to become pregnant without assisted reproduction. She negotiated between the power of

science and technology and nature. Elise's story and the experience of her body as "naturally ordered" and superior to technology restored for her a sense of "normalcy." Although IVF was a means to have a child, how the child was conceived was equally important to Elise, as was also the case for Dana.

Dana

Dana began by describing her IVF experience as an experiment. In seeking medical treatment, Dana's story reflected the same perception she experienced in her daily life: infertility was abnormal and her body was transformed into an object of scrutiny. Dana's personal and professional life course was disrupted by infertility. For Dana, IVF was the only option to regain control of her body. Conception required education, perseverance, and work, and was a goal to be achieved. Strathern (1992) proposed how women become consumers of ART technology, shifting from the role of the patient because they need to make choices and decisions about these technologies after in-depth self-education. At the same time, their identity is undergoing changes when placing their bodies at risk. Dana's story is a clear example of how she educated herself as a consumer of this technology.

Although Dana knew when she got married that she may have difficulties getting pregnant because of her endometriosis, she did not believe that she would ever be so desperate as to need IVF:

I was trying to avoid IVF. I was trying to give all the possible intervention of trying naturally to using Clomid, IUI, all the things that lead up to it. The thought of IVF was just daunting. That was something other people did when they were desperate I never saw myself doing necessarily. I had a very scientific approach. I was learning everything I could so that I gave everything 100%. I charted and everything like that. I was very dedicated to what I could do on my end.

Even though Dana had a dynamic career, her statement reflects the feeling of life being out of control. There was a deep sense of depersonalization. She became an object, a scientific project that she actively participated in to achieve a goal. She went on to say:

You wonder if, in a very nonscientific way of looking at it, if it is maybe forcing nature's hand, and at some point there is going to be a repercussion for that. It is so bastardized by that point. It is not even remotely how it is supposed to happen. We bastardized conception.

In an effort to achieve conception, Dana became immersed in the medical treatment of IVF, entering into a very different model of conception. Her view shifted from the familiar model of a conjugal or natural conception to forcing nature's hand and fears of repercussions. She described not only how infertility disrupted her expected life course, but also how she was then left to sort out for herself the gaps between the medically-achieved conception and the meaning of her reproductive life outside of that frame of reference (the laboratory). I asked Dana if IVF met her expectations. She responded: "No, it is not an exact science. My doctor—I tried to ask his advice. I would say, 'If your wife was in my situation . . . ' and he would never be able to give me a definite—I felt like I was a giant experiment with the whole thing." I asked Dana to share with me what she meant by "experiment." She responded:

They harvested the embryos, and every day you would get a report that so many survived and they are this grade. You are trying to project when they are going to implant them. Every aspect of it was like you were going through the process with your doctor in a lab as they did this experiment that was ultimately going to result in a baby or not.

I then asked Dana since she felt IVF was not how conception was supposed to happen, if she ever considered adoption. Dana described how friends and family suggested adoption, to which she replied, "You can always adopt—like that is a comparable thing, like apples to apples and it is not." She went on to say:

Part of the point—and not to sound elitist—the point of IVF was that this child would be a product of your union. If we were going to go to that length, if we were going to go through IVF with all the unknowns of adoption, [biological ties] would have to be part of the package.

Dana referred to IVF as an experiment, her expectation the results would produce a biological child. I understood Dana to mean she felt like an object in an experiment, willing to participate as long as she received her reward, a child. Similar to the work of Ortner (1995), Dana’s discourse was “conflicted” (179), resistant, and ambivalent in how she had to conceive a child. She was left without an alternative, her choice between the technology that she needed to have a child and the way in which she wanted to conceive the child. She went on to clarify her decision to pursue IVF instead of adoption: “At the end of the day, you view an adopted child as your own. In the back of your mind you know it is not a product of your genes.” Dana’s insistence on a genetic connection is knowing and preserving lineage, race, and class when she makes the comment not to sound “elitist”. Again, Dana equated the idea of adoption, (not knowing the child’s genetic inheritance) to mean the child would not be “comparable” or would be second best compared to a child of their genetic makeup. The idea of a biological child (the best), is in this sense what she considers to be a normal family. For Dana, part of her identity (white middle class) as a mother relied upon having a child that shared in her genetic makeup.

Shortly after her child’s first birthday, she thought about having another child. She described her fears during her pregnancy and after the birth that something could still go wrong. She returned to the IVF clinic: “We had tried FET, frozen embryo transfers,¹⁰ from the previous IVFs and they didn’t work. We were like, ‘We are at the end of the

¹⁰ Frozen embryo transfer is a surgical transfer of the embryo into an IVF patient’s uterus.

rope here. Maybe we should just be happy with one and move on.” Dana did not give up hope and continued to consider how she could get pregnant without IVF. She attempted her own experiment:

I had some leftover meds. I had a suspicion all along that my problem was luteal phase defect,¹¹ that it was a progesterone issue. I had leftover progesterone from some of my cycles, so without telling my doctor I charted and started taking the progesterone. So my first cycle I tried this. I got pregnant and miscarried. That was the first time I had ever gotten pregnant outside of a thoroughly medicated experience. The second month I didn't get pregnant, and the third month I got pregnant with my son and carried him to term. I do think there is a correlation there. It is just too big of a coincidence. We pretty much started trying as soon as I stopped breastfeeding. We had been trying for a good one-and-a-half years. For that to work with the little amount of intervention tells me that I was onto something.

Dana's expression and voice conveyed a great sense of pride as she described her own risks and her determination to conceive without IVF. She went on to describe her success: “It was just my own little experiment. We had nothing to lose. Neither of these things was going to hurt me any more than what I had already done.” Strong in her belief that her body was not like other women's bodies, that she ovulated earlier than what the doctor and medical science indicated, she self-medicated. Despite having to use her leftover medications, she saw this as taking control of her body. Dana was quite confident that her experiment would be successful: “My husband was correspondingly very cautious, like, ‘Don't get too excited. I don't want to see you get upset if this doesn't work.’ I was like, ‘This is going to work.’ I just knew. There was no doubt in my mind.”

Dana then described how she felt when she learned that she was pregnant:

I got the call, and they said I was pregnant but the number was low. There was no doubt in my mind, and I was perfectly happy. Yeah, I did it. We are going to have another kid. That is really saying something, because I am a chronic worrier. I

¹¹ Luteal phase defect occurs when the endometrium is inadequately prepared, either because the secretion of progesterone by the ovary is below normal or because the endometrium isn't responding to the normal stimulation by progesterone.

have to have evidence. I just knew, and my husband was so worried for me. We got to the three-month mark and I was like, “See, I told you.”

Dana took great pride in her experiment. She had taken control over her body with a little help from vitamin therapies and leftover progesterone.

In the making of family, IVF reinforces the cultural idea for women to produce biological children (Becker 2000:35). Dana felt she had no other alternative but to try IVF. However, the “right way” or normal way of procreation for Dana remained the traditional method. She felt changed by the experience despite having had a child with IVF. Dana’s perseverance to have a traditional conception was a way to regain a sense of normalcy and to realize her life plan and her image of parenthood. Throughout my interviews with Dana, the sense of responsibility to create a family rested upon her shoulders. Despite her belief that procreation should be natural, Dana never entertained the possibility that sexual intercourse with her husband would result in pregnancy because of his low sperm count. Instead, the meaning of a natural conception also required some assistance. This also aligns with Becker (2000), who in found women who underwent ART continued to evaluate their bodily knowledge, changes they saw in themselves, and to tried to make sense of their experience (36). In contrast, for Susan, IVF was an opportunity to have the child that nature denied her. Having maintained her pregnancy after her critical illness, Susan wanted to be seen as normal more than ever, and wanted to be recognized socially for her ultimate maternal sacrifice in the making of kinship.

Susan

In the previous chapter, I described Susan’s experience when confronted by her neighbor at a party, and how Susan explained how her children are a result of her and her

husband's combined contribution, their eggs and sperm. Does IVF cast doubt on a child's biogenetic fit within a family? I probed further to understand what Susan's social perception of IVF was and to understand what Susan meant by contributing to "making" a family. She stated,

For me, family is an accomplishment. The big thing for me was I didn't just want to be a mom. I wanted 'us' in those kids. I wanted to be a cohesive, biological family. That's what family means to me. I identify with my parents. I want the same for my kids. I want them to identify and see that they are a part of me, and that we are family and there are identifiers there. There is no question: We are all part of each other.

Susan's response evoked her cultural ideas of family, characterized as biological components of substance—"my stuff and his stuff"—relating to their egg and sperm. Attempting to live up to cultural standards of how she envisioned family, she publicly shared her experiences of IVF. I understood her insistence on a biological relationship with her child as an insistence on normalcy and social acceptance. An integral component of what family meant to Susan and why she chose to try IVF was the opportunity to have a biological child who shared their reproductive substance and had shared "identifiers". Sharing in their genetic make-up proved their kinship and their status as parents and a family.

One way biological terms work in kinship is to characterize family relationships. The example above is illustrative of how ART enacts, in effect a particular model of nature, by which nature is maintained in the form of genetic inheritance. In Susan's discourse, we can understand the importance she gives to the primacy of biology as working in two ways: in identity, being able to trace your lineage, the importance and validity of keeping the bloodline (genes) pure in the preservation of the family. Secondly, genes are linked to ideas of success, intellect, and moral character and are embedded in

ideas of purity and superiority, a valued characteristic of American population (Quiroga 2007).

Susan talked about how her expectations during and after her pregnancy changed because of having triplets. She described how she was not able to do the things that normal pregnant women do, “the progression of we are pregnant...the baby is here...[and family] come to the hospital to hold him or her. I didn’t get to hold them. They took them away. That is normal for me”.

I asked Susan if she feels her family is normal now?

She responded:

What I mean by normal is that they (triplets) are 100% on target five year olds growth wise, emotionally, physically, academic[ally] everything. You don’t hear that often with multiples. There is no setback for my kids. I truly believe that the triplets and the journey that we went through to get them and everything after the IVF [referring to her severe infection], they are here for a reason. I feel like I was a conduit... almost to greatness [that] these three little people are my mark. Something they do or the people they are going to be...[like find the cure for cancer]...they are my greatness.

In the excerpt above Susan associates a “normal” family with attributes of success, superiority, and who they will become. Their potential for “greatness” is through her genetic makeup (as she refers to herself as the conduit), to mean both Susan and her children will be seen as “great”. Rayna Rapp (1978) asserts how American white middle to upper class identified with “who they are” and what they hope to achieve, as a signpost of a “normal” family. She asserts that achieving a normative family comes with substantial and differential costs to both men and women with reference to household incomes (295). Here, we have both emotional and financial capital to achieve a “normal” family.

Wanting a child that shared in their genetic makeup was also the reason Elizabeth and her husband considered IVF.

Elizabeth

After the birth of her son, Elizabeth did not return to the accounting firm; she chose to stay at home. After all the years of sacrifice, Elizabeth wanted to have “quality time” with the baby she had waited so long to have. I asked her what it meant to her after all the years of trying to finally become pregnant and become a mother:

Elizabeth: Just grateful, that I was going to become a mother and that my body was going to produce a child. [I was] still nervous though, because I had had two miscarriages. So until we got through at least the first trimester, I was still very nervous that my body was not going to continue with the pregnancy. I had two IVF procedures and the first was not successful. The second one was. The second time, [I was] much more worried that my body was not able to have a child.

Interviewer: Tell me about your husband during this time.

E: He was just very supportive—very positive person. I am the worrier and he is not. He would say things like, “We can try again. They are not telling us this is the end.” He was my rock. There were many nights when we just sat here and he just hugged me. He was much more convinced that it was going to happen than I was.

I: What was his role in the decision to try IVF?

E: It was very much definitely a combined decision. He very much wanted to have a child and have our child. He knew that it was very important to me to have our child. We thankfully . . . were in the financial position that was not really an overall consideration that we had to make. I know that a lot of couples don’t have that. Because we had gotten married later in life and I was on house number two and my master’s, we had a nest egg enough that we could do it. It was not really a financial discussion between the two of us. It was almost like, yeah this is the next step. It was not even a do we do this or don’t we do this? It wasn’t a huge discussion, it was the next step. This was the next step in what we would have to do.

I: You said “our child” very emphatically.

E: I wanted to have our child just so that it was our child with our genes. The motherly, fatherly desire to carry on your own body. I personally wanted to go through the whole pregnancy process and birthing just from a personal standpoint.

What emerged from these excerpts is the presence of children in defining a family and, more importantly, the insistence of a “biological” relationship between the child and

parents. In addition, Elizabeth and her husband were prepared financially to ensure that they achieved the “next step” in making their family. In the excerpts that follow, Elizabeth shared the disappointments and frustrations of IVF trials that do not work, which threatened her expectation of family as an important social institution. We continued:

Interviewer: Looking back did IVF meet all your expectations?

Elizabeth: It did. I think primarily because we were able to get pregnant. It was a little disheartening that the first time we got pregnant, we had three that were able to be implanted and we did not get pregnant. The second time I was more nervous. The second time we had five implanted and got one child.

I: If there was something you could change about the whole process what would it be?

E: I think the process itself and the people we dealt with were good. I think my most problematic area in terms of IVF isn't with the process itself, it is more the social reaction to IVF.

Elizabeth was not comfortable in sharing with anyone that she had elected to try IVF, and even years later, her experience with IVF remained private. She was concerned that members of her family and friends would not be supportive or find this form of conception acceptable, and that she would be judged, saying:

We told very few people that we went through this partially because my perception is that people do not understand it, and people don't understand the desire to have your own child and what you have to go through to get a child. It is almost looked poorly on or people don't understand. I didn't want to be judged at all.

Although Elizabeth was able to have her first child with assisted conception, her feelings about assisted conception remained complex and reflect an internalization of failure in her body's ability to become pregnant. Elizabeth experienced the tension of her own ideology of wanting her “own” child with how she may be perceived:

I don't know if this is possible—we could get information out that people will understand that this is a medical procedure like, if you had cancer you would have radiation or chemotherapy. It is no different than that. The perception is different I

think in that people think you just go have a baby. Just go have a baby. It is not that easy.

In one example, Elizabeth explained the internal conflict she felt when she went to church one particular Sunday, a place where she should feel at peace, accepted, and above all, not judged. The priest's sermon was on procreation and the priest stated, "Procreation between a heterosexual couple is considered natural, where as procreation in any other form or relationship is not." Elizabeth recalled what that meant to her, that Sunday in church:

Elizabeth: One thing that really struck a chord with me and I really had a hard time with—after we had gone through it all, we were sitting in a mass and something came up about fertility and abortion and things like that which obviously comes up in the Catholic religion. The priest mentioned speeches that he had done on it. I listened to a couple of speeches that he had given and I burst into tears. He said IVF was against God's wishes, it was a sin to go through IVF because if God meant for you to have a baby, you would have a baby. I just didn't know how to react—this is my priest who I look up to, and he is saying this. But my perception of it is that it is a medical procedure and we are given these technologies and the medical profession has these technologies to accomplish this. Again, if you had cancer would you say, "God wanted me to have cancer" and just die? No you wouldn't. The perception is just that it is different. My mother-in-law to this day does not know that we went through it. We will not tell her. I know she will have a huge problem with it. To me it is more just the perception of what IVF is and why you do it?

Interviewer: Why did you do it?

E: Because I wanted to have our child. I wanted to have that experience.

I: Do you think people understand IVF?

E: I think some can. I think some really can. We chose to be very selective in who we told just because we didn't know how people would react. To a certain extent . . . [it's] about your body, some of it for me I think subconsciously was that it may be looked at like there is something "wrong" with Elizabeth because she can't have a baby. It is that body, I am not like other women. It is not as easy to have a child and because, as you see, I get very emotional about it. I didn't want to be emotional with people. I didn't want to have to explain the reasons. It was our decision.

Women going through the process of IVF frequently isolate themselves socially.

Women choose to avoid questions on their progress, finding it both painful and difficult.

Elizabeth rarely attended social gatherings for that reason. At one event, she discovered a good friend was pregnant, relaying:

It was extremely hard for me because I kept thinking to myself, why can't I do this? Why can't I do this? Knowing logically that it wasn't necessarily me, it was just the situation we were in. I think it made me very determined. Extremely determined because I was going to make this work.

As the excerpt above attests, Elizabeth feared she would be perceived like something is “wrong” with her. Feeling her choices may have been “immoral” or “sinful,” following the discussion in church, conflicted by her own moral values. This is similar to the findings of Becker's (1997) work, where the women's discourse illuminated how society views morality, and how cultural ideologies are embedded in moral discourses.

Approximately nine months after Elizabeth had her first child with IVF, she had an unassisted pregnancy. She talked about the mixed emotions she had during her first pregnancy with IVF, her continued fears that she would have another miscarriage. She remained anxious throughout her pregnancy fearing that something would go wrong. She did not share with anyone outside her stepmother and father that she had a pregnancy with IVF, despite her close relationship with her siblings. In her second pregnancy, her sense of difference transformed from a failed body to one that was repaired:

Understanding that it just is what it is. I guess it goes back to just me wanting my body to be like everybody else. Now I know that it can be. It doesn't matter how we got pregnant the first time. I don't know if it would be different if we hadn't gotten pregnant with [a second child] on our own because really I was able to have a child, then two, one with IVF and one without. Just thankful that there are technologies today that enable us to do that, to help our body do, for whatever reason, it can't otherwise do on its own.

Women in the quest for a child with IVF often imagine motherhood and family much like their own families, or how their relationships with their families may change over time, and their own desire for a family. Memories often are linked to imagined

futures of family, types of social bonds, and relationships. They may imagine the people within their family, the personal ties of parenting, nurturing, and sharing; and people's existence embedded in past family relationships, in sounds, smells, affect, and tales of past ancestors and kinship ties (Becker 2000). I understood the biological imperative as a way to connect with her deceased mother. Elizabeth's mother died when she was a child, and her stepmother raised her. She talked about how close she was to her stepbrother and sister. She portrayed her stepmother as very loving, saying she was "just the best, and I love her to death. It is kind of weird, you want to have the biological connection but does that really matter?" I turned to Elizabeth once more and asked, "Does the biological connection matter?" She responded:

Elizabeth: Interesting, when it comes down to it, I don't think it does. I think it is more a personal thing that you want to "pass on your genes." You want to have your own. The loving, the upbringing doesn't make any difference. For me, I think, it was knowing that I could have my "own child," and yeah I guess it is, she is like you, he is like his dad. That is the ten million dollar question. Maybe some of it goes back to the social perception, if you don't have your own children, there is always that question in someone's mind, "why not?" My daughter has a very good friend who is adopted and the mom and I are very good friends. She has never gotten into the reason why they didn't have their own children. Again, I think it becomes the social perception of "why didn't you have your own?"

Interviewer: You believe there is a social perception?

E: Like I said about my perception, about why I didn't tell people because I didn't want to have to explain. I didn't want to have to admit to somebody that there was something wrong. There was. There is nothing wrong with the fact that there is something medically wrong. But the perception is that it is supposed to be easy. People are just supposed to be able to have babies. It is just suppose to happen. People are supposed to get married; people are supposed to have children. It is just supposed to be that simple. It is just more of the social perception that changes things. Having to explain because it is such an emotional situation. It is difficult to have to do.

This excerpt identifies specific cultural expectations of what was "supposed" to happen in Elizabeth's life course. She experienced profound anxiety when confronted with what she

believed she was supposed to do and what she was able to do. I returned once again to understand why she felt she was “supposed to have her own child”:

I don't know if it is just you want yourself to carry on. I think for my husband, he is the last one in his family. His family genealogy, he is the last male . . . the last one to carry on the name. Not that our adopted child wouldn't, but I think it meant more to him because it is that carrying on. I think to a certain extent sometimes I even look at my own children, and I will see my dad in him. I think the physical features are what maybe permeate that reason more so, that it is easier to see those physical things; maybe it is more of a connection from the physical part of the people that came before us.

There is considerable literature on the reasons people pursue having children: someone to care for aging parents, perpetuity, descent, and continuity through the generations (Becker 2000; Fortes 1969; Schneider 1968). Here, Elizabeth described what it meant to her and her husband to “carry on the name” and by “carrying on their genes,” ensuring the lineage between child and parent. The cultural expectation of biological continuity is underscored in the death of a family member, here in the story of Elizabeth's mother as her father tells her that “you are your mother . . . I see your mother in you every day” on an important day for her, graduation. The excerpt illuminates the notion of maintaining generational continuity through biological linkages, also found in Becker's (2000) work. Continuity is one significant reason why people go to such lengths to bring about conception and why they consider ART; to do otherwise would depart from normal behavior (Becker 2000:213).

Elizabeth: I named my daughter after her. I “created” a connection so she would live on. We want to live on. My stepsister [was not] my biological sister but lives on in my daughter. My biological mom passed away when I was eight years old, I mean I am part of her. I will never forget my Dad at my graduation whispered in my ear “you are your mother.” He said, “I see your mother in you every day.” That's the piece that doesn't go away, the physical piece . . . that you can't recreate. . . . It's the physical part that lives on.

Elizabeth continued, telling the story of her stepsister's death while trying to get pregnant, her grief, and the special closeness they shared. Even though she was not her biological sister, she created a connection with her stepsister:

Interviewer: How are you like your mother?

E: Your biological parents just become a part of who you are. It is like the million dollar question: why do some adopted children want to find their biological parents and some don't? It's also a connection, a spiritual connection.

In the excerpt above, Elizabeth valued the physical resemblance she had to her mother, and wanted to create a connection with her step-sister. She valued the relationship she had with her, and wanted to honor her memory in naming her daughter after her. The insistence in our discussion on the biological connection moved towards the value of a spiritual connection.

As Elizabeth and I continued, she described the very deep, lasting pain and sacrifice of going through IVF. She talked about the deep spiritual relationship she had with the process. She remembered the time when the priest commented on IVF not being God's will:

I have had to try not to think about that. It really bothers me a lot. It is a spiritual connection, and it is—you think I didn't pray every night? Really? Then to tell me I am a sinner. [Laugh] It is like, oh my, what we have done is wrong by using the tools that are necessary? No. It is not wrong it is smart. . . . Nobody can truly understand what it is like to go through it. You can't unless you have done it. To appreciate it, not judge it, and just view it at face value to a certain extent that it was the tool necessary. To respect the feelings of those that have gone through it. Some [women] can be very vocal and some can't, because it is so personal.

My discussions with Elizabeth illuminate the enduring complexity that surrounds this technology. For Elizabeth, support from family and the lack of support from her priest were expressions of the moral force of cultural ideologies.

Tanya is in her late forties, a mother of adolescent triplets, and works as a chemist in a satellite laboratory for a national chemical firm. Similar to the other participants Tanya and her husband sought IVF to have a child that shared in their genetic makeup. Adoption was not something either of them would consider because of the unknown that came with someone else's genetic makeup. I asked Tanya to tell me about her family, and what family means to her. She told me how much she had enjoyed the triplets in their preschool years before they were diagnosed with Autism.

Tanya: Well, when they were born they were healthy but then two of the triplets developed asthma and other medical issues.

I: How did the other medical issues affect your life?

T: Well, it wasn't what we expected we had tried for so long and then to have children that were ill is not what we had expected.

I: What did you expect?

T: Not much, what ever happened happened until it did. I didn't have any idea of what my life would be like, but I didn't expect triplets and everything that came with that. I guess I thought we would have an everyday normal family.

I: What is an everyday normal family?

T: I thought everyone lived like us. Everything, our education, buying a home, we lived in a nice community and were exposed to a lot of different things, activities and sports and culture.

I: can you tell me more about the triplets

T: At first they were okay, normal kids, we could deal with the asthma but then when then they were diagnosed with Autism. We weren't prepared for that, everything changed.

According to Rayna Rapp (1978), for all classes of Americans family has two meanings, the first is normative, or the nuclear family. The other meaning includes kin relationships through blood and marriage (280). The family expresses a certain ideology, a distinction between norms and realities (287). Tanya and her husband had been unprepared for the diagnosis of Autism for two of their three children. The concept of an American family is associated with the good life (285). Tanya and her

husband were oblivious to the privilege of their race (white) or class, as Tanya portrayed how she believed everyone lives their life (education, sports etc).

Kin Networks

When I asked the question to the participants, “Who makes up your family, and what does family mean to you?” I received fairly typical responses including spouses, parents, siblings, and children. As the women continued to describe members of the family, various conditions arose: whether there was a good relationship, if they were supportive, and the image of family created by their experiences growing up. Friends became members of the family because they were more supportive and less judgmental than biological relatives (e.g., mothers-in-law, siblings, and parents). As I continued to probe into the meaning of family, they described their childhoods and their family dynamics growing up. They also shared what they hoped to create in their own families in the future.

Elizabeth’s Conception of Kinship

Returning to Elizabeth, she said:

Elizabeth: I think your family is who is there with you, who raises you. A lot of what I define myself now through is in relation to my family. What do I do? I volunteer at school, at the church, most of what I do has to do with the kids. It is all relative to the kids, which then still absolutely fulfills me. I do it because our kids are what is important to me and how they grow up is what is important to me. I do absolutely think that has changed from what I thought it would have been.

Interviewer: How so?

E: In my mind the most ‘optimum’ way of family is traditional, man and woman perspective. I think that just comes more into play with somebody’s own moral thoughts. . . . That goes back to the very first question, our child versus an adoption. I think . . . perception is that adoption is second best. It’s not just the generations that get carried on but those that are carried on through relationships, . . . the biological piece that carries on, . . . the connection knowing that there [is] a certain relationship through your genes.

In the excerpts above, the meaning of family to Elizabeth is described as the “optimum” family, a family that shares “biological ties,” “connections,” and relationships. Elizabeth and her husband’s decision to pursue IVF were intertwined with multiple historical processes, life experiences, and what mattered the most to them in their lives— biological continuity and preserving the memories of ancestors. The transformations Elizabeth encountered over the years did not occur without a struggle, experiencing significant conflicts, sacrificing her own health to bear a child. She worked simultaneously to address a multitude of competing imperatives: the moral force of cultural and moral ideologies, the need for biological continuance, the quest for parenthood, the responsibility of becoming a parent, and the experience of her body during and after medical treatment. Using Elizabeth’s words, “it was all worth it to make our family.”

Melissa

Melissa was 38 years old. She worked full-time as a health care professional. She was married and a mother of triplets. Melissa said she was overjoyed she was getting a “complete” family all at one time. I asked her what she meant and she replied, “You know, where everyone is related to one another.” Melissa’s parents were divorced when she was a toddler, and she described her family as a “mixture” between step-siblings and her own biological sibling. I asked her: “What does mixture mean?”

Melissa: Divorce is more common, and it changes a family, but I think IVF is still about a biological family. It is still yours and his genes and still your biological kid. I do think it is changing. People are adopting. People are having surrogates and not necessarily their gene make-up. I think that it is still their family.

I: Who is in your family ?

M: My husband, my kids, my parents, my siblings, my close friends, my dog. [laughs] Extended, like, aunts and uncles I still consider that [family]. I feel that

family can be extended to close friends that you are closer to than even family, meaning cousins, and people like that, that I never see.

I: So you included close friends. Why the close friends?

M: Because they are still like family to me. People that you can count on and share things with. They share in your kids' lives.

I: Can you count on members of your family?

M: Sometimes. A traditional mother–father family isn't gone. But its expanding now. A mom on my son's hockey team adopted a child from another country. Her sister did the same. The boys have a bond even though they are not related. It's cute.

I: What do you mean by cute?

M: It's cute, because families are about a bond. Someone you can depend on and trust.

I: In what way do you need to trust them?

M: I would consider it someone that I would trust to take care of my kids. Trust[ing] someone with my children. Knowing they are safe with them.

I: Who would that be?

M: My Mom! Besides her, I have one close friend. She is is my children's godmother. I would trust her.

I: Are there other members you would consider?

M: Yes, my immediate family, like my Dad and brother.

In this excerpt, family is described in several ways: a mixture between step (non-biological) and biological relationships; trust and support; however, IVF is “still about a biological family, it is still yours and his genes.” For Melissa, confidence in knowing her children would be safe and take care of is the responsibility and obligation of immediate family members. Despite Melissa stating families are changing and expanding, she defined the roles they would play in her children's life. IVF provided Melissa with a “complete” family, another way to describe a “normal” family. These themes were continued in Jae's emotional recount.

Jae

As Jae told her story, tears streamed down her cheeks. She hesitated for a moment before she began to describe her first ectopic pregnancy. Jae stopped briefly and then began to share how the pain of repeated “failures to get pregnant and stay pregnant”

consumed her life day after day. Jae tried IUI, had a miscarriage, and at that point she said she hit “rock bottom.”

It was really after that point that I kind of slid into a depression, that kind of stuff. [crying] I didn’t want anything to do with fertility treatments for a while after that. We started the adoption process. That gave me a renewed hope. I told my husband, I can’t keep doing this. I need a sure thing.

Jae and her husband begin to explore the idea of adoption:

We started talking to agencies and going to info sessions in town, actually picked an agency out of Texas and sent in our applications, we did our physicals. My husband said we have to make a choice here, we try the in vitro one more time or we move forward with the adoption. I was like I just want to do the adoption. He said this is a \$20,000 decision now, if we go through with the adoption.

Jae agreed to try IVF one more time:

Jae: I was like, if this fails, [sniffing] I am done for a while. I got pregnant with triplets. We transferred two embryos again and one split. I had identical twins and the third too.

Interviewer: Besides the financial reason of balancing the cost of adoption versus IVF, why did you choose IVF?

J: We both wanted our own child too. Ever since I was a kid I wanted nothing more than to be a mom. I did want my own child. Even if we had gone through with the adoption, we wouldn’t have stopped fertility treatments. We would have done it again. I would have felt a lot less pressure. We would have probably adopted one and tried fertility treatments again. I just couldn’t take any more failures and losses at that point. I needed a break at that point and to go into something that was a sure thing. We never questioned doing the in vitro, never.

I: What do you mean by, I wanted my own child, to be a parent more than anything?

J: I just loved kids, since I was a kid I just wanted to be a mom. I wanted a ‘biological’ child. I wanted to experience pregnancy and childbirth and having my own baby and taking care of it from the minute it was born. I just wanted the whole experience.

I: What does it mean to you to have your own child?

J: I want my “own family.” I feel like the family I was born into was a mess. It really got bad after my dad died. I think that is why I took my infertility so hard too. I was like “Oh my God, I was going to have my own family, I was going to “create” my own family unit and now I can’t.” That was a big problem for me too. I feel like, to me, it is very important even thinking about the relationship that my mother-in-law has with my husband and her other son. I will never let that happen. I will always keep my kids close.

Jae alluded to the fact that her family experienced a significant loss when her Dad died. Her family did not come together during their grief, but rather became distant. She described the turmoil, arguments between siblings, her mother's grief, and her inability to take "control" over her older siblings to stop the fighting. This experience left a lasting impression on Jae. She described her life as a series of unfortunate events, and her family as dysfunctional. In describing her dysfunctional family, I understood Jae's desire to have a biological child to mean creating her own family in the way she believed a family should act towards one another.

Interviewer: You said a couple things to me. You were defective, you missed out on things. Can you help me understand why you feel defective?

Jae: I just felt like, what did I do to deserve this with the fertility treatments? [Crying] This is going to sound a little woe-is-me. My life hasn't always been kind to me, all my life. I felt like if I had to struggle for stuff, why this? This is the one thing that I prayed would never happen to me, and it did. I was so mad because it didn't just affect me, it affected my husband. I just felt really bad that he had to deal with this too. I was not just a physical disaster, but a mental disaster.

I: How do you feel now?

J: I don't really talk about this that often because I do feel like it was a different lifetime and I am glad for that. It is like, come on, this does not rule my life. I think about this next to never now. I feel like it was a different me that existed for a couple years and thank God it is not anymore.

Jae described how she had struggled in her life, losing her father and then her best friend in high school. Jae left home to go to college to get away from her dysfunctional family and worked very hard to complete her degree. She said that nothing had come easy in her life, not even having her children. Now that some time had passed I wondered if the family she had "created" was what she had hoped.

Interviewer: What does family mean to you?

Jae: That is a good question. I think it means the people who have your back or are supposed to have your back. For me, it is more important to me [to be] a mother than a wife. My family, I would consider dysfunctional, the family I grew up in. I had a mom and dad and three siblings. I want to be sure that as a "family

unit,” I am the first person you rely on. I want to be sure that when you think about what you are doing you better ask your parents. I want you to want to come home for the holidays. I want them to think of me as their parent, of course, but just like someone you actually want to spend time with. I do want to keep my [kids] close.

What emerges from Jae’s story is how the history of past disappointments in life affected her desire to control her future, how she imagined what a family should be. The tense and unsettling relationships with her family were not how she believed a family should act towards one another, unreliable and unsupportive. For Jae, IVF provided a second chance to create the “best” family, how she had envisioned a “normal family should be.”

Discussion

In vitro fertilization has served as a lens to examine the relationship between technology and society, and its impact on family definitions and dynamics. Although each of the women had a singleton or multiple births, they made complex efforts to cope with social perceptions of how conception occurred and what the need for IVF signified. They faced challenges overcoming their feelings of infertility, and their personal sense of difference when encountering various social interactions. An important part of the meaning of family consisted of relationships both from a biogenetic perspective, consistent with Schneider (1980), and also in the realm of relationships within and outside the boundaries of family consistent with Sahlins (2013). Many of these women devised strategies to overcome negative social perceptions. The strategies ranged from self-experimentation, to educating themselves in every aspect of infertility and IVF procedures, to establishing friendships or based on shared experiences.

The “normal” model of the family is constituted as the biological family according to Schneider (1980), however the advancement of reproductive technologies

such as IVF provide several options to afford some degree of biological parenthood via donor eggs, surrogacy, or the shared reproductive substances of both parents. At the same time, they produce only a certain degree of normalcy because they do not result from a traditional unassisted conception. The family conceived with IVF, at the same time, is normal and abnormal. Thus, IVF legitimizes hierarchal differences based on meaning, and ideologies of natural categories of reproduction and family.

Consistent with Schneider's (1980) theory, the importance of a biogenetic connection between child and parents remained for these women a vital element in the meaning of family. In the excerpts, the women were preoccupied with the idea of physical continuity between parent and child ('my stuff and his stuff'...our 'identifiers') as the basis for the acquisition of identity and belonging. IVF served not only to alleviate their infertility but also to fulfill the preoccupation of genetic inheritance. The preoccupation with physical resemblance may be interpreted in part, much like Wade (2009) who identified between appearance, race and kinship, similar to Thompson's findings (2001) how "genes and blood are differentiated" and that "genes have social categories built into them" (2005:181). The women's preoccupation with passing on their biological traits in the physical appearance of their offspring, are a code for a particular cultural identity, here a white middle class American woman.

This biological imperative may be thought to be especially significant given the degrees of genetic mixture in the United States, which is characteristically a "melting pot" of ethnicities, and races, and the foundation for making of distinctions between kinds. If the biological imperative is recognized as the basis for belonging to a particular (race) or cultural identity and family, then the failure to pass on certain biological traits

may be seen as the failure to pass on an identity and cultural belonging. In effect, the insistence in this sense, is not giving up on their (racial/cultural) identity. The implication differs from Strathern (1992) who suggested that the English preferred (mixed) genetic makeup to create “unique” English citizens, whereas white Americans work to preserve their genetic inheritance with the object of preserving their “purity” and “greatness” (Quiorga 2007). Such preservation work in white American’s are based on a set of presuppositions that cultural belonging, in part is encoded in genes. Therefore, IVF enforces physical continuation between parents and offspring as a form of preservation of whiteness.

According to Seline Quiorga (2007), women are responsible for maintaining the purity of the bloodline by adhering to strict moral standards. I have offered examples whereby IVF casts doubt on the purity of the bloodline as Dana described IVF as a “bastardized” form of conception or in the examples of mothers of multiples who are confronted in public places. Women who have conceived with IVF are left in a double bind: women choose IVF to preserve their identity and adhere to social expectations but at the same time public perception of the possibility of “mixed” genes or “donor” gametes casts doubt on their legitimacy of belonging. In vitro fertilization, as a tool to achieve conception, casts doubt on the biogenetic relationship between child and mother, and the legitimacy of the women’s membership to the kin group.

The women shared the idea that being in control of their lives meant being able to make desirable choices. Making the right choice brought the women one step closer to motherhood within their families. Controlling fertility and choosing to pursue IVF was an act towards meeting the expectations of family. The potential of success using IVF

(despite low odds) outweighed the risk and ambivalence women encounter in their decision to pursue IVF. The ambivalence some of these women experienced is compounded by their morals and values of IVF an illegitimate or, as Dana described, a “bastardized” form of conception, as they attempted to adhere to social roles and expectations.

Women with multiple births experienced an additional set of problems. Unlike mothers of singletons, their daily experiences were chaotic and described as disorganized and out of control. When in public settings, women with twins and triplets were frequently approached by strangers alerting them to their difference, and were subjected to judgment. Some responded with anger, while others sought support from other mothers of multiples and shared strategies on how to handle these types of encounters. Within their sphere of women, they gained a sense of belonging, a greater sense of self, reinforcing, recognizing, and promoting their status as a woman and mother. Although ART are being integrated into peoples lives, they are a long way from being seen as the normal way to have a child or the normal way to make a family. It does not end for some. For the three women in this study who had a child without assisted conception, they were able to recapture a sense of normalcy, but were unable to forget what others take for granted—a biological child—in an unassisted conception. Some of the normative aspects of IVF include the importance of parenthood and the importance of the body. These cultural concepts have lasting effects because ART makes parenthood possible for infertile individuals, and makes it possible to have “normal” families. The concept and the idea of the body as capable of production where it was not prior to IVF may surpass expectations of authenticity for some women, as in the case of providing multiple

children and instant families. At the same time, societal values and attitudes affect these women when this form of biology and technology is deemed unacceptable in their notion of family. Once again, these women renegotiate an “in-betweenness” (Probyn 1996:6) from a category of an infertile self to relocate themselves as normal mothers and families.

Conclusion

In this chapter, the cases presented reveal the deeply embedded personal and social values of biological imperative in relation to IVF. Clearly presented are the values and beliefs of “knowing ones roots” their “genetic inheritance” and the symbolic value of genetic transfer in physical attributes distinctive in a particular belonging, that of self-identity in whiteness. As we have seen, societal interests and values also play a role in what constitutes normalcy and what is considered a “normal” family. From this perspective, the ties of shared reproductive substance, the biological imperative, was the priority for these women to provide authenticity for their parenthood, their identity and the preservation of whiteness.

In sum, with the use of ART, how families are or can be created has changed. It may take time for members of society to accept that change. What did not change, for these women, was the desire to share in the biogenetic makeup of their children. The biological imperative remained the means through which conventions of the white American nuclear family were produced and maintained.

CHAPTER 5 THE MEANING OF SUCCESSFUL IVF

“If you want something you’ve never had, you must be willing to do something you’ve never done.”

– Thomas Jefferson

“Success seems to be connected with action. Successful people keep moving. They make mistakes, but they don’t quit.”

– Anonymous

“In order to succeed we first must believe that we can,” writes philosopher Nikos Kazantzakis (2012). In order to accomplish something, a person needs to identify what they are expected to do, what they may do, and what they can do. For some women in contemporary middle-class America, the dream of success has become a reality in education, career, and family. In the quest for a child with IVF, the notions of pregnancy and parenthood for infertile women are bound with ideas of both success and failure, birth of a child or the inability to conceive. In the previous chapters, I described how the process of IVF challenges notions of normalcy and redefines a women’s sense of self, and identity. Here, I explore what success means in the context of IVF for the women in this study. I show how for some women, achieving pregnancy and a child through IVF “successfully” satisfies their goal and defines their sense of self as exceeding what other women do to become pregnant, while at the same time causing them to defend further their normalcy to others. Here, hard work, perseverance, and determination are seen as the way to achieve motherhood; and the lack of a child is perceived as a personal and social failure. I explore the various domains of success in women who have had a child with IVF; how this technology reinforces the biological imperative, power, the category of normalcy associated with, and the perpetuation of whiteness identity. Throughout, I draw upon Ortner (2006) and Paxson’s (2004) theoretical frameworks of agency and

subjectivity to consider further concepts of the self and identity formation in relation to IVF.

Encouraging Persistence

While IVF is a symbol of scientific progress, knowledge, and hope for many infertile women, it does not come without ambivalence, reservation, and conflict (Franklin 2013). Conflict arises from options in infertility treatment, the notion of risk associated with fertility drugs, the invasiveness of the procedure, and the side effects of ovarian hyperstimulation. Concerns are associated with the economic risk, the financial obligations associated with various treatments, and the moral conflict of feeling obligated to try to become pregnant (Becker 2000; Greil et al. 2010), or unable to refuse an opportunity to try reproductive therapies such as IVF. Some middle-class women view attempting to become pregnant through IVF as fulfilling an obligation to adhere to the normative orders of parenthood and family expectations that they cannot refuse (Greil & McQuillin 2010). At the same time, the obligation of parenthood can be understood as a set of cultural practices where some white women (knowingly or unknowingly) are practitioners of white culture. Parenthood is a normative position of whiteness, lived in class and gender specific ways, here with the support of IVF (Hartigan 1997).

The pursuit of a child through IVF may also mean that women have experienced failure. Even if a woman does not become pregnant with the first cycle, she often continues treatment if she has experienced even a small degree of success (producing eggs with ovarian stimulation) at one stage in the process—this sense of achievement compels her to continue (Sandelowski 1991). For some women, successful IVF remains elusive; unable to become pregnant women are faced with the decision to determine

when enough is enough. For other women, pursuing infertility treatment provides a range of possibilities to succeed in conception, pregnancy, and the ultimate form of success: the birth of a child. Thus, the experiences of the women in this study illuminate the blurred boundaries of expectation and obligation in relation to becoming a parent, questioning what it takes to accomplish their goal, and the ways in which parenthood can be achieved. A defining attribute of the American middle class white woman, is to take advantage of life's opportunities and if need be, to create them. Here, the desire to accomplish parenthood, to gain a sense of achievement, means being obligated to take advantage of an opportunity (Schneider and Smith 1973:20), as well as exercising the privileges associated with whiteness (Quiroga 2007).

In the tenet of the "American dream," success is accomplished through hard work, persistence, conscious effort, and labor. This is considered an essential attribute of the American middle class (Schneider and Smith 1973:20). This ethic is embedded in the American tradition of individualism, where "individuals, unfettered by family or other group affiliation, are given the chance to make the best of themselves, and, through equality of opportunity is essential, inequality of results is natural (Bellah et al. 1986:148-149). In terms of ART, some middle-class women feel obligated to "try" to become pregnant as a matter of a normative order in which they are expected to succeed to make the most of life's opportunities in their education, careers, and the pursuit of parenthood. The notion of obligation and success is supported in the literature (Sandelowski 1993). Sandelowski (1993) identified in the middle class a characteristic pattern of "effort, cash, and determination" that played a key role in the identity formation specific to choosing IVF (92), while Becker (2000) documented the

embeddedness of the pursuit of IVF as a consumer in the ethos of the American Dream (243). Consistent with the tenet of the American dream, IVF provides the opportunity to achieve pregnancy, with the hope and idea of a successful delivery and child (albeit for the privileged few). The idiom of success is associated with superiority, and “being the best you can be” particularly within white middle class Americans. In the United States, a domain of superiority is associated with genetic inheritance via whiteness, “the idea that so called superior traits are linked to success” (Quiroga 2007:145). As I have shown in previous chapters, the women in this study understood IVF as a means to have a biological child, to pass on their genetic inheritance. Thus, IVF provides the opportunity to adhere to the contours of the American kinship model, rooted in biology via blood and genetics, (Schneider 1984:84) whereby success is associated with “purity, superiority, and whiteness” perpetuated by IVF. IVF works in ways to reinforce the importance and association of genetic inheritance, here in the production of “white” families.

In Inhorn’s (2011) study, Middle Eastern middle-class couples sought IVF not only for biological offspring, but to meet social expectations defining “successful” family formation. That IVF is intentionally chosen signifies the complex motivations women feel in choosing this path to achieve parenthood (Franklin 2013). With low rates of success for IVF, however, is it more than a baby that defines success? Webster’s Dictionary defines success as: “a favorable or desired outcome, the fact of getting or achieving something such as fame or respect, or the correct or desired result.” In the Oxford English Dictionary success is defined as “the accomplishment of an aim or purpose, or the attainment of popularity.” Both dictionaries provide a similar definition that includes being recognized or “seen” as having accomplished something. The

questions I will explore in this chapter are: How do the women in this study define and experience success during and after IVF? Do women who have had IVF consider a child the symbol of success?

In the pages that follow I will identify themes of success in the sense of belonging, transformation of identity, social contribution and recognition, and how the quality of achieving and being “normal” is linked to the idiom of success.

Findings

As the paragraphs above have started to show, genetic inheritance and the biological imperative (depicted in the physical characteristics of parents with their offspring) has effects with particular meaning for white American middle class women in this study. These effects, which are arguably the result of normative self imagined ways of practicing whiteness are explored in the context of IVF. I show how a child is understood symbolically to represent not only the couple’s unity (as in Schneider) but in the superiority of their genetic inheritance.

In previous chapters, I offered examples of the importance of children sharing in physical attributes and characteristics of family members, and both parents as an essential marker of shared identity, and “normalcy”. Here we will explore how Susan understands how genes will determine what your children will become: their moral character, intellect, and other traits linked to success that she, in part, attributes to be genetically inherited.

Susan: All babies are miracles but these three should not be here and the fact that they are here, and healthy...[and] are completely normal kids.

I: What are normal kids?

S: I was warned while I was pregnant with triplets about what a high risk pregnancy it was, they could have this problem or that problem, learning

disabilities, autism, GI issues, everything under the sun, but my kids have none, they are “normal” in every sense even though they are 28 week triplets.

I: Let me understand you mean your children are normal because they do not have any physical problems.

S: What I mean by “normal” is they are 100% on target for five years olds; growth wise, developmentally, physically, emotionally, academically everything. They are multiples...preemies and have exceeded in everything.

Her answer is illustrative of some of the ways in which she compares and ranks her children’s normalcy to other children but that it is not enough to look at their progress without taking into consideration their prematurity—because they were able to overcome what other preemies were unable to do. Susan continued to describe how she imagined her “cohesive biological family”.

S: I want to identify and see that they are a part of me...there are identifiers. I identify with my parents and I want the same with my kids.

I: So what does family mean to you?

S: *Accomplished*...to have triplets and not just one baby, more then what we set out to do...the big thing for me was “us” in those kids, it had to be part him and part me. It was my “mark”.

I: What do you mean by my “mark”?

S: I truly believe the triplets and the journey we went through to get them with IVF...and the sepsis (illness described in previous chapters) I feel like I was a conduit for *greatness*. These three little people are my mark. Something they do or the people they are going to be, they shouldn’t have survived...but they did, and they *thrived*. Who knows one day they could cure cancer...or be the next president.

In the excerpts above Susan’s reasoning for her children’s survival and their potential “greatness” is in effect following a particular model of nature, that of genetic inheritance. In this example, genes present in the parents are passed on to their offspring, not only in physical characteristics, but also in intellectual traits. For Susan, genes determine what your child can become, both physical and mental attributes (superior genes as inheritable traits) are passed on to your children contributing to the potential for success. For Susan, genetic inheritance is an “idea

intrinsic to whiteness, their superior traits are linked to success”(Quiroga 2007:145).

Another example of defining success for Susan is in her sense of self, and identity as a mother. She describes the responsibility of motherhood, how she is the most influential person in their life, and how she shapes their moral character.

S: You start to see...your traits. The things you are proud of and not so proud of...then I realize how I am influencing them...you just want them to be nice respectful people.

Susan described an incident that happened at her children’s school. A group of children had used inappropriate language and one of her triplets had followed suit. Susan described how her son had gone to the teacher to apologize. The teacher had told Susan how well behaved her children are, and how she was surprised by this incident, quite out of character for her children. The teacher also stated no other children had come to apologize to her. Susan described this moment:

S: What teacher tells you that she would babysit for your children even with this incident. I think in that sense, even that small *accomplishment* and being recognized for it, no other kids had done it or no other parent had their kid apologize. It felt really good. Because motherhood is so difficult...you are so influential in their lives. I came home and told my husband what had happened and he gave me a pat on the back for how I handled it...it felt pretty awesome.

In this excerpt Susan is concerned with how people view her as a mother based on her children’s behavior. When I asked her what this “accomplishment” meant to her, she responded:

S: I am a person who likes to feel recognized and accomplished. I don’t get that a lot anymore. I think it goes with being an “overachiever”, as a perfectionist and always reaching my goals. I don’t even know where it comes from...I like to feel like I have accomplished something and that I have succeeded and been recognized for it.

In the last five years not working outside of the home and not getting that pat on the back, I don't get a lot of recognition from people. There is just not a lot of recognition in the world of Mom's, and when you get one it feels like a nice *accomplishment*.

Susan acknowledged she is unaware of the origin of this need to be an overachiever, a perfectionist, at the same time she is not aware of the need to be recognized by others. Her experience of being recognized becomes a pattern, where she continued to seek approval from others. Such a pattern would of course vary with context, and ideologies of normalcy, here being seen as "normal" follows models of complying with understood local norms.

For several women in this study, the opportunity to have a child also meant having a second chance at having a family. Several women in this study experienced childhood traumas. For them, creating a "normal" family meant having to work harder than other women. What follows is what a normal family means to Grace.

A Second Chance

The theme of success was quite evident to me the first time I spoke with Grace and then again with a few other women in the study. Grace was 36 years old when she delivered her daughter. She began by telling me the difficulty she had encountered trying to become pregnant, the disappointments and frustrations after three years to "have nothing" to "show for all their effort." I asked her what she meant by "show." She replied: "You know, for some of us [women] it's hard work. It's not so easy. People think it's going to be easy—not so much." I then reminded her of our first phone call when she said, "I am proud that I was able to have a child with IVF, all women should be proud of what they *accomplished*." I asked her if she could tell me what exactly she meant by "accomplished":

You can't imagine the feeling you have when you finally hold that baby in your arms after you have tried for so long, it was the most amazing feeling, I felt like a queen. I wanted everyone to know, and everyone to see: Look what I did. I really did it.

As Grace spoke, the tears welled in her eyes and spilled over her cheeks, while at the same time she was smiling. Her face beamed, her grin kept growing. She reached for a Kleenex sitting at the table and then looked at me and said:

Grace: All women should feel such joy. All women should stick together and help each other. They shouldn't look down on a woman who can't have a baby right away.

Interviewer: What do you mean, "look down on a woman?"

G: Well, it's sad that some women seem to gloat if they can have a baby easy. Some of us can't. We just can't. We don't take it for granted anymore. But I am still happy for her if it's easy. That's what I mean by "women should stick together."

I: Grace, do women stick together?

G: Sometimes, but not when they should. I try to help my friends if they need something. They didn't help me that much. But then, I don't know what they could really do. It was just me and my husband.

I: What did your husband do?

G: He stood by me. He was always there and seemed to know whatever I might need. He was proud of me. He is the best father, and the best husband. I am lucky. I had a rough childhood. Now, it's the best. We have everything—children, a good marriage; that's all I really need.

Grace was able to move beyond her years of infertility to find joy in her family and in her life. She was able to overcome adversity to obtain what meant the most to her, and that was her family. Grace learned from her past experiences the value of family, to determine who and what mattered in her future. In their work on individuals overcoming adversity in health and life crises, Biehl, Good, and Kleinman (2007) showed how, through the experiences of life in time, and within the social spaces of families, neighborhoods, and workplaces, people are aware of the things that matter. People try to preserve and protect those things that are important to them, such as parenthood. Here, constituted in part by her subjectivities (desires, intent, and needs), Grace was able to act

upon those desires to become a mother. Grace had to work “hard” to become a mother. IVF, along with the support of her husband gave her a “second chance” to create a family she had always hoped for. Grace was able to overcome childhood adversity⁷ to regain a sense of self and transform her identity; that transformation, for Grace, was a symbol of success.

Another dimension of success, for Grace was time. Here, social action results in the regulation of life routines to meet a goal over a period of time and space. Time may be measured by the anguish of years of infertility, and the time the women dedicated to IVF treatments to achieve their goal of motherhood. Giddens (1984) discussed the concept of time, explaining how individuals learn to monitor and direct their lives to meet their goals. When Grace and her husband wanted a second child, they tried IVF for a second round of monitoring cycles. Success measured here was the value and feeling that the time spent was “worth” it, a sacrifice that was rewarded with a child. Thinking back to that time, Grace said, “All the pain and the time giving myself those shots was well worth it, like I said before: I did it.”

Social Acknowledgement

The experience and subjectivities associated with success are, at times, reinforced by social recognition. Social recognition may come from different sources such as family relationships, friends, and social media networks. Social networks, in the context of infertility and IVF, constitute a new type of kinship network, or an extension of it based on shared experiences. A few of the women in the study developed new friendships on the Internet through blogs and message boards like The Knot. The Knot is a website that begins with your engagement and then progresses like a life plan to the Bump, when you

⁷ To protect the participant, the nature of this adversity has been kept confidential.

become pregnant, and so on. For women that do not become pregnant, the website hosts a “Trouble to Conceive” message board, which is further categorized into time periods of how long the woman has been trying to conceive. Dana, Melissa, and Susan were active participants of this site. Dana described herself as a stalker, not really sharing information but learning from it, seeking information and knowledge. Melissa however, developed a following of friends. At one point she told me there were over 600 women following her blogs, sharing information while going through her infertility treatments. A month before she conceived her triplets, approximately 50 of the women formed a private blog, where they felt they could maintain their privacy. Many of them became pregnant with IVF, and the women that became mothers of multiples created yet another blog on their own from Internet friends called “BFFs” (best friends forever). At this point, communication moved from Internet-based interaction to meeting face-to-face and planning events. As Melissa described the structure of the message boards, she told me about her one of her BFFs:

Melissa: One of the girls that is my best friend to this day, we met on the trouble to conceive board. We ended up getting pregnant. She did an IUI the same month that I did my in vitro. She got pregnant with twin girls and I got pregnant with triplet boys. She lives in Manhattan and I go out and visit her ever year. My other friend lives in Florida. We are all over the states.

What do these relationships mean to you?

M: Oh my God, I don’t know what I would do without them. They were there for me through all the treatments, telling me not to give up. We were there for each other, pushing each other—one more cycle, one more pill—and then bam. It happens and they are there for you. It’s pretty amazing this started with a chat board. It’s crazy how people are so curious about multiples, then they told me to post my story on the board.

I: Did you?

M: Yes. It was fucking wild, the posts I got. It was phenomenal.

The social media network provided a space, where a collective of women who shared similar life experiences gained a sense of belonging and normalcy. Here social media friends understand the pain and suffering of infertility and the tumultuous journey of IVF. The women selectively chose and developed a type of kinship, much like what Rapp described as a “fictive kinship”, where friends are treated and valued as relatives and sometimes more so than relatives (Rapp 1978). These women supported one another, encouraged one another, and rewarded one another. More importantly, they acknowledged each other’s effort every step of the way, comforting each other in failures, and acknowledging their achievements—no matter how big or how small.

For some women, the need for social recognition needs to be fulfilled in a larger social cultural forum. Like Melissa, Susan also participated on the message board and acquired BFFs of her own. She too described similar experiences, though for Susan the board was not quite enough. At our first meeting, Susan reached into her purse and handed me a letter. “I just wrote a piece, a show about motherhood that I am auditioning for. I wrote about infertility and the in vitro process. This is for you.” She handed me the paper and I thanked her. Susan’s story was entitled *The Ride*. I quickly read the pages she had handed me while Susan sat in silence, waiting and watching me. I took a deep breath before looking at her. She had described the pain, the sadness, the loneliness, and the need to belong, to have a “normal life” and to be accepted like “other” women who had children without IVF. Susan told me she had prepared her story for the national program, “Listen to your Mother.”

A couple of months after this meeting, Susan called me to tell me her submission was accepted. She would be telling her story live before an audience. She invited me to

attend, and I did. The day came before I knew it, and I drove downtown to see and hear Susan tell her story. There were 12 women who told a variety of stories about their lives, from surviving cancer to the loss of a child, then came Susan. She walked onto the stage, her hair pinned on top of her head in a bun. She wore a blue dress and heels. She stood at the podium. I could see that she was nervous, her hands shaking slightly holding the paper. I was seated in the front row. The lights were bright and I hoped that Susan would see that I had come to hear her tell her story. She began by describing her life in the metaphor of a roller coaster, the painful turns, the ups and downs and the fear that she would fall off, that she would never have a child. The room was silent, I turned and could see the tears on many women's faces, Kleenex in hand, wiping their tears and listening. Susan continued. She described how close she came to death, but she fought hard and survived. She survived, and her three unborn children. She told the audience about the first day that they all came home, three babies, her husband, and Susan. Now finally she could "get off the ride—I am a Mother." Susan looked up into the bright lights and then looked out to the audience to see the women give her a standing ovation, applauding. When she turned to walk off the stage, I waved to her. She waved back.

Shortly thereafter, Susan was contacted by a local TV station and asked to participate in a morning talk show about her IVF experience and life with triplets. Her first appearance on the stage was acknowledged, and exemplified by a much greater feeling of success with the offer to participate in a morning show with an even larger audience for social recognition. She called me and sent me the TV clips. I asked her how she felt about doing these shows and her experience. She replied, "It feels good because they [people in general] now know that I didn't have just one baby, I had three." I wasn't

sure what she meant, so I asked her to clarify. Susan replied, “I guess I want people to know that I really accomplished something, something big.”

For Susan, it was not enough to have had three children; she wanted to be seen, to be heard, and to be socially recognized for her years of sacrifice and hard work to accomplish motherhood. Similarly, Inhorn (2011) described the concept of new parenthood identities that require being “seen” to meet social expectations, and how this reveals a desire for more than a baby, for recognition as a mother.

For years, Susan experienced a sense of inadequacy and shame at not being able to do what she believed her body had been “created” for. She worked hard at trying to conceive, but felt “outside of belonging”, similar to a state of “inbetweenness” described by Probyn (1996) when a woman does not become pregnant but is trying to become pregnant. At the same time, Susan felt “out of control”, as she metaphorically described her life like a roller coaster ride, the tension associated with the twists and turns, and the ups and downs of infertility treatment, pregnancy, and then later caring for triplets.

After Susan had completed her talk show series, I asked Susan what it meant to her to share her story and talk about her triplets:

Susan: It was important to me that everyone knew how much harder it is to carry [pregnancy] triplets, and then to raise them.

I: can you share with me why it is important for you?

S: People have ideas, of what they think IVF is like what it’s like to raise triplets, but they don’t have any idea, they don’t know what it’s like to be sleep deprived, to give up your career, everything changes in a drastic way...triplets is not the same as three kids...you work harder then ever...you sacrifice everything and you work harder to become a better mother.

I: What do you mean by a better mother

S: I met all my goals and more...I had to work harder then other women to become a mother, and then even more to take care of triplets...I accomplished what I set out to do.

Here Susan's expectations and how she had imagined her life differ from what she believes her friends and family envision and experience. A core concern here for Susan, is with the social and cultural understandings and expectation of motherhood.

Unlike Susan, Tanya's lived experiences are just as much about success as they are about failures.

Tanya is in her late forties, a mother of adolescent triplets, she works as a chemist in a satellite laboratory for a national chemical firm. Similar to the other participants, Tanya and her husband sought IVF to have a child that shared in their genetic makeup. Adoption was not something either of them would consider because of the unknown that came with someone else's genetic makeup, "you just don't know what you will end up with".

I asked Tanya to tell me about her family. Tanya described how excited they had been to find out she was finally pregnant, it took time to let the idea of triplets settle in. She described her husband as someone who could handle whatever comes his way, however, even he had been more than overwhelmed when two of the triplets were diagnosed with Autism.

Tanya: Well, when they were born they were healthy but then two of the triplets developed asthma and other medical issues.

I: How did the other medical issues affect your life?

T: Well, it wasn't what we expected we had tried for so long and then to have children that were ill is not what we had expected.

I: What did you expect?

T: Not much, what ever happened happened until it did. I didn't have any idea of what my life would be like, but I didn't expect triplets and everything that came with that. I guess I thought we would have an everyday normal family.

I: What is an everyday normal family?

T: I thought everyone lived like us. Everything, our education, buying a home, we lived in a nice community and were exposed to a lot of different things, activities and sports and culture.

Tanya and her husband had been unprepared for the diagnosis of Autism for two of their three children, like most parents confronted with such a diagnosis. Tanya's expectation was to experience the same good life she had experienced as a child and as an adult. My findings are similar to that of Rayna Rapp's (1978), whereby the concept of a white American family is associated with the good life (285). Tanya and her husband were oblivious to the privileges of their class, as Tanya portrayed how she believed everyone lives their life (education, sports etc).

I: Can you tell me more about the triplets

T: At first they were okay, normal kids, we could deal with the asthma but then when then they were diagnosed with Autism... everything changed.

I: Can you tell me more about that

T: It was not what I expected. We worked very hard in our careers to prepare for our family. It cost an enormous amount of money for IVF then the medical bills happened, and still do. After all of this (IVF and its related costs) our lives should have been normal.

I: What do you mean by "should have been normal"

T: How we grew up, like I said what you do, you go to school, establish a career, work hard and have a family. Isn't that what we all expect to happen. That's a successful life, and then unfortunate things occur that you aren't prepared for, that families aren't prepared for, that's why people who really can't afford IVF shouldn't have it because you really are not prepared for the outcome.

In the excerpt above, Tanya shares in the concept of an American middle class family as normative, the correct way in how to live one's life. This finding is similar to Rapp's (1978) findings, whereby working hard and leading a good life is what people do for personal gratification and recognition, the family is the "pay off" for conforming to the rules of the middle class. However, Tanya struggles with not meeting social expectations that are intrinsic to white American middle class. In her view, her reality is not the pay off of a good life that she had worked so hard to achieve. Here, family expresses a certain ideology, a "distinction between norms and realities" (287). Following the examples I have provided above we will examine how

the white American middle class women in this study, as well as the Greek middle class women in Paxson's study, work to preserve their ideology of family, their identities, and the meaning of success.

A Case Study: Working Hard at Success

I provide a case example to explore Paxson's (2003) concept of agency, unpacking how women's identity is established in relation to their reproductive potential. I describe the significance of what it means to be successful to a participant and what it means to her when she is accused of having an unnatural conception or seen as a failure in social situations. I will explore Paxson's example of Greek women followed by the American example.

The Meaning of Successful IVF: With or Against Nature, A Greek Example

I now turn to Paxson (2003) to explore her use of the concept of agency in relation to how women's gender identity is established with respect to their reproductive potential (1854). Through ethnographic fieldwork conducted in urban Greece, Paxson came to understand, in the context of IVF, that the women in her study redefined nature in order to have children and thus be "completed" as women. Conception, pregnancy, and birth were understood through culturally-specific meanings of procreation and human reproduction. She explained the meaning of gender identity and conception (framed as primarily the responsibility of women) foregrounded the women's experiences and the centrality of their reproductive beliefs and practices. Here, I apply Paxson's framework to my own analysis of identity and success. First, however, I will summarize the salient points of Paxson's ethnography.

Paxson (2003) met middle-class Greek women and addressed the relationship between modern womanhood and motherhood. She found that contemporary Greek women viewed motherhood as a personal responsibility and as a goal to be achieved. They viewed motherhood as a moral obligation and part of being a good Greek citizen (2004:211). Because of Greece's pronatalist stance, partial public insurance is offered to couples that face serious problems of sterility to gain access to ART. The women who used the IVF clinic regarded IVF as "natural and normal" because it maintained or treated their bodies to facilitate the making of children to overcome their childlessness. The women viewed this form of assisted conception as proper, because they believed that gestation and birth, rather than conception, is what defines motherhood. Undergoing IVF, for these women, completed their womanhood by allowing them to have a child, and enabled them to fulfill the expectations of marriage.

The women depicted themselves as achieving motherhood by taking charge of a natural process. The process of IVF and the medical regiment was considered a "woman-centered event," and was seen as something "women do." Their extraordinary efforts to have a child were recognized, and they were regarded as "heroines." Some of the women believed their commitment, sacrifice, and tenacity to have a child with IVF made them better mothers than other mothers who conceived without assistance. The women further believed IVF corrected the damage done to them by nature. Women described ectopic pregnancies and metaphysical forces to explain their inability to conceive, and past transgressions of abortion where nature had "wronged them" or denied them. Thus, seeking IVF was a means to take control of what nature should not have denied them in the first place.

Paxson concluded that the couples that talked about IVF openly and received support and praise from friends or family seemed more satisfied and settled with the experience, compared to those that hid their IVF practice. Paxson indicated that modernity in Greece incorporates elements of tradition for women, and this includes motherhood. Paxson concluded that viewing nature as realized through social action reveals how agency is neither a matter of resistance or free will but emerges in ways that reformat and reproduce social relations. In this context, Paxson commented on how the women viewed reproduction as a social event that they orchestrated, responding to their own needs as well as those of society. Paxson contended that the women's choices and actions were part of gender construction and Greek sociality, with the understanding that nature is learned. At the same time, the women had a moral obligation to aspire to motherhood behavior. Success is measured in different ways. For some women, success can be privately enjoyed; for others, to embody success social recognition is required. Women that share similar experiences in life, as in the context of IVF, may experience the feeling of success quite differently. The nature of recognition reinforces the notions of success and failure.

Jae's Plan: Compelled to Try

As is often the case when a woman chooses to follow the path of reproductive assistance to achieve pregnancy, the definition of success tends to be measured in biomedical terms by her physician. The biomedical model emphasizes the abnormal and also works to define both failures and successes. Women who experience ART such as IVF continually renegotiate their sense of normalcy when confronted by distinctions between normal and abnormal conception in social and biomedical contexts. Here, the

desire to succeed and to redefine normalcy is followed in the spirit of American individualism—as a challenge, motherhood is pursued with determination as a goal to be achieved. Women’s reproductive agency emerges to reshape her identity and a sense of self. Women become, in essence, overachievers, working harder to become “better mothers.” A child then represents the ultimate success resulting from hard work and perseverance. Jae’s experience exemplifies this process.

Jae was 35 years old, a college graduate with a very promising career in the healthcare industry. As an executive working for a national insurance company, she was climbing the corporate ladder at a rapid pace. Jae had planned out her life, college, marriage, and desire to have four children in that order, specifically timed over a ten-year period. However, for Jae, life did not follow her plan. After eight unsuccessful IUI inseminations, two ectopic pregnancies, emergency surgery, and two failed IVF transfers, Jae did not believe she would ever become pregnant. Disillusioned and depressed, Jae encountered failure after failure, shaking her sense of self as a woman. At 40 years of age and without fallopian tubes, she attempted IVF for the third time and conceived triplets. The details that follow illustrate Jae’s understanding of success and failure, in relation to her treatment options and then her life with triplets.

Jae described the experience of IVF as a series of small successes, followed by painful failures. As she described the events, I realized how knowledgeable she had become in reproductive medicine. Her sense of self and identity were framed around reproductive language, and her discourse was very much like a physician. She began to describe the process with the grading system in egg retrieval: Grade A meant a “good responder,” the best shape and size of the eggs needed for a transfer to be successful; a

Grade B or less was a “poor responder.” Once the eggs were transferred, the wait began until the time of the Beta test to determine pregnancy. Jae was able to rattle off a range of numbers, what they meant, and how those numbers should progress steadily upward—a “good bump”—to indicate pregnancy. She took great pride in these small triumphs, as each brought her one step closer to success—a child. Jae was elated that she became pregnant with the first try in IVF, but shortly thereafter had a miscarriage. After a series of small successes and failures and without a child, Jae had reached the breaking point:

[In tears] That for me was rock bottom. I was an absolute mess. I think I had all those thoughts—I started seeing a counselor at that point—like I am defective. What is wrong with me? It was really after that point that I kind of slid into a depression. I didn’t want anything to do with fertility treatments for a while after that. We started the adoption process. That gave me a renewed hope. I told my husband, “I can’t keep doing this. I need a sure thing.”

For those women who have not encountered disruption in their life plan, the inability to have a child can be the first major failure in their lives. For Jae, the inability to maintain a pregnancy was distressing. Becker (1997) has described the experience of infertility as a disruption in a person’s life plan. Jae and her husband began to explore the possibility of adoption. Their choice was, in part, financially driven. As they explored the cost of adoption versus Jae’s generous health plan coverage and their desire to have their own child, a decision was made. Jae stated her husband took control of the situation, saying, “We have to make a choice here: we try IVF one more time or we move forward with the adoption. . . . This is a \$20,000 decision now, if we go through with the adoption. . . . I am not saying we can’t, but the IVF was going to cost us \$500 versus \$25,000.” Jae and her husband weighed both the possibilities of success with IVF and the financial impact.

Although she viewed her career as demanding, her efforts were paid off in promotions. Her goals to achieve motherhood were not achieved effortlessly. Filled with frustration, her desire to have her “own child” was worth one more try. Jae wanted “nothing more than to be a mother,” but she “just couldn’t take any more failures and losses.” She wanted her “own child.” Jae was fearful that she would fail again: “If this fails, I am done for a while.” She agreed to try one more time: “I believe there is a God and he put the infertility doctors on this earth to have the brilliance and expertise to help people like me.” Jae’s doctors transferred two embryos. She explained, “I did the exact same thing that I had done when I had gotten pregnant and had the miscarriage. We transferred two embryos again, one split. I had identical twins, and the third too. I got pregnant with triplets. Jae attributed this pregnancy to chance, a mystical explanation, rather than by any action she had taken or the technology: “We were pretty flabbergasted. My doctor was upset [that one split]. I feel like IVF is 75% science and 25% luck—you just don’t know. We did the same treatments that we did the first time. This time we got an even better response.”

At our first meeting Jae had mentioned there were many twins and triplets in her family and she could not understand why she had so much difficulty with maintaining a pregnancy:

I used to brag about the fact that I had triplet cousins. Everyone thought it was so cool. I actually never hoped for multiples. I never had that thought until I was having fertility problems. Honestly, having twins becomes like the Holy Grail to get two for one. Hopefully you don’t have to go through it again . . . to have a boy and a girl then you are done. That is the Super Bowl of fertility treatments. I had that romantic vision in my head—if I can have boy/girl twins then I will be done. After the repeated loss, I was just hoping for a baby.

The implantation of two embryos resulting in three children was not what Jae had ever envisioned, despite the number of multiple births in her family. Jae's previous life experiences of loss—her father's death when she was in high school, and her previous ectopic pregnancies and miscarriage—brought new forms of anxiety and fears of loss with the impending triplets.

When I found out that I was having the triplets, I was pissed because I was like, how are we going to get through this? How am I going to bring home three healthy babies? How am I going to live through this? What if we all don't? Something is going to happen I just know it. Twins would have been great, wonderful. Leading up to the fertility treatments I never wanted twins, just one baby.

Jae shared with me how she attempted to lead a "normal" life after having the triplets, meeting with friends for lunch, and trying to do play dates with their children. Jae described her frustrations of having only "two hands but [needing] three" when trying to pack up the car to go for an appointment or go shopping. She described going out in public: "When you have triplets, you are a walking freak show." When Jae was in public, strangers would approach her and, on more than one occasion, Jae was reminded that she had to have IVF to have her children. Jae recalled an encounter while shopping at a Sam's Club with her mother-in-law:

I was at the check out counter at Sam's Club when my boys were eight months old. My mother-in-law was with me and she was pushing the cart. The clerk checking me out asked if they were triplets. I said yes. She said, "They aren't natural are they. You had to have fertility treatments, didn't you." I looked at her and said, "No, no, they are natural." My mother-in-law then says, "No they are not—what are you talking about?" I pulled her aside when we got done checking out, and I told her, "It is not the Sam's Club clerk's business how I got pregnant. It is not your business either. Approached like that I am not going to tell them how I got pregnant. It is none of your business." If some one asks, "Did you use IVF, I had to do IVF too," then I am happy to share my experience.

Jae viewed being capable, organized, and in control as characteristics of someone who is successful. Shortly after this comment, Jae qualified her statement that she was very “lucky” that her children were healthy compared to several of her friends that had triplets. Their children had suffered complications from premature births, and had feeding tubes and lung problems. She described living through or “trying to get through” each day with triplets as challenging, contrary to how she had imagined her life would be (organized and structured). The triplets created havoc, and disorganization in Jae’s daily life leading her to lose control over her life as she had during her infertility. Once again, she did not know how to regain a sense of control in her life:

It was not something I would have wished on myself. I am thankful that I was successful—not everybody is. It has really been a blessing in disguise. I wouldn’t trade my kids. I do think about those losses I had. I do feel a sense of loss for those pregnancies because for all I know those were perfect babies—they just couldn’t get to where they needed to go to grow. It makes me sad. I also believe I have the kids I was suppose to have for whatever reason and I am still a freak show.

Jae linked her success with past failures. The loss of her pregnancies was her destiny and therefore outside of her control and responsibility—they were “not meant to be.” Her envisioned way of life and family had changed with having triplets—“you have no idea.” Of her first few years with the triplets, she stated, “I can say that my life was hell on wheels.” She continued:

Life has just gotten too crazy. I think more how parenting has affected me. I was lucky they were healthy. We did have some health issues the first couple of years. They didn’t sleep through the night until they were four. I was exhausted for five years. You can’t imagine it. Chances are if I had one [baby at a time], it might be better. There are no guarantees, as I already know.

Jae further described how each day was like an assembly line: feed them, burp them, change them over and over again; “the time I spend each day making formula,

pouring bottles, washing bottles.” Faced with challenges she had not expected, she attempted to restore a sense of order in an increasingly chaotic situation. Getting through each day with triplets for Jae were micro-successes:

It was not what I expected. I feel sometimes cheated out of that perfect experience. I don’t remember sitting in the rocking chair snuggling my sweet little infant for like two minutes at a time before someone else was crying. I don’t have as many of those memories as a singleton mom does. It’s more like trying to stay ahead of the game. I am still alive, that’s all I can say. My path has been a direct result of the IVF. Certainly my life would be extremely different if I hadn’t done it. I wouldn’t have any kids or I would have adopted a couple of kids by now, but only one at a time.

Jae sought support from other mothers of multiples, sharing stories and offering advice on how to cope with the challenges of each day caring for twins and triplets. Jae’s friends who had twins admired how she handled three when they were having difficulty handling two children. Jae stated how it made her feel: “a little special, like full of myself because I did do it.” Jae’s social network acknowledged her capabilities and admired how she was able to manage her triplets; Jae was recognized as an overachiever.

Discussion

The stories and observations I included in this chapter demonstrate the complexities surrounding the women’s lived experiences after IVF in how they define success or failure. In this chapter, I have demonstrated key elements in how the women in this study define success. In the vignettes, I described several themes of success in the transformation of identity, social recognition, a sense of individual and cultural belonging. To illuminate the first theme, I explored how the inner life processes worked for Grace to transform her identity by overcoming adversity of past experiences in her childhood, to repair the past, to make it better by creating the family she had imagined. She identified, and re-defined in her life what mattered the most to her—she was “proud”

of who she was and what she had been able to overcome; for Grace success was defined by an inner transformation.

In the case of Melissa, social media created an opportunity of new friendships and emergent forms of personhood based on having a common experience of having a child with assisted conception. A key dynamic of this group was the sharing of intimate details in their lives, creating bonds that would become lasting friendships. They supported one another and stayed together through treatments until each had a child. The relationships within this group served as a catalyst in reworking identity, to give her a sense of belonging, a normative order. For Melissa success was defined as support and recognition from this network of friendships and chosen kin relationships.

Similar to Melissa, Susan sought social recognition but on a much larger scale. She needed visual recognition, to be “seen” as accomplished and to experience that recognition. Susan’s subjectivities, feelings of difference, and failure remained long after the birth of her triplets. It was not enough to have three children; Susan wanted to be recognized as being “an overachiever” exceeding the norms that for so long she felt she did not meet.

The biological imperative for many of the women in this study and in particular for Susan was a symbol of both “normalcy” as well as their “identities” as a white American middle class woman. In a cultural society as diverse as the United States, social recognition for Susan as well as some of the other women in this study signified a particular type of belonging. Knowing one’s roots and the desire for a biological connection preserved their socio-cultural identity (whiteness). Preserving their genetic inheritance (ensuring whiteness) was embodied as a quality of being normal. This

categorization of normalcy and whiteness is unmarked—invisible to these women as they follow an image of normalcy, to be seen as normal, is to be seen complying with understood local and cultural norms.

The construction and routinization of IVF technology is about the standards of human entry into a community (Rapp 2000:3), a class position, but I ask the question does it also create more stigma? For Susan, success was re-defined in her experiences, and represents a self-understanding of what it means to be normal, construed and experienced in creative ways as in her attempt to change cultural attitudes and thinking about women with infertility and IVF. Historically and cross culturally, many women suffer from social stigmas associated with infertility (Inhorn 1994; Becker 2000; Sandelowski 1993). Along with Rapp, Norsigian (1973) demonstrated how conscious raising methods (a form of activism),⁸ in a collective experience was one way to share embodied feelings and issues where women were marginalized. Susan's presentation on Listen to your Mother is an example of such conscious raising method. She exercises agency not in a form of resistance but in a creative way of gaining acceptance, by educating other women about infertility and IVF, her lived experience, and ability to overcome so many struggles and challenges. The women were able to relate her story as she metaphorically described her life with a roller coaster ride, in terms of meaning, the ups and downs, and how she hung on until she could become a mother. Susan was able to share the depth of her feelings in her story, what it meant to her to finally become a mother. By doing so Susan gains a form of acceptance demonstrated by the audiences standing ovation and applause. The feelings of failure Susan experienced before, during,

⁸ Conscious raising methods is a form of activism with the purpose of raising awareness on a particular issue, such as Breast Cancer or HIV/AIDS.

and after IVF is transformed from a sense of failure to being interpreted by the audience, as well as Susan as achieving success.

In the case study of Jae and Paxson's (2004) work, we see similarities and differences between the women. Paxson's participants' definition of motherhood was "socially realized," meaning that the moral framework of having children was as an ethic of service to the family and to the nation. Contrastingly, Jae did not feel an obligation or a moral duty to the nation; her sense of obligation was to herself and to her husband. The American ethos of individualism is self-fulfillment, not societal fulfillment.

The Greek women viewed motherhood as something to be worked at and achieved as part of their duty, while at the same time it was inevitable, as procreation was not a personal choice but God's will. "Making nature," in the Greek context of IVF, added a dimension of valor. The women were perceived as heroines, exceeding the line of duty to the state, and also in the context of assisted conception. Motherhood for Jae was not socially realized or seen as heroic, but as a "freak show." She encountered social resistance and struggles with her personal and religious values on assisted conception, conflicted at times because her own idea of conception and what she was able to do did not match societal norms.

Although Jae had envisioned an effortless life plan of career, marriage, and children, when confronted with infertility, failed IUI and IVF, Jae negotiated the meaning of what constituted motherhood, and the way in which she would accomplish her goal. Language, knowledge, and past experiences created the capacity for normative decision-making and judgments among possible alternatives of action. In response to dilemmas,

these actions were reconfigured in relation to Jae's hopes, fears, and desires for the future.

Through past experiences and the knowledge gained (historical knowledge), Jae pursued all options and avenues of medical treatment. An alternative solution such as adoption was viewed as undesirable and a last choice due to its financial burden; IVF was a more desirable choice due to its biomedical approach and her generous health insurance coverage. Jae's unlimited access to medical treatment with IVF appealed to her desire to do everything you can to achieve a goal. As a result, she was driven by a sense of obligation to continue trying, as well as a sense of moral responsibility to solve her infertility problem. This aspect of obligation, for example, was in Sandelowski's (1993) study of women and couples experiences of infertility treatments being compelled to try (92).

Secondly, quitting once she had already initiated a biomedical approach (IUI and IVF) would symbolize a dual failure—the failure to conceive and the failure to be cured (Becker and Nachtigall 1992, 468). For Jae, believing that technology was created to assist women to accomplish motherhood laid the foundation for her to acquire the knowledge needed to pursue her goal.

Gaining an understanding of the various forms of reproductive technology provided Jae with the motivation to continue even after repeated failures. Unwilling to succumb to failure, learning that she could become pregnant reinforced her desire to succeed. Furthermore, redefining success in terms of the smaller micro-successes of being able to become pregnant to maintaining a pregnancy to having a child allowed Jae to persevere in a difficult situation.

In this example, we can identify two themes, a double bind where a woman's subjectivities are at opposite ends of the continuum. At one end is failure, the inability to conceive without IVF, a nontraditional conception. At the other end, there is success, an accomplishment not once, twice, but three times—triplets. Jae experienced a double bind, where motherhood was achieved by assisted conception, yet that form of conception was challenged on cultural terms.

In contrast, in the case of Athenian women, Paxson (2003) found motherhood was viewed as a personal responsibility and assisted conception was considered a “natural and proper way” of reproduction in achieving the goal of motherhood, and also as a way of completing a marriage. Unlike Athenian women, Jae did not perceive IVF as natural, normal, or expanding upon nature; rather Jae understood IVF as an opportunity to be taken advantage of solely to achieve her goal of motherhood. In this sense, Jae felt it to be a personal opportunity rather than fulfilling a cultural obligation. In this similar vein, Sandelowski (1991) understood white middle-class women set goals and took advantage of opportunities to meet their goals in relation to reproduction as more powerful than a cultural mandate to reproduce (39).

Jae renegotiated the meaning of IVF technology and conception itself. In Jae's case, a double bind of what she feels she can and cannot control, for example her ectopic pregnancies—one occurs without assistance and one with. Jae re-negotiated the purpose of this technology as a “helping” hand from God giving the physicians the brilliance and power to “assist” and rework nature, rather than attribute her ill fate as God's will. The Greek women viewed IVF technology as being in control by God what he wants to give to you; the outcome was not within her control.

In addition, Jae felt responsibility to educate herself in her medical treatment to converse with her physicians, gaining a sense of control over her life and her self-concept. Jae's use of medical terminology to describe her good results up to the transfer and implantation where she achieved pregnancy served as small successes. These defining moments convinced her to try and try again, to continue to work hard, and to focus on her initial goal of becoming a parent. Jae's use of medical language created categories that attributed responsibility, credit, or blame for an event (Ahearn 2001:131). At the same time, Jae's use of medical language demonstrates her statistical ability, to analyze and compare her failures and her successes. She acquires a type of scientific literacy, which may be interpreted as a cultural accomplishment (Rapp 1999).

However, in Jae's view accomplishment was unable to occur until she had a child. While Jae continued to experience failed IUIs, knowing that she could become pregnant and what it meant to her to become a mother; to miss the love, the hugs, the special moments of feeling like "you are the mother of the year, so proud of your child"—this gave her the strength to persevere as well a sense of accomplishment.

Another finding is a paradox of technology. Here, the birth of Jae's triplets was the ultimate success that transformed her failed sense of self and abnormal identity. Caring for the triplets was an ongoing process that reaffirmed Jae's success and identity as a mother. Supportive friends also recognized Jae's ability to persevere and meet the challenges she faced with feeding, diapering, and caring for three infants. Like Athenian women, some family members did not recognize Jae as a heroine overcoming her infertility to have three children. Instead, Jae was confronted publicly, and unsupported by her mother-in-law, who viewed her children as unnatural. Jae felt the need to defend

her children to strangers as well as to her mother-in-law, whose accusations centered on her unnatural conception and failed pregnancies. Instead, Jae identified her primary role as that of mother. Jae's sense of motherhood included both the living children and the children who would have grown if she had not had an ectopic pregnancy. In summary, the meaning of motherhood for Jae, along with the expertise of reproductive physicians and IVF technology, worked synergistically to facilitate conception and incremental stages of success. The birth of her triplets was a long-awaited success.

What differs between the Paxson study and this study of American women is organization and unity. Unity, in this sense, is shared religious beliefs, Greek Orthodoxy, and organization in their ideologies of nationhood and identity. The Greek Orthodox religion is the basis and foundation of shared beliefs, morals and values. It is a common link that binds these women together they are united. The religious structure of Orthodoxy in this case, absorbs popular beliefs, practices, and traditions expressed in various rituals, and at times the political vicissitudes of the nation state. The authority of religion and political sense confer some semblance of "normalcy" (Mylonas 2003).

Unlike the Greek women, the America women in this study do not share the same religious beliefs⁹, nor do they share in the same ideologies of nationhood. Besides their infertility and IVF experience they are not united in any way. The semblance of normalcy that the Greek women share politically and religiously is absent in the American example. The importance of this distinction is cultural homogeneity. The Greek women were revered as heroines, because perceptions of a national experience conferred a sanctified sense of purpose and legitimacy to these women. Unlike the

⁹ The women in this study identified their religions as Catholic, Protestant, Lutheran, and not practicing any particular religious faith.

American example provided, with differing perceptions, and notions of normalcy. In other words, the difference in how “success” was interpreted culturally was as diverse as its citizens.

Conclusion

Available literature has discussed how infertility transforms women’s identity as a failed self (Greil 2002:105) and, when viewed as an illness, works to reshape identities (Reissman 2003; Todorova and Kotzeva 2004). Jae was considered infertile and, consistent with the literature, she experienced a failed sense of self and identity. The transformation of Jae’s identity and sense of self began with her decision to try a biomedical approach to achieve a successful conception. Although an ART conception is not always supported by a live birth or corroborated in the literature as the first step in the transformation of an identity, what is confirmed in the literature—and in this research—is how women are active agents of their own care in their experiences of infertility and pursuit of motherhood (Reissman 2002). This case further suggests that women who follow the path of IVF are only successful in the biomedical terms of a live birth, until such time a self-understanding of their own fundamental normalcy, reshapes their identity.

What this case exemplifies is success can be measured not just in biomedical terms, but also in alternative ways, in transformation of an identity, support, and social recognition. First, I demonstrated success in the transformation of an identity. The ability to overcome obstacles and life’s adversities and to determine what matters most in life. How the meaning of motherhood was renegotiated and redefined and contributed to the embodiment of success. Secondly, perseverance was a sign of success; for some women

redefining an obligation to pursue motherhood to an expectation allowed them to continue. Not quitting was experienced as incremental successes. Knowledge was another element of success experienced by these women, learning to adapt to a biomedical environment to accomplish their goal to become a mother. Third, another experience of success was support and recognition received from their husbands, members of their family, and friends. Personal recognition of success was demonstrated in the example when a woman said, "I did it," accomplishing her goal to become a mother. Fourth, social recognition was another alternative way in which the women experienced success; in smaller groups as in the example of social media friendships, and in much larger groups as exemplified in Susan's presentation of what it meant to her to become a mother in a large audience. Finally, success came in the formation of new kinship bonds, ones of trust, support, and admiration shared among women who experienced infertility, IVF, and finally, motherhood. Success is interpreted culturally, and as our landscapes change with time, so may our interpretations.

CHAPTER 6 CONCLUSION

The stories and examples that I have included in this dissertation explore the complexities associated with IVF in the lives of ten American white middle class women. One overarching theme in this research was “normalcy” and what it tells us about the normalizing process in contemporary lives of women after IVF. I now speculate on what this research can tell us about the cultural work of normalcy and perhaps more critically the subjectivity of experience, as it involves practices, negotiations, and contestations with others with whom we are connected before, during, and after successful IVF.

In the examples I provided I explored the tensions between what is culturally considered “normal” and what it means to “be normal” after successful IVF. To narrow this huge field, I focused primarily on the interconnections of experience and knowledge that influence our histories and practices in every day life. As our worlds change so do we. By focusing on the fluid meaning of “normalcy” and the practices in which we engage, we gain insight into subjective processes that work to reconfigure our identity’s, our sense of self, as well as reinterpret social and economic positions of ART. There are several aspects in this research I want to consider including the following topics: how experience and historical knowledge work to regain a sense of normalcy, the practice and rhetoric of normalcy, and how the biological imperative works in preserving the identities of the white American middle class women in this dissertation.

What I would like to stress is the complexity and the problems associated with studying IVF in America. Throughout this research I uncovered many different aspects in studying ART from financial barriers, to health risks, cultural ideologies, political and economic positioning, all interwoven within the subjectivities of the women who, simply

stated, just want to have a child. Methodologically, and following Gaye Becker's work in infertility in the context of IVF (Becker 2000), I tried to incorporate emergent forms of normalcy that impacted the lives of women during and after IVF. Which brings me to the theme of "my normal" and how women redefine the meaning of normalcy during and after IVF.

The Practice of Normalcy

The theme of this dissertation was normalcy, both as practice and materiality. In practice, women wanted to lead a "normal" life. Women with infertility pursued IVF to give them an opportunity to have a "normal" family. Trying to become pregnant and experiencing a pregnancy was interpreted as the "normal" thing to do. There were many instances where women described what they were supposed to do, like their mothers. They described their relationships with family members, and the desire to recreate what they had as children, and for some, what they didn't have and what they hoped to have, a "normal" family, to name a few examples. When I asked women what they meant by having a "normal" family? Some responded with to have a biological child. Their response to my question implied it should have been obvious. But to me, aren't all children biological? This was interesting a biological child implied a "normal" family.

Even more interesting what is a "normal" family? Remember Jae, as she described a family as one that is supportive, "having your back", being there for you, nothing to do with biology. Then there was Elise, who described the relationships with her parents, and sibling as the family she wanted to re-create. In both of these examples, the meaning of family was relationships. To this point, Sahlins views kinship relationships as performative and meaningful, whereby persons participate in each other's

existence, besides the connection of biology (Sahlins 2013). Yet, many of the women stated the purpose of IVF was to provide a “biological child” to have a “normal” family and “be normal”. The underlying reason for choosing IVF was at the heart of the cultural ideology of the American family: perpetuation of the origin myth of knowing one’s roots, and the maintenance of kinship traditions. Yet, time and time again I heard the reason the women chose IVF instead of adoption was to have a “normal” family, to “be normal” once again, to be seen as “normal”. The biological imperative, for Susan, was an insistence of being “in the norm not outside the norm” to fit within the normative framework of the American nuclear family.

Regaining a sense of normalcy also meant for these women being faced with challenges associated with traditional assumptions about how the family is constituted. Remember, Dana as she described IVF as a “bastardized conception”. Other examples included public confrontations and how triplets signaled the use of IVF technology experienced by Jae and Susan. Like Becker, I found that the cultural ideology of the biological child that pervades US culture does not lose its power once the child is born (Becker 2000). It is perpetuated in many ways, in “resemblance talk” or the idea of what is natural and normal in kinship. One difference from Becker’s work, was in how the women of twins and triplets felt they needed to defend the “normalcy” of their children when out in public as much as themselves. I gave several examples in how strangers approached these women and the conversations went beyond the inquiry of a genetic link to being questioned “are your children normal?” In this example, a child conceived with IVF implies that children may be less normal compared to children born without ART, an implication for both the mother and child that they are not normal. The women felt

compelled to defend and prove that not only are they normal, but their children are more normal. Which leads me to the practice of social normalcy.

Social Normalcy and Kinship

What does “being normal” really mean? In Chapter 3 I provided examples of how the women in this research wanted to “be seen” as doing what other “normal” women do, as in the example of Susan, wearing maternity clothes and preparing her baby’s nursery. In the course of describing wanting to be normal, the women in this research offered many insights that called upon different realms of sociality and different ways of reckoning with their sense of difference. For example, the story of their infertility experience in many cases was also a story of kinship relationships, of who was helpful and supportive, and who was judgmental. Some of the women in this research reflected on their interactions between family members during their childhood as well as during their course of infertility and IVF. Others led to more stories about family tensions, and their sense of obligation to family, and in some instances destabilizing relationships.

The women could render the experience of their kin relationships on so many different registers, whether in the positive affect because kin relationships remained supportive and intact, or in sorrow and anger heard in their narratives of dysfunctional family dynamics which put their sense of self worth and at times their lives in chaos.

For the women in this research a child that shared in their genetic makeup was a way to both preserve family relationships and to create and fulfill their idea of how members of a family should interact. Remember Elise who wanted to preserve the bonds and family relationships she experienced as a child with her parents and sibling. This finding is consistent with Edward’s description of English kinship, the knowledge of

knowing one's roots, and a sense of belonging within the family unit (Edwards 2000). Creating new kinship bonds were ways to repair past distressing kinship experiences in the stories of Jae and Grace. In both of these examples, they were powerless in controlling the dynamics within their families during their childhoods. This reminds me of the story Jae told me how she spent most of her holidays with a friend's family, rather than her own dysfunctional family. She described them as loving and kind, supportive and looked out for one another. Relationships that she did not have as a child, but believed how they should be. This was how a "normal" family should interact with each other. For Jae and Grace, the ability to repair their past was based on being able to create a future. This meant exercising an element of control over their daily lives, a sense of stability, being safe, one might even say re-defining their self-worth. I do not intend to take the stance that there is one point of view here, but multiple perspectives and ways of addressing the phenomenon of "normalcy" embodied in the inner life of subjects, and their lived experiences. My concern is how we interpret the meaning of a "normal" family through biology and technologies. Of particular concern is how our past experiences, our values, and emotions inform our futures, how they are closely connected, embodied, and projected into domestic spaces, public life, interpersonal struggles, and identities.

Another aspect of reproductive technology and how women redefine their sense of normalcy can be best understood from a cultural context. Women who have had successful IVF confront cultural ideologies surrounding social norms. A consequence for some women during and even after IVF is vulnerability, and a sense of exclusion. Remember Jae, and how susceptible she became to public scrutiny when she went

shopping with her triplets. Here I want to stress the importance of social networks in redefining normalcy, and creating a sense of belonging rather than exclusion. In chapter 4 I described how several of the women sought solace in media friendships during and after IVF treatments, and as Melissa described for me a way to “feel normal”. This social network of women (virtual family) provided a space for women to share ways in dealing with problems and differences during and after IVF. It worked, much like an antidote to remedy the sense of difference that the medicalization of infertility had fostered for so many years. My emphasis here is how social media and social networking becomes a space, a medium for renegotiation of their identity. Their sense of self transforms with the support and guidance in this community of women. This transformation emerges from their statements about how those ideologies of what “normal” means affects their lives. Not only how it shapes their actions, but also how it reshapes their identity. This reminds me of the work of Susan Reynolds Whyte and others in social difference. Whyte’s (2009) work was concerned with subjectivity and bio-power in the transformation of identities. Her focus was on the ways that health conditions impact identity and subjectivity, and the process and action towards change (Whyte 2009:7). Rabinow’s (1996) work examined the way technology actually creates social difference and social groupings, and launched the term “biosociality” to capture the way biological nature, as revealed and controlled by science becomes the new basis for sociality. Here, in the formation of a social network of women post IVF, and how individual identities are reshaped and practices emerge. The women’s experiences of social difference during and after IVF, and the forging of collective identities are similar to the work of Rayna Rapp. Rapp also described communities of difference in her work with Down syndrome

children, and how the parents of these children developed friendships and support (Rapp 1999:302). Concerning “biosociality”, Rapp concludes that biomedicine and technology may encourage such categories of difference, but these claims do not go uncontested in how identities are used and transformed into contemporary social life. To that end, we will shift from the registers of failure and difference to the sense of belonging and success.

Practice and Rhetoric of Success

I identified several strategies the women practiced to determine success beyond the birth of their children. One strategy was the rhetoric of success. I provide examples of how women described the incremental stages of their IVF treatments as micro-successes, and the birth of their children as the “ultimate” success. While describing their birth experience and life after the birth of their children several of the women used words such as “accomplishment”, and “achievement” along with performative statements of “ I really did it, I worked hard to achieve my goal”. I want to expand on this rhetoric of “accomplishment” to understand the context and the conditions that accompany the sense of success.

The mantra of working hard to accomplish a goal to “be successful” falls in line with middle class American ethos as a normative framework of “being normal middle class Americans” (Schneider and Smith 1973). The investment of IVF and the pay off in the form of child with ART, becomes performative, the need to be “seen” is understood as the need to be recognized in relationships; husband, family, friends, social networks, and society as having worked harder than other women to become mothers. In other words, these women do not see themselves as average, or just normal, they have created a

category of “my normal” to be understood as being better than average, above the “normal”.

This idea of being above average was a common thread among the women in this study, a sense of accomplishment overcoming infertility to becoming a mother of multiples, for example. Remember Susan, as she tells her story of infertility and life threatening IVF experience before a live audience of women. Susan is the protagonist. She describes the depth of her sadness during infertility, her death defying experience of IVF. She overcomes tremendous obstacles to become a mother. She gains their sympathy and their recognition for her “over achievement” towards her path to motherhood of triplets.

Another example is the way in which the women experience success is in the form of mothering. Caroline and Susan describe the moral character of their children in comparison to other children in several incidents where other children misbehave. They spend “quality” time with their children because they worked so hard to have them compared to other mothers. Their children’s character, and intellectual abilities are a result of their mothering, hence, their success. A different form of success is in the example of Jae. Jae stated that “being successful” is being able to balance her demanding career and chaotic lifestyle while raising triplets, being able to handle any form of “chaos”. In each of these vignettes, recognition and support came from their social network, BFF’s, which they continued to maintain years after the birth of their children.

At least for the present, women who have had a child with IVF may consider their path and course of treatment with IVF as much about failures as it is about successes. For this reason, some women will never have a child with IVF, others may never even have

the opportunity to try, which leads to me to the discussion of exclusion and inequalities in ART.

Exclusion and Inequalities

Within the corpus of literature on infertility and treatment options, a chosen few are able to consider the option of ART, namely those with economic means, and most often times a particular class position, middle to upper class. The women in this research identified themselves as “middle class” yet the term itself is ambiguous. The term middle class, and in this research “white middle class women” carries certain connotations of productivity, wealth, and specific living conditions (Rapp 1978). Without prompting, many of the women reflected on the social and economic conditions of their childhoods. Some of the women described themselves as “successful” businesswomen rising from poor (blue-collar families) financial conditions, incurring significant debt from educational loans, and to their present professional careers. Only one woman, Tanya, described her lifestyle as carefree and without financial burden growing up.

All of the women in this study considered the access to ART problematic, not only for themselves, but all women regardless of race, or financial positioning. An advocate for ART for all women would be Jae. In her role as a healthcare administrator she had access to corporate leaders in the insurance industry. She became an advocate of ART for all women, lobbying for improved health care coverage and to increase the number of IVF cycles to reduce the chance of triplet births. I bring up this point, because access to health care and ART in particular is associated with the wealthy, and the white middle class. The women in this study acknowledged the privilege of their social class to afford ART, and resisted the idea that only women of wealth should have access to ART.

I wonder if I had studied another group of women (other than white middle class women) would I have uncovered the same sentiment, or would the characterization that white middle class women are not concerned with such inequalities have ever been revealed.

Seline Quiroga's writings about whiteness and superiority are useful in my own consideration of ART and whiteness. According to Quiroga's findings, heritable genetic ties links whiteness with superiority as a genetic trait, a symbol of success that reinforces white kinship patterns. She writes, with "our willingness and ability to resist white genetic imperatives and instead articulate a model of family in which the social aspects of parenting and kinship are primary would be one way to undermine the idea that heritable biogenetic ties are essential to defining family" (157). To that end, I depart from Quiroga's idea of heritable genetic ties reinforcing a white kinship pattern as universally interpretable as genetic essentialism. Rather I suggest the women in this study are preserving their identity as they too advocate for all women to have access to ART, and the preservation of their families and identities. The biological imperative described in each of the chapters are concerned with certain freedoms, the freedom to have access to ART, for some to uphold their ideologies of kinship, identities, means preserving the ideology of family the preservation of their identities and kin relationships. The women's insistence on a biological link emphasizes the importance of past relationships and the preservation of formation of new relationships in their future.

New Sociality: Virtual Kinship

Regaining a sense of normalcy after successful IVF, particularly in the case of multiple births is very different then redefining normalcy after unsuccessful IVF. I want

to take a step back to consider the broader social implications that ART has created in the daily lives of these women, as well as the inequalities of ART.

A decade ago many of the ethnographies in this dissertation were written with the focus on infertility, and regaining normalcy after unsuccessful IVF, or the decision to remain childless or consider adoption. Since that time, the number of IVF clinics has increased considerably in the US and globally. It has become a consumers market to shop for the best prices, the least cost per IVF cycle. Despite cost comparison data in many women's magazines, access to IVF remains for those in the US who can afford the hefty price tag. Excluding women of lower socioeconomic means persists in the world of assisted reproduction today. The Affordable Care Act was yet another snub to women of lower socioeconomic means, providing assistance to prevent pregnancy not facilitate a pregnancy.

The idea that ART has become more "routine" in the past decade stated by Franklin may be true, and that more women and more births occur from IVF today may also be true. But, what also has occurred is considerable more attention in social media and discourse about ART. I wonder, does something, like IVF, that has become more "routine" also become more accepted, normal, or does it become more threatening? Threatening, because of change on many fronts, changing family structures, changing ideologies of family, social norms, preserving and maintaining kinship ideologies and identities. Accepting because it provides childless women and couples a chance, and for a limited few, a child. There was something very different about ART a decade ago, it did not receive the publicity it does today, in social media, television, women's magazines to name a few. Stories about mothers of multiples heighten public awareness, and as I have

shared in the examples in this dissertation, greater attention to the power of technology. For many women social networking has become a medium, to gain access to ART in the form of knowledge and support from other women who have shared similar life experiences. These lived experiences have created new forms of virtual kinship. Rapp conducted studies on family dynamics where individuals chose to foster relationships with friends who were supportive rather than their biological relatives particularly in support groups (Rapp 1978). The difference in “virtual kinship” compared to Rapp’s “fictive kinship” is the space in which this relationship begins, the evolution and maintenance of these relationships long after the children are born compared to short term relationships found in support groups.

Now that IVF has proliferated and more children are born with ART, we see the emergence of new socialities, virtual kinship. This form of social networking originally began to support women with infertility, and flourished into much greater numbers of women, many that followed their stories that did not experience infertility. From there evolved new networks of women, excluding women who did not share in their life experiences. Smaller groups of women then banded together particularly women with multiples supported one another, and eliminated the sense of difference they experienced outside this group. This virtual kinship network became a basis for self-reliance, to encompass personal development and transformation. It will be interesting with time, to see how these socialities and subjectivities change as ART becomes more routine, kinship models change, and multiples become more the norm.

Concluding Thoughts

Throughout this research, I aimed to understand the personal and cultural issues surrounding infertility and the technology of ART. I am honored and grateful for the privilege of working with these women, and for being given their trust to share their personal stories. There were many times that their stories were difficult and painful for them to recount, and revealed their vulnerability. Yet, these women welcomed me, for which I hope they accept my gratitude. I hope my presence listening to their stories made a difference to them as well.

REFERENCES

Ahearn, Laura M.

2001 Of Language and Agency. *Annual Review Anthropology* 30:109–137.

American College of Obstetrics and Gynecology/

2005 The Green Journal

Becker, Gay

1990 *Healing the Infertile Family*. Berkeley: University of California Press.

1994 *Metaphors in Disrupted Lives: Infertility and Cultural Constructions of Continuity*. *Medical Anthropology Quarterly* 8:383–410.

1997 *Disrupted Lives: How People Create Meaning in a Chaotic world*. Berkeley: University of California Press.

2000 *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. Berkeley: University of California Press.

Becker, Gay, and M. Castrillo, R. Jackson, and Robert D. Nachtigall

2005 Infertility among low-income Latinos. *Fertility and Sterility* 85(4):882–887.

Becker, Gay, and Robert D. Natchigall

1992 Eager for Medicalization: The Social Production of Infertility as a Disease. *Sociology of Health and Illness* 14:456–471.

1994 Born to be a Mother: The Cultural Construction of Risk in Infertility Treatment in the United States. *Social Science and Medicine* 39:507–518.

Bell, Ann

2009 It's Way Out of My League: Low-income Women's Experiences of Medicalized Infertility. *Gender and Society* 23(5):688–709.

Bellah, Robert, Richard Madsen, William Sullivan, Ann Swidler, and Steven Tipton

1986 *Habits of the Heart: Individualism and Commitment in American Life*. New York: Perennial.

Berger, P., and T. Luckmann

1967 *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. London: Penquin Books.

Biehl, João, Byron Good, and Arthur Kleinman

2007 *Subjectivity: Ethnographic Investigation*. Berkeley: University of California Press.

Biehl, João, and Amy Moran-Thomas

2009 *Symptom: Subjectivities, Social Ills, Technologies*. *Annual Review of Anthropology* 38:267–288.

Bourdieu, Pierre

1977 *Outline of a Theory of Practice*. Stanford: Stanford University Press.

Bray, Francesca

2007 *Gender and Technology*. *Annual Review of Anthropology* 16:37–53.

Canguilhem, Georges

1991 *The Normal and the Pathological*. C. R. Fawcett and R. S. Cohen, trans. New York: Zone.

Carsten, Janet

2004 *After Kinship*. Cambridge: Cambridge University Press.

Centers for Disease Control and Prevention

2012 *Data Brief*. <http://www.cdc.gov/nchs/data/databrief/db175.htm>

Collier, Jane, Michelle Z. Rosaldo, and Sylvia Yanigasako

1992 Is There a Family? New Anthropological Views. *In Rethinking the Family: Some Feminist Questions*. B. Thorne and M. Yalom, eds. Pp. 31–48. Boston: Northeastern University Press.

Conrad, Peter, and Rochelle Kern

1990 The Sociology of Health and Illness: Critical Perspective, 3rd ed. New York: St. Martin's.

Danziger, Kurt

1997 Naming the Mind: How Psychology Found its Language. London: Sage.

Desrosieres, Alain

1998 The Politics of Large Numbers: A History of Statistical Reasoning. Camille Naish, trans. Cambridge: Harvard University Press.

Douglas, Mary

1966 Purity and Danger. New York: Routledge.

1992 Risk and Blame: Essays in Cultural Theory. New York: Routledge.

Durkheim, Emile

1963 Elementary Forms of Religious Life. New York: The Free Press.

Edwards, Jeannette

2000 Born and Bred: Idioms of Kinship and New Reproductive Technologies in England. Oxford: Oxford University Press.

Ewald, Francois

1991 Norms, Risk, and the Law. *In Law and the Order of Culture*. R. Post, ed. Pp. 138–161. Berkeley: University of California Press.

Feinberg, Eve C., Frederick W. Larsen, William H. Catherino, Jun Zhang, and
Alicia Y. Armstrong

2006 Comparison of Assisted Reproductive Technology Utilization and Outcomes
Between Caucasian and African American Patients in an Equal-Access-to-Care
Setting. *Science Direct* 85(4):888–894.

Finkler, Kaja

2000 *Experiencing the New Genetics: Family and Kinship on the Medical Frontier*.
Philadelphia: University of Pennsylvania Press.

Fortes, Meyer

1949 *The Web of Kinship*. London: Oxford University Press.

1969 *Kinship and the Social Order: The Legacy of Lewis Henry Morgan*. London:
Routledge & Kegan Paul.

Foucault, Michael

1979 *Discipline and Punish: The Birth of a Prison*. New York: Vintage.

1990 *The History of Sexuality, vol. 1 An Introduction*. Robert Hurley, trans. New
York: Vintage.

2002 *On the Order of Things: An Archaeology of the Human Sciences*. New York:
Routledge Classics.

Franklin, Sarah

1995 *Postmodern Procreation: A Cultural Account of Assisted Reproduction*. *In*
Conceiving the New World Order: The Global Politics of Reproduction. Pp. 323
234. Berkeley: University of California Press.

1997 *Embodied Progress: A Cultural Account of Assisted Conception*. London:

Routledge.

2000 Life Itself. Global Nature and the Genetic Imaginary. In S. Franklin, C.Lury & J. Stacey [Eds.] Global Nature, Global Culture Pp.188-227. London. Sage.

2001 Relative Values: Reconfiguring Kinship Studies. Durham: Duke University Press.

2013 Biological Relatives: IVF, Stem Cells, and the Future of Kinship. Durham: Duke University Press.

Giddens, Anthony

1991 Modernity and Self-Identity: Self and Society in the Late Modern Age. Stanford: Stanford University Press.

1997 Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis. Berkeley: University of California Press.

Ginsburg, Faye D., and Rayna Rapp

1991 The Politics of Reproduction. Annual Review of Anthropology 20:311–343.

1995 Conceiving the New World Order: The Global Politics of Reproduction. Berkeley: University of California Press.

Goffman, Erving

1963 Stigma: Notes on the Management of Spoiled Identity. Prentice Hall.

Good, Byron

1994 Medicine, Rationality, and Experience: An Anthropological Perspective. Cambridge: Cambridge University Press.

Greil, Arthur L., and Julia McQuillan

2010 Trying Times: Medicalization, Intent, and Ambiguity in the Definition of

Infertility. *Medical Anthropology Quarterly* 24(2):137–156.

Greil, Arthur L., Kathleen Slauson-Blevins, and Julia McQuillan

2010 *The Experience of Infertility: A Review of Recent Literature*. University of Nebraska-Lincoln.

Hallowell, Irving

1955 *Culture and Experience*. New York: Schocken.

Haraway, Donna

1991 *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge.

1996 *Modest_Witness@Second_Millennium.Female_Man_Meets_OncoMouse*. London: Routledge. Hallowell, Irving

Hartigan, John

1997 *Establishing the Fact of Whiteness* *American Anthropologist* 99(3)Pp495-505.

Holland, Dorothy

1997 *Selves as Cultured: As Told by an Anthropologist Who Lacks a Soul*. In *Self and Identity: Fundamental Issues*. R. Asmore and L. Jussim, eds. Pp. 193–221. New York: Oxford University Press.

Holland, Dorothy, William Lachicotte Jr., Debra Skinner, and Carol Cain

1998 *Identity and Agency in Cultural Worlds*. Cambridge: Harvard University Press.

Holland, Dorothy, and Kevin M. Leander

2004 *Ethnographic Studies of Positioning and Subjectivity: An Introduction*. *Ethos* 32(2):127–139.

Inhorn, Marcia

1994 Interpreting Infertility: Medical Anthropology Perspectives. *Social Science and Medicine* 39:459–461.

Karantzakis, Nikos

2012 *The Selected Letters of Nikos Karantzakis*. Peter Bien, trans. Princeton: Princeton University Press.

Kotzeva, Tatyana and Irina Todorova,

2006 Contextual shifts in Bulgarian Women's Identity. *Psychology and Health* 21(1):123–141.

Leventhal, Howard, E. Idler, and E. Leventhal

1999 The Impact of Chronic Illness on the Self System. In *Self: Social Identity and Physical Health*. Richard Contrad and Richard Ashmore, eds. New York: Oxford University Press.

Luborsky, Mark

1994 The Cultural Adversity of Physical Disability: Erosion of Full Adult Personhood. *Journal of Aging Studies* 8(3):239–253.

Marcus, George E., and Michael J. Fischer

1986 *Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences*. Chicago: University of Chicago Press.

Marcus, Hazel Rose, and Shinobu Kitayama

1991 Culture and the Self: Implications for Cognition, Emotion, and Motivation. *Psychological Review* 98(2):224–253.

Marsh, M., and W. Ronner

1996 *The Empty Cradle: Infertility in America from Colonial Times to the Present*.

Baltimore: Johns Hopkins University Press.

Martin, Emily

1987 *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon.

1994 *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon.

Martin, J. A., B. E. Hamilton, and M. J. K. Osterman

2014 *Birth in the United States*. National Center for Health Statistics.

May, E. T.

1995 *Barren in the Promised Land: Childless Americans and the Pursuit of Happiness*. New York: HarperCollins.

McAdams, D. P.

1988 *Power, Intimacy, and the Life Story: Personological Inquiries into Identity*. New York: Gullford.

Modell, Judith

1989 *Last Chance Babies: Interpretations of Parenthood in an In Vitro Fertilization Program*. *Medical Anthropology Quarterly* 3(2):124–138.

Murphy, Robert

1990 *The Body Silent*. New York: W. W. Norton

Mylanos, Christos

2003 *Orthodox Fundamentals: The Quest for an Eternal Identity*. New York: Central European University Press.

National Health Statistics Report

2014

Norsigian, Judy

1973 *Our Bodies Our Selves*. New York: Simon and Schuster.

Ortner, Sherry

1973 On Key Symbols. *American Anthropologist* 75(5):1338–1346.

1984 *Theory in Anthropology Since the Sixties*. *Comparative Studies in Society and History* 26(1):126–166.

1989 *High Religion: A Cultural and Political History of Sherpa Buddhism*.

Princeton: Princeton University Press.

1996 *Making Gender: The Politics and Erotics of Culture*. Boston: Beacon.

2006 *Anthropology and Social Theory: Culture, Power, and the Acting Subject*.

Durham: Duke University Press.

Paxson, Heather

2003 With or Against Nature? IVF, Gender and Reproductive Agency in Athens, Greece. *Social Science and Medicine* 56:1853–1866.

2004 *Making Modern Mothers: Ethics and Family Planning in Urban Greece*.

Berkeley: University of California Press.

Peletz, Michael

1995 Kinship Studies in Late 20th Century Anthropology. *Annual Review of Anthropology* 24:343–372.

Probyn, Elspeth

1996 *Outside Belongings*. London: Routledge

Quiroga, Seline

2007 Blood is Thicker than Water: Policing Donor Insemination and the Reproduction of Whiteness. *Hypatia* 22:2-143-161.

Ragone, Helena

1998 Incontestable Motivations. *In* *Reproducing Reproduction Kinship, Power, and Technological Innovation*. Sarah Franklin, ed. Philadelphia: University of Philadelphia Press.

Rapp, Rayna

1978 Family and Class in Contemporary America: Notes toward an Understanding of Ideology. *Science & Society* 42:3-278-300.

1999 Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America. New York: Routledge.

Reissman, C. K.

2002 Doing Justice: Positioning the interpreter in Narrative Work *In* *Strategic Narrative: The New Perspectives on Personal and Cultural Storytelling*. W. Patterson, ed. Lanham MA Lexington Books.

2003 Performing Identities in Illness Narratives of Infertility: Masculinity and Multiple Sclerosis. *Qualitative Research* 3:5-33.

Reuters

2014 Number of test-tube babies born in U.S. hits record percentage.

Reynolds Whyte, Susan

2009 Health Identities and Subjectivities. *Medical Anthropology Quarterly* 23(1): 6-15.

Rovane, C.

1998 *The Bounds of Agency: An Essay in Revisionary Metaphysics*. Princeton: Princeton University Press.

Sahlins, Marshall

2013 *What Kinship is-And is Not*. Chicago. The University of Chicago Press.

Sandelowski, Margarete

1991 *Compelled to Try: The Never-Enough Quality of Conceptive Technology*. *Medical Anthropology Quarterly* 5:29–47.

1993 *With Child in Mind: Studies of the Personal Encounter with Infertility*. Philadelphia: University of Pennsylvania Press.

Sandelowski, Margarete, and Sheryl deLacey

2002 *The Use of a “Disease:” Infertility as a Rhetorical Vehicle*. *In Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies: A View from the Social Sciences*. M. C. Inhorn and F. van Balen, eds. Pp. 33–51. Berkeley: University of California Press.

Schneider, David M.

1968 *American Kinship: A Cultural Account*. Chicago: The University of Chicago Press.

Schneider, David, and R. Smith

1973 *Class Differences and Sex Roles in American Kinship and Family Structure*. Englewood Cliffs: Prentice-Hall.

Segal, J. M.

1991 *Agency and Alienation: A Theory of Human Presence*. Lanham: Rowman and Littlefield.

Sewell, William H., Jr.

1992 A Theory of Structure: Duality, Agency, and Transformation. *American Journal of Sociology* 98(1):1–29.

Simon, B.

1997 Self and Group in Modern Society: Ten Theses on the Individual Self and the Collective Self. *In The Social Psychology of Stereotyping and Group Life*. R. Spears, P. J. Oakes, N. Ellemers, and S. A. Haslam, eds. Pp. 318–335. Oxford: Blackwell.

Sokefield, Martin

1999 Debating Self, Identity, and Culture in Anthropology. *Current Anthropology* 10(4):417–448.

Sontag, Susan

1978 *Illness as Metaphor*. New York: Farrar, Straus, and Giroux.

Strathern, Marilyn

1992 *Reproducing the Future Essays in Anthropology, Kinship, and the New Reproductive Technologies*. New York: Routledge.

1995 *Disembodied Choices. In Other Intentions: Cultural Contexts and the Attribution of Inner States*. L. Rosen, ed. Pp. 69–90. Sante Fe: School of American Research Press.

Thoits, P., and Lauren Virship

1997 Me's and We's: Forms and Functions of Social Identities *In Self and Identity: Fundamental Issues*. R. A. L. Jussin, ed. Oxford: University Press.

Thorne, Bellah

1992 Feminism and the Family: Two Decades of Thought. *In* Rethinking the Family: Some Feminist Questions. B. Thorne and M. Yalom, eds. Pp. 3–30. Boston: Northeastern University Press.

Throsby, Karen

2010 Doing What Comes Naturally: Negotiating Normality in Accounts of IVF Failure. *In* Governing the Female Body: Gender, Health, and Networks. L. Reed and P. Saukko, eds. Albany: State University of New York Press.

Todorova, Irina G., and Tatyana Kotzeva

2006 Contextual Shifts in Bulgarian Women's Identity in the Face of Infertility. *Psychology and Health* 21(1):123–141.

White, L., J. McQuillan, and A. L. Greil

2005 Explaining Disparities in Treatment Seeking: The Case of Infertility. *Fertility and Sterility* 85(4):853–857.

Whyte, Susan Reynolds

2009 Health Identities and Subjectivities: The Methodological Challenge. *Medical Anthropology Quarterly* 23(1):6–15.

Yanigasako, Sylvia, and Jane Collier

1987 *Gender and Kinship: Essays Toward a Unified Analysis*. Palo Alto: Stanford University Press.

ABSTRACT**HEALING THE SOCIAL BODY AFTER ASSISTED REPRODUCTION**

by

CVETANA CINDY GOLUSIN**August 2016****Advisor:** Andrea Sankar**Major:** Anthropology**Degree:** Doctor of Philosophy

This dissertation is concerned with the lived experiences of ten women after having children with In Vitro Fertilization. I examine the reshaped subjectivities that emerge within the women's everyday life experiences to deepen understandings of human agency by exploring the intersection of assisted reproductive technologies, cultural ideologies, and social interactions as components in the transformation of the women's identity. The experience of in vitro fertilization offered a fertile place in which to examine the roles that social and interpretive practices play in constituting the subjective experience in recasting a women's identity. The study design consisted of informant interviews and case studies using ethnographic methods to illustrate how social interactions, cultural ideologies, technologies, and personal experience all converge in how we think of key concepts of culture, agency, and subjectivity.

Findings explore how cultural ideologies of assisted conception inform notions of normalcy, influence subjectivity and new forms of sociality. For many women social networking has become a medium, to gain access to ART in the form of knowledge and

support from other women who have shared similar life experiences. From this form of social support I explore the emergence of new socialities—virtual kinship.

The notion of normalcy is unpacked in the quest of parenthood, motherhood, kinship, and the rhetoric of success is scrutinized. The idea of success is unpacked to reveal the fragility of how women categorize success beyond assisted conception and how cultural ideologies inform their everyday practices. These findings may be useful to think about how reproductive technologies inform cultural practices and, in turn, affect human agency, providing a richer conception of human subjectivity especially relevant to the anthropology of agency.

AUTOBIOGRAPHICAL STATEMENT

Cvetana Cindy Golusin graduated from Wayne State University's Department of Anthropology doctoral program in August 2016. She received her BS degree in nursing from the Regents College of New York in Albany, New York; her MSN in health care administration and her MBA from the University of Detroit Mercy in Detroit, Michigan. She is the recipient of the University of Detroit Mercy's Dean's Scholar Award (2000), Chairperson's Award (2000), Alumnae of the Year Award (2004), Beta Gamma Sigma Award (2000), and Cambridge's Who's Who of Executives and Professionals (2007). Ms. Golusin has many years of experience focusing on women's health and cardiology in various hospital and clinical settings, and has served as a consultant in quality of care initiatives and has worked in various administrative roles. She is presently an acting chief executive officer overseeing the operations of various medical clinics in Southeastern Michigan. Current research interests in anthropology include biotechnology, women's health, medical ethics, clinical settings and how third-party payors influence clinical practice and patient's experiences and outcomes.