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Infertility

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Infertility: the Hidden Burden
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Infertility: The Hidden Burden

A Thesis Submitted to

The department of Sociology / Anthropology / Psychology

In partial fulfillment of the requirements for the degree of Master of Arts

by

Sally G. El Mahdy

Under the Supervision of Dr. Saad Eddin Ibrahim

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To my father

whose love, care and guidance

kept me going through

the different stages of my life

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ABSTRACT

This medical anthropological study aims at investigating the impact of infertility on upper class women in Egypt. The study was carried out over 30 months in Cairo, Egypt and included 10 case studies (life histories). All of them were recruited from two major clinics/hospitals one in Helioplis and the other in Maadi; and all of whom fell within the boundaries of upper middle class definition pre-set by the researcher. Anthropological methods included case studies, structured and unstructured interviews, and observation in an attempt to demonstrate the different pressures, ramifications and social devaluations these women bear due to their bareness. The findings of this study demonstrate the significant degree of social stigmatization experienced by upper class infertile women in Egypt who have no other choice to fulfill their societal ascribed role as "women" but to reproduce. Not only do they face problems with their husbands and in some cases are threatened by replacement through divorce or polygamous marriages, but their relationship with their in-laws are often strained and disrupted. Even, community members may fear infertile women's evil eye on their children. Thus, through being faced with different societal ramifications, most upper class infertile Egyptian women have no other choice but to embark on therapeutic quest for therapy, which is exhausting, money consuming and tiring in an attempt to regain their status in the realm of "women". It is asserted that infertility is a culturally constructed phenomenon for all infertile Egyptian women regardless of their education, location, income, and social class backgrounds. Moreover, as infertile women's desire to gain social respect through reaching the state of motherhood is so powerful, and the social pressure (including husbands', in-laws, and surrounding attitudes) is so mighty, many of these women are willing to embark on therapeutic quests with all its accompaniment emotional, and economical turmoil risking all they have including their lives to overcome such burdens, forces, stigmas, and social devaluation.

INTRODUCTION

"Of all the types of persons that one could be in Egypt, there are very few less desirable social identifications than that of infertile women, or the "mother of the missing one" as Egyptians are apt to call her."
(Inhorn, 1991)

A- Mayan's Story

Mayan is twenty-eight years old; she is very well educated, an economics graduate of Cairo University. Very well dressed, her appearance reflects that she comes from a very well to do family (upper middle class). She got married six years ago to the son of one of her father's friends. "They forced me to marry him. I didn't love him and, in fact, I didn't even like him. I guess he didn't like me too, or was not even aware of my existence. He wanted to satisfy his father's will by marrying me. So, I or any one else wouldn't have mattered."

Mayan had to marry someone she didn't like because she did not dare say "no" to her father's wish. "I couldn't have said no; he is the only one who makes decisions; this is applied to my mother, my brother and me too. We can't dare discuss the matter with him, we must say 'yes' and that is the only answer he accepts."

Six months after marriage without conception the spouse's family began to feel concerned, and as a result, her husband began to get worried. The husband's family

wanted to have a grandson who would carry the family's name, especially, since her husband was the only child. "They began to feed him with all sorts of ideas about me being barren and can't bring him a child to carry on his family's name. Then he turned my life into hell. He insisted on my seeing a doctor. I tried to convince him that we don't have to bother ourselves with the matter now, and we can wait until after a year, but that didn't work. Then I began this long journey with hospitals, operations, and doctors."

"He took me to a doctor, a very well known one, who examined me and asked me to make an ultra sound to know what was wrong. Then he decided that I had some cysts on the uterus that are preventing me from getting pregnant, and that I had to get them removed. Again, I tried to persuade my husband to see another doctor, but he said that he trusted this one, and what he said must be done. I was operated on, and assured by the doctor that I would be able to conceive."

Six months after the operation, Mayan had not conceived. She was urged to pay another visit to the doctor. This time he examined her, and ascribed the case to some problems in the fallopian tubes, which needed to be treated. Again, he assured her that everything would be fine, but even after treatment, she didn't become pregnant. Her husband decided to change the doctor. She repeated the same process switching from operations to medications and from hospitals to doctors.

Commenting on her family's reaction towards her problem, Mayan lamented: "Whenever I complained, my mother always told me that I must obey my husband

and that she can't help me. She claimed that if my father knew about my complaints, he would turn our lives into hell."

"After almost four years, I could tell you that I was tired! I have been operated on for two times; each time they cut my tummy as if I was making a cesarean. I have taken several kinds of medications, ranging from tablets to injections, and from plain children's aspirin to hormones. I was fed up! And you know what really hurt me was that through this nightmare, my husband instead of backing me emotionally, was asking me to bring him the son. He was not even asking for a child, but specifically a boy to carry on the family's name! Was I capable of conceiving, in the first place, to bring him the boy?"

Two and half years ago, Mayan underwent a third In Vitro Fertilization (IVF). She had hoped to succeed since she became more and more depressed, especially, that she felt lonely throughout the whole process. "You know my husband never accompanies me to the doctor; he just chooses him and funds the process. He thinks that supplying me with money is all I need." Mayan did not dare share her painful thoughts with her husband. "I won't give him the chance to feel my weaknesses! He would only go about making fun of me in front of his family, as well as, mine."

Mayan's third IVF attempt failed. She lamented that due to her husband's, and his family's pressures, rather hostile attitudes, she went into a severe nervous breakdown, which led her to be hospitalized for almost two months.

After being released from the hospital, her therapist prescribed her anti-depressive drugs to be taken for no less that one year, along with intensive therapeutic sessions in his clinic. Mayan explained with agony: "When my husband understood the fact that I would not be able to conceive while being under anti-depressive drugs, he did not waste time. He immediately chose to divorce me with the blessing of his family. He did not even talk the thing over with me!" She took a deep breath, then added: "You know being divorced from this man was the best thing that ever happened to me over the past four years. I really hated him for putting me through all this, I felt humiliated, and you know who is to be blamed most? My father! He was the one who led me into this painful and ruthless relationship."

Upon the advice of her therapist to get herself, as much as possible, occupied with something she wanted, Mayan applied for graduate studies at the American University in Cairo, and was accepted. After the beginning of her first semester, she appeared a completely different person. She was full of life, gained some weight, and had a very tender smile that added beauty to her face. She explained: "I don't have time to think about anything, although, when I remember, it really hurts. However, I am happy now ..... I almost forgot this feeling. Happiness is something precious that people must thank God for. I think I am accomplishing something; something for myself to fulfill a wish I had for the first time in my life."

During her studies, she met Saleem who was also doing his MBA, and they fell in love. Saleem proposed to her parents to marry her. Commenting on her father's attitude towards Saleem's proposal, Mayan said: "Thanks God that Saleem comes

form a well to do family or else it would have been a problem. My father would not have accepted an ordinary man who is striving to build a career, even after what I have been through." She smiled and added: "I guess I would be kind of envying myself, but Saleem is a wonderful man. He insisted on marrying me even after knowing that I might have an infertility problem; and this alone made me feel I would do anything to please him."

Mayan got married to Saleem six months ago. She insisted on having a very big wedding, the style she wanted: "I feel I am getting married for the first time in my life." After exactly two months of marriage, Mayan got pregnant without any medical intervention. She was in her fourth month. "I can't express how I feel, I think God has rewarded me for all the pain I went through. Thanks to Him."

Mayan's story provides a particularly appropriate introduction to the subject of this thesis since it clearly demonstrates this thesis's five major themes: First it shows that infertility carries along with its physiological aspect, which is usually "hidden" as the infertile displays no "obvious illness features" (Greil, 1991), a hidden stigma borne of shame and secrecy (Sandelowske, Holditch-Davis; and Harris 1990). Second, being classified as an upper middle class infertile women is both significant in the sense that it provides greater possibilities of being exposed to plethora of medical interventions; and it is insignificant since the availability of these options and choices can mean undergoing years of treatment, postponing resolution and continuing the stigma and loss of identity felt by these infertile women. Third, it clearly demonstrates that the secrecy surrounding reproductive behaviors extends

into the discussion and understanding of infertility. Mayan's reluctance to talk about infertility even with her husband, husbands in laws, wife's in laws, and friends clearly demonstrates that infertile women try to conceal their burdens and stresses lest they stigmatize themselves more. Fourth, it also shows clearly how interpersonal, marital, familial, social, and medical forces shape the lived experience of infertility. For these women, the lived experience is all too often one of failure, the failure to conceive, and the perceived failure of the woman. Fifth, it clearly shows that regardless of class distinctions, infertility is considered a stigmatized condition for all Egyptian infertile women. Even though upper middle class infertile women enjoy the luxury of exposure to different medical treatments, which lower middle classes are usually deprived of, still the lived experience of infertility is the same for both of them.

B- The problem

The basic argument of this study evolves from the claim that it is the cultural perception of "infertility" in the Egyptian society that structures the experience of infertile women. It is thus argued that infertility should not be seen as a natural given "illness" per se, but more importantly as a social construct.

In Egypt infertility is estimated to be experienced by nearly three million women. Yet, most of the attention when dealing with this crisis is focused on the physiological aspect of it, neglecting to a great extent the socio-emotional part. Medically, infertility is defined as the inability to conceive successfully after one

year of actively attempting conception (Mazor, 1991). However, many infertile women contend that their problems stem primarily from prejudices and discrimination rather than "functional impairments" (Hahn, 1988).

Having as the starting point of this thesis the assumption that "illness", and in particular infertility, are not to be dealt with as medical problems per-se, but rather as socially constructed categories that emerge from the interpretive activities of people acting together in social situations, it is argued that upper middle class[1] infertile women through their face to face interaction with others, experience the same stigma which has been noted by several anthropologists working with lower class communities in Egypt (Ammar 1963; Morsy 1978a, 1980a; Rugh, 1984). In their accounts, the magnitude of the stigmatization problem for infertile women was reported to be quite high, "With social consequences ranging from marital strain to religiously permitted polygamy or divorce to complete social ostracism" (Inhorn, 1994).

However, in these studies the consequences of the infertility problem was not related to the social class of those affected by it. The ***only*** attempt to relate the consequences of infertility to the social class of those affected by it in Egypt was carried out by Marcia Inhorn in her study Umm El Ghaib (1991). However, her study covered lower/middle infertile Egyptian women only. Consequently, upper middle class infertile Egyptian women were not investigated before. Although women who

[1] The term was based on Gilbert and Kahl's (1993) class stratification model: 1) education: university graduate or more; 2) husband and wife yearly income: LE 50,000 or more; 3) residency: resident of Helioplis or Maadi districts.

belong to upper-middle class have the opportunity to seek medical intervention, which is something that differentiate them form the poor and lower middle class women, this access to medical intervention further stigmatize them. In other words, class distinction is both significant in the sense that it creates for the upper middle class the possibility of a therapeutic quest, and insignificant since this quest becomes a staging area for further expression of stigma and its burdens. Hence, this study should purports to be the first of its kind.

In this study, it will be argued that upper middle Egyptian infertile women through their day-to day interaction experience a triple stigma: un-femininenes (not fulfilling her feminine role), barrenness (not fulfilling her motherhood role), and powerlessness (being oppressed through escalating social hostility). In fact, each of these three stigmas is shaped by class experiences, and in a more particular way, the ability to access different medical technological treatments, which in a way may provide the solution to the physiological problem, yet at the same time, it transforms the problem from an acute one into a prolonged public crises. However, it is important to note that this study is less about infertility as a stigmatizing condition per se than about a society's devaluation and stigmatization of infertile women and upper middle class infertile women in a more specific way.

Although Goffman's (1963) classical sociological analysis of stigma overlooked the power of agency/structure dialectical relationships, more recent studies of women and deviance emphasized the significance of power resources and women's continuing social, economic, political and legal subordination (Schur, 1984). Yet

these studies have largely focused on American and Western societies, and thus, can tell us little about the power relations between infertile women and those dealing with them on a day-to-day basis in the Third World societies in general, and in Egypt in a more specific way.

Thus, this study attempts at adding a "Cross cultural, intrinsically anthropological dimension to the still emergent scholarly examination of power" (Inhorn, 1994) by explicating the power relations that affect upper middle class infertile women's lives in Egypt. These include the power of men over women, extended families over women, fertile women over infertile ones, and even societies over women.

This thesis applies a critical perspective (Greil, 1991) and a feminist methodology (Smith, 1990) in the analysis of the cultural construction of infertility among a sample of ten upper middle class women over a period of 30 months in an attempt to consciously look for interrelations between individual experiences as they occur within a shared social, political and economic context. According to Nielsen (1990): "The critical theorists' approach is to emancipate - that is to uncover aspects of society, especially ideologies, that maintain the status quo by restricting or limiting different groups' access to the means of gaining knowledge."

The aim of this thesis is twofold: First, to demonstrate how socially constructed responses to infertility are embedded in a complicated web of personal, familial, social, and medical expectations that are often damaging and stigmatizing to

the upper middle class infertile Egyptian women. These women, as will be seen from the stories that will follow, have no other choice except to bear different social ramifications and consequences of this culturally defined problem. Second, to investigate whether the social construct "need" to have children is so powerful, and the social pressure (including husbands', in-laws', and community members) is so mighty that these infertile women are willing to embark on therapeutic quests risking all they have including their own lives to overcome such burdens, forces, stigmas, and social devaluation?

C- Personal reflections:

Since I chose the topic of my thesis, I have been haunted by questions and comments such as "Why this topic in particular?" "Why did not you choose something more interesting?" "You have always loved digging into forbidden areas." These questions and comments among others were the reactions I got from any one asking me about my topic whether it be a relative, a friend or a colleague. However, the comment that both upset me and drew my attention to the fact that we live in a world that is entirely governed by cultural taboos that are often biased and harsh, was that of a friend working in a US Aid project. She told me: "Why did you choose that topic? The country is receiving funds for family planning, and you are going about researching those who are "God gifted" for not being able to conceive and trying to help them? Is Egypt in need for more children to be born?" It was after this comment

that I began to question my basic assumptions, and to understand that indeed the problem of infertility has two other sides that have to be considered: a social, and an ethical one.

I began to ask myself questions such as: Why under the auspices of the government different types of family planning programs are advocated towards fertile women at very low prices and in some cases for free? On the other hand, there are no similar programs directed towards infertile women, specially, those who can't afford the high expenses of medical services. These women have no other choice, but to give up theirs, their husbands', families', and in-laws' dreams of having a child; and to suffer from different types of social and marital ramifications that would be tackled in detail later in this study.

It also led me into questioning the cultural context we, as 'normal people' intrinsically inherit, and which governs our way of looking and acting with any one who does not fit into this context. Since infertility is defined medically as the in-ability to conceive after one year of regular sexual relation without any birth control methods (Mazor, 1991); and is defined socially as the in-ability to fulfill women's basic role (being a mother) (Ammar 1963); thus, it violates the physical and cultural "norm", and is considered disease-producing and a form of "disability" (Loustaunau and Sobo, 1997).

We, as 'normal people,' don't know how to deal with what is different. Disability in its various forms, with emphasis on infertility, is to be considered different since it does not fit into the culturally constructed notion of "reproductive

functionality," (Hahn, 1988) and thus is considered deviant from "normalcy" and should be avoided and eliminated. In other words, fearing any direct or indirect contact with any one who is different by labeling him/her as "socially misfit" due to his "disability" is a taboo that we use to escape bearing the consequences of dealing with disability, which we were not culturally educated to deal with. As Loustaunau and Sobo (1997) argued, "Cultural beliefs and notions support, call for, explain and sometimes even mystify or mask structural arrangements."

Reaching this stage, I began to question how am I going to deal with my research, whether I want to tackle the problem of infertility from its various angles giving a complete picture of the infertile women's situation under such a cultural context, which could be reached partly through "hearing" and analyzing my informants' cases. Or whether I need to do something more to help these women, as much as I can. Thus, I realized that "hearing" is not enough, and that there should be room for these infertile women to improve their situation. This would not happen until each one dealing with them asks him/herself "What should I do to help these infertile women?" "Am I willing to change my pre-coded cultural prejudices to give these women a chance to a more plentiful and happier life?"

For example, one of my friends told me that when they advocate the idea of family planning in remote areas they deal with what she called "key factors," such as the husband, and the mother-in-law. Similarly, when dealing with infertility as a burden, speaking to and hearing from everyone who deals with infertile women is essential, should it be the husband, in-laws, family members, or even therapists.

Indeed, the situation seems to be more complex than it appears, and it seems that under such a cultural context there is no room for compromises as Werenck (1997) argued.

Then, the term "society for all" that we constantly hear in the media and on political campaigns "fails" to prove itself with any direct contact with "disability" in any of its various forms. It becomes a slogan that we "normal people" use to show how modernized we are. The society we are living in is not for all, it is for those who "fit" according to the pre-set standards whether it be physical, cultural, or behavioral.

Thus, the society unconsciously, or consciously draws a hard-to-break line between what is "normal" and what is "deviant," and subsequently categorizes people in accordance into two and only two groups, those who fit and those who do not. For example: in the case of infertility, the husband finds it easier to threaten his wife by divorce or remarrying (which are his legal right) to make her risk her own life to bring him the child he wants, than to be labeled by his surrounding as a misfit (not being able to bring a child of his own).

In short, I argue that when dealing with any form of disability, the society's perspective must change. The society as a whole is asked to share in the responsibility, but could this be attainable?

D- Organization of the thesis

To address these issues, I have divided the thesis into five major chapters and a conclusion.

The first chapter entitled: "Theoretical Framework," which is divided into five major sections: the first one provides appropriate definitions and discussion of class in an attempt to show that class distinction is significant in the sense that it creates the means by which therapeutic solutions could be attainable, and at the same time insignificant in the sense that it transforms infertility from a private pain to a public, prolonged crisis grounding the way for further social burdens and stigmas. The second section covers the medical definition of the problem; the third one deals with the objective of the study; the fourth one deals with the conceptual framework, and the fifth one deals with the research hypothesis. The second chapter entitled: "Review of the Literature," is divided into two sections. The first one highlights problems in the anthropological study of infertility in an attempt to set the stage for the second section which clarifies the significance of the research. The third chapter entitled: "Research Design and Data Analysis Methods." This chapter is divided into two sections. The first one deals with the methodology adopted in this study. The second section deals with the potential limitations of the study, and how the researcher attempts to overcome them. The fourth chapter entitled: "Infertility as a Lived Experience." In this chapter a description of the ten upper class infertile case studies is provided in an attempt to set the stage for a description and analysis of the problems they face. The fifth chapter entitled: "Social Structural Consideration," deals with infertile women as a social personae in a larger social structural network consisting of husbands, in-laws (both wives' and husbands'), and community

members. As will be argued in this chapter, it is within this microsturctural framework that infertile women through their face to face interaction with others actually experience the stigmatization of infertility through social relationships that are often strained or disrupted (Inhorn, 1991). The last chapter will be devoted to the summary and conclusion of the study.

Chapter I

THEORETICAL FRAMEWORK

Since this study is concerned with upper middle class Egyptian infertile women because this category of women have never been investigated before, and hence is considered the core significance of this study, a precise definition of their class is essentially needed to be put forward in an attempt to set the stage for the discussions, and analysis to follow.

A- Social class definition

To gain an understanding of what does it mean to be categorized within a certain social class it is necessary to examine what social class is, and how could it be measured? In fact, the answer to these two questions is not that simple because sociologists have no clear-cut accepted definition of social class. For example, conflict sociologists of the Marxist orientation such as Mosaca (1896), and Marger (1987) see only two social classes: those who own the means of production and those who do not. The problem with this view is that it lumps too many people together.

However, most sociologists agree with Weber that there are more components of social class than a person's relationship to the means of production. Thus, most sociologists define class as a large group of people who rank closely to one another in wealth, power, and prestige. These three elements separate people into different lifestyles, give them different chances in life, and provide them with distinct

ways of looking at the self and the world. Having said so, it is necessary to break down the three elements by which a class could be measured.

Wealth:

Wealth consists of property and income. Property could be measured through land, buildings, cars, etc. Income is money as wages, rents, interest, etc. However, it is very crucial to distinguish between property and income. For example, some people may have property, but little income such as the "fallah" who owns a piece of land, but the high cost of machinery and fertilizers may cause the income to disappear. Or vice versa, people might have income but no property. According to Henslin (1995) "Beyond the numbers lies the reality that profoundly affects people's lives. The difference in wealth between those at the top and the bottom of the class structure means vast differences in lifestyles."

Power:

Back in the 1950's sociologist C. Wright Mills (1965) was criticized for insisting that power, which he defined as the ability to carry out your will in spite of resistance, was concentrated in the hands of the few, for his analysis contradicted the dominant ideology of equality. Mills argued that wealth and power rested in the hands of a group of likeminded who share ideologies and values; and who belonged to the same club, district, etc. These shared backgrounds and vested interests all served to reinforce their view of the world and of their special place in it. Sociologist

William Domhoff (1990) builds on Mills definition and argues that wealth brings power and extreme wealth brings extreme power.

Prestige:

Most people are highly conscious of prestige. Surely prestige is tied to wealth and power. For prestige to be valued, people must acknowledge it. The most significant area in which prestige could be valued is occupation, and this explains why do people give some jobs more prestige than others. According to Henslin (1995) people rank jobs at the top according to four elements:

- They pay more.
- They require more education.
- They offer greater autonomy.
- They entail more abstract thought.

Having defined the three dimensions by which class is measured, I was faced with two profound problems: How can I measure their power in a society that is currently marked by vast political, economic and even cultural transformations? Indeed, I found it nearly impossible to measure such a variable when the "real power" lies in the hands of the government top officials. Then I began to ask my self: could people's power be measured through their "power" manifested in voting to bring their elected representatives into "power" i.e. the parliament? But again the trouble is that it just doesn't go far enough. It is just as sociologist Marger (1987) puts it "Such views of being a participant in the nation's "big" decisions are a

playback of the ideology we learn at an early age, an ideology that Marx said is put forward by the elites to both legitimate and perpetuate their power." It is as Judd (1991) calls it "the democratic façade" that conceals where the real power lies in the society.

The other problem was how to measure the consequence of their class category, i.e. their subculture, which is a profound variable in characterizing the overall living profile of this group. Again, I found it very hard to measure, for the very same reasons mentioned above. The Egyptian society has undergone several drastic cultural, political, and economic changes starting from the July revolution in 1952, followed by the open door policy in the 70's, and ending with economic transformation and privatization. Indeed, each era of those three had profound impacts on the subcultures of each social class, to the extent that it became so very difficult to relate any given social class to a particular subculture.

Thus I found Gilbert's and Kahl's (1993) definition of class structure in contemporary societies (updating on Weber's model) essentially applicable to the study under investigation. After reviewing their model carefully, I found that they have divided social classes into six-class models (as shown in the chart below), of which I will use their upper middle class model as it perfectly defines to the group under study. Gilbert and Kahl defined upper middle class as the one most shaped by education. Almost all members of this class have at least a bachelor's degree, and many have postgraduate degrees. As Gilbert and Kahl explains: "They may not grant prestige equivalent to a title of nobility in the Germany of Max Weber, but they

Social Class	Education	Occupation	% Population
Capitalist	Prestige university	Investors and heirs a few executives	**1%**
Upper-Middle	College or university, often with postgraduate study	Professionals and upper managers	**14%**
Lower-middle	At least high school: perhaps some colleges or apprenticeship	Semiprofessionals and lower managers, craftspeople, foremen	**30%**
Working Class	High school	Factory workers, low-paid craftspeople, retail sales	**30%**
Working poor	Some high school	Laborers, service workers, low-paid salespeople	**22%**
Underclass	Some high school	Unemployed and part-time on welfare	**3%**

certainly represent the sign of having "made it." Their income is sufficient to purchase houses and cars and travel that become public symbols for all to see and for advertisers to portray with works and pictures that connote success, glamour, and high style."

In fact, all women in the study received their bachelor degrees from recognized universities, and 20% of them have Master degrees. Moreover, all of these women's income (family income) exceeds LE 50, 000/year, which is quite sufficient to live a respectful life. They have their own cars, they own their houses and they travel

abroad nearly each year. Moreover, they reside in two well-known districts (Maadi, and Helioplis). Thus, based on the above arguments, the sample in this study falls within the boundaries of upper middle class.

Indeed this discussion of class was also important because it is both significant and insignificant. It is significant in the sense that women who fall within the upper middle class boundaries have the opportunity (i.e. enough money) to seek medical intervention, which differentiate them from other poor or lower/middle class women who have been investigated before in several studies. It is insignificant because this medical quest becomes a staging area for further expression of stigma and its burden.

B- Medical definition of infertility

The question is then, when is the woman considered infertile? Some people here in Egypt, especially in remote areas, consider a woman to be infertile if she gets her menstrual period any time during the first month of her marriage. "For adult women in the child bearing age, the major problem lies in the inability to conceive in the first few months after marriage" (Nelson, 1977).

On the other hand, the new technology that has been introduced in the field of gynecology and especially in the treatment of infertility argues for the fact that "disability to conceive" is a "disease" that is rarely found nowadays. "Complete infertility, sterility, is rare. It can happen that the couple has no chance of conception when the woman has premature menopause, or if the man has a complete lack of sperm. But infertility is mostly due to some degree of sub-fertility, in which the chance of conceiving naturally is not excluded, though; it may be very slight" (http://www.fertinet.com).

Regardless of the fact that most infertile cases could be treated "medically," with the aid of high quality techniques, infertility has another side that must not be ignored during the different stages of treatment, which is the social consequences and the different ramifications women pass through as a result of their barrenness.

However, through a review of the related literature, I found no definition that accounts for both the medical and social sides of the problem. All I found, were medical definitions and appropriate medical solutions to different causes of

infertility. For example, "Medically, infertility is defined as the inability to conceive successfully after one year of actively attempting conception" (Mazor, 1991). The definition proposed by the American Fertility Society has been widely used, accepted and states that "A marriage is to be considered barren after a year of coitus without contraception" (Mazor, 1991).

The World Health Organization, WHO, provides another dimension to the definition of infertility. In its 1975 report, WHO noted that "The term infertility is used in relation to couples, but that the indicator of the problem is the woman, whether the failure to conceive is due to the woman or the failure of the man to impregnate her" (WHO, 1975). In the study under investigations, this definition will be adopted since it breaks down women's infertility into three major categories reflecting the status of barren women as it appears in real life.

WHO proposed peritoneal definition of infertility:

1- Primary infertility: Women's failure to conceive despite regular sex relations for two years.

2-Secondary infertility: The woman has previously conceived, but is currently unable to conceive, despite a period of regular sex relations for two years. This pregnancy may have resulted in delivery, abortion, or induced abortion.

3-Pregnancy wastage: The woman is able to conceive but unable to produce a live birth.

Based on the above categories, I found Inhorn's (1991) term "Hierarchy of Fertility" essentially applicable in the current study since infertile women use it to place each other in the proper place on the scale of fertility according to each woman's situation. According to the findings of this study, it follows logically that on top of this fertility hierarchy lies secondary infertile women with living children. In the second category comes secondary infertile women with no living children, then lastly comes primary infertile women who view secondary infertile ones as lucky because they have been, at least, able to conceive when they can't even do this.

From the secondary infertile women's point of view, although they rank themselves in a higher position than primary infertile ones, for the very same reason, ability to conceive, they still-deep inside-feel that they can't fulfill their roles correctly. However, it is important to not that this distinction between the above mentioned categories made by infertile women themselves, is not applied to their social view since from the social point of view they are regarded as misfits (Inhorn, 1994).

Another distinction is to be found inside the secondary infertile women's category between women having one child or more, but seeking therapy for another one, and those who are able to conceive, but fail to bring live births. Surely, the former is ranked in the highest position because they have at least fulfilled their motherly-hood roles. The latter, may sometimes be hostile towards the former since,

from their point of view, they needn't seek therapy, and must thank God for what they have, and stop being selfish.

Secondary infertile women with children are in fact sometimes urged to seek therapy for other children due to different forces and strains they experience during their daily lives; especially if they don't have a boy. They face many stresses from within themselves, their husbands, extended families and their surroundings. Social and marital insurance may be the number one factor for secondary infertile women's quest for more children. The second factor that may encourage secondary infertile women to seek therapy is the depravation feeling that women experience as a result of not being able to conceive as before. The third factor is social pressures practiced on them that is considered as great as the social pressures practiced on other primary infertile women. Threatening by remarrying, divorce or just abandoning the woman are common forms of stresses that the husbands use to urge their wives to seek therapy.

Thus, it can be assumed that social pressure, in its various forms, is the number one factor in explaining the reasons behind upper middle class infertile women's willingness to subject their bodies to, in some cases, deleterious therapies in an attempt to escape social devaluation and inequity.

B- Objective of the Study

Bearing in mind the above mentioned argument, the major objective of this study is to find out how infertility is culturally constructed in Cairo and how upper-middle class Cairene react to this problem.

The specific objectives are:

First, explicating the power relations that affect upper middle class infertile women's lives through a consideration of social structures and interactions that take place within the complex social setting.

Second, determining the underlying different structure/agency dialectical relationships, such as the power of men over women, families over individuals, and community over its members in an attempt to understand the power of the infertile status itself in shaping the lives of upper middle class infertile women.

Third, to prove that "the quest for conception" or "the search for children," (Inhorn, 1994) is a fierce quest for societal respect, a woman's search for the fulfillment of her achieved societal role in a society that is marked by vast social discrimination and inequity in evaluating or devaluating women according to their ability to produce offspring.

C- Conceptual Framework

a- Stigma: the hidden burden of infertility

In his classical book entitled Stigma: Notes on the Management of Spoiled Identity, Goffman (1963) provides a valuable working definition of the concept of

stigma and the effect of stigma on an individual's social identity. Goffman defines stigma as follows: "An attribute that makes [her] different from others in the category of persons available for [her] to be, and of a less desirable kind in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. [She] is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap .... Not all undesirable attributes are at issue, but only those which are incongruous with our stereotype of what a given type of individual should be."

Goffman further argues that individuals who are stigmatized by possessing such attributes might by viewed as a single category for the purposes of sociological investigation. More important, he distinguishes this category from that of social deviants or individuals engaged in some type of collective denial of the social order, which results in their being stigmatized.

As Goffman explained, the crucial feature of stigma is that it violates "norms of being," a special set of norms that could be described as follows: "Failure or success at maintaining such norms has a very direct effect on the psychological integrity of the individual. At the same time, mere desire to abide by the norm, mere good will is not enough, for in many cases the individual has no immediate control over his level of sustaining the norm. It is a question of the individual condition, not his will; it is a question of conformance, not compliance" (Goffman, 1963).

Inhorn (1994) argues, building on this definition, that infertility is an attribute that is highly stigmatizing to Egyptian women because it violates a crucial "norm of being" that of "motherhood". She further adds that motherhood is a normative requirement that women themselves do not question; instead, following marriage, they strive to uphold it as immediately as possible so as to achieve social recognition of their status as fully productive members of society, as well as, to fulfill a more basic desire to become "normal human beings" through motherhood. In other words, given the choice, a married Egyptian woman would inevitably choose to sustain the normative standards of her society by becoming a mother, and thereby completing her womanhood and femininity. Consequently, infertility when it occurs, violates Egyptian women's norms of being by making it impossible for them to become mothers like every other normal woman.

Inhorn (1991) further argues that the equation of "motherhood" to "normal womanhood" occurs widely in Egyptian society in which the opportunities for alternative role fulfillment for women are limited. Thus, women who "fail" to achieve membership in the "cult of motherhood" because of their barrenness, are stigmatized by other members of their society who view them at best as pitifully abnormal, and at worst as not fully human. Griel (1991) argument supports Inhorn's and Goffmans's above mentioned arguments: "The heart of the experience of infertility appears to lie in the inability to proceed with one's life according to life course norms that are both reinforced by others and accepted as valid by the affected individual."

Infertility, among those women in the study and those reported in the literature (Lasker 1987, Sandelowski 1991, Sandelowski, Holditech-Davis and Harris 1990, Miall 1985, Forrest and Gilbert 1992, Becker 1990) is inexorably tied to shame and guilt. To be childless in a patriarchal society is to run against the norm with all its concomitant sanctions. "In a society that values fertility, childlessness becomes an attribute of the individual which can be discrediting or stigmatizing. It seems clear that for most people, involuntary childlessness or infertility is regarded as a deficient or abnormal condition" (Miall, 1985). According to Veevers (1980) and Miall (1985), two primary procreative norms predominate in paterlienial societies. One is that all married couples should reproduce; the other is that all married couples should want to reproduce. As members of such a society, many women respond positively to the cultural pressure to have children. This culturally shaped desire to have children appears to be extremely strong, transcending sex, age, race, religion, ethnicity, and social class division (Peel and Carr 1969, Van Keep 1971).

For many infertile women in patriarchal societies, infertility is a secret stigma, distinguished from more obvious examples of stigmatization because it is invisible. Unlike paraplegics or the blind, the infertile display no obvious stigmatizing features; only their own knowledge of their condition distinguishes them from others. "The external invisibility of difference makes the life-shattering experiences about which women spoke even more surprising" (Greil, 1991).

However, an important point needs to be put forward: although infertility affects both men and women, and could be a devastating problem for both of them,

their responses are filtered through differential role power, expectations, and socialization. It is thus argued that gender role power play a major role in shaping the relation of the infertile woman with her surrounding including her husband, in-laws, friends and even her community.

b- Patriarchy, power, and resistance as stigmatized factors:

The term patriarchy is polysemous with a multiplicity of meanings dependent upon scholarly venue. Many feminist scholars, for whom the term serves as a "theoretical metonym" (Abu lughod, 1989), adopt a liberal definition of the term, viewing it broadly as "gender oppression" (of females by males) or as "Male domination/female subordination" (Inhorn, 1996). Radical feminists, whose view of patriarchy is often criticized as being totalizing, monolithic, unrealistic, and too abstract (Jaggar 1983; Kandiyoti 1988), viewed "the patriarchal system," as a universal system rooted on economic, legal, and political structures, as well as social and cultural institutions, that oppresses women, through the assertion of male power, dominance, hierarchy, and competition (Tong, 1989).

At the other extreme, strict definitions of patriarchy including traditional anthropological and sociological ones, situate gender oppression exclusively within the family. Turner (1987) described this: "A patriarchal relationship is one in which the male head of household dominates the members of the house, whether these are male, female, adult or juvenile. This patriarchal structure is legitimized by legal, political, and religious norms which give the adult male a virtual monopoly over the

subordinate groups within the traditional household. In such a system, the wife ceases to be a legal personality on marriage, and divorce is typically proscribed as a system for the dissolution of marriage."

In the literature on the Middle East, definitions of patriarchy reach both ends of the spectrum, and are sometimes accompanied by a troubling, conceptual conflation of the meanings of patriarchy, as father dominance, and gender oppression (Inhorn, 1996).

Yet, it is clear from the works of feminists scholars who have theorized Middle Eastern patriarchy based on studies of women's lives in the past or the present that patriarchy is actually practiced in the domestic realm and family life. "Namely the traditional Arab family structure is patrilineal, patrilocally extended (three-generations), patriarchal, pyramidally hierarchical, and preferably endogamous" (Kandiyoti, 1988). Hatem (1987b), and Joseph (1993; 1994) argue that the socialization into patriarchal role taking among males and females occurs within the family at an early age. Moreover, support for patriarchy is often derived from retrogressive Muslim personal status laws that shape family life, and are institutionalized by the contemporary neopartirarchal nation-state (Hatem 1986a; Sharabi 1988). They further argue that throughout the Middle East, female subordination is intimately tied to the dynamics of family life, as well as to a more generalized patriarchal familialsim. Thus, for this region of the world, definitions of patriarchy as gender oppression, and patriarchy as oppression within the family requires a synthesis.

For the purpose of this study, it is useful to merge the liberal and strict definitions of patriarchy by referring to it as follows: patriarchy is characterized by relations of power and authority of males over females which are: 1) learned through gender socialization within the family, where males wield power through the socially defined institution of fatherhood; 2) manifested in both inter/intra gender interactions within the family, and in other interpersonal milieus; 3) legitimized through deeply grained, pervasive ideologies of inherent male superiority; and 4) institutionalized on many societal levels (legal, political, economic, educational, religious and so on) (Hatem, 1984). Accordingly, women's subordination is first experienced sometimes subtly, sometimes profoundly within the family, which serves as a template for the reproduction of patriarchal relations in other realms of social life.

From the above mentioned argument, it is clear that patriarchy is always accompanied by power and authority. Thus it is necessary to define both terms. Many feminist anthropologists use the term "power" to mean, either implicitly or explicitly, "the ability to make someone do what they do not wish to do, to act effectively on persons and things, to take decisions which are not of right allocated to the actor's role or to the actor as an individual" (Moore, 1988). Thus "power" as a term incorporates a number of concepts such as force, authority, and legitimacy. "Authority" is defined as "the right to make a particular decision or follow a particular course of action, and to command obedience" (Moore, 1988). It is important to note that whether "power" is exercised through influence or force, it is inherently subject to competitive pressures, whereas "authority" entails a hierarchical chain of command and control (Rosaldo, 1974).

However, it is necessary to point out the fact that power and authority are not synonyms, and that the use of one term does not imply the presence of the other. For example, much of the cross-cultural research have shown that even though women may have neither the right nor the duty to make decisions (lack of authority), they often have the power through demonstrable influence on the decisions that are made. (Rosaldo, 1974). Cynthia Nelson (1974), recommended rethinking notions of power as an embodied quality institutionalized in types of social structures, and instead recognizing it as a particular type of social relation as "reciprocity of influence." Instead of Middle Eastern men always assuming power over women, as earlier male biased ethnographies seemed to imply, Nelson argued for the concept of "negotiated order" an ongoing dialectical process of social life in which both men and women were involved in a reciprocity of influence vis-à-vis each other. If power were to be defined as such, she claimed then the relevant question for the study of Middle Eastern women would become: In what ways and in what spheres of activity can, and do women influence men to achieve their own objectives?

Nelson's call to study the domain of women's power in the Middle East, led many anthropologists and ethnographically minded social scientists to document the many ways in which women assume power in any given patriarchal society through influencing the lives and decisions of others, including men. As noted by several anthropologists, the household is the primary site of power for most Middle Eastern women. This is manifested in the actual decision making, and authority women assume over household resources, children's education, and marriage negotiations

(Youssef 1978). Early (1993) further adds that women in their homes, have power as wives and mothers. She argues that fertility, the ability to bear men's children for them, is women's most significant form of power over men. Thus, infertility, when it occurs, is considered to be the most potent source of women's power; it strips women of this power, and thus can only by seen as unusually threatening. Not only infertility poses a threat to women whose fundamental value in the eyes of their husbands, relatives, communities, and themselves may be closely bound to their reproductive abilities, infertility threatens men as well, for it effectively nullifies proof of their virility and masculine procreativity, as well as their ability to perpetuate the patrilineage, its name, and its patrimony.

Inhorn (1996) builds on this and applies it on the Egyptian social context by assessing that infertility can be particularly threatening to both women and men under conditions of classic patriarchy, where the "patriarchal fertility mandate valorizing both motherhood and fatherhood as personal imperatives is felt especially strongly." Under this mandate, all women are expected to marry and become mothers. Motherhood is believed to be the most important role for women and the perceived essence of a woman's identity. Moreover, for men, the institution of fatherhood is at the ideological core of classic patriarchy. Fatherhood alone allows men to reproduce the particular relations of family life that are crucial to the reproduction of patriarchy itself. Thus, infertility undermines women's domestic and nondomestic relations, it represents a threat to their marital, social and economic security. "Infertility affords the examination of negative or paradoxical forms of

attributed power, namely because they are feared by Egyptians for the ways in which they jeopardize the well being of those around them."

Thus, based on the above mentioned theories and analysis, it is argued that infertility is an outcome that is believed to be greatly feared on a multiple levels, as will be shown in the chapters to follow. As a result upper middle class infertile women in Egypt go to great lengths to overcome childlessness through medical treatment.

In the light of the above mentioned conceptual framework, the research hypothesis of this study was formulated:

D- Research hypothesis

The primary hypothesis of this research is: Infertility stigma is a culturally constructed phenomenon for all infertile Egyptian women, regardless of their social class, education, and location backgrounds. A related question emerges, and needs to be investigated: whether the desire to gain social respect through reaching the state of "motherhood" is so powerful, and the social pressure (including husbands', in-laws', and surroundings' attitudes) is so mighty, that many of these infertile women are willing to risk all they have including their lives to overcome such burdens, forces, stigmas, and social devaluation?

In the next chapter, a review of the literature will provide an overview of the body of knowledge on the problem in an attempt to set the stage for pointing out the significance of this research.

Chapter-II

INFERTILITY AS A PROBLEM

A- Problems in the Anthropological Study of Infertility:

Since World War II, medical anthropologists have turned in increasing numbers towards the cross-cultural study of medical systems and the biological and socio-cultural factors that influence the incidence of health and disease. However, one of the areas that was under-privileged as a topic of serious scholarly investigation, especially in third world countries, was that concerning woman's infertility. This may be due to several reasons that would be dealt with in details later in this chapter.

a- Infertility in the third world

Given the relationship of the problem of infertility to so many other anthropological concerns, it is unusual and unfortunate that the topic of infertility in the third world countries has been largely neglected by anthropologists in general, and medical anthropologists in particular, and other social scientists as well.

This lack of expertise on the subject of infertility, which is apparent in the Middle Eastern literature, may be due to several reasons:

First, from reviewing the literature done on topics related to women's health and illnesses, it would appear that most Western, as well as Middle Eastern intellectuals

working on that topic in the Middle East have undoubtedly accepted what George (1976) has called the "population myth;" that the major problem facing third world countries, is overpopulation. In other words, third world countries, such as Egypt, are world widely known for its overpopulation problems and hence are regarded as "hyperfertile" societies in need for reproductive regulation. Thus, infertility has been largely neglected as a social problem. In explicating this view, Inhorn (1985) in her book *The Barren Woman East* argues that most of what is known about infertility in the region can be derived from the examination of fertility. She contends that literature on Middle Eastern fertility trends and family planning initiatives contains information on infertility that is often inserted aside as interesting, but irrelevant.

Second, the *Eurocentric* focus of medical anthropological scholars in general might have led to ignoring infertility as a problem in non-Westernized countries (Inhorn, 1991). In other words, social scientific study of infertility has been oriented almost towards the problems of Western women (particularly those in America, Western Europe and Australia). So much that infertility appears from this literature to be an exclusively Western bourgeois concern.

Third, a general problem with anthropological research on the Middle East is that it was mainly targeted towards rural and/or nomadic areas. This bias is a result of the earlier structural functionalist notions in anthropology of the nature of society and the consequent tendency of anthropologists working in the area to "divvy up" the societies they study into what they believed were its component parts: namely the peasant village, the nomadic tribe, and the Muslim city. As Edward Said (1978) puts

it, anthropologists working in the Middle East tended to head for the hinterland leaving urban areas for the so-called orientalist scholars who tended to portray cities in an idealized fashion. Thus, anthropological studies of contemporary life in the Middle East are frankly uncommon.

Fourth, because anthropologists look for re-current patterns of behavior and the ideological norms that sustain them, they have tended to overlook cultural "irregularities" and deviation from normalcy. Thus, groups who were marginal in any given society were usually not the focus of anthropological investigations and studies of deviancy have largely rested in the hands of sociologists who tended to study Western societies (Cohen, 1977).

Finally, few anthropologists have been interested in issues of health and illness in the Middle East. As a result, anthropological literature on these related subjects remains limited in both content and theory (Morsy, 1981).

In fact, Middle East Women were rarely the focus of any anthropological study before the 1970's. In Inhorn (1987a) *The Anthropology of the Middle East* she notes that most of the monographs and essays were written almost exclusively by males who treated women as if they were non-existent. Even when they mentioned them, it was done in a passing kind of way especially when discussing patrilineal parallel cousin marriages or the notion of honor and shame. Thus, women "were out of sight and out of mind" in the purported 'private sphere' (Ferenea and Joseph, 1976). Thus, male anthropologists did little to change the stereotype of Middle Eastern women, as

veiled, circumcised, obedient, and powerless. This stereotype is derived in part from western scholarship on Middle Eastern woman with its persistent "orientalist" bias. (Nader, 1989).

This may be partly due to the fact that these societies are highly segregated, which makes it difficult for male anthropologists to "penetrate" female domains. Moreover, I argue that it is not only the problem of high segregation that hinders male anthropologists from getting into the realm of women, but gender identity counts more. In other words, women feel free to talk-out their intimate private matters and feelings with a female researcher who shares with them the same identity, being a woman.

It is important to note that feminist researchers have tackled sensitive topics dealing with intimate and private areas of women's lives more heavily, and if one can say, more successfully. According to Oakly (1981), women researchers and female participants share the same subordinate structural position in a male-dominated society. This provides them with shared identification with one another as women, and hence the outcome of this is self-disclosure and better collection of data.

In fact, with the "Infusion of women into the field of medical anthropology, during the last twenty years, a major corrective action has begun. Middle Eastern women did not only become the subject of investigation in their own right, but many scholars are also attempting to place women and women's roles in a larger social, political, economical, and cultural context" (Inhorn, 1985).

Yet, as Keddi (1979) notes, even research conducted on Middle Eastern women by females did not tackle intimate domains such as husband-wife relation and sexuality. In fact Keddi asserts that discussion of female sexuality in the Middle East will remain on the ideological, and metaphorical levels until female researchers overcome their own discomfort in asking questions about actual sexual attitudes and practices.

b- Categories of medical anthropological literature

Generally, literature on medical anthropological topics can be grouped according to four categories:

First, **documentary historical based studies**, which deal with the history of customs and taboos of certain groups of people. Edward Lane (1908) was the first ethnographer of Egypt who wrote the classic *The Manners and Customs of the Modern Egyptians*. His work provided a rather detailed account of a wide range of Egyptian customs as he observed them during his twenty-year residence in the country. Also Judith Tucker (1985) historical work: *Women in Nineteenth Century Egypt,* which dealt with lower class Egyptian women who were marginalized by virtue of their infertility. The study focused on two classes of poor marginalized women in the nineteenth century Egypt, namely prostitutes and slaves. As she notes, although these women represented only a small subset of nineteenth century Egyptian society, their very marginality of their social existence made them

important for the contemporary understanding of the set of attitudes that shaped the position of women in the Egyptian society.

The above-cited books among others, are historical descriptive accounts that provide an indispensable basis necessary for undertaking any research relevant to women. However, most of these works neither test any hypothesis, nor relay on theory.

Second, **qualitative, basically descriptive studies**, which focus on different aspects of women's lives. Abou Lughod (1986) *Veiled Sentiments*, is an excellent example of this category. In her study of Awlad Ali, Bedouin society, she examined in details and analyzed the well-developed concept of honor and shame through the use of poet and *Ghenewaa,* which Bedouin women tell and recite at different occasions. She demonstrated the emotional resistance to the changing way of life in a patriarchal society through their particular brand of oral poetry. Also, the work of Kenddy (1977) *Struggle for Change in Nubian Community*, in which the concept of supernatural danger and taboos constraint was investigated and analyzed within the Nubian cultural and societal framework. Another example of this category would be the book by Janice Boddy (1989) *Wombs and Alien Spirits*, in which she discussed fertility quests, traditional ways of achieving fertility, and the rituals that women out of despair seek to become pregnant to fulfill their role in the eyes of their society.

Attempts at evaluating in some details traditional therapies for "barrenness" in Kenya was investigated by Sydney Katz and Selig Katz (1987) in their book: *An*

Evaluation of Traditional Therapy for Barrenness. They dug into taboos and rituals that barren women undertake to overcome their barrenness.

However, in spite of the fact that these works contributed heavily to our knowledge of traditional ways of healing, they remain more descriptive than analytical. This may explain why the anthropological literature is still replete with passing references to the problem of infertility, usually commenting on the social difficulties of infertility for women or on the traditional beliefs surrounding this disorder (Wood, 1979).

Third, **culturally, and socially analytical studies**, which deal with different aspects of women's lives but within social and cultural contexts. The research done by Browner and Carolyn Sargent *Anthropology and Studies of Human Reproduction* investigated the "paradigms of maternity". In other words, they investigated the socially and culturally constructed forces that shape maternal roles, childbirth, and related reproductive activities; and that linked culturally constituted notions of femininity to maternal behavior. In their review, they have summarized the multi-various, recent research on almost every aspect of the human reproductive life cycle, from the management of menstruation and menopause, to obstetrical events, to fertility regulation. Yet, as they have noted in their conclusion, very little attention have been made to investigate issues such as social class, role of men in all aspects of human reproduction, and their impact on women's reproductive desires.

Other studies that are worth mentioning and conducted in Egypt include Unni Wikan's (1977) *Life Among the Poor in Cairo*, and Andrea Rugh (1984) *Family in*

Contemporary Egypt. Both studies explore women's lives through the structure of the Egyptian family. Both of them focus on women and family life in poor urban areas of Cairo. Both books explore in detail the disappointment of poor urban Egyptian women struggling for survival, and for maintaining their families under harsh economic circumstances. Also, Hind Khattab (1997) *Women's Perception of Sexuality in Rural Giza*, in which she investigated women's perception of sexuality, social taboos that govern this concept, and how women perceive it.

Other feminist researchers have been interested in power relations, class differences, belief systems, and the impact of colonialism and neocolonialism on health care. Sohier Morsy's (1978) volume on *Gender, Sickness & Healing in Rural Egypt* is an excellent example of this category. It is considered the first sincere medical anthropological ethnography on the Muslim Middle Eastern countries. However, even after Morsy's review of Middle Eastern medical anthropology, very few studies have emerged from the region. Most of which came from a small group of medical anthropologists including Morsy (1984,1986, 1988) and her colleagues Lane (Lane 1987, Lane and Miller 1987, and Millar and Lane 1988).

Moreover, although a number of Middle Eastern scholars have conducted research on topics that can be relevant to medical anthropology, very little of this research is available in published form, and much of it has been taken as "rapid ethnographic assessment" under the auspice of larger Western sponsored development projects (Social Planning, Analysis and Administration Consultants, 1989).

Fourth, **studies, which deal with women's health and illnesses**, especially the problem of infertility. There have been some in-depth, critical and courageous attempts to tackle the world of infertile women trying to uncover the reasons behind their never-ending quests for conception. Through this process, a highlighting of the social, political, and economic aspects affecting the status of infertile women have been investigated. I argue, that these written ethnographies mark the beginning of an in-depth analysis of the infertility dogma that have long been neglected by medical anthropologists.

An example is Inhorn (1994) excellent work *Ethnography, Epidemology and Infertility in Egypt,* in which she interpreted infertility from a medical anthropological perspective featuring a cross cultural research on infertility from Cameroon, Egypt, India, and the United States. Also the work of Hania Sholakamy (1997) *Women's health Perception* on women's understanding of their bodies, health and well-being. The study covered the social, economic and political aspects related to the topic investigated. Also, Attyia (1982) book: *Khul-Khaal*, which examined the lives of poor Cairene women through the vehicle of the life history. She dealt with five Egyptian women telling their stories; one of them happened to be an infertile woman expressing the feelings of a poor infertile woman and her perception of the harsh judgment of her society. In fact, Attyia's work is considered a pioneer in the field of "life history as a study" in the Arab world.

Lastly, the magnificent works by Inhorn *Quest for Conception (1992), Mother of the Missing one (1991), and the Missing Mother (1994)* that dealt with lower/middle

Egyptian infertile women explaining the rush for conception through investigating and analyzing women's surrounding environment (family, society's pressures, economic hinders, ethnicity, social class, education, rituals, taboos, social judgment, lack of medical technologies, and many other factors which affect women's situation).

These studies, although constructively organized, dealt with different aspects of the problem analytically within a well developed theoretical framework, framed and tested new hypotheses, **they did not address upper middle class infertile women, nor did they deal with the emotional side of the problem**.

In short, this study presents a relatively little explored area of study requiring the effort of this research not only to update information, but also to explain this phenomenon through theory, to analyze it through comparison, and to prove earlier arguments that were left undocumented.

B- Significance of the research

Indeed the situation of "childlessness" is extremely important to any discussion of the Egyptian family because "The Egyptian family is defined by what it is not, i.e. a husband, wife, and without children. This problem of the missing family is one that plagues infertile women, their husbands and their family members" (Inhorn, 1991).

This study attempts to focus on a group of people who by virtue of their social identity as highly educated upper middle class Egyptian infertile women have literally never been investigated before by any anthropologist.

First, this study would contribute to previous research on gender in several ways. The aim of the study is to uncover what does it mean to be an upper middle class infertile woman, and the marital, familial, and social problems faced as a result.

Second, although research was done on the nature of women's oppression in Middle Eastern countries, this study will explore a new aspect of oppression, which is husbands' attitudes towards their infertile wives.

Third, the study aims at contributing to the already existing medical anthropological research conducted in the Middle East. Indeed, the total published contribution of medical and socio-cultural anthropologists, both foreign and indigenous, working in Egypt remains quiet limited-especially when compared to the significant amount of highly acclaimed anthropological literature from the West.

Fourth, the study described here attempts at adding an "intrinsic anthropological dimension to the still emergent scholarly examples of women's dis-empowerment" (Inhorn, 1991) by explicating the power relation that affect upper middle class infertile women. This would be achieved through investigating the different dialectical power relations of men, extended families, surrounding, and community over infertile women.

Fifth, this study would be both microstructure, in its concern with individual behaviors and responses to the problem of infertility, and macrostructure in its emphasis on the social, cultural, and economic determinants of the stigmatization

process associated with this "disorder of human-and societal- reproduction" (Inhorn, 1991).

The next chapter discusses how the research has handled the study of upper middle class infertile women through giving a detailed description of the research design and methodologies adopted.

Chapter III

RESEARCH DESIGN AND METHODOLOGY

Before going into describing the methodological approaches adopted to investigate the problem, I would like to make it clear that I am aware that studying "parts" of the society does not give a full picture of the whole. Nevertheless, one of the key strengths of field research is the comprehensiveness of perspective it gives the researcher. This is done through going directly to the social phenomenon under study and observing it as completely as possible, which adds a deeper and fuller understanding of it. "Field research is especially appropriate to the study of social processes over time" (Babbie, 1991). Moreover, by making sure that the same types of attitudes, behaviors and reactions are observed, the researcher might be able to make certain generalizations.

A- Ethnographic field research:

Since this study aims at revealing the stigmatization, and social ramifications upper middle class infertile women bear due to their barrenness, and the fact that this problem is affected by different marital, familial, social, and other variables that are conflictual, powerful, and stressful, an ethnographic field research method deems inevitable to be conducted.

As for the methodology itself, I will adopt the strategy proposed by Dorothy Smith (1990) in The Everyday World as Problematic: A Feminist Sociology since it is the most appropriate method to investigate in depth the early mentioned hypothesis. Smith argues that it is the core of the "sociology for women" to create a space for the usually "neglected" subjects. In other words, to acknowledge subjects as active members of the study not just as mere objects to be investigated. Furthermore, there is no single neutral vantage point for understanding human experience, but rather its interpretation depends on the perspectives of particular socio-cultural groups that are shaped by social, political, cultural, economic, ethnic, and gender values. Thus, because reality has particular meanings within particular contexts and cultures, it is necessary to participate within a culture to understand how participants interpret reality and construct meanings within that particular socio-cultural context.

In fact, the more I think about The Everyday World as a Problematic, the more I realize how much my experience with infertility reflects such perspective. At first, when I started to gather information on infertility, the only sources I found were scarce sources that tackled the problem from a scientific way of writings, which were (at least from my point of view) in no way related to the real infertile women I began to meet. It was the daily interaction with infertile women, their husbands, in-laws, families and friends that led me to: a) question my assumptions regarding what it is to be an infertile woman in a society whose parameter for a woman's successful life is solidly grounded in her ability to reproduce. 2) Alerted me to the importance of listening to the experiences and expectations of those women as a starting point to understand what it really means to be an upper middle class infertile woman, as well

as, to acknowledge all related and interdependent factors such as cultural, social, martial and physical when discussing infertility.

In fact, the construction of such an approach as proposed by Smith, required a "step by step approach," which to me, was best attainable through conducting case studies.

a- Case studies:

Case study research was carried out to answer questions on "how" and "why" upper middle class infertile women embark on therapeutic quests that are often unfruitful in search for the child. For example, whether choices they made for seeking treatment were affected by social and cultural norms? How do they perceive themselves, and how did their condition affect their daily lives? How do relations with husbands, direct family members, and community members stigmatize infertile women?

A multiple case study design was employed for the distinct advantage of generating more reliable and compelling data through replication of cases having different health experiences while having similar living conditions.

Ten case studies were conducted over a period of 30 months from (October 1997– May 2000). Certainly, although this method tends to be intensive and time consuming, it adds richness to the data collected and helps in developing a better

conceptual framework for the analysis of the data collected. This helps in giving solidarity, reliability, and credibility to the end results. During this period, I have been able to spend considerable time with these 10 women either in their homes or outside in public places. At the beginning, the interviewing process of each case was in depth, i.e. informants were free to express their feelings, problems, and sufferings under the overall topic and its framework. In fact, I believe that it is through giving the informants room to 'speak' with the researcher acting as a moderator, directing the conversation within the boundaries she sees appropriate to the topic under examination that a comprehension of the different aspects affecting the problem could be attainable, and thus, a fuller picture of the problem under investigation could be provided.

The initial guideline for interview was as follows:

- The meaning of infertility to upper middle class infertile women.
- Women's families' reactions towards the problem.
- In-laws' reactions towards the problem.
- Husbands' reactions towards the problem.
- Gender role in the quest for conception.
- The infertile women perceptions of themselves.

For the analysis of the case study research data, two strategies were adopted: 1) a descriptive approach whereby the life histories of the women served to give a complete picture of the living conditions and the environment of the women studied, and 2) use of the initial theoretical accounts in guiding a content analysis of the women's own accounts, and in organizing observations made during the interviews in an attempt to find causal relationships between the willingness of these infertile women to risk their lives in search for children, and the social forces that infertile

women face on a day-to-day basis. Moreover, an attempt was made to find patterns within the group as well as associations, themes and typologies.

Besides informal interviews, I have also relied on other methods such as observation. As Babbie (1991) suggests, the investigation of such a particular phenomenon is best accomplished through using different methodological techniques since every methodology has its own weaknesses and strengths. Babbie further argues that if one decides to limit himself to just one method, this means that he is limiting his ability to comprehend the phenomenon under examination, as well as, the world as a whole. This method and how the researcher made use of it will be briefly described below.

b- Observation:

I was not by definition a participant observer since I was not involved in the every day activities of my cases. Yet, during my meetings with these women in their homes, or in public places, I was able to spend untold hours of participant observation, and informal interviews with women themselves, their husbands, various family members, and friends. Thus, I have been able to observe their reactions, attitudes and behaviors towards their problem. Such a process, as I learnt over time, enabled me to analyze the data collected with more confidence. In fact, observing their different reactions, as well as, their non-verbal gestures proved to be an invaluable source of data in the analysis process.

c- Field site

I chose to begin the initial phase of my fieldwork (recruiting participants, and explaining the aim of the research to them) at two famous gynecological clinics/hospitals; one located in Helioplis and the other in Maadi. The choice of these two clinics was due to:

1- The two clinics are specialized in dealing with infertility problems.

2- The two clinics are run by two famous gynecologists very well-known for treating and curing infertility problems.

3- All infertile women at these two clinics fall within the researcher's definition of upper middle class infertile women; and come from (almost the same) social, educational, and economic background, which provided the researcher with a wide sample to choose from.

4- Each clinic is located in each doctor's hospital, thus the clinic is part of a wider medical institution, which served as an obstetrical/gynecological care for upper middle class infertile women; and hence provided a wide variety of difficult infertility cases.

5- Both hospitals had artificial insemination units and in vitro fertilization (IVF) programs, which attracted large numbers of infertile women. As a result, large numbers of hospitalized women and out-patients were available most of the time for recruitment into the study.

Given the study site and research methodology outlined above, I would point out the potential limitation of the study.

B- Potential limitation of the study:

a- *Gender bias*:

Since this study is about women in particular, interaction with men or more specifically husbands was quite limited. However, with my 10 case studies, (since I came to know them on a more personal level, and with occasional visits accompanied by my husband[2]) I managed, to some extent, to interview the husbands on a more informal basis. Although the relation between the husbands and me never became at any point casual, they cooperated to their best extent with me.

However, given the above mentioned limitation, I strongly argue that gender role in this study would serve in enriching the data collected. This is because when dealing with sensitive topics, especially those intimate ones, which are directly or indirectly related to women's private lives, being a female (i.e. sharing the same identity with participants) would ease the situation and would make women open up and tell their stories without having much reservation.

Having said so, I argue that gender role as a female researcher investigating sensitive topics related to women is an advantage to the researcher since in Arab societies where sex segregation is highly considerable, male researchers would not

[2] It is important to say that my husband's presence strengthened my agency as a female researcher in dealing with my ten cases' husbands. I was culturally accepted by these husbands as a wife who always accompanied her husband who became accepted as a friend as time passed. Building on this relationship, I have been able to have informal conversations with these husbands, and to observe their attitudes in reaction to their wives' infertility problems.

be accepted. As El Solh (1989) argues: "Whatever the degree of rapport that a male ethnographer could achieve with female respondents in research settings, such as Kharga, the fact remains that not only would he be unable to gather data touching upon the intimate spheres of their lives, equally important is the fact that cultural perceptions of his sex role and social status preclude his acceptance as an honorary female in the social world of women, assuming that a male fieldworker would accept such a categorization."

b- Locational bias:

Since this study is limited to Cairo, and more specifically, to two of the upper middle class districts (Maadi and Helioplis), generalizing the study findings to the rest of Egypt, Middle East or the Arab world generally must be done with great caution. However, I strongly argue that by comparing the results found with other research results done on lower/middle class infertile Egyptian women, generalizability could be achieved, if the results proved to be the same (more or less).

c- Class bias:

As explained earlier in Chapter I, it was very difficult to categorize my informants' social class due to several reasons mentioned earlier. However, having adopted Gilbert and Kahl (1993) upper middle class definition, part of the problem was solved. However, an important question needed to be answered: how can I be certain that my informants fall within the category of upper middle class? In fact, Henslin (1995) provides three ways by which social class can be measured:

1- Subjective method: This method is simple and direct, however filled with problems because it rests on the fact the respondents determine their social class. The problem with this method is that people may classify themselves according to their aspirations, i.e. where they would like to be instead of where they actually are.

2- Reputational method: People are asked what class others belong to, based on their reputation. This approach provides an understanding of how people in a community see major social divisions. However, its use is limited to small communities where everyone knows each other.

3- Objective method: In this method researchers rank people according to objective criteria such as wealth, power, and prestige (discussed earlier in chapter I). However, there is always the possibility that the researchers might err in their judgment.

In fact, I have applied both the subjective and objective methods in categorizing my informants. First, I asked them what do they think their social class are. Then after gathering their demographic data, and knowing their income, occupation (or their husbands' occupations), their place of residency, etc., I compared this data with the upper middle class criteria pre-set earlier, in order to make certain that they actually fall within its boundaries.

Another problem regarding the issue of class which is the fact that this study is limited to upper middle class infertile women. However, this homogeneity of the class background is a major strength to the study under investigation. A review of the related literature revealed an extensive amount of research done on

lower-middle class infertile Egyptian women. Thus, researching the upper middle class infertile women deems inevitable to support/examine the universality of the infertility stigma.

d- Observer bias:

The fact that I am an Egyptian can be viewed as problematic. In fact, gender identity is directly or indirectly associated with the researcher's status as an insider/outsider. Previous research done on this notion (insider/outsider) have suggested the importance of a researcher's foreign status in escaping gender roles commonly ascribed to natives, and hence attaining more "role flexibility" (Papanek, 1964). This notion has been more apparent and applied when doing research in Arab societies. Studies carried out in Arab societies suggested implicitly or explicitly the "more flexible role" given to foreign researchers than to local ones. However, indigenous status is affected by the researcher's marital status, too. For example, in this study, being a married woman who previously experienced infertility and went through the harsh stages of treatment, whether it be physical, emotional, or social ramifications, would enable me as a researcher to understand and sympathize with women's feelings and problems. It would also give me the ability to quickly understand women's 'infertility vocabulary' while expressing their feelings. Indeed, this would allow an advantage of being able to attach meanings to patterns easier and faster than an outsider who happens to be unfamiliar with the 'indigenous culture' of the group under study. I thus argue that indigenous status allows the researcher to digest minimal clues to social realities better and faster.

From the infertile women's point of view, talking to a female researcher, married, and who experienced infertility and managed to overcome it by treatment would be a beneficial experience. It would serve as a thread of hope to know and to believe that there is hope in overcoming the infertility dilemma.

Thus, gender role combined with shared language, deviant position (being infertile) and holding an indigenous status, would serve the study to a great extent. Above all it would build up a rapport between the researcher and the participants. Indeed this rapport is the starting point towards mutual trust between both parties of the research. This trust is the necessary seed for enriching the data collected and ending up with a detailed and in-depth data, which all qualitative researchers aim for.

To sum up, given this over all context, this study is, indeed, to be regarded unique and should prove to be useful and purports to be the first of its kind to examine the social ramifications upper middle class infertile women bear due to their barrenness.

In the next chapter, a comprehensive idea about the living conditions of upper class infertile women, with special emphasis on how different structure/agency dialectical relationships affect their status, and further stigmatize them, will be provided through the ten case studies' demographic, biomedical, and socio-emotional profiles, narratives; analysis and discussion.

CHPTER IV

EVERYDAY WORLD: A PROBLEM

Upper middle class infertile women is the subject of this thesis and of this chapter. My objective here is to describe the ten case studies in an attempt to set the stage for a description and analysis of the problems they face. The characterization of the cases presented here is divided into three parts: demographic profile, bio-medical profile, and socio-emotional profile. As should become apparent, such a description is essential to understand why from a social structural perspective these women hold tenuous positions in the upper middle class Egyptian society; and why as "social personae", they are dis-empowered, marginalized and stigmatized (Inhorn, 1991).

A- Infertile Women's Profile

a- The Infertile Woman: A Demographic Profile

As this demographic profile should make clear, the ten infertile women were all from the upper middle class echelon of Egyptian society. These women were highly educated, and highly skilled.

Age: All of the women were in the reproductive age, mostly between the ages of twenty and forty. 50% were aged 20 to 29, and 50% were aged thirty to thirty nine.

Residency: all women in this study reside in Cairo governorate, specifically in Helioplis and Maadi districts (the two are considered upper middle class districts). All women classified themselves as Cairene. In addition, 30% percent of these women reside within extended-family households with other relatives (in these cases, they were all husbands' in-laws who kept separate apartments in the same buildings).

Religion: All women in this study were Muslims. The degree of religiosity varied considerably. However, most of these women considered themselves to be "good Muslims," and the majority of them prayed regularly. Symbolic expression of religiosity as reflected in the dress code (Rugh, 1986) varied considerably among these women. 60% were veiled (muhagabat) The majority of whom (80%) indicated that they had become veiled by choice, and 20% indicated that they had become veiled upon the demand of their husbands. The remaining 40% were not veiled.

Education: All women in this study were highly educated. 80% had received their Bachelor degrees and 20% finished their post graduate degrees. 70% of these women received their high school degrees from English language schools, and 30% received their high school degrees from French language schools.

Employment: Given the fact that these women were highly educated, it was quite surprising to find that the majority of these women 60% were not employed, and that they described themselves as housewives. However, it is important to mention that of these women 50% used to work before marriage. They became housewives upon the request of their husbands to leave work. Almost all of these

women expressed interest in being employed, but believed that their husbands would not agree. The remaining 40% worked in prestigious places.

Income: Because the majority of these women were not employed, they were entirely reliant on their husbands as economic providers. Yearly combined family incomes were estimated for each woman in this study based on women's report of their husbands' (and theirs in the case of those employed) salaries. These incomes were then categorized and percentage was estimated as follows: 20% of the couples had yearly income of LE90, 000 – LE120, 000; 40% of the couples had yearly income of LE70, 000 – LE80, 000; and 40% of the couples had yearly income of LE50, 000 – LE60, 000. In spite of the fact that the majority of these couples' yearly incomes were considerably high, women in this study complained from the fact that much of the money earned went to support infertility diagnosis, and treatments.

b- The Infertile Woman: A bio-medical Profile

Based on the infertility definitional terms discussed in Chapter II, women in this study have been categorized as follows:

Primary infertility: 70% were primary infertile in that they had never conceived before. The average duration of infertility in this group was three years.

Secondary infertility: 30% were secondary infertile in that they have conceived before, and had at least one confirmed pregnancy that resulted in a child, but were unable to conceive again following at least a year of exposure. The average duration of infertility following each woman's last confirmed pregnancy was seven

years. Only one woman had two daughters. One woman experienced spontaneous abortions, and one had an induced abortion.

On a basic level, these infertile women were united by a common desire: their wish to have a child. Moreover, and as will be discussed later in this chapter and in the chapter to follow, most women in this study began their therapeutic quests within few months to two years of marriage. Quests that were encouraged by husbands, husbands' in-laws, and other relatives who awaited the birth of a child as eagerly as the women themselves.

Given the demographic and biomedical profiles, some particularly "salient social facts" (Miall, 1985) about the study population bear repeating, as follows:

c- The Infertile Woman: A socio-emotional profile

The fact that these women represented difficult cases of infertility in that their problems were of long duration of multifactorail etiology, many of them had been under various forms of therapy for years, often with no success.

These facts combined with the direct social pressure and less direct social stigma that these women faced in their day-to-day lives (which will be discussed later in this chapter, and with details in the next chapter) had a profound impact of the well being of the women in the study. In questioninning them about their perception of infertility, a number of distinctive patterns emerged:

Fear:

The majority of women in this study reported that fear has become a pattern of life. Due to the social strain infertile women face, from husbands, families, etc, and the fact that they had to bear questions and inquiries that were often intrusive, they began to habituate themselves to a new form of life associated with fear. They feared the present, the future, and mostly they feared the inability to conceive.

Fear of future childlessness was noted by women who had been undergoing infertility therapy for extended periods of time, and by women who were in their late thirties. On the other hand, only one woman denied being afraid, attributing the matter of having children and marital insurance to God.

1-Emotional fear

They feared the consequences of not being able to conceive, how they will be looked upon by their surrounding, how will they evaluate themselves, and how can they secure their marriages when the base of it is shaking?

2- Sexual fear

The unstable sexual relations infertile women encountered may be related, in some cases, to the medical treatment women took, which might have caused them to be tensed and upset. In some cases, it changed the nature of the sexual relation from a pleasurable one into a forced one. A relation to be done serving only one aim: "conception." "Sex is no longer a spontaneous pleasurable activity, it is an assignment, a mission with a definable goal, pregnancy" (Mazor, 1991).

Women in this study described being obliged to do this pleasurable relation at certain specific times as something humiliating to a certain degree. Also, the fear and anxiety partners experienced awaiting each menstrual period, led to a tensed and unstable relation, and this led to fear of emotional abandonment of the partners.

***Anxiety*:** All women in the study described themselves as being worried, often by the same reason generated from their fear, namely the inability to conceive. Expressions such as " I am fed up," "I am tiered," "I am tensed," "I feel helpless," and " I am upset," were commonly repeated.

Depression: Many women were clearly depressed. Women often posed during interviews in an attempt to prevent themselves from crying; and many women admitted that they cried a lot at home, especially, when they were alone. "Defective" was the word used commonly. Several women contended that they would never be happy until they conceive. When they were asked about what would happen if they were unable to have children? The majority noted that their psychological status would worsen, and that this would only leave them "devastated," "collapsed," and "at a complete loss." On the other hand, when they were asked what would happen if they conceived? All of them explained that their lives would change completely. Not only because their marriages would stabilize, but because they would be able to get rid of the stress and fear they had to bear.

Loneliness: Most of the woman admitted suffering from profound loneliness. All of them contended that their triple stigma (mentioned earlier), and the fact that their surrounding "went into deep private areas," which they did not which to talk

about, added to their deep sense of "defectiveness," led them to internalize more and more their surrounding's negative perception of them, and as a result, became more and more lonely or to be more specific alienated.

Inadequacy: Many women felt incomplete, and defective in the sense that they have not fulfilled their feminine role properly. Many women also compared themselves to other women especially to their sisters in-law. They noted how these comparisons have affected their lives leading them to feel "hurt," and "inferior". Moreover, these women lamented that feeling different from other women made them hypersensitive to comments and attitudes on the part of others that might suggest this.

Anger: Many women expressed their anger at being infertile. Questions such as "Why me in particular?" "Why God deprived me of children, when I do love them?" and "Why do other women who don't deserve to be mothers have children?" were constantly asked.

Hope: In spite of all their feelings of angst, many of these women hoped to conceive in order to alleviate their sufferings, secure their marriages, and fulfill their ascribed social role (being mothers).

These demographic profiles were appropriate introduction to the nature of the upper middle class infertile women's lived experience, which is considered to be the true source of stress, which we now turn to.

B- Infertile Women's Lived Experience

I spent considerable amount of time trying to figure out how to present the ten upper middle class infertile women's case studies bearing in mind my sincere desire to do something to help these women, as mentioned in the introduction. Thus, I opted to allow these women whose life histories, stories and truths constitute the core of this thesis, to speak for themselves, and to make their words available to others in an attempt to try to change the pre-coded prejudices of the whole society. By doing so, I aimed at demonstrating that infertility carries along with its physiological aspect, which in most cases requires prolonged and painful medical treatment, a hidden stigma borne of shame, inadequacy, guilt, and secrecy.

In fact, over the course of 30 months, I have been able to share with these women some of their confidential moments, feel their weaknesses, contradictory feelings, hear their painful retellings, and share their memories. Without exception, these women wanted to know about my infertility experience; and how I managed to overcome it. In fact, this invaluable experience proved to be of great importance in understanding what is meant by being an upper middle class infertile women. Thus, presenting these cases, (although in a condensed way) empirically provide evidence for the influential power of the agency/structure dialectical relationship; and how these relationships, which are often strained and hostile, further stigmatize these infertile women.

Thus, I opted to present these stories in a narrative way bearing in mind the guidelines, which separate literary writings from ethnographies.

a- Primary Infertile Cases

1- Rehab's Case

Rehab is twenty-eight years old. She has been married for four years. She works for a private company. Rehab lamented that she was over weight by 20 Kilograms. Rehab acknowledged she used eating as a coping mechanism for the intense anxiety generated by her infertility, and the extensive related diagnostic and treatment experiences. She and her husband had been trying to have a baby for two years. Her doctor referred her case to be polycystic ovary disease (PCO) that prevented her from ovulating.[3]

Rehab grew up in a strong religious family and still maintains: "Family is very important to me." She felt her infertility has stripped her of any positive sense of identity or self-image. "I would say I have felt worthless, less of a woman-like I don't have anything in common with other women. I didn't know anyone else who couldn't have a baby, until we started going to the doctor's clinic. I always looked on people who didn't have children as maybe selfish and just not like I wanted to be. My whole sense of what you do with your life is family. My family is very close. Everything I do socially revolves around my family. Eid is a big deal. My sisters and brothers come with their children, and they are all happy. I feel real worthless."

[3] This disease is a complicated endocrine disorder associated with long-term lack of ovulation and excess androgen circulating in the blood, possibly due to adrenal gland over-stimulation (Lasker, and Borg 1987). Every month that Rehab's ovaries fail to release an egg, cysts form inside her ovaries, so that over time the ovaries become filled with cysts. The more androgen she produces, the more weight she gains. The more weight she gains, the more androgen she produces.

Defective was the word she used a lot. "That's how I feel. I play games like if I do this, if I put up with this, then maybe I'll get pregnant."

In trying to analyze her case, she explained: "After marriage I used a birth control method, houbob mane' el hamel (contraceptive pills) for almost a year and half. I did not want to get pregnant immediately after marriage, especially that I did not know my husband enough before marriage. We were engaged for only six months. So, I wanted the time to get used to him first, then get pregnant. After I stopped the pills, I waited for around eight months, but I did not conceive. So, I decided to seek medical help."

Commenting on her husband's role in the decision to seek medical help, she said: "My husband is a business man, he is very kind but at the same time very busy. I told him that I might have a problem, and that I needed to see a gynecologist, he immediately agreed."

Rehab's husband accompanied her only once to the doctor. "My husband is too busy to come with me, he only came once when the doctor wanted him to be examined. He did the examination and that was the last time he accompanied me." She suffered from this loneliness: "The treatment cycles are really exhausting emotionally and financially. Therefore, I need someone to lean on during these exhausting cycles, even my husband is not there for me."

Rehab spoke of the diagnostic testing and treatments almost as a punishment for being infertile. "It is almost like you have to. You're infertile and you have to go through it.[4]" Rehab took the prescribed drug for several months without conceiving. So, she added "The doctor switched me to a more intensive sort of medication (injection type), he recommend the powerful fertility drug Hemogon.[5]"

Rehab complained from the high cost of the treatment: "Hemogon is running approximately LE 3000/month. Moreover, each ultrasound costs LE 80." Rehab was undergoing the third and final cycle. "I want to get pregnant, I am fed up with the doctor's visits and hormonal therapy; the medicine makes me go nuts. I have noticed this, after taking the injection, I go crazy, I don't want to talk to any body or to see anyone, I just want to be left alone."

However, the last and final cycle failed and Rehab had to experience Artifical Instamination. For Rehab, the insemination experiences have become symbolic of her feelings of being punished for being infertile. She spoke of feeling embarrassed and humiliated in front of the office staff in the physician's office. "The secretaries.... I feel inadequate. I mean I feel embarrassed in front of these women.

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[4]Her doctor explained the treatment prescribed to her: "Ovulatory problems such as Rehab's are treated with hormones used to promote growth and maturation of the follicle of the ovary. The drug, taken by mouth, helps women whose ovaries produce some estrogen, but who fail to produce enough pituitary hormones to stimulate ovulation. Consequently, this drug is meant to help stimulate regular ovulation in Rehab, whose ovaries are unable to mature and release eggs on a monthly schedule."

[5] Hemogon, taken intramuscularly, stimulates the ovaries to mature and release several eggs. According to her doctor "Hemogon does, however, have the potential to cause multiple births, and can have some potentially serious side effects due to over-stimulation of the ovaries. Some patients have bloating, abdominal pain, nausea, hot flushes and depression. Hemogon is usually given for a period of three months, during which time the woman should be closely monitored for the level of estrogen in the blood, and ultrasound monitoring of the developing follicles" (Lasker, and Borg 1987).

They take the semen sample, and I am ashamed that they knew what my husband had to do that morning, that I have to be inseminated, and that everyone knew. There is a big feeling of having no privacy, and you feel you have to expose yourself. They have a vaginal ultrasound that they use on me every day. It is humiliating. It's gotten to the point where I've lost a lot of my self-respect. It comes to the point where you don't care anymore. You just want them to go ahead and do what they must. I have to; I want this, and this is the price I have to pay for it."

Rehab was also seeing a psychotherapist to deal with the intense depression related to her emotional response to her fertility difficulties and their attendant interventions. "The doctors had just about given up on me. They tried everything, but I was just not responding to any medications or treatments. I seemed to be the exception to the rule."

Rehab was angry about being infertile. She expressed anger and jealousy at women she felt less likely to be good parents. She was angry at not knowing exactly why she was infertile. "You expect that you are going to be able to have your own baby with your husband because you love him, and you begin to look at reasons, you look at excuses. I never took a drug, he never took a drug. All the reasons infertility is on the rise-we never had any of that."

Rehab complained from her surroundings' interference. "My husband's family are concerned with my case, I understand that, but what I can't understand is their consistence interference. They dig deep into private areas that I don't want to talk

about. If I refuse to talk, they become upset. People don't understand what infertile women go through. They think that by consistently asking about the progress of the process, they are doing me good. In fact, they are hurting me and I want to be left alone."

2- Donia's case

Donia has been married for seven years. She is 28 years old. Her husband and she met in an advertising firm for which they both worked, and married after dating for about a year and a half.

Donia started seeking medical help after one year and half of marriage without conception. She went to several physicians before seeking the help of her present one. Each physician diagnosed the case differently, ranging from ovulation problems, cysts on the uterus, to blockage in the fallopian tubes. She sadly said: "I have been like a laboratory animal for almost five and half years, they have tried on me several medications, and the case as I now understand is a surgical one."

In relating her history, Donia admitted being concerned about her fertility even before she was married. "It was never normal. I had always had cramps and feelings that there was something there other than a normal period, and I've always had very, very bad periods, where I would be sick and just basically couldn't even move. All of a sudden I heard about this thing called endometriosis that happened to women, who didn't have children by their late 20's. So, somewhere in the back of my mind, I

started thinking that could be it. Of course, at the time, I wasn't even married, so I couldn't just run right out and have a baby. I didn't even bother having it checked out to see if that indeed was what was causing all my pain." She further added: "I guess my present doctor was the only one who asked me for a regular check up, since, he had noticed something that was not right in the uterus. He suggested a laparoscopy."[6]

Donia indicated that she wanted to know what was wrong, but she feared that something would be found that might indicate that she could not have children "We went ahead and had the laparoscopy done, and it was diagnosed as endometriosis- between level two and three." [7]

In recounting the pain associated with diagnosis. Donia wept. "The doctor said that I had two options. Either to try a certain oral medication, or just try to get pregnant on my own. So, we took a year, and just tried to get pregnant. I used temperature charts and all that. I did everything on my own because that was all the doctor told us. He said "just go ahead and relax." She laughed and then said, "I think we subsidize a home pregnancy test. We must own stock in that company now."

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[6] Laprosecopy is a procedure to view the interior surface of the reproductive organs and abdomen. This procedure is used when other infertility tests have not revealed a definite cause for infertility. A laparoscope's is usually done under general anesthesia and involve a laparoscope (resembling a thin telescope with light at the end) being inserted through a small incision in the navel. During laparoscopy pelvic problems such as adhesions, tubule blockages or endometriosis, can be assessed before major surgery is recommended (Lasker, and Borg 1987).

[7] According to her doctor, Endometriosis, a so-called Benigr disease, and is one of the major causes of infertility. This is a disease of unknown etiology in which misplaced menstrual tissue identical to the endometrium (the lining of the uterus) grow outside of the uterus in the pelvis. In some women this out-of-place tissue can eventually implant itself into the pelvic organs, often on the ovaries. During each menstrual cycle this tissue, called endometriosis mimics the uterine lining. Since it is responsive to hormones it builds up, breaks down and bleed. Endometriosis can cause rubbery bands of scar tissues to form between surfaces inside the body, preventing the fallopian tubes from capturing the egg, thus causing infertility (Lasker, and Borg 1987).

Her smile faded as she continued, "Anyway, we went back to the doctor a year later and told him we would try the medical treatment. He basically told us that it was too late, that we should have thought of that ahead of time." The disease had progressed beyond drug treatment by that time.

Remembering that conversation, Rehab said: "The doctor felt like the disease had grown so much to the point that he talked about a major surgery-going in there and cleaning it out and that type of thing; and I was totally not prepared for that. He also suggested a second laparoscopy to go in, and to verify the stage. We basically left his office with me in pieces. I remember walking around a neighborhood where we just didn't know where we were. I was just sobbing and sobbing. I didn't know where to go. I thought that even an amoebae can reproduce. Why can't I?"

After several months, Donia had the surgery, took Clomid with no results, and spent two months on Hemogon with still no pregnancy. "All I have left is just one month. The doctor said that I can't do more than three cycles with Hemogon, and that if I don't conceive, I would have to go through a more advanced stage, which is IVF."

Through the harsh stages Donia went through, her husband attitude towards her relieved some of the physical and emotional pain she experienced. "My husband is very supportive, I don't know what I would have done without him being beside me. God really loves me. I truly love him for his support and kindness. He backs me a

lot, especially, in front of his parent's and family. He never gives them the chance to talk to me in a bad manner, or to comment on my case. He is a real gentleman."

3- Rokaya's case

Rokaya is 34 years old. She married twice. She is a business woman. Her infertility came as a blow to her because she had always wanted to get married and have a baby. Her family is a close, child-oriented one. She grew up with four brothers and sisters.

According to Rokaya, her mother got a lot of attention from her father when she was pregnant. She traces her desire to become pregnant to her early experiences. "I think it first goes back to when I was growing up, and babysitting a lot from three, four or five years old. As I look back on it, I really think I was almost obsessed with it. In high school, all I could think of was having a baby. The physical aspect of it was attractive to me, you know, being big and fat." She laughed a moment and then added, "Maybe it was because I was always so skinny, and I loved the thought of being big and fat, and being helped around. I always dreamt and really spent a lot of time thinking about it. I loved the idea of raising a child and having my life spill over into another life."

Rokaya described herself as having been more focused on having a baby than on finding a husband. "My father called it to my attention before I was even out of high school because I was always so concerned with having a baby. He said "Well, what

about a husband?" I wasn't really concerned. I knew there was going to be somebody."

At age 17, she married the first man she dated. This man was 16 years older than her and already had two children. "He told me that he is never going to have children again, but I figured I could talk him into it eventually."

During the nine years of this marriage, Rokaya spent the last five years trying to get pregnant. The marriage was deteriorating, but she was reluctant to leave. Eventually, the marriage did fail. "I could never forgive him for denying me a child when we first married, and then insisting I use the IUD (Intra Uterine Device) that damaged my tubes." This device finally had to be removed.

Although Rokaya was a successful businesswoman with her own real estate company, she found it hard to relinquish the image of herself as being pregnant, having a baby, and becoming involved in all the activities that women do with their children. "I sometimes let down my obsession with all the infertility treatment, and realize that I might die and never have had a baby come out of my body. I really want the experience of being pregnant. I want people to recognize me as a potential mother. I want to be pregnant. People give special attention to pregnant women. They pat them, and hug them, and ask them how they are feeling. I want to produce a child and have my husband be proud that I had his baby. I think of being in the hospital, him being with me and bringing me flowers."

Rokaya stopped and took a breath before relating an experience that happened one afternoon. "I stopped at a school crossing and all the little children were walking across the street going home, and I was so full of sorrow that I could hardly drive on. I wondered why God punishes me like this? Why does everyone else get to have children? Why not me? I know that I have made a success of myself professionally, but I feel deep down, that having a child is really the only worthwhile thing I could do. Why am I even here if I couldn't do that?"

Rokaya got remarried again. She has been married for three years now, and still finds herself obsessed with having a baby. She had surgery to reconstruct her tubes, and twice became pregnant. Both pregnancies resulted in miscarriages, and she felt that she was to be blamed for one: "I didn't even know I was pregnant, and I went off a high diving board."

She thought she had let her husband down by not having a child from him. The fact that he has a child from his first wife pressured Rokaya to thrive for a child also. "I try not to let myself believe that I'm not as great of a person as I would be if I had a child. But I think of it as a failure."

She perceived herself as a changed person, a more isolated individual: "I think I've finally realized that maybe I would never have a baby, and that I really don't want people to know why I don't have one. This has caused a real personality change in me."

Rokaya was under hormonal therapy and ovulation monitoring to increase her chances of getting pregnant. She seemed pretty annoyed with the high cost of treatment, which added another burden to the already existing one. "Hormonal therapy is very expensive, and also ovulation regulation visits."

Rokaya's main reason behind seeking therapy was her feeling that she lacked something crucial; she felt that she didn't complete her role properly. "God gave me everything, a loving husband, money, friends, and a high social status, thanks to him, but I feel I am lacking something very crucial. I guess my husband deserves to have a child, though he did not bring the subject up, I feel it. I feel it through my in-laws talking, my friends, and through even my husband's working mates."

Rokaya stressed on the importance of the husband's support by saying: "Without having the feeling that you are being understood and comforted through these painful stages, it would be very hard to pass through them."

4- Azza's case:

Azza is a 34 year old woman, who has been married for10 years. She cried frequently as she described what life has been like for her. She holds a successful management position with a large financial institution. She and her husband Marwan, met in college and married following graduation. Their infertility problem came as a

shock to them. They suffer from unexplained infertility[8]. They planned that when Marwan finished post-graduate studies, they would start their family.

Azza described the anxiety brought about by their inability to conceive. She paused frequently to prevent herself from becoming too tearful to speak. "My husband finished his studies three years ago. About a year and a half prior to his graduation ... we started trying. I mean we stopped trying not to have children. We haven't used any form of birth control for seven years. We've just used rhythm and knowing the symptoms, avoiding the times we thought we could become pregnant. After he graduated, we started getting concerned because we weren't having any luck at all. We began the process of looking for doctors and started out with one, worked with him for a year and a half, and just got frustrated with the whole experience."

Her awareness of infertility as an assault on her identity began in the doctor's office. Azza described the experience at the doctor's office as very impersonal. "I always left with a bad taste in my mouth because I just didn't feel as though he was very sensitive to the turmoil I was going through, and it was as if he was saying, "I don't have an explanation for you, so let's just go on to the next test. Please see the receptionist and pay your bill." I finally decided I was not going to deal with that man any more and went to my present doctor. It was nice to find that he was a human-being who dealt with not only the fact that there was no medical reason for

[8] Approximately 1-15% of infertility patients who undergo complete diagnostic testing are told that nothing abnormal can be found. These individuals are placed in the category of "unexplained infertility." Some doctors call these patients "normal" infertile, a misnomer because the term implies that with time, these couples will eventually conceive. Unexplained infertility is an extremely frustrating diagnosis because by not knowing the specific cause of the infertility the individual is unable to decide which specific treatment to try. Many women in this situation find themselves unable to accept that they may not be able to conceive and, therefore are unable to move on with their lives (Lasker, and Borg 1987).

me to be infertile, but also that I was unhappy and frustrated. His staff are also wonderful."

The process of infertility testing, of consistently having the results of her tests returned normal, and the repeated failures to achieve pregnancy were compared by Azza to "an emotional roller coaster". "It is a very frustrating experience that adds strain on the marriage." She posed for a while then added: "You go through all those tests and in the back of your mind, each of you wondering, is it my fault or is it his fault?" She continued, with more intensity of feeling, "Who's to blame for this? The fact that you can't have a child together causes a little bit of blaming and a little bit of guilt to exist between the two of you. The plus has been that the 'who' experience has obviously led to some incredible conversations and communication, and you reach a real understanding of each other."

Issues related to family and ties of descent were emotionally laden for Azza. "My husband is originally from Sharqyia, and for the nine years that we have been married, I have known that his having a son has been so important to him, as well as, to his family; and my not being able to deliver has been a real difficult thing for me to deal with."

The values placed upon lineage for her husband's family were powerful. "My mother-in-law has been pushing for grandchild since the day we got married. My

husband has a brother and a sister, who each have two children, but Marwan is Marwan Jr., and it is important for him to produce a Marwan III."

One of the ways in which Azza attempted to cope with feelings of powerlessness over her continuing inability to conceive was to play what she called "head games." "I found myself playing so many head games with myself, and would share them with my husband; and I guess he just got to the point where he realized that the best thing he could do was just to listen and be sensitive. I kept thinking, All right, this is January, and if we go through this test and take this drug, maybe by March I'll be pregnant for Mother's Day, and we can tell the family. Over the years, I would tell myself next Mother's Day, I would be a mother or by next Eid for sure."

"Each little event that happened, and my wish didn't come true, was just a little disappointment, another step back. Every month when I realize that I am not pregnant, I go through a period of two or three days of depression."

Azza used her job as a coping mechanism to fight these feelings: "I try to throw myself into my work as a distraction. I concentrate totally on what I do, as not to think about it."

The turning point came after Azza's laparoscopy; she described the surgery as: "The last step in the process. Nothing else turned up, so we thought for sure it was endometriosis." Azza sighed and said "Well, they found no endometriosis. It was determined that we fell into this 10% of unexplained infertility."

Looking back at the infertility treatment, Azza talked about the process of dealing with infertility. She had given up her denial and the "head games." "If I think about the whole process in terms of a four and a half years period, I think up until the time of the surgery, there was always in the back of my mind this glimmering little hope that they were going to find something wrong, that they would fix it, and everything would be wonderful."

She raised her arms above her head as she described her doctor's response following the surgery. ""He said, I throw up my hands, I don't know what else to do." It wasn't really until that moment that I knew that I had to come to live with the fact that I may never bear my own child; and that was something I was very unwilling to deal with. Up until then, I would not let go of that little hope."

After what the doctor said, Azza was left with nothing but to try to get herself occupied in work. After six months without taking any medication, Azza realized that her period was delayed. She went to the doctor, who after examining her, told her that she was pregnant. "I can't tell you how surprised I was. I nearly screamed when I knew, I even hugged the doctor. My marriage was about to collapse. Isn't God merciful?"

5- Nawal's case

Nawal is twenty-seven years old, has been married for almost three years. She graduated from the Faculty of Commerce, Ain Shams Univerisy, and is a housewife.

Nawal suffered from Vaginismus (a form of sexual disorder that makes penetration impossible). She explained: "It is very difficult when he (her husband) tries to penetrate me. Something happens that makes it very difficult."

Nawal lamented that she did not love her husband and that she married him because her parents wanted this. " They thought that he was the perfect one for me. I had to marry him, and what made things worse, was the fact that I was in love with someone else. Unfortunately, we could not marry because of some stupid financial matters. My parents wanted me to forget about this man, and thus, thought of getting me married, as soon as, possible to the first suitable man."

Nawal hated her husband and perceived him as the source of her misery: "This man (her husband) came to take me from the one I loved. I hate him because he deprived me of happiness. However, I tried ever since I got married to get over my feelings, but I could not, I really hate him."

Nawal's sexual relationship with her husband was best described as turbulent. She did not wish to talk-out her feelings with her husband, and he too did not

respond to her consistent demand to seek medical help to overcome her pain. "I have been brought up on the fact that I must respond to my husband's needs, especially the sexual ones, even if I did not feel like it. This indeed, hurt me a lot, and what hurt more was his passive reaction towards the problem. I think he has no feelings. How could one sleeps with his partner when he feels that s/he hates him? I really hate this man. I feel with each intercourse attempt that he is raping me."

After one year and half, Nawal finally sought medical help. "When I explained to the gynecologist the symptoms I suffered from, he immediately diagnosed the case as Vaginismus. He advised us (her husband and her) to seek psychiatric help. However, my husband refused the idea of attending these counseling sessions, and told me that he was not insane. He felt insulted. He did not think of me. All he thought of was getting me pregnant, in an attempt to satisfy his ego, and more importantly to satisfy his family."

Nawal psychiatrist, after examining her, prescribed her anti-depressive drugs, and a lubricant cream to be used before any intercourse attempt. He also advised her to attend some therapeutic sessions at his clinic that would help her overcome her problem. "The doctor tried everything on me, but nothing worked. It was as if my body resisted anything that would ease the situation, and hence bridges the gap between him (her husband) and me."

Nawal and her husband did not tell their families of the type of their problem. "He did not wish to tell his family because he was ashamed to do so. He perceived it

as a threat to his virility. On the other hand, I did not wish to tell my family because I knew they would not let go, and that I would be subjected to different questioning and interrogations, which I did not want to deal with."

However, after almost two years, both families began to get concerned, each in its own way. The husband's family began to ask for a grandchild. At first this desire was passed out implicitly: "They always imply in front of me how important it is to have a grandson and that children are considered "the decoration of life." Then their wish to have a grandchild began to be more explicit, and to some degree hostile: "My in-laws began to explicitly ask for a grandchild, and began to ask their son to find a solution to this problem. Comments of me being barren and can't bring them the grandson, really hurt me."

"As for my family, my mother began to dig into deep private areas that I did not wish to speak about. I tried to make her feel the agony I lived in, but she insisted on the importance of pleasing my husband and his family."

Nawal's husband, as a result of his family's vigorous pressure, had to tell them that Nawal suffered from vaginismus, and that she might not be able to conceive. Thus, his family urged him to divorce Nawal. She was divorced a couple of months later: "This was the best thing that happened to me. I am glad to have gotten rid of this man. And thanks God that he was the one who asked for a divorce, because my family would not have allowed me to do so."

Nawal was aware of her new situation as a divorced woman, and its consequences. "Although my parents are not happy with the new situation, it is more bearable than the three years I had spend with this man. Sure, my parents are treating me like a prisoner ..... I am not allowed to go out alone, talk on the telephone in private, or even go to the hairdresser alone, but all these reactions I can bear and tolerate .... The situation now, even with their attitudes, is much more comfortable."

6- Mona's Case

Mona was a thin, petite somewhat freckle faced woman. She is 25 years old, a graduate from the Faculty of Hotels and Tourism, Helwan University. She has been married for three years. She is a housewife.

Mona lamented that she intentionally delayed pregnancy for one year and a half: "I wanted to have some time to get to know my husband. So, I used contraceptive pills to prevent conception. I did not consult any gynecologist before doing so. Actually, a friend of mine advised me to use a certain type of pills, and I began to use them. However, after one and a half years of marriage, my husband began to ask me for a child. I thought it was the right time to do so. Then we began trying to conceive."

Mona and her husband tried to conceive on their own for six months without success. Her husband proposed the idea of seeking medical help. " Mahr began to get

worried and started asking me to seek medical help. I felt that there was no point of loosing time, and that it was a good idea."

After intensive medical examinations, her case was diagnosed as immunilogical infertility. "The doctor examined me, asked for some blood analysis and then asked my husband to under go some examinations. Then the doctor asked me to visit him immediately after intercourse; he examined me. Finally, he attributed the case to be immunilogical infertility. The case was that I produced antigens to my husband's sperms, which immediately killed them."

The doctor's treatment required her husband to use condoms during intercourse for six months. At the same time, he asked Mona to pay him pre-scheduled visits to monitor her ovulation in order to be sure of her exact date when her ovulation is at its peak. "The doctor said that after the six months period, and based on the scale of my ovulation, he would be able to name a specific date for us to have intercourse on, without using condoms, in an attempt to conceive. He also mentioned that if this attempt fails, we would have to repeat the same process again."

Their first attempt failed and they began their second trail. "It is an awkward situation. It is as if we are playing hide and seek. However, we have no other options, but to try over and over again. It is very painful to bear the feeling that so many people know your problem, and know exactly when you are going to have sex with your husband. I feel deprived of my privacy, my self-esteem, and my dignity. However, it is the price I have to pay in order to have a child of my own."

Mona complained from her in-laws' and family members' constant invasion into her private life: "They want to know everything about my private life, and if I refused to talk about these intimate areas, they get upset and feel humiliated. I wonder who should feel humiliated? I am fed up with their comments, questions, and even concerns. I want to be left alone. No one understands how hard it is to be labeled infertile, and how hard it is to bear the consequences of this natural given problem."

Infertility shaped not only her relations with her family, but also with her friends. "I hate to admit this. The only person I've admitted it to has been my husband. We had been very close to a young couple and we had a lot of similarities. We did everything with them. On weekends, we were with them constantly. About one and a half years ago, she got pregnant with their first child, and all through her pregnancy we were excited together and it was like we went through all that together. We would dream about my being next, and how we were going to put our babies in their strollers and walk down the block together, and do all the things that young mothers do. After the baby came, it was like her whole life was consumed by this baby and I couldn't relate. I couldn't relate in that I wasn't going through the same thing and also, there was a piece of me that was very, very jealous. So, I found myself pulling away from her and finding excuses not to spend time with them. It hurt too much to be around them; to hear her talk about what fun things she did with the baby today."

Mona stressed on the importance of husbands' support in reaction to women's infertility problems. "My husband is very supportive. He always told me to relax and never worry about the end result. He is so tender, caring, and a very loving husband. I don't know what I would have done without him being beside me."

b- Secondary infertile cases

1- Naglaa's Case

Naglaa is thirty-one years old, a house wife. She has been married for nine years; has two daughters, the eldest is eight, and the other one is five years old. She married her husband after a long love story. "My husband is a very loving man, I really love him and would do anything to please him."

Commenting on the reason behind her seeking therapy: "My husband want a boy to carry his family name, and to protect me and the girls after his death, long life to him" she added.

Naglaa's case according to her doctor was due to irregular ovulation, which needed to be treated using hormonal therapy. Naglaa began her first hormonal cycle two years ago expressing her willingness to do what ever needed to please her husband: "He is always nice when bringing the subject up, but he is talented in cornering me to seek therapy through his nice words and sweet talking."

Naglaa, complained from the fact that the medication was relatively expensive, and that hormonal therapy was so painful. She had to take three hormonal injections/per day, besides another medication in the form of tablets. She explained "I did not imagine that the treatment could be that expensive. Moreover, it was not just expensive, it was painful as well. The injections really hurt and I have to take them three times a day for five days a month. You know the treatment per month nearly costs LE 3000, including the doctors' fees. That is too much, I wonder what would other infertile women, who can't afford the expenses of the treatment do? I really pity them. The government must do something about this."

Nagalaa's first attempt to get pregnant failed. She immediately began her second cycle. Commenting on the failure of her first cycle, she said: "Well, the doctor explained to me that it rarely happens that a patient gets pregnant as early as the first cycle. What I am just hoping for is to conceive after this one. I really hate injections, and I want to get rid of people invading my private life without permission."

Nagalaa complained from her in-laws constant invasion into her private life. "They always ask about what happened, as if, I did not bring them grandchildren before. Each time I visit the doctor, they ask me what happened. Mind you, I visit the doctor each other day during the cycle for my ovulation monitoring. So each other day they ask the same question, as if, they think one time I would come from the doctor's clinic saying: Oh look suddenly I got pregnant!"

Naglaa lamented that one of the influencing factors in her seeking therapy was the unfair treatment she received from her in-laws, "My parents in-law preferred my sisters in-law because they have the sons who would carry the family name." She also complained from the treatment she received from her sisters in-law, since, they always gave her the impression that she would envy them for having the sons; and asserted that this made her avoid visiting them. "This made me feel sorry for myself and I am asking God to give me the son to get rid of all these comments."

However, even after she sought therapy, she complained from their negative comments, saying: "They always teased me by asking about the progress of the treatment, then saying "why are you doing this to yourself? You have two girls, or you want to get him the son?" Then they add: " Well we have heard that if you eat lots of fruits, your chances of having a boy becomes greater, so try it may be you would be lucky enough" then they laughed. This really hurt me and made me feel that I want to scream at them telling them to leave me alone, but something stopped me. I don't know what, but I guess the feeling that they were ranked by my in-laws in a higher position than me, and the fact that if I responded to their negative comments, I would be a loser, may have prevented me."

Another factor that encouraged her to seek therapy was her mother's advice: "I have encouraged her to go for the this baby since the boy protects his mother and sisters. Moreover, I am not happy at all with the way she is being treated, but her husband is such a wonderful man. Her in-laws don't dare talk to her in a bad way in

front of him. He always protects her. But she is still young and can carry another child, so why not. God knows her suffering so I don't think He would let her down."

Naglaa's husband, although, was the number one factor in her seeking therapy, was very understanding when it came to the emotional part, and that he was appreciating what she was doing. Moreover, he often accompanied her to the doctor, even though, she said he was pretty occupied managing his own business.

Regarding his attitude towards the problem, Naglaa explained, "He is very considerate, and often accompanies me to the doctor, he is supportive, caring and a loving husband, I feel like doing anything to please him." She also explained that he had never let any one (in his presence) treat her badly, however, the problems began when he was not around, she explained: "They do not dare do anything in his presence. However, when he is not around they go crazy. But I never told him because after all they are his family, and I do not wish to spoil this relationship."

Naglaa's second cycle also failed: "I know I am to be blamed for this failure, because my ovulation was at a perfect level, but I could not do sex upon demand. My doctor named a certain date for us to have intercourse on. I did not tell my husband, since, he would have urged me to do sex on that day. I hated this..... I know that we are spending all this money to get me pregnant, but the idea itself irritated me. We are not machines."

Naglaa's third cycle was a very stressful one for her, she explained in sorrow: "I was fed up with all this; I was tired of hormonal injections and the day after day

scheduled visits to the doctor, and lastly the day after day blood analysis. You know I have counted the injections I took each month between hormones and blood tests, they were 57 injections."

Her doctor informed her husband of the date on which they had to have intercourse. "He (the doctor) did not want to take risks, so he told Ahmed, he did not trust me." She added laughing.

After a month, she paid the doctor a visit since her menstrual period was eight days late. After examination, the doctor congratulated her for being pregnant. "I can't imagine I did it" she hugged her husband in front of all the patients in the clinic, who were actually happy for her. She added "Thanks God for being so merciful, I have seen lots of women here in the clinic who have been trying to get pregnant for one or two years."

Naglaa refused to know if she had a boy or a girl: "My husband wants to know, but I think it is better to wait. Moreover, my in-laws have changed their attitudes completely. They turned into being caring, and loving. My mother in-law cooks for me, and always tells me to rest. They even do not allow my sister in-laws to harass me as before. You know I am kind of afraid to know if it is a boy or a girl, because I know if it turned out to be a girl, all this would vanish, and I would be subjected to all sorts of stresses once again."

Naglaa had a baby boy. "I knew I had a boy, this is something a mother can feel....my husband is very happy and so are his parents. I feel I had won the most important battle in my whole life."

Commenting on her in-laws' attitude towards her, Naglaa explained: "They are happy because they have longed for this boy since Ahmed is the eldest..... I have forgotten all the agony and stress, and I really feel happy and thankful for what God has given me..... I am happy for my husband, who supported me through these difficult stages and backed me up. He always told me during my pregnancy "No matter what you carry, I will always love you, appreciate all you do, and the treatment you tolerate to please me.""

Zeyad, her son, is almost a year. Naglaa confirmed the fact that her in-laws still treat her in a very nice way. She just mentioned that the only problem she was facing was from her sisters in-law who felt that she has taken it all "They were jealous because my parents in-law play with Zeyad and love him. I guess they did not imagine that such a day would come, when things would turn upside down, and the poor little miserable girl who used to tolerate their teasing and harassment would get it all. I thank God every day.... However, I also try not to reciprocate in the same way. I still want our relationship to be of a friendly and a passionate one. I am trying hard to gain their friendship; and I would never give up."

2- Nashwa's case

Nashwa is thirty-nine years old, resident of El Mohandesseen. She got married twice. In retelling her first experience, she explained in agony: "I loved one of my colleagues at the faculty of Engineering, Cairo University. My parents did not approve of this marriage, however, I eventually managed to make them accept. I married Alaa, but he turned out to be a monster. He used to insult me, and once slammed me on the face for refusing to give him money." Nashwa asked for a divorce and he eventually divorced her after taking a big sum of money. She described her situation: "I was torn apart, I felt I did something that was terribly wrong. I felt ashamed of my self, and thanks God that I did not get pregnant, though, I did not use any contraceptive method."

Although Nashwa was aware of the fact that she did not conceive form Alaa, the thought that she might be infertile, did not occur to her: "Well, it did not occur to me, all I thought of was to get rid of him. Moreover, we were only married for about a year and half. Half of this period we were separated. So, I thought that I hadn't have enough time to get pregnant and that was all."

Nahswa refused to re-marry for almost two years, then Kamal came into the picture. Although Nashwa contended that there was a great societal difference between them, she decided on marrying him for two main reasons: "The first time I saw him, he attracted me. He is very talented in writing poetry. He wrote one describing me, which made me feel so happy. The second reason for accepting

Kamal was the fact that I was getting older, divorced and my chances of finding a man who had never been married before, was nearly minimal. Kamal did not get married before. He works as a journalist in Oman, and I really wanted to leave home for a change and start a completely new life."

Nashwa agreed on marrying Kamal without any mahr (dowry), no shabka (wedding ring) and even no m'oakhar (delayed payment). She said: "I was buying a man. My father explained to him the stressful experience I went through and told him that all I needed was someone to care for me and to make me feel comfortable."

After marriage, Nashwa immediately got pregnant "It was the happiest moment of my life, I thought that finally things were beginning to straighten up for me. Everything was going fine. The responsible doctor for my case was an Indian lady in her mid thirties, who at each monthly visit assured me that everything was going fine. However, by the sixth month, I had unbearable pains and I was hospitalized. The doctor examined me and told me that the baby had died. Till this moment I never received a convincing argument of what exactly happened wrong."

Nahswa had to be operated on to get the baby out, and the doctor assured her that she would be able to conceive again very soon. " From that time till now I have been trying to get pregnant with no success! I thought may be the problem was with the doctors there, so I decided to see a doctor here in Egypt. I went to a famous one who asked for a laprescopy, and then told me that I had several cysts on the ovary that needed to be removed. I had to be operated on for the second time. After the

operation he told me that I would be able to conceive safely. I went back to Oman and over a period of nine months I tried to conceive, following the doctor's instructions on the appropriate dates of intercourse on which my ovulation was supposed to be at its peak, but with no success."

Nashwa each summer, for the past eight years, came to Egypt, paid several visits to different gynecologists. Each one asked for different types of tests, analyzed the case differently, and prescribed her different medical treatments that were usually hormonal. For the past eight years she took each year three cycles of hormones to improve her ovulation. Then she returned back to her husband in Oman and tried for nine months to conceive, following the doctor's instructions, but with no success. She lamented: "I was fed up, hormonal therapy makes me crazy, the injections hurt, cost a lot; and more importantly put me in a very depressed and nervous mood. I feel like an "animal." I come each year alone to "swallow" some pills, be injected with different types of hormones, and then go to my husband to be tested if the treatment succeeded or not." She added with great agony: "These hormones made me put on a lot of weight. I had skin rash as a result of the therapy. Moreover, I lost interest in everything, all I want is to get rid of that burden and just get pregnant."

To add more agony to her story, her husband who was turning 44 started two years ago to threaten her by remarrying. "He said that God allowed him to do so because I am barren. He comes from El Falaheen, Talkha, Mansoura. His family's pressure is so influential, they want a grandson. They put a lot of weight on this issue. At first I thought that he was just threatening me, because I know he loves me

too much, and more importantly, he knows that I am trying my best to get him a child. I have done what I have been asked to do; and I am willing to do more to please him and to get my self out of this miserable state."

A year ago, and while she was in Cairo taking the hormonal cycles, her husband got married to a woman from his village. Certainly he did not tell Nashwa. Not only this, but he took his newly wedded wife with him to Oman. She stayed at Nashwa's home, in her bed, using her personal items and feeling comfortably at home. When it was the time for Nashwa to join her husband in Oman, he sent his second wife back to her village.

Upon her arrival, Nashwa sensed that something went wrong; she said with great anger: "When I first arrived at my home, I felt something was wrong. The home was not tidy, not clean and not organized the way I left it. Knowing that Kamal was so clean and tidy, I suspected that something went wrong, but it never occurred to me that he would have done something like this. Bringing another woman to sleep in my bed, was something that I could not imagine. I asked him what happened, but he gave me silly excuses. Next day, my neighbor came to visit me, and told me the whole story. I felt stupid. He slaughtered me."

Nashwa confronted her husband with what she knew, and he admitted doing so, and begged for her forgiveness. He told her that the only reason he had for not telling her was that he loved her, and did not want to hurt her. "He told me that he did not

love the other woman, and that she did not conceive. He promised to divorce her, however, he did not do so."

Nashwa began to suspect everything her husband told her. She was aware that her husband did not send her to Egypt last summer to be treated, but he wanted to bring his second wife in order to make her conceive. "I know he is going to get her to stay with him for the summer, he would not divorce her, not because he loves her, but because he is dying for a child. Moreover, he told me that they (new wife's family) made him sign the "A'ima" (a list with all the furniture bought by the bride) in the amount of LE30, 000. He also agreed on the Mu'akhar in the amount of LE10, 000. So if he decides to divorce her, he will have to pay her around LE50, 000. He says that he can not afford to do that now, but I know that this is only an excuse."

Nashwa was not sure how to handle the situation: "I am 39 years now, if I get divorced, this would be my second one. Moreover, it would be widely known that I am divorced because of bareness! Who would agree to marry me? And I don't think I have feelings left for any one to give. Although Kamal is very kind to me, what he did lastly made me feel how fool I was to believe in men. I am in a complete mess. However, I told him on the telephone that he must choose between her and me. I can not stand it any more. All I am left with is waiting."

Nashwa took this initiative under pressure from her family, her mother explained: "She is very kind, I can't understand what is happening to her. She had

never had a quite life, I pity her, but what can I do. May God be merciful on her. Her father told her that she is most welcome to stay with us. I told her not to humiliate herself more than that. Her father's home is always be opened for her. I also told her that this should be Kamal's last chance. He must choose between her and the other women. May God direct her to what is best for her."

Nashwa knew that Kamal would not divorce the other woman, especially after she conceived; so she asked for a divorce. Kamal refused to divorce her. "He said that he loves me and can not live without me. He said that the only job for the other woman was to get pregnant. It was like a film that I was watching." Nashwa asked for a divorce through the "khol'e[9]". "I have nothing to loose, he gave me nothing to return to him, no dowry, no Muakhar and nothing."

A month later, Nashwa got divorced. She was devastated. She felt that she lost everything, and that she would never live a normal life again. "I am now 39 years old, divorced and barren. Who would marry me..... I guess I am not even ready to get myself into a relationship that I don't know how it is going to end."

On the advice of her family, Nahswa sought the help of a psychiatrist. She began her sessions with him. She explained that these counseling sessions had helped her a lot. Her doctor advised her to get herself occupied as much as she can. She also began a diet to loose some weight; and had her hair cut in a new style. She began to

[9] A woman has the right in Islam to ask for a divorce, and is granted one, only if she returned back to her husband what he paid such as dowry, gifts, etc.

search for a job in an attempt to get herself as much as possible occupied in different activities, in order not to think about her experience.

3- Alia's Case

Alia is thirty three years old. She received her BA from the Faculty of commerce, Ain Shames University, and pursed her graduate studies in the same discipline. Alia got married eleven years ago. She is a housewife. Alia described her husband by saying: "He was the perfect husband to be, he had everything a girl would look for in her future husband. Good working position, a car, and an apartment."

Alia suffered from the inability to bring live births. She got pregnant eight times. Her problem was related to the failure of the placenta at a certain time during pregnancy to supply the embryo with food and oxygen, which resulted in the death of the fetus. Her treatment, as prescribed by her doctor, was plain children aspirin and regular visits to the doctor, once a week.

Alia was pregnant for the eighth time. She was in her eighth month of pregnancy, and the possibility of completing this pregnancy was considerably high. "I want more than anything in the world to complete this pregnancy, I have been exhausted. Feeling deprived of something that moved inside me for almost nine months is devastating."

Alia had been determined on having a child, she explained that, even though, she got pregnant eight times, with no living children, she explained that she would repeat the whole process over and over again until she "brings him (the child) to move in the real world" " I want to have a baby, to cuddle him, and to hear him say this lovely word "Mama". I love children very much and ought to have one of my own."

With regards to her husband's attitude towards all this, she said "He is a person who accepts his destiny, he never blamed me for not being able to bring live births, instead, he always encouraged me to pass through the difficult times."

Although Alia passed through some difficult times, she was aware enough to seek help through a psychiatrist relative. On these difficult times she said, "You would never imagine how it is difficult to bury my own son or daughter immediately after delivery. My husband has done this seven times."

Alia did not complain from the cost of the treatment, since, the treatment she was receiving was not expensive. But she mentioned that she had to spend a huge amount of money delivering her seven still births: "Hospitals are very expensive and doctors fees are expensive too."

Commenting on her in-laws interference and/or pressure, Alia said: "Sure, my in-laws want to have a grandchild, but they appreciate the fact that I am doing my best. My mother in-law always prays for me. They are very kind. But I understand

their concern to have a grandson. Moreover, my husband is very supportive. He always praised me in front of them."

Alia also admitted that her husband's support played a major role in providing her with the necessary strength needed to overcome the prolonged period of treatment. "Without my husband, I would not have been able to make it. He is so patient, calm and understanding. I really respect him for all he did."

C- Discussion of the Cases

The pain, stigma, and spoiled identities of these ten women reflect the hidden burden of infertility or to be precise the stigma of infertility. Their narratives, their stories, their truths reveal the gulf that separates the medical industrialized reality of infertility from its lived experience. Their stories provide us with substantiation of alternative visions of reality; visions unlike the dominant medical story which is often a story of one more try, one more cycle or one more treatment. Infertility for women in this study was associated with the stigmatizing feelings of shame, guilt, inadequacy, failure, negative qualities, being de-valued, abnormal, incomplete and not whole.

a- Infertility: an assault on women's identities:

All women in the study reported being stigmatized, and socially de-valued as a result of their failure to fulfill their socially ascribed roles (being mothers). Nashwa's words expressed this clearly: "I do believe it [infertility] lessens you in some

people's eyes, makes you different; like God is punishing you or something." In Goffman's (1963) discussion of stigma as a potentially polluting substance, he acknowledges how that status can have serious consequences, and can be "Deeply discrediting to its possessor and to the social identity of its possessor". As a result of accepting a cultural construction of gender that defines women in reproductive terms (Martin, 1987), women who fail to reproduce are stigmatized by their failure.

Indeed, women in the study were aware that they had to bear the negative consequences, social devaluation and stigmatization of their infertility problem, and as a result, were much more stigmatized than their husbands. Goffman (1963) explains this and argues that for women, in contrast with men, infertility "spoils" their identities rendering them incomplete and diseased in their own eyes.

The notion of being socially devalued and reproductively incompetent has been constantly repeated throughout the case studies. Women complained from their surrounding interference, negative comments, and even hostile attitudes. In fact, this proves Scott's (1978) argument: "Stigma, carrying with it a series of moral imputations about character and personality ... the fact that ... stigma leads [non-affected people] to regard [the affected] as their moral inferiors, psychological, moral and emotional inferiors transforming biological infertility into socially defined inadequacy." As a result, the unaffected find it difficult to imagine the identity infertile women find themselves assuming, and often being consumed by.

Moreover, as a result of feeling socially devalued, stigmatized and inferior, more than half of the women studied 70% reported that they were reluctant to talk about

infertility even with their husbands; and no one, if given the chance, wanted to tell their mothers-in-law. For example, Mona's infertility problem made her relationship with her husband's family difficult. "It has been a real disappointment to my husband's family, my mother-in-law in particular. In her family, women got married very young and had two or three children by the time they were in their mid-20s. So she was very caught up with the idea of having grandchildren."

Other women refrained from telling family, friends and co-workers about their fertility problems, and consequently suffered the constant joking questions and comments about their sexual behavior and potential/absent outcomes. Rokaya, who after a prolonged period of trying to become pregnant succeeded only to have the pregnancy end in miscarriage, told no one except her husband. "I'm a private person. I kept my miscarriage a secret. One of my biggest fears of going back to work was what they were going to say."

For all women in the study, the lived experience of infertility was one of stigmatization, isolation and alienation. Furthermore, the stigma of infertility extends to the social identity of the whole woman, polluting her other accomplishments, and attributing moral hegemony to the "normals". They felt as though they have broken some accepted, if unspoken, cultural rules, and they had to pay for it by being classified as the "other." Infertile women referred to their fertile sisters as "normals," while placing themselves in the "other" category. Women who have children, they say, are understood and accepted; women without children are neither.

This conceptualization of being the "other," being culturally rejected, being forced into isolation, being denied both the social expression of grief and sympathy is caused by perceived deviation from the group norm. According to Goffman's typology of stigma, stigma arises through physical deformities, individual character deformities, or through the deviation from the group identity (Goffman, 1963). While other authors have suggested that infertility is more closely associated with Goffman's physical deformity type (Miall, 1985), my analysis suggests that the stigma attached to infertility rests not on the perceptions of a physical deformity, but on the sense of having broken a group norm. I argue, that this is particularly true in a patriarchal, medicalized society where the only external expression of infertility is the absence of children. In addition, the frequent lack of a clear etiology for infertility denies women a recognized illness category to blame for their stigmatization (Sandelowski, 1990). This denial is especially significant in a society where the validation of social identity is formed by the cultural construction of gender roles linked to reproduction (Martin, 1987).

The sense that their identities have been "spoiled," their dignity and privacy destroyed by infertility, and the fact that they are infertile women in a society that places motherhood above all other female role expectations, kept women struggling to overcome the condition through the only acceptable life choice that of motherhood. However, in many cases this choice becomes an engulfing endeavor for those who are unable to achieve it.

b- A Child: A "mission" that has to be accomplished

Without any doubts, having children is one of the major goals of marriage among upper middle class Egyptians, as has been shown from the case studies, and will be further discussed in detail in the coming chapter. This indeed proves Inhorn's (1996) argument that infertility can be particularly threatening to both women and men under conditions of classic patriarchy, where the "patriarchal fertility mandate valorizing both motherhood and fatherhood as personal imperatives is felt especially strongly." Under this mandate, all women are expected to marry and become mothers. Motherhood is believed to be the most important role for women and the perceived essence of a woman's identity. Moreover, for men, the institution of fatherhood is at the ideological core of classic patriarchy. Fatherhood alone allows men to reproduce the particular relations of family life that are crucial to the reproduction of patriarchy itself. Infertility undermines women's domestic and nondomestic relations, it represents a threat to their marital, social and economic security.

All women in the case studies asserted explicitly or implicitly being driven by the social construction "need" to conceive a child who will perform the social tasks of extending the family and bearing its name. By consciously deciding to seek therapy, they chose to take part in the social construction "need" for offspring, and thus, structuring their day-to-day life in accordance. In fact, all women expressed the need to conceive in order to maintain a stable marital life, and to please their husbands and their extended families.

The "need" to conceive a child is thus to be considered the "norm" for any marital relationship. This indeed proves Goffman's definition used earlier to situate infertility as a stigmatized condition. Goffman further adds: "Failure or success at maintaining such norms has a very direct effect on the psychological integrity of the individual. At the same time, mere desire to abide by their norm… mere good will is not enough, for in many cases the individual has no immediate control over his level of sustaining the norm. It is a question of the individuals' condition, not his will, its is a question of conformance, not compliance." This argument clearly explains why infertility is considered highly stigmatized to Egyptian women, merely because it violates a "crucial" norm of being that of "motherhood."

In fact, all the cases in this study asserted that motherhood is a normative requirement that women themselves don't question. Instead, following marriage women strive to uphold it as quickly as possible so as to achieve social recognition of their status as productive members of the society. As well as, to fulfill a much more basic desire to become 'normal human beings' through motherhood. Sholakamy (1997) attributes this strive of gaining women's socially ascribed role (motherhood) to cultural processes that begin from childhood in which girls are trained to regard "motherhood" as the ideal, and the most highly valued status that all women must strive to achieve. Indeed, this idea has been explicitly repeated throughout all the cases, and was clearly manifested in their usage of expressions such as "defective" to describe their failure to achieve this highly desirable status.

Not only this but, some women, out of being completely obsessed by the fact that they are "defective," and combined with stress and social devaluation they face in their day-to-day interaction, equated their case to being handicapped or even dead. Donia described it: "My maternal instinct is being denied. It's a slap in the face. I feel like I'm isolated in a prison; I have no one who understands how horrible this is. People don't know what to say to you. I think I'm alternatively dealt with as either someone who has died or a handicapped. And I think people approach it like that because they don't understand death; they don't understand handicaps; and they don't understand infertility."

Carling's (1962) argument supported what these women felt to the extent of using the same words and expressions women used to describe their situation. Carling equated infertility to being crippled and compared the handicap of being crippled to that of women who "felt inferior and different because of... [their] inability to bear children." This sense of involuntary childlessness as a handicap was repeatedly expressed by Rehab: "I wish more people understood about handicaps. We just don't as a culture. We don't want to because we have this glamorized ideal about what everybody should be, and we all strive to do that, and if you don't ... if you are not like that, then you are somehow different, and you're ostracized rather indirectly, and many times rather directly."

c- Encounters and dis-encounters

All women expressed their anger and frustration over their surroundings, especially their in-laws, constant invasion into their private life and their desire to go

into deep private areas that they didn't wish to talk about. They also asserted that if they refused to satisfy their in-laws' eagerness to know everything about the situation, they get upset. On the other hand, all women in this study were aware of the structural obligations and constraints placed upon them as members of extended families. This awareness was brought through their expressed feelings of obligations to please their husbands, and their in-laws by bringinning them the child they longed for.

In fact, this proves the argument proposed by Rugh (1984) in which she convincingly argues that reproduction is a necessity to the extended family. "Coorportance" is highly valued in Egypt and "individualism" is not, in that Egyptians regard social groups as "indivisible" unities that persist regardless of the constituent members." Rugh contends that of all possible cooperate social groups, family is the most "intense" and is the " ideal by which other social groupings are measured."

Adding to this point, Kandiyoti (1988) further argues that Egyptian society is organized patrilineally, and as a result, fear of "social death" on both the individual and group levels, lead members of the husband's "aila" (family) to work in order to breakup infertile marriages of family members, which they often view as "pointless at best, and dangerous at worst."

As a result, it was clear from the case studies that the husbands' extended families formed aggressive social units reminding their sons/siblings of their desire

to have a grandchild/nephew. In most cases, this familial pressure involved not only the husband, but also his wife who was stigmatized as "un-productive" and "un-deserving" of their son/sibling as a marriage partner. Indeed, this familial pressure could in some cases be so intense and aggressive to the extent that the husband incline to his family's wish and divorce his wife, as in the case of Mayan and Nawal. Or, if the husband loves his wife, he might choose to remarry another woman to fulfill his family's wish, keeping his first wife as in Nashwa's case.

In fact, these attempts to stigmatize the wife in the eyes of her husband, and thus prompts him to end his infertile marriage to her has been explained by Goffman (1963) in which he attributed it to the issue of the "courtesy stigma." As he noted, individuals who are related through the social structure to a stigmatized individual may also be stigmatized by "association": "The problems faced by stigmatized persons spread out on waves, but of diminishing intensity .... In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated, where existing."

This argument also convincingly explains the husbands' eagerness to have children, which was implicitly expressed through urging their wives (directly or indirectly) to seek medical help in order to overcome their barrenness (even without knowing who has the reproductive failure). It is argued that the husbands feared the stigma of infertility in the sense that it consisted a threat to their virility, as well as, to the continuation of the patereline, as will be argued in the next chapter.

However, this does not mean that these infertile women were merely passive in reaction to the above-mentioned stigmas and burdens. In fact, infertile women with the help of other women close to them (such as infertile women's "aila") managed to find ways of resisting not only male power (e.g. to replace or divorce them), but "also the subordinating power ploys of other women (especially mothers in-law), whose overt strategies of marginalization can be nothing short of cruel" (Inhorn, 1996). Thus, many of these infertile women were everyday resisters engaged in everyday struggles to overcome the stigma of their childlessness.

In spite of the fact that upper middle class infertile Egyptians are resisters, their individual efforts cannot be counted as truly "counter-hegemonic", for the infertile constitute no fundamental group in the Egyptian society, and hence, lack a collective voice as "subalterns" (Inhorn, 1994). This lack of collective organization is reflected in the absence of national infertility self-help associations in Egypt (such as RESOLVE in the United States), or even a nationally coordinated policy or program to help the infertile seek medical redress of their conditions.

Moreover, as has been discussed earlier, infertile women tend to bear stigmas, social devaluation and inequity more than men because their agencies are considered weak in reaction to their structures. Men on the other hand, hold a socially ascribed power that enable them to manipulate their agencies in relation to their structures, as has been demonstrated from the case studies. This agency/structure dialectical relationship is the subject we now turn to.

d- Agency/structure dialectical relationship

Throughout the case studies the power of agency/structure dialectical relationship has been clearly demonstrated. It seemed that each individual involved in the relationship was aware of his agency in relation to the structure s/he belonged to. In other words, all infertile women were constantly aware of their own agency, which was quite explicit through their refusal to have sex upon demand, their reluctance to the therapy process, their complaints of its expenses and the associated emotional and physical pain.

However, they were all aware of the structural obligations and constraints placed on them as members of extended families. This awareness was brought up through their desire to conceive in order to escape the "deviant" position they were placed in as a result of their reproductive failure. Thus, they often restored to the weaker position in the relation fearing further stigmatization and devaluation.

This was clear in all the cases, even in the cases where the husbands supported their wives. Although the wives in these instances were aware of their husbands' supportive attitudes, they could not manipulate these attitudes to counter the claims of their in-laws on their privacy and life lest they spoil their relationship, as was clear in the cases of Naglaa, Nashwa, and Rokaya.

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their relation to their wives manipulated this agency/structure dialectical relationship to their best interest. This has been clearly demonstrated throughout the case studies, as the relative contribution of the husbands and their wives towards the problem has not been equal, reflecting the differential power relation between them. Husbands in all cases (except for one case) were the primary factors in urging their wives to seek therapeutic help. They urged their wives without knowing who has the physical impairment, which demonstrated to a great extent the power ascribed to the husband in manipulating the life of his wife, and his very sense of his agency in relation to the marital structure.

Moreover, husbands' reactions to their families' constant pressure to remind them of the importance of having children, reflected their position in the agency/structure familial relation. In this relationship, almost all husbands 80%, restored to the position of the weaker. This was mainly due to the fact that their families manipulated their man-hood by constantly tying it to reproduction, which was considered an assault on their virility. Moreover, they also manipulated their integrities by constantly reminding them that their infertility problems pose a threat to the continuation of the pateriline.

In addition, husbands' in-law, especially women, through manipulating the power ascribed to them by reaching the state of "motherhood" (Early, 1993) further stigmatize their sons' wives for not being able to fulfill their roles as mothers. Not only this, but also husbands' in-law in their reaction to their daughters' in-law, bore in mind their "deviant" position and the weaknesses they held as a result. They

manipulated these feelings by constantly pressuring their sons to divorce them or at least to remarry. This posed a real threat on infertile women's marital status and security and added further burden on them.

Even the physician was aware of this agency/structure dialectical relationship and manipulated it to achieve the desired therapeutic results, as was clear from Naglaa's case.

Other fertile women were aware of their agency in relation to the reproductive structure. In their relation with infertile women, they perceived themselves as the powerful party since they have achieved the socially desirable status of motherhood, and in that sense they ostracized infertile women fearing their evil eye, and rendering them inferiors till they overcome their barrenness.

Thus, as has been clear from the case studies, each one involved in the relation knew how to manipulate his/her agency/structure dialectical relation in favor of his/her own benefit.

e- Infertile women's medical exploitation:

Another important point that I want to highlight as it was repeatedly mentioned throughout the cases, which concerns the diagnosis and treatment of the cases. It has been demonstrated in this study that upper middle class Egyptian's definition and response to this problem has become highly "medicalized" (Illich, 1976). Women in this study live the consequences of their social identity and the

medicalization of infertility. Hence, with the acceptance of the medicalization of infertility, they accept the corresponding sick role (someone with defective reproduction).

Almost all women asserted the fact that the process of medical intervention further stigmatized them and devalued them for any accomplishments outside of reproduction. It is as Mayan puts it "Once into the process, you are never allowed to leave without conception." The result is that once a woman enters into the medical intervention process, there is great pressure placed on her (whether it be from her husband, in-laws, her family, and even the physician) to continue treatments until there is either a successful outcome, or all the options have been exhausted. Indeed, the medicalization of infertility builds on the flawed social identity of infertile women (Oakley, 1979).

Moreover, they suffer because they have internalized the social norms expressed in dominant gender roles and in so doing see themselves as "defective". They suffer from being denied the opportunity to proceed with their lives as others do. Their attempts to remediate the problem, and to fix the broken part require that they give all they can of their time, energy, and money to the treatment process in order to become "whole normals" and to remove the secret stigma of being infertile (Harkness, 1987).

In fact, almost all women in this study 80% noted the fact they had to switch physicians several times until their cases were properly diagnosed (or so they

thought). Furthermore, when patients switched physicians, diagnostic procedures were randomly repeated, often with little or no attention to previous tests the patient might have undergone. Hence, because women in this study visited as many as three to five physicians during their careers as patients, they were likely to undergo a variety of diagnostic tests, which were physically, financially, and emotionally exhausting.

Having said so, some questions need to be asked: Why does this happen? These women sought the help of well-known gynecologists, so what went wrong? Why weren't their cases properly diagnosed? Why rushing them into intense medications, and in some cases crucial surgeries (as in the cases of Mayan, and Nahswa) when they did not need them at the first place? Who is to be blamed? Should infertile women be blamed for accepting to be treated as "laboratory animals" as Donia stated? But these women are not experts on medical issues, besides infertility came as a blow to them, so they did not have the time or the effort to go about "researching" gynecologists trying to find who was best for their case.

Then, should gynecologists be blamed for not giving each infertile case enough time for proper medical investigation and analysis? I argue that indeed these gynecologists should be blamed. This argument is further documented from the infertile women's retellings, previous research findings (Inhorn, 1991,1994,1996), and from the two gynecologists who participated in this study. One of them explained: "Gynecologists don't give enough time to each infertility case. Infertility cases should be carefully investigated and analyzed before reaching the stage of

diagnosis. However, many gynecologists have lots of cases to investigate each day, ranging from mere pregnancy follow-ups to complicated infertility cases. How can one gynecologist carefully investigate, in some cases, up to 80 or even 100 cases each day? For sure, he will not give each case the desired attention."

Nevertheless, although being overloaded is a crucial problem, it is not an acceptable excuse for exploiting infertile women physically, financially and emotionally. Moreover, I also argue that since the physician's professional identity is dependent on the successfulness of the outcomes, s/he would not let go of the case until the desired result is achieved. However, in so doing, bearing in mind the lack of proper diagnosis, the physician might be willing to exploit the infertile women physically, financially, and even emotionally through unrealistic hopes of conception. Thus, I argue that there is a crucial need for a critical evaluation of Egyptian's biomedicine's role in defining and dealing with infertility due to its extensive negative impact on the overall well-being of infertile women.

f- Are you with me on this?

It has been clearly demonstrated throughout the case studies that although infertility affects both the husband and his wife, the relative contribution of each one of them towards the problem reflects culturally constructed gender role expectations for men and women regarding reproductive functionality. Indeed, Goffman's statement published in 1963 is still true today. There are gender differences in the way men and women respond to infertility in which women's identities are more

likely to be "spoiled," as stated earlier. For example, in all the case studies, the wife was the one to be tested first (without knowing who has the reproductive failure)[10]; the husband would only be tested upon the request of the physician. This proves Griel's (1991) argument, "Regardless of who has the reproductive impairments, the female partner is likely to be subjected to a series of painful and intrusive tests."

However, it is also important to note that it has been clearly manifested through the case studies that two crucial factors strengthened the female agent in relation to her social reality. The first one is husbands' positive attitudes toward their infertile women during the treatment process. Women who asserted the fact that their husband supported them during the difficult times they passed through, explained that this relieved much of the pain, ramifications, and burdens they faced as a result of their barrenness. They also mentioned that their husbands' understanding, comprehension, and tenderness during the difficult times they passed through added "closeness" to their marital relationship.

In a relating point, it is important to note that all women stressed the importance of husbands' positive reactions toward their surrounding, specially in-laws', interferences and hostile reactions. In other words, women expect their husbands to act as a "back-fire-wall" against their families' hostile comments and attitudes. They argued that their deviant position as infertile, compounded by being considered "outsiders" to their husbands' extended families, situated them in very

[10] Inhorn (1991) in her discussion of the 100 lower/middle class Egyptian infertile women concluded that women were the ones to seek medical help first derived by their desire to secure their marriages. She also noted that not all husbands inclined to the physicians' requests to be medically tested, and that they considered it shameful to do so.

weak positions to the extent that they could not react. In fact, this supports the idea of the necessity to regard infertility as a couple's problem, and stresses on the importance of treating it through this perspective in order to overcome or at least minimize its negative consequences.

The second factor in strengthening the female agent in relation to her surrounding is women's employment. Indeed, it has been clearly demonstrated through the four cases, in which women were employed that this added relative strength to the female agent in her relation to the nuclear family, extended family, and surrounding. It added to her relative independence to pursue certain aspects of her life. These women used their work as coping mechanisms to fight negative feelings associated with the treatment process, such as, isolation, loneliness, depression and grief. Alia's case is an excellent example. Her husband's support, encouragement, and understanding, added to her work, which she used as a coping mechanism to forget about her problem, enabled her to fight back misery, agony, negative valuation, and to deal with her problem in a more rational and capable way.

Thus, it is argued that the women in this sample lived the consequence of their infertility. They suffered because they have internalized the social norms expressed in dominant gender roles, and in so doing, labeled themselves: defective. They suffered from being denied the opportunity to proceed with their lives as others do. Thus, until our society's dominant cultural norms value women equally for their reproductive and productive roles, flawed social identities for women will remain.

In the next chapter, and based on the case studies' narratives, it will be argued that in Egypt children tie a man to his wife by examining the multifarious non-fertility related forces, which impinge on the marital relationship. It will be argued that depending on the individual reaction to these forces that some of these marriages remain relatively secure and equivalent in terms of power sharing, and others are relatively insecure and governed by men who "in using their societally sanctioned power, may abuse it and the wives whose marital lives they control" (Inhorn, 1994).

CHAPTER-V

SOCIAL STRUCTURAL CONSIDERATION

"El Mal Wil Banoun Zenat El Hayat El Donia"

"Wealth and Offspring are the decoration of life in this world"
Qur'an XVIII:46

Before discussing the external social pressures on infertile marriages, which could lead in many cases to serious marital problems and to further stigmatizations of the infertile women, I would like to make clear that the discussions hereunder were derived from my infertile cases' interviews, and they represent their own perception of how external factors play major roles in their stigmatization and social devaluation.

All women in the study asserted the fact that the stigmatization of infertility began at home with the husbands, and extended families playing major roles in it, and ended in the community where infertile women were often feared as casting the evil eye.

A- Infertile woman and her husband:

Having no culturally constructed notion for the term "couple" is problematic in Egyptian infertile marriages because in social structural terms a husband and a wife

without children do not constitute a socially recognized unit in Egypt[11]. "Marriages are viewed as vehicles for family building, a marriage that is not "productive" in this sense, is ultimately un-productive for society at large and is considered, at best, pathetically deviant, and at worst dangerously useless and something to be destroyed" (Inhorn, 1994). Thus, social pressure on both the husband and wife in an infertile marriage is in most cases quite intense, and this pressure naturally affects the "gender politics" of the marital relationship.

Having said so, it deems necessary to understand the differences between marriage's expectation and reality, i.e. how upper middle class marriages are expected to be, and how they actually are. To do so, it is necessary to show how upper middle class Egyptians weigh the success of fertile versus infertile marriages, and how children act as the essential tying bond between the wife and her husband.

Among upper middle class Egyptians, marriage is a highly valued institution. Although this class may not get married at an early age compared to their mates of lower classes, they eventually get married at least once. Moreover, when they get married they value the relation highly in the presence of children[12]. In fact, in Egypt, and more specifically, among the upper middle class category, there are two types of marriages that take place within this category: arranged marriages and love marriages.[13] The two types of marriages will be briefly discussed hereunder.

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[11] It is important to note that this term "couple" is widely used among young men and women referring to a man and a woman who are dating. However, strangely enough, this term completely disappears after marriage.

[12] Nahswa told me that her brother in-law, even though, was not happy in his marriage, and felt that his wife was not the right partner for him, still respected the marriage relation on the over all for the sake of his young children "He sacrificed his own happiness in-favor of his children's!"

[13] However, it is important to note that "bachelor" and "spinsters" became socially recognized terms among this category.

a- Types of marriages

1- Arranged marriages:

These marriages are usually arranged by families. The family of a young man identifies a suitable bride who is usually known to them; and the engagement process begins if both the young woman and the young man accepts[14]. In most cases, marriage proposals are accepted by the authority figures in a young woman's life- usually her father- not herself. Ideally, she will grow to feel something for the man to whom she is going to be engaged to, and who will visit her and her family on a formal basis during the engagement period. The young woman is allowed to go out with her fiancée alone. However, she is not allowed to return home late at night. Usually there is a certain hour set for her, and she is not allowed to return home after it.

Before the engagement party, both families agree on the "mahr," (dowry) which ranges between 25-50 thousand Egyptian pounds, the "shabka," (wedding ring) which is usually a diamond ring ranging between 15-30 thousand Egyptian pounds, and the "mua'khar", (delayed payment) which is usually in the same amount as the "mahr". It is customary that the bride's family arranges and pay for the engagement party, which in most cases is held in a five stars hotel. Sometimes the bride's family agrees on not having a fancy engagement party, and share in the expenses of the wedding party with the groom.

[14] Two main factors play key roles in whether or not the young woman receives suitable marriage proposals: first, her physical attractiveness; second, her family's prestigious status; such as her father occupation, or the name of the family.

During the engagement period, the couple prepare for their future home. The groom provides a suitable place for accommodation (an apartment), which the bride's family must agree on. The groom also provides for the necessary equipments and appliances such as the fridge, washing machine, dishwasher, etc. The bride selects and provides for furniture, curtains, carpets, etc., which usually the groom's family has a say in it. The wedding party usually does not take place unless the apartment is ready to receive the newly wedded couple. However, it is necessary to point out that if both families of the bride and groom failed to reach an agreement on any of the above mentioned items, the wedding could be canceled at any time[15].

The wedding party (dukhla) usually takes place several months after the engagement one. The 'dukhla' literally means: when the bride and groom become a man and a wife[16]. The wedding party usually takes place in one of the biggest hotels or in the ranch of one of the family members. It consists of the "zefa," two or more well known singers who sing for the bride and groom and a belly dancer. The bride wears an ornate, white wedding gown, and her husband wears a suit. After the party, the couple flies for their honey-moon trip, which usually takes place abroad in Europe or in the United States.

During the early months of marriage, the couple receives relatives, family members and friends to congratulate them on their new home. It is during these early months that the husband and his wife become accustomed to each other. This stage

[15] Donia mentioned that before her current husband, she was engaged to another one, whose family did not want to pay the dowry her father asked for, and thus, the engagement was canceled at once.

[16] It has been noted by almost all women studied 80% that they did not have sexual intercourse on the wedding night due to being excessively exhausted from the wedding party, which usually lasts till the early hours of the next day.

women usually describe as "the creation of understanding," where patterns of behavior are established during this stage.

2- Love marriages:

In this case a young man chooses a suitable bride that he loves and asks his family to go and ask the young woman's parents for her hand. All formalities, such as "mahr," "shabka" and the wedding party are dealt with as described above. The only difference is that the young couple love each other and choose to be married.

However, it is important to note that in some cases, especially when there is difference in the social classes of the two families, the young couple may face difficulties in getting married[17]. Still, class hierarchy is essentially important and constitutes a major obstacle in finding a suitable suitor.

However, it is important to say that according to the findings of this study, love marriages are more stable and successful when facing infertility problems. Field notes about two women illustrate this point:

Naglaa, a very attractive secondary infertile woman, in her late thirties, was urged by her husband in "a nice way," as she puts it, to seek therapy to overcome her infertility problem. She was under hormonal treatment in order to bring her husband *the son* he longed for. She has only two daughters. She expressed her situation by saying: "I got married to my husband 12 years ago, but I have been in love with him

since day one in college; that was 17 years ago. I really love him because he is so tender and caring. He too loves me a lot, but he feels that we need to go for another trail to get a son ..... Surely, he knows that this is something he controls, but since I love him, I am willing to do anything to please him." When I asked her what she thinks the situation would be if she failed to bring him the son? Without hesitation she said, "We would live a normal life as the one we are living now. I couldn't imagine myself living without him and neither could he. He only wants the son to protect me and his daughters after his death, long life to him" she added.

Mona, a primary infertile, very smart and attractive; suffered from infertility due to immunilogical factors, said: "We are not allowed to have normal sexual intercourse for six months; my husband has to use condoms during sex, which he does not like. Then after six months, we have only one chance to conceive; only one day we are allowed to have sexual intercourse without using condoms. This day the physician pre-sets for us after complicated medical examinations and blood tests. However, we have not been lucky so far. Although each one of us separately is normal, we together have a problem. However, my husband keeps saying to me "You are the one I want, I don't care if we have children or not; this is something for God to deiced; if he wants, He will enable us to conceive, and if not, then we have to accept it".... I can't tell you how his words relived me. I truly love him and respect him for being so tender; and as a result, I would certainly stay married to him even if I do not have children."

[17] This was experienced by Nawal who lamented: "Being deprived of the one you love is something that really hurts. I will never forgive my parents for doing this."

3- Expected marriage as opposed to real ones among upper middle class:

Romantic notion of the ideal marriage is the dream of every upper middle class Egyptian woman. Most women wish to achieve the marital ideals, especially that they were given a considerable amount of choice in the matter of choosing a suitable partner. Women dream of satisfying their husbands' needs; and wish in return for their love and respect. They dream of children to satisfy their motherhood instinct and to tie them to their husbands. For them, marriage is the institution that serves as the source of their childhood fantasies. However, women in this study view the success of marriage as dependent upon the man who happens to fill the role of the husband. It is the *man* and not the *marriage* that Egyptian women view as essential in the success of the marital relationship. Feelings of attraction, and the growth of love after marriage may not be mutual. However, most of the women in this study argue that the growth of love and comprehension is a reciprocal process that must be initiated by the man. In other words, if the man is "good" and treats his wife in a respectful way, then she would have to reciprocate in the same attitude; and hence love and comprehension find their way into the relation. It is from this point that 'real marriage' relationship becomes apparent. Indeed, this proves Cynthia Nelson's (1974) early mentioned argument that notions of power in any given relationship should be thought of in terms of "reciprocity of influence" that there must be an ongoing dialectical process of social life in which both men and women are to be involved in a reciprocity of influence vis-à-vis each other.

Thus, it could be argued that gender politics of marriage is a subject that upper middle class Egyptian women have much reason to ponder over, since, their own lives after marriage are often lived out in reaction to their husbands' behavior towards them. Women expect love to grow after marriage, and for most women, love is a product of their husbands' behavior towards them. Thus, it could be said that not all arranged marriages develop into love ones, and not all love marriages manage to maintain this passion. Lack of love may emerge from one partner or the other. From the women's point of view, feelings of love may not occur if the woman is badly treated by her husband or truly forced into this marriage, and especially, if she had hoped to marry another person. Thus, it could be argued that gender stratification is an essential factor in framing the marital relationship, and in some cases (especially in infertile marriages) may further stigmatize infertile women.

Having said so it deems necessary to try to break down the factors that constitute the overall context of the expected marriage, and which if not achieved turn into being a problem to the married couple:

b- Factors that may threaten the continuity of marriage

1- Respect

In love marriages, as well as, in arranged marriages respect is the "first stone" (according to the women's own expression) in building a successful relationship. Naglaa told me: "I married my husband after a very long love story. I had fantasies

about our relation, and how it could survive anything with the magic word "love." However, I learnt after several months that respect was the right word. Mutual respect between the man and his wife puts this sacred relationship on the right track and makes each one feels that he is a real human being." She nodded and then added: "Although I truly love my husband, I respect him more, and I think that it is through this respect that we nurture our love."

However, for most women, respect is the product of their husband's attitude towards them. In other words, it is the same scenario again the husband acts and his wife reciprocates accordingly. Donia told me commenting on this: "My husband has this tendency of insulting me in front of any one. Although, I know that he does this out of being nervous and then he apologizes, I deeply feel humiliated and scattered." She added: "He is in general a good man; however, this lack of respect creates lots of problems and makes me try to avoid him in public in order to avoid being humiliated." I then asked her who she thinks people would blame: her husband or her? She answered sadly: "I know people would blame him; and that is something I truly hate because he is my husband and his image is very important to me." Then she added "Respect is something crucial in any given marital relation even if love is present ..... love would fade away if not being backed up by respect."

2- Sex:

Sex in most cases becomes a problematic area for the newly wedded couple. It is a problem in the sense that the bride in most cases has no idea of how sex is going to

be after marriage. That is mainly because young women stay virgins till they get married; and so they don't have a clue of how sex is actually practiced. Regardless of the fact that most of the women in this study reported that they did not have intercourse on the night of their wedding day, they affirmed that the decision of having intercourse merely lied in the hands of their husbands. They were the ones who determined the frequency of intercourse, and not the women who considered it shameful to ask for sex.

Almost all women studied complained from the fact that their husbands were the ones who control sex relations for several reasons: first, sometimes women were exhausted from work inside or outside the house and were not willing to have intercourse, however they could not say no to their husbands' wishes. Second, sometimes they might not be in the mood, yet they must incline to their husbands' wishes. Third, intercourse in the early days of marriage has been reported by all women in the study to be painful, however, they had to bear the pain in order to please their husbands.

Thus, sex and its frequency may become a problem in the marital relationship, especially for the newly wedded couple, given the cultural context that urges the woman to please her husband and never say no to him.

3- Money

Money is a source of expected difficulties among the newly wedded couple. The bride, who used to manage her needs, be it through money she earned, or from what she took from her father, now finds herself faced with the fact that she has to ask her husband for money. Rehab commented: "At the beginning it was very difficult to ask him for money. I expected him to ask me if I needed some money. I was ashamed to ask him; this was really embarrassing, but at the end I had to do so. Then we agreed on him giving me a fixed amount of money at the beginning of each month, which was really a good idea."

Another problem arises if the wife works outside the house, and earns a fixed salary by the end of each month. Sometimes, husbands ask their wives to share with a certain amount of money in the expenses of the household, in return for giving her the permission to work. On the other hand, women find this strange and unfair since before marriage they were free to do whatever they want with their salaries, but now they have to share it with someone else who is supposedly the one to provide for the necessary expenses of the household. However, from the husbands' point of the view, the economic situation in Egypt has been growing increasingly worse in recent years, and in order for a household that belongs to the upper middle class (as defined earlier) to establish and maintain its existence, usually the women's economic input is not escapable.

4- Children

As discussed earlier, having children is one of the goals of marriage. Children are very important in all types of marriages. However, they are more important in arranged marriages as they serve as the tying power between two strange people who happened to be tied through marriage. Thus, having children is perceived to be one of the major ways in overcoming feelings of estrangement, and fostering love between a man and a woman (Inhorn, 1994).

Surely, both men and women perceive marriage to be partly or wholly a vehicle for having children. However, the reasons for wanting children differ between men and women, relating again to gender stratification and differences.

In the case of women, motherhood is viewed as a natural instinct that has to be fulfilled. Children complete the woman by making her a "mother". Children occupy women's time, provide her with joy and happiness, and make her feel that she is nurturing a child who will grow to be an adult and make her proud of him/her. Most women view children as their number one accomplishment. Even if they had their own successful careers, they still rank the success in bringing up a child their major challenge; and thus, their number one accomplishment. Moreover, according to the findings of this study and other studies conducted earlier (Inhorn 1985, 1991, 1994, Ammar 1963; Rugh, 1984), it is usually the children who provide women with intimacy and affection even more than a loving husband. It is as Inhorn (1994) puts it recalling the words of infertile women: "Children provide the taste of life."

As for men, children are viewed as a proof of men's virility and potency, and having children make them equal to other married men. In other words, they are not to be considered deviants from the norm. Men fulfill their ego gratification need when they have children, though, they are not directly involved in the care taking of the child rearing process. However, children for them are a source of pride since they have been able to fulfill their manly-hood role. They also become proud of their children as they care for them when they become elders. Adding to this point, men consider children the only way to be remembered after death as they carry their names and their families' names.

Based on the above, any violation to the "norm" of having children is to be considered "deviance" and brings about problems to the married couple. Surely, deviance from the norm of having children would be the disability of having children or infertility.

5- Infertility

Because the desire for children is so mighty to ensure marital protection, societal respect and positive self evaluation, most newly weds hope to conceive a child within the first year of marriage. Mona explained: "It was a dream that I had since I was almost nine years. I wanted to get married for the sake of having children. I love them, and I remember that I used to walk my neighbor's child around the park every day. This is something that I would give my life for."

However, when conception does not occur, one or more of the following marital problems are expected to ensue, and are usually in this order:

c- Marital problems expected as a result of infertility

Emotional turmoil: Women begin to worry and eventually experience many of the psychological ramifications of infertility to be described in the next section. According to infertile women and as Mona puts it: "Infertility is a problem that affects the psychology of a husband and his wife; the predominant emotion is sadness over dashed hopes, especially, if the husband and wife loves each other."

Quest for therapy: Women who have not conceived within the first year or two of marriage are expected to begin searching for an explanation and a "cure" for their infertility. This process usually involves their husbands who are requested by the physician to undergo evaluation. However, it is important to note that the willingness to embark on therapeutic quest differs from men to women. Women are usually more keen on undergoing any therapeutic quest out of fear of divorce or polygamy, as will be discussed later in this chapter.

Fighting: Infertility has been proven to be a major source of fighting between the husband and his wife. Fights, in most cases, stem from husbands' families' pressures reminding their sons of the importance of having children. As a result, the husband usually blames his wife for her inability to conceive, and hence, fights begin. As Azza explained: "His mother was so influential, but in an indirect way. She

always compared my husband to his brother. The latter has three boys and a girl. She always told him "kid are 'ezwa' and you are like a tree with out leaves.""

In-laws: As will be discussed later in this chapter, in-laws, and especially, those of the husband, are considered to be a great source of trouble for the infertile couple, and especially the wife. Blame for the infertility problem is usually assigned to the woman even before knowing if she is the one with the reproductive failure or their son?

Divorce/polygamy: The commonly cited marital problem associated with infertility is the collapse of the marriage either by divorce or polygamy (Inhorn, 1991). However, in either case, the woman is the only one to lose. In the case of divorce, she looses her home, and if lucky will move back to live with her father, who in turn, begins searching to find her another husband as soon as possible. However, her chances of finding a suitable one are minimal due to two factors: being divorced and barren. According to Morsy (1980), "Divorced women are socially stigmatized, and considerably more so if they are known to have been infertile in their first marriages. Not only are childless divorcees "used property" like other divorcees, but they are used property that was returned because of "defectiveness" in the most important area of marriage i.e. reproduction."

In the case of polygamy, the infertile woman's position in the new marital structure will be the elder, childless co-wife, "One of the worst possible structural positions for a woman to occupy in the Egyptian society" (Inhorn, 1991).

One point worth mentioning here, polygamous marriages occur when the husband loves his wife, but social pressure, especially from his family, is so great on him. However, even if the husband tries to protect his wife form the negative valuation of others, she is a stigmatized woman, since her infertility problem makes her different from others. "Her stigmatization is exacerbated, furthermore, by the fact that she, and her reproductive failing are juxtaposed continuously to a reproductively successful co-wife, who may flaunt her fecundity in an effort to affect change in the marital structure form a polygamous relationship to a monogamous one" (Goffman 1963).

d- Factors enhancing the continuation of infertile marriages

However, it has been noted by some scholars (Morsy 1980, Inhorn 1991, 1992, and Rugh 1984) that in some cases, infertile marriages may last and are relatively secure. Such marriages may last according to three factors:

Male infertility: Women have been noted to accept a childless marriage when the husband is the one having an infertility problem (Morsy, 1980). Although male infertility is socially recognized as a legitimate cause of divorce, women are reluctant to choose this option because of the shame associated with a woman's request for divorce for this reason.

Husband's love: When extraordinary love ties a man to his wife, infertile marriages are expected to last securely and the husband manages to overcome all stigmas and social burdens that may affect his marriage. As Alia explained: "I have

been in this endless quest for over eight years; my husband has never ever during these years made me feel that he was upset. He always said: "This is our destiny, and if God wants us to have children, He will give us." He loves me, and he always told me that the only thing that matters is seeing me happy. That is why I would do whatever it takes to have a child, even if they asked me for my life."

Religious faith: Although Islam permits divorce and polygamy, men who are considered faithful are not expected to exercise those rights because of their acceptance that this is God's will (Inhorn, 1994).

Based on the above, the stability and security of such infertile marriages depend on the individuals' reactions. Usually the husband is the key person in determining the future of the marital relation who through using his societal sanctioned power may/may not choose to abuse the relation and the wife whose marital life he controls. The role of the extended families in helping men to assert this control over women is the subject we now turn to.

B- Infertile woman and her husband's extended family

In addition to the infertile woman's fear about her reproductive health and marital status, she is obsessed by another fear, which is the ability of others to influence her husband and hence negatively affect her marital relationship. The most powerful party in doing so is the husband's extended family, and particularly his parents who exert great pressure on the husband to replace his "un-productive" wife

with another one who can bring him children. Thus, the relationship between the infertile woman and her in-laws may be extremely stigmatized, strained, and hostile on both sides (Goffman, 1963).

In trying to investigate the pressured relation between the infertile woman and her husband's extended family, a number of perspectives have to be dealt with: 1) reproduction failure as a threat to the extended family, 2) husband's extended family's reaction as a stigmatized factor, and 3) wife's extended family defensive reaction.

According to the findings of this study, the social production of stigma begins at home with the infertile women's in-laws and families playing major roles in the social drama surrounding the inability of the women to conceive.

For more than half of the infertile women in this study 70%, the problem of infertility was exacerbated by in-laws' pressure i.e. "Significant interference into a woman's life and marriage from her husband's "aila" (family)" (Inhorn, 1991). For these women, this interference directly affected their lives and consisted mainly of covert/overt social pressure on the infertile wife to conceive. Attempts to discredit infertile women, and thereby stigmatize them in their husbands' eyes were also commonly reported by infertile women in this study.

Given this scenario, a question poses itself here: Why does infertility pose a threat to the extended family? In order to answer this question, the nature of the Egyptian family must be examined.

a- Reproduction failure as a threat to the extended family

Rugh's (1984) argument in Family in Contemporary Egypt explains extended families' hostile reaction towards infertility. She argues that corporateness is highly valued in Egypt and individualism is not. Rugh further specify that of all the possible corporate social groups, the family is the "most intense" and is "the ideal by which other social groupings are measured." Inhorn (1991) in her study UmmEl Ghaib asserts this notion, and adds that Egyptians are "group oriented" thinking of themselves "Not as autonomously functioning individuals, but rather as members of collectivities, upon which their individual actions and life situations reflect."

Kandiyoti (1988) further argues that the Egyptian society is organized paterilineally, with the individual "a'ila" (family) acting as the most powerful social structure that includes both husband's and wife's mothers, fathers, and relatives whom they can draw upon for support.

However, in Egypt, the term "usra" is widely used in reference to the nuclear family i.e. husband, wife, and children. It could be argued that with modernization the tendency towards individualization grows more, and the term "a'ila" would gradually loses its weight in favor of the term "usra." However, through literature review, it appeared that in Egypt the term "usra" is *nested* in the term "a'ila," and

that the latter consists of a number of "usars." "The "a'ila" is viewed as an overarching structure, which links together a number of atomized but related "users," and which forms a network of social relations with the power to influence its component parts." As a result of this, although "usars" may be spatially isolated from the rest of "a'ilas," they are closely tied to the broader bilaterally linked kin network with direct influence over its members (Ammar, 1963).

Given the above-mentioned definition, a husband and a wife alone do not constitute an "usra" since the term implies the presence of children in this setting. Moreover, with the absence of the term "couple" discussed earlier, "A childless husband and wife constitute a liminal, unstructured combination for which Egyptians themselves do not find a name." (Inhorn, 1991)

Since the "a'ila" is a paterlineal social structure, thus, in order for the paterline to continue, each generation must reproduce itself by producing children, specifically, male ones who will carry the family name to future generations. Thus, infertility when it occurs poses a threat to the structural integrity of the "a'ila" as a corporate entity. Based on this, the husband's a'ila, and especially, his parents and siblings usually apply social pressure on the woman's reproductive unsuccessfulness; blame and stigmatize her for the failure to conceive. Thus, the infertile woman's stigma begins at home where the husband's family reacts to an infertile marriage in a strong and negative way.

b- Husband's extended family's reaction

These reactions usually evolve around two main scenarios:

1- Exerting different kinds of social pressure on the infertile woman:

According to the findings of this study, as well as, other studies, (Inhorn 1991, 1994, Attyia 1982, Ammar 1963) the oppression of the infertile women is usually exerted by fertile women of the husband's a'ila, which takes two forms: First, the husband's female relatives are the ones to notice that the wife has a problem with getting pregnant, and hence begin pressuring her to seek treatment. This was explicitly demonstrated through the case studies. An example is Nahswa's case: "My sister in-law was the first one to make a remark on me being late in getting pregnant. She told me: "Why don't you go and see a doctor, darling, instead of wasting the time doing nothing.""

Second, women of the husband's a'ila are often the most vicious commentators on the wife's failure to become pregnant in an attempt to demonstrate to the husbands the incompatibility of their wives due to their bareness (Attyia, 1982). Naglaa contended that her sisters in-law used to comment negatively on her inability to conceive in front of her parents in-law, and that the latter did nothing to stop them.

2-Pressuring the husband to replace his wife:

Almost all women in the study reported that their in-laws used to devaluate them in the eyes of their husbands in an attempt to encourage the husbands to replace them by fertile ones. Strategies for doing this evolved around "overt" and "covert" efforts to remind the husband of the importance of having children, and convincing him that his own happiness and future are directly tied to his production of offspring. This familial pressure on the husband often becomes more intense, and aggressive in cases in which the husband is the eldest or the only son in his family, as in the case of Azza.

This escalating pressure served infertile women negatively as they internalized the negative evaluation of themselves as "incomplete women." However, because of their weak structural position as "daughters-in-law," their lack of social power as "outsiders" to the husbands' "a'ila", and their internalized psychosocial negative valuation as "incomplete women," infertile women are usually unable to "fight back" and are forced to tolerate these various forms of social inequity, control and censure. Naglaa explained: "I have been tolerating these hostile attitudes for over five years; and as time passed without me getting pregnant, the hostility tendency grew much more dense and offensive. But what can I do? They don't do anything wrong in front of my husband; the problems begin when he leaves. I never told him anything; after all it is his 'aila' and I couldn't do something like this to him. Moreover he is very nice with me, and that is all that matters to me."

It is apparent from the findings of this study that where as the women of the husband's "aila" were the major stigmatizers of the infertile woman, the women of the wife's "aila" acted as "major stigma managers" in an attempt to aid their infertile

member "control information about herself in a way that would serve to decrease stigma potential" (Inhorn, 1994).

c- The wife's extended family's reaction:

Thus, whereas the relationships between infertile women and their in-laws are usually strained, hostile and stigmatized, the infertile own "a'ila" particularly the women play a counter balancing role attempting to undo the damage done to the infertile women's marriages, and self images by their husbands' extended families. Naglaa told me: "I don't know what I would have done without my mother. She always told me: "Wait God will reward you. Take care of your husband and never give your in-laws the opportunity to come in between you and your husband.""

Where as the women of the husband's "aila" were aggressive in their desire to break the infertile marriage, women of the wife's "aila" tended to support infertile marriages urging marital negotiation, compromise, and perseverance. In no case in this study did families of infertile women cause problems for the infertile husband and wife.

Women of the wife's own "aila," specially mothers and sisters, were viewed as best friends. In general, the mother-daughter relationship was among the strongest of all familial relationships. Almost all infertile women in this study spoke of their mothers as primary providers of emotional support throughout the often "tumultuous courses of their infertile marriages" (Inhorn, 1991). Over half of the infertile women studied 70% expressed their concern over the fact that their infertility consequent

problems had caused their parents, and in particular their mothers, to worry about them.

Thus, infertile women's own aila and, in particular their mothers, acted as infertility stigma managers in an attempt to undo the damage done to their infertile member by her husband's in-laws. However, the husband's in-laws are not the only source of stigma. Members of the community also play a major role in the process of stigmatization, as will be discussed in the following section.

C- The infertile woman and her community

The infertility stigma begins, as shown earlier, at home and ends in the community where the infertile women are often feared as casting the "evil eye," which could make young children ill or even make them die. Indeed the power of this particular stigmatized condition, associated with infertility, shape infertile women's daily interaction with others in which infertile women are forced to manage the social tension engendered by such "mixed contacts" with "normals" (Goffman, 1963).

The majority of infertile women in this study 80% chose a style of stigma management characterized by separating themselves from the community of "normal" women. Women in this study viewed their fertile surrounding as enemies, who could hurt them, if they attempted to gain social acceptance. This mistrust was based on painful experiences infertile women had to deal with in their interaction with these "normal" women. Such experiences, which were often compounded by

stigmatization, especially within the husband's extended family, caused these infertile women to be extremely reluctant to mingle with "normals."

Inhorn, (1991) reveals through a study on 100 infertile Egyptian women the widely shared conviction that infertile women are viewed by others as "incomplete" individuals who are missing the key ingredient to the achievement of full person-hood namely, the production of living offspring. Thus, until their "productivity" is proven, women who are "barren" are viewed as "liminal personae" (Turner, 1964) within their communities and at best are pitted and at worst feared.

Indeed this fear from the evil eyes of infertile women by fertile ones led the former to fear this fear, and as a result defended themselves by avoiding contact with others who feared them. As they explained, they knew that if they mixed with others, especially in the presence of children, and then something bad happened, they would be blamed for this misfortune, and that was a risk all infertile women were unwilling to take. Rokaya lamented: "I became so suspicious that people would fear me, as if every one in the street knew that I am barren. Do you imagine that my sister in-law never allowed me to play with her children, or even touch them; she feared my eyes. She always told me when I called to ask about them that one of them was sick or something, and then I discovered that what she said was not true. You know it hurt, it hurt a lot. No one could feel it, except those doomed like us."

For almost all infertile women in this study, they attempt to manage their stigmatization in their communities by avoiding their potential stigmatizers. "Such

separation meant that these infertile women preferred living in isolation than to expose themselves to social scrutiny and potentially painful ostracism" (Inhorn, 1994).

The fact that infertile women are actually feared by their surroundings as an endangerment to children attests to the magnitude of the stigma associated with infertility, and the power of this particular stigmatized condition that shape infertile Egyptian women daily lives.

CHAPTER-VI

CONCLUSION

This thesis was about people who by virtue of their identity as upper middle class infertile Egyptian women, had to bear different social consequences of this culturally defined problem. Although this study focused on infertility as a devastating and stigmatizing condition for upper middle class women, it also focused on much broader issues such as: What does it mean to be an upper middle class infertile women in Egypt, and why is motherhood so important in any given marital relationship.

Through answering these basic two questions, an understanding of why upper middle class infertile women are stigmatized was attainable. Rugh's (1984) argument was used as the basis for answering these questions. She argues that individual identity in Egypt is nearly synonymous with corporate identity, with the most important cooperated group being "family." The western ethic of "rugged individualism" is empirically lacking in Egypt. Individual actions are usually taken in consideration of how these actions will affect other members of the group. However, this does not mean that individual egos in Egypt merge entirely with those of the family or group members. It has been clearly demonstrated in chapters IV&V that the desire for children is partially driven from the need to fulfill personal ego

gratification, and that the inability to have children affects the individual's marital normative value.

Nevertheless, it has been clearly demonstrated that men and women are not alone in their desire for children, and in their consequent fears of infertility. Children were proven to be extremely important for reasons that are marital, familial, and social; and infertility has been shown to pose a threat to group formation, from the level of the nuclear family to the Egyptian society at large. "The replacement value of children to society is an extremely compelling group concern, and is played out most obviously in the efforts of patrilineal extended family members to ensure that male children are born, so as to carry the family name to future generations" (Inhorn, 1994).

Building on the above argument, infertility has been considered in this study as one of the classical features of stigma, which Goffman (1963) defines as "An attribute that makes [her] different from others in the category of persons available for [her] to be, and of a less desirable kind in the extreme, a person who is quite thoroughly bad or dangerous, or weak. [She] is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive."

Furthermore, it has been proven through this study that upper middle class infertile women experience a triple stigma that stems from social relationships that are often strained or disrupted: womeness (not fulfilling her feminine role), bareness

(not fulfilling her motherhood role), and powerless (being oppressed though escalating social hostile). As a result of these stigmas, infertile women have no other choice, but to carry a triple burden: the burden of blame for conception failure, the burden of negative valuation as unproductive members of society; and the burden of responsibility to over come this failure through an often unfruitful therapeutic quest. Accordingly, Egyptian upper middle class infertile women stand in a very dis-empowered social status, which is further enhanced by other forces such as men over women, extended families over women, fertile women over infertile ones, and even communities over women. Thus, these women had no other legitimate escape, but to subject their bodies to different therapeutic quests, which were often unfruitful, risking all they have including their lives to overcome such burdens, forces, stigmas, and social devaluation.

Findings of previous studies that dealt with infertility in Egypt such as: (Ammar 1963, Rugh 1984, Attyia 1982, Khattab 1997, Shalakamy 1997; Morsy 1978a, 1980a, and Inhorn, 1991, 1994), proved that the magnitude of the stigmatization problem for infertile women is reported to be quite high ranging from marital strain to religiously permitted polygamy or divorce to complete social ostracism. However, these studies either mentioned the problem of infertility only in a passing way, therefore, did not differentiate between the consequences of the infertility problem according to the social class of those affected; or dealt only with lower/middle class Egyptian infertile women.

Drawing on these studies' findings, and the fact that this study concentrated on upper middle class infertile women who were revealed to suffer from the same, more or less, stigmatizing conditions, burdens, and social devaluation, I strongly argue that the hypothesis put forward in this study is true. Indeed, infertility is a culturally constructed phenomenon for all infertile Egyptian women regardless of their education, location, income, and social class backgrounds. Moreover, it has been asserted that infertile women's desire to gain social respect through reaching the state of motherhood was so powerful, and the social pressure (including husbands', in-laws, and surrounding attitudes) was so mighty, that many of these women were willing to embark on therapeutic quests with all its accompaniment physical, emotional, social, and economic turmoil risking all they have including their lives to overcome such burdens, forces, stigmas, and social devaluation.

However, this does not mean that infertile women were merely passive in reaction to the above-mentioned stigmas and burdens. It has been demonstrated in chapters IV&V that infertile women with the help of other women close to them (such as infertile women's "aila") managed to find ways of resisting not only male power (e.g. replace or divorce them), but "also the subordinating power ploys of other women (especially mothers in-law), whose overt strategies of marginalization can be nothing short of cruel" (Inhorn, 1996). Thus, many of these infertile women were everyday resisters, engaged in everyday struggles to overcome the stigma of their childlessness. However, their individual efforts cannot be counted as truly "counter-hegemonic", for the infertile constitute no fundamental group in the Egyptian society, and hence, lack a collective voice as "subalterns" (Inhorn, 1994).

This lack of collective organization is reflected in the absence of a national infertility self-help associations in Egypt (such as RESOLVE in the United States) or even a nationally coordinated policy or program to help the infertile seek medical redress of their conditions.

It has been demonstrated in this study that upper middle class Egyptian's definition and response to this problem has become highly "medicalized" (Illich, 1976). Women in this study lived the consequences of their social identity and the medicalization of infertility. Hence, with the acceptance of the medicalization of infertility, they accepted the corresponding sick role (someone with defective reproduction). Moreover, they suffered because they have internalized the social norms expressed in dominant gender roles, and in so doing see themselves as "defective". They suffered from being denied the opportunity to proceed with their lives as others do. Their attempts to remediate the problem, and to fix the broken part required that they give all they can of their time, energy, and money to the treatment process in order to become "whole normals" and to remove the secret stigma of being infertile (Harkness, 1987).

The pain, stigma and spoiled identities of infertile women described here in this study reflect the hidden burden of infertility, or in a more specific way the stigma of infertility. Their narratives, "truths", and stories reveal the gulf that separates the medical industrialized "reality" of infertility, from its lived experience. The medicalized story of infertility is one of possibility, of future interventions of new processes and new diagnostic techniques. All too often is the story of one more

treatment. The lived experience is all too often one of failure, the failure of the treatment, and the perceived failure of the woman.

The tragedy of infertility lies in the loss of human potential, and the unrealized self-submerged in the medical quest for reproduction. Infertility is not a fatal condition. Many women choose not to have children and live full and productive lives; others are unable to bear children and successfully channel their energies into other activities. Infertility does not have to destroy women; that it does is a reflection of a stigmatized social identity and the medicalization of intervention. Ironically, the cultural construction of identities, including or excluding reproduction, provides women with choices upon which to construct their social roles. Many women, however, are either not aware of those options, or are not able to create such destigmatized identity for themselves (Shapiro, 1982).

Lastly, based on the findings of this study, I strongly recommend that the infertility problem should be regarded as a couple's problem. Husbands active involvement in this process is an essential element in providing infertile women with the necessary strength to overcome different personal, marital, and social ramifications. The couple must learn how to face their fears, share all the problems together, and work towards solving them. In fact, this is the shortest way to a mutual level of respect and understanding. It may, indeed, open new doors to the future and strengthen the couple's relationship in ways never imagined before.

My conclusions end up here. Nevertheless, I strongly recommend that support of the couple's families, friends, contact with other infertile women, reading about the problem and the association of ex-infertile couples, may aid in eliminating or at least minimizing the hidden burden (stigmas) associated with the problem outside the medical environment. Active participations of these members is indeed essential and should purports new area for investigation in the psychology of infertile women's treatment. Thus I argue that it would be helpful, and indeed essential (although I understand the difficulty in conducting such a research dealing with such an intimate subject) to examine the role of counseling within the context of individual, group, or family settings, as a means of understanding, and dealing with different socio-emotional stigmas and burdens associated with the crises of infertility.

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