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“IT’S WAY OUT OF MY LEAGUE”

Low-income Women’s Experiences of Medicalized Infertility

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The cultural construction of motherhood represents women of low socioeconomic status (SES) as excessively fertile, placing them outside of the infertility discourse. Previous research on infertility reinforces poor women’s exclusion by focusing on the experiences of women receiving medical treatment, typically women of high SES. In this article, the author explores how 20 poor and working-class women negotiate their experiences of infertility. In-depth interviews expose the contextual experiences of infertility among women of low SES, specifically revealing the structural inequality apparent within those experiences. The women are not passive objects of dominant discourses; they are active subjects in resisting, redefining, and accepting the discourses according to their contexts. Women of low SES are outsiders—within to dominant understandings and resolutions to infertility. Their unique insights not only provide a more nuanced understanding of infertility but they also begin to deconstruct the stratified system of reproduction.

Keywords: *reproduction; class; gender; stratification; family; health; medical*

I am the social services director here at Saving Grace,¹ and we received your email concerning your . . . project and the recruitment of women who may be experiencing not being able to conceive. . . . Quite honestly, it seems as though most of the women that we serve do not experience infertility. We’re actually pushing women into birth control because so many of our young women seem to have multiple births and quite honestly many of them are having multiple births out of wedlock, which of course then causes them to go on state aid or seek assistance through organizations like ourself or financial support or emergency financial distress. But,

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I do want to talk to you about it because sometimes phone messages and emails don't quite convey the real intent of what you're trying to do.

—Voicemail message from *Saving Grace* to the author (March 14, 2008)

In response to my research request, this nationally recognized social service agency serving low-income populations offered the current U.S. metanarrative around poor women's fertility and subsequently its antithesis, infertility.² Dominant views of class and motherhood have stereotyped notions of fertility and infertility along socioeconomic divides (McCormack 2005).³ Poor Black women have been constructed as highly (and uncontrollably) fertile and unfit to be mothers with images of the welfare queen, crack babies, and teen mothers reinforcing this depiction, whereas middle- and upper-class white women are commonly portrayed as infertile with successful higher order multiple births infiltrating the media (Sandelowski and de Lacey 2002).

This class-based framing of reproduction has fueled various policies and responses to infertility. As reflected in the introductory quote, even programs that are meant to "serve" marginalized populations attempt to control the fertility of those who do not adhere to social norms, such as the unmarried and underprivileged, while encouraging reproduction among the dominant groups. For example, Medicaid covers contraceptive methods but not infertility treatments, while the reverse is true for several private insurers (King and Meyer 1997). In other words, there are "those for whom there is contraception if they'd only use it, and those for whom there are infertility treatments" (Cussins 1998, 73).

There is, however, a significant disjuncture between the construction of poor women's fertility and the realities of their lives. In fact, just as many women of low socioeconomic status (SES) are infertile compared to their wealthier counterparts. Nearly 14 percent of women with less than a high school education reported impaired fecundity, compared to approximately 12.5 percent of women with at least a college degree.⁴ Despite having similar rates of infertility, women of low SES receive less treatment. In 2002, only 10 percent of women with less than a high school education received any infertility service, compared to 18 percent of women with at least a college degree (Chandra et al. 2005).⁵ The current focus on treating infertility rather than preventing it reflects an implicit policy focus on women of high SES, whose fertility problems are more likely because of their late marriages and delayed childbearing. Poor and working-class women's infertility is more likely to be because of sexually transmitted infections or environmental and occupational

hazards—factors that could be resolved through preventive public health interventions (Green et al. 2001).

The experiences of infertility among women of low SES have also been overlooked in the literature. Studies of infertility tend to frame it as an issue of the wealthy. Most infertility research utilizes convenient, treatment-based samples, typically composed of women of high SES (Heitman 1995). While this provides insight into one type of infertility experience, it reinforces the stereotype that infertility is an affliction of the rich and overlooks nonmedicalized experiences of the phenomenon. How do women experience infertility when they are outside of its discourse and unable to attain medical treatment to resolve the issue?

This article is an attempt to answer that question. First, I reveal how infertility is socially constructed along class lines. As Sandelowski and de Lacey (2002, 36) aptly reflect, infertility can be thought of as a “cultural disorder” because it serves as a “mirror” of cultural norms and a “barometer” of cultural change. Reviewing the social construction of infertility will not only shed light on individuals’ infertility specifically but it will also reflect the political economy of reproduction in general and the institutional powers that shape it (Ginsburg and Rapp 1991). Second, I examine how poor and working-class women negotiate experiences of infertility in a context of structural inequality. Such women are the “other” to motherhood on two accounts; they are both childless and economically disadvantaged (Letherby 2002a). They must grapple with the stigma of being childless while simultaneously rejecting the negative stereotype that they should not be mothers in the first place. Ultimately, I aim to understand how poor and working-class women actively resist and negotiate the dominant ideologies surrounding infertility.

To accomplish these goals, I initially review the basis for classed notions of motherhood, thereby explicating classed notions of nonmotherhood. Next, I explore how dominant ideologies are played out in policies and practice, specifically those involved in reproductive control and benefits and the medicalization of infertility. Finally, through economically disadvantaged women’s own voices, I examine how they experience infertility.

THE SOCIAL CONSTRUCTION OF INFERTILITY

The “motherhood mandate” (Koropeckyj-Cox and Pendell 2007; Russo 1976) requires *all* women to mother, as it equates womanhood to

motherhood, yet the current “intensive mothering” ideology outlines *who* should mother as well as *how* one should mother (Hays 1996; Johnson and Swanson 2006). These intersecting ideologies provide a conflict for women who cannot adhere to one or both of the ideals. Lower- and working-class women experiencing infertility are one such group. Not only are they childless, placing them at odds with the mandate, but they are also unable to attain the physical, emotional, and financial demands of intensive mothering (Fox 2006). As Hays (1996) describes, intensive mothering is based on a white, middle-class, heterosexual standard to which “other” mothers are compared. Women who are self-sacrificing and child centered are defined as “good” mothers according to this ideology. Women unable to fulfill this ideal are marginalized and systematically devalued (Connolly 2000; McCormack 2005). This is a process of normalization whereby proper motherhood is produced and variation of experience is diminished. Women of low SES are thus marked as “bad” mothers. They do not possess the resources of the middle class yet are expected to achieve its standards of motherhood (Baker and Carson 1999; McCormack 2005). Not only are increased demands placed on women who do not fit the narrative of motherhood, but they are also set up for failure according to the social expectations of “good mothering.”

These ideas play out in policies and practices around infertility where ideological positions are put into action. A historical view of reproductive policies in the twentieth-century United States illustrates the inherent power relations within the stratified system of reproduction (Roberts 1997). Groups that adhere to social norms are defined as “fit” and “deserving” mothers, empowered to reproduce, whereas those not fitting the dominant model are discouraged from having children (McCormack 2005). This binary understanding was enforced by the eugenics movement in the first half of the century (Steinberg 1997), followed by sterilization abuse in the 1960s and 1970s and federally funded family planning programs in the 1970s and beyond (King and Meyer 1997). All of these programs were attempts to reduce the reproduction and heritability of the unfit, marginalized, and abnormal groups, such as poor women and women of color.

Women of higher classes were also affected by these movements in that they were subject to pronatalist policies and therefore unable to access methods to limit their reproduction (Glenn 1994). For instance, after the Supreme Court decision in *Roe v. Wade* (1973), abortion came under the control of medicine rather than individual women. In turn, access to abortions ironically became more difficult for women of high SES once abortion was legalized (Gordon 2002).

Current reproductive benefits around infertility continue to reproduce classed notions of fertility. King and Meyer (1997) argue that insurance coverage of infertility treatments is implicitly underpinned by a eugenic logic (Steinberg 1997). In Illinois, for example, the state mandates that employer-based insurers provide coverage of infertility treatment, typically to middle-class women, yet poor women on Medicaid do not receive such benefits. In addition, Medicaid recipients have mandated coverage of contraception, yet the same is not true for private, employer-based insurance policies. This “dualistic natalist policy” discourages births among women of low SES and encourages them among women of higher SES (King and Meyer 1997).

Issues around insurance coverage of infertility treatments came to the fore with the increased medicalization of the issue. Medicalization is a process whereby a previously natural, social, or behavioral entity is transformed into a medical one, therefore requiring medical treatment. Since the advent of reproductive technologies in the 1970s and 1980s, infertility has increasingly been constructed as a disease and something to be treated rather than a social construction or natural part of life (Bates and Bates 1996). One of the primary forms of social control associated with medicalized infertility entails maintaining the norms of children and family (Becker and Nachtigall 1994; Sandelowski and Pollock 1986). For example, Franklin (1990) analyzed the discursive construction of infertility and identified the social norms at stake in its conceptualization: biological capacity, social reproduction of parenthood, traditional family values, and heterosexuality.

In addition to controlling and defining social norms, medicalization also defines and controls to whom those norms apply. The medical establishment functions within and is reflective of the “underlying moral economy of the U.S.” (Becker 2000, 20), in part by limiting its services to select groups. Medicine is both a social institution and ideology that is founded on and reifies class meanings and practices (Collins 1998). The selection of who receives treatment is driven by a private medicalized market in which only a few select individuals can afford treatment; thus, medicalized infertility may be medicalized only for some (Conrad and Leiter 2004). In other words, according to the dominant narratives of motherhood and medicine, childlessness may not be deviant for everyone in society.

Institutionalized classism is apparent within the institutions of both medicine and motherhood. Deserving and undeserving mothers, typically divided along class lines, are treated differentially by providers. Being

part of a private medicalized market allows infertility treatment to be promoted for women of high SES (Conrad and Leiter 2004). Part of this marketing strategy includes advocating women's reproductive choice. By excluding this choice from women who cannot afford to make it, women of low SES are instead blamed for making incorrect choices, such as failing to control their fertility (Brubaker 2007). The medicalization of infertility thus does not unite women around the commonality of medicine (or motherhood); instead, it perpetuates differences between them (Litt 1997).

Class-based ideologies of both motherhood and medicine are normalized so that their promotion of inequality becomes unconscious and unrecognizable. To achieve a state of naturalization, however, both processes rely on and reinforce the systematic exclusion of women who do not reside on the dominant end of their spectrums (Harding 1997). For example, hegemonic notions of motherhood are located within the heterosexual family (Blank 1997). This ideology then infiltrates the medical establishment, which perpetuates these norms by preventing unmarried couples or individuals from receiving infertility treatment. Because Black women in particular are less likely to be married when they attempt to access infertility treatment, medicine also becomes a racial gatekeeper (White, McQuillan, and Greil 2006). Marginal populations are thus positioned through exclusion, thereby normalizing inequality.

This article centers the voices of those who are marginalized through such exclusions. Doing so will begin to deconstruct the notion of the "Infertile Woman" and expose infertility as contextual and produced through diverse social processes. In this particular study, I examine one aspect of marginalization within reproduction, social class; however, interlocking systems of oppression are apparent within motherhood and medicine. Ageism, classism, racism, sexism, and heteronormativity are all present in discourses around fertility (Browne and Misra 2003). I focus on social class relative to other demographic characteristics for several reasons. First, it adds class to the extant dialogue of infertility. Beside references to inequalities in treatment access, social class has been virtually ignored within infertility research (Letherby 2002b). Second, the scant research that has been done on diversity within infertility examines racial dimensions (e.g., Ceballo 1999). Stereotypical images of poor women's fertility, such as the welfare mother, are also racialized, but their basis in economics has been less explored. Despite their mutual implication, it is necessary to examine class separately from race because "couching class within race . . . impairs our understanding of both social forces" (Bettie 2000, 19). Moreover, previous researchers (e.g., Lareau 2003) have found

class to be a salient factor within the family structure, both independently and in interaction with race. Finally, giving voice to women who are marginalized along class lines recognizes how class, like race, is a social system, rather than an individual characteristic, that is entrenched in the politics of motherhood and medicine. This article aims to understand how that embeddedness informs individual experiences and interpretations of infertility. How do economically disadvantaged women experience infertility, and more specifically, how do they negotiate that experience within a context that excludes them from the institutions that control reproduction—motherhood and medicine?

THE STUDY

This research, part of a larger study on infertility, is based on data from 20 in-depth interviews with women of low SES. Given the findings from prior research (e.g., Greil 1991) that reveal the salience of infertility for women over men, recruitment for this study was limited to women. Eligibility criteria included ever having experienced involuntary childlessness for at least one year, having less than a college degree, and being between the ages of 18 and 44. Women were recruited via flyers posted in public venues (e.g., libraries, grocery stores) and agencies affiliated with low-income populations (e.g., shelters, food programs). In addition, a posting was made on the classified ads Web site craigslist.org under the “volunteers” section. Women were recruited approximately equally from each method with no significant differences identified between them. The participants were given a \$10 grocery store gift card on completion of the interview.

Because the women self-selected into the study, and because of the difficulty of recruiting women along all dimensions of SES, the eligibility criteria for social class were limited to education level. However, all 20 participants were considered low SES along at least one dimension of the status—education, income, or occupation. Moreover, despite variations in income and occupation, all participants were categorized as lower or working class according to U.S. Census Bureau (2000) and Department of Labor income and occupation statistics. Half of the participants completed some college; however, eight women never went beyond high school. Eleven women were unemployed. All participants reported annual household incomes of less than \$35,000.

The study sample was diverse; eight women were white, nine Black, one Asian, and two Latina. One participant was lesbian, while the other

participants reported being heterosexual. Nine of the participants were married, one was in a committed relationship, seven were never married, and three reported being divorced. The average age of the sample was 32 years, with a range between 20 and 44 years.

Nine women had private health insurance; two of these women were covered by their parents' health insurance. Seven were on Medicaid, two were covered by Medicare, and two were uninsured. Half of the participants received some type of infertility service, 70 percent of which was diagnostic consultations with little to no follow-up. Two women received medication to stimulate ovulation, while one participant underwent intrauterine insemination (IUI) because of her conception attempts as a lesbian.

I conducted the majority of interviews between April 2008 and October 2008. Sixteen were held in private study rooms of public libraries, two were conducted in the women's homes, one was conducted in my office, and one was conducted in a fast food restaurant. All locations were in southeastern Michigan, a state with no mandated insurance coverage for infertility treatments. Interviews lasted on average 90 minutes, but length ranged from 35 minutes to 2.5 hours. Prior to the interview, participants completed a brief survey to collect demographic information. The semistructured interview covered women's backgrounds, conceptualizations of infertility, experiences of living with infertility, and attitudes toward reproductive technology and treatment. The interviews also captured psychosocial factors that may influence women's experiences with infertility and health in general.

Each interview was transcribed verbatim. I then read the transcripts to identify themes and coded the transcribed interviews utilizing Hyper-Research 2.8 (2008). This produced thematic reports that I compiled and analyzed to parse out women's experiences of infertility. In the findings that follow, I deliberately selected examples to reflect the sample's diversity in terms of race, age, and sexuality, but for this article in particular I focus my analysis on the participants' social class. All of the quotes and examples used are typically the "most illustrative" examples I selected among many of the women with similar experiences.

EXPERIENCES OF INFERTILITY AMONG WOMEN OF LOW SES

Setting the Scene: The Context of Experience

Women of low SES are outsiders—within to the medicalized context of infertility. They are marginalized within reproductive policies and practices

yet aware of the potential resolutions that they offer. This unique perspective allows inequalities to be illuminated (Collins 1990). The following passage from Donna, a single, Black 33-year-old, captures how the poor and working-class women in this study understand their own experiences of infertility through their awareness of the dominant group's experiences.

So the medical treatment options, do you have one in particular that you've thought about? No. I haven't. I haven't. My—it's probably a denial stage like I am more or less in denial but like I said, I see it on TV and you hear about it and it's like, "Wow, that sounds interesting." Let's see. Was it—I think it was Angela Bassett was the last thing I seen and she got twins but they took her egg out of her and put it in another woman and used her husband's sperm and I'm thinking, "Wow, that is quite a bit." So that was kind of amazing to me. But I know that's expensive so that's way like out of my league but that's something interesting and I thought about like, "Wow. She couldn't have kids and that was something really nice opportunity she had to have her own child so that was really nice." Yeah, but I haven't really looked like for myself.

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

Despite their constrained economic circumstances, nearly half of the women I interviewed received initial diagnostic consultations about their infertility; however, most did not proceed with medical intervention thereafter. By reviewing the experiences of infertility among such participants, it becomes apparent that medicine is built on middle-class interests—a context that is incongruent with those of the lower classes (Steinberg 1997). For instance, Nicole, a married, white 28-year-old, describes how the appointment structure and high specialization of infertility care do not align with her own circumstances.

The only way I could ever talk to [physicians] is if I have an appointment and I don't understand that. And they—it's like they don't understand that, you know, we can't just always pay \$20 all the time or \$25 every time just to have an appointment just to talk to you for two seconds. You know, and that's the frustrating part is that they don't get it. And then they always want you to have an appointment in the middle of the day and, you know, well, you know, I go to work to be able to afford this appointment [laughs], you

know? It's—and it's very frustrating. Yeah, so I mean like last year I went to doctors' appointments so many times and it was—I had to work, you know, my bosses were giving—giving me like, "Okay, why do you have so many doctors' appointments?" And, "I'm, you know, dealing with a lot of stuff and medical issues right now," and luckily I kept my job, you know, they didn't let me go or anything, which I was really grateful for and so everybody understood and this year I just let it go for the most part because I just can't do that all the time. Just—I mean my job is my number one priority right now. I've got to keep my job.

Nicole acknowledges both financial and structural impediments to her fertility care. It was difficult for her to pay the copay at each appointment, yet it was also the excessive frequency of appointments and timing of the appointments that caused her to have to "let [treatment] go." The physicians, however, "don't get" the predicament in which they have placed Nicole. Doctors are enmeshed within the dominant structure, unable to recognize its inequality. Nicole has subsequently become uninsured, further excluding her from medical care.

In addition to the appointment structure and division of labor within reproductive health care, the content of appointments also contributes to poor women's exclusion from medicalized infertility. The communication divide between the highly educated doctors and the less educated women pursuing care caused many of the poor and working-class women to discontinue medical treatment for their infertility. Jocelyn, a single, Black 20-year-old, reflects on such interaction.

Did they explain to you why you needed [infertility treatment]? Not really. They just, you know, they didn't—they didn't even give me a booklet. I had to find me a book and research on my own. [How can you] be a physician and [get] a degree and . . . not [be] open with the patients and you're not showing them that you're caring. . . . I had to do everything by myself. I had to buy a \$25 book; [money] that I could have . . . kept in my pocket. . . . *Because the doctors wouldn't explain it to you?* Not like they did—I mean just they come back, "Take these pills, you know, for three months. Come back." [laughs] I mean that's crazy.

In this brief dialogue, Jocelyn highlights numerous ways in which her interaction with her physician was negative and unproductive. The doctor was not only uncaring but also uninformative about Jocelyn's specific reproductive issue as well as the treatment to resolve that issue. This medical encounter was the only one Jocelyn received for her infertility. The lack of communication and its negative tone caused her to seek out

her own sources of information and not bother returning for follow-up care. Although this is an interaction between individuals, it is situated within a social and political context. As Fisher (1986, 4) states, "Physicians have medical knowledge . . . that patients usually lack. By virtue of the authority vested in their professional role, physicians can and do control patients' access to and understanding of that information. In the process, they act as gatekeepers, providing options to some, denying them to others."

The influence of doctor–patient communication on the experience and construction of infertility is also apparent among women who did not receive medical care specifically for their fertility issues. Given their marginalized status and construction as "bad" mothers, many participants perceived discrimination from medical providers when they requested reproductive health care during general medical visits. These experiences can deter the women from seeking such care. Breheny and Stephens (2007) found in their research on teen mothers that the young women avoided medical care because of the negative reactions they received from health professionals. The authors conclude that the "wider discursive context of 'judgmental' health care provision" must be taken into account when examining the utilization of medical care among marginalized populations (Breheny and Stephens 2007, 123; Brubaker 2007). Such a context is evident in Michelle's experience with reproductive health care. She is single, Black, and 25 years old:

Have you been to the doctor about [your infertility]? No. . . . Because I thought that, I was thinking you could just get pregnant. I don't know what—well they probably could tell me some stuff that I could do. But most doctors try to talk you out of getting pregnant.

Michelle had never contemplated seeking medical care for her fertility issues because, to her, "doctors try to talk you out of getting pregnant." How could physicians assist her in becoming pregnant when they had always discouraged this in the past? Discriminatory remarks had become normalized in Michelle's interpretation of reproductive care, erasing the possibility of resolving her infertility medically. Similar to Jocelyn's interaction with her physician, Michelle's experience demonstrates how the doctor–patient relationship is constructed and constrained within a social and political context. The discourse is shaped by and reproduces the dominant norms and relations of the status quo.

Beyond the practices and structure of medical care, the women's accounts reveal that many inequalities of infertility are driven by the policies surrounding such care. For instance, insurance status is a barrier to

infertility treatment for many of the participants. As Nicole and Jocelyn's experiences reflect, even when covered by insurance, the structure of medicine may prevent poor and working-class women from receiving medical care. However, the type of insurance one has also influences the experience of infertility. Keisha, a single, Black 33-year-old, describes her denial of medical care based on her status as a Medicaid recipient.

So have you ever talked to [the doctor] about becoming pregnant besides, you know, when you go in for [other reasons] . . . ? No, because I feel they're going to be like, you know, you're on Medicaid and you—they don't cover for this and that and this and that. And I don't want to be let down like that, you know, I really don't. And I feel because I'm on Medicaid, I do try to get some help in some other way and that—and they're like, "Well, you're on Medicaid, you know, you shouldn't be, you know, trying to do all of this on Medicaid."

Medicaid does not cover infertility treatments. In addition to this explicit exclusion, however, Keisha is also implicitly excluded from receiving fertility care because of her fear of being "let down." She has been told too often that she should not be "trying to do all of [these things] on Medicaid," so she avoids that conversation altogether by not inquiring about her infertility. Medicaid is a status marker for class. Not only does this preclude the inclusion of infertility treatment coverage within its policy, it also shapes the treatment women on Medicaid receive from physicians. The context in which insurance policies for infertility are constructed is one that is historically constituted in class- and race-specific ways. Thus, such policies regulate who can and should reproduce and mother according to those sociodemographic dimensions (Steinberg 1997).

Ultimately, the women's experiences of exclusion within medicalized infertility become naturalized, reinforcing the stereotype that infertility occurs among economically and racially dominant groups. Because of this, many women in this study consciously or unconsciously accept hegemonic notions of classed fertility, failing to recognize the forces behind such inequality. The stereotype of infertility as an upper-class issue combined with medicalization's perpetuation of that myth meant that Candace, a single, Black 41-year-old, did not even try to seek treatment.

I believe I could have did a lot of things to change it. I didn't think—I didn't think—I thought maybe only a rich person could do it maybe. Or maybe—I don't know—maybe—I didn't think I could really do it like get a—get fertility pills or get my uterus scraped or—I had heard of things but maybe I didn't really think I could do it.

Candace interpreted the medical treatment of infertility as something for the “rich”; the exclusion of women of low SES from medicine was naturalized. In turn, she perpetuates such constructions and thus her exclusion by not pursuing medical care for her infertility. Candace cannot articulate why only a “rich person could do” infertility treatments. However, by deconstructing the medicalized context of infertility, these women’s stories reveal the structural and ideological bases for such disparities.

Infertility is not something “in which there are ‘social factors’; it is itself profoundly social as a phenomenon for study” (Schneider and Conrad 1983, 227). Women of low SES face barriers to infertility treatment both inside and outside the medical realm. By examining the lived experiences of infertility among women marginalized in reproductive narratives, inequalities within medicalized infertility are apparent. The structure of medicine, doctor–patient interactions, and insurance policies are informed by dominant norms, in turn regulating reproduction and motherhood by placing poor and working-class women outside the bounds of infertility.

Negotiating Infertility Experiences

Situated within a stratified system of reproduction, the social location of women of low SES informs their experiences of infertility. Competing issues such as shelter, finances, and marital status prevent economically disadvantaged women from achieving the maternal ideal (Connolly 2000). However, poor and working-class women should not be perceived solely as victims of dominant representations of motherhood. These women agentically identify other ways to mother given their circumstances and available options as well as derive alternative, nonmedical solutions to achieving biological motherhood.

Because women of low SES are excluded from medical treatment to attain biological motherhood, many pursue routes to social motherhood instead. This echoes Parry’s (2005) finding that infertile women extend their understandings of family beyond the traditional ideology focused on biological children. However, for economically disadvantaged women, options for such extension are limited. Similar to the classist basis of medicine, adoption is also constructed on such notions. Rothman (1989) describes how all levels of the adoption process are situated in class. The women giving up their children for adoption are typically of lower class than those seeking to obtain children through adoption. Moreover, adoption is a type of commodified motherhood through which children are bought and sold, providing an advantage to those with higher incomes. In

other words, "Adoption is as much a class issue as it is anything else" (Rothman 1989, 130).

Given this exclusion, women turn to other forms of social mothering. Several of the women in this study undertook the primary role of stepmother to fulfill their mothering desires. In searching for the meaning behind her infertility, Arti, a married, Indonesian 44-year-old, reasons that her role as a stepmother is the role she is meant to have.

Sometimes I told myself like this, okay. Maybe my . . . inability to have a child [is] because I have to be a mother to these two boys because their mother, you know, herself is—is like I said, they call her the It. Even I don't think she deserve to be called as a mother. I think [that is] the reason why I am here, I am who I am right now, you know?

Arti constructs herself as a better mother than her stepchildren's biological mother. Through this process, she justifies and understands her infertility as allowing her to correct the inadequate mothering that her stepchildren are receiving. Heather, a married, Black 29-year-old, also reconciles her infertility in this manner.

So if you were to outline the next five or ten years of your life, which of those options, [adoption, IVF, or stepmothering], do you think will pan out? I think it's the stepmom because my husband and I have talked about him taking full custody, you know, of his younger son just due to the situation he's in. And I think that comes from wanting to be a mom plus not liking the situation he's in and if we could give him better, why are we not? I think we're obligated, you know, to give him better so he can do better.

In deciding how to resolve her infertility, Heather chooses stepmothering over adoption or IVF. Perhaps her acceptance of being excluded from the latter options causes her to prioritize the one that is most attainable. Like Arti, Heather justifies this decision based on the notion that she "can do it better" than the children's biological mother. The women gain a sense of being a "good" mother yet are forced to apply it to situations that fit their contexts and normalized understandings.

Taking care of others is a dominant theme around motherhood; hence, many participants negotiate the infertility experience through this action (Hays 1996). Jackie, a white, married 23-year-old, explains it as follows:

I'm just trying to fill something and like with my brother coming to live with us, I think maybe we asked him because I wanted somebody else to take care of. You know, my mom said that once he starts college, he can't

stay with us but at the same time, I feel like if he leaves, then it's just back to me taking care of my husband, you know. And I—it's not that I don't love that. I want to take care of my husband but I just—he's not there all the time and so, you know, he works a lot of hours. And so I just—I'm trying to fill it with other things and I shouldn't be.

Jackie is able "to mother" in the sense that she is taking care of someone other than her husband. Not only does this allow her to attain a salient characteristic of motherhood, but it also relieves her loneliness due to her husband's absence.

Candace also extends the ideology of motherhood to include experiences beyond biological children. After struggling with infertility for years, Candace had a hysterectomy because of cervical cancer. This surgery dampened any prior hopes she had for having her own children. The following reflects how she coped with and negotiated this realization:

So how did you feel after all of that: knowing that now you probably wouldn't have kids without a miracle? Just like—it's just like God to me because a lot of people are coming to me with, "You can do everything. You—you can still be a mother." You can take care of other children [by teaching] young girls to not go down the path I went down in the negative sense to drugs and alcohol. So I could be like a mother. . . . So that's what [crying] I'm going to do.

Candace can "be like a mother" in ways that extend beyond biological children yet encompass normalized characteristics of motherhood, such as caretaking.

While stepmothering and caretaking are not limited to women of the lower classes, they are more prevalent among such groups. According to the National Survey of Family Growth, nearly 21 percent of women with less than a high school education have cared for a nonbiological child, including stepchildren and children of other kin, compared to 8 percent of women with at least a college degree (Chandra et al. 2005). Thus, the infertile women of low SES in this study, with limited resolutions to childlessness, participate in the perpetuation of the stratified system of reproduction by adopting roles typically associated with their class status.

In addition to crafting alternative ways to enact mothering, many participants in this study still tried to achieve biological motherhood by using nonmedical means. For instance, Carrie, a white 32-year-old lesbian, attempted to change her nutrition to promote fertility.

I think I was doing a few things like [pauses] raspberry leaf tea to enhance my fertility. . . . So now I'm on the message boards and talking to other women who are trying to conceive and, you know, trying everything you hear, you know, "Eat an Egg McMuffin." . . . You know, pineapple, [pauses] acupuncture, Chinese herbs, and all of those things.

After unsuccessful interactions with the institution of medicine to resolve her infertility, including a few attempts at IUI, Carrie sought advice from peers sharing their experiences online. From what she ate to what she drank, Carrie altered her diet in the hopes of achieving biological motherhood.

After being denied medical care because of her Medicaid status, Keisha also turned to alternative solutions for her infertility.

So what's out there treatment-wise that you think you might benefit from?

As far as the vitamins, you know, [pauses] you know, as far as reading about it and what they do, that should help. It should help I think.

In the hopes of "helping" her infertility, Keisha takes fertility enhancing vitamins. Not only is Keisha not giving up on resolving her infertility, but she is also actively researching nonmedical (or nonprescription) remedies for her childlessness. Carla, a married, Black 31-year-old, also considered such measures but resisted purchasing them because "you don't know what's truthful and what somebody's just trying to get a scam on all these little medicines you can take for natural unblocking."

These women of low SES are forced to negotiate their infertility in restricted contexts. Most participants cannot afford or are excluded from the primary solutions to infertility—medical treatment and adoption. Therefore, they must reconcile their childlessness through other means. Becoming stepmothers, caretaking, and mothering others are alternative routes that women of low SES follow to achieve social motherhood. Even so, some women still attempt to achieve biological motherhood by overcoming their infertility through nutritional changes and alternative medicines. These alternatives are not exclusive to women of low SES; however, their employment of these mechanisms may be more frequent given their exclusion from other potential solutions.

DISCUSSION

By centering the voices of the marginalized, this study exposes how class-based fertility policies play out in the lives of women of low SES and, more specifically, demonstrates how such programs affect experiences of

infertility. Doing so not only overturns the generalized image of poor women as hyperfertile but it also reveals the importance of context in shaping the infertility experience. Ultimately, this is an article about structure and agency—structures hinder poor and working-class women from achieving certain medical resolutions to their infertility, but as agents the women overcome such barriers to develop alternative ways to cope with their childlessness.

As outsiders-within, women of low SES expose invisible privilege, describing not only their financial exclusion from the institution of medicine but also their structural exclusion. These barriers, not present for women of high SES, are unique to economically disadvantaged women, thus creating a unique experience of infertility. As their reproductive choices have been limited throughout history, so too are the poor and working-class women's choices restrained today when it comes to resolving infertility. The main solution to achieve biological motherhood, medical treatment, is financially out of reach and inherently exclusionary. Yet the primary source to gain social motherhood, adoption, is also a classed system.

The women I interviewed attempted to access both types of mothering. Some pursued roles as stepmothers, others extended their caretaking to their social networks, and still others tried to enhance their fertility through alternative medicines and alterations to health behaviors. These agentic negotiations of infertility run counter to much of the current understanding of responses to infertility. Many researchers employ the activist-fatalist dichotomy to differentiate reactions to childlessness by social class (Zadoroznyj 1999). Valuing choice and control is a universalized characteristic of women of higher social standing, while passivity and submissiveness are understood as common attributes of economically disadvantaged women (Fox and Worts 1999; Jenkins 2005). These categorizations, however, reduce social phenomena to individual labels (Martin 1990). Moreover, they reinforce the dominance and stability of ideologies, failing to recognize their flexibility. Women of low SES are not passive objects of dominant discourses. They are active subjects in resisting, redefining, and accepting the discourses according to their contexts (Reid and Tom 2006). The activist-fatalist binary is thus a false dichotomy that furthers the division among women and maintains a status hierarchy.

In understanding infertility, we must move beyond medicalized understandings that silence lower- and working-class women's voices. Past literature constructed a false dichotomy of control and passivity by not recognizing solutions beyond medical treatment. Examining the participants in their own contexts, outside of a medicalized realm, reveals numerous ways that the women of low SES cope with infertility.

Exposing infertility as a social process may help bring attention to alternative support programs and resolutions to infertility rather than solely focusing on medical treatments and insurance accessibility issues. In addition, overcoming the dominant narratives around fertility that frame poor women as hyperfertile and infertility as primarily affecting wealthy women can alter family planning programs, adoption procedures, welfare regulations, and other reproductive health policies that are currently structured on stereotypes.

By examining one aspect of inequality within reproduction, social class, this study is an initial step in deconstructing the "Infertile Woman." The findings begin to reveal the diversity within infertility and how marginalized women negotiate their childlessness when challenged by hegemonic ideologies. However, it is clear that social class is not acting alone in shaping women's experiences. While these findings highlight the classed nature of the inequalities, many of the disparities could be caused by several systems of oppression, such as race, age, and sexuality. For instance, the internalization of fertility norms experienced by Candace along class dimensions occurs along racial dimensions as well (Ceballo 1999). Future research must conduct intersectional analyses to understand how medical, motherhood, and class ideologies are navigated by and applied to women differentially according to shifting dynamics of power and identity.

This study is one of the first to focus on poor and working-class women's experiences of infertility. Doing so overcomes two dominant, neglected narratives around fertility: that poor women are highly fertile and that infertility is primarily an affliction of the rich. Overcoming this binary is a first step in reviewing the policies and practices around reproduction. We need to reexamine our assumptions and begin focusing on those suffering the most from infertility.

NOTES

1. All personal and place names are pseudonyms.
2. Infertility is a medical diagnosis. Because the women of low socioeconomic status (SES) studied in this analysis are outside of the medicalized discourse and thus the experience of infertility, many do not consider themselves "infertile" *per se*. However, all of the women are involuntarily childless because of difficulties in conceiving or carrying an infant to term for at least one year, fitting the medical definition for infertility.
3. Class is a complex category, difficult to define. For the purposes of this article, class and SES encompass typical indicators of measurement including occupation, education, and income (Hout 2008).

4. A woman is classified as having "impaired fecundity" if she reported that it is impossible for her (or her husband or cohabitating partner) to have a baby for any reason other than a sterilizing operation, if it is difficult or dangerous to carry a baby to term, or if she and her husband or partner have been continuously married or cohabitating, have not used contraception, and have not had a pregnancy for three years or longer (Chandra et al. 2005).

5. Any infertility service includes advice, tests on the woman or man, ovulation drugs, medical help to prevent miscarriage, surgery or treatment of blocked tubes, artificial insemination, and assisted reproductive technology (Chandra et al. 2005).

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