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FROM NO HOPE TO FERTILE DREAMS:

PROCREATIVE TECHNOLOGIES, POPULAR MEDIA, AND THE CULTURE OF INFERTILITY

by

EVELINA WEIDMAN STERLING

Under the Direction of Wendy S. Simonds

ABSTRACT

Throughout history, both popular and scholarly literature depicted infertility as a devastating experience in a woman's life. Infertility was unbearable, filled with stigma, and a perpetual state of conflict between those who cannot have children and the rest of the world who can. Until recently as treatments for infertility developed, families assumed childlessness as hopeless. While the process of overcoming infertility is still arduous, unpleasant and unpredictable, many options are available today to overcome infertility and have children. As a result, the portrayal of involuntary childlessness and

infertility especially by popular media, changed significantly over the years. Current procreative technologies encouraged families to believe that the dream of having a baby was achievable for all. Using social constructionist and feminist theories, I analyzed the culture of infertility between 1960 and 2010. I used a mixed-method approach to the historical study of the infertility culture tracing the way the public became aware of the various medical treatments for infertility. First, I utilized a modified grounded theory approach to analyze the norms, values, beliefs, attitudes, and goals pertaining to infertility and the treatment of infertility as reflected in popular magazines. Next, I interviewed six fertility specialists who practiced reproductive medicine and the treatment of infertility between 1960 and 2010 to gain their perspectives regarding how the expectations about infertility and treatments changed over time from the medical point-of-view. Finally, I analyzed data available from the Center for Disease Control and Prevention's population-based National Survey of Family Growth describing public attitudes and behaviors with regard to infertility, infertility diagnoses, and the utilization of infertility treatments over all the years that the survey was conducted. Shaped heavily by issues related to power, patriarchy, gendered expectations, social stratification, and heteronormativity, the cultural story of infertility between 1960 and 2010 was much more complex and diverse than typically told by social science researchers. Overall, I found that although the increased media attention and the availability of procreative technologies changed the landscape of family building, the underlying social forces influencing decisions about procreation did not.

INDEX WORDS: Infertility, Fertility, Procreation, Medicalization, Procreative technologies, Reproduction, Women's Health

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EVELINA WEIDMAN STERLING

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Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

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CHAPTER 1

INTRODUCTION

Whether driven by biology, emotional needs, or social pressures, most people desire children at some point in their lives (Marsh and Ronner 1996; Fidler and Bernstein 1999; van Balen and Bos 2004). A wide selection of world literature, including early works such as the Bible and the writings of Aristotle, refer to the severe emotional and physical hardships of infertility (Marsh and Ronner 1996; May 1995). For centuries, men and women searched for an explanation for being “barren” or “sterile.” Many cultures promoted the notion that people simply brought childlessness upon themselves through ill thoughts, words and/or deeds. The only place to turn in order to bring about the possibility of a desired pregnancy was to various kinds of anecdotal advice from family, friends, and sometimes even strangers. Because limited knowledge existed about how pregnancy occurred in the first place, no medical treatments were available for families with infertility problems.

It was only during the twentieth century that physicians started to take an interest in investigating the causes of infertility, correcting infertility, and restoring fertility (May 1995). Thus, the medical community began to consider infertility as an actual “disease” and something that could be “fixed” by specialists through surgeries and medications (Marsh and Ronner 1996). In 1978, the first baby was born as a result of *in vitro* fertilization; today, expensive high-tech measures such as *in vitro* fertilization, gamete donation, embryo donation “adoption,” and surrogacy are performed by fertility specialists around the world on a daily basis in order to attempt pregnancy (Zourves 1999). Medical treatments for infertility are now so routinized within our society that many see them as the preferred (if not only) method for overcoming infertility. As a result, individuals are left on their own to understand the realities of treating infertility as well as weigh competing values and make judgments. In general, a better understanding of the cultural aspects of how people define and deal with involuntary

childlessness, infertility, and infertility treatments through a social-scientific perspective could improve approaches, treatments, and solutions (Bos and van Rooij 2007; Roudsari et al. 2007).

1.1 Purpose of the Study

In this study, I systematically examine infertility from a sociological perspective. It is a study of the culture of infertility, including the norms, values, beliefs, and goals pertaining to infertility and family building as reflected in popular magazine articles. I conduct an intensive and in-depth qualitative analysis of popular magazine depictions of infertility published from 1960 until 2010, as well as interviews with six infertility specialists who practiced during this time period and an analysis of infertility-related behaviors as captured by the Centers for Disease Control and Prevention's National Family Growth Survey. Overall, characterizations of infertility in popular media either reflect the current culture of infertility or serve as a stimulus to changing perceptions of the culture of infertility. More specifically, I further investigate the following key research questions: 1) How have popular print media portrayals describing infertility stayed the same or changed between 1960 and 2010?; 2) How do these portrayals of infertility differ according to the year printed, target audience, type of publication, and/or author's background?; 3) What are the relationships between trends seen in the popular print media portrayals of infertility and the actual availability and usage of procreative technologies during the same time period?; 4) How have infertility specialists observed the public portrayal and sharing of information related to infertility between 1960 and 2010?; and 5) How is the infertility experience culturally defined between 1960 and 2010—a time period in which the infertility experience went from being seen as hopeless and full of despair to anyone being able to achieve the dream of having a baby despite their situation or prognosis?

1.2 Importance of the Study

This study is important for several reasons. Although infertility is a global phenomenon, there is no universal definition of infertility. According to the American Society for Reproductive Medicine (ASRM), the primary professional organization that oversees the diagnosis and treatment of infertility, is defined as

The result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment. (American Society of Reproductive Medicine 2010)

However, different interpretations exist. For example, even in their mission statement, ASRM (2010) states that they are “dedicated to the advancement of the *art*, science, and practice of reproductive medicine” (emphasis added). The usage of the word “art” implies some variability in treating infertility. The assessment, prevention, treatment, and policies involving infertility intersect the disciplines of medicine, epidemiology, environmental health, health services research, law, ethics, and maternal and child health as well as social and behavioral sciences. Social norms concerning motherhood, marriage, age, family organization, and even medicine influence these perceptions of infertility (Inhorn and van Balen 2002). Moreover, these changing definitions shape our understanding of infertility as well as how the problem should be resolved (May 1995). Additionally, infertility or the inability to have a baby can be a major life crisis for those who want children. When one experiences difficulty becoming pregnant or carrying a pregnancy to term, the dream to have a child can be overwhelming and the pain of each failed attempt can be excruciating (Zouves 1999). According to existing research (Greil 1991; Harwood 2007; Earle and Letherby 2003), most people go through a series of intense feelings after being diagnosed with infertility, including anger, sadness, grief, guilt and self-blame. Individuals are hit at their very core as infertility challenges basic beliefs, faith and hope in the “normal” workings of our bodies, and may leave people feeling broken and defective (Becker 2000; Martin 2001).

Infertility and culture strongly influence each other. As technological advances are made, the experience of infertility and its treatments reflect changing values and norms within our society. Infertility has transformed the ways in which Americans have looked at themselves, life and family, especially in terms of expectations about appropriate family size and timing of pregnancies, the proper roles of wives and husbands, the nature of relationships between parents and children, the connections between families and the larger community, and exactly what is considered “natural” or “normal” (Cooper and Glazer 1998). Over the past several decades, biomedical interventions facilitating fertility exploded. Likewise, infertility was the subject of significant media attention and public discussion (Fidler and Bernstein 1999). As the availability of assisted procreative technologies continues to escalate, individual and cultural attitudes change as well about which measures are necessary and appropriate to treat infertility (Marsh and Ronner 1996).

Many questions about the beliefs and behaviors related to infertility or involuntary childlessness remain unanswered. Much of behavioral and social science research regarding infertility lags behind the fast pace of technological advances. Infertility is rarely viewed as a major social concern, either by those who currently work in the fields of procreative medicine and infertility or by the general public. Instead, infertility researchers and practitioners have focused primarily on the individual journeys of infertility. As a result, society as a whole has been ambivalent about accepting infertility as a legitimate societal problem (Jones and Toner 1993).

1.3 Overview of Chapters

This study is divided into seven chapters and an appendix section. This first chapter provides a brief introduction about the culture of infertility, the purpose of this study, the research questions, and the importance of the study. The second chapter presents a comprehensive review of the literature. The third chapter describes the theoretical background and methodology, including how the sample was

selected, the forms of data collection, how the data were analyzed, triangulation of data, and study limitations. Chapter 4 presents the results of the qualitative analysis of the themes that emerged in defining infertility. Because infertility lacks a concrete definition, I discuss the various factors which contribute to defining infertility in this chapter, including its prevalence, causes, influences, and dimensions. Similarly, Chapter 5 highlights themes related to controlling fertility. During the past 50 years, the infertility experience exchanged biological control for another type of structural control, involving government, big business, medicine, and religion. In Chapter 6, I use data from the National Survey of Family Growth to describe the actual utilization of fertility services in the 1970s, 1980s, 1990s, and 2000s accompanied by rich quotes depicting perceptions about procreative technologies obtained from both the media analysis and interviews with fertility specialists. In this chapter, I address the evolution of procreative technologies over time, how they were introduced and normalized, and their impact on society. Finally in the last chapter, I explain the overall results of this study, the implications for theory development, practice, public policy, and future research. There is also a bibliography and appendix section that includes additional information about the history of infertility between 1960 and 2010 and data collection.

CHAPTER 2

LITERATURE REVIEW

Most medical experts define *infertility* as not being able to get pregnant after at least one year of unprotected sexual intercourse (for those over 35, this is often adjusted down to 6 months). Women who are able to become pregnant, but then have repeated miscarriages, are also considered infertile. Infertility can occur at any point in life: either with a first pregnancy (primary infertility) or after at least one child has been born (secondary infertility). Infertility can be caused by illness (such as cancer or thyroid disorders), lifestyle habits (such as tobacco and other drug use or nutritional factors) or biological defects in the reproductive system. According to the National Center for Health Statistics (CDC 2010), about 10-17 percent of women of childbearing age (15-44) are unable to get pregnant or carry a pregnancy to term. In fact, an estimated 25 percent of all women and their partners will experience an episode of infertility during their lifetime (CDC 2010). Moreover, these infertility rates have remained relatively constant for many decades (May 1995).

Still, the precise definition of infertility varies between cultures. As a result, the Western, clinical definition may not capture variations in cultural perceptions on childlessness. Infertility often does not strictly mean the inability to give birth to a child after a specified period of time; in some places, the inability to have the number of children that cultural norms dictate also may be considered involuntary childlessness. In other places, infertility may be understood as having no sons or not becoming pregnant soon after initiating sexual activity (Inhorn and van Balen 2002; Giwa-Osagie, 2001). Social norms concerning marriage, divorce, parenthood, genetic ties, and family organization also influence perceptions of childlessness.

Another concept influencing the cultural understanding of infertility is “social infertility.” There is no accepted definition of “social infertility.” This term originally described the experiences of single

women and lesbians who may not fit the “traditional” definition of infertility but need procreative assistance to have a child nonetheless. If we extend this definition, couples in which the husband spends long periods away from home; couples who pursue active careers that keep them apart for significant periods of time; and couples who simply delay pregnancy for a variety of reasons and then attempt to become pregnant at a time when natural fertility has either declined rapidly or ended are also included.

2.1 The Significance of 1960-2010

Several major social changes between 1960 and 2010 enhanced the social visibility of infertility. Scritchfield (1995) suggests that several interrelated factors contribute to the redefinition of infertility. First, *the declining and differential nature of fertility rates* increased public attention toward infertility. In the late 1950s, the total fertility rate (or the average number of children that would be born to a woman over a lifetime) peaked at 3.7, and by 1999, it decreased to two children. Since then, the total fertility rate has fluctuated between 1.7 and 2.1 (CDC 2010). While birth rates declined among all groups, substantial differences with regard to social class and race existed. In general, whites had the lowest fertility, particularly those who were highly educated and financially secure (Census Bureau 2010). As a result, the highly desirable middle-class “market” of families seeking traditional obstetrical and childbirth services decreased. At the same time, a demand for fertility services grew causing many ob/gyn’s to shift their focus capturing this new market segment looking for help getting pregnant. These patients, when pregnant, would go on to seek previously waning maternity services as well. Although families of all backgrounds experienced infertility, upper-middle-class white couples were more likely to seek (and pay for) assistance for fertility problems (Aral and Cates 1983).

Secondly, *advances in contraceptive methods fostered a greater sense of control over procreation*. Improved knowledge about fertility and contraception altered views toward procreative

capacities. Procreation no longer involved uncertainty. Personal choice played a significant role not only in not becoming pregnant, but also in the details of when and how to become pregnant. As a result, many reached the conclusion that conception was a simple, natural process resulting in the perception that anyone could procreate on demand (Layne 2003; Reinhartz 1988). Suddenly, when “mother nature” does not cooperate, people are shocked and experience a marked sense of loss of control causing them to want to try anything to regain this personal control.

Another factor contributing to a heightened awareness of infertility was *couples and individuals were increasingly postponing childbearing*. While most people expect to become parents at some point in their lives, many were waiting longer, often well into their 30s, 40s, and sometimes beyond to attempt family building. According to the National Center for Health Statistics (CDC 2010), nearly half of all babies born had mother aged 30 and older while over 20 percent of babies are born to mothers aged 35 and older. Moreover, the birth rate of women age 40-44 increased the fastest. Those postponing tended to be white, relatively affluent, highly educated, and employed (Bachu 1993). Yet, biology does not always cooperate with delayed childbearing. Since reproductive capacity peaks for both men and women in their late 20s, postponing parenthood may entail dealing with decreased fertility (Aral and Cates 1983). While it is not impossible for older women to become pregnant, rates of infertility clearly increase with age (CDC 2010; Hendershot 1982) (See Figure 2.1). Research (Dunson et al. 2004; Kidd et al. 2001) also shows men’s fertility, particularly semen quality, declines with age, but exact statistics remain unclear. When pregnancy does not occur on schedule, many people, particularly those who are believers in personal efficacy, planning, and the achievement ethic experience immense frustration and anxiety (Caminiti 1994). Because of access to resources and their desire for control, some families are more likely to pursue treatment at any and all costs (Menning 1988).

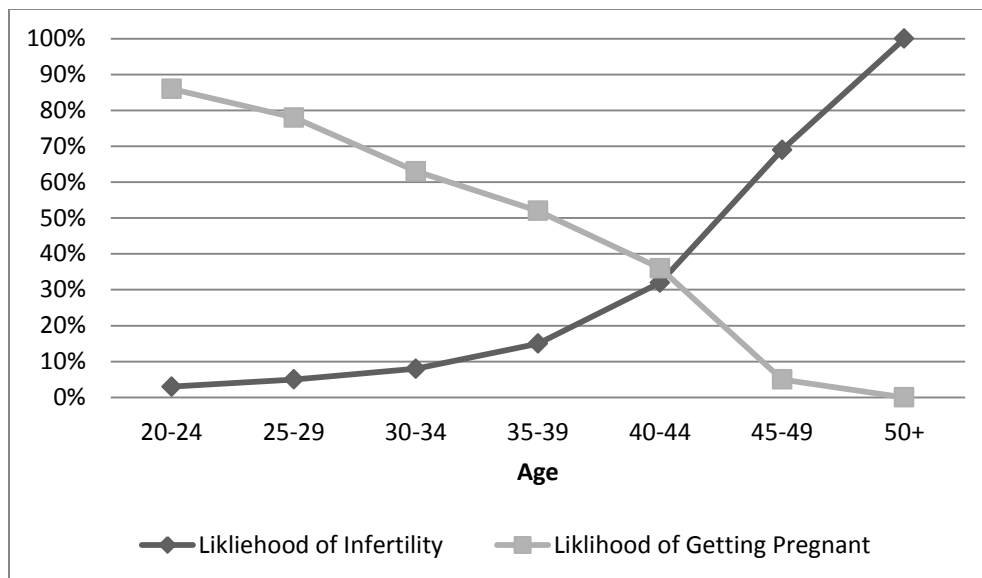


Figure 2.1. Rates of Infertility by Age of Woman (CDC 2010)

New diagnostic and treatment protocols also redefined the infertility experience and the amount of public attention paid to infertility. People came to perceive that infertility could be easily identified as well as easily treated. Infertility was no longer hopeless. With this new sense of personal control, families could exercise other options to become pregnant. However, this sense of control was more exaggerated than real. Success rates were relatively low, and many treatment options were very expensive and not available to those without independent means to afford them (Lasker and Borg 1987). The promise of a baby provided by procreative technologies often pressured families to go to great lengths to attempt treatments and keep trying (Harwood 2007).

Although infertility has existed for centuries, limited options were available to ameliorate it (Spar 2006). With the first “test tube” baby in 1978, the fertility industry finally altered the supply side of the equation. According to Spar (2006), long-established demand followed by a sudden supply will control the market. Unlike any time period before, the years between 1960 and 2010 were especially significant, both historically and culturally, because a more complete understanding of the procreative

process and new technologies affecting fertility (both in terms of preventing pregnancy and encouraging it) emerged.

2.2 A Social and Historical Context

Tremendous advances in technology and a strong faith in the medical community during the mid-twentieth century produced to the cultural belief that everyone has the basic right to control his or her procreative abilities with the help of medical experts (May 1995). Beginning in the early 1940s, Dr. John Rock of Harvard University and his research assistant Miriam Menkin worked feverishly to achieve fertilization of human eggs outside the body. Although a major highlight in procreative medicine, contemporaries differed in their reactions to such work. Rock and Menkin were often referred to as “egg chasers,” and one physician even complained that their work was tantamount to “rape *in vitro*.” Their endeavors were recounted by journalists who compared them to cattle-breeders. Nonetheless, these sentiments did not deter hundreds of childless women from contacting Rock about infertility treatments that might be available (Marsh and Ronner 1996).

Also during this time period, doctors’ interest in carefully reviewing medical histories as a method to explain current or future health issues grew. Chart reviews helped discover past trends in the diagnosis and treatment of infertility issues. For instance, many women with untreated gonorrhea or who were forced to have sterilizations without their knowledge were infertile. This type of information, along with the sudden advances in treatment options, challenged many long-held professional beliefs about treatment for infertility or involuntary childlessness (May 1995). In 1950, the American Society for Reproductive Medicine (ASRM) established the journal *Fertility and Sterility* to disseminate new scientific information about the growing field of infertility to medical professionals. Additionally, using the term “fertility” instead of “sterility” became increasingly important to convey a sense of hope for families interested in becoming pregnant. Infertility clinics even began to advertise

their treatment options and success rates in popular magazines such as *Look*, *Good Housekeeping*, and *Redbook* (Marsh and Ronner 1996).

Still, many infertility specialists struggled with their own personal views about infertility. These views were further complicated by issues of religiosity, class, race, and gender. Many physicians segregated their patients into “clinic” and “private practice” in order to differentiate between social classes. Although clinics offered reduced or free treatment to those lacking funds, resources and expertise were not evenly split between clinic and private patients. Success rates differed greatly between the two groups based on their ability to pay; clinic patients experienced lower pregnancy rates compared to those in private practice (Marsh and Ronner 1996). Similarly, many disagreed on where men fit into their courses of treatment. Many physicians (as well as their female patients) were reluctant to encourage male partners to attend the appointments. Also, there was no scientific consensus regarding what exactly constituted male infertility. Donor insemination, while used during this time, was usually shrouded in secrecy. Many physicians at this time emphasized the connection between fertility problems and emotional issues, suggesting infertility was caused by women’s psychological problems (May 1997).

Potent fertility medications, such as Pergonal and Clomid, were also introduced during the mid-twentieth century. Pergonal was first obtained from the pituitary glands of deceased women, but was later acquired through the urine of post-menopausal women. Although treatments for infertility expanded and many ovarian problems were remedied, tubal blockages remained a problem that could rarely be corrected through surgery. Consequently, over 85 percent of infertile women still turned to adoption in order to become parents during the middle part of the century. Further emphasizing the psychosomatic causes of infertility, the stories of women who became pregnant soon after adopting were common. Moreover, health care professionals often corroborated these stories that women could become pregnant after infertility by just relaxing and adopting (Marsh and Ronner 1996).

The Late Twentieth Century—The Baby Business Boom

As members of the baby boom generation began to procreate at later ages than previous generations, many experienced difficulties increased the demand for fertility information and services. However the political and economic uncertainty at the time contributed to shifts in pronatalism and family building. Many became less sympathetic about the inability to have children. Thinking about eugenics and overpopulation increased. As a result, many people proudly expressed their desire to remain “child-free.” With so many unwanted children in the world, why would anyone want to make new ones, especially children who would not be properly cared for? By the 1970s, Masters and Johnson pointed out that we lived in a contraceptive culture where children no longer had to be born at random (May 1995).

Prior to the 1970s, there were few resources for those having difficulty procreating. RESOLVE, the National Infertility Association, was formed in 1974 by a small group of infertility patients and their doctors to provide compassionate support and information about infertility and raise public awareness through education and advocacy. Given the available information and treatments, many physicians did not see any reason for anyone to struggle with infertility anymore, especially alone (Marsh and Ronner 1996; May 1995).

As technologies expanded exponentially in the 1970s, 80s, and 90s, new areas of concern evolved, especially with regard to third-party reproduction. Surrogacy itself was not new or high-tech; in fact, there were stories of surrogate mothers in ancient Roman plays and the Bible. However, modern commercial surrogacy, which formally matched surrogates with intended parents, began in the 1970s. This new version of surrogacy involved legal contracts, payment structures, and assisted reproductive technologies to achieve a pregnancy. While over 35,000 babies have been born via surrogacy (CDC 2010), most of the media portrayals included surrogacy as a risky venture with frequent complications regarding custody disagreements (McLaughlin 2001). Also, in the 1970s, amniocentesis

and genetic testing became available, raising serious questions related to the meaning of life. Many wondered how this new test would affect the pregnancy experience as well as women's integrity and self-efficacy (Rapp 2000; Rothman 1993). As access to potent hormones increased, side effects became apparent which also contributed to the way society viewed the risks associated with procreative technologies (Mundy 2008).

Among fertility specialists, the race to produce the first *in vitro* fertilization baby spanned the entire globe from the United States to the United Kingdom to Australia. After many false starts (the most notable is Landrum Shettles and his patient Doris Del-Zios at Columbia University in 1973), many realized that this technology was quickly coming to fruition. As a result, the American Medical Association placed a moratorium on *in vitro* fertilization research in the United States, and the Vatican condemned assisted procreation within its doctrine. Louise Brown, the very first baby in the world to be born of *in vitro* fertilization, was born in England in 1978 through the work of Drs. Patrick Steptoe and Robert Edwards. The first *in vitro* baby in the United States, Elizabeth Jordan Carr, was born to Judith and Roger Carr at the Virginia clinic of Drs. Howard and Georgeanne Jones a few months later (Mundy 2008; Henzig 2004). By 1982, there were five major IVF clinics in the United States, all at private teaching universities (Marsh and Ronner 1996).

Since the start of *in vitro* fertilization in 1978, procreative technologies expanded tremendously. The first successful birth resulting from donated eggs occurred in 1984 in the United States. At first, egg donors tended to be family and close friends of women undergoing infertility treatments. As the need for egg donors grew, the recruitment of anonymous egg donors emerged as a new business venture, and hundreds of independent egg donor agencies were established in the mid-1980s matching donors with intended parents (Glazer and Sterling 2005). Currently, over 10,000 families attempt egg donation each year, and over 50,000 babies have been born via egg donation since 1984 (CDC 2010). While still very much in the early stages, several hundred babies have now been born from frozen eggs (CDC 2010).

Intracytoplasmic sperm injection (ICSI) was another recent breakthrough. Allowing men with very low sperm counts to become biological fathers, ICSI involves carefully injecting a single sperm into the egg's center for fertilization. In hopes of increasing the chances for a viable pregnancy, preimplantation diagnosis (PGD) also became more prevalent. PGD genetically tests the embryo for defects before it is transferred to the uterus through *in vitro* fertilization.

Where Are We Now? Infertility and Treatments in the Twenty-First Century

According to the CDC (2010), there were nearly 500 Assisted Reproductive Technology (ART) clinics in the United States performing over 100,000 cycles of IVF in 2008, a phenomenal increase in just a few short decades. ARTs allow many individuals and couples to achieve pregnancies who might never have had this opportunity otherwise. At the same time, ARTs carry risks and complications for many—emotionally, physically, and financially—due to the invasive, demanding, and expensive nature of the treatments. Because of the lack of clinical trials or longitudinal studies of those undergoing infertility treatments, very little data exist regarding any negative impacts. Those within the infertility field claim it is 100 percent safe while others suggest links between infertility treatments and a wide range of diseases and disorders affecting both mothers and children (Mundy 2008; Spar 2006).

The expansion of procreative technologies is far from over. With no hint of specific guidelines or regulations in sight, some believe that this is only the beginning of the complete medicalization of procreation. For instance, will engaging in sex just be considered for “fun” while *in vitro* fertilization becomes the preferred method for conception, offering parents-to-be more “control” over their offspring as some fertility specialists have started suggesting? Will this intense pressure to seek medical assistance to become pregnant with no guarantee for success continue to line the pockets of infertility specialists while leaving thousands of families feeling defective, miserable and in debt?

(For a more complete overview of the key developments in infertility treatments and ARTs between 1960 and 2010, please refer to Appendix).

2.3 Social Structures—The Impact of Gender, Sexual Orientation, Race, Religion, and Class on Infertility

Infertility itself does not discriminate--it affects people of all ages, ethnicities, socio-economic statuses and backgrounds. However, access to information, treatments, and coping methods vary greatly. Infertility and its treatments are conceptualized and structured largely around a professional, coupled, heterosexual, consumer-oriented nuclear family scenario. In general, procreative technologies primarily benefit white, married, middle-class women (Thompson 2005). As a result, the overall experience of infertility is strongly influenced by issues of gender, sexuality, race, and class.

Gender

Even though there are as many infertile men as women, women have traditionally borne the brunt of the medical, social, and cultural burdens when a couple fails to become pregnant (Becker 2000; May 1995). Throughout history, reproductive health has been “women’s business;” even today, culture and medicine clearly define “infertility” as a “woman’s problem” (Earle and Letherby 2003, p. 2). It has long been an American cultural expectation that women will want to become mothers. In fact, when a woman marries, she is expected to procreate (Becker 2000; Rothman 2000). Consequently, women often feel stigmatized if they are childless, whether by choice or involuntarily (Becker 2000). Men also feel stigmatized in a childless situation since cultural ideals about manhood are often intertwined with cultural ideas about fertility and virility. When a man cannot “get his wife pregnant,” he may feel that others (including his own partner) view him as less of a man (Marsh and Ronner 1996). Nevertheless,

women experience a disproportionate share of the negative impact regarding being labeled infertile (May 1995).

In 1973, Joyce Chopra and Claudia Weill's documentary *Joyce at 34* chronicles the difficulties experienced by an "older" woman who decides to become pregnant at age 34. Today, older mothers who are well into their late 30s, 40s and even 50s are gaining more attention in popular media. In fact, a recent documentary, *Pregnant at 70*, shown on the Discovery Network's The Learning Channel (TLC 2010) followed three women from around the world who gave birth in their late 60s and 70s. Fertility specialists report that over fifty percent of 37-year-olds will need some sort of procreative assistance in order to have a baby. At age 42, this statistic jumps dramatically to 90 percent of women requiring some type of medical intervention to become pregnant (CDC 2010). However, it is not certain whether or not the statistics hold true for the entire population of older women, since data are rarely collected from women in their late 30s and 40s who become pregnant on their own. Likewise, it is unclear how many older mothers, especially those who are post-menopausal, who are highlighted in popular media, became pregnant through the use of donor eggs, a reality that is often omitted.

Whether or not women are intentionally choosing to delay childbearing, mainly due to the availability assisted procreative technologies, is not clear. According to a survey conducted by the National Parenting Association in 2001, entitled, "High-Achieving Women," almost 90 percent of women age 28 to 40 said they believed assisted procreative technologies would make it possible for them to get pregnant well into their forties (Hewlett and Vite-Leon 2002). Similarly, a bold advertising campaign launched in 2001 by the American Society for Reproductive Medicine suggested many women are delaying childbearing because of their perception that procreative technologies afford them more time to have children (see Figure 2.2 below). This ASRM campaign included large advertisements placed on city buses and subways and sought to warn women about the limitations of assisted conception and to

educate them about the importance of age as a factor in infertility (Kalb 2001). This type of tactic perpetuates the belief that women's bodies become more inadequate with age.

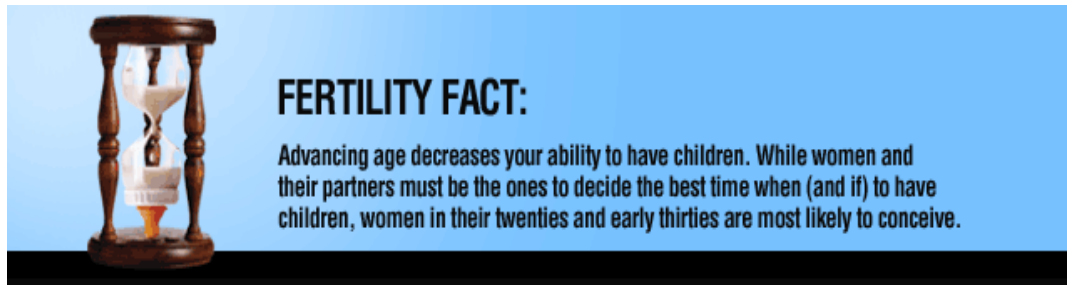


Figure 2.2. ASRM's Media Campaign on Age and Fertility

Many social scientists disagree about whether infertility is really a disability or handicap that needs prevention and immediate treatment. Rothman (2000) points out that holding women accountable for their own fertility is problematic for several reasons. For instance, data are not consistent as to the exact causes of infertility. Also, success rates for treatments, while expensive, are not typically good—only 40 percent in the best of situations. Finally, society has diminished the role of men in procreation and the decision-making process with regard to having children (Rothman 2000).

Sexuality

In the past, un-partnered parenting was typically a phenomenon of life circumstances, such as divorce, widowhood, or unplanned pregnancies. However, single, gay, and lesbian parenting via assisted procreative technologies became increasingly prevalent by the end of the twentieth century. Although the use of assisted reproduction by single men and women and same-sex couples is not universally available, many have achieved parenthood this way since the 1980s (Agigian 2005). In the United States, there are an estimated 6 to 14 million children being raised by at least one gay or lesbian parent, although many of these are the result of a previous heterosexual relationship (Daar 2008;

Patterson 1992). Still, approximately 20 percent of the over 400 fertility clinics in the United States publicly report that they will not treat gays or lesbians (CDC 2010).

Race

In *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, Roberts (1997) describes how new procreative technologies enforce patriarchal roles and objectify the procreative capacity of women. Furthermore, this type of control is reinforced by a racist standard of procreation (Roberts 1997). The most glaring example of this is that procreative technologies are almost used exclusively by white people (Green et al. 2001). The treatment of infertility is clearly a white middle-class phenomenon, and media images mirror racial disparity as well. This is particularly disturbing since African Americans have an infertility rate one and one-half time higher than that of whites, largely due to a life-long experience of poverty and poor reproductive health care (Roberts 1997).

According to Roberts (1997), there are several reasons that further contribute to this disparity. Even if they desire treatment, many African Americans are unable to pay for the high costs associated with procreative technologies not covered by most insurance programs. Furthermore, many physicians integrate their own societal views about racial and ethnic differences into their standards of care. Many diagnoses and suggestions for treatment center on race. For example, severe pelvic pain often leads to a diagnosis of endometriosis for white women and pelvic inflammatory disease (PID) in African American women. Finally, Roberts (1997) suggests that these racial differences might be the result of an act of resistance—an unwillingness to submit to medical scrutiny or risk being mistreated by the medical establishment. The health care experiences of African Americans have been marked largely by disregard, disrespect, lack of access and even abuse (Johnson and Smith 2002). Hinting at eugenics, infertile African American women cannot access fertility treatments while at the same time other African American families are encouraged to stop having children altogether (May 1995; Roberts 1997).

Roberts (1997) also holds that African Americans share a different view of genetic ties and are less likely to seek a technological fix for natural circumstances. For these reasons, even when access to health care and health information is provided, many tend to underutilize it (Johnson and Smith 2002).

Religion

Advances in reproductive medicine create a number of moral, ethical and religious dilemmas. Religions throughout the world have different attitudes toward assisted reproductive technologies and the treatment of infertility (Roudsari et al 2007). For example, Protestants, such as Methodist, Lutheran, Presbyterians, and Episcopalians, typically maintain liberal views toward *in vitro* fertilization using the couple's own eggs and sperm. However, they differ in their stance on using donated gametes and surrogacy (Greil 1989). Judaism allows the practice of all forms of assisted procreative technologies when the egg and sperm belong to the husband and wife. On the other hand, the Roman Catholic Church and the Eastern Orthodox Church oppose all forms of assisted procreative technologies (Schenker 1997). Even within a single religion, as seen with the Muslim faith, the same issue can be interpreted differently by various scholars. Some Muslim leaders have permitted infertility treatments while others strongly oppose them (Inhorn 2005).

Many families struggle with wanting to overcome their infertility while still abiding by their own religious doctrine. Several studies have illustrated that choosing assisted procreative technologies is heavily influenced by religion (Braverman and Corson 1995; Inhorn 2006; Isikoglu et al. 2006). Some researchers have found that while many women seek medical consultations, they also consult with spiritual clergy in dealing with infertility (Sundby 1997). Sewpaul (1999) described five overarching themes when it comes to understanding infertility through a religious lens: infertility as a punishment for wrongdoing; infertility as a destiny in preparation for a higher mission in life; infertility as an opportunity for growth and positive change; infertility as something beyond human power; and

infertility as a biological error that is not attributed to God. Often an individual's level of involvement with religion, and their personal idea of and relationship with God, can influence decision-making about procreation.

Class

Although infertility affects people of all social classes, the childless poor usually do not have the access, time or money to undergo a lengthy series of tests -- commonly called an "infertility work-up" - to determine the cause of the problem. Class also influences a person's ability or willingness to endure sacrifices typically associated with a long-range goal like saving up for fertility treatments. For these reasons, many consider the inability to get pregnant and bear children as a middle and upper middle-class dilemma (Inhorn and Van Balen 2002; May 1995).

2.4 Women and Procreation in Print Media

The reproduction of dominant ideologies is a fundamental function of the media (Lupton 1992). In his work on media, culture, and spectacles, Douglas Kellner (2003) suggests that popular media portrayals often tell us a great deal about the values, experiences, and conflicts of our times. Consequently, media images in popular magazines contribute to society's perception of fertility and procreation (Taylor, Layne and Wozniak 2004). Throughout media, women are associated with procreation, nurturing and motherhood. The media are instrumental in exacerbating stereotypical images of women and women's health (Engelen-Maddox 2006). Shugg and Liamputtong (2002) find that women are portrayed as "mothers" regardless of their fertility experience. In general, the media suggest "the ideal woman is kind, nurturing, heterosexual person who chooses to have children later, and, as such, relies of medical technology to conceive" (Shugg and Liamputtong 2002:726). Media reinforce the notion that the infertile woman is "unhappy and unfulfilled" (Lupton 1998:169).

Routinely, *in vitro* fertilization and other assisted procreative technologies are represented as technological saviors offering a “medical miracle” as the only solution. Women are seen as desperate for children, passive, reacting emotionally to their chance to experience the joys of desired motherhood. Various methods for family building have also changed the interpretation of the word “mother;” motherhood can include “egg mother, birth mother, name mother, surrogate mother, gene mother, biomother, adoptive mother, foster mother, legal mother, organ mother, nurturing mother, earth mother” to name a few (Lupton 1998:168). Whether assisted procreative technologies create more choices for families or if patriarchal control from the infertility field removes any agency remains unclear (Lupton 1998). Unfortunately, critiques of procreative technology and discussion of its complexities, limitations, failures, or side effects are rarely given attention in coverage by popular media (Franklin 1990).

Society often assumes medicine is scientific fact rather than an important component of culture. In reality, medical experiences influence behavior patterns. Integrating sociological theory with the products of popular media provides unique insights. Magazine articles can be analyzed in terms of how media influences people’s overall knowledge and expectations about medical issues such as infertility. People clearly construct their understandings of the world, including their beliefs about medicine, health care, disease, and health, from their interactions with culture (Harwood 2007; Franklin and Rangone 1998).

Franklin (1990:217) identifies three major themes regarding popular media representations of infertility: social loss; biological destiny; and medical hope for a cure. *Social loss* is largely illustrated in stories of childless women described as “desperate” and who view the availability of new procreative technologies as the ultimate solution to their sorrow. Media make no mention of the low success rates of the technologies, the costs involved, the invasiveness and traumatic nature of the procedures, and the substantial moral and ethical questions that arise. Accounts of childlessness focus only on the

biological infertility of married, heterosexual couples creating a sense of *biological destiny*. Media tend to neglect how complicated issues such as unemployment, low income, lack of child-care facilities, disability, sexual orientation or relationship status may impact couples' decisions. As a result, the "cure" of childlessness is also portrayed as medical treatment, not social change. Finally, *medical hope for a cure* includes the ability to depersonalize and dismember women to the point that they are considered only in terms of their procreative parts and their potential. Women's only hope to become pregnant lies with fertility specialists. Media indicate that it is only through modern medicine that the infertile are able to have their wombs filled and become mothers (Franklin 1990).

While there have been studies assessing women's health issues in print media, we still have limited understanding about how the media specifically portray infertility and the infertility experience, particularly in relation to the rapidly changing field of reproductive medicine. According to Letherby (2003:174), "the medical and social scientific study of the social, emotional, and medical issues surrounding the experience of 'infertility' remains underdeveloped." A more thorough analysis of how infertility has been socially constructed over the past several decades might explain how people view infertility-related knowledge and practices, especially as fertility treatments become available. Likewise, how the mass media and related social institutions further support the positions and interests of the multi-billion dollar infertility-industrial-complex might be explained (Lupton 2006).

2.5 Media Images and Social Behavior

For centuries, magazines, especially those directed at women readers, have offered their readers a mixture of news, advice and entertainment (Winship 1987). Ideally, media representations provide readers with some coherent sense of the broader social forces that affect the conditions of their everyday lives (Gamson et al. 1992). In fact, researchers have concluded that an interdependent relationship exists between print media and society. Media portrayals must be compatible with the

sociocultural context so that the audience will find them acceptable and attractive, therefore achieving the publisher's economic goals to sell more copies of their magazines and solicit advertisers (Ball-Rokeach 1985).

The content is influenced by those who create it as well as those who consume the it. According to Hoffmann and Novak (1997:43), "People also bring their own backgrounds, limits in perception, and communication" which all affect how media are received. There are business demands in terms of what the media, particularly popular print media such as magazines, will do to make money for their publication also contributing to what information is conveyed. Overall, the entire media process serves as a "gatekeeper" by deciding what information is included and what is left out about a particular topic (Hoffmann and Novak 1997). Often popular media outlets mine the work of scientists and other scholars, conveying information to the general public in ways that encourage appeal or amazement (Storey 2006).

Previous media research includes the media's influences on social behaviors as well the impact on beliefs and values. Content analyses often depict how media content departs from reality with regard to who is represented, and in how groups and situations are portrayed. Researchers have shown how the social context of media use is crucial and relevant to the way people interpret and area affected by the media (Blumer 1969). Likewise, previous research focuses on the power to select and be critical of media context (Milkie 1999).

Although media coverage of infertility increased significantly over the past several decades, very little information exists about social perceptions and behaviors about infertility and the factors that shape them. Dijksterhuis and Bargh (2004) define social perception as the activation of a perceptual representation. In turn, perceptions regarding certain issues (like infertility) have a direct effect on social behavior. While it appears that media have a stro

ng social and cultural impact upon society, this relationship is complex and variable. Similarities and differences between media portrayals of infertility and the “realities” (including behavioral, technological, and economic) can be identified and evaluated. Additionally, how society’s interpretations and reactions to infertility have changed over the years can be described.

2.6 Infertility and Culture

According to Wendy Griswold, author of “Culture and the Cultural Diamond,” the concept of culture is difficult to define (1994). Often culture refers to some combination of norms, values, beliefs, and expressive symbols. Griswold suggests that culture contains both implicit and explicit meanings (1994). More specifically, Griswold (1994:11) defines a cultural object as “shared significance embodied in form” or “a socially meaningful expression that is audible, or visible, or tangible, or can be articulated” (1994:11). Griswold (1994) suggests that the “cultural diamond” consists of four essential components of culture: cultural creators, cultural objects, cultural recipients, and the social world. Furthermore, culture is also a result of how these various aspects interact with one another allow culture to result from a collective production. In terms of infertility, cultural objects take various forms, such as success rates, the clinic environment, perceptions and beliefs of health care providers, the marketing of treatment options, and the infertility experiences as explained in popular media.

Studying culture includes the documentation and explanation of “the processes of producing and circulating meaning through the channels of the artifacts and practices of culture” (Lupton 2006:18). This allows sociologists to carefully examine the rules, norms, and symbolic meanings attached to the daily habits of everyday life, including procreation. As a result, seemingly individual characteristics and activities are understood to be highly influenced by socio-cultural norms, such as age, gender, sexuality, social class, and ethnicity. The same holds true for infertility. The culture of infertility is constructed through gender relations, knowledge, language, and the infertility experience itself (Mealey 2006). In

turn, this cultural understanding of infertility significantly influences how infertility is defined, and what can be done to overcome infertility both now and in the future (Earle and Letherby 2003).

Over the past few decades, scholars have touched on some of the cultural aspects of infertility and procreative technologies. In her study, *The Woman in the Body: A Cultural Analysis of Reproduction*, Martin (1987) is one of the first to argue that the concepts of reproductive biology are permeated by cultural stereotypes. Specific cultural expectations can color even the most scientifically-grounded observations. Through her qualitative research, Martin aims to increase the awareness of the scientific community and the general public alike regarding the importance of analyzing science and medicine from a feminist perspective. With advances in procreative technologies, menstruation, conception, pregnancy, and menopause are no longer private matters. Instead, they become issues of public concern. Likewise, there has been a paradigm shift in our understanding of procreation and motherhood which are no longer seen as automatic and natural. Women are separated from procreation since maternal function can be achieved through technology whether it be through *in vitro* fertilization, donor eggs, surrogacy or cloning. (Hanson 2004).

Martin (1987) clearly points out how women's experiences with the medical community are rooted in social hierarchy and control. Michie and Cahn (1997:3) use the philosophies of Foucault to emphasize that the "most profound exercises of power are not those that take place in public spaces like the courtroom, the government, or police stations, but those that are so diffuse and pervasive that they turn individuals into self-policing subjects." At a most basic level, science is seen belonging to men, and women's bodies are often acted upon by this science (Britt 1998). According to Thompson (2005:27-8), "Reproduction has rich literal and metaphorical meanings that spill well beyond the biological and permeate the public sphere and intimate lives alike." The biological basis of procreation intertwines with the personal, political, and technological meanings.

Both the process of medicalizing procreation and infertility and the public buy-in to this medicalization has transformed the nature of the entire infertility experience and eventually culture surrounding infertility (Greil 1991). Similar to what has occurred with pregnancy, childbirth and breastfeeding, Americans have come to define infertility as a medical problem and turn to medical professionals for solutions (Baumslag and Michels 1995; Earle and Letherby 2003; Mundy 2008). Consequently, the infertility field is shaped by industrialism, bureaucracy, competition, and moral uncertainty which typically dominate medicine.

Based on interviews with 550 infertile individuals, Greil (1991) concludes that the experience of infertility is dependent on the socio-cultural context framed by age, gender, occupation, social class and ethnicity. The actual ability of medicine to treat, and perhaps even cure, infertility is limited. Using an analytic framework to illustrate the “disparate medical encounters and emotional crisis” that together make up the experience of infertility, Michie and Cahn (1997) situate infertility into the larger cultural story of procreation. Individual choices about infertility and its treatment are obscured by social pressures and dominant reproductive narratives.

As procreative technologies expanded over the years to include *in vitro* fertilization, gamete donation, and surrogacy, the fundamental views on human reproduction and procreative processes have been redefined. In fact, the cultural values of scientific progress, consumer choice, and economic growth have expanded what we accept and expect in terms of the “facts of life.” Franklin (1997) utilizes narratives to compare, contrast, challenge, frame and re-frame the development of procreative technologies within our cultural understanding of conception models. In their book *Gender, Identity, and Reproduction: Social Perspectives*, Earle and Letherby (2003:222) point out how issues of power, control, resistance, and agency work to challenge traditional discourses about procreation and the overall concept of “authorized knowledge.”

How people deal with “infertility” and “the treatment of infertility” varies greatly. Not everyone has the same access to appropriate information, support, and treatment options. Due to the complicated structure of the medical system and availability of information, only the elite are usually able to access reproductive medicine (Letherby 2003; Inhorn and van Balen 2002). However, even this accumulation of information and services does not necessarily add up to knowledge, causing even the elite to feel powerless (Letherby 2003). As a result, many individuals who seek fertility care further add to their “burden on infertility” (Letherby 2003).

The dynamic relationships between technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of infertility all works together to define nature, self, and society (Thompson 2005). Procreation includes personal, political, and technological meanings which have significantly changed over time in response to “identities, social stratification, certain techniques, scientific knowledge, law, politics, and our experienced of bodies and reproductive and parental roles have been produced, reproduced, and challenged” (Thompson 2005: 8). In turn, this “culture of infertility” shapes and reflects the overall infertility experience itself.

CHAPTER 3

THEORETICAL BACKGROUND AND METHODOLOGY

3.1 Theoretical Background

The framework guiding this research combines social constructionist and feminist theories. The premise of social constructionism is: "Reality is socially constructed and the sociology of knowledge must analyze the processes in which this occurs" (Berger and Luckman 1966:1). Social constructionists argue that social problems arise or are constructed through social explanations about how these problems should be understood (Best 2009). For any given social phenomenon, various opinion leaders offer explanations reflecting the social structure of society and its cultural values and beliefs (Gusfield 1985). For example, excessive consumption of alcohol has been explained or constructed over time as a sign of moral failure, then as a physiological disease state characterized by a lack of control over drinking behavior (Spector and Kitsuse 1977).

Those who attempt to explain these types of social phenomena can be experts in theory, law, ethics, and medicine. Likewise, clinicians, mental health professionals, politicians, journalists, special interest groups, individuals personally involved with the social phenomenon in question -- as well as the community at large -- also contribute to our overall understanding. These different claim-makers often compete for the right to explain a phenomenon in a certain way and seek to influence policymaking and clinical practice in a specific directions. More importantly, these explanations or claims may or may not result in phenomena being defined as a social problem (Hanson 2004).

Traditionally, infertility has been viewed as a medical condition and managed within the medical model of diagnosis and treatment. The standard medical model implies little ambiguity about health and illness. Burr (2003:36) states: "Either [the body] is disease-free, normally functioning and we are healthy or there is a presence of some disease or malfunction and we are ill." But with infertility, if you

are unable to conceive, are you ill? What about the woman who cannot become pregnant, but no underlying organic pathology or “disease” can be found to explain her infertility? Illness is not a pathological matter, but a social one. Moreover, infertility is not a static condition with predictable outcomes. Instead, infertility is a dynamic, socially conditioned process that is continuously in flux as the field of procreative medicine changes and individuals struggle to deal with and make meaning of their experiences (Frankin 1997).

Social constructionist theory is critical to understand how people interpret infertility. More specifically, it clarifies how meanings related to infertility evolve over time, especially through popular media. Central to the social constructionist perspective is the argument that no matter what the incidence of a particular illness, it only becomes socially validated through observation and report. Overall, the experience of infertility is a human product (Willis 1986). Many people are familiar with infertility and its medical treatments through media representations which communicate specific messages. For example, the early coverage of assisted procreative technologies facilitated public receptivity and the process of commodification (Becker 2000). While in actuality a single infertility treatment carries a low success rate, many physicians and fertility clinics advertise that, in reproductive medicine, “success” rates are cumulative and as many as 90 percent of couples will have a baby with continuous treatments (CDC 2010). In fact, personal interest stories about infertility are largely those of hope and achievement, despite the realities. American culture, like other Western cultures, reveres success and achievement. As a result, communication about infertility includes much more than just public education. The specific language used and meanings surrounding treatment options, infertility, and involuntary childlessness influence discourses about infertility (de Lacey 2002).

The ways in which motherhood, procreation, and pregnancy have also been socially and historically constructed have been well-documented by feminist scholars (Rothman 2000 ; Franklin 1997; Thompson 2005). However, there is no single feminist platform regarding procreative

technologies. Feminists struggle with views about infertility, and much of the feminist debate surrounds the acceptability of “new” procreative technologies. Supporters of developing procreative technologies and infertility treatments often approach the issue from a perspective of individual rights and the ability to make family-building choices. Other feminists object because they fear these new technologies will have harmful long-term consequences for women as well as society. Feminists see that procreative technologies weaken the link between sex and motherhood as well as fragment women’s bodies (Dworkin 1983; Sandelowski 1990). Procreative technologies intersect with women’s roles as mothers, the institution of family, and the relationship of sexual difference to sexual equality impacting the way women are liberated and/or exploited (Harwood 2007; Rothman 2000). Rather than multiplying the options available to women, some feminists predict that the escalation of procreative interventions will actually limit women’s choices. For example, procreative advances may create a type of motherhood mandate in which some women may not have the power to say “no” to using technologies to have a baby. In this case, conception seems coercive, and women’s bodies are controlled by doctors and scientists, causing women to lose their power and identity (Greil 1991).

Within the past several decades, a major shift occurred in the way procreation is controlled. The availability of infertility treatments expanded the power that the medical industry has over procreation. The fertility industry views women’s bodies as objects for the new technologies to act upon. These types of technologies are integral parts of the socially structured fertility industry which controls procreation and population growth. Separating the individual from the social is impossible when considering the treatment of infertility (Harwood 2008; Spar 2006). How a woman experiences infertility depends on her experiences as a woman within a particular time, place, and power structure. These power relations are also shaped by the wider context of inequalities already present in our society (Letherby 2002). By continuously expanding what can be done in reproductive medicine, doctors enhance their status and create an atmosphere of “big business” by partnering with large

pharmaceutical and medical device companies (Klawiter 1990; Spar 2006). Ultimately, the infertility-industrial-complex (consisting of infertility specialists and related businesses) is responsible for deciding who can have children and under what circumstances.

The growth of consumer culture encouraged further theorizing about the body (particularly a woman's body) and its procreative capabilities. The human body can be considered a "product of certain kinds of knowledge and discourses which are subject to change" (Lupton 2006: 23). Consistent with the writings of Foucault (1990) and de Beauvoir (2011), bodies are not born, but made. With infertility, certain body parts are further isolated as to their procreative function (or lack thereof) (Gergen and Gergen 2005; Martin 2001). However, the social consequences of these biological practices have not been fully addressed through research. It is imperative from a feminist perspective to pay greater attention to the "relationship between bodily processes and social relations" (Lupton 2006:27). In fact, Martin (2001) explains that the procreative process often mirrors cultural stereotypes of men and women, in which the male/sperm is seen as all powerful and heroic while the female/egg is relegated to the role of damsel in distress in need of saving particularly through procreative technologies.

The experience of infertility is intimately connected to the availability of new technologies and expectations related to family building intertwine with the social, political, and technological realms (Allen et al. 1991). During the time period of 1960 to 2010, infertility has been subject to multiple realities depending whose interests are being considered. By further investigating these types of meanings through the lenses of both social constructionist and feminist theories, changes regarding the culture of infertility can be better understood.

3.2 Popular Media Analysis

To obtain the sample of popular magazine articles addressing infertility, I examined issues of *The Reader's Guide to Periodical Literature* from January 1960 to December 2010. All articles indexed under the main subject headings of STERILITY and INFERTILITY were considered. As the term "infertility" was redefined over the years as new technologies became available and perceptions changed, I added to the list of classifications entries to include other related terms, such as "*in vitro* fertilization," "fertility drugs," "sperm donation," "egg donation," "surrogacy," and "fertility clinics."

I selected the sample from articles spanning the years from January 1960 to December 2010. I chose this time-frame because it began the full decade before the advent of *in vitro* fertilization, the first technology that opened the doors for cutting-edge treatment of infertility problems, and ended with the most recent indexed entries available. This era was marked by phenomenal advances in procreative technologies in addition to a tremendous rise in the number of individuals who sought medical treatment for their infertility.

Since all the entries under the headings STERILITY, INFERTILITY and other related topics, yielded an unwieldy and vast number of articles--some of which had very little, if any, relationship to a sociological study of the culture of infertility, I developed a sampling method to narrow down the focus and define the appropriate sample to be used in my specific study. These steps included:

- I assigned all possible article citations related to infertility as per the *Reader's Guide to Periodical Literature* a number and entered into an electronic filing system/data base manager program.
- I identified subtopics, such as: Coping with infertility, specific infertility treatments (IVF, egg donation, surrogacy, sperm donation, etc.), personal stories (both positive and negative), and physician-written pieces in order to weed out articles that were not sociologically significant for this study, such as those related to animal husbandry.

- To collect further demographic details and ensure diversity with regard to perspective, I coded the articles by the type of magazine in which they appeared: 1) Women's magazines aimed at a female audience; 2) Health magazines featuring health issues and concerns; 3) News magazines whose major goal is to report the news; 4) Popular magazines which have a mass market appeal and are general in nature; 5) Psychology/Science magazines that deal with issues from a scientific perspective geared towards a lay audience; and 6) Religious/Special Interest magazines that target a specific group.
- Because the number of articles about infertility grew exponentially from 1960 to 2010 as procreative technologies increased, I utilized a more systematic sampling method ensure the sample size would be both realistic and manageable.
 - Starting with 1980 and continuing until 2010, I used a table of random numbers to select 75 articles (out of 135 articles recorded) between 1980 and 1989; 150 articles (out of 296 articles recorded) between 1990 and 1999; and 225 articles (out of 346 articles recorded) between 2000 and 2010. If one particular article could not be located, I moved on to the next in accordance with the random numbers table. These sample numbers were consistent with the ratios of articles printed during the decades of 1980s, 1990s, and 2000s as the number of articles addressing infertility proliferated (1:2:3 or 75:150:225).
 - Since the decades of the 1960s and 1970s contained very few articles (a total of 50), I included all obtainable articles published during this time in my analysis.
- All in all, this sampling method provided a total sample size of 512 articles between the years of 1960 and 2010 for analysis.

Once I identified the final sample, I obtained hard-copies of all articles included in this sample through online databases, local libraries or inter-library loan. To aid in the analysis, I put together a

brief “face sheet” for each article to capture important data, such as the title of the article, major topic(s) of focus (i.e., infertility “problems,” infertility “solutions,” etc.), year it was published, the name of the magazine, magazine circulation and readership, article length, the name(s) of the author(s), their backgrounds (i.e., infertility professional, academic, journalist, patient, etc.), gender of the author(s), and any other critical background information. For example, women’s magazines such as *Redbook* and *Ladies Home Journal*; news magazines such as *Time* and *Newsweek*; popular or general magazines such as *People* and *Saturday Evening Post*; science-type magazines such as *Health*, *Prevention*, and *Psychology Today*, and specialty magazines such as *Jet*, *Essence*, *Ebony*, and *The Advocate* as well as Christian publications. Overall, about one third of the articles did not have an author listed. (Please see Appendix C and D for the distribution of articles by decade regarding the author’s gender and type of publication). Additionally, I assigned all articles used in my sample a four digit number with the 1000s representing articles from the 1960s, 2000s representing articles from the 1970s, 3000s representing articles from the 1980s, 4000s representing articles from the 1990s, and 5000s representing articles from the 2000s. Throughout the remainder of my dissertation, I identify each article by its unique number, magazine title, and year published.

After I read the articles in their entirety, I began coding the articles using modified grounded theory methods (GTM). Overall, grounded theory is

A detailed grounding by systematically and intensively analyzing data, often sentence by sentence, or phrase by phrase of the field note, interview, or other document; by constant comparison, data are extensively collected and coded. The focus of analysis is not ordering a “mass of data,” but organizing many ideas which have emerged from the analysis of the data (Strauss 1987: 21-22)

GTM are often used in health and sociological research when one wants to develop or generate a theory derived from empirical data to explain a social phenomenon or process (Green and Thorogood 2009). Through my other research (Boss and Sterling 2009; Glazer and Sterling 2005) focusing on the psychosocial aspects of infertility, I am already familiar with much of the literature in this area. As a

result, a modified grounded theory approach was most appropriate for this analysis. My previous knowledge about infertility influenced my ability to analyze the data through the use of pure grounded theory methods (GTM), making it more difficult to allow the theory to completely emerge and not be forced. While GTM allowed for flexibility in the techniques used for data analysis, I still adhered to the key principles of GTM, namely concept and theory generation from the actual data; theoretical sampling; the constant comparative method of data analysis; and core variables discovery (Glaser and Strauss 1967). Overall, GTM provided a rich understanding of how the culture of infertility changed between 1960 and 2010.

I began my analysis by combining broad themes identified in the titles of the articles, such as infertility 101, physician interviews, *in vitro* fertilization, embryos, surrogacy, etc. Given GTM's constant comparison process, the stages of data collection and data analysis did not occur in a linear sequence. Instead, research and analysis were cyclical in nature. Constant comparison resulted in fracturing and reconstituting the data, regrouping concepts which fit with other developing concepts (LaRossa 2005). For example, in terms of "What is infertility?" I assembled all the descriptions of "how common is infertility" into one group, all responses to "what causes infertility" into another, and "who is affected?" into yet another. I then looked at each group of descriptions to find similarities and differences within each. At first, I underlined indicators within the data that suggested emergent concepts and circled words and terms that seemed particularly important. For causes of infertility, I identified physical causes, lifestyle causes, causes for women's infertility, causes for men's infertility, age-related causes, and so on. This process continued until each concept was theoretically saturated (or grounded), meaning no new dimensions were added to the category. LaRossa (2005) suggests that an adequate level of abstraction occurs when the grouping of similar concepts contains neither too many nor too few indicators. However, in the end, not all the concepts were used since some of the concepts were too abstract or too vague to be supported by the data set, such as adoption, miscarriage, embryo

banking, terminology, and celebrity stories. Likewise, some concepts were subsumed under new broader categories when they were identified as inter-related or redundant.

Once I completed this process, axial coding allowed concepts to be systematically linked and relationships among variables to be explored. My goal was to produce concepts that related to my overall research questions. I emphasized causal relationships, fitting elements into a basic framework of generic relationships, particularly answering the questions who, what, when, where, why, and how. This generated a tentative conceptual framework which explained how infertility was defined, controlled, and treated, especially through procreative technologies. I also looked at changes regarding how new treatments for infertility were approached over time. This was especially important to consider because journalists invoked different forms of telling stories (Charmaz 2006). Through the overall process of axial coding, I identified several categories related to infertility and culture that were somehow linked, including the occurrence of infertility, causes, the role of men, race and infertility, emotional impact, stigma, pronatalism, procreative choices, the business of infertility, religion and morality, treating infertility, procreative technologies, and collaborative reproduction.

Finally, three central or core categories—defining infertility, controlling infertility, and treating infertility through procreative technologies--emerged as the core categories through the “selective coding” process. In this phase of coding, these core categories further guided theoretical sampling and data analysis, focusing on the conditions, interactions, strategies, tactics, and consequences. In my study, all the other categories shared some sort of connection with one of the three core categories. These seemed to be the common threads which held together all the other categories and best explained people’s attitudes, behaviors, and expectations regarding infertility. Because I also looked at gender, race, and class as well as other socio-demographic variables, I included these aspects in the interrelationships among variables with the core categories, as appropriate. Thus, my final analysis

included a full range of variation of knowledge, meanings, attitudes, behaviors and expectations infertility within this sample with regard to the culture of infertility from 1960 to 2010.

3.3 Fertility Specialist Interviews

Because much of the media content was informed by the physicians working in the field at that time, I felt it necessary to include their perspectives in this study as well. I interviewed six physicians who were involved with treating infertility from 1960 to 2010. Since I keep in touch with a number of infertility specialists who practiced over the entire time period covered by this research (1960-2010) as a result of my other research in the area (Glazer and Sterling 2005; Boss and Sterling 2008), I started with them. The interviewees were a very homogenous group--all of them white men over age 75, educated at top schools, who worked most of their careers in metropolitan areas within large healthcare systems throughout the United States, and are still involved with infertility today despite reaching retirement age. To protect identities, I changed the names of respondents and places where they practiced. Every attempt was made to talk with them in person, but due to scheduling and health issues, I conducted two phone interviews and one via email correspondence. Each semi-structured interview took about one hour and was tape-recorded and transcribed. (Please see Appendix for the semi-structured interview guide.)

Because of my previous interactions with these fertility specialists, the interviews were very conversational in nature. Similar to Diana Parry's (2006 and 2005) methods in exploring women's experiences with infertility, I embraced the interplay between me, as the researcher, and the respondent. I focused on shared information and insight, striving to examine the various meanings and constructions that developed. In this sense, "knowledge was generated through dialogue, listening, and talking" (Thompson 1992:10).

To analyze these qualitative data, I utilized GTM in a similar manner to the aforementioned process regarding the media analysis. Given each physician's perspectives were clearly biased based on his own personal experience in the field as well as current realities, GTM also allowed for assumptions and biases to be overt. While I originally aimed for about 7-10 interviews, after six interviews I sensed that I was no longer collecting any new information. As my research progressed, sampling was more purposeful and focused. The same patterns seemed to emerge again and again. By moving back and forth between the data collection and analysis, I soon became satisfied that I had a wide enough range and density of specific concepts and indicators to effectively support my major theoretical categories found in the media analysis. In sum, categories become saturated when gathering new data no longer led to any new theoretical insight nor uncovered any new properties. Because GTM place a greater emphasis on theoretical saturation instead of actual sample size, I was able to use this very small sample to supplement the media analysis (Charmaz 2006).

3.4 National Survey of Family Growth Data

Because very little information exists regarding the actual behaviors related to infertility, the National Survey of Family Growth (NSFG) provided more detailed information about the incidence of infertility and pursuit of treatment by individuals in the United States. Sponsored by the National Center for Health Statistics of the United States Department of Human Services, it is a population-based multipurpose survey based on personal interviews with a national sample of women (all cycles) and men (beginning with Cycle 6) 15-44 years of age in the civilian non-institutionalized population of the United States. Even though it is cross-sectional, the NSFG is not representative, but instead deliberately oversamples Hispanics, African-Americans, and teenagers. The survey's main function was to collect data on factors affecting pregnancy and women's health in the United States. NSFG data were collected

from seven different cohorts during 1973 (Cycle 1), 1976 (Cycle 2), 1982 (Cycle 3), 1988/1990 (Cycle 4), 1995 (Cycle 5), 2002 (Cycle 6), and Cycle 2006-2010 (Cycle 7).

The NSFG supplements and complements the data from the National Vital Statistics System on births, marriage and divorces, fetal death, and infant mortality. It is also a significant part of the Centers for Disease Control and Prevention's public health surveillance for women, infants, and children—particularly in regard to contraception, infertility, childbearing, and pregnancy. Major topics covered in the series include: the number of children women have had and the number they expect to have in the future; intended and unintended births; first sexual intercourse and partners; marriage; cohabitation; impaired fecundity; sterilization operations; breastfeeding; maternity leave; child care; adoption; stepchildren; foster children; health insurance coverage; family planning; and health conditions and health behaviors, including smoking, HIV testing, pelvic inflammatory disease, and sex education. Beginning with Cycle IV (1988) corresponding issues for men were investigated. Infertility specific topics include: delayed childbearing; fertility-related doctor visits; use of fertility services (tests, ovulation drugs, surgical treatments, artificial insemination, and IVF); expectations about future family size; experience with infertility.

All data from these surveys, in addition to complete survey questionnaires, codebooks, and other documentation, are available to the public via the CDC website <http://www.cdc.gov/nchs/nsfg.htm>. (Please see Appendix for description of National Survey of Family Growth).

For this study, I utilized mostly questions contained in Section H (Sterility and Infertility Services) for the years 1976 (Cycle 2), 1982 (Cycle 3), 1988/1990 (Cycle 4), 1995 (Cycle 5), and 2002 (Cycle 6). Because the survey questions, sample, and sampling methods changed between the cycles (often in response to the development of new procreative technologies and understandings of infertility as the field significantly grew within these years), it was difficult to conduct a thorough quantitative analysis of

these data, particularly comparisons between cycles. Unfortunately, due to the lack of infertility services available at the time, there were no useable data in the Cycle 1 (1972). Additionally, Cycle 7 (2006-2010) was not publically available at the time of my analysis. Although the data were limited, I used the NSFG to assess survey participants' knowledge, attitudes, and behaviors regarding infertility and infertility services identify general trends in basic attitudes and utilization rates of fertility services. Moreover, I compared these trends to representations in the media. This aided in evaluating both the accuracy of the media portrayals as well consistency of behaviors with the changing culture of infertility. Using SPSS, I conducted basic summary statistics, descriptive analysis and cross-tabulations regarding fertility services and basic demographic information (mainly, age, religion, and race/ethnicity). I also wanted to use education, especially as a proxy for socioeconomic status, but the categories were too limited to be useful. Education was captured only under less than high school, high school, and more than high school.

3.5 A Mixed Method Approach

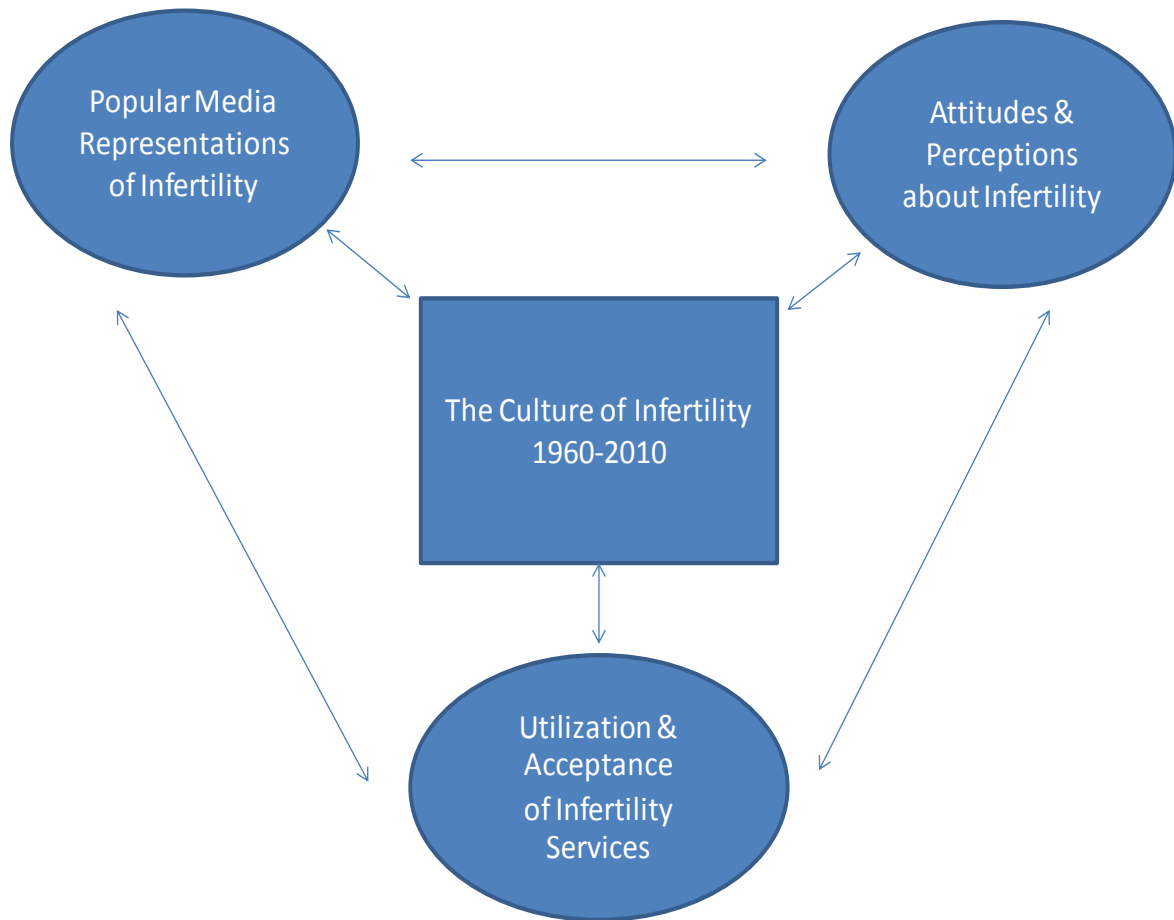
Because infertility is a complex issue involving social, behavioral, and biological sciences, a mixed method approach provides the opportunity to integrate different theoretical perspectives such as social constructionist and feminist theories. Through the use of multiple data sources, I present different perspectives about infertility between 1960 and 2010. The popular media analysis physician interviews focus primarily on the meanings and contexts of the infertility experience. In general, I explore the overall process of dealing with infertility and how perceptions about infertility change over time. The quantitative component provides additional evidence about how procreative technologies were utilized during certain time periods addressed by this study.

Using a convergent design, I develop a more complete understanding of the culture of infertility by taking a macro picture of what was happening in the infertility field in terms of treatments and

scientific advancements (quantitative data) and merging it with a richer context involving information about individuals and the greater society in which they live (qualitative data). Overall, I explain how the infertility experience is culturally defined and highlight influential factors. Through this triangulation of data, I investigate exactly how the culture of infertility went from one of despair and hopelessness to the belief that the dream of having a baby can be achieved by anyone despite the situation or prognosis. (See Figure 3.1: Triangulation of Data for Understanding the Culture of Infertility.)

The main limitation of this study is that it only reflects the experiences of a small sub-section of the millions of people worldwide who experience infertility. Most of those experiencing infertility reflected in these data are homogenous -- predominately white, middle-class American women who can access and afford fertility services. Additionally, my study focuses on those individuals who identify as "infertile" and opt to pursue treatments. As a result, the findings cannot be generalized to the larger population of anyone experiencing difficulty getting pregnant. Still, this study provides insight into the impact of infertility on the lives of individuals, couples, and families, particularly those who pursue infertility treatments. Implications from this study can inform education and prevention efforts; explain the use and misuse of procreative technologies; and answer ethical, legal, and religious questions that touch on the very meaning of parenting, family, and life itself.

Figure 3.1: Triangulation of Data for Understanding the Culture of Infertility



CHAPTER 4

DEFINING INFERTILITY

For there is nothing either good or bad, but thinking makes it so.
-- William Shakespeare, *Hamlet, Act II, Scene 2*

Not long ago, infertility was an invisible phenomenon. When families had trouble procreating, the experience was personal and not part of a larger public or social conversation. More recently, considerable public attention focused on the plight of those defined as “infertile.” Infertility typically results from the inability to get pregnant after a specified period of unprotected sex or “actively trying.” However, existing definitions of infertility lack uniformity and only apply to heteronormative families. No definitive test for infertility exists, and terminology is confusing. While the words “sterility” and “barrenness” were routinely used for centuries, the term “infertility” gained popularity in recent years in order to negate any finality of the condition and offer hope that pregnancy can occur. However, even the word “infertility” connotes a distinct medical definition as opposed to a fluid social experience. Infertility is not a concrete, objective or definitive term. As a result, people who experience difficulty getting pregnant must determine on their own whether or not they are “infertile” and exactly what this means for them. In this chapter, I analyzed articles and other supplemental information addressing the different factors that work together to define infertility, especially involving questions related to who, how, why, and when infertility occurs.

A Note about Terminology Used to Describe Infertility

Given the variability in defining infertility, I purposely chose to utilize more sociologically appropriate terms over those used in the media or physician interviews. Adding to the difficulty in defining infertility, the language used to discuss infertility was diverse, both between disciplines and even within the same disciplines. For instance, for the most part, I used “procreation” instead of

“reproduction” based on sociologist Barbara Katz Rothman’s (1988) perspective that children cannot be “produced.” Likewise, I omitted the word “conception” from my dissertation all together since “conceiving” holds a metaphysical connotation and does not constitute any medical reality of when life begins. Instead of “female” and “male” infertility, I included “women’s” and “men’s” infertility in order to effectively distinguish between biological sex and gender, a distinction that is ignored within procreative medicine. I also referred to physicians who focus on infertility, “fertility” or “infertility specialists” as opposed to fertility doctors or reproductive endocrinologists. As my study shows, the infertility field blurred the line between medicine and business. Additionally, infertility was not always a medical condition needing a clear medical treatment or “cure.” As a result, I felt “specialist” more accurately portrayed these professionals providing fertility services. Finally, I replaced “third-party reproduction” with “collaborative reproduction” to describe sperm donation, egg donation, embryo donation, and surrogacy. More professionals working in this aspect of procreative medicine are using “collaborative reproduction” in order to further separate gamete donors and surrogates from parentage. Journalist Liza Mundy (2008) and Attorney Charles Kindregan (2008) were a few of the first to publish using this specific term. While still not ideal for describing the complexities of these procreative processes, collaborative reproduction more accurately reflects the experience than third-party reproduction in my opinion.

4.1 The Occurrence of Infertility

Social science researchers Marsh and Ronner (1996), May (1995), and Scritchfield (2009) stated that infertility rates remained relatively constant throughout history. However, I found popular media, including well-known national news sources (#1106, *Time*, 1960; #3026, *Time*, 1984; #3027, *Time*, 1984), emphasized that infertility was far commoner than generally supposed. At first glance, reputable statistics and research supported these upward trends. For example, *Time* (#3026, 1984) reporter

Claudia Wallis highlighted research conducted by the National Center for Health Statistics stating the incidence of infertility among married women aged 20 to 24, normally the most fertile group, jumped 177 percent between 1965 and 1982. A decade later, according to *Newsweek* (#4006, 1995), the National Center for Health Statistics concluded that the percentage of “childless, infertile couples has increased from 14.4 in 1965 to 18.5 [in 1995].” Around the same time, *Time* (#4108, 1997) reported that the number of American women of childbearing age who suffered from fertility problems “jumped” from 4.9 million to 6 million, a 25 percent increase between 1988 and 1995. In 2005, *Newsweek* (#5106) referenced the Centers for Disease Control and Prevention in that an estimated over 6 million people or one in eight couples “cannot have children,” up more than 20 percent since 1995.

Journalists also interviewed experts who weighed in regarding the current state of infertility. In *Time* (#3027, 1984), reproductive endocrinologist Dr. Martin Quiqley of the Cleveland Clinic called infertility “an epidemic” in the United States, claiming the incidence of “barrenness” nearly tripled over 20 years to more one in six Americans who still cannot get pregnant after one year of trying. Another article in *People* (#4112, 1990) quoted fertility expert Dr. Robert Franklin of Baylor College of Medicine: “When I first started practicing in 1962, an estimated one out of every 20 couples had fertility problems. Now the figure is one in six.” A special report and cover story by Anna Quindlen for *Life* in 1987 (#3053) claimed “facing widespread infertility, a generation presses the limits of medicine.”

However, was the United States truly in the midst of a serious infertility epidemic as these experts and journalists stated? Moreover, I wondered how journalists reached their conclusions. Consequently, I looked more closely at the specific statistics used in these articles (#1106, *Time*, 1960; #1031, *Time*, 1968; #1031, *Today's Health*, 1968; #2006, *Today's Health*, 1972; #2024, *Newsweek*, 1978;; #3053, *Life*, 1987; #3051, *Time*, 1987; *Time* #3051, *Time*, 1987; #3062, *Psychology Today*, 1988; #3065, *Time*, 1989; #4001, *Time*, 1991; #4006, *Newsweek*, 1995; #4008, *Redbook*, 1998). When doing this, I found that infertility rates actually remained relatively constant (See Table 4.1). By the 2000s, the

American Society for Reproductive Medicine (ASRM) ultimately concluded about 10 percent of those of reproductive age or 7.3 million women and their partners struggle with infertility--a statistic that remained for the rest of the decade (#5090, *Psychology Today*, 2005).

Table 4. 1: Media Reports of Those Affected by Infertility

	Reported Percentage Affected by Infertility	Reported Number of Those Affected by Infertility
1960s	20 percent	3.5-5 million
1970s	13-25 percent	Not Available
1980s	8-17 percent	2.5 million
1990s	10 percent	6 million
2000s	10-12.5 percent	7.3 million

Despite the media attention indicating otherwise, most experts recognized that infertility rates were constant. More science-oriented magazines explained these common variances with these statistics. After all, no definitive test for infertility or absolute answers existed. The infertility statistics were only gross estimates and were considered far from definitive. Ginel Kolate, a reporter for *Science* (#2025, 1978), explained:

There are no good data on the incidence of infertility. The American Medical Association estimates 15 percent of all married couples in this country are unable to have any children and an additional 10 percent have fewer children than they wish. (#2025, *Science*, 1978)

Interviewed by Kolate (#2025, *Science*, 1978), Emil Steinberger of the University of Texas at Houston pointed out: "There is not even a good definition of infertility." According to Steinberger, infertility was difficult to define because original descriptions of infertility came from animal husbandry when a female in heat failed to become pregnant after several exposures to a known fertile male. With humans, a woman can have sex with men for several years over the course of dozens of ovulatory episodes. If she produces only one offspring, she may still be considered fertile. In her study, "The Social Construction of

Infertility: From Private Matter to Social Concern,” Shirley Scritchfield (2009) also found assessing the prevalence and nature of infertility in the United States difficult.

Media messages about the occurrence were more than just rational acts of transmission. Instead, they belonged to much broader systems of social and cultural meanings influenced by different interpretations. Further legitimizing the need for fertility specialists, experts in the field regularly promoted the perception that infertility was on the rise within the media. Scritchfield (2009) suggested that this growing attention toward infertility in the media reflects new social constructions rather than a biological epidemic which will be discussed throughout this study.

4.2 Causes of Infertility

Many patient advocates reinforced the medical definition of infertility as “A disease of the reproductive systems of both men and women that can result in the inability to conceive or carry a pregnancy to a live birth” (Aronson 2000:6). In a “Letter to the Editor” in *Newsweek* (#5138, 2006), the executive director of RESOLVE, the National Infertility Association, Joseph Isaacs, stated, “For many women, infertility is caused by underlying clinical problems that can be successfully addressed with drug therapy, medical procedures and/or surgery.” Popular media between 1960 until 2010 somewhat supported this definition of infertility as a medical condition affecting both men and women at relatively similar rates. Across each decade, articles reported that in roughly 40 percent of cases, it is the woman’s infertility that prevents pregnancy; in 40 percent, it is the man’s; and in 20 percent it is both partners’ or of unknown cause (#1005, *Time*, 1960; #3001, *Time*, 1980; #4006, *Newsweek*, 1995; #4008, *Redbook*, 1998). As a greater understanding of the human body and procreation emerged within reproductive medicine, media reported general medical reasons for infertility, mainly ovulatory disorders, tubal problems, cervical problems, uterine abnormalities, and sperm factors (#4112, *People*, 1990; #4001, *Time*, 1991; #4003, *Redbook*, 1993; #4008, *Redbook*, 1998; #4029, *Ebony*, 1995; #4112,

People, 1990). In terms of specific medical causes, only a few mentions of the most common infertility diagnoses--endometriosis followed by polycystic ovary syndrome (PCOS)--appeared (#3016, *Time*, 1982; *People*, 1985; #3053, *Life*, 1987; #3038, #5011, *Health*, 2000; #5054, *Advocate*, 2003).

On the other hand, journalists did not always portray infertility as a disease. In fact, the vast majority of articles published in popular media between 1960 and 2010 attributed infertility to lifestyle choices (see Table 4.2). Moreover, articles primarily blamed infertility on women's poor decision-making (both directly and indirectly). Starting the 1960s, journalists told readers that a diet low in vitamins or protein, poor absorption of food, too much alcohol, too little sleep, "nervousness," venereal diseases, or wrong kinds of vaginal douches could all lead to infertility (#1005, *Time*, 1960).

Table 4.2: Causes of Infertility

	Total Number of Articles Including All Causes	Number (and Percentage) of Articles Including Lifestyle Causes
1960s	5	4 (80 percent)
1970s	7	5 (71 percent)
1980s	10	7 (70 percent)
1990s	10	9 (90 percent)
2000s	22	16 (73 percent)
TOTAL	54	41 (76 percent)

In a 1984 *Time* (#3027) article entitled "The Saddest Epidemic," Dr. Martin Quigley of the Cleveland Clinic blamed "liberalized sexual attitudes among women having led to an increasing occurrence of genital infections known collectively as pelvic inflammatory disease which impact the fallopian tubes, ovaries, and uterus." Through their depictions directly linking sexual behaviors to infertility, the media agreed with Dr. Quigley. For example, several articles (#3016, *Time*, 1982; #3033, *People*, 1985; #3053, *Life*, 1987) emphasized that Chlamydia was considered by many to be the "venereal disease of the 1980s" spreading faster than AIDS or genital herpes and affecting between three million and ten million Americans in 1985 alone. Since symptoms often went unnoticed, media

pointed out the severity of the situation by saying women could experience “infertility or even death” if it were left untreated. It is important to note that journalists commonly compared infertility to death when describing its impact. In other words, not having a child equated death perpetuating stigma that I will discuss in more detail at the end of the chapter.

In the 1990s, journalists writing about sexually transmitted infections and infertility turned their focus toward infertility prevention among young women who might not have yet engaged in sex. These articles stated sexually transmitted infections, especially Chlamydia, often contracted as teens led to infertility later on in life (#4112, *People*, 1990; #4022, *Time*, 1998; #4017, *People*, 1995;). Even an article printed in a more scientific magazine (#4018, *Science*, 1995) claimed undiagnosed sexually transmitted infections likely caused the majority of cases of unexplained infertility, which accounts for at least 20 percent of all infertility cases, again placing the responsibility of fertility on back on women.

In general, “reification” refers to the act of attributing a reality to analytic or abstract concepts (Ritzer 2011). Given the fluidity of infertility, the fertility field as a whole seized many opportunities to provide a concrete reality to any ambiguity or abstractness used when describing infertility. For example, the American Fertility Association, a major infertility patient advocacy patient group primarily funded by fertility specialists and fertility drug companies, reified this link between sexual behaviors and infertility. In 2009, the American Fertility Association launched a slick new national campaign called “Manicures and Martinis” in 2009 (see Figure 4.1). The main goal of this program was to educate women in their 20s and 30s about infertility prevention, particularly through sexual decision-making: “Let’s talk about: the reality of your biological clock, sexuality, family planning, and the harmful effect of STDs” (#5220, *Newsweek*, 2009). The additional wording used, “Chat with a leading fertility expert in a safe and comfortable setting,” implied that fertility was a “scary” and “uncomfortable” topic that young women may find so complicated and unnerving that martinis were needed to reduce any inhibitions. Moreover, singling out “a leading fertility expert” to lead this discussion established a hierarchy of

physicians based on their ability and effectiveness in discussing matters related to fertility. (More about this later.) Although clinical research showed no change in infertility among young women due to sexually transmitted infections, birth control, or the environment, the media continued these messages about infertility prevention as if fertility could be controlled and infertility avoided (CDC 2010). Researchers Karey Harwood (2007) and Gayle Letherby (2003) both found that women commonly attribute their infertility to past decision-making—an idea reinforced by the media. All in all, these types of media messages further placed the blame on women for their infertility as well as distanced infertility from actual medical causes.

THE AMERICAN FERTILITY ASSOCIATION

*Manicures & Martinis**

We know, we know -

- You're in your twenties or early thirties.
- You're simply not ready to have a baby right now.
- Someday. When the time is right. But not now.

Join us for a complimentary Manicure & Martini.

Chat with a leading fertility expert in a safe and comfortable setting.

February 10th - East Hills, LI with Allison Styne, M.D.

February 24th - Brooklyn with Michael Zinger, M.D.

March 10th - Gramercy Park, NYC with Joel Batzofin, M.D.

Cost: Free! (but reservations are required)

Manicures & Martinis is a program of The American Fertility Association.
Reservations: Corey Whelan at (718)853-1411 or corey@theafa.org.
www.theafa.org. *Alcohol-free Fertilitinis available

Figure 4.1. American Fertility Association's Fertility Prevention Program (#5220, *Newsweek*, 2009)

From the late 1980s to the 2000s, the majority of journalists changed focus again by centering on exercise, diet, and stress even though most also stated that researchers did not fully understand their connections with infertility. For instance, an article entitled “Running Woes,” informed women joggers that they faced “jogger’s infertility” which is “easily reversible if they just stay off their feet” (#3014, *Time*, 1982). While most health care providers prescribed exercise for everyone as a critical part of a healthy lifestyle, women trying to become pregnant were often not included. In general, “too much” exercise was bad for women—turning off menstruation and ovulation. Getting pregnant trumped other health needs for women, and women’s bodies were reduced to their procreative potential. To circumvent this conflicting advice, journalists intertwined “old advice” with “new advice” about physical fitness, encouraging “get yourself in shape before the sperm meets the egg, with diet, exercise genetic tests, and dental care,” “Best to put off such enhancements like tattoos, belly piercing, and Botox until after the baby is born or even training for a marathon” or “Be prepared physically for multiples by getting yourself in shape now” (#5178, *Time*, 2008; #5140, *Newsweek*, 2007).

In 2007, a new book written by Harvard researchers, Drs. Jorge Chavarro and Walter Willet and entitled *The Fertility Diet: Groundbreaking Research Reveals Natural Ways to Boost Ovulation and Improve Your Chances of Getting Pregnant* (2007) received significant media attention (#5140, *Newsweek*, 2007; #5153, *Redbook*, 2007; #5139, *Newsweek*, 2007). This attention further contributed to journalists conveying to readers that lifestyle choices were a legitimate cause of infertility. More specifically, Chavarro and Willet looked at the role of diet, exercise, and weight control. Although infertility could be caused by a wide range of factors, the alleged epidemics of obesity and diabetes had the biggest reproductive repercussions according to several articles published in popular magazines (#5140, *Newsweek*, 2007; #5153, *Redbook*, 2007). Previous to Chavarro and Willet’s research, the question of how diet and exercise affects fertility had always been unclear. As a result, the Harvard researchers focused on 18,000 women participating in the Nurses’ Health Study. They found several key

eating and nutrition choices aimed at preventing and reversing ovulatory infertility: slow carbs, not no carbs; balancing fats; the protein factor; and eating more full-fat dairy like milk and ice cream (#5140, *Newsweek*, 2007; #5153, *Redbook*, 2007; #5139, *Newsweek*, 2007). In fact, women who ate at least one daily serving of full-fat dairy were 25 percent less likely to experience infertility due to ovulation problems than women who had only one serving or less (#5152, *Redbook*, 2007).

The sound-bites that came from these diet recommendations included (perhaps half-jokingly) eating more ice cream sundaes-- “a scoop of creamy vanilla ice cream crisscrossed by rivulets of chocolate sauce, sprinkled with walnuts and topped with a spritz of whipped cream”—as a temporary “health food” for those trying to become pregnant (#5140, *Newsweek*, 2007; #5139, *Newsweek*, 2007). Despite this lightheartedness to describe the impact of diet on fertility, body weight was perceived as important to fertility. Weighing too much or too little could interrupt normal menstrual cycles, throw off ovulation or stop it all together (#5216, *Time*, 2010). *Time* (#5103, 2005) and *Newsweek* (#5140, 2004) both predicted infertility would continue to increase with the rising obesity rates and designated BMIs within the 20 to 24 range as the “fertility zone.” According to fertility experts, this weight was ideal for ovulatory function and chances of getting pregnant, but articles provided no specific information about achieving a healthy weight. Additionally, many fertility clinics blatantly denied treatment to overweight women. In an already weight-obsessed society, the overall responsibility was placed solely on women who wanted to become pregnant giving her one more reason to feel inadequate and responsible for infertility. Additionally, both journalists and infertility professionals ignored the consequences of dieting.

The connection between stress and infertility was initially mentioned in the media in the 1960s and 1970s (#1005, *Time*, 1960; #2024; #2006, *Today's Health*, 1972; *Newsweek*, 1978). At this time, the conclusions varied from *Time* (#1005, 1960) stating that fertility specialists agreed “emotional disturbances” do not cause infertility (#1005, *Time*, 1960) to *Today's Health* (#2006, 1972) claiming,

Mental stress can cause the flow of hormones, thereby inhibiting ovulation and/or the production of sperm. Just as an emotional upset can cause spasms of the stomach or intestines, bringing on indigestion, so tension and anxiety can interrupt the functioning of both the male and the female reproductive systems. (#2006, *Today's Health*, 1972)

However, by the 1990s, the media portrayed stress as an actual cause for infertility. According to *Health* (#4013, 1994), this started as,

One afternoon psychologist Ron Drabman fell into a conversation with a couple of the nurses: they told him, "You psychologists may think you know a lot about stress, but you don't—not the overwhelming stress we see in infertility patients." (#4013, *Health*, 1994)

In "Can Stress Be to Blame?" (#4013, *Health*, 1994), Drabman said that four out of 14 couples attending his stress reduction program conceived in their first attempt at *in vitro* fertilization—which was actually no different than the expected success rates of *in vitro* fertilization overall. In 1993, another psychologist Samuel Wasser at the University of Washington in Seattle found that women whose infertility was caused by hormonal problems showed much higher levels of stress than those whose partners were found to be infertile or whose infertility was caused by anatomical problems, like blocked tubes. He concluded in *Health* (#4013, 1994) that "This is exactly what you'd expect if stress caused the disorder."

Even when the infertility problem was purely physical, science journalists from *Health* and *Psychology Today* (#4013, *Health*, 1994; #4023, *Health*, 1999; #5090, *Psychology Today*, 2005) reported that stress may impede pregnancy. As a result, psychologist Alice Domar used behavior modification techniques, including relaxation and stress management, at Boston's New England Deaconess Hospital to increase fertility (#4013, *Health*, 1994; #4023, *Health*, 1999). In the same articles, Dr. Alan DeCherney warned that while this evidence may be striking, most specialists have a problem working with the idea of stress and infertility because it is difficult to prove and "they'd rather go into high-tech areas where results can be quantified" (#4013, *Health*, 1994). (More about this common focus on high-tech treatments among fertility specialists in Chapter 7.) Domar responded that this talking cure is relatively cheap compared to *in vitro* fertilization: "I don't care if it's affecting the egg or uterus; I just care that

we can treat the problem” (#4024, *Health*, 1999). In fact, according to researchers quoted in *Psychology Today* (#5090, 2005), emotional stress was the second highest most frequently cited reason for dropping out of treatment, trailing only financial constraints. However, Domar made her livelihood charging \$1,000 a piece for teaching infertility patients about the mind/body connection at her new Domar Center for Mind/Body Health creating a financial incentive for promoting the relationship between stress and fertility.

Appealing to a much broader audience and further legitimating stress as a cause for infertility, Domar strategically highlighted her connection between stress and infertility directly to mainstream media. She noted seeing more and more women who failed to put themselves on their own list of priorities, even when they were trying to become pregnant—something most women could appreciate regardless of fertility (#5017, *People*, 2001). Based on work by Dr. Herbert Benson, a professor of medicine at Harvard Medical School, Domar found that expressing emotion in appropriate, balanced ways, was good for your health, including fertility (#5017, *People*, 2001; #5084, *Newsweek*, 2004). Soon after, yoga instructors talked to the media about new classes incorporating the mind-body approach to promote fertility (#5056, *Time*, 2003; #5084, *Newsweek*, 2004). In fact, articles eventually included that meditation was recommended by physicians as a method to prevent or slow down infertility, implying that Domar’s philosophy about stress and fertility had been adopted by conventional medicine as well (#5056, *Time*, 2003). Most likely, clinicians thought even if these techniques did not help, they would not hurt. Despite the outcomes, infertility clinicians who adopted new complementary methods, like Domar, would appeal to even more families by suggesting they were concerned about patients both physically and emotionally. According to a study conducted by Benjamini et al. (2005), patients expressed more satisfaction if they perceived that care was individualized, supportive, and friendly. Overall, fertility specialists had nothing to lose by stressing the importance of stress reduction in getting pregnant.

Similar to women's infertility, articles blamed men's infertility on poor choices, including work environments, heat to the testicles, and lifestyles. Due to gender stratification in the workplace, journalists in the 1960s regularly mentioned environmental toxins, such as radiation, lead or pesticide exposure, associated with certain traditionally masculine, blue-collar occupations (#1021, *Time*, 1966; #1030, *Time*, 1968; #1031, *Today's Health*, 1968). Reports on occupational hazards to fertility were also commonplace in the 1970s. For example, Occidental Chemical Company in California received considerable press because a number of men who worked in the pesticide division experienced infertility. Government officials recommended the production of a certain chemical, DBCP, be stopped. At this time, no one knew if exposure to this chemical would be reversible and if it caused sterility among the men who worked with it, what else could it cause? (#2021, *Newsweek*, 1977). What I found to be "toxic scares *du jour*" continued into the 1990s with articles about "endocrine imposters" such as vinclozolin, a fungicide residue often found on fruits, which slips into the receptor meant for testosterone, causing male rats to become hermaphrodites and unable to reproduce (#4020, *Newsweek*, 1996). Based largely on gendered expectations, this connection between men's infertility and women's hormones was prevalent in the media portrayals of men's infertility.

Since sperm related to manhood (which I will discuss in more detail later in this chapter), the detriment of heat on sperm production received a lot of attention as well. It had been common knowledge for some time that warmth reduced sperm count, but researchers finally reported several clinical experiments, including having fertile men wearing athletic supporters all day and treating the scrotal area with heat directly (#4021, *Esquire*, 1997; #4046, *Esquire*, 1996). Health journalists warned men that heat was a serious issue and keeping the testicles cool was an important measure for all men to preserve their fertility (#1031, *Today's Health*, 1968; #2006, *Today's Health*, 1972; #4021, *Esquire*, 1997). For decades, media said avoiding tight underwear was key (#2001, *Time*, 1970; #4046, *Esquire*,

1996; #5037, *Newsweek*, 2002), and during the computer age, the effects of heat from laptops was highlighted as another danger to sperm (#5079, *Time*, 2004; #5098, *Discover*, 2005).

Articles with harsh titles like “Are You Screwing Up Your Sperm?” (#4021, *Esquire*, 1997) also scrutinized men’s behaviors. However, men’s lifestyle choices did not seem as permanent or life-altering as they did with women. Articles focusing on the causes for men’s infertility also did not include sexual behaviors or associated moral judgments as I addressed before with women’s infertility. Through the media, the public learned about research on marijuana and sex: Testosterone levels dropped by a third leading to infertility or impotence among men who used pot for nine weeks. Fortunately for these men, journalists stated that once stopping pot, testosterone levels and sexual ability returned to normal (#2018, *Time*, 1975). Men were told directly to avoid cigarettes, drinking, using Tagamet (for ulcers) and the antibiotic erythromycin, which all lead to a drop in sperm numbers (#4021, *Esquire*, 1997; #5170, *Newsweek*, 2008). Even past sports injuries involving testicular trauma contributed to infertility later in life so preventative measures were encouraged (#4014, *Health*, 1994).

In addition to controlling their own fertility, the media held women responsible for their partner’s, children’s and future children’s fertility. Journalists considered the role of mothers (as well as mothers-to-be) to be the nurturer for the entire family. For example, women’s magazines (#5058B, *Good Housekeeping*, 2010; #5107, *Redbook*, 2005) included advice for women to share with their partners, particularly about diet and fertility assuming most women controlled household eating habits. Mothers were also primarily responsible for noticing the anatomy of their small sons as well as reporting an undescended testicle to the doctor early in the child’s life. If not corrected by age five, permanent damage could be done; sterility was almost certain if it not addressed by puberty. In general, mothers were told by *Time* (#1034, 1969) that they contributed to a boy’s future fertility by preventing illnesses and ensuring diet, proper nutrition, exercise, and good health practices. More recently, mothers worried about what type of diapers they used on their children. *Discover* (#5012, 2001) explained how a

team of German researchers found “anybody who used plastic-lined diapers knows how hot it can get in there especially for developing testicles which can affect the sperm even as adults” (#5012, *Discover*, 2001).

Appearing in the 1980s, heartbreaking stories about DES in the media (#3001, *Time*, 1980; #3016, *Time*, 1982; #3053, *Life*, 1987) held millions of more women accountable for their children’s future fertility. To reduce the risk of pregnancy complications and miscarriage, over two million pregnant women took DES (a synthetic estrogen called diethylstilbestrol and another example of women’s culpability in infertility) between 1940 and 1970 before the Food and Drug Administration alerted physicians to its dangers. In addition to causing vaginal and cervical cancers in daughters, DES was linked to genital abnormalities and infertility in sons as well as increased rates of miscarriages in daughters. To differentiate these children, the media coined the terms “DES-daughters” and “DES-sons.” These stories of mothers causing infertility among their children further supported the mother-guilt found in the work by Seaman and Seaman (1977) and Earle and Letherby (2003). In general, this guilt created on-going emotional stress for both mother and child, especially if future fertility was threatened. Although the medical community was to blame for DES, women who took DES carried the burden of their decision the remainder of their lives.

Overall, my analysis supports Rothman’s (2000) claim that data are inconsistent as to the exact causes of infertility. Additionally, clinical researchers provided very little data to popular media as to which factors directly affect fertility. With causes ranging from diet to sexually transmitted diseases to birth control to stress, women were held responsible for fertility (and even that of their partners and children). In fact, 76 percent of all articles assessed in my study addressing the causes of infertility between 1960 and 2010 focused on lifestyle issues, many of them exclusively. Through the media, the “infertile” were portrayed as deserving of their infertility, mainly through lifestyle choices and past decision-making. Sociologist Shirley Scritchfield (2009:141) concluded that the modern health care

system features an “individualist ideology that emphasizes what individuals do wrong and then treats the outcomes of such self-destructive behavior.” However, these articles failed to mention any social causes or contexts that may influence people’s choices. For instance, sexual decision-making, health habits and stress are all influenced by society and larger structural issues, including education, economics, access to care, and family background. As a result, my study also supports researchers Marsh and Ronner (1996) and May (1995); we all found that media compels women to blame themselves individually for infertility which the media further perpetuates.

4.3 Age

One of the most well-known media narratives is that getting old causes infertility (Harwood 2007; Thompson 2003). Over the past 50 years, expectations about pregnancy and parenthood changed. For generations, doctors considered a woman pregnant for the first time after age 35 an “elderly primigravida,” reflecting the medical establishment’s longtime disapproval of delayed motherhood. Although the risks of older motherhood were not well understood, the common “traditional” viewpoint expressed in the 1960s suggested a pregnant woman in her 30s equated complications and caesareans. In *Time* (#1033, 1969), Dr. Widukind Lenz, an obstetrician, concluded “the present trend toward earlier sexual maturity, earlier marriage and earlier reproduction is biologically favorable.” Not surprisingly, photographs and interviews included in the articles proved the media’s target audience in the 1960s for prime childbearing was roughly age 20-29.

Age started to become a bigger issue within the media during the 1970s as many social changes and new demographic trends increased labor force participation among women as well as childlessness. At first, many fertility experts directly attributed infertility to these changes. For example, in one of the first articles specifically addressing age (#2031B, *Newsweek*, 1978), Dr. Luigi Mastroianni of the University of Pennsylvania School of Medicine said one of the chief causes of increasing infertility was

that more and more women were postponing pregnancy while pursuing careers. Using scare tactics and blaming past decisions, fertility specialists tried to deter women from adjusting their social expectations about motherhood. Similar to my previous discussion about the causes of infertility, journalists at *Newsweek* (#2031B, 1978) reported that declining infertility among women resulted from their lifetime use of birth control, including abortions and IUDs, as well as “venereal” diseases. Media portrayed rates for birth defects among older mothers as high. *Time* (#3016, 1982) suggested, “A woman is twice as likely to give birth to a defective child at age 40 than she was at 25 and five times as likely at 45.” Again blaming women for infertility, a 40-year-old woman exposed to twenty more years of pollution, pesticides, and x-rays increased the likelihood something would go wrong. Dr. Martin Quigley of the Cleveland Clinic harshly warned that “by postponing childbirth until their mid- or even late 30s, women risk a barren future” (#3016, *Time*, 1982). A Yale University study of 40 childless women discussed in *Time* (#3027, 1984) found that after 35 years of age, the time it took to get pregnant lengthened from an average of six months to more than two years. In general, these articles implied that women should forgo revised societal norms, careers and graduate school to have their families young.

As older motherhood became more common, fertility specialists publically offered care to older women wanting to become pregnant. Minimizing previous risks attributed to older motherhood, Washington, D.C. obstetrician Dr. William Gold told reporter Tony Kornheiser of *People* (#3024, 1984), “We’ve learned that women over 35 can have normal pregnancies. Age is not necessarily a problem.” Gold (#3024, *People*, 1984) also said that because women over 30 were in better shape than ever before, more women considered having children at older ages: “They are in better health than many younger women.” Suggesting women could somehow control their fertility (for both good and bad), reproductive biologist and physician Cecil Jacobson said improved diets and healthy lifestyles helped “conserve reproductive capacities” (#3016, *Time*, 1982). By the mid-1980s, the number of women having their first child between the ages of 30 and 34 had quadrupled, articles reported that women in

the United States had the highest incidence of postponing childbearing (#3053, *Life*, 1987; #3024, *People* 1984). In his article, “The Birthing Dilemma, Baby Boom or Bust,” Landon Jones predicted that with current advances, women born in the 1946-50 cohort who reaching prime childbearing age in the 1980s would be biologically capable of producing babies until the year 2000 when the youngest members turned 50 (#3020, *Saturday Evening Post*, 1982). Sociologist Harwood (2007) stated that with more control over the timing and manner of reproduction, women perceived having a baby at an older age as a personal accomplishment, therefore further encouraging older motherhood.

However, the reality was that the fertility field had made relatively few inroads in reversing the effects of, as journalist Annetta Miller (#4098, *Newsweek*, 1999), using antiquated terminology, put it, “age-related barrenness.” Overrun with older women wanting to become pregnant, fertility specialists interviewed by journalists in the 1990s reverted back to warning readers about the risks of delayed childbearing (#4001, *Time*, 1991; #4025, *Time*, 1991; #4008, *Redbook*, 1998; #4015, *People*, 1994; #4025, *Time*, 1991; #4026, *People*, 1992; #4027, *Jet*, 1997; #4028, *Newsweek*, 1997; #4098, *Newsweek*, 1999). Fertility doctors once again said, “The most formidable enemy of fertility is what they refer to as AMA: advanced maternal age” (#4098, *Newsweek*, 1999). Articles provided more details about how eggs remaining in ovaries get older and less fertile with each passing year. Media shared the results of recent studies concluding it is the age of the eggs, not the age of the reproductive system that causes fertility to decline sharply after age 40 (#4001, *Time*, 1991; #4098, *Newsweek*, 1999).

Experts also purported that the most fertilizable eggs are released earlier in life. Dr. Sherman Silber, director of the Infertility Center of St. Louis at St. Luke’s Hospital, explained in an interview with Betsy Israel of *Redbook* (#4008, 1998),

The decline isn’t completely steady. Throughout your twenties and early thirties, fertility dips gradually. But then, at 37, there’s a sharp fall off. Because a man is continually producing new sperm every day, his age doesn’t influence his fertility. (#4008, *Redbook*, 1998)

Dr. Mark Sauer, head of New York's Columbia Presbyterian Medical Center's division of reproductive endocrinology, also said society wrongly celebrates older motherhood. Many of his patients were shocked to learn that science often cannot help them get pregnant using their own eggs. He continued,

In school we teach young girls about sex education; we encourage them to defer motherhood until they've finished their education and begun a career. What we don't teach them is that if they postpone motherhood too long, their chances of having a biological child may be very small. (#4098, *Newsweek*, 1999)

Because older motherhood had been normalized by this point, older women did not revert back to previous behaviors and continued trying to become pregnant with the help of fertility specialists despite the new media coverage.

The relationship between media portrayals and social behavior was complex and problematic. Despite the positive media attention regarding older motherhood, the success rates for older mothers remained low, many fertility clinics were wary of accepting patients over age 40 (the significance of these success rates will be discussed in more detail in the next chapter). Using donor eggs could certainly improve the odds, but journalists rarely mentioned egg donation (if at all) in general articles about older mothers. (More about donor eggs in Chapter 6.) In fact, none of the articles analyzed provided information about the specific methods used to get older women pregnant giving the impression that treatments were a relatively easy process.

Because many viewed older motherhood as unremarkable, any social problems associated with this trend were ignored in the media as well (Harwood 2007; Roberts 1997). Fertility doctors wanted to decide for themselves whether or not to accept or reject patients on a case-by-case basis; therefore, the media ignored any discussion about age limits or other restrictions. Older women became dependent on their personal relationship with a fertility specialist to become pregnant. Most likely, decisions about promoting older motherhood revolved around marketing and business plans to recruit new patients and increase profit. Regardless, the media predicted "it is unlikely that many senior citizens will be storming infertility clinics" (#4028, *Newsweek*, 1997). However, Dr. Richard Paulsen, head of

reproductive endocrinology and infertility at the University of Southern California, also told *Time* (#4109, 1997), “Nobody’s tried it in 70 or 80-year olds yet, but at present there’s no evidence of an upper age limit.” This ambiguity left it open to expand the acceptability of motherhood at any age as needed.

Eventually, journalists wondered “how old is too old?” Unfortunately, no one agreed, creating confusion for readers. Some experts even changed their minds several times over the years. Dr. Sauer, who had also warned the public about the myth of older pregnancies (#4098, *Newsweek*, 1999), was one of the first to tout in *Time* (#4025, 1991) that he essentially reversed the effects of menopause and established a pregnancy in a 55-year-old woman. By the mid-1990s, some 100 women ages 50 and older had borne children in the United States, and the previously recommended 60-year-old barrier had been broken several times over. First, a 59-year-old British businesswoman gave birth to twins, using donated eggs implanted in her uterus at a fertility clinic in Italy. This was quickly eclipsed by the news that a 62-year-old Italian woman at the same clinic delivered a baby (#4077, *Newsweek*, 1994). Arceli Keh (see Figure 4.2) became pregnant and gave birth just three months shy of her 64th birthday (#4106, *People*, 1998). In 1994, the media reported that Rosanna Delia Corte became the world’s oldest mom at 64 through a new program in Rome specifically targeting women over the age of 50 (#4015, *People*, 1994). These media depictions reinforced the essentialists view that all women, and at all ages, are adept at motherhood.



Figure 4.2: 63 Year Old Arceli Keh (#4106B, *National Inquirer*, 1998)

When asked about mothers in their mid-40s and beyond, Dr. Robert Franklin of Houston, Texas stated, "They are the happiest people you ever saw" (#3028, *Time*, 1984). Journalists pointed out many positive aspects of older parents, such as that they were more likely to be emotionally and financially stable, even if their stamina to keep up with a young child was lower. Other reporters described older parents as more thoughtful, using less physical discipline, and spending more time with their children (#5082, *Newsweek*, 2004). In general, older parents appearing throughout the media believed their children came at just the right time, reinforcing the "readiness" narrative prevalent in discussions about procreative planning which I will discuss in more detail in the next chapter. According to Scritchfield (2009), positive portrayals of older motherhood gave women a strong sense of personal control over all parts of their lives, including procreation.

Whether or not older motherhood should be encouraged from a feminist perspective was highly debated among reporters as well. According to medical ethicist and author of *Ethics and Economics of Assisted Reproduction: The Cost of Longing*, Maura Ryan (2001:92), “The rising rate of infertility among older, professional class woman is an ironic chapter in the great feminist struggle for women’s reproductive liberty.” In an article published in *Harpers* (#4100, 1994), journalist Katha Pollitt argued that assisted procreative technologies leveled the playing field: “Until we are ready to severely castigate the so-called start-over dads, I don’t think we can be too judgmental and moralistic about women who avail themselves of technology that exists.” Other reporters contended fiddling with nature’s clock is a perversion of reproductive medicine and perpetuates sexist views of women as baby-making machines. George Annas, head of the Health Law Department at Boston University, explained to *Newsweek* (#4028, 1987), “The bad news is that some women could feel obligated to this. Do guys have the right to expect their 60 year-old wives to go to a clinic and have babies? That’s horrific.”

Despite these contradictions about the benefits and challenges of older motherhood, the underlying message to the public was clear by the 2000s as articles returned attention once again to younger motherhood and challenging women, “Should you have your baby now?” (#5022, *Newsweek*, 2001). Further controlling the state of older motherhood in the United States, the American Society for Reproductive Medicine (ASRM) initiated a \$60,000 bold media campaign educating women about the effects of age on infertility and received significant media attention in 2001, both in print and television. Although they did not want to turn away potential patients, doctors believed advances in fertility treatments had given women too much hope. Alarmed by what they viewed as a widespread lack of understanding about age as a risk factor for infertility—and a false sense of security about what science can do—they decided to pepper doctors’ offices with pamphlets educating women about how age can affect fertility—and what can go wrong. Fertility specialists complained “fortysomething women arrive at their offices pleading to be the exception to the rule—and they are crushed when technology cannot

help them” (#5022, *Newsweek*, 2001). The doctors also claimed, “It’s our duty to let people know” (#5022, *Newsweek*, 2001). The visual they used was an upside-down baby bottle in the shape of an hourglass with the message: “Advancing age decreases your ability to have children” (see Figure 2.2 on page 17). The American Society for Reproductive Medicine (ASRM) President Dr. Michael Soules explained, “It’s kind of like issuing a warning (#5022, *Newsweek*, 2001).

Attempts to warn women about age and fertility came under fire for scaring women with an oversimplified message. Kim Gandy of the National Organization for Women said,

To emphasize a woman’s age above all other factors can be just one more piece of misleading information. There are two people involved in [baby-making], and yet we’re putting all the responsibility on women and implying women are being selfish if they don’t choose to have children early. (#5031, *Futurist*, 2002)

Journalist Claudia Kalb questioned the motives of this campaign in her article “Should You Have Your Baby Now?” (#5022, *Newsweek*, 2001). Kalb asked if the ASRM was just launching a public relations campaign to make themselves look more responsible while they were also raising false hopes through headlines about 63-year-old moms. Amy Allina of the National Women’s Health Network told Kalb:

The skeptic in me wonders if the group may even have a financial stake in raising worries about getting pregnant. If women are more anxious about pregnancy, they might be more likely to seek medical help earlier, which would be in the interest of fertility doctors. (#5022, *Newsweek*, 2001)

ASRM publically refuted this interpretation saying their business had boomed from about 40 clinics in 1986 to over 360 in 2001; “We’re overwhelmed with patients already. This truly is altruistic” (#5022, *Newsweek*, 2001). Upholding their patriarchal control on fertility and access to information about treatments, the ASRM did not involve any women or women’s organizations in the development of this campaign.

Supporting ASRM’s campaign, others in the fertility field, funded almost exclusively by the fertility specialists themselves, fired back through the media as well. Pamela Madsen, a patient-

advocate and founder of the American Fertility Association, argued the biological imperative is there whether women knew it or not:

I cringe when feminists say giving women reproductive knowledge is pressuring them to have a child. That's simply not true. Reproductive freedom is not just the ability not to have a child through birth control. It's the ability to have one if and when you want one. Unfortunately, men do not face the cruel choices women must confront. No one is suggesting going back to the 1950s, but women in their late 20s should consider having children especially since men are not ready to commit any earlier than that. (#5036, *Time*, 2002)

Bringing up gender inequality, Allison Rose, a clinical psychologist in New York City focusing on infertility, disagreed with critics of ASRM's campaign: "This is not a case of male doctors wanting to keep women barefoot and pregnant. You lay out the facts, and any particular individual woman can then make her choices" (#5036, *Time*, 2002). However, these conflicting portrayals of older motherhood and unrealistic expectations placed on women to control their fertility effectively—all at the hands of the infertility field—severely limited women's agency.

Also encouraging a woman's choice in planning her family, a new book by economist Sylvia Ann Hewlett entitled *Creating a Life: Professional Women and the Quest for Children* (2002) made its rounds through the media (#5036, *Time*, 2002; #5031, *Futurist*, 2002). Hewlett warned that waiting to have children until 40 is much too late. Hewlett said if you listen to successful women discuss their failure to have a baby, the grief comes in layers of bitterness and regret. According to Hewlett, women debated for a generation about how to balance work and home life. Suggesting gender stratification, she described a masculine model of single-minded career focus. In fact, according to her research, 42 percent of high-achieving women in corporate America were still childless after age 40, and this number increased with incomes more than \$100,000. When asked about their original intentions, only 14 percent stated they definitely did not want any children. Like the aforementioned ASRM media campaign, Hewlett, who called herself a feminist, said she was just trying to correct the record in the face of widespread optimism about fertility. She originally set out to write a book about the difficulties for professional women faced to become mothers, but she soon discovered how many accomplished

women she interviewed had no children. However, Hewlett also pointed out she herself gave birth at 51 using her own eggs and infertility treatments (#5036, *Time*, 2002; #5031, *Futurist*, 2002). Because most women do not have the resources to become a single parent in their 50s, Hewlett's statements were confusing as to whether or not older motherhood was truly an individual choice.

Throughout the 2000s, the media reveled in celebrating older women giving birth, especially celebrities: Jane Seymour, age 44; Mimi Rogers, age 45; Cheryl Tiegs, age 52 with a surrogate; Madonna, age 41; Susan Sarandon, age 45; Wendy Wasserstein, age 48, just to name a few (#5022, *Newsweek*, 2001). At age 52 and single, Aleta St. James's told *People* (#5061, 2004) that she decided after swimming with dolphins in Mexico and meditating with shamans in Macchu Picchu, "You know what? It's time to have children." After two years of working with a fertility doctor, she gave birth to twins at age 56. Journalist Kyle Smith described St. James as a "miracle" (#5061, *People*, 2004). Some of these older celebrities were giving birth for the first time while others had additional children after their other children have grown and left the house (#5095, *People*, 2005). Overall, older celebrities interviewed by the media were depicted to be happy about their decisions to postpone motherhood.

Also addressing having a baby in later life, Julia Vargo and Maureen Regan's book *A Few Good Eggs: Two Chicks Dish on Overcoming the Insanity of Infertility* (2006) received media attention (#5119, *McLean's*, 2006). Similar to Hewlett, Vargo and Regan explained that their book was intended "as a wakeup call to their peers." When they each found themselves in their late 30s trying to have a baby, they felt like a "waking science experiment." They told readers even if you look 25, you are still really 38 and you are operating with 38-year-old eggs, not to mention at 38-year-old uterus and Fallopian tubes. The statistics do not change, even for multi-millionaire pop stars. They further lambasted nameless celebrities for not sharing the truth about infertility and for making motherhood seem so effortless: "We don't want to hear another girlfriend say 'Well, you know, I read in the paper that (fill in the blank with name of famous celeb) had her first baby at 45, so there's no rush.'" Vargo and Regan urged

women not to waste time and go straight to a reproductive endocrinologist as soon as possible promoting the need for immediate medical intervention if trying to become pregnant at a later age (#5119, *McLean's*, 2006).

Although age and fertility was typically portrayed as a women's-only concern, men were also involved. By 2004, about 250 births a year were from women over the age of 50 in the United States (#5061, *People*, 2004). On the other hand, *Newsweek* (#5082, 2004) reported more than 20,000 children born to men between the ages of 50 and 54, up from 14,000 in 1992. Celebrity late-in-life dads included: Anthony Quinn, age 81; Tony Randall, age 78, Saul Bellow, age 84; and David Letterman, age 56. Very few journalists associated any risks with older fatherhood. In the late 2000s, *Psychology Today* (#5141, 2007) briefly mentioned that as men aged, the chances of passing down genetic risks to their offspring, such as non-verbal intelligence, schizophrenia, autism, breast and cervical cancer, and brain disorders increased. In fact, by age 60, 85 percent of sperm were clinical abnormal, something researchers attributed to normal aging. On the other hand, men in their 20s had the maximum amount of mature sperm cells and the least DNA damage, and the risk of producing birth defects or causing other problems in offspring would be as low as it will ever be. Supporting traditional gendered expectations, mainstream magazines like *Redbook* (#4060, 1998), *People* (#5061, 2004), and *Newsweek* (#4060, 1990; #5082, 2004) allayed fears about older fatherhood by telling readers since a man continually produces new sperm every day, his age does not influence his fertility.

Only one personal narrative about being an older dad appeared (#4060, *Newsweek*, 1990) written by a Stephen Foreman about his son Sevi who "was a long time coming." After marrying a woman who experienced infertility herself, she asked him "You really want a child, don't you?" In reality, he admitted he had always felt he would be a father. At age 47, they adopted, and he saw himself as "a 47-year-old man with silver hair taking a baby into his arms." He said that he did not think

he looked like a grandfather, yet most of his peers looked like him and *their* children were in college.

He explained,

I feel as if I've been in training for this all my life. What I've done is reverse the time-frame. My child-rearing years will be in the last third of my life instead of the middle third. I've been fortunate. While others my age were struggling with their careers and raising families, I was living a life of textbook adventure. My heroes had always been men like Gorgon, who charted the Nile, and Lawrence of Arabia. I don't mean to imply that I operated on their scale or with their skill, but, like these men, I was driven to pit myself against myself in exotic places. There is a photograph of me from this period. It shows a man with a week's growth of beard leaning against a tree in a jungle. A cigarette dangles from his mouth. His eyes look out at you with amusement and appraisal. There is too much swagger. What I remember most vividly from those times, really is the loneliness. I was attached to no one. Nowadays everything I do has taken on a whole new dimension, even the small things. (#4060, *Newsweek*, 1990)

He admitted that the adjustment to older parenthood was not always been easy. However, he was convinced he was a better father now than he would have been when he was younger. Still, he would not recommend older parenthood for all men. While parenthood happened to him at the right time, he continued to worry about staying healthy and agile enough to be the parent he wants to be. At the time, he felt great: "I have this feeling that I'm going to be around for a long time; that I might even get to be a grandfather, for God's sake" (#4060, *Newsweek*, 1990). He also revealed that their adoptive daughter had just been born making him a older father of two very young children. In terms of older parenthood (for both men and women), hope outweighed any risks or concerns.

Not too long ago, older adults at the playground were mostly grandparents; more recently, they are just as likely to be mommy and daddy. Clearly, older motherhood is here to stay, but the media has been unclear whether this is good thing or not. I think this ambiguity stems from the conflicts experienced by the infertility community that makes older motherhood possible in the first place. These internal conflicts are especially important because the infertility community provides the majority of the information about aging and infertility to the media. Technologies emerged rapidly ahead of social considerations. As demand grew, the infertility field tried to keep up and accommodate as many patients as possible. On one hand, fertility experts appreciated the added patient load and

accompanying revenue. On the other hand, they also understood the risks of older parenthood placing them in a quagmire: Is it their responsibility to deny treatment even if the patient understands all the risks or should they give treatment to anyone wanting it? This uncertainly trickled down to others more peripherally involved with infertility, such as ethicists, mental health clinicians, and patient advocates resulting in further varied opinions. Experts determined how much information was shared about age and infertility, exerting greater social control over older motherhood. No one wanted to admit that women, and to a lesser degree men, were limited by biology. Furthermore, the fertility community did not want to imply a finality in terms of women's procreative capacity since this would only result in fewer people seeking fertility care. Overall, articles in the media about age and fertility did not offer any facts that could enable women to make better choices.

4.4 The New Infertile

For most of the 1960s, 1970s, and 1980s, articles about infertility focused solely on married heterosexual couples that were also predominately white and middle-class. Specific groups that adhered to the standard life course and heteronormative behaviors were most likely to seek medical treatments for infertility. Describing the essentialist perspective in that procreation is a fixed trait, Anna Quindlen wrote in a major cover story for *Life*,

Once upon a time, there was a man and a woman. They met, fell in love, and married. And very soon they decided to have a family. They made love, and within a year, their first child was born. That one was very soon followed by others. And they lived happily ever after. This is a fairy tale. For millions of people in America in 1987, it is as patently fantastic as *Sleeping Beauty*. (#3053, *Life*, 1987)

As infertility treatments grew in both acceptance and availability, the number of people interested and able to seek fertility care plateaued (CDC 2010; Harwood 2007). As a result, the infertility field had to appeal to new patients who would also benefit from infertility services but may not fit the traditional definition of infertility. Author of *Barren in the Promised Land: Childless Americans and the Pursuit of*

Happiness, May (1995: 216) explains, “Marriage has become desirable, but not necessarily a required precondition for parenthood.” Although the infertility field largely catered to the procreative needs of married couples, the importance of this heteronormative family structure expanded to others.

By the start of the twenty-first century, media interest also grew regarding other groups interested in family building. As births among unwed 30 to 40-year-olds rose 20 percent from 1991 to 2006 (CDC 2010), the media paid more attention to this new trend of single “motherhood by choice.” For example, 44-year-old professional journalist Louise Sloan who realized she had only two choices: accept she might never become a mom or consider single motherhood wrote the book *Knock Yourself Up: No Man? No Problem: A Tell-All Guide to Becoming Pregnant* (2007) (#5157, *Redbook*, 2007; #5163, *Newsweek*, 2007). Sloan used sperm from someone whom she called “Unknown Donor No. 2,” a tall, handsome green-eyed actor, to inseminate herself in the attic of her “very conservative” family’s summer home in Maine (#5163, *Newsweek*, 2007). Sloan expected to feel lonely and sad without partner to share parenthood with, but she told *Redbook* (#5157 2007) from the moment her son was born, all she has experienced is great joy. She advised other women,

Don’t allow yourself to get isolated with your kid. The single moms I met really make an effort to get out there and be social. I think that’s a lesson they learn faster simply because they don’t have partners. (#5157, *Redbook*, 2007)

Sloan also said through her research, she found single moms by choice wanted to be mothers so much that the hard times really did not seem so hard to them.

A few years later, Rachel Lehmann-Haupt, New York socialite and daughter of award-winning journalist, critic and novelist Christopher Lehmann-Haupt, wrote *In Her Own Sweet Time: Unexpected Adventures in Finding, Love, Commitment, and Motherhood* (2010) in which she talked to women who became mothers in every conceivable way, weaving in stories of her own journey toward motherhood. She told *Redbook* (#5206 2009) about the importance of community for both single moms and older moms. In fact, Lehmann-Haupt said there are studies showing friendship was more important than

family for health; since single moms did not have a “natural family structure,” they created communities with other moms. She also said the stigma of being a single mom or an older mom today was lessening, but difficulties still continued. She recommended to *Redbook* (#5206, 2009) readers that single motherhood is such an individual decision dependent on one’s values, suggesting individual choice.

In the 1990s and 2000s, same-sex couples also appeared in media portrayals of fertility and family-building. In fact, May (1995:216) stated that there was a “virtual baby boom in the lesbian and gay community.” Journalists promoted the same heteronormative desire to have children among gays and lesbians by including them in stories of family-building. This “traditional” ideology of family included the “social construction of infertility as a problem requiring high technology medical treatments to produce a biologically related child” (Miall 1996:310). One lesbian, Jane, explained to *People* (#5050, 2004), “Wanting a child is a gut thing, a longing from somewhere deep in my soul.” As a fertile woman, she had biology on her side, but as a lesbian, she had to do a little creative planning in order to get pregnant. Lesbian celebrities such as Melissa Etheridge, Jody Foster, and Rosie O’Donnell publically shared their stories through the media as well (#5002, *People*, 2000; #5060, *People*, 2004). Magazines also contained stories of “regular” unconventional parents mentioned in the media. One lawyer specializing in LGBT family law explained,

Gays and lesbians are coming forward, feeling comfortable and excited about creating families, and expecting their doctors to provide the same medical assistance they would provide to a man and a woman. It’s new and exciting chapter in our movement. (#5112, *Advocate*, 2005)

Just how many people were “breaking this mold” remained unclear since no statistics were included, but many journalists reported it as an increasing trend nonetheless.

While critics of gay and lesbian parenthood existed, the majority of media stories about gay and lesbian family building were positive and reinforced heteronormativity. For example, lesbian moms, Meg Gaines and Margaret Mooney, use used sperm from a couple of gay friends (who also both had partners) to create two children (each giving birth to one) who call six different grown-ups mom and dad

(#5226, *People*, 2010). Similarly, Monica Hallinan and Michele Gan used a close friend as their donor. While he signed away his parental rights, Hallinan and Gan still kept him informed of important decisions regarding their daughter. They also felt very lucky to have this type of relationship. Another couple in the same article, Audrey Koh and Gaeta Bell used Bell's brother's sperm to inseminate Koh. They had two sons together who maintain a close relationship with Bell's brother (#5002, *People*, 2000). Overall, these positive accounts promoted confidence to seek out fertility services for themselves. However, any details as to the complexity--physically, emotionally, and financially--of assisted family building were conveniently omitted from these media accounts, making the process seem easier than it was. In her book *The Infertility Treadmill*, Harwood (2007) states that about 20 percent of fertility clinics turn away unmarried women, including lesbians. While procreative technologies were technically available to lesbians and same-sex couples, their experiences remained very different from traditional heterosexual couples. (More about this in Chapter 6.)

In the late 2000s, Lindsay Nohr Beck, daughter of a wealthy California family, founded Fertile Hope, a non-profit organization linking young people diagnosed with cancer with doctors who would help preserve their fertility so they could go on to have children later. Again, this expanded fertility services to a new population. Beck was one of the initial beneficiaries as she had three children after surviving cancer twice in her 20s. As a result, the fertility field became very interested in young cancer patients as potential new infertility patients. This new interest quickly made its way to the media. Even though cancer among young people occurred very rarely, at least six different articles appeared in the media solely about this topic between 2004 and 2010 (#5217, *Time*, 2010; #5220, *Newsweek*, 2010; #5185, *People*, 2009; #5181, *Newsweek*, 2008; #5078B, *Good Housekeeping*, 2006; #5078, *Time*, 2004). Journalists reported as more young adults became cancer survivors, concerns about family building increased. In fact, out of the 125,000 people under 45 diagnosed with cancer each year, roughly half received treatments that would affect their fertility (#5220, *Newsweek*, 2010). Until recently, doctors

shared little information with patients about cancer and infertility, and few options for preserving fertility existed. Encouraged by Beck, fertility specialists recognized this and used the media to promote their services to help young cancer patients preserve their fertility before their life-saving cancer treatments. In the 2000s, a new field known as onco-fertility emerged and was discussed regularly throughout mainstream media, especially news magazines (#5140, *Newsweek*, 2007; #5220, *Newsweek*, 2010. #5181, *Newsweek*, 2008).

Most commonly, magazines included dramatic, feel-good stories about innocent victims who were forced to lose their fertility through no fault of their own. Unlike my previous discussion about the causes of infertility, cancer survivors were not portrayed as “deserving” their infertility. For example, in 2004, a woman who survived cancer when she was 25 became the first mother to give birth to a baby through ovarian tissue that was removed earlier, frozen, and transplanted back eight years later allowing her to ovulate (#5078, *Time*, 2004). By 2010, 15 babies had been born from frozen ovarian tissue taken from cancer patients (#5220, *Newsweek*, 2010). After a storybook wedding in 2002, Julie Atteritano, age 25, was diagnosed with ovarian cancer. Before her chemotherapy started, she decided to freeze embryos created from her eggs and her new husband’s sperm. Two years later, she had the embryos “transferred” to her uterus and gave birth to twins (#5078B, *Good Housekeeping*, 2006).

Because their children were too young to make their own decisions about future fertility, parents of teens with cancer were targeted by these articles as well. Journalists appealed to parents’ desires to eventually become grandparents and marketed fertility preservation directly to them. At age 16, Chris Biblis underwent chemotherapy for leukemia. He said that marriage and children were the last thing on his mind, but his parents insisted he freeze his sperm. Driving with his dad to an Atlanta sperm bank, he recalled “They were the quietest car trips ever made.” At age 39, he became the father of a new baby (#5185, *People*, 2009). Parents of another teen-aged girl whose doctor suspected cancer were devastated at the chance any further testing would cause their daughter to be infertile: her mother

explained, “Having given birth to my kids is such a large part of who I am, and I didn’t want my daughter to miss out on the experience of childbearing,” reinforcing the saliency of motherhood within women’s identities. Parents of young cancer patients defended this motivation to think ahead to their child’s parenthood in the midst of a life-threatening situation, “We wanted to embrace the possibility that they might survive. I thought wow—if they actually think he’s going to be around for 20 years, this is a good thing” (#5220, *Newsweek*, 2010).

By bringing attention to new groups that could benefit from fertility services, the fertility industry was successful in its goal to recruit new patients. However, no statistics existed as to how many people actually responded and sought fertility care because of this expanded media coverage. Moreover, the infertility community did not actively address any other issues important to these groups, such as same-sex marriage, adoption reform, or cancer prevention, indicating this was purely an economic decision compared to any type of political or social stance. It will be interesting to see which groups the fertility industry targets next.

4.5 The Role of Men

Past research suggests that men and women differ in their experiences with infertility (Thompson 2003; Deveraux and Hammerman 1998). However, journalists paid little attention to men’s perspectives of infertility in the articles analyzed in this study. Overall, 38 articles addressing men’s infertility appeared in a variety of magazines throughout, with numbers increasing in the 1990s and 2000s (See Table 4.3). Appealing to traditional gender roles that women were responsible for fertility, articles about men’s infertility also targeted women and appeared equally in women’s magazines, like *Redbook* and *Good Housekeeping*. Additionally, half of the articles about men’s infertility were written by women, again emphasizing women’s roles in promoting fertility. Previous research also states most

men gain their information about procreation from women (Malik and Coulson 2007; Weissman et al. 2000).

Table 4.3: Men's Infertility in the Media

	Number of Articles about Men's Infertility Appearing in General Magazines	Number of Articles about Men's Infertility Appearing in Women's Magazines	Number of Articles about Men's Infertility Appearing in Men's Magazines	TOTALS
1960s	1	0	0	1
1970s	2	0	0	2
1980s	2	0	0	2
1990s	12	5	4	20
2000s	10	1	1	12
TOTAL	27	6	5	38

Men are often uninterested in infertility due to the connections they place between fatherhood, manhood, and sexual ability (Earle and Letherby 2003) Only two articles (#1031, *Today's Health*, 1968; #2006, *Today's Health*, 1972) stressed that fertility was not related to virility in men. In an interview with *Today's Health* (#2006, 1972), Dr. Jacob Epstein of the Margaret Sanger Clinic explained,

Unfortunately, some men confuse the two and consider a diagnosis of sterility a blow to their manhood. A potent, sexually active male may not have normal semen—while another man with a low sex drive can be extraordinarily fertile. (#2006, *Today's Health*, 1972)

However, the majority of articles analyzed solidified the connection between sperm and manhood. In fact, the same *Today's Health* (#1031, 1968) discussed above reported that Dr. Carl G. Hartman concluded through his research, "A man may be identified by his semen." Since sperm comes in all shapes and sizes with over 60 different kinds, Dr. John McLeod of Cornell University took it a step further by saying, "A man's semen can be as individual as one's fingerprints" (#2006, *Today's Health*, 1972). In her book *Sperm Counts: Overcome by Man's Most Precious Fluid*, Moore (2008) states that defining sperm depends heavily on who defines it and under what social circumstances.

Articles further highlighted the importance of sperm, including its quantity and quality. For example, men were told they can produce up to 500 million sperm and were shown to be elated upon learning they have “good” sperm, further stressing sperm’s role in virility. In terms of evaluating sperm for infertility, men were assured that most come away from this appointment “rejoicing.” One article in *People* (#5095, 2005) described,

Will—who was depressed about turning 50—called the lab and was told he had the highest-powered sperm they had ever seen. He grinned ear to ear. How often does a man get to find out he’s superhuman? (#5095, *People*, 2005)

Even celebrity singer Robin Thicke appeared under the headline “Robin Thicke is ‘So Proud’ of His Super Sperm” (#5229, *People*, 2010). Potent American sperm was seen to be so highly valued that online catalogs offered the world this “super sperm”: “Select the sperm, pay a fee, and it’s on its way.” (#4054, *Newsweek*, 1998). Through these depictions, men were clearly masculinized through their identification with their sperm despite any rhetoric otherwise. During her interviews with infertility patients, Thompson (2005) also notes similar representations of virility during clinical sperm analyses.

Not surprisingly, when seeking information about infertility, men wanted to know specifically about their sperm and how it influenced their manhood. For example, in a question-and-answer piece published in the men’s magazine *Esquire* (#5050, 2003), men wondered if the size of their testicles affected sperm quality. Emphasizing virility (of course, no man would have “small” testicles), Dr. Robert L. Barbieri responded bluntly, “For 90 percent of the population, there isn’t much difference in sperm count among those with medium, large, and extra-large.” Similarly, men asked whether excessive masturbation limited the ability to get a woman pregnant (#5099, *Esquire*, 2005). Medical experts assured men that masturbation was fine; however, a few days of abstinence before trying to get a woman pregnant might be helpful. In the woman’s magazine *Redbook* (#5107, 2005), men were concerned about the volume of semen as a sign of fertility. Ian Kerner, PhD, author of “He Comes Next” (#5107, *Redbook*, 2005) explained that men’s infertility was due to a low sperm count—having almost

nothing to do with the quantity of fluid. Healthy guys produce anywhere from a half of teaspoon to one teaspoon of semen, but a man with a high volume of ejaculate may have a low sperm count and vice versa (#5107, *Redbook*, 2005).

Perhaps to scare men into taking a more active role in the infertility process, articles in the 1990s instigated fear that men's sperm counts were decreasing inexplicably. Several articles indicated that sperm counts were down by as much as a third over the last 20 years (#4047, *Time*, 1995; #4058, *Futurist*, 1999). One article even announced "What's Wrong with Our Sperm?" (#4052, *Time*, 1996). Some guessed environmental estrogens affected the sperm –again shifting the blame to women and their hormones (#4048, *Macleans*, 1996; #4053, *Psychology Today*, 1997). Other journalists said sperm counts fluctuated due to temperature and climate changes (#4051, *Jet*, 1997). On average, men appeared to be making less sperm. Several articles described sperm that swim poorly, take on a funny shape, fail to reach concentrations higher than 15 million per milliliter or otherwise struggle to impregnate an egg. Gary Cherr, a reproductive toxicologist at the University of California, Davis explained, "Even the most fertile men, there are quality issues" (#4048, *Macleans*, 1996). By the late 2000s, media typically emasculated men by describing sperm as "underachieving."

Infertility was usually defined as a woman's problem (Rothman, 1991; Corea 1985; Scritchfield 2009). Not surprisingly, journalists also assumed that infertility was primarily a woman's issue. For example, one doctor interviewed by George Corner of *Time* in 1960 (#1006) explained,

One of the greatest difficulties in treating childless couples is not the medical but just the male pride. Many men refuse to believe that they may be to blame and will not submit to examination or treatment. The publishers of *Human Fertility and Problems of the Male* were doing a humming business in mail orders from laymen. But not one writer admitted that he wanted to book for himself. It was always for a cousin, or a brother or a friend who needed it. (#1006, *Time*, 1960)

To pique their interest in this seemingly feminine topic as identified by Thompson (2005), other journalists emphasized masculinity within procreation. In his article "The Sperm Scrimmager," Adam Fisher compared fertilization by sperm to a football game. He described fertilization as many players all

working together for a common goal in which the whole team wins. Moreover, he personified sperm by describing there is the tackle, the blocker, and the quarterback who eventually scores the proverbial “touchdown” (#4049, *Esquire*, 1997). As for the *in vitro* fertilization process,

Imagine the embryologist as the general manager of a professional football game. In this case, he will start with the defense—also known as eggs. Out of the 20 or so recruits, a few will be cut immediately. Too mature, not mature enough, lacking a chromosome or two, you know the drill. Not it’s time to call up all those offensive sperm cells that have been waiting patiently on the bench. In a sort of ‘open tryout’ the whole lot of them will take to the field, also known as a petri dish, and enter a fierce skirmish with the defensive eggs. Most will be eliminated early on, but a few lucky players will rise to the occasion. If the number of sperm cells proves inadequate, however, then open tryouts are cancelled and a single sperm will be chose as an early draft pick. (#5224, *McLeans*, 2010)

The article entitled. “...And May the Best Sperm Win” (#4055, Redbook, 1998) encouraged masculine competition by describing a “winning “sperm as simply being “good looking and strong.” Further promoting masculinity, journalists told men that their sperm was responsible for producing male heirs. A recent study found that there are more boys than girls “pumped out during the first year of marriage, when sex is hot, than ever after” due to the likelihood that boy-making Y-chromosomes just don’t have the staying power of those that make girls (#4056, *Esquire*, 1998). Drawing on Butler and Fausto-Sterling, Thompson (2005:118) states that “performing masculinity” is common when men are confronted with infertility threatening the “heteronormative biomedical” progression from “sexuality to reproduction to parenthood.”

Researchers Greil (1991)and LaRossa (2011) found that men usually experience infertility and childlessness through their wives. Men were expected to support their wives in these situations. In my analysis, the primary role of men in infertility was also to support their wives through the infertility process. In their research, Deveraux and Hammerman (1998) suggested that men are largely seen as the protectors of their family—strong, fearless, and heroic, even when it comes to infertility. Basically, a man’s primary job was running “interference” for their wives every once in a while, sometimes having to tell friends to “shut the hell up” when they’ ask her how it’s going. Most often, however, it involved a

quiet aside after the fact to make her feel more comfortable and secure. Julia McKinnel of *McLeans* (#5224, 2010) explained that men should expect their wives would not want to be around other children: It is just too painful. In terms of treatments, men should just “put up” with the treatments, including giving her shots of fertility drugs.

Although the culture of fatherhood encouraged more involvement by men (LaRossa 1988), men varied in their participation with regard to infertility. Journalists assured men regardless of the cause of the infertility, the woman was treated (#1031, *Today's Health*, 1968; #2025, *Science*, 1978). When seeking fertility care from a specialist, doctors told men to attend the first appointment in order to talk briefly about radiation exposures, previous surgeries, or diseases which could contribute to infertility. Another reason men needed to go to this appointment was the confidence and security his willingness gave his wife. It let her know her husband loves her and wants to share in a mutual search for the reason of their childlessness, even if the burden is ultimately on her (#1006, *Time*, 1960; #1031, *Today's Health*, 1968). Another woman explained, “Tom [my husband] is involved as I am. He’s been my support all along. I get concerned and nervous. He is much more relaxed” (#3042, *People*, 1986). After failed attempts, women claimed they were “basket cases” while men were never described as visibly upset making it unclear how invested he was in the treatments in the first place. As a result, media portrayals of men’s roles in infertility established expectations of men being marginalized and serving as a “silent” partner rather than expressing any emotions. As sociologist Thompson (2003:16) describes, men (like women) continued to “perform gender” in the midst of infertility.

This ambivalence about men and infertility continued until the late 2000s when a couple of new high-profile books specifically targeting men experiencing infertility were published: *How to Make Love to a Plastic Cup: A Guy's Guide to the World of Infertility* (2010) and *What to Expect When She's Not Expecting: How to Support Your Wife, Save Your Marriage and Conquer Infertility* (2010) by Los Angeles comedy writer (and son of famed singer Neil Sedaka) Mark Sedaka. An increased focus on men’s

infertility attempted to enhance men's roles in the infertility process. Both authors appeared on daytime television, including *The View* and *The Today Show*, talking openly about their experiences with infertility albeit with a humorous twist. Rather than reaching men directly, the authors appeared on television shows targeting women who were assumed to relay this information to their partners. In an interview with *McLeans* (#5224, 2010), Sedaka said, "More often than not, we poor schlubs are left to fend for ourselves—not quite sure when to chime in, when to keep quiet, when to take action, and when to lay low." Overall, psychologists Deveraux and Hammerman (1998) stated that it is common to portray the standard masculine response to infertility as unemotional. Additionally, Sedaka characterized men as clueless in terms of fertility. Sedaka also warned men about

A little thing called procreating sex. In other words, the planned mandatory acts of copulation that will be required as your wife charts her monthly cycle. Expect all spontaneity to disappear from your sex life . (#5224, *McLeans*, 2010).

To placate husbands during infertility, Sedaka also directly advised women (and assumed women would be reading his book as well) to have sex when it does not fit the fertility calendar, force a conversation that doesn't revolve around fertility treatments, hold hands, pick your battles, and have sex when you don't really want to but he does (#5119, *McLeans*, 2006). As seen here, journalists commonly separated sex from procreation deeming procreative sex as more "work" than "fun." Despite the media attention and strong reviews, neither book sold well nor entered Amazon.com's best-sellers ranking for infertility books suggesting that men might really not be too interested in the topic. Consistent with other self-help books, these books experienced very short shelf-lives (Simonds 1992).

Although women's study professor Thompson (2005) suggested men are negatively impacted by infertility, media representations in this study did not include many details about how men are diagnosed or treated. Women were still the primary focus for infertility throughout media representations. Personal accounts expressed by men via media interviews varied greatly. Despite men's desire to be involved, many articles still showed men as alienated and distant. According to the

article “Men without Children” published in *People* in 1986 (#3042), men talked about their wives being “too nervous” and needing them for support. Since pregnancy happens within a woman’s body, men felt “out of the loop” and if something went wrong, “not entirely sure what it means” (#5019, *Esquire*, 2001). One man explained “Infertility affected [my wife] more than me, because I saw fatherhood as a separate issue. Infertility denied her not just a family but a career as well” (#3024, *People*, 1984), and another confided “It’s always tougher for the wife” (#2006, *Time*, 1972). Social research (Harwood 2007; Greil 1991; Greil 2009) consistently found that men are not as devastated by infertility leaving women to cope with the diagnoses, treatments, and outcomes. Although men experience infertility at similar rates as women, their experiences differ greatly compared to women, largely based on gendered expectations.

4.6 Race and Infertility

Consistent with Roberts’ (1997) descriptions of racial disparity in procreative health, very little mention of race and infertility appeared in popular media until the 1990s. Beginning in the 1990s, journalists paid attention towards African Americans and infertility only through a dozen or so articles published in magazines specifically targeting this group, such as *Jet*, *Ebony*, and *Essence*. No other medical representations analyzed for my study included any discussions of other races or ethnicities. Additionally, most of the statistics and information presented only pertained to those families who actually sought fertility care which were predominately white and middle-class. All other stories, interviews and photographs regarding infertility in “mainstream” magazines included only white families and physicians. This lack of diversity in the media mirrored research findings that infertility was mostly a white, middle class phenomenon (Thompson 2005). Scritchfield (2009) stated that these race and class differences suggest that the majority of concern about infertility focuses almost exclusively on white couples, especially since birth rates have fallen below replacement. Harwood (2007:13) hypothesized

that “race and ethnicity, to the extent that they serve as a proxy for socioeconomic status, may now distinguish those who can afford “higher end” or specialized services.” Given their low probability of utilizing fertility services, perhaps, non-whites appealed less to both the fertility field and hence, the media.

In African American publications, journalists described African American women as very fertile in general. For example, African American fertility included “getting pregnant seems as natural as exhaling, especially for Black women”; “Infertility isn’t our problem”; and “it’s White women’s mess. At least that was the myth” (#5058, *Essence*, 2004). Monique Burns, author of “A Sexual Time Bomb: The Declining Fertility Rate of the Black Middle Class” (#4029, *Ebony*, 1995) said, “When it comes to making babies, nobody does it better than Black folks.” She also stated 19 percent of all African American teenagers aged 15-19 become pregnant each year, compared to only 8 percent of White teens. According to this article, less known—and just as critical for the future of African American Americans—is the “baby bust” which affects African American couples aged 25-44 at a time when they have the maturity and financial mean to establish and nurture strong families. In an interview with *Ebony* (#4029, 1995), Monica Matthews stated, “I kept asking myself why is it that crack mothers can have babies and we—who could provide a good home for a child—can’t?” Crystal Lewis, another infertility patient said, “Emotionally, I felt embarrassed and inadequate because I couldn’t give my husband a child. Being African American, I felt we’re fruitful people and it was shameful to have this problem” (#4038, *Essence*, 1994).

As reported in *Essence* (#5058, 2004), the Centers for Disease Control and Prevention (2010) and the National Center for Health Statistics observed no difference between the fertility rates of white or African American women aged 25-44. However, African American couples often did not get diagnosed and treated for infertility, which I will discuss again in Chapter 6. Dr. O’Delle Owens, the first African American board-certified fertility specialist explained, “White couples tend to seek treatment in greater

numbers than African Americans. For White couples, infertility is often the first road block they've faced—while African Americans are distracted by such primary roadblocks as food, shelter, and clothing" (#4029, *Ebony*, 1995). Although the "official" reasons for infertility among African Americans and whites were similar, for many families featured in these articles, the cause of their infertility stemmed from pelvic inflammatory disease. Pelvic inflammatory disease (PID) is often caused by a previous sexually transmitted infection perpetuating the myth that women, especially African American women, were hypersexual and responsible for harming their fertility.

African American women interviewed in these articles exhibited an "overwhelming desire to experience motherhood" often "causing them to want to die"—again suggesting that infertility was a fate worse than death (#5113, *Ebony*, 2005; #5202, *Essence*, 2009). One article entitled "Baby Hunger" (#5058, *Essence*, 2004) quoted actress Valerie Pettiford, "I didn't only want to play a mom on TV. I needed to be one" However, African American women did not become pregnant on their own had a much higher chance of not becoming mothers at all compared to white women in the same position. Money was a major factor prohibiting fertility treatments, and Tracy Robinson reported in *Ebony* (#5113, 2005) that costs could get as high as \$100,000 for medical expenses, much higher than average costs depicted in other articles. Because limited options existed for African American women experiencing infertility, journalist Linda Villarosa (#5008, *Essence*, 2004) told women "the most important thing you can do is to be patient." Ty Canady, author of *What to Expect When You're Not Expecting* (2003) and founder of Atlanta's Hannah's Prayer, a support group for infertility, said "When I stopped focusing on the desire to have a child and started looking at things I could control, that's when it happened. (#5008, *Essence*, 2004). Journalists did not convey this message of patience to white audiences, the primary target audience for fertility clinics. Instead, articles encouraged white women to seek medical care as quickly as possible. Ironically, even though every few African Americans had access to appropriate fertility care, *Essence* (#5201, 2009) rated getting help having a baby as one of the "Best

Advances for Us in Reproductive Health” along with the Human Papilloma Virus (HPV) vaccine and Plan B “morning after pill” (#5201, 2009).

Journalists also described many African American couples who did not seek fertility treatments or were unsuccessful and remained childless as concentrating on nieces and nephews or “devoting time to Black children through community organizations” (#4038, *Essence*, 1994). Adoption was also promoted as a viable option within the African American community, especially since 45,000 to 60,000 of the 75,000 to 100,000 children available for adoption in the United States were African American. Journalists indicated that African American couples in particular provided supportive and stable life while “contributing to the success future generations of African Americans” and provided the ingredient “missing from far too many Black homes these days, namely baby love” (#4029, *Ebony*, 1995). Martha Southgate emphasized in *Essence* (#4038, 1994) that infertile African Americans needed to consider adoption seriously since so many African American children were waiting for adoptive homes. On the other hand, journalists did not discuss adoption in the context of infertility in other mainstream magazines. For predominately white, middle class audiences, the preferred family building option was procreative technologies.

Journalists for African American magazines also assumed a negative attitude towards infertility among African American men. Because fertility and potency were linked so strongly, African American men typically balked at being tested and treated for sperm abnormalities that keep couples from getting pregnant (#4029, *Ebony*, 1995). African American men did not want to talk about infertility: “I knew Jeffery had always wanted children and I was trying to get him to talk about it, but he wouldn’t (#5049, *Jet*, 2003). Dr. Chiledum Ahaghotu who treated almost exclusively African American men assured readers in *Ebony* (#5114, 2005) that medical advances give 90 percent of infertile men a good chance to conceive their own genetic child:

I have not had issues related to hesitancy of men about moving forward after they have been diagnosed as being infertile. We know so much more about male infertility than we did 10 years ago that, once presented with the facts, men take the necessary steps to increase their chance of reproduction. (#5114, *Ebony*, 2005)

Despite assumed racial differences, African American men experienced infertility similarly as I discussed in the aforementioned section about the role of men. However, it is important to note that while about two-thirds of journalists reporting on infertility were women, all the articles targeting African Americans were written by women. Perhaps this indicated that gendered expectations regarding African American men are more deeply seated, although my sample size is too small to ascertain for sure.

Although these publications tried to provide information about infertility to African American audiences, Johnson and Smith (2002) conclude that even when access to health care and health information is provided, many African Americans tend to underutilize it. Perhaps the rest of the infertility community assumed this as well explaining why African American's were not specifically targeted in media presentations about infertility. Likewise, whether African American's lack of interest in infertility was a reality or a just a reflection of embedded racial assumptions was unclear in my study.

4.7 The Emotional Impact and Identity

In the 1960s and early 1970s, articles about infertility focused primarily on the physical impact of infertility as opposed to the emotional impact. Many at this time believed since infertility was not life-threatening, women should react calmly and not hesitate to discuss their medical history and experiences with others. However, starting in the 1970s, professionals told journalists that they realized "something psychologically raving about infertility, something that brings out extreme behavior in many patients" (#2025, *Science*, 1978). Sociologist Franklin (1997) stated that coping with infertility is the most emotional demanding aspect of the entire experience. Likewise, social science researcher Pheffer (1987) explained that infertility often results in desperation. Consequently, in these initial articles about the psychological aspects of infertility, fertility specialists shared stories ranging from women adamantly

refusing to publically use the word “infertility” to suicide attempts—all of which they defined as the “emotional impact” of infertility. Some fertility specialists questioned the motivation of women with infertility stating, “There are extreme cases in which women want to primarily to become pregnant. For these women, the state of being barren rather than the state of being childless is devastating” (#2025, *Science*, 1978). This article in *Science* (#2025, 1978), targeting more professional audiences, suggested that women were incapable of making rational decisions about procreation without the help of professionals perpetuating the need for fertility specialists to maintain control which I will discuss in more detail in the next chapter.

Mainstream magazines described the emotional side of infertility mostly through personal accounts. Portrayals of desperation were most common within the media. One woman interviewed in *Time* (2006, 1972) explained,

It’s been a long road. At first, I did not feel desperate, but I was getting worried. I put off seeing a doctor for fear he might tell me something was seriously wrong. You begin living from period to period. Each time, as the day nears, your hopes rise, your expectations grows. And then, when it happens, the letdown comes and each succeeding month it’s worse. It’s hard to go on. (#2006, *Time*, 1972)

Another article specifically focusing on psychology cited an infertile woman named Patricia,

Each month was another cycle of stress, depression, and desperation. Do the meds, do the drugs, do the blood tests, have the ultrasound, have wait of the test results, meds, do the drugs...Then you get your period, and it is like a death. But you only have a few hours to grieve before you have to start the pills and needles and the tests again. (#5090, *Psychology Today*, 2005)

However, in the Opinions section of *Time* (#4034, 1998) Elaine H. Menard of Exeter, New Hampshire wrote, “For those who have never experienced infertility or the intense desire for a child, it is easy to pigeonhole as obsessive or desperate those who have” (#4034, *Time*, 1998). In my study, personal accounts overwhelming portrayed women experiencing infertility as desperate and unfulfilled, willing to do anything to have a baby—a common narrative based on traditional gender roles that women were most involved with fertility.

Because no one expects to face infertility, women struggled with their new role as “infertile.” As a result, infertility could be identity-altering as women expressed their roles (Mathieson and Stam 2008). In *The Infertility Treadmill*, Harwood (2007) stated that while infertility is considered a personal crisis, infertility does not become the master status as described by Goffman (1963). However, I found that infertility could be highly salient within depictions of women experiencing infertility in my analysis. Constructing the infertility identity was highly individualized and often dependent on one’s specific social situation which I will discuss next.

Defining infertility often involves negotiations with one’s social network. Because of the specific target audience for fertility care, journalists assumed that most cases of infertility involved otherwise happily married heterosexual couples. As a result, journalists primarily explained how infertility affected marriages. Both men and women reported that disappointments related to infertility ruined their marriages. Psychologists Lara Deveraux and Ann Hammerman (1998) stated that with the loss of infertility comes a whole host of other losses. In an interview with *Time* (#3026, 1984), Cleveland businessman James Popela, age 36, explained,

It is a long hard road that leads a couple to the *in vitro* fertilization clinic, and the journey has been known to rock the soundest marriages. If you want to illustrate your story on infertility, take a picture of a couple and tear it in half.

Karril and Tony Kornheiser also reported,

The strain on our marriage was deep. We even talked about a divorce so one of us could go out and have children with someone else. The strain on our marriage was the worst when, each month, we’d try—and fail—to conceive a child. (#3024, *People*, 1984)

Because media portrayals reinforced that a couple without children is not a valid family, couples often forgot about the family roles they already had—with each other—when trying to have a baby.

Some couples turned to relationship advice columns for help repairing their marriages. They reported trying to get pregnant was driving a wedge between them emotionally and sexually, emphasizing that procreative sex was not enjoyable. Experts suggested working on communication.

They advised men to keep their emotions in check to prevent additional stress and disappointment for their wives, similar to what I discussed previously about the role of men in infertility in that infertility was predominately a “woman’s problem.” Also, couples needed to find ways to connect sexually again like they did when they were dating or first fell in love, again separating procreative sex from other more “enjoyable” non-procreative sex (#5177, *Redbook*, 2008; #5205, *Redbook*, 2009). Betty Orlandino, a mental health counselor in Oak Park, Illinois who specialized in infertility responded,

It is not just the pain and indignity of the medical tests and treatment. Infertility rips at the core of a couple’s relationship; it affects sexuality, self-image, and self-esteem. It stalls careers, devastates savings, and damages associations with friends and family. (#3026, *Time*, 1984)

Through her research, Harwood (2007) explains that many women view infertility as the ultimate failure, bringing down everything with it and placing even more personal blame on themselves.

For some couples struggling with infertility, journalists reported that infertility could have the opposite effect on marriages. Despite infertility, some marriages adjusted. Bud Peters, in an interview with *Life* (#3053, 1987), explained, “I think it takes a lot more life to go through what we’ve gone through all these years than it does to hop in the sack.” For Debbie and Tom Newell, infertility brought them closer (#3042, *People*, 1986). Even Tony and Karril Kornheiser admitted in the end, “Infertility drives you together. We shared the pain as we would walk through a zoo and see all the families” (#3024, *People*, 1984). Studies have long supported that confronting crises together can bind partners together (Greil 1991). Previous studies also found that the impact of infertility on marital relationships depends on the sociocultural context (Aghanwa et al. 1999). However, my analysis found that a marriage being strengthened by infertility was a much rarer interpretation in the media compared to the contrary. In either case, women were found to be not only responsible for their infertility but also its effect on their marriages whether it be positive or negative.

Articles showed the impact on other relationships as well. Greil (2009) stated others seen infertility is a product of processes of social definitions. When it came to infertility, journalists portrayed

a lack of closeness and emotional distance among friends and family. More specifically, women experiencing infertility no longer fit within their own families and society at large. This created a breakdown of social bonds between an individual and her community or a mismatch between personal and group standards, resulting in a fragmentation of social identity, similar to how Emile Durkheim (2007) describes the concept of “anomie.” Holidays were especially hard, and articles portrayed women as not wanting to be around people who are talking about children and pregnancy. Strangers would say clichés like, “Don’t you know how? I’ll show you” as if infertility was purely a sexual problem. Alternatively, many friends and family assumed if it was not physical than infertility had to be all in one’s head. Highlighting the extreme lengths so families are willing to go to avoid the detrimental social effects of infertility, the Kornheisers could not bear it any longer so they moved from New York to Washington to withdraw: “We just didn’t go to parties, so our social circle narrowed. We did it voluntarily, but we felt ostracized” (#3024, *People*, 1984). Journalist consistently portrayed women as not only responsible for their own infertility but also responsible for doing whatever it took to effectively cope and minimize the negative effects on themselves and their families.

Through the media, friends and family members of people experiencing infertility received advice as well. Barbara Collura, executive director of RESOLVE, the National Infertility Association, explained people should just be prepared to listen and not feel compelled to try to fix things by saying things like “Have you tried IVF/Acupuncture/headstands?” or “Just relax and it will happen” (#5214, *Redbook*, 2010). “There are so many myths about infertility—relaxing, drinking coffee, meditation, a so on,” said Kristin Foristall, age 34, who used *in vitro* fertilization to have her daughter (#5214, *Redbook*, 2010). Foristall continued, “Sorry that none of that fixed my problem. Science did!” Reducing infertility to anecdotal comments minimized the infertility experience. Lifestyle issues were once again attributed to causing infertility as discussed earlier in this chapter. Leading to many misconceptions, especially

among friends and family with already limited knowledge about infertility, accurate information about infertility was scarce.

Sharing pregnancy news was also tricky. Journalists cautioned readers not to make assumptions about how infertile women would react. In an interview with *Redbook* (#5215, 2010), Collura said, “Most women want to hear about other people’s baby news, in a matter-of-fact way and early enough so they are not the last to know.” While many emotions may be felt, Collura assured readers that happiness is among them (#5214, *Redbook*, 2010; #5215, *Redbook*, 2010). If people hesitated to talk about their pregnancy, the infertile might feel like they are “pitying you and they are avoiding telling you things. When they do that, it makes it that much harder” (#5208, *Washington Post Magazine*, 2010). However, no alternatives as to what to say were presented. Readers received conflicting advice including not talking about pregnancies and children while at the same time not purposely ignoring these topics either.

To cope with the isolation of infertility, journalists promoted formal support groups, especially in the 1990s and 2000s. Diane D. Aronson, executive director of RESOLVE, the biggest support group for infertile couples, stated, “The most important thing in battling infertility is to become well informed and connect with others. You see others around you and they all seem to have families, it’s so hard for you” (#4038, *Essence*, 1994). Journalists also described many women who found solace and relief through support groups. Although these groups provided emotional support, the process towards resolving infertility was unpredictable making the overall goal of these support groups ambiguous. As the social landscape changed, online support became popular in the 2000s, allowing people to maintain some anonymity and avoid stigma which I will discuss in the next section. When people posted their fertility challenges online, often this prompted others to respond with similar stories. Susan Jenkins explained to Ian Shapira of the *Washington Post Magazine* (#5208, 1984), “I found a huge community of

infertile women.” However, current research shows that this type of social disconnect from online-only groups results in depression for many women experiencing infertility (Esptein et al. 2002).

While support groups, both in person and online, originally served as a mechanism to share information about infertility, unexpected social consequences occurred, including normalizing the treatment of infertility by fertility specialists and establishing the “good patient” role. Many support groups invited fertility specialists to speak at these groups or serve as “guest bloggers” online. Additionally, many clinics allowed infertility support groups to meet regularly in their clinic space or provided monetary resources in exchange for publicity. As a result, clinics controlled the information shared with patients as well as set expectations that were in accordance with their own clinic’s policies and environment. In fact, many of these infertility support groups established “rules,” such as not mentioning specific clinic or doctor names.

Infertility support groups were also more socially complicated than most journalists portrayed, often creating a bigger divide between the “infertile” and “fertile.” Given the fluidity of the infertility experience, social networks and the dynamics of friendships changed repeatedly depending on the ultimate resolution or lack thereof. For some, comfort found through support groups—either in-person or online--was short-lived:

One day I telephoned a woman I had gotten to know, and she sounded funny. I asked her what was the matter, and she said she was pregnant. I remember feeling the rush of being thrilled for her and then immediately disappointed for myself. Our infertility had been the basis of our relationship. All of a sudden she had graduated, and I had been left behind. (#3062b, *People*, 1986)

These women initially relied on friendships with others experiencing infertility, only to become resentful. Journalists described other women who continued to meet assuming, “By operating as a group, we thought we would have more strength, more knowledge.” An alliance was formed, and they became fast friends with a common goal: a baby for each. At times people found it difficult to keep attending. Some thought of dropping out as pregnancies occurred, but they finally concluded they still

drew strength from the group. For the group that vowed “six for six,” all became parents over the next two and a half years. They described their experiences becoming parents together as rewarding: “His soul was supposed to be with us;” “Our new daughter erased all the bad memories;” “We refused to become consumed by fear;” “This was all meant to be;” “We were constantly drawing strength from the group;” and “ It makes you believe in God” (#4007, *Good Housekeeping*, 1996). This “never-give-up” type attitude stressed that patience always results in a baby in the end, a theme that will be discussed in more detail in the next chapter.

Harwood (2007) explained that in reality, the majority of people stay away from infertility support groups. Since infertility support groups necessitate the need to evoke the identity of infertility more readily, the longer they stay away from these groups, the less likely they have to identify as “infertile.” For this reason, no good options existed for those who wanted to actively address the psychosocial concerns related to infertility. Despite the inclusion of a few examples of how infertility impacts people emotionally within the media, journalists still portrayed infertility as mostly a physical concern. In fact, no fertility specialists were interviewed in any articles about the emotional side of infertility emphasizing the gaps between physical health, mental health, and social health.

4.8 Stigma

According to Erving Goffman (1967), stigma is the extreme disapproval of a person based on perceived characteristics meant to distinguish them from other members of society. Researchers often found that the infertile see their condition as stigmatized by society-at-large (Greil 1991; Hart 2002). Fertility was the natural state, and infertility was a medical phenomenon. However, many media portrayals of infertility in the 1960s indicated being childless no longer bore any social stigma (#1013, *Saturday Evening Post*, 1963; #1032, *Time*, 1969). Another article claimed the purpose of this past stigma was only to “ensure high enough fertility to overcome high mortality” (#1032, *Time*, 1969).

Journalist Martha Southgate (#4038, *Essence*, 1994) told families that they should not feel alone: “Infertility is not something that people should be ashamed of anymore.” Journalists also pointed out, if you were at a gathering with more than five couples, someone would be talking about infertility. In fact, articles suggested for married couples in their thirties, people struggling with infertility are encountered “all the time.” With over 500 separate articles between 1960 and 2000s contained in this study, no doubt that people were aware of infertility. Media also constantly asserted a lessened stigma as medicine progressed and allowed more options to treat infertility.

Still, the physical reality of infertility differed from the social reality. Although the media suggested no social stigma, the everyday experience of men and women facing infertility indicated otherwise. While sharing their personal stories, individuals experiencing infertility first-hand expressed a much different perspective that stigma regarding infertility was still present. All in all, strong social and institutional pressures stigmatized couples and single women as “abnormal” if they had no children. Women experiencing infertility feared rejection. In a personal essay written in 1960, one woman (who remained anonymous) relayed her feelings as “longing for a baby above all else in this world” (#1001, *Saturday Evening Post*, 1960). She would cry every day because her arms were empty. The only ones she could turn to were her doctor and a good friend—she did not dare tell anyone else. In the end, her doctor and good friend “rescued” her from infertility by finding a baby and giving it to her. They remained silent and private by simply ringing the doorbell and secretly leaving the baby to be found on the front stoop where no else would see to avoid embarrassment and further stigma. Once she became a mother, she said that “she finally felt part of the world again” (#1001, *Saturday Evening Post*, 1960).

While a lot changed between 1960 and 2010, the underlying feelings of being stigmatized by infertility did not. Although procreative prospects—or lack thereof—became the subject of countless news stories illustrating our nationwide infertility “crisis” (and as I discussed previously in this chapter), infertility was still not a common conversation topic on the individual level. Most women were

selective in their disclosure about infertility. With the rise of social media in the late 2000s, many people coped with infertility online as well. Men and women experiencing infertility were often bombarded by exuberant broadcasts about pregnancies and parenthood. In an article entitled “Infertility Couples Cope with Prolific Facebook Friends” (#5208, *Washington Post Magazine*, 2010), Diane Colling, age 28 from Baltimore, Maryland, said “I know it’s not meant to hurt, but you feel like you’re getting kicked every time you see these.” Before Facebook, “infertile” couples could avoid pregnant people at work and social gatherings, “limiting their exposure to triggers of bitterness or jealousy,” as I discussed in the previous section. Now, with more than a half-billion people using Facebook and other social networks, they felt trapped. One fertility clinic nurse told a reporter Ian Shapira (#5208, *Washington Post Magazine*, 2010) that more and more patients talked about “Facebook envy.” Despite the heightened media attention on infertility seen from 1960 to 2010, women still experienced invisible pain of infertility.

Since millions of women kept their baby-making challenges under wraps, *Redbook* began a campaign to end the shame and secrecy of infertility in 2010. While everyone had the right to privacy, the secrecy of infertility left countless women to cope alone, in pain, and often unformed. Barbara Collura, executive director of RESOLVE, The National Infertility Association, explained the new campaign with *Redbook*:

It’s frustrating that our society is not more open about infertility. When women dealing with infertility can communicate with others in their situation, they get through it in a much better state of mind and also share needed information about their options. However, women have responded they stayed quiet because ‘I didn’t want people to put pressure on me; I already felt like a failure.’ As a result, *Redbook* decided to join with RESOLVE to launch, “The Truth about Trying” an online video campaign to start an open conversation about infertility which is said to “strike one in eight women in the United States.” More openness about infertility also might help more families access help. We need to create a lot of noise to get more media coverage. (#5215, *Redbook*, 2010)

Given the stigma surrounding infertility, many women struggling with infertility assumed no one shared their stories, especially publically. But, was this actually the case?

In 2004, a new magazine, *Conceive*, launched to specifically target the millions of women trying to become pregnant. Each month *Conceive* contained dozens of personal stories. While *Conceive* focused on getting pregnant at any age, another new magazine, *Plum*, targeted the surging population of pregnant women 35 and over. Kim Hahn, founder of *Conceive*, said “You have brides’ magazines and then you skip right to pregnancy, children and working mothers. This is a huge untapped market” (#5085, *Newsweek*, 2004). Both of these magazines made their way to newsstands and doctor’s offices nationwide (#5085, *Newsweek*, 2004). However, despite the demand for more coverage about infertility, both of these publications went out of business within a few years. Similar to my discussion about infertility support groups, perhaps women were not willing to evoke their “infertile” identity in order to purchase and read an infertility-focused magazine in public view.

Celebrities also had a long history of telling their fertility stories in the media. In 1982, Mike Flanagan, a baseball player for the Baltimore Orioles who played in the 1979 and 1981 World Series, and his wife Kerry were the first celebrities on record (#3011, *People*, 1982) to speak publicly about their infertility story involving *in vitro* fertilization. As a result, they quickly became the poster family for infertility. Married in 1976, Kerry had a history of ectopic pregnancies so her doctors planned a complete hysterectomy when Kerry was only 28 years old. With the news of the *in vitro* fertilization success in Virginia, the Flanagans wanted to give it “one last try”—a common reason for turning to procreative technologies. In October 1981 (after the baseball season), Dr. Howard Jones “harvested” her eggs, fertilized them with Mike’s sperm, and transferred back two embryos into Kerry’s uterus. Nine months later and during they baseball season, the Flanagans welcomed a healthy baby girl. Articles reported although the Flanagans initially kept quiet about the fact their child had been conceived *in vitro*, they were not upset when the news leaked a month before the birth. Although Kerry’s mom “was upset at first—it was hard for her to understand how you could have a baby like that,” the Flanagans soon became a resource for others families seeking treatment. The Flanagans advised “childless”

couples to see a doctor “if you have any problems or doubt at all, and don’t give up hope,” another common narrative throughout this media analysis (#3011, *People*, 1982).

In 1990, Connie Chung was of the first to celebrities over 40 to admit the challenges of late motherhood. After 20 years in the news media, Chung age 44 decided to cut back on her grueling schedule to concentrate on having a baby. With this unusual candid public statement, Chung joined the growing number of American women seeking to become first-time moms after the age of 40. Chung said although she never felt pressured to procreate, she was convinced that to make this work, she needed to be very aggressive. A few years later in 1993, Chung hosted a show on her 47th birthday, she said she felt like she could be the poster child for “Career Women Who Have It All Except the Baby They Want More than Anything.” Chung’s husband Maury Povich said they were still trying to conceive; “We’ve been disappointed by not discouraged.” When asked if she wished she had started a family sooner, she replied “I’m a big should’ve, would’ve, could’ve person” (#4041, *People*, 1993).

By the 2000s, magazine articles were full of celebrity fertility success stories via procreative technologies with numbers growing each year, covering single motherhood, same-sex parenting, *in vitro* fertilization, sperm donation, egg donation, and surrogacy. Overall, over 40 different celebrity names were mentioned in the media along with several books, television shows, and movies containing infertility themes from *in vitro* fertilization to surrogacy (See Table 4.4).

Table 4.4: Celebrity Infertility Stories

	Number of Celebrity Infertility Stories
2000	1
2001	1
2002	3
2003	3
2004	8
2005	5
2006	2
2007	3
2008	6
2009	10
2010	6
TOTAL	42

With all of these public stories of infertility, how could people still feel stigmatized about infertility? As stories about infertility became more common, infertility was normalized similar to Herbert Blumer's societal reaction theory "nothing unusual is happening" (as discussed in Emerson 1973). For example, one articles, entitled "Friends and Mothers" (#5151, *Redbook*, 2007) integrated personal experiences with assisted reproductive with accounts from women who got pregnant "naturally." Of the three childhood friends, all in their late 20s or early 30s and each expecting a baby, Jody Urbas got pregnant using *in vitro* fertilization following a miscarriage and several failed attempts to get pregnant using other assisted reproductive methods; Jenny Taylor got pregnant using fertility medications barely a year after the tragic death of her newborn son from sudden infant death syndrome; and Carrie Brainerd became pregnant just as soon as she started trying (#5151, *Redbook*, 2007). Recounts of Jody giving herself injections in the behind and taking Valium and Vicodin to prepare for a surgical procedure alternated with Carrie complaining about gaining six pounds of water weight (#5151, *Redbook*, 2007).

Likewise, media stories contained unrealistic portrayals of infertility making treatments seem quick and easy:

I can't tell you now infuriated I become when I get home and turn on one of the TV talk shows and they show a starlet who's forty-five, who's parading around a child and saying "Look what I had and it's mine. "Many of them were products of donor eggs. And' I've had patients who've come in at age forty-five and declare "Well, I'm ready." The probability of conceiving and delivering a child with a woman's own eggs at forty-five is virtually zero. (#5019, *Esquire*, 2001)

Nearly all the articles, including personal and celebrity stories, resulted in a happy ending with a new baby. In reality, this is not the case for everyone. Furthermore, details, such as time in treatment, costs, and other pressures were almost always omitted. Overall, these simplistic media representations minimized the infertility experience perhaps making those who actually experienced the harsh realities of infertility feel even more isolated and stigmatized.

The media also portrayed infertility as lighthearted and humorous in other forms of popular culture like plays, novels, television, and movies making it hard for the general non-infertile public to relate to the seriousness of infertility. In 1966, a play opened at the Lincoln Center entitled *Yerma* which was written by Spanish poet and dramatist Federico Garcia Lorca. *Yerma* means "barren" in Spanish and tells the story of the heroine Yerma who yearns publically and privately to have a baby, often beating her chest and moaning. Unaware of the realities of infertility, one reviewer joked, "The playgoer comes out of this hot bathos convinced that this Spanish town could certainly use an adoption agency" (#1020, *Time*, 1966). Another reviewer said the music was thought of as compelling, but as for the dramatic story itself, "*Yerma* remained yermo [boring]" (#2002, *Time*, 1971). In the 1990s, a new novel by Liz Nickles received rave reviews and appeared on the *New York Times* best-sellers' list telling the story of the Kate, age 39 and founding editor of a trendy Child-style magazine who is unable to conceive even though she has already decorated the nursery. In a twist, she splits from her husband, suddenly finds herself pregnant and alone, and attempts "pregnant dating." Critics said this novel *Baby, Baby* (1991) was "both a social commentary and rollicking comedy"—a funny novel about yuppie

infertility (#4043, *People*, 1991; #4042, *Newsweek*, 1991). Television shows and films about infertility included the likes of *Friends*, *Donorboy*, *Inconceivable*, *The Back-up Plan*, *The Switch*, and *Baby Mama*. In 2005, a new musical debuted off-Broadway entitled, *Infertility: The Musical That's Hard to Conceive*. Clearly, infertility had infused the public consciousness. Despite the quantity of media references to infertility, silence still persisted on an individual level creating a “silent sigma” not necessarily recognized in the media.

4.9 Fertility Specialists’ Perspectives about Defining Infertility

Setting the Stage

I was very excited to interview these fertility specialists in order to gain their insight into some of my findings from the media analysis. Given my connections within the infertility field, I felt it important to listen to the lived experiences of actually providing fertility care during this unique period in history. For three of my six interviews with the fertility specialists, I visited them in their fertility clinic offices. When I checked in with the reception desk, the front desk staff immediately assumed I was a patient and told me to fill out paperwork, probably because I appeared to fit the typical patient profile. Also, for two of the three, the receptionist was hidden behind a glass window creating a very cold and impersonal environment, as well as making me feel the physical separation between the “fertile” and “infertile” worlds. All three clinic waiting rooms were relatively small and decorated nicely but simply—not quite what I expected from a “multi-million dollar business.” All had pictures and photographs of children and babies on the walls in addition to parenting-style magazines spread across the tables. However, none displayed “inspirational” or “motivational” sayings of hope and perseverance, which I will discuss in the next chapter. One of the clinics also had an advertisement for an onsite infertility support group. Very few patients were in the waiting rooms. Of the handful of patients who were there, all were white

women appearing to be in their 30s or 40s—consistent with the overall target audience for these clinics. No husbands were present emphasizing their marginalization in the infertility process.

Five of the fertility specialists included in my study were personally involved with between 75 and 200 *in vitro* fertilization cycles per year. I interviewed one fertility specialist who was not actively practicing fertility medicine; however, he was very involved with leadership and advisory roles within reproductive endocrinology and infertility field. I noticed many staff people walking around one seemingly small clinic so I looked up their website. I learned that this one particular doctor (who was in practice with one other doctor) had 34 staff people listed—office help, financial specialists, marketing assistants, administrators, patient coordinators, nurses, and medical assistants—highlighting his sense of importance and strong connection to “business.” (In comparison, my own primary care physician employs a receptionist and a medical assistant for her 250 patients.)

Two of the doctors were on time for our meeting, greeted me and led me to their office to talk. Again, their offices were small and modest. One of the fertility specialists was about 30 minutes late and asked me to join him for lunch at a restaurant nearby after apologizing for the delay. I conducted two other interviews via telephone by calling the doctor’s personal cell numbers which they emailed me ahead of time. The final interview was conducted through email correspondence through his personal assistant. Overall, I found the fertility specialists very approachable and willing to talk about their experiences with me, especially compared to doctors in other areas in medicine. Most likely, this increased access was due to 1) the limited patient responsibilities (low patient load and rare emergency or on-call hours) and 2) their dependence on direct marketing and networking to recruit more patients. (In fact, one of the premiere fertility specialists involved with initial development of *in vitro* fertilization and an influential leader in the field of procreative medicine—whom I also interviewed for my study—just contacted me through the social networking sites LinkedIn and Facebook and stated that he wanted to stay in touch.)

Defining Infertility

Overall, my interviews with the doctors further validated many of the themes identified in this media analysis. Given the homogeneity of this group, many of their responses were similar, especially on issues impacting the integrity of the fertility field as a whole, which I will discuss more later. Because I noticed such fluidity with the definition of infertility early in my study, I started off asking them about the definition of infertility. All of them disagreed with my finding that infertility lacked a clear definition. They all resorted back to the “official” American Society of Reproductive Medicine definition that many of them helped create:

Infertility is the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment. (ASRM 2010)

To them, this definition was very clear and did not need amending. When I asked about specific groups, like those who fell under “social infertility,” they assured me that these groups still fit within this definition. By using qualifiers like “should” and “unless,” this definition allowed fertility specialists to adapt it to fit a variety of situations that would necessitate earlier intervention. Ultimately, the fertility specialist controlled whether or not someone fit this definition.

During my interviews, I also asked whether or not they thought infertility was increasing. All the doctors first stated yes, at least in terms of their practices. For instance:

I don't know the exact statistics, but we've always been busy. I've never had a problem getting patients. They call me. I'm sure the numbers are growing, because my practice certainly has. (Dr. Elliott)

I had a waiting list before I even opened my doors. And it's worse now. There are plenty of people with infertility. Always has been. Always will. (Dr. Carter)

They say there is an infertility epidemic. I guess that's true, especially with all the environmental toxins and obesity and such. I wouldn't be surprised. (Dr. Appleton)

When I pointed out that statistics showed no change in infertility rates, they stated that they already knew this information as well. I also asked them about the news that fewer people were seeking infertility care. In order to maintain their competitive edge, none reported seeing fewer patients at their clinics, but some had “heard” that other clinics experienced this. None described having long waiting lists at this time; most patients could get an appointment within a few days or weeks at most. However, they saw no problem with perpetuating the myth of an infertility epidemic. Using the always of supply and demand, perhaps more patients would seek out fertility specialists if they thought infertility was more common and resources were scarce. Also, all described actively marketing their clinics, mostly through informational sessions, popular media advertisements, billboards, and the Internet. All also agreed that maintaining an active Internet presence was critical since most patients gathered information online. One of the fertility specialists told me that he even hired a “reputation expert” after receiving bad reviews on a local doctor-rating site. These fertility specialists often had more success with reaching patients directly rather than depending on referrals from ob/gyns or other doctors. As a result, they employed a number of standard business practices aimed at increasing revenue, blurring the line between medicine and business.

When I asked about causes for infertility, not surprisingly, all the fertility specialists included only medical causes, with ovulation problems being most common. When I inquired about possible lifestyle causes as much of the media depictions pointed to, Dr. Carter responded,

Yes. I suppose there are some things a person can do—don’t smoke, don’t drink, eat well and so on. But, for the most part, infertility is a physical problem, and nothing the patient does is going to change this. It’s up to us to fix it.

The other doctors agreed. None of them spent too much time focusing on a patient’s lifestyle as opposed to trying to find a specific diagnosis for their infertility. Dr. Elliott explained,

Today we like to find the physical cause so we can start the best treatment right away. People expect results. We try to do the best we can. Of course, sometime we can’t, but we try anyway.

Two of the doctors regularly denied *in vitro* fertilization overweight patients, but they did not offer any support or resources for weight loss. Dr. Carter explained, “If a woman wants to get pregnant, she should be motivated enough to lose the weight.” However, Dr. Carter also told me of a colleague who had just opened up a weight loss center right next door to his own fertility clinic as a “smart business” move. As I will discuss more in the next chapter, these fertility specialists very much acknowledged their control in women’s procreative health, especially over a woman’s own individual control. As a result, messages from the fertility specialists conflicted with other data gathered in my study suggesting that women were ultimately responsible for their own fertility. All in all, women had very little control over their fertility, especially when consulting a fertility specialist.

Age was also seen as a major cause for infertility as well as a topic of interest among these fertility specialists. This is most likely because older women represented a large percentage of their practices. Dr. Carter explained,

I’ve seen women in their 40s, 50s, and 60s. They want to me to get them pregnant with their own eggs. Most of the time, this is not possible so we talk about egg donation. I lose about half of them at this point. Women need to know about their biological clocks and what can be done. It’s just not possible. Not now. Probably not ever. I would say age—and women’s lack of knowledge about how age affects fertility—is the single biggest cause for infertility. (Dr. Carter)

However, all six of the fertility specialists I interviewed agreed that age alone should not be a reason to deny treatment, despite the low chances for success.

I think women should have options. If they want to get pregnant at 50 who I am to tell them no? I will do whatever I can to help them. I had my first child at 50. If they don’t want to give up, neither will I. (Dr. Appleton).

Whether we agree or not, older mothers are the new reality. They are my clinic’s bread-and-butter. I am their last hope. They come to me, and I’m happy to help. Of course, I wish them would come to me a bit sooner. The sooner they see me, the more I can do. It’s probably our responsibility to let them know. But, they won’t have it. Whenever we try to bring up age, women go crazy. They just don’t want to know. I do what I can to help them. (Dr. Elliott).

Some 45 year old women think that a 5 percent success rate is pretty good and want to go ahead and try. As long as she knows the statistics, I won’t turn her away. But, I do warn her of the cost. I don’t want her to spend all her money on this and run out of money and not be able

to try other options later. Treating infertility is a mixture of time, money, energy and frustration. (Dr. Davis)

Although they recognized age and infertility as important topics with many misconceptions, none offered any advice about how to effectively educate women about this topic. As I discuss throughout this study, fertility specialists often deflected any responsibility back onto the patient. They all recalled the ASRM media campaign a few years back. In fact, several of them were involved with this as well. Despite the public criticism, they did not see this campaign as a failure. Overall, they felt that they raised awareness about the topic regardless. Justifying their efforts and highlighting their altruism, Dr. Grant said, "All press is good press in my opinion. If it helped one woman then we were successful." They also stated that they purposefully did not include any patients or possible consumers in the development of this campaign; they did not see the importance of getting feedback from women about their attitudes and perceptions about age and fertility. They all blamed the media and did not accept any responsibility on behalf of the infertility field in perpetuating this. When I asked them if they felt this was patriarchal (as many of their critics accused them of), they did not see the significance of this adhering to a patriarchal approach at all.

From my interviews with the fertility specialists, I determined that fertility specialists were conflicted with regard to age and fertility. On one hand, older women comprised much of their patient load. As one fertility specialist described, older women were "their bread and butter." Fertility specialists expected a constant stream of older women seeking assistance to become pregnant. On the other hand, these physicians also recognized the limitations in getting older women pregnant and did not know how to relay this information to potential patients without jeopardizing their own interests. Overall, these fertility specialists did not want to discourage women from seeking fertility assistance, but they also did not want to be blamed for "failure." As a result, they attempted to place the ultimate responsibility back on their patients, as I also found in the media analysis. If they told women the realities of age and fertility (at least their version of this reality) and "allowed" her to make her own

choice, they relinquished any responsibility and could “chalk it up” to just helping women achieve their procreative goals.

When asked about patient diversity and access to care, they did not see this as an important topic. For example, Dr. Elliott explained,

I know there are REs that specialize in helping gays, lesbians, and single women. That’s not my practice. Not that I’m against them. I just think there are others out there that cater more to these folks and have made a business out of it. I know one RE who said that two lesbians gave him a big Hershey kiss after the birth of their baby and told him “You are the first straight guy that we’ve ever kissed.” He still keeps it on his desk.

Dr. Carter also responded about race,

I don’t see many African Americans either. More Asians, mainly East Indians, yes. But, there are several African American REs now so I suppose they are going there. I’m not really sure.

They were also aware that many fertility clinics accepted only married couples. While none of these fertility specialists admitted to consciously discriminating against specific groups, they respected the choices of those colleagues who did, protecting autonomy. As I discussed above in my media analysis, a clear difference between the lived experiences of different populations experiencing infertility existed. Although infertility treatments were portrayed by the media as helping families have children, very few families had access to these treatments. In general, the infertility-industrial-complex is set up to best meet the needs of a very specific population, white, middle-class married couples creating “reproductive stratification” (Rapp 1995).

Although infertility impacts families in many ways, these fertility specialists were primarily concerned with the physical effects. Dr. Elliott recalled during our interview,

You know I never really considered there was an emotional side to infertility early on. Women came to me wanting to become pregnant. I thought I can help them. It never occurred to me that they could be depressed. They never said anything like that. It wasn’t until I went to a group meeting of infertility women sometime in the 1970s that I saw them crying and consoling each other. Today it’s all over the place. And I now have professional counselors that I can refer out to help with this. Plus there are plenty of support groups like RESOLVE. It seems to be a big issue now.

While many of these fertility specialists acknowledged an emotional or psychological component to infertility, their emphasis varied. Four had professional counselors on staff while another one contracted out to mental health professionals if needed. However, these fertility specialists mostly utilized mental health professionals for screening potential egg donors and surrogates. They expected patients to seek out their own psychological support if needed. At least one sponsored an online weekly infertility support group. However, they all saw themselves as being ultimately responsible for deciding the overall mental well-being of the patients regardless of any input from the counselors, promoting patriarchal control and ignoring the expertise of others. These fertility specialists perceived infertility as predominately a medical issue needing specific medical advice. However, this was not the definition of infertility portrayed in the media. Through the articles that I analyzed, women were still held responsible for fertility and their ability to become pregnant regardless of any medical diagnosis. As a result, despite the medical definition promoted by the infertility field, women still had to decide for themselves what infertility really meant for them. Moreover, women and men facing infertility had to navigate through a number of strong social forces in order to make these decisions.

CHAPTER 5

CONTROLLING FERTILITY

*They must find it difficult...those who have taken authority as truth,
rather than truth as authority.*

--Gerald Massey

For centuries, pregnancy was just something that “happened” in life. At one time, nature was in control, but over the past 50 years, scientists and physicians learned to manipulate the mechanics of fertilization, pregnancy and birth for a wide range of families. The relationship between infertility and medicine is complex. Decisions as to what is abnormal and what steps should be taken to correct this condition are all made within the social context, often marked by power, status, and gendered expectations. Sociologists distinguished between the physical reality and social reality of infertility, depending on the meanings ascribed to them (Rothman 1991; Greil 2009). Data analyzed in this chapter describe these realities—from deciding even if to have a baby to seeking high-tech procreative technologies. As procreative options grew so did concerns about the morals, ethics, and social impacts creating more opportunities for social control over procreation. Treating infertility was not just an individual decision—it affected families as well as the greater society. My analysis explores the main factors that influence decisions about having children and seeking fertility care.

5.1 To Procreate or Not

Whether to have children or not is a deeply personal decision. However, this decision is also influenced by many different social forces. In my media analysis, depictions about family planning expectations and what it is meant to have a child were written within the context of modernization, birth control, women’s liberation, environmental concerns, economics, and religion. While all societies are pro-natalist (Parry 2005; Ulrich and Weatherall 2000), media stories that I analyzed about procreation fell into three main categories: those about people who did not want any children, those

about people who did not want to be coerced into having children when they were not ready, and those about people who wanted lots of children. Perspectives from “conventional” families that opted for one or two children were clearly missing from the media. Moreover, decisions about procreation appeared definitive, and journalists did not include discussions regarding ambivalence or vacillating between wanting or not wanting (more) children. Overall, these narratives about procreation reflected complex issues related to power, control, and stratification.

May (1995) stated that family-building plans in the 1960s were affected by lack of security regarding economics, future opportunities and overall safety. Likewise, the *Saturday Evening Post* (#1013, 1963) reported on the recent use of the atomic bomb, an insecure job market, and growing societal pressures and responsibilities just to survive. News journalists also predicted overpopulation as a further threat to an already weakened sense of security. Dr. Alan Guttmacher, a staunch Planned Parenthood advocate, wrote in the *Saturday Evening Post* (#1004, 1960) that an impending population explosion “endangers the security of nations as well as families” and must be dealt with swiftly directly through government intervention. Other physicians joined Guttmacher publicly advocating government responsibility in increasing the use of birth control pills among poor families. Wanting to provide disincentives for large families, these physicians also recommended tax code changes within the article “An Explosive Desire for Children” (#1032, *Time*, 1969).

Journalists stressed that children no longer had to be born at random. Families should have no more children than can be adequately care for. However, not all births needed to be prevented, only the “unwanted” children. In the 1960s, journalists clearly differentiated between “wanted” children and “unwanted” children. According to journalists at both the *Saturday Evening Post* (#1025, 1967) and *Time* (#1031, 1969), “wanted” children were seen as “all babies who are wanted and hoped for, admired and cherished” compared to unwanted children who were considered to be “excessive and unreasonable.” As a result, racial and class divides within procreation were established, similar to what

was seen in Chapter 4 regarding other depictions of African Americans and fertility. Additionally, fertility was assumed to be “on demand” as if procreation was always just a matter of individual choice. However, as seen throughout my study, agency with regard to procreation was not guaranteed.

By the late 1960s, journalists suggested that a major shift in pronatalist attitudes altogether was needed to avert overpopulation, which not only threatened society, but individuals as well. One article entitled “To Protect the Unborn” appearing in *Today’s Health* (#1031, 1968) suggested not all couples “should” even have babies: “There are thousands of couples who have rich and satisfactory sexual relations, delightful companionship, and even a closer and deeper relationship without children.” Note the reference to “satisfactory sexual relations” being unconnected to procreative sex, a theme found in the previous chapter as well. In an article simply called “Population Control,” a reporter from the *Saturday Evening Post* (#2004, 1972) identified as problematic, both wanted and unwanted pregnancies as problematic:

It is fair to say, then, that the major element in the world today is not the birth of too many unwanted children, but the birth of too many wanted children. People are choosing to have more children than is good for the health of human society—more children than is good even for the health of those children. (#2004, *Saturday Evening Post*, 1972)

During the 1970s, several articles promoted “Zero Population Growth” or ZPG for short—the theoretical point at which births balance deaths. Prominent leaders, including John D. Rockefeller II, separated lovemaking from childbearing and encouraged small families (#2017, *Saturday Evening Post*, 1975). In fact, *Time* (#2014, 1974) reported that almost 80 percent of leadership from large companies polled in a 1970 Fortune 500 survey believed some sort of effort should be made to curb population growth in order to maintain overall health. Given these strong messages that permeated the media, there seemed to be some sort of connection between the interests of medicine, government, and business and the zero population growth movement with regard to population control.

Additionally, anti-pronatalist messages appeared side-by-side with messages promoting women’s independence. Having children and being independent were established as mutually-

exclusive. For example, journalists described some women who dreamed of having children, but were concerned about both overpopulation and preserving a lifestyle that “includes evenings at the theater or movies, morning at the tennis courts in Central Park, and working late” (#2014, *Time*, 1974). In fact, women constituted about 46 percent of the work force in the early 1970s, and a growing number of these women did not want to assume the burden of motherhood (#2014, *Time*, 1974). Women who enjoyed being mothers and housewives said they also felt like “intellectual dropouts.” In her book *Embodied Progress: A Cultural Account of Assisted Conception*, Frankin (1997) pointed out this common conflict among women with regard to paid work and reproductive work. In my analysis, the tension between employment and procreative labor was exacerbated by regularly pitting one set of demands against another within the same articles.

Consistent with messages about age and fertility as discussed in the previous chapter, the topic of whether or not to have children shifted to delaying motherhood in the 1980s. Readiness for motherhood was a recurring theme in the media. Journalists suggested that all women wanted to become mothers; the only issue was timing for which procreative technologies could now overcome. Two categories emerged to explain women without children: the deliberate types who made their decision not to have children early in life and those who just wanted to wait until they are ready. For many baby boomers, starting a family was not at the top of their priority lists. Jane Mattes, a psychotherapist who founded “Single Mothers by Choice” in 1981, stated,

I think the issue of intimacy is this generation’s [the baby boomers] biggest issue. Relationships are now disposable. People split. Being a parent is a place to work out intimacy where your partner can’t leave you. You are forced to grow. You have no choice. (#3053, *Life*, 1987)

Journalist Anna Quindlen said the real issue was “The question America’s baby-boom mothers are posing for the future is whether or not their lowered fertility will prevail” (#3053, *Life*, 1987). Quindlen predicted women would not make the choice to return to the traditional procreation ethic of producing many children as early as possible. Other journalists further rationalized the current social and

economic trends, such as the movement of a traditional agrarian society to modern, industrial society, cohabitation, divorce, and working women. As a result, Landon Jones, author of the “The Birthing Dilemma: Baby Boom or Bust” (#3020, *Saturday Evening Post*, 1982), suggested that lower fertility was here to stay. Public Opinion Expert Daniel Yankelovich further explained in *Time* (#3059, 1988), “In the 1950s a single breadwinner could support a family of five. Now it takes two breadwinners to support a family of four.” In general, social changes influenced procreative plans for most people.

Postponers, as Stephen Hall of *Time* (#3059, 1988) called them, refused to make a decision, allowing relationships, professional commitments, and finally nature to make the choice for them. Articles included images of women who did not adhere to the old adage “fish or cut bait” or purposely decided to marry men with children so they would not feel pressured to make a decision right away. For example, Dr. Karen Rhode, 40, a suburban Chicago obstetrician told journalist Hall (#3059, *Time*, 1988) that she had some regrets about not having children, but was devoted to her medical career and her second marriage to a man with grown children. In a “Point of View” piece in *Redbook* (#4037, 1993), the author also relayed her experience not to have children. Supporting older motherhood, she stated that society often ignored the demands for talent, discipline and patience needed for raising children, traits often possessed by older parents. These stories mirrored other narratives about age and fertility as discussed in Chapter 4. As options for extending fertility existed, decisions about childbearing no longer needed to be rushed.

In the late 1990s, family building trends changed once again. As discussed earlier in Chapter 4, the infertility field provided much false hope about the reality of older motherhood necessitating the need to back-peddle in the media. A backlash of sorts against childlessness and delayed pregnancies began with younger women feeling pressured to consider procreation. Spokespeople for Crate and Barrel and Williams-Sonoma who tracked trends of young brides listed on their registries noted that couples were getting married earlier. According to the article “The Young and the Nested” in *Time*

(#4031, 1997), these “early nesters” reacted to the experiences of their older siblings—those who were single-minded and career focused and still ended up lonely. One young infertility specialist “gasping” at the number of 40-year-old women coming in crying for children said, “That was the life I had embarked on. But then I began to wonder: You hit your target zone with your personal trainer, have great suits, and eat a lot of sushi. What does it mean?” (#4031, *Time*, 1997). According to media reports, young adults who watched parents divorce and saw technology increasing over human touch, began to head to things of comfort: family, religion, marriage and kids. Anne Stringfield, age 24, who lived and worked in New York said, “They [my friends] have all the accoutrements of domesticity” (#4031, *Time*, 1997). To make younger motherhood more appealing, journalists also reported that having babies, especially at a younger age, was also as good for your health. Focusing on a fear common among women, one study cited in *Time* (#4004, 1994) found women who gave birth in their 20s were the least likely to get breast cancer—as much as a 60 percent reduction in risk. Overall, the media at this time focused primarily on reasons why women should consider earlier childbearing.

By the 2000s, discussions about childlessness occurred primarily in intellectual magazines, like *McLeans* and the *Futurist*. Through these limited depictions, journalists imposed racial and class assumptions on procreative choice. These articles described how “sweeping social changes over recent decades have made people more open to a variety of life patterns, removing much of the stigma and guilt of childlessness that once led to pity from others and depression” (#5051, *Futurist*, 2003). Society’s shift in attitudes toward childlessness by choice was most evident in the language with the term “child-free” replacing “childless” written by reporter Anne Kingston in *McLeans* (#5188, 2009) article “No Child, No grief.” Child-free living was becoming the “norm” in American as nearly half of childbearing aged women did not have children. Several magazines cited U.S. Census data showing that families without children finally surpassed those with children by 1.5 percent in 1985 and growing to 6.7 percent more by 1999 (#5188, *McLeans*, 2009; #5031, *Futurist*, 2002; #5030, *Futurist*, 2002). Overall,

childlessness increased mostly among older women (#5031, *Futurist*, 2002; #5030, *Futurist*, 2002). Despite advances in fertility treatments, the U.S. Census reported for women age 40 to 44, childlessness rose to 19 percent, up from just 10 percent two decades earlier (#5031, *Futurist*, 2002). This trend reflected the narratives discussed in my study about how the fertility field gave many older women hope that they could become mothers at any age while hiding the low chances for success.

Child-free women also became more vocal in the media, typically among intellectual audiences who journalists indicated were most impacted by age-related infertility. Again, journalists reinforced class assumptions about fertility. In general, procreative pursuits directly opposed intellectual pursuits. Books such as *Nobody's Mother: Life without Kids* by Leslea Newman (2006) and *No Kids: 40 Good Reasons Not to Have Children* by Corinne Maier (2009), hit bookshelves. Regarding her book, *The Childless Revolution* (2001), Madelyn Cain wrote, "At its almost fundamental level, the emergence of childlessness means women are seizing the opportunity to be fully realized, self-determined individuals, regardless of what society at large thinks of them" (#5040, *McLeans*, 2003). In response to what they saw as the barrage of "pronatalism" faced by the childless, support groups for childless singles and couples sprung up around the country and advertised in the media. However, in my analysis, journalists wrote more articles highlighting the benefits of child-free living compared to promoting childbearing under headings related to infertility. For example, "Childless by Choice" was one such support group, which provided reading material, workplace advice, legal rights information, and even suggestions for movies and television shows reflected the childfree point of view. Zero Population Growth, while not a support group per se, continued to actively encouraged childlessness out of concern for the environment (#5031, *Futurist*, 2002). Another group was called "No Kidding!"-- a social club for couples and singles who are not parents (#5040, *McLeans*, 2003). In general, these groups felt parenthood was a choice not an obligation. In fact, most thought long and hard about the decision not to have children.

They understood having a child was an enormous responsibility and their lives would never be the same with children.

In more mainstream publications, well-known childless individuals talked publicly about finding fulfillment in other ways when directly asked by journalists about their lack of children. In the late 1980s, Gloria Steinem, a self-proclaimed deliberately childless woman, explained at age 54:

They spend the first three months staring at the baby. I won't give my life over to that. The Smurfs become your life. I either gave birth to someone else or I gave birth to myself. (#3059, *Time*, 1988)

Gossip columnist Liz Smith concentrated on her friend's child. She took her new role as godmother very seriously and learned all the ins and out of preschools, babysitters, homework, and birthday parties. She admitted keeping up with a child was demanding. However, she was thrilled to witness him figure out something for the first time, see the little stranger in a goalie mask make a great save, and watch his shark imitations in the pool (#5134, *Good Housekeeping*, 2006). Likewise, Diane Sawyer spoke publicly and proudly many times about not having children. In an interview titled, "10 Questions for Diane Sawyer," she explained that she had stepchildren as well as "a basket filled with children whom I adore" to keep her busy (#5218, *Time*, 2010). Note one of the "10 Questions" to this accomplished news anchor was invariably "Why don't you have any children?" something not usually asked of men. Even renowned Feminist Gloria Steinem felt compelled to broach the subject of childlessness giving more validity to this topic. Legitimizing gender roles, childless women defended their choice by still focusing on acceptable "feminine" replacements for motherhood—being involved with other children's lives or "giving birth" to oneself as Steinem indicated.

Other journalists focused on the positive aspects of childlessness. *McLeans* (#5188, 2009) highlighted a research study which found that as childless men and women aged, loneliness and depression were not inevitable. Contrary to popular beliefs about the benefits of having children, researchers at the University of Florida found seniors without children are no more vulnerable to

depression that those with children. In general, the benefits of having children resulted from having good relationships with them. According to an interview with sociologist Tanya Koropecj-Cox in the *Futurist* (#5051, 2003), without strong relationships with their children, senior parents were more likely to report psychological problems than their childless peers. Likewise, other researchers interviewed in *McLeans* (#5188, 2009) suggested people derived more satisfaction from eating, exercising, shopping, napping or watching television than taking care of their kids. Studies reported in *McLeans* (#5188, 2009) also stated that the childless by choice were more content, had higher levels of well-being and were less distressed than those who were childless through infertility.

A “counter trend” regarding procreation emerged in the 2000s, the height of procreative medicine. With titles like “For More Parents, Three Kids are a Charm: Professional, Educated Women Lead the Trend” (#5525, *Newsweek*, 2004) and “Opportunity to Raise A Big Family is a Tremendous Liberation for Women” (#5526, *Christianity Today*, 2006), journalists suggested more people were choosing to have large families. News outlets like *Time* and *Newsweek* also included positive depictions of large families, such as “a mother of nine who is athletic and fit, not a bulge on her body” (#5525, *Newsweek*, 2004) or “an Arkansas woman who gave birth to her 16th baby in October in is “ready for the next one” (#5183, *Time*, 2009). Journalists portrayed having lots of children as the epitome of being productive, a theme that I will discuss again in Chapter 6 with regard to multiple births.

How did these varying messages about procreation expectations affect those experiencing infertility? One infertile woman interviewed by Jeff Gordiner of *Esquire* (#5019, 2001) balked at society’s beliefs that anyone actually has any control over procreation:

You will have two kids. Maybe three. Your wife will get pregnant in September, ideally, so that she doesn’t have to schlepp all that extra poundage through the hot, sweaty months of summer. But you’re going to wait a few years before you start trying because you want to buy that house first, you want to save some money, you want to go to Italy or Turkey or Thailand, and what’s the rush right? (#5019, *Esquire*, 2001)

Regardless of whether they wanted children or not, most people took fertility for granted—usually after having spent many years trying to prevent pregnancy. If and when they decided to have children, the process of family building typically began with hope, joy, and excitement. Given the emphasis on individual control in procreation, people were shocked to learn of their infertility and often tormented themselves for wasting time with birth control or waiting too long to conceive.

Women negotiated their experiences with infertility within a pronatalist society which included very “traditional” ideas about family structures. In the midst of publicity about accepting childlessness, many experiencing infertility separated themselves from this group of voluntary “childless,” like journalist and infertility patient, Karril Kornheiser:

There was never a time in our lives when we didn’t want children. This separates us from a lot of people in our generation who have serious doubts about becoming parents but who eventually decide when the woman is in her 30s, “Hey, let’s have kids.” We wanted them right from the start. (#3024, *People*, 1984)

According to those experiencing infertility, the hardest part about infertility was their perceived loss of choice. One woman struggling with infertility explained to Tom Well of *People* (#3062, 1986), “People pooh-pooh it and say there are worse things that can happen to you. Yes, there are, but I feel like my freedom of choice has been taken away. I did not choose to be childless.” However, journalists regularly indicated that having a baby or not was simply a matter of personal choice. Similarly, infertility was commonly attributed to certain lifestyle choices as discussed in Chapter 4. Ironically, many would still never be able to have a baby for reasons totally out of their control. Greil (2002) suggested that this sense of loss of control leads them to treatments where they lose even more control. (More about this in the next chapter.) For those experiencing infertility, conflict arose between the physical and social experiences of not having children.

5.2 Procreative Choices

The infertility field struggled with where it fits within conversations about procreative choice and abortion politics. On one hand, treating infertility seems like the antithesis of preventing or terminating a pregnancy. On the other hand, intentional procreation includes both being able to have a baby as well as not have a baby when one wants. Additionally, successfully creating “babies” through infertility treatments involves the destruction of embryos. Advances in procreative technology further transformed attitudes toward procreative capacities, blurring the lines between pro-choice and pro-life. (More about this later.) However, as the fertility field evolved, journalists commonly connected choices about birth control and abortion to fertility and family building. In her book, *Barren in the Promised Land: Childless Americans and the Pursuit of Happiness*, May (1995:216) states, “The movement for reproductive choice, although focused on the issue of abortion rights, also drew attention to the plight of the infertile.” Women realized they could turn privately to medicine, controlled by a very small (and somewhat incestuous as discussed in the physicians’ perspectives sections of my analysis) community of white male physicians, to help both with having babies or avoiding pregnancy. Dr. Sidney Shulman of New York Medical Center spoke to *Newsweek* (#2012, 1974) about the logical overlap between birth control and helping couples become pregnant,

If we can find out what causes infertility then we should eventually be able to prepare a contraceptive “vaccine” designed to produce antibodies in couples who want to limit the size of their families. (#2012, *Newsweek*, 1974)

Overall, advances in birth control and infertility treatments went hand-in-hand. In fact, sociologist Harwood (2007) describes infertility as the last frontier of reproductive health.

To counteract any negativity surrounding birth control in the 1960s, many fertility experts emphasized the fertility enhancing aspects of birth control, despite seeming like an oxymoron. Physicians explained to the media that women who took birth control pills wanted only to space their children and desired to maintain their fertility long-term. In their messages to the public, birth control

manufacturers also focused on the fertility-related effects. Dr. John Rock, an active Roman Catholic layman who was instrumental in developing birth control pills, told *Time* (#1002, 1960) that these pills were only merely a means of modifying a woman's natural cycle and nothing more. Additionally, *Time* (#1014, 1964) reported birth control stimulated fertility and postponed menopause leaving women fertile beyond the natural limit of 45 to 50. Doctors also explained in *Time* (#1014, 1961) that birth control pills actually "established conditions conducive to pregnancy" and "should be used to treat many menstrual disorders which might threaten abortion in many cases of infertility." In fact, throughout popular media in the 1960s, journalists (#1004, *Saturday Evening Post*, 1966; #1002, *Time*, 1960; #1024, *Saturday Evening Post*, 1966) called hormone pills "the new sterility-fertility pills" helping both the 10 percent of U.S. couples who want but cannot have babies and the other 90 percent who, without contraceptive measures, would have more babies than they want.

Unlike birth control, the stigma and immorality linked to abortion was harder to break. However, to ensure their success in achieving successful pregnancies, fertility specialists needed to control both sides of the procreative continuum. As a result, "wanted" children were emphasized in the media along with fertility specialists' role in achieving this. One article entitled "Babies: For and Against" featured in the *Saturday Evening Post* (#1025, 1967) stated that "all children needed to be created out of love." Without this, the child did not have a future of "limitless hope and opportunities." The author of "Babies: For and Against" (#1025, *Saturday Evening Post*, 1967), an obstetrician, asked readers to consider if the anti-abortion laws should apply "to an infant that is doomed before birth and to be denied everything that enables a child to become an adult, doomed to be dehumanized." Even Drs. Patrick Steptoe and Robert Edwards, the "fathers" of modern procreative medicine, blurred the lines between pregnancy creation and pregnancy termination by telling the media earning from legal abortions funded their early work on *in vitro* fertilization (#4103, *Time*, 1999). When asked about the morality of tinkering with a process as "sacrosanct" as procreation (whether it be for pregnancy

prevention or promotion), Edwards responded, “These decisions are not for judges and moralists to make, but for the mother who must carry this child and raise it” (#4103, *Time*, 1999). Once she made her decision, the fertility specialists believed that their role was to carry this decision out. Again, fertility was portrayed as solely a woman’s choice removing procreative medicine from any responsibility or moral judgment. As discussed elsewhere in my study, physicians often portrayed themselves as only “helping” women through their work. Foucault (1973) suggests that this power imbalance creates an environment where social control can readily be packaged as “helping.” As also discussed throughout this chapter, fertility was very much controlled by the infertility-industrial-complex that directly profited from a woman’s right to choose.

This seemingly close relationship between pregnancy prevention and pregnancy promotion was short lived in the media as the fertility specialists noted they no longer gained any benefit. As procreation became more visible in the media, birth control options and abortions received more attention. Magazines reported horror stories about both birth control pills and abortions (#3070, *Time*, 1989; #3088, *People*, 1981; #3016, *Time*, 1982). Journalists warned women that if they used contraception, particularly birth control pills and intrauterine devices (IUDs), they would have more difficulty becoming pregnant later. Although millions of women used both the Pill and IUDs, articles like “Perils of the Pill” (#2009, *Time*, 1973) and “A Life Giving Choice” (#2004, *Saturday Evening Post*, 1970) discussed major side effects, including irregular menstrual cycles and infertility. Similarly, journalists described abortions as dangerous treatments being performed in back alleys, unethical “recruitment” of patients by doctors, taking advantage of patients’ desperation, and using experimental or unproven methods (# 1007, *Saturday Evening Post*, 1961; #1009, *Saturday Evening Post*, 1961; #1008, *Saturday Evening Post*, 1961; #1035, *Time*, 1969).

Journalists explored the dilemma: Does science contribute anything to the principles of morality and public policy by making contraception, therapeutic abortion, and infertility treatments feasible?

Saturday Evening Post (#1003, 1960) reported that the majority of obstetricians and gynecologists dreaded relinquishing any control of medical decisions to the non-medical. Fertility specialists claimed that they needed complete autonomy in order to reduce the desperation and eliminate dangers for their patients, physically, emotionally, or financially, whether they were trying to have a baby or prevent one. Fertility specialists feared that procreation was suddenly becoming non-medical issue laden with moral judgments. Trying to keep infertility out of moral discussions, fertility specialists separated themselves from birth control and abortion all together by refusing to comment in articles related to these topics.

5.3 Medicalizing Conception

Reissman (1987) states that medicalization results from two interrelated processes. First, a medical meaning is given to certain behaviors or conditions which are defined in terms of health and illness. Secondly, medical practices become the vehicle for controlling the problems that they professional deems as deviant. As treatments for infertility became available, fertility specialists medicalized conception to establish new social norms. While journalists briefly mentioned difficulties in getting pregnant in the 1960s, 1970s, 1980s, they typically described getting pregnant as “natural” and “mysterious.” Detailed accounts about the complicated process of conception did not appear in the media until the fertility field fully blossomed in the 1990s and 2000s. Many different articles, in both science and mainstream magazines alike (#4008, *Redbook*, 1998; #4009, *Science* 1995; #4010, *Essence*, 1996 #4011, *Science*, 1996), described the exquisitely intricate orchestration of hormones and engineering required to make a baby. A cover story in *Time* magazine on September 20, 1991 (#4001), simply called “Making Babies,” described the process by likening it to war preparation:

Couched in halo of nutrient cells, an egg smaller than the dot on an I drifts slowly down the Fallopian tube, one of a pair of narrow passages that lead from a woman’s ovaries to her womb. Like a beacon guiding ships at high, the egg sends forth a calling signal. A convoy of sperm—the

remnants of an armada that was once a couple of hundred million strong—sails into view, their long tails thrashing vigorously. Lured by the chemical signal, several hundred of the most energetic swimmers close in on the egg, their narrow tips unleashing a carefully time sequence of biochemical salvos. One substance dissolves the jelly-like veil surrounding the egg. Another softens the egg's tough outer shell, preparing it for penetration. In the last moments before conception, a few dozen sperm race to break through the final barricade. One and only one succeeds. The instant it tunnels its way past the egg's outer layer, an electric charge fires across the membrane and a signal from the sperm causes the eggshell to snap shut, blocking entry to any remaining contenders. The successful seed then releases its tightly coiled package of DNA, which fuses with the egg's own DNA and sets in motion a series of genetic events that culminate, nine months later, in the birth of a new human being. (#4001, *Time*, 1991)

Although several researchers, such as Layne (2003) and Reinhartz (1998) suggest that many people believe conception is a simple and natural process, no article analyzed in this study suggested that getting pregnant was at all easy. By stressing the complexity of procreation via the media, fertility specialists legitimized the need for assisted procreative technologies.

Setting the stage for expectations about infertility treatments and their chances for success, depictions of conception, especially in science-type magazines, promoted the mysteries of getting pregnant. For instance, scientists and physicians admitted to not knowing exactly how women become pregnant, even into the twenty-first century. For instance, scientists were still learning how sperm cells navigate the female reproductive tract to reach the egg. *Discover* (#5048, 2003) explained that why among dozens of sperm that reach the egg, only one will successfully “burrow through” the egg's thick surface and initiate fertilization still remained unanswered. Magazines also reported that scientists could still not determine which embryos were “good” and which ones were not in order to boost pregnancies through *in vitro* fertilizations. In general, journalists described human embryos as horribly inefficient in dividing and developing into a viable fetus. More often than not, the process “failed.” Similar to the success rates of assisted procreative technologies, experts interviewed for these articles estimated between 60 percent and 80 percent of embryos are lost at the very earliest stages, often due to poor egg quality. The only way to know for sure if an egg was good was to achieve pregnancy, placing the ultimate responsibility for success on the woman's body. Further preparing the public for “failure”

after infertility treatments, *Discover* (#5069, 2004) reported an estimated 31 percent of all implanted embryos later miscarry. It is important to mention that in all the articles that I analyzed, there was very little mention of miscarriage, especially as a component of infertility. This omission surprised me since I recently read *Centuries of Solace: Expressions of Maternal Grief in Popular Literature* by Simonds and Rothman (1992) about the increasing visibility of this topic in popular publications. In many cases, journalists portrayed a pregnancy as the end-goal of infertility treatments, not necessarily a birth. Miscarriages might have just been part of the expected collateral when attempting to get pregnant through procreative technologies. Despite all the technological advances surrounding assisted conception over the past five decades, *Discover* (#5069, 2004) reported (emphasis added), “IVF remains, at best, a hopeful *art* driven by the best of intentions and less than complete knowledge.” Once again fertility specialists shifted the responsibility for procreative success away from them and onto women themselves.

5.4 The Business of Infertility

Journalists first considered treating infertility as a novelty, reporting on the latest and greatest breakthroughs. By the 1990s, infertility was a booming industry. Scritchfield (2009:140) and Spar (2006) verified that by the late 2000s, getting pregnant was “big business.” In fact, Spar, (2006) estimated infertility was a multi-*billion* dollar business (emphasis added) which is largely fee-for-service since insurance coverage was rare. Over the years, the menu of baby making options and resources grew to bewildering lengths. As treatments became more commonplace, mainstream media normalized infertility treatments and the process of seeking help to get pregnant as “no big deal.” Journalists (#4006, *Newsweek*, 1995; #4112, *People*, 1990) told patients to ignore the “give it time” advice and seek help as soon as possible. To dispel any public myths, the media advocated that infertility treatments were a much needed medical service and not experimental or a frivolity. *Newsweek* (#4071, 1997)

described infertility as just a “90s affliction” that could easily be overcome by seeing a fertility specialist. Sharon Begley of *Newsweek* (#4006, 1995) even reported that “getting a baby” through assisted procreative technologies was almost as easy as getting a tattoo.

However, success rates provided by the media were not consistent. Across all the years analyzed in my study, the most common reports included a 50/50 possibility of getting pregnant through infertility treatments. As fertility treatments became available in the 1970s, both *Today's Health* (#2006, 1972) and *Newsweek* (#2024, 1978), reported that the “cure” rate for infertility was between 40 and 50 percent. Again, in the 1980s, *Psychology Today* (#3062, 1988) and *People* (#3062b, 1986) stated that the chance for solving infertility problems was about 50 percent at best. By the 1990s, reported success rates for treating infertility remained stable at about 50 percent according to *Redbook* (#4008, 1998) and *Newsweek* (#4006, 1995). For families seeking high-tech treatments, the statistics were lower. *Newsweek* (#4006, 1995), *Time* (#4099b, 1996; #4098, 1999), and *Redbook* (#4008, 1998) all reported only about a 20 to 30 percent success for procreative technologies. Regardless of the exact statistics, this concept of a “chance” of success (whatever it may be) signifies not only the scientific probability but also encourages never ending hope. If there is any amount of chance (no matter how small), hope remains.

Some journalists claimed much higher success rates, like in a *Science* (#2025, 1978) article reporting 80 percent of infertility cases were “cured” within a year and in *Time* articles (#3016, 182; #3027, 1984) stating that infertility could be “fixed” at least 95 percent of the time. Others in the media criticized these claims by saying they were overinflated or inaccurate. One article appearing in *Time* (#3065 1989) entitled “Trying to Fool the Infertile” reported the performance of infertility clinics varied enormously, and many clinics overinflated their success rates. Even fertility specialists interviewed in this article agreed; Dr. Geoffrey Sher, former medical director of San Francisco’s Pacific Fertility Center explained, “The consumer is in the dark. A startling number of programs have never had a single baby

born, and they are still quoting statistics" (#3065, *Time*, 1989). Dr. David Wilson said, "It's very easy for the medical profession to take advantage of infertile couples because they so desperately want children" (#3065, *Time*, 1989). As I searched the medical literature, the science behind infertility treatments remained weak, and any clinical evidence newer procedures were better than the old ones was scarce. Thompson (2003) suggests that these types of overinflated statistics legitimized infertility treatments by concentrating on the productivity of the treatments. Moreover, a gap existed between the statistics and lived experiences as many families went home without a baby. Fertility specialists expected patients to believe these high chances for success, creating more hope even within the worst of situations.

In his article about ethics and infertility, Geoffrey Cowley of *Newsweek* (#4075, 1995) claimed while most clinics publicized their success rates, the pressure to produce pregnancies could drive a physician to cheat. This caused many couples to become bitter about their experiences with infertility clinics; Sharon Mead told *Time* (#3065, 1989), "I put trust in people, and that doesn't work. I have this desire so bad for a baby. I would do anything to make it work, and I find out I've been ripped off the whole time." Attempting to protect patients and avoid these situations, several news magazines (#3065, *Time*, 1989; #4075, *Newsweek*, 1995; #4076, *Newsweek*, 1995; #4099b, *Time*, 1996) reported on the progress of Oregon Democrat Ron Wyden who planned to introduce legislation requiring IVF labs to be certified by the federal government. Comparing the infertility field to the "wild, wild west" in that "anything goes" when it comes to treating infertility, Wyden stated, "You have this combustible mix of big money, rapidly changing technology and very vulnerable people. It's kind of like Dodge City before the marshals show up" (#4075, *Newsweek*, 1995). Lori Andrews of the American Bar Foundation explains "We have Model T laws catching up with space-age technology" (#3044, *Time*, 1986). Supporting his bill, Wyden said "if a husband and wife put down \$7,000, they have a right to know what chance they have of getting a joyous return on their investment" (#3065, *Time*, 1989). Concerns about

the infertility “market” were non-partisan with Democrats and Republications advocating for stricter guidelines. Fertility specialists interviewed by *Time* (#3065, 1989) insisted that “customers” were not cheated because patients are told their chances of having a baby are slim from the beginning. These contradictory opinions about the influence of statistics further challenged the amount of choice and agency women really had when seeking treatments for infertility.

Complicating matters for patients even more, clinics dangled hope in front of desperate patients to increase demand despite poor statistics. In fact, these magazine articles did not include any hopeless cases, and extreme success stories abounded. For example, stories about “older mothers” or “hopeless cases” always ended up with photographs of mothers beaming over occupied bassinets. Fertility specialists perpetuated this hype as well. *People* (#4112, 1990) interviewed a Dr. William Fine about his experiences: “I had one patient who had fibroids and endometriosis, and her treatment was very slow and expensive. It looked like she would never become pregnant. But she became pregnant and had a gorgeous baby at 46. In addition to maintaining hope, journalists portrayed a “never give up” type attitude necessary for overcoming infertility. Journalist David van Beiena (#4006, *Newsweek*, 1995) explained the moral of the story was to never give up. Stories about infertility treatments also commonly included pictures of the walls of infertility clinics papered with photos of patients turned parents suggesting to potential patients believe they could easily be among them as well (#4006, *Newsweek*, 1995; ADD).

In an interview with *People* (#3042, 1986), a patient explained that one major problem about infertility is “You fanaticize about everything and keep thinking you won’t need another treatment because you are going to get pregnant.” In another article (#4006, *Newsweek*, 1995), a woman explained,

Everything has dragged so long, because I’ve always wanted to experience pregnancy and giving birth. It’s difficult for me to let go of that. Just one more time they say. I’m getting closer that it’s not going to happen, but there’s always that little bit of hope. (#4006, *Newsweek*, 1995)

Ronny Diamond, a New York social worker who counseled infertile couples concurred with his professional perspective:

With so many new technologies at their disposal, it's impossible for doctor's to say "We've gone as far as we can go." And the couples themselves have an even harder time saying 'Enough is enough. (#4077, *Newsweek*, 1994)

Michael Headerle of *Newsweek* (#4006, 1995) called this the never ending "infertility machine."

Infertility treatments offered a sense of temporary relief—that hope existed as long as families were "actively" trying. Researchers Greil (1991), Lasker and Borg (1989), and Scritchfield (2009) suggest that the ever growing list of possible medical treatments pressures families to keep trying. Journalist Headerle explained the problem is as old as life itself: "Those that are afflicted are given hope—sometimes false hope—that science can deliver what nature cannot" (#4006, *Newsweek*, 1995). As a result, dichotomously titled articles like "For the Infertile: Heartbreak and Hope" (#4033, *McLeans*, 1999) told the stories of couples spending years suffering, consulting specialists, trying to pinpoint their problems and pursuing high-tech, low-success options involving repeated, hours-long visits to fertility clinics for endless tests and medications in order to be rewarded with a baby at the very end. Annetta Miller warned in *Newsweek* (#4098, 1999) that despite all the recent advances, it may be decades before the most complex fertility mysteries are solved; until then, many of those seeking treatment "will continue on a Sisyphian quest for a baby of their own." As a result, these depictions standardized never giving up when trying to become pregnant, especially through procreative technologies.

Journalists also encouraged readers that those experiencing infertility should be prepared (and willing) to do whatever is necessary to get pregnant. Interviewed by *People* (#3062b, 1986), Debbie and Tom Newell admitted over five years, they submitted to almost every procedure and test medical science had to offer. Throughout the process, they also endured the tactless remarks of strangers, the well-meaning advice of friends and had run the gamut of emotions. Several articles relayed quotes from

physicians about how infertility patients are second only to terminal cancer patients in that they are willing to do anything anybody suggests (#3062b, *People*, 1986; #3024, *People*, 1984). Journalists commonly equated infertility to life-threatening situations implying an “anything goes to be saved” type of attitude. Patients agreed, and one explained:

We had mistletoe over our bed for a year because I’d read that it was a fertility symbol. I ripped it down one day when I got my period. Somebody told us they’d gotten pregnant and the only thing they did differently was to change their soap. I went all over town trying to find that soap. (#3062b, *People*, 1986)

Couples who had a strong compulsion to try again and again after treatments fail were highlighted throughout magazine articles like these. Journalist Claudia Wallis (#3026, *Time*, 1984) compared infertility patients to gambling addicts: “Each time you get more desperate, each time you say ‘Just one more time’ and risking it all for one small chance.” Edward Kaplan, a medical ethicist from Yale University agreed, “It’s like going to a casino. There is always going to be, in a few minutes, a winner. You hear the money clinking down. But, what you don’t hear are the losers” (#4006, *Newsweek*, 1995). Bob and Norma, interviewed by *Life* (#3053, 1987), admitted to having spent half their lives pursuing a baby. They had taken out a second mortgage, and they estimated spending more than \$40,000 on countless treatments. Still, they concluded this is a small price to pay if they are successful. *Time* (#3026, 1984) and *Essence* (#4038, 1994) included stories of people mortgaging their homes, selling their cars or borrowing from relatives to scrape together the money. Becker (2000) explains that with today’s technologies, infertility now lasts until the couple’s emotional and financial resources are exhausted. However, my analysis did not show this. Instead, all the families included in my analysis eventually came home with a baby, especially just before they were completely exhausted or about to give up. As a result, these portrayals encouraged readers to keep going with treatments.

Even though no clinical data supported that multiple treatments or attempts resulted in any higher success rates, many articles, especially in the 1990s, indicated that persistence resulted in success. For instance, the Jennifer and Andrew Hale knew shortly after they married in 1991 that they

needed *in vitro* fertilization since Jennifer's tubes were completely blocked. In the process, they also found out Andrew had a problem as well. During their first attempt, only two out of a dozen eggs fertilized. Two more attempts did not work as well. However, their next try (their reported "last one") resulted in a baby: "This time we had an angel on our side." Another story described Lisa, a registered nurse who specialized in monitoring high-risk babies, and her husband Ira, a social studies teacher, had been trying to have a baby for over five years. They had undergone test after test and everything came back "normal." They tried surgeries, intrauterine inseminations, fertility medications, and *in vitro* fertilization. Nothing worked. Finally, one last cycle of fertility medications resulted in a pregnancy (#4008, *Redbook*, 1998). Similarly, at age 42, Melissa Moore described in detail to *Newsweek* (#4100, 1997) her 11 years of trying to become pregnant unsuccessfully, including surgeries, and several attempts at *in vitro* fertilization, one of which transferred six fertilized eggs into her uterus. Even though it took her two years to recover from this latest failure, she promised her husband she wanted to try one last time. She became pregnant and gave birth to Jesse. When Jesse was one year old, she decided to use some of the 18 frozen embryos she had left. Again, she had six embryos "put back" and became pregnant again; this time she had twins, Paul and Samuel. Journalists suggested that desperation about infertility eventually paid off with a heteronormative family as the ultimate prize.

In general, fertility specialists told families that they did not want to look back and wonder if they should have tried harder so they should be willing to do whatever they can afford physically, emotionally, and financially. Letherby (2003) states that viewing stopping treatment as a negative decision is unique only to Western cultures. Similar to what Lasker and Borg (1989) described in their book *In Search of Parenthood*, "The New Origins of Life" (#3026, *Time*, 1984) showed a picture of a bulletin board in the waiting room of the Eastern Virginia Medical School's fertility clinic containing a small picture of a soaring bird and the message, "You never fail until you stop trying." One patient who was sitting in that waiting room under the picture agreed, "You have to dream to come here and get

pregnant. It's the chance of a lifetime. I won't give up" (#3026, *Time*, 1984). Ethicist George Annas from Boston University explained,

American society has a lot of faith in medicine and science, and people believe what they want to believe. Physicians doing IVF have not done much to discourage the belief that this is a miracle technology. (#4006, *Newsweek*, 1995)

In 1998, the Society for Assisted Reproductive Technologies (SART), a professional group for reproductive endocrinologists, told a *Redbook* (#4008, 1998) reporter that "finances aside, it's worth trying IVF any many times as you can if you want to get pregnant." The heartbreak, tragedy, and anger accompanying infertility were often combined with hope. Supporting a neoliberal ideology with open markets and deregulation, journalists suggested that women's bodies could eventually perform with enough effort and hard work.

Even though men experienced infertility equally (at least statistically), infertility remained predominately a woman's issue. Researchers showed that women are usually the ones who initiate treatment, receive treatment, and cope with the difficulties associated with infertility regardless of the diagnosis (Greil 2011; Becker 2000). Journalists reinforced this narrative as well. For example, journalists defined men's fertility mainly through their contribution of sperm. Additionally, men typically experienced infertility only through their partners. Further complicating matters, most of the fertility specialists (especially among the "older" and more experienced doctors) were men. As a result, gender inequality shaped the experience of infertility on many levels. Traditional gender roles dictated that women should have children. Likewise, these gendered expectations influenced when women should have children, what lengths women should undergo to have children, and how women should react when faced with infertility. Eventually, the reach of traditional gender roles with regard to procreation extended to "non-traditional" women such as single women and the LGBT community through procreative technologies. Although journalists suggested that new opportunities for women

changed attitudes, women without children experienced a “silent stigma,” further limiting agency, due to these mixed messages about procreative choices.

The media also often discussed money with regard to infertility. It is important to note that the use of the words “returns,” “investments,” “markets,” and “customers” by journalists in these stories clearly aligned infertility with capitalism, a term typically rebuffed by the infertility field. Although what constitutes capitalism has changed over time, the treatment of infertility became a commodity as its value was determined through the process of exchange. Infertility clinics competed for patients, each extolling their unique skills and attributes in successfully getting women pregnant. Fertility specialists concentrated on their contributions to procreation while ignoring the women (and their partners) involvement in the creation of a baby. In very basic Marxian terms, the fertility field deprived families of their value in the procreative process (Marx and Engels 2013).

Journalists told readers that infertility was just another hurdle that an informed determined couple could overcome with the help of expensive drugs, cutting-edge science and infertility experts. According to the media, babies born through infertility treatments have always been expensive, and paying for infertility treatments was nothing new. In 1981, *People* (#3010, 1981) reported that Judy Carr, the first woman to have a baby after *in vitro* fertilization in the United States, paid about \$2,500 for her procedure, a little less than the \$3,000 she paid nine months later for her C-section. Over the next few years, the media continued to report these escalating costs. In the UK, British citizens paid \$2,340 while foreign visitors paid \$3,510 for a single attempt at IVF (#3011, *People*, 1982; #3026, *Time*, 1984). By 1989, *Time* (#3067, 1989) found infertility medications alone quickly rose upwards of \$1,000 per month; one *in vitro* procedure was about \$5,000-\$6,000; and surrogate motherhood cost least \$25,000 (#3067, *Time*, 1989). However, journalists provided no information about how costs were figured and why treatments were so expensive.

Treatments costs presented by the media in the 1990s remained expensive and out of the reach of most, ranging from \$7,000 to \$100,000 per live birth (most estimates were between \$8,000 and \$10,000) (#4001, *Time*, 1991; #4006, *Newsweek*, 1995; #4023, *Health*, 1999; #4090, *People*, 1992; #4112, *People*, 1990; #4110, *People*, 1997; #4098, *Newsweek*, 1999; #3124, *Time*, 1999). In 2004, *Redbook* (#5087) tried to compare costs of family building to put it in perspective: Baby #1 -- \$325 because she had a pregnancy and delivery without complications and was insured; Baby #2 -- \$13,000 because she adopted; Baby #3 -- \$20,000 because IVF was used; and Baby #4 -- \$63,274 because a gestational surrogate was used. Infertility was an anomaly in medical history. The fertility specialists exploited the elite society instead of the underprivileged. In hopes of having a baby, the wealthy paid great sums for the opportunity to be guinea pigs as to whether or not infertility treatments work.

The poor, and even most of the middle class, could not afford these new ways of having a child. In the 1970s, before *in vitro* fertilization really took off, *Science* (#2006, 1972) and *Newsweek* (#2031b, 1978), reported that clinics advertised reduced costs for those unable to pay. For instance, the Fertility Services of the Margaret Sanger Bureau charged \$10 for an initial interview, \$175 for all examinations, tests, and treatments for the husband and wife for the first six months, and \$75 for each six months thereafter; however, these fees did not include medications, surgeries or any tests that would have to be performed outside the Bureau's offices. Unfortunately, any efforts to make infertility treatments affordable did not last long. After this, media (#3053, *Life*, 1987; #3062b, *People*, 1986) vocalized concern about less affluent families having access to fertility care. But, fertility specialists, disagreed. Dr. Howard Jones, a pioneer in the *in vitro* technique told Anna Quindlen, author of "Baby Craving" in *Life* (#3053, 1987), "Just as there are people who like to buy a fine car and have to settle for something else, so there are people who cannot afford this." Likewise, Leroy Walters at Georgetown University Kennedy Institute of Ethics said,

While society should pay for the diagnosis of the problem, beyond that, given the cost, I'd place the financial responsibility on the couples themselves. It may for instance be in everyone's best interest to encourage intractable infertility couples to adopt. If that's not what a family wants, they can pay for the alternative. (#4001, *Time*, 1991)

Regardless, many fertility specialists believed while expensive, where there is a will, there is a way.

Scritchfield (2001) called this the "illusion" of control. The ultimate decision-makers once again included medicine, big business, and government. Articles routinely conveyed that empowerment to overcome infertility depended on effectively working with doctors, employers, insurance companies, and legislators, deemphasizing the any control among infertility patients. In fact, one infertility patient advocacy group, Fertility within Reach (www.fertilitywithinreach.org), promoted this "path to empowerment" further legitimizing patients' lack control (See Figure 5.1).

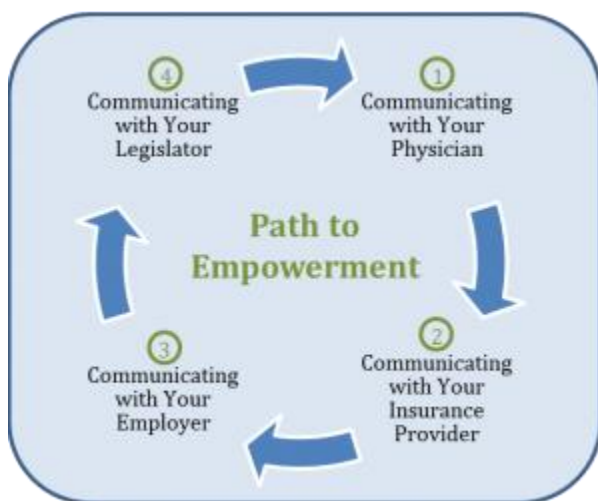


Figure 5.1. Fertility within Reach: Path to Empowerment for Infertility Patients

In 2001, Claudia Kalb, one of the most prolific journalists in terms of infertility with dozens of articles under her byline, first brought up that the number of families seeking procreative technologies was decreasing (#5022, *Newsweek*, 2001). IMS Health, which monitors pharmaceutical sales, told Kalb that prescriptions for fertility drugs were decreasing by the mid-2000s and the demand for *in vitro* fertilization treatments which had previously climbed exponentially during the past 20 years

had plateaued. Given the economic downturn taking place in the United States, fewer families seeking fertility care was plausible. Joseph C. Isaac, former President of RESOLVE, told *Newsweek* (#5106, 2005) that “there are huge economic barriers to access. However, some see the trend as a testament to technology. Infertile couples who seek treatment now conceive more quickly, thus requiring fewer procedures. We are victims of our own success” (#5106, *Newsweek*, 2005). *Newsweek* (#5022, 2001) also reported this downward trend was largely due to the baby-boomer population aging as well as new generations not being as optimistic about the future. With so much political and economic uncertainty, people worried the world was unsafe for children anyway.

Given this threat to their “business,” the infertility field had to get creative to find new patients, as discussed in Chapter 4. In the early 2000s, several fertility specialists also worked with Nancy Hemenway, a 55-year-old former special education teacher who experienced infertility herself to found the International Council on Infertility Information Dissemination (INCIID). In order to off-set costs, INCIID started a program called “INCIID the Heart” giving “scholarships” to families who did not have enough money to build their families. This term “scholarship” was especially significant given scholarships are typically based on the character, qualities, activity, or attainments, again emphasizing personal control over infertility. Moreover, fertility patients competed with each other in telling the most compelling story. According to a feature story in *People* (#5093, 2005), Hemenway directly solicited fertility clinics and drug companies raising \$1.3 million in donated IVF services and fertility medications (as opposed to cash that could be used at any clinic for any treatment). By the mid-2000s, she arranged *in vitro* fertilization cycles for 39 couples all with household income levels of below \$65,000. In the tear-jerker article “The Gift of Life,” Thomas Fields-Meger (#5093, *People*, 2005) suggested the grants provided “take-home babies” rather than just receiving one fertility treatment that had a 50/50 shot at success at best. In fact, all the families included in the article were successful in getting pregnant. Fields-Meger (#5093, 2005) reported these grants were a win-win situation for all—

couples got their chance at a family and the fertility clinics got free publicity—just what the clinics wanted.

By the end of the century, fertility medicine expanded online, making it easier to reach “desperate” families. One article “To Make a Baby, Click Here” (#4065, *Redbook*, 1999) reported all the available online resources for building a family—ordering donor sperm, finding an egg donor or surrogate, or locating a child to adopt. As online commerce for fertility services grew, *Newsweek* (#4064, 1999) and *Time* (#4062, 1999) included stories about how Ebay prohibited the selling of eggs and sperm or any involvement in creating what they called “trophy children” through procreative medicine. David Adamson, MD, president of the Society for Assisted Reproductive Technology (SART) stated that the infertility specialists were concerned about the growing online fertility options: “It’s exploitative, inappropriate, potentially dangerous, and we strongly recommend against this kind of marketing” (#4065, *Redbook*, 1999). Perhaps Adamson’s comments were a reaction to others infringing on their long protected turf rather than concern for the welfare of patients.

Assisted procreative technologies have remained among the least regulated medical specialties in the United States. In fact, the United States does not require fertility clinics to be licensed meaning any physician can start up a clinic even with little experience or no specialized training. *Newsweek* (#4077, 1994) compared the United States to other countries struggling with what to do about the complexities of treating infertility. According to the article “How Far Should We Push Mother Nature?” (#4077, *Newsweek*, 1994), government ministers from around the world raced to curtail high-tech options: French officials proposed banning *in vitro* fertilization for women past menopause; Italy announced plans to limit artificial pregnancies among older women; and Britain considered placing restrictions on “fertility tourism” where women could seek treatment elsewhere. Due to the lack of guidelines or standardization, *Time* (#4109, 1997) reported that the United States had some of the best and some of the worst infertility clinics in the world so “buyer should beware.” This media analysis

reinforced that the fertility field is truly a business with all the rights and responsibilities as such. Unlike other aspects of medicine, infertility patients become confused as to whether they are getting medical care or purchasing a product or service, an uncertainty further perpetuated by media portrayals.

5.5 Science or Miracle

As discussed in Chapter 4, fertility specialists strongly stressed the medical definition of infertility. However, this chapter also illustrates the complexity of conception and the unpredictability of procreative technologies. As a result, I was curious as to how journalists portrayed infertility treatments— for example, as medical services, extraordinary events, or something else.

Infertility specialists portrayed themselves as “getting women pregnant” against seemingly insurmountable odds and thus as personally responsible for the “happiness and love” experienced by countless families. In fact, fertility specialists were ultimately responsible for giving families “the gift” of a child. Both health care professionals and patients alike expressed their feelings to the media about pregnancy after infertility. For example, one physician remembered,

The mothers never fail to cry when they are first assured that they are pregnant. Parents send me pictures of their children at Christmastime and include heart-warming notes of gratitude of this kindly physician who made their parenting possible. (#2026, *Saturday Evening Post*, 1978)

Likewise, a fertility clinic nurse explained,

I could sense the drama in the doctor’s life as he told me of the fulfillment found in this home as a result of the wife’s pregnancies. They have been dedicated and loving parents for over seven years, and he was able to give them a gift of a baby. (#2026, *Saturday Evening Post*, 1978)

When asked “How many couples have you been able to help?” another physician responded to the *Saturday Evening Post* (#2026, 1978),

I would guess 75-100. Usually after the conception, my patients are referred back to their own obstetricians for delivery. Since I specialize in fertility problems, or more correctly “sterility” problems, I usually do not deliver the babies. For that reason, in some cases, I lose count. Many of the couples have returned to me begging me for more babies. They want me to help them again and again because they know I can do it. (#2026, *The Saturday Evening Post*, 1978)

Implying ownership of the babies born through procreative technologies, Howard and Georgeanna Jones, who brought *in vitro* fertilization to the United States, were reported as keeping large scrapbooks of “their babies”—not just their own, they have three plus seven grandchildren, but also the hundreds they’ve helped bring into this world through their *in vitro* fertilization expertise (#4106, *People*, 1998).

Dr. Alan Beers, a pioneer in preventing miscarriages, was described during a party in his honor as,

No one, not even a clown he hired for a party last August to celebrate the opening of his new clinic on Staten Island, NY works a crowd better than fertility expert Dr. Alan Beers. Surrounded by 200 people arriving from 19 different states to honor him, Bear hugged and kissed most of the 50 children between the ages of 2 and ½ months and 10 years who he had helped bring into this world, uncannily recalling the name of each child. Then he turned to their mothers and recounted their personal medical histories, including how many miscarriage they had had before giving birth and how he fulfilled their dreams. (#4010B, *People*, 1996)

Writer Jan Wulf (#4124, *Time*, 1999) posed the question when thinking about infertility, were we interfering with the natural order of things and allowing doctors to play God? Fertility specialists responded to this question through their comments and quotes. Dr. John E. Buster, a UCLA physician, was described by his wife as “He just goes around getting people pregnant. He is just like God” (#3022, *People*, 1983). Dr. Michael Tucker of Atlanta, Georgia replied to *People* (#4110, 1997), “I do my best to help the couples we treat—to provide good patient care. I’d like to think what we are doing, as much as anything, is God’s work.” Similarly, when asked whether playing God is an unfair description of reproductive medicine, Dr. Zev Rosenwaks, director of the Center for Reproductive Medicine and Infertility at the New York Hospital/Cornell Medical Center, said “All of us in medicine are facilitators, essentially, to put back the way they work in nature.” (#4109, *Time*, 1997). Dr. Edward Fugger, a leader in procreative technology, said, “God uses people in many ways. I just feel fortunate that I’ve been able to help people this way” (#4134, *People*, 1998).

Given journalists regularly compared fertility specialists to God, numerous detailed descriptions of *in vitro* fertilization as a “miracle” for many families permeated the media (just to name a few--#4001, *Time*, 1991; #4111, *Life*, 1993; #4099B, *Time*, 1996; #4106, *People*, 1998; #4124, *Time*, 1999; #4103,

Time, 1999). Louise Brown's doctors called her "our miracle baby" from the very beginning (#5039, *Time*, 2003). Robert Edwards, who together with his partner gynecologist Patrick Steptoe, were responsible for the birth of Louise Brown, stated, "Our duty was to make a thousand other *miracles* so she wouldn't be alone" (#4106, *People*, 1998, emphasis added). Nick Charles recounted the experience of Dr. Geoffrey Sher's, a fertility specialist in Las Vegas,

On a recent visit to his optician, Sher was asked by a young clerk who noticed the name on Sher's lab coat, "Are you the Dr. Sher?" When Sher admitted he was, the young man laughed and stuck out his hand, "My mom told me how I got here. I'm one of your babies. A miracle. (#5000, *People*, 2000)

While fertility miracles are not new in history, the growth of fertility treatments provided more opportunities for a modern miracle through fertility medicine and procreative technologies. Even with sophisticated drugs, daily injections and whose long-term toll may be yet unknown, the possible return was considered a miracle. As social science researcher May (1995:217) concluded, this led many Americans to believe that they could triumph over most (if not all) physical limitations inhibiting fertility. According to these popular media portrayals, hopeless cases did not exist.

5.6 Devil or God

As infertility treatments expanded, the media focused more on mistakes, misconduct, and the potential for abuse. However, journalists vacillated between describing terrible mistakes and heinous behaviors at the hands of fertility specialists and exalting these same doctors for their ultimate outcome of creating a "miracle" baby for a desperate family. Consequently, journalists evoked images of fertility specialists as both devil and god within the media. In attempt to create a media frenzy about the uncertainty of procreative medicine, the final results of many of these controversial cases were never clearly publicized, leaving readers to wonder what happened. As a result, journalists allowed readers to define these situations for themselves based on their own social contexts.

Even before the first *in vitro* fertilization baby was born, the media hinted at trouble brewing within this growing and often not well understood field. In 1978, *Time* (#2031a,) reported the first scandalous story involving rogue physicians. Unable to become pregnant due to blocked tubes, Doris Del Zio, age 34, agreed to allow Dr. Landrum Shettles to place an egg said to have been fertilized by sperm from her husband John, a 59-year-old Florida dentist, into her womb. But, upon learning of this “experiment,” Shettle’s boss, Dr. Vande Wiele, Chief of Obstetrics and Gynecology at Columbia University, decided the procedure was too risky and lacked approval from the hospital’s committee on human experimentation, and destroyed the embryo on the spot. Convinced that Shettles was their savior, the Del Zio’s claimed this ruined their only chance to ever have a child of their own. Mrs. Del Zio also said this experience hurt her physically and emotionally, upset her sex life, and jeopardized her marriage, suggesting that infertility was more than just “getting” a baby. The Del Zio’s brought suit against Manhattan’s Columbia-Presbyterian Hospital for \$1.5 million. The author of “The First Test Tube Baby” featured in *Time* (#2031a, 1978) predicted if the jury favored the Del Zio’s, other doctors involved in such “experiments” would have to weigh carefully the legal liability before considering these types of new procedures, despite their intentions.

By the 1990s, high-profile stories of physicians behaving badly appeared with some regularity within popular media. The first story of a well-respected infertility specialist clearly crossing the line appeared in 1991. *Time* (#4098, 1991) quoted 55-year-old Dr. Cecil Jacobson from Virginia who called himself the “babymaker” and equated himself to God by stating, “God doesn’t give you babies, I do.” Jacobson fraudulently gave patients hormone treatments that simulated the effects of early pregnancy. He would then show them sonograms of what he said was the fetus, only to announce several weeks later that their baby had died. Soon after Jacobson’s initial court hearing, several concerned patients requested genetic testing which revealed the doctor had actually fathered their babies himself. DNA tests linked him to at least 15 children. He was found guilty to 52 counts of fraud and perjury,

sentenced to a five-year prison term and \$500,000 in fines. Pat Eldner, author of “The Cruellest Kind of Fraud” in *Time* (#4080, 1991) called Jacobson as a “charlatan, motivated by greed and egomania.”

Even though Jacobson was convicted, sent to prison, and lost his medical license, he maintained supporters who blamed this situation on “disappointed women who had difficulty conceiving” and “ignoring the other side of the coin” of the hundreds of women Dr. Jacobson had “given them babies to” (#4152, *People*, 1992). Additionally, Jacobson’s family and friends argued those women who got pregnant with his help should simply count their blessings, enjoy their children and stop worrying about genetic linkages. Journalist Bill Hewitt (#4152, *People*, 1992) interviewed Jacobson’s wife, Joyce, who said: “The father is the person there when the baby is born and nurtures the baby. The sperm doesn’t make the father. Anyone who got his sperm is lucky.” Jacobson agreed, “I didn’t do anything fraudulent. I knew my semen was safe because I haven’t slept with anyone but my wife in our 30 years of marriage” (#4152, *People*, 1992). Despite his egregious mistakes, Jacobson held to his elite status and power over women as a fertility specialist.

Creating even more confusion about the legitimacy of the infertility field, Jacobson’s story was made into a movie starring Melissa Gilbert. Gilbert’s character, a woman violated by Jacobson, said about Jacobson during a courtroom scene, “This man, your honor, this doctor not only violated my body but he violated my hopes and my dreams and my trust” (#4148, *People*, 1994). Still, movie reviewer David Hiltbrand decided to take a light-hearted approach: “It’s hard to tell whether to wince or giggle” (#4148, *People*, 1994). Adding more comedic value to this otherwise serious story, the media quickly dubbed Jacobson as the “Sperminator” (#4151, *Time*, 1992; #4152, *People*, 1992).

In 1995, a story appeared in *Newsweek* (#4006, 1995) about two of the United States’ most renowned fertility specialists accused of unethical experiments in their California fertility clinic along with prescribing unapproved drugs, neglecting informed consent, and stealing eggs or embryos from some patients to create pregnancies in others. Not surprisingly, journalist Sharon Begley (#4075,

Newsweek, 1995) described the physicians involved, Dr. Jose Balmaceda and Dr. Sergio Stone, as “mistaking themselves for God” further supporting my findings mentioned in the previous section (#4075, *Newsweek*, 1995). Likewise, talk-show host and journalist Geraldo Rivera sought help from New York gynecologist Niels Lauersen (affectionately nicknamed by Rivera as “dyno gyno” for helping to get his wife pregnant) who was later charged with insurance fraud. Prosecutors said he gave couples infertility treatments, including *in vitro* fertilization, generally not covered by insurance, and submitted claim forms saying he was treating insured conditions like ovarian cysts. His case attracted widespread attention both because it is highly unusual for such a prominent physician to be charged with fraud and because of the impact a conviction could have on the medical profession. Lauersen’s lawyer argued “what he did was treat real sick people and that the case just comes down to paperwork.” He stated if his unconventional billing practices meant poor couples were able to start a family than it is not much of a crime (#5009, *Time*, 2000). Often, journalists called these fertility specialists “miracle workers” regardless of the negative outcomes (#5054, *Good Housekeeping*, 2004; #5093, *People*, 2005).

Stories of clinic mix-ups provided a different take on the devil and God paradox. Journalists portrayed those involving mixed race pregnancies as tragic (#4097, *Jet*, 1990; #4096, *Newsweek*, 1990; #4142, *Jet*, 1996; #4082, *Newsweek*, 1999; #4124, *Time*, 1999; #4129, *Jet*, 1999; #4143, *Jet*, 1996; #4146, *Jet*, 1995). Also important to mention is that along with the African American publications discussed in Chapter 4, these fear-mongering references to race were the only other depictions of African Americans and infertility included in mainstream media. Due to mistakes handling sperm or embryos, white women typically gave birth, only to discover the baby was African American. These families usually sued the clinic for negligence. In 2009, a similar situation occurred involving all white families. Turning tragedy into triumph, *People* (#5055b) reported about the Savages and Morrells. Unlike previous stories involving mixed-races, the clinic called Carolyn Savage immediately upon learning that they wrong embryos had been transferred. The embryos were actually from another couple, the Morells, who lived

90 miles away. Because of serious health issues, this was Carolyn's last chance to become pregnant. The Savages were given two choices—terminate the pregnancy or give birth, only to hand over the baby to the Moreells. The Savages said they easily chose the latter. While both families declined to name the fertility clinic involved, both the Moreells and Savages agreed: "At the end of the day, there is a life coming. Even though it is an unusual way, it's still a gift" (#5055B, *People*, 2009). All in all, the end justified the means whenever fertility specialists made mistakes.

5.7 Religious Narratives

As discussed earlier in this chapter, the media explored who should have the ultimate right and responsibility to make complex decisions about whether one should be pregnant or not—society, religion, the medical establishment, or the woman herself? In 1969, *Time* (#1035) announced procreation, either preventing it or encouraging it, was "a moral decision, not a medical one." In mainstream media, religion was often portrayed as a reason why families pursued fertility treatments. People's religious affiliations, nearly always Christian, were regularly disclosed during interviewees' descriptions. Researcher and scholar Ryan (2001) states that those experiencing infertility actually found their religion to be one of the most painful parts of being infertile, largely because they felt invisible and marginalized. For instance, Sam and Patti Frustaci, parents of the first septuplets explained "We were attending [the Mormon] Church in Huntington Beach, and the Mormons are very family oriented. It's difficult for a woman who is trying to have children to go to a church where all you see is children" (#3035, *People*, 1984). Furthermore, media implied many religious women felt their role was to be a mother. And if that does not happen, they think something is wrong with them. Kathy Jones, described as a young happy school teacher living in the mid-West, admitted in a human interest story for *People* (#3035, 1985) that while she continued going to the church she had attended her entire life, she began to feel depressed as if everyone was looking down on her. Likewise, the Biblical injunction "Be fruitful

and multiply” haunted Tony and Karril Kornheiser for nearly a decade (#3024, *People*, 1984). As a result, many families believed that children brought them closer to God.

Although journalists described children as blessings from God, they also portrayed childlessness as “an affliction.” In an attempt to continue their pro-family stance, Catholics grappled with their early position on birth control pills in relation to promoting fertility. News journalists asked if such pills used on a doctor’s advice for fixing extremely irregular ovarian cycles are legitimate even if they involved temporary sterilizations? Catholic leaders initially compared hormone pills to a variation of the rhythm method (#1010, *Time*, 1961; #1014, *Time*, 1964). Pope Pius XII told the *Saturday Evening Post* (#1004, 1960) that the Pill is legitimate if it is used to prevent miscarriage. *Christianity Today* (#4061, 1990), a common critic of assisted procreative technologies, also reported in its earliest article about infertility “Christian doctors approve *in vitro* fertilization” as well as a number of other new reproductive technologies “as long as sperm and egg are provided by husband and wife.”

As one in eight couples experienced infertility, intense religious beliefs likely informed the way infertility was approached for many. For many traditional Judeo-Christian women, having children was critical to identity. Michelle Friedman, a New York City psychiatrist said, “Not having children is unheard of. The continuity of the covenant is bedrock” (#4077, *Newsweek*, 1994). Many said their decisions to have children were based on religion: “Happy is the man whose quiver is full” and “Children are a gift from the Lord.” Christian publications extolled the unique benefits of large families. Leslie Legland Fields explained in *Christianity Today* (#5136, 2006) that children with many siblings were more tolerant. Large families practiced living with a variety of temperaments, quirks, and ages. They learned to get along, work together, and share. They could not retreat every time they got annoyed. Children have to help each other and enjoy each other’s company. Society benefited too by balancing out “the top-heavy, resource-consuming society of elders” (#5136, *Christianity Today*, 2006). Fields quoted scholars throughout history explaining “wealth flows” in that large families and high fertility rates actually result

in the economic benefit children bring to their parents' lives. According to this perspective, children were resources that garnered happiness, wealth and provision for aging parents.

Women who wanted to bear children on their God's terms faced excruciating choices. Between differences in faiths and strong pressures exerted by the medical industry, couples were often bewildered as to what to do. In articles devoted solely to the complexities of religion and infertility, *Newsweek* (#5080, 2008; #5180, 2008) reported tough ethical decisions even if infertility treatments were allowed: Can a Orthodox Jewish woman use a donor egg from a non-Jewish donor? Can a conservative Christian adopt frozen embryos, knowing that some of those embryos might die in utero? Can Mormons use donor eggs or surrogacy if needed? In 2006, *People* (#5130, 2006) highlighted the epitome of religious conflict through the story of parochial school teacher Kelly Romenesko and her husband Eric who struggled with their religion's staunch views on infertility. Kelly, aged 37 and a lifelong devoted Catholic, said "I'd go to church every day and pray to God to bless us." Still, they had 30 negative pregnancy tests in five years. Finally, with the help of *in vitro* fertilization using Kelly's eggs and Eric's sperm, their prayers were answered in a single attempt, and they gave birth to twins Alexandria and Allison. However, her employer, a Catholic school district in Wisconsin, fired her since the church forbade *in vitro* fertilization. Kelly violated the school rules requiring her to live according to the Catholic doctrine in that childbirth should be the result of natural conjugal relationships, not events in a test tube. While she decided to sue the school district, experts said she faced an uphill battle. Although she admitted she still agreed with much of the Catholic Church's teachings, they had their daughters baptized in a Lutheran church where they now worship. She said she had no qualms about how she brought her babies into the world and that their decision "is between us and God" (#5130, *People*, 2006).

Churches became more vocal in the media against infertility treatments after the growth of procreative technologies in the 1990s and 2000s. Similar to previous research conducted by Sewpaul

(1999) and Greil (2009), several narratives emerged during my analysis which explained infertility through the lens of *religion*. First, infertility was *directly linked to abortion* as discussed earlier in this chapter. Religious leaders used the “slippery slope” argument. In their opinion, the “silent acceptance” of controlling conception regardless of intent could eventually threaten society similar to abortion. For example, *America* (#5204, 2009) described, Project Rachel. Project Rachel was a church supported post-abortion ministry that extended its reach to infertile couples as well through a network of priests and counselors trained to give spiritual and psychological care to people suffering from the aftermath of abortion. Church leaders assumed people coping with infertility preferred to seek help privately, just like those struggling with the aftermath of abortion. Through Project Rachel, people learned infertility could be treated in “harmony with the church’s teachings” like through adoption or forgoing parenthood in exchange for devoting themselves to “their marriage, careers, friendships, and volunteer work on a level beyond what many parents can manage.” Religious leaders suggested that couples seek out doctors who were sensitive to how many embryos are created to prevent having unused embryos. In addition to medical options, Christian reporter Julie Irwin Zimmerman suggested that physicians should give patients moral options too (#5204, *America*, 2009).

Christian publications routinely *criticized the infertility field for immoral actions*. According to Christian magazines, while the goal of helping families have children was laudable, the fertility industry was moving far beyond its original purpose and pursuing procreation with seemingly little concern for the moral cost. These articles used sensationalized stories to support their points: Being pressured to try *in vitro* fertilization, a single mother of six other children giving birth to the octuplets, choosing a baby’s sex and eye color, having over 500,000 frozen embryos with no future plans, and genetic screening and selective reduction (or as some said “eugenics by abortion”) (#5203, *America*, 2009; #5222, *Christianity Today*, 2010). Even Lisa Miller a reporter for mainstream *Newsweek* (#5180, 2008)

wrote that those with deep religious convictions often “feel kind of brutalized by physicians who dismiss your religious views. If you choose against IVF, it is your fault you will have not baby.”

Knowing that procreative technologies were a new reality in our society, Christian publications, also *discouraged medical treatments in the first place* in order to avoid moral dilemmas later. As described in an article published in *America* (#5204, 2009), Catholic leaders acknowledged “by the time Catholics have been to a fertility specialist, it is too late for the church’s teachings to play a role in their decision-making. The desire for a family is too strong at this point to be tempered by a document written by Vatican officials.” Other Christians explained that in the secular world when deeply religious families reject reproductive technologies, they are asked “Do you have a moral objection to conception taking place outside the human body?” They considered this more than a moral objection; they viewed it as separating conception from sex which had long been the goal of the infertility field as previously discussed. Additionally, these articles stressed that marriage joined two people into “one flesh” so whose “fault” it was remained irrelevant. They chastised physicians who tried to solve the problem before couples could even absorb there is a problem. They encouraged readers to believe, “I do want a child of my own flesh and blood. But I want the child to come from my love for my husband. Not love the in abstract” (#5160, *Christianity Today*, 2007).

Christian journalists also framed *prayer* as a viable option for desperate couples, but not as frequently as I expected. For example, infertility was such an unaddressed issue among religious communities that journalists from *Christianity Today* (#5038, 2002) interviewed the pastor of Cedar Park Assembly of God in Bothell, Washington. This paster promoted his Presentation Sunday as a time to pray for “infertile couples.” The authors of this article said more than 150 couples of all religions, including Muslims and Buddhists, credited the service for their new children creating hope for others who simply prayed about their infertility.

In order to move from “spiritual crisis to spiritual quest” (Ryan 2001:160), the final narrative found in Christian magazines was that *God might be sending another message through infertility and childlessness*. Sarah Hinlicky Wilson wrote “Blessed are the Barren” for *Christianity Today* (#5182, 2008) which explored the biblical themes of “barrenness” and for the first time spoke infertile woman to infertile woman. She encouraged those experiencing infertility to use it as an opportunity to minister to others like she had done. In this article, Lynn Karidis also said after four miscarriages, it occurred to her God might want her to have “spiritual babies” rather than physical ones. As a result, she went to seminary to help others through teaching, speaking, advising and spiritual direction. She was confident her miscarried babies awaited for her in heaven. Karidis said, “My womb may be empty, but my heart is full.” Wilson encouraged readers to embrace their church family and biblical teachings. She continued “we will live on after death because we will rise like Christ. We do not see the reality now. It is hidden from us. It is a promise to be fulfilled in the eschaton. To many the eschaton is far away.” According to the Christian media, couples experiencing infertility should feel blessed. In general, these media messages implied that religion and infertility treatments were incompatible.

5.8 The Status of Embryos

To combat religious objections to procreative technologies, supporters said assisting infertile couples who wanted children was noble and within God’s teachings. On the other hand, religious opponents argued since human life begins at conception, the accidental but inevitable destruction of some embryos during some fertility treatments was murder. Even fertility specialists were inconsistent in their portrayals of embryos. On one hand, embryologists explained in the magazines that embryos are “just a group of cells.” On the other hand, Dr. Mason Andrew’s, Eastern Virginia Medical School chief of obstetrics and gynecology, commented “I’d say seeing the picture of that four-cell embryo that went into Judy Carr’s uterus is a most inspiring religious experience” (#3011, *People*, 1982). As I

discussed earlier in this chapter, fertility specialists, as a whole, purposely distanced themselves from public debates regarding personhood or defining when life begins in order not to offend any of their patients. Because the fertility specialists often dictated media's interest in infertility, few stories appeared in mainstream magazines focusing on embryos, particularly the complexities involved with excess frozen embryos.

As the number of frozen embryos grew exponentially in the 1980s, 1990s, and 2000s, eventually resulting in over a half million by 2010, Christian magazines devoted over a dozen articles exclusively to embryos. The issue of "when does personhood begin?" was a common theme within these popular Christian publications. Robert White summarized for his article in *America* (#4073, 1996):

There is really only one essential and ethical question that arises in regard to the use of the human embryo. Does the embryo, even a single fertilized cell, the zygote, represent the true beginning of human life in all of its dimensions, including the spiritual? (#4073, *America*, 1996)

The Catholic Church maintained a strong stance that vitro fertilization was tantamount to abortion in that when sperm and egg unite, a fertilized egg or embryo must be awarded the unconditional respect that is morally due to the human being. In the 1980s, Pope John Paul II, denounced virtually all the rapidly spreading methods of "artificial procreations," deeming them to be violations of both the rights of man and the laws of God:

A child must never be desired or conceived as the product of an intervention of medical or biological techniques; this would be equivalent to reducing him to an object of scientific technology. (#3050, *America*, 1987)

According to the Christian media (#5073, *Christianity Today*, 2004; #5072, *Christianity Today*, 2004), *in vitro* fertilization undermined the value of human life and paved the way for using embryos as raw material for biotechnology sparking similar conversations about stem cell research. Reports of anti-stem cell research appeared side-by-side mentions of infertility. For instance, the government banned federal funded laboratories from embryo research, including extra cryopreserved embryos (some of which had already been frozen for decades as a result of infertility treatments), simply because embryos

may be destroyed regardless of their viability (#5005, *Christianity Today*, 2000). Superman star Christopher Reeve—who was paralyzed in 1995—“was horrified by the waste, arguing it is a pity because these embryos sitting in fertility clinics which contain some perfectly good stem cells, could be put to good use.” Reeves asked, it is more ethical for a woman to donate unused embryos that will never become human beings or let them be tossed away as so much garbage when they could help save thousands of lives (#5073, *Christianity Today*, 2004)? Still, Christian leaders believed using embryos was too close to “playing God” which they repudiated whenever the issue was discussed (#5005, *Christianity Today*, 2000; #5006, *America*, 2000). However, based on my analysis illustrating the God-complex perpetuated by the fertility specialists themselves, this was actually not a huge stretch to question their participation in “playing God.”

Readers shared concerns about embryos with the secular media as well. Families were conflicted--what should be done with frozen embryos? The multibillion dollar infertility industry pushed freezing embryos in order to grow their business. Many infertility patients created as many embryos as possible freezing them for to be transferred later. The fertility specialists made clear in their media interviews that frozen embryos were becoming a major concern with very few reasonable solutions (#3067, *Time*, 1989; #3053, *Life*, 1987). Basically, only four choices existed for patients: they could have their keep their embryos frozen indefinitely (costing about \$500-\$1,000 per year for storage costs), donate them to another couple, offer them for experimentation, or destroy them. Fertility specialists explained that lack of education, government restrictions and high costs prohibited them from offering other options. Physicians encouraged patients to advocate the government on their own for more choices, especially regarding research and embryo donation. In reality, as I discussed previously in this chapter, patients had no power and were completely dependent on doctors, business, and government for their options. Still, fertility specialists tried to remove themselves from this decision and any

responsibility. However, their vague recommendations only delayed patients from having to make an inevitable choice about what to do with frozen embryos.

Another major debate in popular media regarding embryos was ownership of the embryos. Who should made decisions on behalf of embryos? Within a little over ten years after the first successful *in vitro* fertilization, *Time*, through a series of articles on this specific topic, (#3069, 1986; #3069, 1989; #3068, 1989) estimated with the exponential growth of frozen embryos, this dilemma would continue. *Time* (#3069, 1986) presented Risa and Steven York who participated in an *in vitro* fertilization program operated by the Howard and Georgeanna Jones Institute for Reproductive Medicine in Norfolk, Virginia. After three failed cycles, the Yorks moved from New Jersey to California and asked the Institute to ship their remaining frozen embryo to a comparable clinic in Los Angeles. Much to the couple's surprise, the Jones Institute refused their request arguing that the consent agreement signed by the Yorks gave them no rights to the embryo outside Jones' jurisdiction. Moreover, a statute in Louisiana defined a frozen embryo as a juridical person, meaning it has legal status and can only be represented by a lawyer. In hopes of mitigating additional problems, the American Association of Tissue Banks began drafting rules for the handling and disposition of frozen embryos. However, most ethicists interviewed for these articles (#3069, *Time*, 1986; #3069, *Time*, 1989; #3068, *Time*, 1989) agreed the couple's proprietary right to their embryos is not absolute regardless of new guidelines or laws.

Custody battles became commonplace in the mainstream media as well, bringing more attention to the legal status of embryos. In 1993, *Time* (#4109, 1997) told the story of Maureen Cass who was infertile due to DES exposure. Cass sued her ex-husband over embryos created after failing to conceive through numerous cycles of IVF costing them a total of \$75,000 over five years. Maureen argued Steven, having helped conceive the embryos, has no right to "unconceive" them. New York judge, Angelo Roncallo, agreed basing his decision on the U.S. Supreme Court's holding that "a woman,

and not her husband, has the right to decide whether or not to get an abortion as it is the woman who physically bears the child and who is more directly and immediately affected by the pregnancy (#4109, *Time*, 1997). Steven's attorney responded that the right to control her own body should not extend to a can of liquid nitrogen. A leading authority in the field of reproductive rights, University of Texas law professor John A. Robertson, suggested that a spouse should not be forced into procreating unless the frozen embryos represent the other spouse's last chance for parenthood (#4069, *People*, 1998).

With still no guidelines as to embryos more than a decade later, lawsuits among parents arguing about embryo "custody" continued to be highlighted in the media. *People* (#5143, 2007) included human interest stories, such as Natallie Evans who was diagnosed with a pre-cancerous condition that threatened her ovaries and could destroy the chances of having a bay. As a result, she visited a fertility clinic with her fiancé Howard Johnston and created embryos and froze them to use later "when—and if—she survived her cancer." Shortly thereafter, Evans and Johnston split up. Evans received a letter from the fertility clinic saying Johnston wanted the frozen embryos they created together destroyed. Johnson claimed he removed his consent because he did not want a child born with whom he was not involved. The court ruled in Johnson's favor finding his decision to not have a genetically related child with her outweighed her desire to be a mother.

Embryos remained biggest controversy related to procreative technologies in the media, inviting the most criticism and questioning ethics and morals within popular magazines. However, it was not just a political or moral issue. Many families, regardless of political leanings, did not know what to do about their "left-over" embryos. In general, there were no good solutions or anyone. Additionally, a lack of education about how to make a decision and an inconsistency as to what people usually do about this issue existed. As a result, most people just put off the decision indefinitely and continued paying the clinics thousands of dollars per year for storage. Given the vast amount of frozen embryos and the length of time many of families were been in limbo about this, time became a very real concern in that

eventually someone would be forced to make a decision, most likely based on political gain. In fact, pending legislation and the continued silence of the fertility field on this issue brought this reality closer each year.

5.9 Fertility Specialists' Perspectives about Controlling Fertility

For many men and women, biology inhibits the ability to procreate. However, as seen throughout this study, infertility extended beyond basic biology to include many social situations, such as age, sexuality, race, and class. Given varying expectations about procreation as well as the expense of fertility treatments, fertility specialists must actively recruit new patients. As a result, the infertility field's control extended beyond the individual patient. When asked about the media's relationship with infertility and how infertility has typically been reported by the media, all the fertility specialists I interviewed indicated they originally sought media attention. In fact, several of them were directly quoted in the magazine articles I analyzed elsewhere in this study. These fertility specialists piqued media's interest in treatment, mostly to encourage patients to call their clinics. As a result, these fertility specialists often supplied the information contained in the articles and looked for ways to promote themselves and their clinics further. Given procreative medicine was a new field, they had to find ways to reach potential patients, and the media were viewed as the best and most direct method:

We knew from the very beginning that in order to get patients, we had to get the media involved. We all hired PR agents. At first, we would send out press releases explaining that we had "big news" and it would be announced at a specific time and at a specific place, usually our clinic. They would all show up and then we would end up on the news. (Dr. Appleton)

The media have always been interested in the newest and greatest. The first IVF. The first IVF in Kansas. The first IVF resulting in twins. The first set of septuplets. And so on. The media wasn't [*sic*] much interested in the regular stuff, just the innovations. Often they exaggerated, but as long as they got patients to call us and come in, we didn't really care. After a while, the media also started reporting what I usually like to call extreme human interest stories that chronicled people's unusual journeys through infertility usually resulting in a happy ending. We just told them what they wanted to hear. (Dr. Davis)

Consistent with my media analysis in this chapter, the field of procreative medicine was unique in that it straddled the line between medicine and business, probably more so than any other medical specialty or discipline, with the exception of possibly plastic surgery. Infertility lacked a clear diagnosis, and treatments were expensive and largely paid for out-of-pocket. As a result, I was curious as to why these doctors would purposely choose this particular field which is officially called “reproductive endocrinology and infertility” or REI. All board-certified fertility specialists started out as primary care physicians or ob/gyns and then completed a two to four year fellowship focusing only on infertility and procreative technologies. According to the fertility specialists whom I interviewed, REI was very homogenous, outcomes based (a woman either gets pregnant or not), and self-governing, as opposed to obstetrics and gynecology. Few guidelines or restrictions existed regarding treatment decisions allowing fertility specialists to design their own standards of care. These varieties in standards of care allowed fertility specialists to develop their own competitive edge when attracting new patients. When asked what first attracted them to REI, they said:

At first, people went into the infertility field because it was a mission. They wanted to help people and change lives. After IVF, REI [reproductive endocrinology and infertility] was the field to go into. At this time, there were all kinds of women, babies, and problems with women trying to have babies. Lots to do and lots of money to be made. (Dr. Davis)

I went into infertility because I had two uncles who experienced infertility, and I thought that it could happen to me. Ob/gyn was boring to me so I thought infertility would be more exciting. There was a lot of technology and that interested me very much. After I got into it, it became a good living. It was very stimulating and not a lot of hours. Plus the money was good, although probably not as good as people think. (Dr. Elliott)

Although these doctors shirked the connection between medicine and business, I found it interesting that both of these interviews included mentions about money. Throughout my interviews, other “business” terms were used as well, such as ROI (return on investments), revenue, sales, discounts, customers, and marketing, clearly reinforcing the business side of infertility.

At the same time, the fertility specialists whom I interviewed tried to downplay the business aspects of the infertility field. Most made contradictory comments. For example, “working with

infertile couples is very rewarding, but I don't make as much money as people think," "I always donate an IVF cycle or two each year for families who really need it. It's great publicity for us," and "We keep close track of how many IVF cycles we sell." In terms of access to appropriate fertility care, the fertility specialists I interviewed were divided. Three supported insurance coverage and cheaper costs:

If insurance can cover a \$10,000 surgery for tennis elbow, why not infertility? It doesn't make sense. Young productive people are paying into the insurance system. They are healthy, but when they need IVF it's viewed as elective. (Dr. Appleton)

The other three disagreed. For example,

My patients want to pay out-of-pocket. This way they don't have to deal with the insurance company at all, and they know what they are getting. They wouldn't want it any other way. (Dr. Carter)

However, none of them knew the current costs for *in vitro* fertilization at their respective clinics or thought about the financial stress experienced by their patients. They typically referred me to their business offices for more information about pricing. Dr. Baker explained, "I don't want to have to worry about money when I treat my patients. That's not the job of a doctor." Most assured me that they were doing it for the lowest price they could, although prices for *in vitro* fertilization varied between clinics—from about \$5,000 to \$15,000 according to their websites. Also, no transparency for these prices, such as what each cost includes, existed either. These fertility specialists limited a patient's ability to make a thoughtful decision perhaps declining treatments by abiding by the "trust me, I'm the doctor" and "you should be willing to do anything for a baby" type mentalities.

As seen in my media analysis, another method for generating interest in infertility was to portray the complexity of procreation and the need for professional involvement in "controlling" fertility, either to prevent pregnancy or to achieve it. The fertility specialists whom I interviewed were all very proud of learning to control fertility. Despite their claims of altruism, all readily stated that their ultimate goal was to "control" all aspects of procreation. Moreover, they did not see this "control" as problematic. Dr. Baker said,

For most of my early career as an ob/gyn, conception was mysterious. No one really had a clue what happened during conception. Little by little, we figured it out. Once we figured it out, we wanted to learn how to control it—or to influence it so more people could have babies. Why leave it up to nature when we can better ensure outcomes? We made conception much more efficient.

Because maintaining procreative control was critical for sustaining the REI field, Dr. Carter explained,

Everyone who works in infertility has been involved with all aspects of family planning from birth control to delivering babies to creating them. It's always the same people doing all the work figuring out the best ways to do things. It's a small world and very interconnected, even incestuous some might say.

Although fertility specialists competed with each other for new patients, they maintained an overall sense of camaraderie that was essential in order to perpetuate their collective control over procreation.

Because of the clear separation between procreation and sex promoted within fertility medicine as I discussed earlier, I also asked if procreative medicine would ever replace sex. Dr. Elliott responded,

Yes. I see a day when busy couples, with the financial resources, will come to us right away to get pregnant. Sex is very inefficient. It can take months or even years to get pregnant on your own. Many couples today do not have time for this, especially if they are older. We aren't there yet, but I do see a day when it does happen. Of course, sex will never go away, but it won't always be needed for making babies.

Supporting findings elsewhere in my study, procreative sex was portrayed as not enjoyable but rather as work. These fertility specialists ascribed to the hegemonic discourse that medicine is always better, especially compared to “natural.” Further negating the biological process of procreation, one doctor felt that fertility specialists should determine who should have children:

I think it is reasonable for a fertility doctor to assess whether or not someone is capable of being a good parent. I've had patients who come to me for all the wrong reasons, and I feel like it is my job to tell them or refuse to treat them. I know there are others who will treat anyone, but I don't think this the best idea. It usually ends badly. (Dr. Baker)

One of the fertility specialists continued to present me with scenarios (i.e., an unemployed single mom, a woman with a husband dying of cancer, a woman with six other children, a woman who wanted to use her daughter's eggs, etc.) and asked me if I would “approve” procreative technologies for each. He then

told me what he decided in the real situations (he “approved” them all saying who was he to stop a woman from obtaining fertility services if she wanted it and could afford it further equating fertility care to a commodity). Additionally, several of the fertility specialists preferred working in REI over ob/gyn due to the caliber and quality of the patients. Dr. Davis explained, “When I was in private practice as an ob/gyn, I saw women of all walks of life, making all kinds of decisions. REI allows me to work with professional and motivated women who want a baby.” Comments like these highlighted significant social stratification within infertility, both in terms of receiving and providing care.

Given the exponential growth of the infertility field, I expected these fertility specialists would be concerned about the diversity in care. When asked about the need for guidelines to ensure consistency across clinics and fertility specialists and prevent problems (something that was rarely discussed in the media), Dr. Baker responded,

Guidelines are okay, but I’m against government regulations. Fertility clinics need flexibility. I read the guidelines, but if I disagree, I need to be able to make my own decisions. This is far better for the patients in my opinion. Realistically, regulations could be the end of this field.

The consensus was that the fertility field was already successful at self-regulating itself. As a whole, they were not at all concerned about mistakes or misconduct by their colleagues. Despite the numerous media stories to the contrary, these fertility specialists felt that these types of abuses were few and far between:

While some clinics are clearly better than others, I don’t know of any fertility doctor that has done something unethical. Maybe it’s not something I would have done, but their intentions were good. It’s not my job to judge another doctor. We are trained professionals who devote our lives to practicing medicine. I respect my fellow doctors. I wouldn’t want someone to question any of my decisions.

Others downplayed the negative media stories pertaining to infertility, even when I brought up specific examples included in my media analysis. Dr. Davis said, “Those types of things rarely happen, although the media is all over it when they do, making it seem much worse than it is” This remark shifted any

blame or responsibility away from the fertility specialists. Overall, these fertility specialists saw their autonomy as very important and supported decisions by their fellow doctors even if they did not completely agree. Overall, this fertility specialist “elitism” resulted in opportunistic entitlement and an arrogant rejection of fallibility. With only 900 fertility specialists nationwide, this group of doctors was small and close-knit, encouraging them to work together toward common goals.

None of the fertility specialists saw any conflict between religion and what they did. Four called themselves “religious.” However, none were active in discussing infertility within the context of religion, especially with those patients who might be conflicted. They claimed patients needed to decide for themselves, and doctors should not be involved with this discussion, again holding patients ultimately responsible for their decisions and neglecting social forces that influenced procreation. All the fertility specialist also viewed embryos as a major point of contention within the fertility field. Given the current proposed “embryo as personhood” legislation in several states throughout the country (including Georgia), they were well aware of this political hot-button. However, they were reluctant to get personally involved or even express opinions, even though these new laws could threaten access to infertility treatments. For example,

I can't get involved. I see patients from all sides of the political spectrum, and I can't afford to make anyone mad. If patients want to keep IVF available, then they need to be the ones who lead the fight. They should be the ones writing letters and calling their legislators. I don't really see it as my job. I'm busy enough as it is, and I don't have any time to get involved with politics.
(Dr. Davis)

Not only were women responsible for their own fertility, but fertility specialists also expected them to become politically active in order to keep procreative medicine legal for everyone else.

Although the fertility specialists clearly opposed any personhood laws that would restrict infertility treatments and harm their business, their views about embryos were inconsistent. They all explained reality that not all fertilized eggs result in a live birth, even in “natural” conditions. Still, all of

the fertility specialists felt that they “cared for” the embryos in an ethical and respectful manner. Dr. Carter replied,

I get so angry when people accuse me of not being ethical with embryos. I view all embryos as a potential for human life. I treat them with utmost respect. I take good care of them and worry about their futures. I know my colleagues do as well.

Dr. Grant called them “tiny souls on ice.” These remarks reinforced personhood for embryos although this might not have been their intention. I think this conflict stems from fertility specialists being so caught up within their own context as fertility experts that they do not realize how specific words sound to others, especially to those with opposing views. Most people hold a distinct viewpoint on personhood issues and are unable to navigate any gray areas in between.

I also asked about some of the ethical questions pertaining to embryos, such as who really “owns” them or who is ultimately responsible for them. Dr. Grant responded,

Yes. It’s true. At first, we [those who were involved with the early *in vitro* fertilization procedures] “owned” the embryos. After all, we didn’t know what we were doing, if it would be successful or what would happen next. We needed to protect ourselves and our interests. We had lawyers and the university’s leadership advising us. Of course, we changed our thinking once we saw what was happening. However, there were no good options that everyone liked. (Dr. Grant)

For the most part, they agreed that patients now “owned” their own embryos, based on signed contracts; however, the clinics administered their own contracts and ultimately the oversight of the embryos, making it difficult for a patient to challenge a clinic if a problem or disagreement arose. In addition, clinics were reluctant to destroy or dispose of any embryos even if patients agreed with this method of disposition, were unreachable, or missed storage payments. Dr. Grant said that he did not want to be held responsible if families changed their minds later and regretted their decision to destroy any embryos. For liability reasons, he said it was safer to keep them frozen indefinitely. Again, this sent mixed messages about the status of embryos, especially in the eyes of fertility specialists.

Although many issues of control permeated the infertility experience, women were not passive participants. Ultimately, women must define their own experiences and construct meaning in situations not of their own choosing (Greil 2009). However, because the fertility specialists strongly influenced information shared by the media, accurate and unbiased information about infertility and its treatments were virtually non-existent. Consequently, women's decisions were more difficult given their lack of agency. A variety of social forces, especially within a largely capitalist environment, dictated the value of parenthood and the methods necessary to achieve it.

CHAPTER 6

PROCREATIVE TECHNOLOGIES

Any sufficiently advanced technology is indistinguishable from magic.

--Sir Arthur C. Clarke

In 1978, the first baby was born via *in vitro* fertilization. This technological breakthrough sparked a new age for infertility in which procreative technologies proliferated as did media attention towards them. Although very little data explaining public attitudes and behaviors surrounding infertility treatments existed, the National Survey of Family Growth (NSFG) collected limited data related to infertility among women of childbearing age (15 to 45) since the 1970s. Because procreative technologies evolved significantly over the past several decades, these data sets were inconsistent and changed with each cycle making comparisons across time impossible. As a result, there are few published studies utilizing these data from which to draw; therefore, I verified trends found in my media analysis and interviews with fertility specialists by analyzing the original data sets.

To place the media representations of infertility treatments in better context, I highlighted some statistics directly from the NSFG in my study. Although this type of self-reported data used in the NSFG, especially regarding sensitive topics like procreation and infertility, was limited, these data provided some insight into the actual usage of infertility services compared to the media attention received. Articles specifically addressing procreative technologies saturated the media starting in the 1980s and continuing throughout the 2000s, with each decade containing more articles than the previous one. Each new treatment option generated tremendous publicity about infertility and the resulting medical, legal, and ethical issues. Culminating in the late 2000s, literally hundreds of articles highlighting procreative technologies ultimately concluded that procreative technologies were relatively commonplace with over one millions babies born via *in vitro* fertilization.

In 1976, two years before the first successful birth via *in vitro* fertilization, all 16 questions related to infertility included in the NSFG (Cycle 2) were listed under “Sterility,” a term evoking a more permanent status with no opportunity for medical intervention. More specifically, all of the “sterility” related questions asked of the 8,982 married women who completed the survey revolved around sterilizations intended to prevent pregnancy permanently. Overall, 28 percent of all respondents stated that pregnancy was “impossible” for them. Of these, 92 percent explained this “impossibility” was due to surgical sterilization. For the other 8 percent, no other reasons for their inability to become pregnant were listed even though 90 percent of these women wanted additional children. Family planning questions also included only topics related to birth control. Overall, researchers developed this national survey about “family growth” based on an essentialist view point that motherhood was natural and inevitable. By also asking women about their family size expectations and desired gender make-up in this survey, researchers assumed women were in control of their fertility as discussed throughout my study. They suggested that “Sterility” only resulted from one’s personal decision not to have more children.

As procreative technologies became more available, these data in the NSFG expanded each year as well. By 1982—a few years after *in vitro* fertilization became available--the NSFG (Cycle 3) collected more data about infertility, including 25 new questions. Of the 7,969 married women surveyed, 30 percent stated that it was “impossible” for them to get pregnant. Again the researchers implied the permanence of infertility. Researchers also continued the question category “Sterility,” and included only surgical reasons for not being able to have children. More specific data were collected about dates of surgeries, reasons for sterilizations, type of procedure performed, and desires for reversal.

By the next version of the NSFG (Cycle 4) in 1988, a new category of “Infertility Services” was added to the existing “Sterility” category. In addition to surgical sterilization, researchers asked a few other questions about the “impossibility” of getting pregnant, such as illness, accidents, no menstrual

periods, and menopause. Respondents could also indicate if they experienced a “problem” or “difficulty” with getting pregnant, although no specific reasons for this difficulty were included. Only 3 percent indicated that it was “impossible” to get pregnant while nearly 10 percent of the 8,450 women surveyed stated that they encountered a “problem” or “difficulty.” Since this survey was not just limited to married women this time, 98 percent of unmarried or un-partnered women stated that they expected that it would be possible for them to get pregnant, suggesting unrealistic expectations about fertility.

Of those who had difficulty, about half had ever visited a doctor about getting pregnant, with 80 percent actually receiving advice or treatment representing hope in that their infertility could be overcome. Conversely, only about 5 percent of those who responded that it was “impossible” to get pregnant sought medical assistance, indicating a greater sense of hopelessness. In terms of specific services and treatments, responses included advice, testing, surgery, fertility medications, artificial insemination, and *in vitro* fertilization. Because the survey did not specify the type of doctor seen, over half of all respondents receiving some sort of fertility treatment stated that they received medical advice about intercourse and conception. As I will discuss later in this study, doctors did not enjoy talking to their patients about sex. (In fact, the medicalization of conception allowed fertility specialists to forgo this conversation.) About 30 percent of the survey respondents received ovulation drugs, five percent underwent artificial insemination, and less than 2 percent had *in vitro* fertilization. Although very few families pursued procreative technologies, media attention still grew giving a false impression about procreative technologies. However, as I will discuss throughout this chapter, the media portrayed the utilization of procreative technologies as more common.

By 1995, the data set for the NSFG (Cycle 5) completely differentiated between “Sterilizing operations” and “Infertility,” introducing new categories of questions on: “Infertility services,” “Medical help to get pregnant,” and “Infertility diagnosis.” Of the 14,000 women who responded to this survey,

only 5 percent reported receiving medical help to get pregnant. Half of those women who indicated they received medical help getting pregnant only visited the doctor once or twice—not long enough to receive any treatment, especially involving procreative technologies. In terms of timing, advice about intercourse and conception was usually provided first, followed by fertility testing, ovulation drugs, and “artificial” methods involving “surgeries.” Given that there were no public or low-costs infertility clinics, nearly all the respondents sought care from a private physician with 75 percent of these visits covered by private insurance, suggesting that a fertility specialist was most likely not consulted.

Recognizing the men were involved with “family growth” as well, researchers included both women and men in the NSFG for the first time in 2002. Overall, 12,571 women and men completed this survey the NSFG (Cycle 6). However, the survey only included eight very general questions for men about infertility. As I discussed in Chapter 4, many fertility experts assumed that men were uninterested in fertility and disconnected from any treatments. For women, 62 questions were asked under “Infertility Services and Reproductive Health” which also now included questions about HIV as well as douching, pelvic inflammatory disease, endometriosis, uterine fibroids, ovarian cysts and diabetes—all independent of their impact on fertility. Although researchers (Greil 2009; Becker 2000) found that women are more likely to initiate fertility treatments, about 8 percent of both men and women reported seeking medical help with getting pregnant in this survey. Similar to the previous NSFG survey cycle, most women seeking fertility care visited a private doctor covered by private insurance suggesting a class difference in accessing fertility care. Again, advice was the most commonly received treatment followed by fertility testing, ovulation drugs and artificial insemination. However, at this point, more patients received fertility testing earlier in the process, indicating that ob/gyns and primary care physicians increased their involvement in fertility care. As I discuss throughout my study, fertility specialists also became more vocal about the need for specialized fertility care under the direction of a

trained professional in the media as well. Specific questions about procreative technologies only included artificial insemination.

Perhaps this lack of data about procreative technologies resulted from the passage of the 1992 Fertility Clinic Success Rate Certification Act that required the CDC to publish annual success rates regarding all assisted procreative technologies. According to CDC's 2010 ART (assisted reproductive technologies) Success Rates, 147,260 procreative technology cycles were performed at 443 reporting clinics in the United States resulting in 47,090 live births (deliveries of one or more living infants) and 61,564 infants. The CDC also stated that use of ART is still relatively rare as compared to the potential demand with only 2 percent of Americans utilizing procreative technologies. As I discussed in Chapter 5, fertility specialists controlled information released about their clinics regarding infertility treatments and success rates in order to increase the number of patients seeking their help. As a result, it is very difficult to obtain accurate data about the usage and outcomes of such treatments that is not influenced by the fertility field itself.

As I discussed in my previous chapters, differences by age, race, and religion also existed in terms of infertility across of the cycles of the NSFG as well. With each survey cycle, the percentage seeking medical assistance increased with age, especially over the age of 35. The highest rates were seen at age 45 (the oldest women "of childbearing age" surveyed) with between 15 and 20 percent seeking medical help getting pregnant. Although infertility affected men and women of all ages, these "last chance mothers" were a significant component of consumers of infertility service, making it difficult for fertility specialists to discourage them regardless of chances for success. Also, a higher percentage of African American women indicated that it was "impossible" for them to get pregnant while a higher percentage of white women indicated that they experienced a "problem" or "difficulty" with getting pregnant. Overall, African American women perceived their infertility as more permanent (and perhaps less hopeful) than white women. Additionally, half as many African Americans as whites,

Asians or Pacific Islanders, and Alaskan Natives or American Indians reported ever talking to a doctor about getting pregnant. African Americans had a much different lived experience with regard to infertility influencing their utilization of fertility services. Moreover, these significant differences were not adequately explained in the articles that I analyzed in Chapter 4.

Religion also played a role in fertility related behaviors, but not in the way suggested by the Christian publications analyzed in Chapter 5. In general, a respondent's religion did not inhibit fertility care: the same percentage of Protestants; Catholics; Jews, and "others" sought fertility care. Similarly, rates of obtaining specific fertility treatments, including *in vitro* fertilization and artificial insemination, remained consistent across all religions. However, those stating "no religion" were less likely to seek fertility care or receive treatments. In general, religiosity encouraged parenthood through any means necessary rather than deterring families from utilizing current procreative technologies. In sum, these data supported my finding a variety of social forces influence decisions about infertility which I will now discuss in this chapter.

6.1 Treating Infertility

Even before the availability of procreative technologies, articles in the 1960s reported that physicians were "swamped" by patients wanting help with infertility (#1016, *Time*, 1964; #1018, *Time*, 1965). While a couple of articles mentioned using newly discovered fertility medications to promote ovulation (#1031, *Today's Health*, 1968; #1005, *Time*, 1960), primary causes for infertility included sexual dysfunction and lack of sex education. Again, as I discussed throughout this paper, doctors held patients ultimately responsible for their fertility. The article "Cures for the Childless" in *Time* (#1066, 1960) suggested that infertility patients just might be sexually incompatible never resulting in "fruitful mating." Another article in *Newsweek* (#1015, 1964) entitled "Flat Chested Opinion" blamed infertility on the body type of the woman. Women with an "ectomorph" body type—slender with small hips and

busts—were less likely to bear children compared to fuller figured women. Furthermore, this sexual “defect” was predicted by intelligence. Dr. William Sheldon told *Newsweek* (#1015, 1964) that he found over half of women with this body type had been in the top 10 percent of their class and over two-thirds were above average intellectually. Adhering to specific gender roles, Sheldon perpetuated the idea that infertility was an affliction faced mostly by highly motivated and educated women due to their rejection of traditional roles for women.

In 1966, famed sex researchers Masters and Johnson designed a detailed program lasting up to a year to “cure” infertility highlighted in *Time* (#1022, 1966). This program explained basic physiology and reassured husbands that infertility did not mean impotence despite that most of the media indicated otherwise. Next, Masters and Johnson explained the best timing for intercourse in relation to ovulation and the best sexual positions to increase the likelihood of pregnancy. Masters and Johnson indicated this program proved successful for at least one couple out of eight. Reinforcing a social hierarchy with regard to fertility knowledge, *Today's Health* (#1031, 1968) reported just learning about conception and receiving assurance from a medical professional was enough to start many couples toward parenthood within just a few months. Journalists implied that couples needed professional medical assistance to learn about how to get pregnant, further emphasizing the complexity of procreation as discussed in Chapter 5 and supporting the need for fertility services.

In the 1970s, 1980s, and 1990s, the media reflected a rush of information about the growing infertility field. With titles like “New Hope for Couples Who Want to Bear Children—and Can’t” (#2024, *Newsweek*, 1978), “New Hope for Barren Women” (#2025, *Science*, 1978) and “Promising New Treatments for Infertility” (#1015, *Science*, 1978), journalists’ presentations focused on the newness of procreative technologies and offered encouragement that these new infertility treatments were successful. Through interviews, quotes, and guest columns, fertility specialists turned directly to the media to encourage potential patients to seek specialized fertility care as soon as possible. *Redbook*

(#4008, 1998) explained a major disconnect between the infertility field and primary care providers—a disconnect that has continued throughout the decades placing a chasm between primary care and specialty care in terms of who controls fertility care. (More about this later.) Much to the dismay of fertility specialists, many women trying to get pregnant stayed with their gynecologist month after month, even for years. Diane Clapp, medical information director of RESOLVE, a national information and advocacy organization for couples experiencing infertility that also worked closely with fertility specialists as well, said in *Redbook* (#4008, 1998), “The expertise of an infertility specialist can make the difference between years of infertility and successful pregnancy.” In the same article, Dr. Chriso Zouves, medical director of Pacific Fertility Medical Center in San Francisco added

[Primary care] doctors may be resistant to suggesting high-tech approaches. They’ll approach infertility treatment with an attitude of ‘let’s try this, then this, then this...’ not realizing that they’re using up precious time, especially if a woman is in her mid-thirties.” These comments contributed to a hierarchy of physicians and further separating those who were skilled to treat infertility and those who were not. (#4008, *Redbook*, 1998)

Given the small group of people able to access fertility services, the fertility specialists’ main goal was to get as many women to seek their specialized and elite assistance as possible.

By the 1970s, many clinics specialized in treating infertility. *Newsweek* (#2020, 1976) reported the best source of information about infertility was The American Infertility Society in Birmingham, Alabama, a professional organization for physicians treating infertility, which could be contacted directly by mail to receive names and addresses of local specialists. *Newsweek* (#2020, 1976) also reported that fertility specialists were some of the busiest physicians given the huge demand for their services and expertise. Through their research, Spar (2006) and Mundy (2008) describe the growing business of infertility as well. *Today’s Health* (#2006, 1972) explained the goal of a fertility specialist was to “check out every link in the reproductive chain from the very beginning, and discover where the fault lay and correct it—if possible.” This qualifier, “if possible,” relinquished fertility specialists from any guarantees of success. Because each patient is different and getting pregnant is often

unpredictable, many fertility specialists relied on trial and error to find out what worked best. Because most had to pay for each new attempt out-of-pocket, families found it problematic to rely solely on the discretion of the physician without any standard protocols or transparency. However, if a baby was born, they often considered any difficulties as a fair price to pay.

In a more recent attempt to maintain complete control of the field, fertility specialists interviewed in *Redbook* (#4008, 1998) suggested looking at the American Society for Reproductive Medicine's (formerly the American Infertility Society) listing of 300 or so clinics that are registered members. Although information was readily available elsewhere, including in Internet, journalists encouraged readers to call the American Society for Reproductive Medicine directly to talk to a "marketing representative" or visit their website www.babies.com, now replaced by their professional website www.asrm.org. Trying to support businesses compared to providing medical care, fertility specialists appealed directly to patients implying they could create babies and taking out any "middle-person" who might say otherwise. Accounting for a variety of factors such as success rates, experience, cycles canceled, complication rates, innovation, numbers of multiple births, and multifetal reductions, *Redbook* (#4008, 1998) recommended ten specific clinics in their "Ultimate Fertility Guide"—the first (and only) list of its kind that differentiated or ranked clinics. The author of this article, Toni Gerber Hop, expected patients would be willing to travel to the "best" clinics rather than seek care locally. However, the exact process used to determine the "best" clinics was unclear. Given my previous discussion about the unpredictability of fertility clinic statistics and self-reported data in Chapter 5, this list likely depended on subjective criteria determined by the fertility field.

Despite the availability of procreative technologies, journalists still included less-advanced methods, alternative therapies and even old wives tales. Perhaps journalists wanted to appeal to a broader audience, most of whom could not afford procreative technologies. In her extensive cover story "Baby Craving," Anna Quindlen (#3053, *Life*, 1987) encouraged temperature charting,

acupuncture, “rebirthing” to discover early traumas blocking fertilization, and standing on your head for three minutes after intercourse as realistic alternatives to medically-oriented fertility treatments.

Likewise, married journalists Deborah and Tom Well, who experienced infertility themselves, minimized procreative technologies by recommending positive thinking: “The doctors tell infertility patients all the time to go home and think good thoughts. It does work” (#3042, *People*, 1986). Again, these articles supported personal control in regulating fertility. Not only were women held responsible for not getting pregnant, women could “will” themselves pregnant too.

In the article entitled “How to Make Baby-Making Sexier,” a reporter from *Redbook* (#5135, 2006) stated that watching sexy movies “with your guy” might help achieve pregnancy faster according to a study conducted at the University of Western Australia. Focusing on the hyper-masculinity of procreation, the reporter explained from an evolutionary point of view, when a man watches a couple having sex, his primal sense of competition with the other man kicks in, and his body goes into overdrive to produce more powerful sperm—and ultimately, healthier offspring. Likewise, taking cues from established gendered expectations and placing the responsibility of fertility back on women, journalists claimed women’s own behaviors were seen to stimulate or prohibit fertility as well. Matthew Hudson, a reporter from *Psychology Today* (#5142, 2007), wrote in “The Strippers Secret” that “Subconsciously, women dress more provocatively and men find them prettier when it’s prime time for conception.” Dr. William Karow, Director of the Southern California Fertility Institute defended these tactics during his interview with *Life* in 1987 (#3053), “My philosophy has always been to try everything that is humanly possible no matter what. You never know what will work.”

This history of juxtaposing “natural” or low-tech treatments with discussions about high-tech methods created uncertainty about infertility treatments. For instance, journalists did not always portray infertility as a legitimate medical condition needing formal intervention. Additionally, journalists stressed that many of the causes of infertility were the result of lifestyle choices (as I discussed in

Chapter 4). Given journalists intermingled messages about seeking medical help with overcoming infertility alone, when to seek fertility care and when to just be patient and not medicalize infertility remained unclear. As follows in the remainder of this study, fertility specialists were motivated to provide more information about the benefits of procreative technologies and the need for medical intervention to overcome infertility.

6.2 Manipulating Biology and *In Vitro* Fertilization

By the early 1970s, Gina Shaw, a reporter for *Time* (#2008, 1973), predicted,

In a matter of years they will be able to remove an egg cell from a woman, fertilize it and grow it as an embryo in a test tube, and then implant it in the mother or even in the uterus of a volunteer, where it will continue to develop until delivery. (#2008, *Time*, 1973)

Leading up to the first baby born via *in vitro* fertilization, *Time*, a major news outlet, provided much of the information regarding this impending technology. Most of these articles were not attributed to specific journalists and the content was largely dictated by the experts interviewed, both for and against advancements in procreative medicine. Initially, *Time* (#2029, 1978) suggested the biggest concern regarding procreative technologies was the welfare of the children produced: “What should be done with the mistakes, the children born deformed or defective as a result of science’s attempts to manipulate life?” *Time* (#2029, 1978) pitted doctors against doctors on this issue. Journalists interviewed Dr. James Watson, the famed co-discoverer of the double-helix who believed doctors had not fully considered the potentially disastrous consequences of their interference in natural processes like procreation. He said while “normally conceived” babies can be born defective, the chances of errors were even greater in a baby produced by “artificial” means like *in vitro* fertilization. This original term “artificial” used to describe procreative technologies implied that these treatments were “unnatural.” As a result, Watson urged his fellow physicians who would attend the births of laboratory-conceived human babies to be given the right to terminate the lives of the infants in they were grossly abnormal.

Again, infertility treatments were tied to abortion, another political and moral hot-button that I discussed in the previous chapter. Because pregnancy termination was sometimes needed for successful pregnancy promotion, doctors reinforced patriarchal control over all aspects of procreation.

By the time summer of 1978, journalists anxiously awaited the birth of what would be the world's first test tube baby with both excitement and skepticism. Months before the birth, words like "Frankenstein" and "Monster" described the baby (#2028, *Time* 1978; #2031, *Time*, 1978). Still unconvinced the birth would even happen, journalists did not know whether to equate it to other medical breakthroughs like the first kidney or heart transplant or see it as more similar to a recent cloning hoax. Fears surfaced about opening "baby farms of mass-produced kids" if *in vitro* fertilization proved successful (#2031, *Time*, 1978). Conversely, another reporter at *Time* (#2028, 1978) predicted if the *in vitro* fertilization was successful, it would give new hope to the roughly 10 percent of married women who wanted to bear children but could not. There was so much uncertainty surrounding the birth that *Time* (#2028, 1978) published rumors that the test tube baby's family, the Browns, agreed to accept \$565,000 allowing only reporters from the *London Daily Mail* to access to the Browns. If the baby died, the newspaper would receive a 40 percent discount suggesting *in vitro* fertilization was more of a commodity than medical treatment. Despite all their coverage of this story, reporters at *Time* never indicated whether or not they thought this first *in vitro* fertilization would result in success or tragedy. Instead, they reported the facts as told to them by experts and left it up to their readers to decide for themselves.

Louise Brown was born on July 25, 1978 in Britain premature, but healthy. In magazine articles across the country (#2037, *Time*, 1979; #2031b, *Newsweek*, 1978; #2036, *People*, 1978), Drs. Patrick Steptoe and Robert Edwards, the doctors responsible for the first successful *in vitro* fertilization, announced Louise Brown was completely healthy. Together with Louise's parents, Steptoe assured the public that "She's going to be an ordinary girl." Louise Brown's father pledged "What I'm hoping is that

by the time she goes to school, there will be hundreds like her" (#2036, *People*, 1978). Despite this "normalization" of the new technology, speculation did not cease. After the birth of Louise Brown, *Time* continued publishing accounts of uncertainty and controversy surrounding *in vitro* fertilizations. Through the media (#2031, *Time*, 1978), scientists around the world "sounded warnings about its disturbing moral, ethical, and social implications."

Criticism of *in vitro* fertilization followed as *Time* (#2035, 1978; #2034, 1978; #2031, 1978) published a series of articles reporting how Chicago's Barren Foundation abruptly withdrew an award that was supposed to be presented to Steptoe and Edwards. (Based on the name of the "Barren Society," these medical professionals still supported the permanency of infertility which *in vitro* fertilization threatened.) The reason for the withdrawal: the two had yet to provide adequate details of their achievement. Dr. Richard Blandau of the University of Washington the board's vice chairman explained to *Time* (#2034, 1978),

There is great concern that Dr. Steptoe has failed to publish and explain fully what he did. To many of us with great experience in the field, it still has not been proved that there was a test-tube baby. For all we know so far, the baby could have been conceived by natural means (#2034, *Time*, 1978).

Blandau also charged Steptoe of violating medical ethics by selling his story to the *National Enquirer* for \$650,000 instead of publishing results in a scientific journal again showing the business side of fertility medicine. Most importantly, he blasted Steptoe for giving "false hope to millions of women because he had not revealed how many failures he had before this one birth" (#2034, *Time*, 1978). As I discuss throughout this study, this false hope continued. Due to the intense competitive nature of the infertility field from the very beginning, fertility experts often expressed opposing views, especially in front of the media. Overall, magazine journalists and readers alike became confused from the very beginning about the benefits and risks of *in vitro* fertilization.

Time also played both sides of the issue by attempting to counteract any fears about *in vitro* fertilization technology with positive attributes, sometimes within the same news publications and

articles. For example, *Time* (#2029, 1978; #2031, 1978) stressed that *in vitro* fertilization was being conducted by very “respected scientists whose accomplishments and progress had been documented in many published papers.” *Time* also distanced *in vitro* fertilization from other public fears such as cloning (a major public health concern that I will discuss at the end of this chapter). Cloning is “asexual, single-parent reproduction” while *in vitro* fertilization “lets nature take its course—sperm from the father and an egg from the mother unite albeit in a test tube” (#2029, *Time*, 1978).

In another article, reporters from *Time* (#2030, 1978) described *in vitro* fertilization very systematically and linked it back to getting pregnant “naturally,” perhaps to make it seem more familiar and allay fears of the unknown:

- Step 1: The woman is treated with hormones to stimulate maturation of eggs in the ovaries.
- Step 2: To locate the ovary, an optical system, called a laparoscope, is inserted through an incision in the abdominal wall. Under direct vision, a needled is then inserted into the ovary to draw out the eggs.
- Step 3: An egg is placed in a dish containing blood serum and nutrients, to which sperm is added for fertilization.
- Step 4: Once an egg is fertilized by one of the many spermatozoa, it is then transferred to another dish of blood serum and sustaining nutrients. For the next three to six days, the fertilize egg divides, creating a cluster of cells called a blastocyst.
- Step 5: After a woman receives further hormone treatment to prepare the uterine lining the blastocyst is placed in the uterus, where it attaches to the wall and normal embryo development proceeds—as it would from a natural conception. (#2030, *Time*, 1978)

Moreover, this passive description of *in vitro* fertilization minimized the role of the physician making him invisible. Again, this helped to naturalize the process. In the end, the sperm still fertilizes the egg creating a “baby” that grows inside the uterus without any assistance—a very simplistic and patriarchal understanding of procreation. The early media portrayals of *in vitro* fertilization were especially important as patients redefined their own sense of what is natural and acceptable. Thompson (2005:141) suggests that “a significant way to normalize the newness of the techniques and the kinship relations and social interventions they represent is to naturalize them as much as possible.”

Although *in vitro* fertilization was still relatively rare in the 1980s, media stories about *in vitro* fertilization grew. Rather than just factual or historical news reports like those appearing earlier in *Time*, reporters from *People* (#3010, 1981; #3011, 1982; #3012, 1982) were intrigued with the human interest angle, especially regarding Allison Carr, the first *in vitro* fertilization baby born in the United States. These glowing reports about *in vitro* fertilization prompted families to seek out *in vitro* fertilization from the handful of clinics offering it. Even though the “success” rates were low, fertility clinics had long waiting lists of thousands of women who wanted to attempt *in vitro* fertilization, often waiting years to obtain an appointment (#3011, *People*, 1982; #3039, *People*, 1986). In a few short years since between Louise Brown’s birth and Allison Carr’s, journalists portrayed *in vitro* fertilization as a viable option for treating infertility that helped many women become pregnant. By not understanding the specifics of *in vitro* fertilization, women remained hopeful that their infertility could be overcome.

By the end of the 1980s, somewhere between 5,000 and 10,000 babies had been born via *in vitro* fertilization (#3012b, *People*, 1989; #3065, *Time*, 1989). In fact, journalist Matthew Hudson (#3012b, *People*, 1989) coined the phrase “the test-tube generation” for children born in the 1980s. Hudson (#3012b, *People*, 1989) also reported on the world’s first gathering of children born via *in vitro* fertilization at Bourne Hall, the very first *in vitro* fertilization center in the world. They had a celebration of “ice cream, balloons, cakes, pony rides, and a Punch-and-Judy show.” In fact, Hudson reported that Bourne Hall was responsible for 1,295 in all, about 10 percent of all “test-tube” babies worldwide (#3012b, *People*, 1989). Consistent with my previous discussion about procreative technologies being considered a miracle over science in Chapter 5, one patient described visiting Bourne Hall as “is like dying and being a friend of St. Peter’s” (#3026, *Time*, 1984). Sparking even more interest and hope among families experiencing infertility, among the most celebrated “accomplishments” were the clinic’s only set of quadruplets and the Britain’s first test-tube twins, Hannah and Peter Emmerson whose mother said, “Hannah believes she is already as famous as Michael Jackson” (#3012b, *People*, 1989). *In*

vitro fertilization, and the babies born as a result, surpassed “normalization” and reached celebrity status, which I will discuss again later with regard to multiple births.

Giovanna Brue a reporter for *People* (#4112, 1998) described the 1990s as the “Golden Age of Fertility Medicine:” infertility patients were increasing, more women over 40 wanted to become pregnant, and more treatment options existed than ever before. Fredrick Golden of *Time* (#4103, 1999) stated that “artificially assisted pregnancies are commonplace—an estimated 300,000 have taken place over the past 20 years.” On her 18th birthday, Louise Brown, the world’s first test tube baby, announced to *Newsweek* (#4099A, 1996), “I want to have my own children, whatever it takes. I would use the *in vitro* method if I couldn’t have a baby.” *Newsweek* (#4073, 1995) was the only popular magazine to include that fertility treatments “fail more often than they succeed.” However, this statement was quickly followed with a quote by fertility expert Dr. Mark Sauer: “We’ve seen huge changes in the past ten years, it’s hard to imagine where we might be in another ten,” dismissing any concern that the accolades may not be accurate (#4073, *Newsweek*, 1995). Again, any fear about procreative technologies was off set with hope.

Over three decades later, popular media brought the coverage of *in vitro* fertilization full circle. *Newsweek* (#5213, 2010) reported that Robert Edwards, the man who made it all possible, who readers had probably forgotten all about at this point, received the highest form of recognition by winning the Nobel Prize in Medicine. Starting in the 1950s, his research led to the birth of some 4 million people nationwide through *in vitro* fertilization. The Nobel committee said Edward’s work represents “a milestone in the development of modern medicine” (#5213, *Newsweek*, 2010). In 50 years, manipulating the mysteries of biology through *in vitro* fertilization went from impossible to hoax to one of the world’s greatest scientific breakthroughs.

As *in vitro* fertilization became more routine, articles about *in vitro* fertilization subsided. Often, mentions of *in vitro* fertilization were just absorbed into general articles about infertility making it

difficult to separate *in vitro* fertilization from treating infertility in general. As I discussed in my previous chapters, journalists portrayed infertility as something that could be overcome with the right technologies and enough money, time, and effort. After *in vitro* fertilization, journalists focused on newer technologies and other procreative medical firsts to garner more attention to infertility and provide hope to even more families.

6.3 Artificial Insemination and the Value of Sperm

In the 1960s, artificial insemination, using the husband or donor's sperm, was the only form of assisted procreative technology available. Over 25 articles about sperm donation appeared in the media between 1960 and 2010, second only to surrogacy (see Table 6.1). The earliest article about artificial insemination analyzed in this study "A Child of AI" featured in 1967's *Time* (#1028) stated that at least 150,000 Americans had been born through artificial insemination. In the 1960s, artificial insemination was still limited to married couples and controlled by physicians. George Corner of *The Saturday Evening Post* explained,

Conscientious physicians will not attempt artificial insemination unless both the husband and wife are ready for parenthood and fully agreed upon it, nor without complete anonymity of the donor, and careful selection of one suited by lineage and physical character to substitute for the sterile husband. (#1003, *Saturday Evening Post*, 1960)

Anticipating a growing demand for donor sperm, Dr. Edward Tyler announced his plans to create the first frozen semen bank in *Today's Health* (#1031, 1968). Highlighting the potency of sperm, Tyler explained that a frozen semen bank offered complete anonymity and possibly even "better" sperm from the heredity point of view than the husband's. Donor sperm could be used not only to treat infertility, but also for servicemen away at war in the case of disability or death or safeguard sperm from radiation during a nuclear attack (a topic not discussed again in the media until the 1990s and 2000s).

Emphasizing the power of sperm and the "normalness" of artificial insemination, Tyler stated that sperm

could be stored for a long time and many normal, healthy babies had already been born from frozen semen.

Table 6.1. Number of Articles about Collaborative Reproduction

	Sperm Donation	Egg Donation	Surrogacy	Embryo Donation	TOTALS
1960s	1	0	0	0	1
1970s	2	0	1	0	3
1980s	6	1	16	1	24
1990s	13	7	7	0	27
2000s	3	5	11	3	22
TOTAL:	25	13	35	4	77

Focusing first on the uncertainty and potential problems associated with donor sperm, *Time* (#1028, 1967) warned that sperm banks were controversial given many moral, legal, ethical, philosophical, and religious considerations. For instance, as early as the late 1960s, *Time* (#1027, 1967) published a story about a California court hearing the nation's first artificial insemination by a donor (AID) *criminal* case. The fate of a six-year-old boy Christopher Sorensen who was the product of artificial insemination by a donor was being decided. After a divorce and subsequent illness, the mother demanded child support payments from her sterile former husband, Folmer J. Sorensen. The district attorney charged the husband with a misdemeanor for violating the state law prohibiting the willful nonsupport of a legitimate child. All but one previous case on record considered children born via donor sperm to be illegitimate, whether the husband gave consent or not. Judge James E. Jones, Jr. decided "all children born in wedlock are presumed legitimate of the marital partners" (#1027, *Time*, 1967).

However, whether Jones' ruling would stand up in higher court or how other families interested in donor insemination would be affected was unclear. Even though seven states had tried to enact legislation establishing the legitimacy of children born via donor sperm, not a single state or federal law addressing children born of donor sperm existed throughout the 1960s leaving these children and their families in limbo. Nearly twenty years later, *People* (#3045, 1986) reported that only 29 states accepted the husband of the woman who had the baby, whether or not he the sperm provider, as the father creating more uncertainty about parenthood and genetics.

Insemination with frozen anonymous donor sperm was heavily promoted in the 1970s, 1980s, and early 1990s in an attempt to normalize it. Although no formal records were kept, experts guessed artificial insemination (AID) by donor sperm was increasing (#3045, 1986; #4096, 1990; #4091, *Redbook*, 1992). As with other aspects of infertility, journalists regularly reported growth despite not having accurate statistics. In order to continue normalizing sperm donation, journalists reassured families by stating that pregnancies conceived through AID were considered safe and not any more likely to end in miscarriages. In fact, babies born through AID were "normal in every way" (#2026, *The Saturday Evening Post*, 1978). According to interviews with experts featured in the *Saturday Evening Post* (#2026, 1978), the semen was completely safe, especially since it came from such higher regarded members of society further perpetuating class differences with regard to procreation:

Usually provided by medical students, interns, and medical residents. We are able to get good medical histories from the sperm donors. This is important since it is, of course, desirable to screen out any possibly dangerous hereditary diseases. (#2026, *Saturday Evening Post*, 1978)

Dr. Sherman Silber (#3018, *Saturday Evening Post*, 1982) also told readers that sperm donors are carefully screened, especially for genetically transmitted diseases, gonorrhea, herpes, AIDS and to rule out drug use and/or promiscuity. Sperm donors remained anonymous and relinquished all parental rights. Journalists also portrayed donor insemination as not only safe, but also "good for the family." A study published in the *Saturday Evening Post* (#2026, 1978) found "couples who seek artificial

insemination with a donor sperm (AID) have only one-eighth as many divorces as couples in the population has a whole.” As a result, physicians regularly encouraged “deserving” couples to seek donor insemination. This patriarchal model inhibited women from choosing donor insemination without a physician’s approval.

Journalists also framed donor insemination as a viable (and often preferred) method for family building, especially compared to other methods such as adoption, increasing the market for fertility services. The *Saturday Evening Post* (#2026, 1978) reported many couples turned to AID because adoption options are almost non-existent since “abortion has dried up the market.” In an article entitled “Babies for Infertility Couples Part 2...for Males” (#3018, *Saturday Evening Post*, 1982) written by Dr. Sherman Silver, artificial insemination was described as the simply “adopting sperm” for couples who are unable to adopt a child (due mainly to the fact that “unwanted babies are no longer easily available”) (#3018, *Saturday Evening Post*, 1982). Similar to *in vitro* fertilization, journalists linked insemination with donor sperm to more natural and traditional methods for family building. However, in my analysis, adoption was rarely discussed within the context of infertility except in comparisons between treatments like I just mentioned. Journalists did not view adoption to be relevant to readers interested in procreative technologies. Apparently, the target audience interested in adoption was different than those pursuing procreative technologies.

Journalists promoted sperm donation using gendered expectations. For instance, AID allowed infertility to be kept secret, illustrating that infertility was still stigmatized, particularly men’s infertility. Given the strong connection between sperm and virility described in the Chapter 4, donor insemination allowed a “remarkable morale boost for men.” No one needed to know his sperm did not impregnate his wife and his infertility could remain invisible. Most of the time, only the doctor and the parents knew about the use of donor sperm. In fact, even the obstetrician delivering the baby usually was not aware of the AID. For mothers, AID also satisfied the “craving for caring a child from conception” which

adoption did not (#2026, *The Saturday Evening Post*, 1978). Consequently, journalists emphasized the importance of pregnancy and genetic ties between mother and child (compared to fathers) within the AID narrative.

By the mid-1990s, fertility experts introduced ICSI or intracytoplasmic sperm injection dramatically decreasing the need for donor sperm (see Figure 6.1). Before this, the only option for men with low sperm counts was sperm donation. ICSI allowed men with very low sperm counts to become biological fathers by injecting a single sperm into the egg during *in vitro* fertilization. Annetta Miller of *Newsweek* (#4098, 1994) first reported on this new breakthrough by interviewing Dr. William Gibbons, chairman of the department of obstetrics and gynecology at the Jones Institute for Reproductive Medicine at Eastern Virginia Medical School who explained, “It’s an extraordinarily exciting time.” Both *Redbook* (#4105, 1998) and *Time* (#4109, 1998) included the personal story of physician and testicular cancer survivor Jim Redington and his wife Sarah of Hot Springs, Virginia. Almost immediately upon hearing of this technology, they went to the Eastern Virginia Medical School in Norfolk to try it with Jim’s sperm that had been previously frozen. In August 1995, their baby girl was born—the first baby born through ICSI in the United States. Similarly, *Redbook* (#4008, 1998) reported another heart-warming ICSI story about Ken Kreher, a paraplegic, sought the assistance of Dr. Sherman Silber in order to extract sperm directly out of his testicles to fertilize his wife Lori’s egg through ICSI. The first attempt failed, but three months later she became pregnant. He remembers, “We just went wild” (#4008, *Redbook*, 1998). Although it sounded promising from the media reports, ICSI just added to the overall price of the procedure, and researchers did not know whether or not ICSI increased chance for success. Appealing to patients’ desperation, clinics had no problem convincing patients that this was a worthwhile added expense. By 2010, ICSI was used with almost every *in vitro* fertilization, regardless of sperm count, making it more of a business decision than medical necessity (CDC 2010).

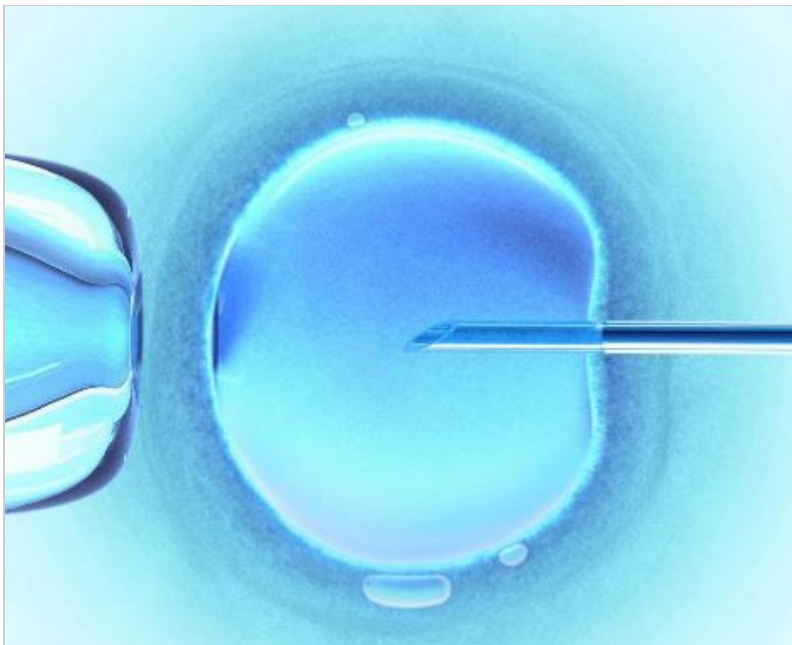


Figure 6.1. Intracytoplasmic sperm injection (ICSI)

Despite ICSI, journalists reported that sperm donation continued to grow. They shifted gears and focused on non-heteronormative uses of donor sperm. *Newsweek* (#5021, 2001) reported that single women accounted for about 40 percent of “business” in many popular sperm banks. Lesbians also used donor sperm. A journalist at *Redbook* (#5236, 2010) said that lesbians typically used a friend or someone they knew instead of a sperm bank. For example, Ilka Bailey and Beth Kluender had dinner with Ilka’s cousin and her husband:

One night at dinner, we were talking about how Beth and I wanted a family and what our options were. Out of the blue [my cousin’s husband] James said I’ll give you my sperm. We were like really?” While the women searched sperm banks, they seemed very impersonal and very expensive so they took James up on his offer and gave birth to a two children within two years. Our kids know the whole story. It’s very clear we’re the parents, but James is in our children’s lives—we see him at least once a week. He is Uncle James. (#5236, *Redbook*, 2010)

Journalists often portrayed lesbian fertility care as separate from more “conventional” families. Usually, lesbians found their own donors or sought care at agencies and clinics specializing in LGBT family

building. These distinctions might have made lesbian procreation more appealing to the general public by implying gays and lesbians “keep to themselves” and were not necessarily involved with the more heteronormative infertility-industrial-complex. Using Howard Becker’s (1960) side-bet theory for motivation, fertility specialists were much more invested in providing treatment to middle-class married couples. However, as patient numbers leveled off, or even dropped in some cases, they targeted new groups. Due to the controversy surrounding same-sex marriage and family building, fertility specialists hedged their bets in order to preserve their primary activity or “main bet” of treating middle-class married couples just in case they lost their “side -bet” of including same-sex couples or vice versa.

Although sperm donation expanded to non-heteronormative groups, gendered expectations and patriarchal control still prevailed. More specifically, most fertility clinics mandated at least one visit with a mental health professional for un-married women, not something routinely recommended for their married counterparts. While fertility clinics did not see themselves necessarily as “gatekeepers” per se according to the article “Sperm and the City” (#5225, *McLeans*, 2010), they wanted to prepare single women emotionally as to what to expect. The infertility counselors interviewed by *McLeans* (#5225, 2010; #5021, 2001) about sperm donation concluded they could tell within ten minutes if a single woman was ready for donor insemination or just panicking. Again, reverting back to specific gender roles and a heteronormative family structure, these counselors expected that most women who chose insemination still hoped to meet a man who could share in the parenting.

Extending the reach of sperm donation even more while also stressing the value of sperm, sperm banks marketed to the military in the 1990s where ultimate masculinity was highlighted. According to the article “Saving Plans for a Generation” (#4092, *Newsweek*, 1991), “Banking on the future has taken on new meaning for some military families.” This article portrayed numerous military men as regularly stopping at sperm banks before shipping out to the Gulf. Overall, *Newsweek* (#4092, 1991) reported sperm banks across the country reported getting about 25 donations per week and

hundreds of phone calls. Appearing charitable while growing their businesses, many sperm banks advertised charging about \$450 for two years of storage, as opposed to \$400 per year for civilians. Still, some men were reluctant about this new trend, “You don’t want to be the prophet of doom and gloom. If we have to fight, everybody’s going to come home” (#4092, *Newsweek*, 1991). Journalists countered with the wives’ perspective: “Knowing that he’s going to be in the potentially dangerous situation, I wanted to make sure that I could still have children. His children” (#4092, *Newsweek*, 1991). Similar to Chapter 4, sperm was portrayed as an extension of the man.

Posthumous reproduction as a result of this military sperm banking began to make headlines almost a decade later. Although posthumous reproduction was incredibly rare, six different articles (almost a third of all articles covering sperm donation) depicted different families’ experiences with having children after the death of their husbands between 2004 and 2008 (#5157, *Jet*, 2008; #5062, *People*, 2004; #5147, *People*, 2007; #4025, *Time*, 1994; #5033, *Redbook*, 2002; #5101, *Good Housekeeping*, 2005). As a result, journalists made posthumous reproduction seem more common than it actually was. Additionally, these stories supported the value placed on a husband’s sperm, especially over becoming a mother through other means. Again, sperm equated virility and manhood, even after death. All of the women featured in these stories were successful in getting pregnant with their deceased husband’s sperm and described these children as “a greater love greater than I could have ever imagined” (#5062, *People*, 2004); “an eternal legacy” (#5167, *Jet*, 2008); and “a gift from heaven” (#5101, *Good Housekeeping*, 2005). Because these women still represented heteronormativity, journalists gave no mention to ensuring the mental health of these women as seen with single women and lesbians. Instead, posthumous procreation was portrayed as a normal and natural desire among young widows.

Another popular topic among journalists writing about sperm donation was that of Robert Graham, a wealthy California businessman who collected sperm from Nobel-prizewinning scientists

through his company Germinal Choice, (#3025, *Time*, 1984; #3013, *People*, 1982; #3004, *Time*, 1980; #3006, *People*, 1980). This infamous “genius” sperm continued to make the news for decades.

Graham’s efforts sparked a 2005 book, *The Genius Factory: The Curious History of the Nobel Prize Sperm Bank* (2006) by David Plotz, which received even more press about the children born via this sperm bank. The author spent three years tracking down as many donors and offspring from the bank as possible. Plotz discovered Graham only got three Nobel Prize winners to donate, including William Shockley, a physicist known for his racist views. Contrary to previous reports, Graham did not vet intelligence test scores and veiled the identities in privacy. Plotz also stated after talking to eight of the 215 offspring, they are

Above average as a group, but the range is very wide. The kind of women who went to the Nobel sperm bank really cared about how her child turned out. They were determined to have accomplished kids. Measuring what the donor contributed is impossible. (#5089, *People*, 2005)

He concluded while the Nobel sperm bank offered women more choices, “you can’t manufacture geniuses with a few smart sperm donors” (#5089, *People*, 2005). Still, most people assumed the power of genetics in that families regularly sought gametes from donors with high intellectual achievement—an assumption that the infertility-industrial-complex capitalized on through marketing efforts (i.e., colleges attended, test scores, grades, etc.).

After decades of reporting on sperm donation, journalists finally shared a little bit of information about the real-life sperm donors in the early 2000s. Until this point, sperm donors were clearly missing in media reports about sperm donation indicating sperm was more valuable than the donor himself. The message was consistent across journalists regarding sperm donors—they donated because they really wanted to help other people. *McLeans* (#5025, 2002) and *People* (#5120, 2006) stated despite rumors, sperm donors did not want their genetic offspring to think someone just did it to make a few bucks. Instead, they really wanted to help women have families. More specifically,

McLeans (#5025, 2002) described the story of a medical student talking with a young mother of a donor conceived infant. She said to him,

You should be a donor! He thought about it and decided, People donate blood and bone marrow. This isn't exactly the same thing, of course, but I've got something of no particular use to me right now that's of use to somebody else—it's a good thing. (#5025, *McLeans*, 2002)

A few years later, *People* (#5120, 2006) addressed families worrying about the psychological impact of sperm donation on their children: "No child gets to choose who their mother's partner is, what their creed is, or how much money they will have. I think the vast majority would say they'd rather exist than not." The impact of sperm donation on children and family formation will be discussed in more detail at the end of this chapter in the section, "What Makes a Family?"

I was surprised that journalists focused so much attention on artificial insemination and sperm donation, the simplest of all procreative technologies. In fact, women have long been known to inseminate themselves using the proverbial "turkey-baster method." Because secrecy and shame still shrouded infertility and procreation, perhaps increased media coverage encouraged more women to adhere to the patriarchal model of needing medical assistance for insemination. After all, sperm donation was a multi-million dollar industry in need of a growing customer base (Agigian 2004; Cahn 2009). However, media messages about sperm donation were conflicting. On one hand, sperm was portrayed as interchangeable, replacing one man's sperm with that of another to achieve a much desired pregnancy. On the other hand, as with ICSI and posthumous reproduction, sperm was immensely valued, its power even extending beyond death. In any case, repeated stories about sperm donation normalized the option for all women—married, widowed, single or lesbian--looking for sperm to get pregnant.

6.4 Egg Donation and Preserving Fertility

In 1983, *People* (#3022) announced that UCLA physician Dr. John E. Buster performed the first egg donation procedure, originally called a “human embryo transplant.” This term linked eggs to embryos more strongly than sperm ever was. In this article, journalist Sue Ellen Jares described the procedure, done in a doctor’s office, as involving just five “simple” steps: 1) the ovulation dates of the donor and recipient are synchronized naturally; 2) the egg donor is inseminated with sperm of the day of ovulation is expected; 3) the donor’s uterus is washed after the hormonal peak and a soft plastic tube is used to “capture” the free floating egg; 4) the fluid is viewed under a microscope to find the egg and 5) the fertilized egg is transferred back to the recipient mother with a thin plastic tube. Similar to the early descriptions of *in vitro* fertilization, the doctor remained invisible, yet ironically in total control of procreation.

Unlike *in vitro* fertilization and sperm donation, egg donation could not be easily described as “natural.” When people opt to parent without biology, they rethink parenthood (Becker 2000). As a result, journalists emphasized the benefit of experiencing pregnancy in becoming a parent through egg donation. Buster told *People* (#3022, 1983) that most women would prefer egg donation to adoption because they could still experience pregnancy. Likewise, interviews of women who became pregnant through egg donation included women who saw egg donation as a godsend: “Being pregnant was just the most wonderful feeling,” “I didn’t want to give up that joy of being pregnant,” and “The fact that I wouldn’t be carrying baby not genetically my own wasn’t too much a concern for me as long as I could experience the pregnancy” (#4045, *People*, 1990).

Still, journalists stressed problems with egg donation, particularly with regard to the lack of genetic connection. Many courts gave a genetic parent a stronger legal claim than the gestational parent which was very concerning to women considering egg donation. In the article “And Donor Makes Three,” *Newsweek* (#4093, 1991) journalist Ken Ames interviewed lawyers about the potential for egg

donors to turn around and break “the deal.” Because no clear resolutions as to who is the “mother” existed, genetic claims on the part of the egg donor were very possible. To allay fears about egg donation, journalists lessened the perceived genetic hold of egg donors. Ames (#4093, *Newsweek*, 1991) also interviewed doctors for this article who said the egg donation process as only contributing tissue not a baby. *People* (#4085, 1999) included a story in which one two-time anonymous egg donor said, “I gave an egg. That egg gave the couple the means to have a child. They’re really the parents.” In this same article, another egg donor added, “I didn’t actually make the child, grow the child, give it air and life. I may have given the yeast, but the bread isn’t mine.” A four-time egg donor admitted that she occasionally wondered about the children her eggs produced and hopes to meet one or more of them someday: “The might have healthy problems or family questions or just be curious. But, I am certainly not their mother” (#4106, *People*, 1998). Another egg donor explained, “You know how I am. If I give birth, it will be my child. Egg donation is just a lot easier” (#3053, *Life*, 1987).

To minimize potential risks regarding egg donors changing their minds, physicians emphasized to the media their strong control in the process. Fertility specialists stated they do their best to select donors unlikely to cause problems down the road. Journalists (#4093, *Newsweek*, 1991; #4085, *People*, 1999) explained clinic staff were cautious about accepting donors and looked for donors with a stable social situation and no psychological issues (as far as they could tell at least). Because no standards existed regarding recruiting and screening egg donors, other articles reported much less stringent policies working out fine as well: “Throughout the pregnancy, Kath [the egg donor], who had just one 20-minute counseling session, had no problem remembering whose baby she was carrying” (#4089, *People*, 1993). However, through her research on egg donors, Kalfoglou (2000) found that egg donors frequently lie during their screening interviews. Egg donors apply to become egg donors because they want to donate their eggs. Because they want to be matched with a recipient family, egg donors will often provide answers that put them in the best light.

Unlike sperm donation, articles about egg donation included a lot of information about egg donors from the very beginning. Given the trepidations about using egg donation, journalists allowed readers to “get to know” egg donors personally, perhaps to make readers feel more comfortable with egg donation and the lack of genetic connections in general. Marjorie Rosen from *People* (#4095, 1990) stressed altruism among egg donors: “Whether she is helping a desperate sister, friend, colleague or stranger, the average donor acts out of altruism.” Given more intimate connection assumed between women and their eggs, reporter William Plummer also reported in *People* (#4089, 1993) that many egg donors come from family members or close friends: “So Linda turned to her sister Ann, to whom she was so close they’d had a double wedding 11 years earlier” (#4089, *People*, 1993). Ken Ames from *Newsweek* (#4093, 1991) reported that some egg donors remained anonymous while others like Sue Scott, age 34, who had two children by her husband and made 11 donations in California “demands not to be anonymous.” Emphasizing the doctor’s control of the situation, Scott received her doctor’s “approval” first. Then, “She meets with prospective parents before she agrees to cooperate and later asks them to accompany her on her doctor’s appointments.” She admitted that she gets pure enjoyment from helping families become parents (#4093, *Newsweek*, 1991). Also, Buster explained “We like women who have fulfilled their desires for childbearing because they have a stronger motivation: They feel strongly about motherhood and want to share it with someone else” (#3022, *People*, 1983).

In 1991, (#4093, *Newsweek*) journalist Ken Ames described the current egg donation process in detail. Although a lot had changed with regard to the egg donation process, no details were provided in the media between the first mention in 1983 and the early 1990s. Because egg donation was time-consuming, uncomfortable and sometimes painful, the less readers knew about it, the easier for fertility specialists. More specifically, the egg donor received daily injections of a variety of drugs to induce her ovaries to produce as many eggs as possible. For three weeks, she went to the clinic every morning so

doctors could check her blood and monitor the eggs' maturity through blood tests and vaginal ultrasounds. Then, when the eggs were ready for "harvesting," she underwent surgery with anesthesia. An ultrasound-guided needle was inserted into the ovary, where the eggs were picked from their protective follicles and sucked out. Overall, Ames explained that this was a very involved process for someone to be doing completely altruistically and with no real personal benefit.

Journalists primarily used these detailed descriptions of egg donation to justify compensation. Anne Taylor Flemming, a reporter for *Newsweek* (#4083B, 1999; #4083A, 1999), pointed out that "harvesting" eggs is far more onerous than sperm donation and therefore, deserved higher compensation. *Newsweek* (#4093, 1991) also included an interview with Jan Silverman, an infertility counselor at Sunnybrook and Women's College Health Sciences Centre in Toronto, who warned restrictions on payments could create a black market where financially needy donors are recruited through suspect methods "such as ads in the university papers." She continued, "Instead of protecting all parties by setting up a system where we set the fee and put in good guidelines to screen people, we could create a situation where no one will be well served" (#4093, *Newsweek*, 1991).

Although experts claimed this situation was an anomaly, journalists reported on "desirable" egg donors who received exorbitant fees. Anne Taylor Flemming of *Newsweek* (#4083A, 1999) boldly stated "people with bigger bucks are able to buy better genes" suggesting "good" eggs were a very desirable commodity. In stories about egg donation, journalists focused on families that placed ads in Ivy League newspapers seeking an intelligent, athletic egg donor who is tall, attractive, and has an SAT score of 1400 or better. The payoff: \$50,000 for one cycle worth of viable eggs (#4083B, *Newsweek*, 1999). Clearly, money motivated since hundreds of women responded to ads like these. Likewise, journalists included even more outlandish examples. One article in *Time* (#4126, 1999) suggested that although genetics are not guaranteed, some of these prospective parents might be seeking Ivy League egg donors in order to establish "legacies"—offspring of alumni. At Ivy League colleges, alumni children were

admitted at twice the rate of other applicants. For this reason, “egg seekers” may not actually need “genuine smart-kid” genes for their children; after all, an applicant whose mother and father and egg donor were all alumni could be considered a triple legacy (#4126, *Time*, 1999). *McLeans* (#4033, 1999) also included an interview with Ron Harris, a 66 year old “soft porn” photographer from Los Angeles. Hoping to cash in on would-be parents’ wishes, Harris offered eggs from beautiful young women who also modeled for him. In *People* (#4083, 1998), Harris responded to critics by saying “his offer is a reflection of American society, where beauty can be purchased by the highest bidder.” The bids started at \$15,000 and went as high as \$150,000, further commodifying eggs.

Even though egg donation helped thousands of young women with no ovaries or ovarian function become pregnant, journalists focused on egg donation as a method for averting menopause and turning back the biological clock. Ken Ames of *Newsweek* (#4093, 1991) reported that the average patient for egg donation was 45, and Dr. Maria Bustillo of Genetics and IVF in Fairfax, Virginia claimed egg donation was the best treatment for women over 40 to conceive. Older women were an important untapped market for the infertility field. Although great advances had been made for treating infertility, fertility specialists were limited in their ability to assist women with “old” eggs. However, older motherhood was complicated as seen in Chapter 4. In 1990, *People* (#4095, 1990) dedicated an entire article to this issue entitled “Turning Back the Biological Clock.” Arthur Caplan, a medical ethicist from University of Pennsylvania, explained, “Men have fathered children into their 70s, and no one has had a big moral qualm, but there’s some disquiet about older women becoming mothers—maybe because people think they should be around at least through adolescence” (#4095, *People*, 1990). Through interviews with the media, women who had undergone egg donation cautioned other older women: “I don’t want to give the impression you can postpone having children indefinitely. You can’t and it’s very complicated” (#4095, *People*, 1990). Consistent with the mixed messages about age and fertility that I discussed in Chapter 4, women were both encouraged to use egg donation as an option for older

motherhood and warned of the risks at the same time. As a result, decisions about egg donation were complicated and relied heavily on input from fertility specialists, lessening any agency.

Unlike other forms of procreative technologies, egg donation was never really normalized by women. Rather, many saw egg donation as an intermediary solution while researchers worked on ways to preserve fertility indefinitely in anticipation of genetic children. By the late 1990s and 2000s, “new options for mothers” appeared alongside information about egg donation. In fact, more articles existed about these budding alternatives for preserving fertility than about egg donation itself. These alternatives included experimenting with immature eggs and ovarian tissue, experiments on aborted fetal tissue as a rich source of eggs, and surgically transplanting the chromosome-containing nuclei from older women’s eggs into younger women’s eggs (#4109, *Time*, 1997, #4099B, *Time*, 1996; #4109, *Time*, 1997; #4077, *Newsweek*, 1994). Additionally, Michael Lemonell from the *Futurist* (#5007, 2000) reported that researchers were searching for a “career pill” that would make it possible to preserve a woman’s own eggs, either by freeze-banking or even slowing down the aging process in the ovaries, eventually eliminating the need for egg donation. If all went well with these technologies, the timing of menopause could become a matter of choice.

In the 1990s, journalists also began to cover advances in egg freezing. Over half of all articles focusing on aging eggs included information about egg freezing. Egg freezing eliminated the need for donor eggs by extending a woman’s own fertility until she was ready to have a baby. In 1997, several articles (#4099B, *Time*; #4109, *Time*; #4108, *Time*) reported that a 39-year-old Georgia woman who had undergone premature menopause gave birth to twins conceived by eggs frozen for over two years. In 2002, CHA Fertility Center in Los Angeles established the first commercial egg-freezing facility. Journalists from a wide variety of magazines (#5029, *People*, 2002; #5104, *Discover*, 2005; #5029, *People*, 2002) claimed many women considered egg freezing a great hope: those who face fertility-destroying illnesses, but lack a partner to help them conceive; those with fertility problems whose religious

convictions prohibit them from freezing embryos; and single women who want to delay childbearing until they find a partner or reach career goals but worry that by then their eggs will no longer be viable. Given that aging eggs rather than aging bodies are “the leading cause of female infertility, a young women who wanted a career before starting her family—or even choosing a mate—could freeze her eggs in their prime and use them later” (#5151, *Redbook*, 2007). However, egg freezing was expensive costing between \$10,000 and \$20,000 for one “batch” plus \$500 per year for storage. Additionally, for best results, egg freezing was only recommended for women under age 35, and about 50 percent of the eggs frozen will not make it through the thaw process—issues that were omitted in articles about egg freezing (CDC 2010; ASRM 2010).

When asked by reporter Richard Jerome about the potential for egg freezing for the article “In the Bank” (#5029, *People*, 2002), Dr. Norbert Gleicher, medical director of the Center for Human Reproduction in New York, responded, “Nobody had yet gone beyond what we call sporadic clinical success. The choice is ultimately, up to the patients, as long as she understands the odds.” Also, how egg freezing affected the baby’s chromosomes was unclear. Unfortunately, Gleicher said this information would not be known until thousands of babies had been born and followed until adulthood (#5029, *People*, 2002). In *Newsweek’s* “Fertility and the Freezer” (#5083, 2004), experts agreed that without more data, especially regarding the physical and emotional risks—egg freezing was not appropriate for “biological-clock patients.” Still, journalist Claudia Kalb (#5083, *Newsweek*, 2004) predicted, “It may not stop single thirty-somethings from lining up with their credit cards and their dreams.” Despite the limited success of egg freezing, journalist Sara Wildman of the *New York Times Magazine* (#5230, 2010) stated that egg freezing is the “ultimate New York careerist dream: Work (and play) now, conceive later.” Overall, journalists promoted hope for women wanting to have a genetically related child at any point in their lives.

6.5 Redefining Motherhood and Surrogacy

Even though surrogacy had a very long history, journalists became interested in surrogacy during the late 1970s as surrogacy shifted from an informal arrangement to commercial venture. Surrogacy received more media attention than other forms of collaborative reproduction (see Table 6.1 on page 169). One of the first stories about surrogacy appeared in *People* (#2023, 1978) about Detroit lawyer Noel Keane, a father of two young boys himself, who changed his entire law practice to focus exclusively on surrogacy after he developed a special interest in “surrogate mothering” or “proxy motherhood.” Keane founded the Infertility Center of New York and was considered by the media as America’s undisputed father of surrogate motherhood. According to *People* (#3049, 1987), his agency contained “binders filled with surrogates,” reducing women to only their procreative function. Keane also reported his surrogacy arrangements produced 65 children in 1986 alone and resulted in hundreds of thousands of dollars, including a six-figure salary for himself connoting that surrogacy was primarily a business endeavor instead of a medical treatment, especially compared to other procreative technologies.

Many predicted “anything goes” regarding surrogacy as lawyers, doctors, psychologists, and even former housewives set up their own surrogacy businesses. William Handel a lawyer who ran a Los Angeles surrogacy agency stated, “You could rent an office, hang up a shingle that says ‘Surrogate Parents, Inc., Babies for You, Cheap,’ and no one could stop you” (#3021, *People*, 1983). The business of surrogacy often created conflicts of interest in terms of whose interests were being protected. For example, *Time* (#3028, 1984) referred to “relationships between surrogate and their *employers*” (emphasis added). As a result, journalists questioned the intent of surrogacy as well as all those involved with titles like “Baby Sellers or Sisters of Mercy?” and “Baby Broker or Saint?” (#3021, *People*, 1983; #3049, *People*, 1987; #3064, *People*, 1989). As with most complicated issues pertaining to infertility, journalists covered both sides and offered no resolution.

Appealing to specific gendered expectations about women, journalist Claudia Wallis (#3028, *Time*, 1984) described surrogates as motivated primarily by altruism and “genuine, sincere, family-oriented women.” Many surrogates told journalists they loved being pregnant as well, focusing on the importance of pregnancy (#5131, *People*, 2006; #5032 *Redbook*, 2002; #5131; #5166, *Newsweek*, 2008). A reporter from *People* (#5131, 2006) interviewed one surrogate who stated after stumbling across a surrogacy website, she was intrigued by all the birth stories with happy endings and decided “I could do it. I love being pregnant. And I’ve always been the adventurous type” (#5131, *People*, 2006). Still, many wondered exactly what type of woman would become a surrogate—negating the unbreakable bond between birth mother and child.

Lorraine Ali wrote the article “The Curious Lives of Surrogates” (#5166, *Newsweek*, 2008) exploring many different viewpoints about surrogacy. Ali wrote that society still stereotyped surrogates to what you see on Jerry Springer or comedies like *Baby Mama*—“either hicks or opportunists whose ethics could use some fine-tuning.” However, the experiences of surrogates varied greatly ranging from a working-class single mom to a young military spouse to a small business owner. The typical surrogate was usually in her 20s or 30s, married with kids of her own, and driven by more than just good will (#5166, *Newsweek*, 2008; #5032, *Redbook*, 2002). Surrogates derived a heady sense of power from her ability to give two people the one thing they want most: a baby. In *Redbook* (#5032, 2002), psychologist Andrea Braverman explained, “I call it positive narcissism. This is their opportunity to be center stage.” One surrogate explained,

When you go home, it’s so quiet. The crash comes. It’s not the baby blues. It’s not postpartum depression. It’s that the performance is over. I was practically a celebrity during the pregnancy—someone was always asking me questions. After I had them, no one was calling. Now nobody cares. You’re out. You’re done. It’s the most vain thing. I felt guilty and selfish and egotistical. (#5032, *Redbook*, 2002)

Emphasizing the importance of procreation for women and reducing women to their procreative abilities, experts said that surrogates know that “on their deathbeds, this is what they’ll be proudest of” (#5032, *Redbook*, 2002; #5131, *People*, 2006).

According to journalists, money was also a key motivator for surrogates (#3053, *Life*, 1987; #3049, *People*, 1987; #3044, *Time*, 1986; #3028, *Time*, 1984; #3021, *People*, 1983)--usually about \$10,000 plus \$2,400 for the six weeks of lost work due to maternity leave to the surrogate, \$5,000 for the medical expenses, and another other \$10,000 for the agency fee. Should pregnancy not result, surrogates were still paid \$1,000 and \$3,000 for a miscarriage linking her payment with her time and effort, not the ultimate outcome. As with all commodities, parents via surrogacy warned readers of *People* (#3021, 1983), “Let the buyer beware. Human nature hasn’t changed. With any new marketplace, there are going to be unscrupulous merchants.”

In terms of exploiting women’s procreative abilities, journalist Brad Darrach (#3064, *People*, 1989) emphasized a number disturbing issues about surrogacy:

Is a woman who bears a child for another woman a surrogate mother or just a surrogate uterus? Is she renting her womb or selling her child? If surrogacy is sanctioned, will society develop a breeder class of poor women employed by the rich as incubators? With a surrogacy rate that quintupled in a single decade, are we entering an era of depersonalized reproduction? (#3064, *People*, 1989)

Offering a glimpse into the dark side of surrogacy, the Baby M case received more media attention than any other topic related to collaborative reproduction (#3049, *People*, 1987; #3047, *People*, 1987; #3040, *People*, 1986; #3021, *People*, 1983; #3058, *Time*, 1988; #3064, *People*, 1989; #3046, *Time*, 1987). The Baby M case, spanning 1986-88, was the first American court ruling on the validity of surrogacy and prompted a surge in public attention and opinions about surrogacy. The recipient parents, the Stern’s, and their lawyer reduced down the whole surrogacy process to a signed contract. The Stern’s posed the question: “It either it is or it ain’t [*sic*] a valid agreement. If it is, surrogate motherhood will continue. If it is not, there will be no more surrogate mothers.” Their surrogate Mary Beth Whitehead argued back,

“It was like I was a breeder and they were just interested in what I could produce” (#3040, *People*, 1986). To make matters worse, the media lumped the Baby M case with other pending court cases in which children were caught in the middle: involving the adoption of Native American children, parental abductions, and children who tested positive for drugs after birth (#3087, *People*, 1987). Journalist Richard Lacayo explained that difficulties with surrogacy were as old as the practice itself:

One of the simplest and most venerable of the new conception options. Even the Bible offers a parallel (in the Book of Genesis, naturally). When his wife proved unable to conceive, Abraham impregnated her handmaiden Hagar, who bore Ishmael. There were hard feelings in the aftermath of that arrangement too. (#3051, *Time*, 1987)

The problems brought to light by the Baby M case scarred traditional surrogacy forever and were repeatedly cited within nearly every article about surrogacy published after 1986.

In most surrogacy arrangements at this time, including the Baby M case, the gestational carrier was also the biological mother, since the baby was conceived using her egg and artificial insemination with the “rearing” dad’s sperm. As I discussed previously, procreative technologies could not alter the perception that genetics played an important role in motherhood. As a result, fertility specialists looked for additional ways to lessen the link between genetics and motherhood. In a *Life* article in 1987 (#3053), a few years after the first successful egg donation, the possibility of using a donor egg with a surrogate was mentioned for the first time. After losing a baby conceived by *in vitro* fertilization in the seventh month, one woman in England asked if she could take her eggs, fertilize them with her husband’s sperm and having another woman do the carrying? After all, journalists told stories of women using the eggs donated by their best friends to become pregnant through *in vitro* fertilization (#3072, *Redbook*, 1986).

People were torn: Some doctors told the media this was a “wild idea” while others stated “we aren’t doing that quite yet” (#3044, *Time*, 1986). As with other procreative technologies, fertility specialists eventually embraced surrogacy with egg donation as just another method to achieve pregnancies. Dr. Richard Levin, a Louisville infertility specialist explained, “I’ve devoted my life to

helping women get babies. I will do anything that is legal and ethical" (#3005, *People*, 1980). Dr. Wulf H. Utian at Mt. Sinai Medical Center in Cleveland responded, "I'm a traditional physician and there had never been a case like this" (#3053, *Life*, 1987), but after careful consultation with the couple, Dr. Utian decided to go ahead. Nine months later, their baby Shira was born, and her mother claimed her as "our impossible dream" setting the stage of a new version of surrogacy which seemed more palatable, especially after the Baby M fiasco. Cristie Montgomery, director of Surrogate Parenting, explained,

Not too long ago, some doctors wouldn't even mention surrogacy. Now, it's very much accepted as a viable option. With today's technology, surrogates are able to carry babies without any genetic link. Some say this makes it easier for them to carry someone else's baby unlike previous traditional surrogacies. (#5032, *Redbook*, 2002)

As a result, journalists referred to surrogates as "gestational carriers" indicating their lack of genetic connection to the child being carried. Moreover, the surrogate's role was minimized: "We considered what we were doing as intense baby-sitting" (#4089, *People*, 1993). As seen in my previous analyses, many fertility specialists viewed surrogacy as just another example of the end (the ultimate baby) justifying the means.

Once gestational carriers with egg donation became more common, stories about surrogacy shifted. These new stories about surrogacy were also overwhelming emotion-laden and atypical almost bordering on "miraculous," including many religious overtones. For example, Becky Ripley, age 38, and Beth Yates, age 34 were featured in *People* (#4085, 1999). After discovering she would be unable to carry a child, Beth offered to be Becky's surrogate. Eighteen of Becky's eggs were extracted and fertilized with her husband's sperm. Once fertilized, they were inserted into both Becky and Beth's uteruses even though Becky assumed she would not get pregnant. Surprisingly, both became pregnant and gave birth to two boys 16 days apart. Essentially raising twins or "twiblings," Becky had no regrets. Similarly, after Rachel Schwartz was diagnosed with cancer at age 28, her sister Deb Brenner told her, "You know I will always carry a baby for you if you can't" (#5173, *People*, 2008). After Alex was diagnosed with cervical cancer, her identical twin sister Charlotte donated the egg and her other sister

Helen carried the baby to term giving birth to Charlie. All three sisters admitted Charlie was the result “of all the love that went into creating him. With God’s help, he’s got all our best bits” (#5132, *People*, 2006).

Also, in the late 1980s, the first story of a grandmother giving birth to her own grandchildren appeared. According to “Mother’s Love Works a Miracle” in *People* (#3048, 1987), at age 48, South African Pat Anthony had her daughter’s (who had previously had a hysterectomy) eggs removed and fertilized with her son-in-laws sperm and they placed the fertilized embryos back into Anthony’s uterus. She then gave birth to three healthy babies. This made her not only the first woman to give birth to her own grandchildren, but also the first surrogate to produce *in vitro* triplets. The reaction to these births were generally favorable: Anthony’s minister explained,

From a Christian and ethical point of view, I know some ministers in this town do have problems with it, but everybody had great respect for Mrs. Anthony and for the love she has shown her daughter. There was no payment, no commercialism. It was an act of pure love. I never thought I was doing anything different, just what anyone would do for a daughter deprived of having children. (#3048, *People*, 1987)

Emphasizing the religious acceptance of procreative technologies (as also seen in the NSFG), the article pointed out Anthony’s husband drove to a Roman Catholic Church after the birth to give thanks.

In 2005, *Essence* (#5096) featured Camille Hammond. Hammond was a family physician living in Maryland, whose own mother, a university professor, offered to be her surrogate. Unlike other African Americans portrayed in Chapter 4, this unique story perpetuated Ginsberg and Rapp’s (1995) description of “reproductive stratification” in that journalists encouraged African American’s with financial resources to seek fertility treatments. After struggling with infertility for years, Camille’s mother Tina Cade, wanted to help, especially after she saw “the light in her daughter’s eye fade” after being diagnosed with infertility. She soon became pregnant at the age of 54 with triplets conceived from Camille’s eggs and her son-in-law’s sperm. Again supporting the religious acceptance of her choice to use procreative technologies, Camille admitted to “praying a lot” and micro-managing her mother

throughout the pregnancy. With triplets, Camille and her mom made the conscious decision to keep all three babies and let God decide to take one of them if he wanted a theme common among families with multiples in the media. Camille and her husband Ronald explained, “If there is not a door here, God will make one.” Cade said, “There are people who do heroic things all the time. I’m not one of them. I just did something for my child” (#5096, *Essence*, 2005). For the most part, these portrayals suggested that women are “caring” and “willing to help each other,” rather than highlighting emerging complex family relationships (such as aunts who are actually biological mothers, cousins who are siblings, and grandmothers giving birth to their own grandchildren).

Also helping to normalize surrogacy among a certain class, celebrities brought additional attention to surrogacy by relaying their personal stories in popular magazines. *People’s* (#4088, 1995) “Oh Mamas” detailed soap star Deidre Hall’s public story. After half of a lifetime of desperately trying to conceive, she turned to surrogacy. Hall’s surrogate, a 30 year old divorced mother of three, was artificially inseminated with Hall’s husband Steve Sohmer’s sperm. Throughout the surrogacy, their relationship was close with Hall and Sohmer visiting often and attending doctor’s visits. Robin said she did it because, “Most women love creating a life. The day after the birth, I said ‘I could do this again tomorrow.’” Robin continued, “This is their child, so my thinking is more like a babysitter.” Hall admitted when considering options, “I felt it important to have a child that was biologically related to one of us” (#4090A, *People*, 1992). A few years later in 1995, Hall and Sohmer had a second son again using the same surrogate whom they refer to as “a gift from God” and who received \$12,000 for each pregnancy. Hall stated “We’ll explain it to the children when they’re old enough to understand” (#4088, *People*, 1995).

Journalists claimed that surrogacy was “booming” in the 2000s even though few statistics existed (#5172, *People*, 2008; #5032, Redbook, 2002). While most people seeking surrogates were heterosexual couples in their late 30s and early 40s, surrogacy expanded its reach to same-sex couples

and singles—both men and women interested in achieving the heteronormative definition of family (#5032, *Redbook*, 2002). To make it easier for same-sex couples, the *Advocate* (#5161, 2001) highlighted Dr. Jeffrey Steinberg who founded the Fertility Institute in Los Angeles to both legitimize and simplify the family building possibilities for gay and lesbian families. He often heard how exhausted same-sex couples were by the runaround they received. As a result, he put together his own in-house network of doctors, egg donors, surrogates, lawyers and psychologists focused on gay and lesbian issues. Also, he dramatically cut the price from \$145,000 to \$90,000 to make it more affordable; however, at this price, most families were still excluded. Like with lesbians seeking sperm donors, articles described same-sex couples as “separate but equal” in their access to appropriate fertility care outside of “traditional” realm of fertility care often reserved for heterosexual couples.

Although the media did not report any cases of exploitation as feared by many initial critics of surrogacy (Meyer 1997; Roberts 1998) surrogacy appeared complex in the media nonetheless. In general, surrogacy was changed from a very intimate experience between two women to legally binding words written on a paper then back to the ultimate expression of love between mothers, sisters, and daughters. These changing narratives lessened the fear that surrogates would be able to change their minds and keep the baby, as seen earlier with the Baby M case. Reflected in my analysis, Berend (2012) states that the voices of gestational mothers are scarcely heard. For surrogates in the media, meaning was derived from their relationships with the intended parents and overall joy of carrying a baby for another family. As a result, media representations remained largely from the perspective (and representing the interest) of the intended parents. Given the strong influence of the infertility industry on the media, journalists raised interest about surrogacy among potential intended parents and made them feel safer and more comfortable about the decision to use surrogacy.

6.6 Protecting Embryos through Embryo “Adoption”

As I discussed in Chapter 5, leftover embryos and options for embryo disposition plagued the infertility field since its beginning. Embryo “adoption” was first reported by *Newsweek* (#4098) in 1999 as Dr. Mark Sauer in New York City set out to make costs of fertility treatment more competitive. As another method to grow his fertility business, he started the first “embryo adoption *business*” (emphasis added) at his clinic. By “adopting” embryos created from sperm and eggs donated by others, patients could forgo some of the costs associated with traditional assisted reproduction. Sauer joined forces with GenCor, a medical practice management company that handled the business side of his program. Sauer said the move helped cut the rate for first-time *in vitro* fertilization, including medications, cryopreservation, and one year’s egg storage to \$8,600—about \$4,000 less than the “competition,” establishing himself as the “best” source for fertility care. Based on those fees, Sauer signed preliminary agreements with several insurance companies willing to cover the costs of treatments. For reasons unknown, his embryo adoption business never materialized and there was no mention of embryo adoption in the media for several years.

In 2002, embryo adoption reappeared in the media in the article “Last Chance Family” by journalist Richard Jerome (#5026, *People*, 2002). Adding to the uncertainty about embryo adoption, no one could even agree on the right terminology. Medically speaking, embryo donation and embryo adoption were the same; however, using the term “adoption” recognized an embryo as human life. Susan Ince of *Good Housekeeping* (#5197, 2009) explained although this process had many elements of the adoption process (such as a home study), legally the actual transfer of the embryos was generally governed by property/contract laws. This meant once the contract was signed and embryos turned over, donors could not change their minds, and they had no further legal rights or responsibilities to the embryos or the offspring. Similar to my discussion about the status of embryos in Chapter 5, the vacillation between the terms embryo donation and embryo adoption created more uncertainty as to

personhood attributed to embryos. Again, fertility specialists refused to take a public stand and clear up any confusion.

Embryo donations could also be anonymous or not, with families determining the level of ongoing contact or information exchanged. Although embryo donation was often called “a supreme gift of love,” the practice continued to be a minuscule part of fertility treatments, mainly due to assumptions about genetics, fears, logistical complications, and ethical concerns. Out of 50,769 babies born as a result of assisted procreative technologies in 2006, only 365 were from donated embryos (CDC 2010). Elizabeth Ginsburg, MD, president of the Society for Reproductive Technology said, “There’s not as much acceptance of embryo donation as you might think” (#5026, *People*, 2002). Despite the fertility field trying to convince people otherwise, most people wanted a genetic connection with their child if it is at all possible. Moreover, most couples are not comfortable having embryos created for them going to another couple. As a result, fertility specialists and mainstream media rarely mentioned embryo adoption.

Highlighting the value placed on embryos, embryo adoption became predominately a Christian pro-life issue as reflected in Christian magazines throughout the 2000s. For those who believed “life begins at conception and is worthy of protection and a chance to impact the world as God intended, only one choice for embryos remained: birth” (#5222, *Christianity Today*, 2010). *Christianity Today* (#5222, 2010) also interviewed Barbara Olsen, 36, and her husband Dan, age 39, of Minneapolis who stated, “I was distressed over the fact our embryos were just in storage, and I felt convinced that they deserved a chance to be born.” As a solution for families like the Olsen’s, Ron Stoddart and the Christian Adoption and Family Services started the Snowflakes Embryo Adoption Program in Brea, California. Stoddart said the name “Snowflakes” was appropriate because embryos are “unique, they’re fragile, and of course they are frozen.” *Christianity Today* (#5222, 2010) stated that Snowflakes offered “genuine alternatives to the slaughter of the innocent: destroying “spare” embryos.” Embryo adoption allowed

embryos to be born, rectifying a bad situation and acknowledging an embryo as a child. Supporting its legitimacy, Snowflakes' pro-life stance received millions of dollars in federal funding from the Bush administration culminating in a meeting at the White House between President Bush and many of the "young success stories" (see Figure 6.1) who wore "Former Embryo" stickers (see Figure 6.2) on their chests (#5521, *New York Times Magazine*, 2005; #5026, *People*, 2002). In attempt to remain neutral and non-partisan in the eyes of their patients, no fertility specialists actively protested. However, most fertility specialists did not support this effort given its potential threat to the infertility field as a whole by attributing personhood to an embryo.



Figure 6.2. Snowflake's Former Embryo Sticker

Other Christians expressed serious misgivings about embryo adoption (#5004, *Christianity Today*, 2000; #5222, *Christianity Today*, 2010). They feared the practice of embryo adoption would only make irresponsible activities more likely, such as collecting and fertilizing more eggs than will be implanted. To appease some of the concerns, many Christian families engaging in *in vitro* fertilization further agreed to not dispose of any embryos transferred to them and carry to term or donate them to another like-minded couple: "They intend to offer safe haven and rescue of abandoned embryos from an absurd fate" (#5004, *Christianity Today*, 2000). Through embryo adoption, families could uphold

their religious standards and values while building their families, a major dilemma that I discussed in Chapter 4.

6.7 What Makes a Family?

In her book *The Elusive Embryo: How Men and Women Approach New Reproductive Technologies*, Becker (2000:218) states, “People start out on the fertility journey wanting to be a normal family and wanting others to see them that way.” As collaborative reproduction grew so did concerns about parentage with articles like “Six Parents, One Orphan” (#4087, *Time*, 1997) and “And Baby Makes One” (#4068, *Newsweek*, 1998). In an interview with *Time* (#4087, 1997), Alexander Morgan Capron, a professor of law at Georgetown University, explained ten different ways to making babies. His final version involved using an egg donor, sperm donor and gestational carrier as well as the social parents creating five different “parents.” However, legally, she is parentless. Media depictions of procreative technologies raised many questions: What constitutes a parent? Are the hot markets of surrogacy, egg donation, and sperm donation, tantamount to baby-selling? Journalist Andrew Sacks (#4090B, *Time*, 1990) concluded, “Just because you donate a sperm and an egg doesn’t make you a parent.”

Some journalists dealt with these serious dilemmas through humor. For example, jokes ensued with one cartoon in the *Johannesburg Sterran* in which one triplet whose grandmother served as the surrogate quipped to another, “Legally, I could be your uncle” (#3048, *People*, 1987). Another cartoon featured in *People* (#3022, 1983) made it look like nothing out of the norm: the new father announces to his mother “See Mum! He was made from a frozen egg and sperm, then a frozen embryo.” Standing over the baby, the new grandmother responds, “He’ll need a little cardigan.” Whether this lightheartedness further normalized these new family building methods or just marginalized families utilizing these family-building options remained unclear. In any case, this type of family building had reached public consciousness.

Other journalists stressed the secrecy surrounding collaborative reproduction. Unlike adoptive parents, who had long been counseled to be open with their children about their origins, parents who used collaborative reproduction did so secretly and were often told by fertility specialists that this is a secret they can keep forever. David Towles, director of public relations for Xytex, one of the five largest sperm banks in the United States, explained to Nina Burleigh of *Redbook* (#4084, 1999), "Until about five years ago, I'd say about 70 to 80 percent of patients were not telling their children." Physician and social science researcher Dr. Robert Nachtigall (1993) suggests that parental preference for secrecy often conflicts with children's right to know promoting a sense of competition rather than what is in the best interest of all involved.

For many children, they find out their genetic heritage unexpectedly like Barbara Richardson, also interviewed by *Redbook* (#4084, 1999), who learned the truth about her genetics only as her parents' marriage was unraveling. Likewise, Nancy Johnson had harbored suspicions ever since she studied blood types in a high school biology class. Before Jenny Baker's father died of cancer, her sister asked him directly if he was hiding anything since he was notorious for keeping secrets. He said no, but they found out the truth at his funeral. Susan Hollander, PhD, of the Alliance of Donor Insemination Families in Englewood, Colorado explained to *Redbook* (#4084, 1999) that children are very intuitive and likely have a sense there is something not being dealt with: "What we know about secrets is that they are very powerful mocks to trust and open communication. I believe that children have the right to know where they come from."

Next, debates sparked in the media over whether children should have a legal right to information about their genetic background. However, this was often a moot point given most parents had little to tell even if they wanted to. In *McLeans* (#4033, 1999), a 17-year-old girl from British Columbia stated, "Absolutely without a doubt I have the right to know about my genetic father. Parents don't realize the child will become an adult. They don't have the right to make that decision for me."

Small businessman, Wayne Velestuck, age 50, estimated he donated about 120 times during the mid-1980s and strongly believed that recipients should receive more intensive counseling so that they carefully consider what it means to raise a child who is genetically linked to someone else (#4033, *McLeans*, 1999). One advocate for donor offspring said, “We are bringing children into this world, but they are the ones who tend to get lost as grownups do what works best for them” (#5021, *Newsweek*, 2001). Previously, infertility treatments had been all about achieving a pregnancy. Although journalists reported on the children born via procreative technologies in the 2000s, society was unprepared for this new view of family formation.

Consequently, the media included stories of children born via donor sperm who became frustrated at the lack of record-keeping and dead-ends in finding their genetic information. Politicians began listening to these stories and recommended proposals for a more open system. One solution was that those conceived through donation of reproductive material would get access to detailed medical information, but the donor identity would be handled the same way adoptions are handled. Given the importance placed on genetic ties, this possible solution appeased worried parents by placing their needs over their children’s. In fact, in the article “Who’s My Birth Father,” donor children were compared to adopted children; journalist Mary Boone (#5025, *McLeans*, 2002) said it is not the adoption or donor insemination that causes the rift in families, it’s the secrecy, lies, and things that aren’t said. Some sperm bank staff told children born via sperm donors very bluntly they did not have the right to know about their genetic roots. As a result, these children felt “We’re the only group of people who don’t have that birthright” (#5021, *Newsweek*, 2001). For children born via collaborative reproduction, their birth was only the beginning of their life story of being a donor conceived child.

The media also reported on families taking matters into their own hands and turning to the Internet to connect through national registries, like the Donor Sibling Registry. Of the 30,000 children born each year from gamete donation, this site put together more than 2,500 of them, suggesting a

great need for this information (#5120, *People*, 2006). All of the stories about children finding their genetic roots were exclusively positive. In fact, meetings between children and donor parents exceeded expectations about genetic heritage. For example, the revelation that she shared the same biological father with other children brought tears to one donor offspring's eyes: "I felt like I was in the middle of a miracle" (#5025, *McLeans*, 2002). Moreover, several dozen children discovered their donor was "a happily married critical care pediatrician" (#5120, *People*, 2006). Another donor said, "I want to tell them how much raising my own children has made my life rich and complete. If I meet my donor children, I'd even let them in on my favorite book, Dr. Seuss' "Happy Birthday to You." (#5025, *McLeans*, 2002). After going through her sperm bank's "Donor Release Program," Christina told *People* (#5046, 2003) about a phone message that she left for her donor dad:

Hi, Philip, this is Christina. Eighteen years ago you donated sperm, and I'm the girl who was born after the donation. I wanted you to know that I turned out really well and I would like to talk to you and possibility meet you. (#5046, *People*, 2003)

Now a medical assistant in Oakland Hospital's trauma unit, Philip responded, "When I heard her voice, I was elated. My current life melted away and another part of me was born." When they finally met, Christina said, "I always knew we would click. It was better than any of my dreams" (#5046, *People*, 2003). Additionally, *People* (#5120, 2005) further explained that many children's lives were saved by accessing their genetic information and finding out critical medical information. These glowing stories encouraged children to seek out their donors in hopes of similar outcomes.

Fertility specialists tried to minimize genetics in order to create a baby using any means necessary. They warned that biological information raised the danger of genetic elitism and a false sense of genetic determination. As Tom, a young man born via sperm donation explained to *Esquire* (#5097, 2005), "Genes give you the possibilities, but the way you were brought up influences whether you fulfill them. It's like your genes are a map of the city, but the directions you take are the way you were raised." However, this was not the predominant message portrayed to readers of popular magazines.

Journalists suggested repeatedly that genetics and genetic connections were very important. Despite the wide variety of family structures now evident, a hegemonic view of a “conventional” family tied together through genetics was both reflected and reproduced within popular media.

6.8 Risks and Fears

Throughout the past 50 years, journalists raised concerns about the health and well-being of women and unborn children due to procreative technologies. In addition to causing risky multiple pregnancies, which I will discuss in the next section, critics claimed fertility medications could leave women infertile, cause cancer, or result in babies with severe defects (#1002, *Time*, 1960; #1014, *Time*, 1964). While fertility specialists admitted there was still a lot to learn about the effects of manipulating hormones, they reported that no adverse consequences with fertility treatments to the media. Instead, the benefits of the emerging treatment options were highlighted. In *Time* (#2031, 1978), fertility specialists reported *in vitro* fertilization was an important new laboratory tool for devising ways to cope with genetic diseases and testing new methods of contraception. *In vitro* fertilization was perhaps most importantly, the studying of “one of nature’s most awesome and baffling processes: the first stirrings of life.” Dr. Carl Pauerstein of the University of Texas also explained *in vitro* fertilization had the potential for adding greatly to the knowledge of the reproductive biology of our species (#2031, *Time*, 1978).

By the 1990s, specific physical risks linked to fertility treatments became more public. Articles cited several scientific studies showing that fertility medications could be linked to cancer—both ovarian cancer and breast cancer (#4132, *Good Housekeeping* 1998; #4004, *Time*, 1994; #4150, *Health*, 1993; #4004, *Time*, 1994). Journalists also reported a surge in risks associated with the offspring of assisted procreative technologies, including birth defects, heart and kidney abnormalities, cleft palate, undescended testicles, low birth weight, cognitive problems, and cancer (#5217, *Time*, 2010; #5155,

Redbook, 2007; #5219, *Time*, 2007). Similar to other controversial issues related to infertility, experts were split in terms of the harmfulness of infertility treatments and provided conflicting advice.

Some experts suggested to the media that until further studies are completed, fertility drugs should be considered experimental. With hundreds of fertility clinics around the country combined with thousands of ob/gyns and internists prescribing fertility drugs to patients, *Good Housekeeping* (#4132, 1998) warned large numbers of women are getting different and unregulated treatments, reinforcing a hierarchy within the medical profession. Dr. Mark Sauer, chief of division of reproductive endocrinology at Columbia Presbyterian Medical Center in New York City concluded, "I can't say that fifty years from now, we won't see a problem with fertility drugs. But, I can say that after twenty to twenty-five years, there doesn't seem to be any proof that they harm anyone" (#4150, *Health*, 1993). Dr. John Glaspy, medical director of the University of California, Los Angeles Joint Medical Surgical Oncology Center, said having evidence of danger is not the same as having an assurance of safety (#4150, *Health* 1993). Again, readers decided for themselves whether or not to take the risk.

Fertility specialists publicly expressed their doubts about these risks by pointing out lack of long-term follow-up and confounding factor in the media. In *Good Housekeeping* (#4132, 1998), fertility specialists argued they would not give medications or perform a procedure that they did not think was safe for their own family members. Additionally, experts told the media that the link between fertility drugs and cancer would be too difficult to prove, especially since drug regimens vary widely. Dr. David Adamson, a Stanford University School of Medicine professor, told *Time* (#5035, 2002), "It does not do the country a service to present this out of perspective. Even with these new studies and statistics, 91 percent of ART babies are still born perfectly healthy." Deciding to concentrate only on the positives, Adamson provided no explanation as to the other 9 percent who were not born healthy.

Despite the media attention to possible risks, usage of procreative technologies did not change indicating that people heard only what they wanted to hear. Joan Kiplinger, a former infertility patient,

explained to *Good Housekeeping* (#4132, 1998), “It is a cruel joke on all of us who have undergone this treatment. Not only do we take our chances to get pregnant, but now we face this possibility.” *Health* (#4150, 1993) interviewed Judy Norsigian, co-director of the Boston Women’s Health Book Collective, about this. Norsigian said, “Almost no one—not women, not their doctors—wants to call these treatments experimental.” Also, in *Health* (#4150,1993), Nancy Grossman, a former infertility patient, said it did not really matter if fertility treatments were harmful or not--“I would go ahead and try again. It is such a raw desire to have a child. You do what it takes and pay the consequences later.” Dr. Zev Rosonwaks explained, “If you ask a couple if they would rather not have a child at all or try to have a child that over 90 percent of the time will be normal, I think they will choose to have the child” (#5035, *Time*, 2002). Pamela Madsen, executive director of the American Fertility Association agreed, “Infertile people want the joy of a child. If you tell us we have to be careful—in fact, if you tell us we have to stand on our head for nine months—we’ll do it” (#5035, *Time*, 2002). Regardless of the potential risks, the decision was ultimately the parents who sought fertility treatment; as long as they understood the risks (according to their physicians’ biased input), all was considered good. By focusing on the desire to make babies, journalists and the medical professionals who informed them swept aside fears about fertility medications and treatments.

6.9 Instant Family through Multiple Births

By the mid-1980s, tremendous media attention was paid to multiple births. While exact statistics were unavailable, all of these articles highlighted this new phenomenon; for example, “In an unprecedented worldwide multiple birth boom, mothers are delivering babies by twos, threes, fours, fives, and sixes—will someone make it seven?” (#3030, *Saturday Evening Post*, 1984). Between 1984 and 2010, 35 articles appeared specifically addressing families of multiples. These articles included both the positives and negatives with titles like “Babies on Parade” (#3030, *Saturday Evening Post*, 1984);

“Oh What a Birthday” (#3035, *People*, 1985); “Thankful for Five Tiny Blessings” (#3054, *People*, 1988); “Too Much of a Good Thing” (#3032, *Time*, 1985); and “The Bitter Cost: Dangers of Multiple Births” (#3060, *Time*, 1988). Like other controversies in procreative medicine, journalists offered no conclusions as to the societal effects of multiple births. As many families of multiples landed on the covers of these magazines, these stories promoted an almost voyeuristic interest among readers in this extreme depiction of “productive” procreation.

Explaining the sudden surge in multiple births, Donald M. Keith, executive director of the Center for the Study of Multiple Births told *People* (#3035, 1985),

There aren't even any good new statistics. Reporting of multiple births isn't even done systematically from state to state so it's hard for anyone to know what's really going on. We do know that far more multiple births are occurring now than would be expected—were it not for fertility drugs.

However, families taking fertility medications told journalists that they understood the risks beforehand. Even a cardiologist, Dr. Steve West, a proud father of quadruplets, explained to Maynard Stottard of the *Saturday Evening Post* (#3030, 1984),

We had a very good understanding of the risks. But they always seemed remote. When we were first found out Jan was carrying multiples, we were scared. We knew there was a risk to her and the babies. But there was nothing we could do. Now that the birth is over, and the children are all well, we couldn't be happier. And I really couldn't recommend fertility drugs to other women because of the risks. You know the odds are one in a thousand, but if it happens to you, it's a hundred percent. (#3030, *Saturday Evening Post*, 1984)

Again, this placed all the responsibility (and blame) of any associated risk on the parents themselves. *Time* (#3060, 1988; #3032, 1985) claimed multiple births could be avoided if clinics would use fewer embryos during *in vitro* fertilization and if fertility medication dosages and monitoring were more careful. However, Leah Holley of Covington, Kentucky explained in her letter to the editor:

If any of the people who are critical of Patti Frustaci [the first mother of septuplets] for using a fertility drug knew the agony of wanting a baby and not being able to have one, then he would understand her decision to use Pergonal. If my doctor told me that the only way I could get pregnant was to take Pergonal, you can be sure I would take the risk of multiple births. I would take any drug or have any procedure done with the hope one day I can have the child that I

want to have. Ask any infertility patient if she understands Patti Frustaci's use of Pergonal, and I'm sure she will tell you she agrees with her decision. I do! (#3036, *People*, 1985).

Because fertility clinics were autonomous and unregulated as I discuss throughout this study, fertility specialists encouraged a sense of success at any cost continuing the boom in multiple births.

Despite any hardships, most parents of multiples appearing in the media told journalists they had no doubt that they did the right thing and would not have it any other way. Even with one baby stillborn and one who died three days later, the Frustaci's "experienced euphoria, sadness, excitement and anxiety." The Frustacis admitted their lives have never been the same since, although in a good way (#3035, *People*, 1985). Likewise, Michele L'Esperance, another mother of multiples, explained,

Nobody in their right mind asks for quintuplets. But, I'll tell you think: I feel real special because I feel that whoever is running things upstairs doesn't give anyone anything more than they can handle. There must be a reason for these babies. Either that or He has grim sense of humor. (#3054, *People*, 1988)

As I discussed in the last chapter, babies born via procreative technologies were considered miracles. If one baby was a miracle, multiple babies compounded the miracle exponentially. In general, multiple births signified efficiency and productivity. Women who were once told they would never have children were now pregnant with three, four, sometimes even eight or nine fetuses. This chance at an "instant" family caused many other infertile families to follow suit and attempt multiples through fertility medications and multiple embryo transfers, especially since the outcome was depicted by the media as good.

Some families of multiples were given the choice of "fetal reduction" (#3035, *People*, 1985; #3032, *Time*, 1985; #3060, *Time*, 1988). Dr. Richard Berkowitz, head of the Mt. Sinai team told *Time* (#3060, 1988) that the vast majority of patients come to them for fetal reduction for medical reasons, not social ones. Regardless, the media clearly equated selective reduction with abortion. Dr. John Willke of the National Right to Life Committee linked fertility treatments directly to abortion. Willke explained, "Fetal reduction is the thinly veiled killing of unwanted babies" (#3032, *Time*, 1985). None of

the families featured in the magazines elected for fetal reduction. Due to their deep religious beliefs, the McCaughey's rejected "abortion" in order to save some of the babies (#4137, *Time*, 1997). The McCaughey's friends and family talked about the birth: "It was beautiful—the harmony and everything. The spirit of God was there." They were sure that seven healthy babies born at once was a "clear testament to the marvelous workings of nature and God" (#4137, *Time*, 1997). When doctors originally told the parents of the Collins sextuplets that they were pregnant with six, they never considered "selective reduction" because they did not believe in abortion (#4140, *People*, 1997). Likewise, the Louis octuplets' mother said she also felt "blessed." Although one died shortly after birth, she continued "Looking at these babies, seeing how well they are doing, fills me with so much joy. Sometimes I have to wonder: Who else could this be but God? We are so happy and grateful" (#5018, *Good Housekeeping*, 2001). Other families appearing magazines also opted against selective reduction, most often based on moral or religious grounds: they explained, "It's in God's hands" or "Doctors can only go as far as science lets them. From there on, it's a leap of faith," (#4133, *Good Housekeeping*, 1998; #4128, *People*, 1999). Because fertility specialists wanted to keep out of abortion politics and avoid criticisms as I discussed in Chapter 5, religious explanations removed them from any responsibility or blame. Patriarchal control allowed doctors to be off the hook as long as patients "understood" all the risks and did what they wanted anyway, or at least what they thought God wanted.

Many families with multiples became instant celebrities. Journalists portrayed them as the "ultimate" parents just because they defied the odds and had multiple children. One journalist stated that through raising septuplets, the McCaughey's dedication and faith in the face of adversity inspired countless lives. When Bobbi McCaughey made a special appearance at a religious event in Des Moines, Iowa, more than 12,000 people came to hear her speak. Both Bobbi and Kenny McCaughey created their own cottage industry by working full time as inspirational speakers with bookings all over the county. Even President Bill Clinton called them with congratulations, "You know those kids all go off to

school, you will be able to get a job running any major corporation in American.” Additionally, an unprecedented bounty of gifts came, ranging from around the clock volunteers to a lifetime supply of diapers from Pampers to a new house and free college education (from St. Ambrose University in Davenport, Iowa) (#4140, *People*, 1997; #4137, *Time*, 1997). A local dentist even donated braces to Bobbi. The McCaughey’s winced when people condemned fertility treatments and blamed any criticisms on jealousy (#4127, *Good Housekeeping*, 1999). These stories reinforced the competitive nature of procreation, judging by their procreative abilities.

Families with multiples also became reality television stars. The world’s fascination with multiples appeared deep. The Canadian Dionne sisters, the first quintuplets to survive infancy in 1934, were the original reality stars by growing up in “Quintland” which was open to the public for tours. They forewarned, “Multiple births should not be confused with entertainment, nor should they be an opportunity to sell products. Our lives have been ruined by the exploitation we suffered” (#4138, *Time*, 1997). However, exploiting families of multiples is exactly what the media did. The Pisners—four boys and one girl born after their mother took Pergonal—also starred in their own reality show of sorts in the 1980s. From the moment of their birth, news trucks staked out their house, photos of them were on the front pages of newspapers nationwide, they appeared on the cover of *Life* magazine, in a Barbara Walters special, *Good Morning America*, and as a regular series in the *Washingtonian Magazine*. The children, now grown, explained, “We don’t know any different. It’s just how we grew up” (#3036, *People*, 1985). With each new story, journalists predicted that since multiples were no longer a rarity, they would lose some of their circus-act qualities. But, this was not the case.

In the late 2000s, Jon and Kate Gosselin and their eight children—twins plus sextuplets—took the media by storm through their television show *Jon and Kate Plus Eight* (#5165, *People*, 2008; #5184, *Newsweek*, 2009). Raising their brood on camera had become their main priority: “We call it our family job” said Kate (#5165, *People*, 2008). In fact, over 9.8 million viewers tuned in during their peak (#5184,

Newsweek, 2009). Jon responded, “the TV show has been a blessing” providing them with a house, free trips, and even a tummy tuck for Kate. They were now thinking about adopting: “We want another little girl. We want to know what ‘one’ is like.” (#5165, *People*, 2008). Following the Gosslins in the limelight came “Octomom” (#5184, *Newsweek*, 2009; #5186, *People*, 2009). The media was inundated with stories about Nadya Suleman, a single mom who received fertility treatments to give birth to eight babies at once in addition to the other six children she already had at home (#5184, *Newsweek*, 2009; #5186, *People*, 2009; #5209, *People*, 2010; #5210, *People*, 2010; #5207, *Time*, 2009; #5211, *People*, 2010). The Pew Research Center reported in *Newsweek* (#5184, 2009) that 23 percent of Americans followed her story.

For the first time in the media, journalists blamed the infertility field for the “Octomom” fiasco. The infertility field was finally taken to task and scrutinized by journalists. In her article, “Ethics and the Octomom” (#5207, *Time*, 2009), reporter Bonnie Rochman used the Octomom situation to support government regulation of fertility treatments forcing leaders in the field to get involved. After several more months of public criticism, the American Society for Reproductive Medicine (ASRM) expelled the fertility specialist responsible for the “Octomom.” Beverly Hills Dr. Michael Kamrava reportedly broke with the organization’s guidelines by “implanting” six embryos in Nadya Suleman, two of which were thought to have split. The ASRM recommended transferring only one or two embryos to women younger than 35 in order to avoid these types of results (#5209, *People*, 2010; #5210, *People*, 2010). While the ASRM did not have the power to revoke a medical license, ASRM leadership believed “it’s our responsibility to set standards of care” (#5186B, *USA Today*, 2009). Kamrava repeatedly declined to comment to the media about the case (#5209, *People*, 2010). Finally, a year after the octuplet’s birth, a tearful Kamrava said “I’m sorry for what happened. When I look back at it, I wish I had never done it and it will never happen again” (#5211, *People*, 2010).

With few exceptions (mainly the families of aforementioned cardiologist Dr. Steve West and actor Richard Thomas who was a father of triplets), media portrayals about multiples births focused on young working-class or lower middle class families, many of whom already had other children as well: Patti and Sam Frustaci, who were in their early 30s and worked for an oil development company in Southern California; Kenny and Bobbi McCaughey, age 27 and both employed as sales clerks; Michele and Raymond L'Esperance in their late 20s who lived in a duplex apartment outside Detroit and worked as a \$26,000 a year corrections officer and shelter for abused women; Ria Gadeyne, a 24 year old nurse and her husband Edwin Van Hove from Belgium; Suzanne and Sidney Gaither, an African American couple in Indianapolis who held several radio-thons to raise money for the quintts; Debbie Strickland a counselor and her husband an auto mechanic from Nobelsville, Indiana who gave birth to two sets of quadruplets in 16 months; Rick and Ellen Taylor, teachers from Indianapolis; and 29 year old Daniel and Pamela Pisner from Olney, Maryland who report their family income as less than \$60,000 per year; the Gosselins who worked as a nurse and retail sales associate and already were parents to twins; and Nadia Suleman, a single mother to eight young children (#3032, *Time*, 1985; #3035, *People*, 1985; #3054, *People*, 1988; #3030, *Saturday Evening Post*, 1984). Class differences were apparent with regard to multiple births. Socioeconomic status determined access to appropriate infertility treatments and decisions about procreative technologies. This social stratification in terms of multiple births explains how procreative decisions are influenced by social forces. Most likely, middle-class and upper class families had more access to procreative technologies that did not increase the chance for multiples, such as *in vitro* fertilization (as opposed to the cheaper insemination after fertility drugs) and single embryo transfers. Additionally, families with higher incomes were more likely to consider selective reduction.

Just as interest in multiple births topped out in 2010, a new version of multiples appeared in the media-- "twiblings" or having multiple babies close together through various procreative methods

(#5076B, *New York Times Magazine*, 2010). For example, Lauren and Joe Kamnik had three children in one year. Lauren started trying to conceive at 29. However, she was not able to conceive due to ovulation problems. She also tried intrauterine insemination and *in vitro* fertilization, but they did not work. They then opted for surrogacy and adoption. They adopted a baby boy Oliver and hired Jennifer as a surrogate mother at the same time. After a few weeks, Lauren found out she was pregnant too. In the end, they had three babies all under 13 months old. By making it seem like an ideal situation, Lauren and Joe wanted to give people hope:

It's been a nutty ride, but we have bonded tightly over the supreme unlikelihood of our story. We are proud of the way our family has been created. There are three possibilities for having a child. And we did all three. We've shown that anything is possible. The biggest surprise in all of this? I didn't know how much love I had to give. (#5235, *Redbook*, 2010)

Even after all their efforts, Lauren explained, "If you want to be a parent, one day you will be a parent. It might not be in the traditional way though." Twiblings offered families another option for an instant family without the risks of multiples. However, because twiblings could only be provided through assisted procreative technologies, fertility medicine maintained control.

In 2009, journalist Bob Meadows (#5184, *Newsweek*, 2009) questioned if multiples have now "reached their 16th minute." After years of obsessions, was the fascination waning? However, just when the Octomom seemed to be enough, journalist reported that an unnamed Tunisian woman was said to be pregnant with 12 babies—six boys and six girls. The woman and her husband were thrilled with the number, and were committed to a natural birth in spite of doctor's grave warnings about the danger. Not surprisingly, the babies were conceived through fertility treatments. So far the record for multiple births is an Australian woman who gave birth to nine babies—all of whom died—in 1971 (#5076B, *Newsweek*, 2009).

As I discuss throughout this study, this trend of "one-ups-manship" pertaining to procreative technologies will likely continue. Because fertility clinics rarely turned down desperate patients' requests (as long as they understood the risks), fertility specialists encouraged patients to be

“productive” in seeking out whatever they needed (and could afford) to help them build the family of their dreams.

6.10 Getting What You Want -- Designer Babies

Increased knowledge about genetics and the availability of fertility treatments were gate-ways to discussions about designer babies in the media. Sex selection in humans was the first foray into “designer babies” as scientists tried to select the sex of an infant before fertilization. In 1964, *Time* (#1014) reported that by inseminating women with specially prepared sperm that separated by sedimentation, sex might be able to be determined. Typically, the upper portion of the sample produced males, the lower portion produced females, and the middle portion produced both males and females equally. While tried in farm animals, scientists and doctors were excited about the potential uses among humans. Two decades later, *People* (#3023, 1984) stated that through his company Gametrics, Ronald Ericsson, a rancher and biologist, patented and licensed a technique which involved taking sperm for the father’s semen and placing it in a glass full of human albumin. Emphasizing virility, the fastest, strongest sperm, most of them containing the Y, or male chromosomes, typically swim their way to the bottom. They are then placed in other glass column containing thicker albumin and swam down again. These sperm could be isolated in order to increase the chance of producing boys.

In the 1990s and 2000s, sex selection technology was publically marketed through the media by several fertility clinics. For example, Dr. Edward Fugger heavily promoted MicroSort which separated the X chromosome producing a female child, and the Y chromosome yielding a male. *Time* (#4131, 1998) reported that MicroSort raised the odds of sex selection by 65-85 percent, with producing girls a bit easier than boys. Expert opinions about as to the social effects of sex selection varied. Fugger told *People* (#4134, 1998) that this technology could be used for good or for bad (#4134, *People*, 1998). As a result, sex selection ignited an ethical backfire in the media. Dr. Jamie Grifo explained, “I think it’s

valuing one gender over another. I don't think that something we should be doing" (#4130, *Newsweek*, 1998). Others believed it should only be used for "gender balancing" in families: "If you have three boys, and you want a girl, that's not gender bias at all" said University of Texas reproductive-law professor John Robertson (#4130, *Newsweek*, 1998). Ronald Ericsson did not think of his work in sex selection as raising tough moral questions: "I'm in favor of anything that improves the quality of life. Sex selection does that, because people who want to use the method have to sit down and think about what they are doing" (#3023, *People*, 1984). Many thought that if procreative technologies provided families with desired children, families should also get exactly what they wanted, much like any other commodity. Robin Marantz Henzig, author of the book *Pandora's Baby How the First Test Tube Babies Sparked the Reproductive Revolution* (2006) warned, "The more it [sex selection] is done, the less you are going to see concerns." Overall, these conversations reflected an overall lack of understanding among medical professionals about sex and gender. Instead of distinguishing between biological sex and gender role, the medical professionals supported that gender was a fixed trait through the media. Based on the work of Simone de Beauvoir (2011), producing genetic males and females does not equate to raising boys and girls.

This essentialist view of procreation and the permanency of certain characteristics expanded into the 1990s as researchers refined preimplantation genetic diagnosis (PGD) or the ability to look at the genetics of a growing embryos before they were transferred back to the uterus. During initial usage, 76 babies had been born as the result of PGD used to produce children free of genetic diseases like cystic fibrosis, hemophilia, and Duchenne muscular dystrophy (#4105, *Redbook*, 1998; #4109, *Time*, 1998). Families using new genetic technologies were told they had the "added benefit" of being personally involved with the eventual elimination of a genetic disease (#3019, *Saturday Evening Post*, 1982). Alex Capron, co-director of the University of Southern California's Pacific Center for Health Policy and Ethics told *People* (#5014, 2001), "If we think it's okay for a parent to select characteristics in a child

to avoid a lethal disease, how can we not approve of a parent saying it is useful to have a child with an athletic ability or one who is tall? Where you get to the slippery slope is when a baby becomes a useful commodity.”

Additional strides towards designer babies were also mentioned. In an article entitled “Can You Make My Kid Smarter?” one parent who used to technology explained, “Why is it unethical to provide my child with the best possible chance for a healthy life?” (#4122, *Time*, 1999). Journalist Michael Lemonick (#4123, *Time*, 1999) predicted within a decade or two, it would be possible to screen kids almost before conception for an enormous range of attributes, such as how tall they are likely to be, what body type they will have, their hair and eye color, what sort of illnesses they will be naturally resistant to, and even conceivably their IQ and personality type. He also concluded that in a society comfortable with cosmetic surgery and psychopharmacology, this is not a big step (#4123, *Time*, 1999). Interviewed by *Time* (#4123, 1999), Princeton’s Lee Silver, said,

Typically, medical researchers are moved by a desire to cure disease more effectively. Reprogenetics [a term coined by Silver] was going to be driven by parents or prospective parents who want something for their children. It is the sort of demand that could explode. (#4123, *Time*, 1999)

Some predicted new technologies would boom and “the day will come when parents and doctors created the perfect baby in the laboratory.” However, *Time* (#4090B, 1996) assured readers that genes had not been found for good looks, high IQ, or artistic talent yet. Dr. Michael Tucker of Atlanta, Georgia did not see this as a great threat: “While we scientists push the envelope of technology, the ethics and morals of it are not just our problem. It’s up to all of us to be aware of potential abuses” (#4110, *People*, 1997). Dr. James Watson, co-discoverer of the structure of DNA, said, “There may be problems, But, I don’t believe we can let the government or anyone else start dictating the decision people make about what sorts of families they will have.” The fertility specialists again placed their autonomy ahead of the

societal concerns. Fertility specialists assumed that they would always be ethical regardless of their clear business interests as I discussed in previous chapter.

Journalists also feared human cloning, and many viewed assisted reproductive technologies and genetic testing as setting the stage for this. In February 1997, the announcement was made about the birth of a sheep named Dolly, an exact genetic replica of its mother, a major step towards cloning humans (#4120, *Time*, 1998). As seen with nearly all new procreative technologies, assumptions abounded comparing this technology to Frankenstein or predicting lifeless bodies would soon be developed and kept alive as a future source of organs (#4120, *Time*, 1998; #4135, *Time*, 1998; #4103, *Time*, 1999). In light of the ethical dilemmas with cloning, why would families want to utilize human cloning? Couples unable to have children might choose to have a copy of one of them rather than accept the intrusion of genes from a donor. Likewise, according to *Time*, (#4101, 1999) copying was also suggested as a means by which parents can have the child of their dreams—choosing to copy an already deceased child, a film star, baseball player, and scientist, all depending on their interests. Additionally, the most vocal proponent of cloning was named “Fertility and Genetics” further connecting fertility with cloning. Despite these breakthroughs, Ian Wilmut a scientist involved with early cloning research, said human cloning should be banned, however, he feared the full meaning of cloning will not be felt until we get a taste of its abuse (#4102, *Time*, 1999). House Majority leader Dick Armey advocated for restrictions for both human cloning as well as related procedures that promise new treatments for infertility saying “This the right thing to do, for the sake of human dignity.” (#4070, *Time*, 1998). President Clinton also blasted the idea as “untested and unsafe and morally unacceptable (#4135, *Time*, 1998).

In 2001, a new technology closely related to cloning was announced. Originally developed to help infertile women in China, it took a patient’s fertilized egg, scooped out the chromosome-bearing nuclear material and put in a donated egg whose nucleus had been removed. *Newsweek* (#5022, 2003)

reported one triplet pregnancy—with three healthy babies—resulted from this new procedure. Some doctors and ethicists were upset that this so-called nuclear-transfer technique had also been used in the past to produce clones, including Dolly the sheep. The only significant difference was that with cloning, the inserted nucleus comes from a single, usually adult cell, and the resulting offspring is genetically identical to the parent. Researchers in the United States stopped working on this technique because of the stringent government approval process. According to critics in the media, the bottom line was that perfecting a technique that could be used for cloning, even if it were developed for another purpose such as family building, was just a bad idea (#5055, *Time*, 2003; #5022, *Newsweek*, 2001).

Overall, technology was getting closer to creating designer babies. Lori Knowles from the Hasting Institute, explained, “We’re well on our way towards designer children. If we don’t say there’s anything wrong with choosing the gender of a baby, how can we say there’s anything wrong with choosing its hair or eye color or height?” How this would be introduced to potential consumers (as well as society) remained unclear. Based on history, fertility clinics would likely use this opportunity to grow their business and create new markets for fertility care beyond the traditional definition of infertility. The infertility field is almost strictly a fee-for-service industry blurring the line with regard to capitalism and commodification. Based on other forms of assisted procreative technology (which all started off as being unimaginable as well), there is no reason to think this new chapter in procreative medicine will differ from other previous methods used to provide families with their ultimate family-building dreams.

6.11 Fertility Specialists’ Perspectives about Treating Infertility

The fertility specialists whom I interviewed were most enthusiastic and vocal about their personal involvement in the development and expansion of new procreative technologies. Although I chose to use the term “procreative technologies” based on Rothman’s (1989) work suggesting that children cannot be “produced,” all of the fertility specialists whom I interviewed used to words “Assisted

Reproductive Technologies” or ARTs. I found selecting appropriate terminology to be problematic for several reasons. For example, ARTs connoted needing professional “assistance” to get pregnant. As I discussed before, according to fertility specialists, this assistance could only be provided by trained professionals as all doctors were not knowledgeable about infertility. Although Rothman indicated that children cannot be produced, these doctors probably very much thought they were “producing” children, given the capitalistic environment of procreative medicine. While using the words “assisted reproductive technologies” was not most appropriate from a sociological perspective, this term actually better described what the fertility specialists were trying to accomplish—producing babies through their specific expertise and assistance.

All verified that before the advent of *in vitro* fertilization, there was little they could offer infertility patients—mainly sex education, information about adoption, and occasionally fertility medications. Even though my media analyses showed that physicians commonly provided advice and education about sexuality and fertility before procreative technologies became available, none of these fertility specialists felt comfortable talking to patients about sex. Dr. Carter provided the most detailed response:

They taught us about sex education in medical school. It was very clinical. Masters and Johnson came in and spoke to us about their research. We watched what were essentially porn films. Men having sex with men which was hard to watch. Women having sex with women which was easy to watch. And old people having sex, although “old” back then was 40. I was in my 20s so 40 did seem old. These movies were supposed to prepare us so we wouldn’t be shocked. But, this education didn’t do anything for me in terms of talking with patients about sex. I always hated it.

Previous research (Hinchliff, Gott, and Galena 2005) indicated that health professionals in general do not often talk to their patients about sexually related issues. Still, I was surprised that Dr. Carter used such an emotionally laden word such as “hate,” especially given he had devoted over 50 years to the study of fertility—a component of sex. He also clearly evoked sexual stigma and reinforced sexual stereotypes through his comments. Given physicians controlled much of the health-information

reported by the media as I discussed in my analysis, I was no longer surprised that patients remained ignorant of the details about sex, whether related to procreation or not.

As my study also included, little information existed for patients about fertility. As a result, many families had no choice other than to seek professional medical assistance, even for basic information about how to get pregnant. Again based on an elitist and patriarchal view about medical knowledge, these fertility specialists assumed most people required their professional help in understanding the complexities of procreation. Dr. Baker explained,

We started with the basics of how babies are made. They knew the parts, but nothing about how the body actually worked, especially in terms of ovulation or timed sex. It was a big awakening for some.

As I discussed in Chapter 4, for those not experiencing infertility, getting pregnant was easy, something not requiring a lot of education or preparation. Pregnancy was just something that “happened,” almost mysteriously and with minimal effort. However, for those experiencing infertility, procreation was not portrayed as simple, natural, or something that could be easily understood, especially without the involvement of a trained physician. Because of gendered expectations, many women considered procreation as an instrumental component of being a woman, and any deviation from this was unexpected and often rejected:

Women who came to me were not at all prepared for the possibility of infertility. They were completely oblivious to it. And I had no books to give them so I had to educate them myself. Most of the time, they didn’t want to hear it. (Dr. Elliott)

Similar to the physicians interviewed by the media, these fertility specialists’ described women as not wanting to identify with infertility regardless of the diagnosis. Because no definitive test for infertility existed, the “infertility” diagnosis was dependent on the fertility specialist to ascribe it and the patient to accept it.

Patients were not the only ones misinformed about sex and fertility. In fact, procreation was considered so complex that that many other doctors, who were not fertility “specialists,” relayed inaccurate information to their patients as well:

We had a fellow doctor practicing in the area. He was a nice family physician. Well liked. Popular. Back then ob/gyns weren’t as common as they are today. Women would just go see their family physician. He used to confirm pregnancy by internal exams alone—no chemical pregnancy test (and I’m talking about the old rabbit test which you probably don’t remember). He used to tell women they were pregnant. Months would pass. They wouldn’t get bigger. They wouldn’t have symptoms. Some would get their periods and assume miscarriage, but some would not if they had infertility issues. They would come to me perplexed. How could this have happened? How could I not be pregnant? They thought being told by a doctor that they were pregnant simply made it so. It took a lot of explaining. (Dr. Appleton)

During my interviews, four of the fertility specialists described situations in which they had to “clean up” after other doctors “failed” or made “mistakes.” Fertility specialists clearly identified themselves as the pinnacle of “expertise” regarding all aspects of fertility. Even though they were initially trained as ob/gyns, they all preferred to be called “fertility specialists” or “reproductive endocrinologists,” further differentiating themselves. My interviews reinforced the narrative portrayed in the media that patients should seek help as quickly as possible from a fertility specialist instead of wasting their time with anyone else.

I was practicing in a mid-sized town the in the mid-west. Just out of residency and passed the tests to become a board certified RE [reproductive endocrinologist]. There were only three of us in the whole state. Before that, people’s only option was there regular doctor. If they were lucky, he might now a little something about infertility, but it varied. We were the only ones who could really help people. (Dr. Carter)

However, the NSFG showed that most people experiencing difficulty getting pregnant did not seek help from a fertility specialist. Health care providers, mostly primary care physicians, provided advice about procreation more often than fertility treatments. A disconnect existed between specialists and non-specialists, perpetuated by the fertility specialists themselves. Several of the fertility specialists whom I interviewed expressed frustration with having to educate ob/gyns about infertility and when to refer

patients to a fertility specialist (which in their opinion was immediately). Consequently, those without access to a fertility specialist were at a greater disadvantage for having their infertility resolved.

These strides in treating infertility through procreative technologies also resulted in fewer “sterile” people needing to adopt. Because adoption was not presented within the context of infertility during my media analysis, I asked these physicians how adoption fit within the scope of treating infertility. Dr. Davis explained,

At first, all I did was talk about adoption to infertility patients. There was nothing else. After IVF, I didn't bring it up at all. That's not what people who saw me were looking for. They wanted a baby of their own. I offered them more choices. If they stayed with me long enough, we could usually find something that would work. I can't remember the last time I talked in depth to a patient about adoption. Sometimes I give them some resources, but they usually don't ask me any specific questions which is good because I don't have the answers.

With very few articles about adoption included under the INFERTILITY/STERILITY headings, the media reflected these sentiments as well—being infertile did not equate to wanting to adopt. Apparently, infertility and adoption were two distinct issues with different target audiences. In fact, the media often portrayed infertility treatments as the opposite of adoption. As Dr. Appleton said, “Adoption is not a cure for infertility.”

All the fertility specialists whom I interviewed stated that they enjoyed their work far more once procreative technology became available. Overall, new fertility treatments gave them more control over the entire procreative process and further separated procreation from sex, a topic that they found uncomfortable. Going forward, they could address fertility without discussing sex. Moreover, these fertility specialists defined infertility as pathology, a medical condition with no connection to emotional, social, or sexual issues. For example,

There was no need to talk to my patients about sex. They had many resources. There were books of all kinds out there, including how to “enhance your marriage” by doing things like showing up at the front door naked after your husband came home. There was nothing I needed to teach them. If they couldn't figure it out, they could find out elsewhere. I could just concentrate on their medical needs now. (Dr. Davis)

All of the fertility specialists were also involved with the initial development of *in vitro* fertilization in some capacity. In addition, all of them were connected with each other through their early work—training or being trained by one another. Dr. Grant said,

To get into this field, you had to know someone, one of the leaders. If they liked you, you were golden and could go on to open a clinic of your own. We were all handpicked to be able to do this. A laying on of hands you could say.

Almost from the very beginning, treating infertility became a very competitive process among these physicians. Dr. Appleton explained,

As soon as we heard about Dr. Jones and the Carrs here in the United States, I jumped on the next plane to Australia. The Australians were really the ones doing the advances at this point. I didn't know anything about embryology so I found an embryologist who worked with animals and took him with me. For a good IVF, you need a good embryologist, and at this time no one was working on humans. We learned together. I told him if you could do this in animals, you can certainly do it in humans. I was determined to bring IVF to [my home state] as quickly as possible before anyone else did.

As I also discussed in the previous chapter, infertility specialists were still very loyal to their chosen profession. This loyalty was necessary to maintain autonomy and control. When I questioned Dr. Grant what the overall goal was for the infertility field, I expected him to say something along the lines of “curing infertility.” Instead, he informed me that the goal was “To get as many patients as possible to walk through our doors.” Dr. Appleton told me that he considers every person to be infertile and all cases of infertility treatable “unless proven otherwise.” Because there was a very small target population for fertility services, they had to actively promote their services to any potential patients, often at any cost. (I discussed specific marketing tactics used by these fertility clinics previously in Chapter 4 and 5.)

Given the steep learning curve and low chance for success, I asked the fertility specialists how they relayed this uncertainty to their patients wanting to try *in vitro* fertilization, especially in the early days:

At first, none of us knew what we were doing or if IVF would even work. In fact, our patients didn't even know what we were doing. All they knew was maybe whatever we were doing would allow them to have a baby. We just didn't have much information to give them. As an aside, Louise Brown's mother just passed away recently. I read an article that said she never knew she was the first success IVF patient until she read it in the paper. She had no clue that IVF at that time was just experimental. Talk about no informed consent. Sounds shocking, but, it was all the same everywhere. We always just felt lucky when something worked. (Dr. Carter)

Drs. Davis and Baker explained that while these success rates might seem low now, *in vitro* fertilization was actually a huge breakthrough. Everyone knew it and wanted to give it a try anyway. According to my interviews, there was no way to discourage the public, doctors or patients from procreative technologies, regardless of the data, a situation that continues today. Although consistent with my analysis throughout this study regarding overinflated statistics and the strong emphasis on hope, this was difficult for me to hear because informed consent and evidence-based decision-making are usually highly valued throughout other aspects of medicine. However, Dr. Carter stated that evidence-based medicine does not work in infertility given so many of the decisions are based on the fertility specialist's personal experience and expertise, again highlighting power and autonomy, as well as an assumed hierarchy within procreative medicine.

In terms of the future of *in vitro* fertilization, Dr. Davis reflected,

I think we have done all we can. We have gotten it as successful as it will ever be. I think it has actually plateaued at this point and success rates will remain relatively constant. The only research that is being done right now is trying to improve implantation rates. If we can figure out more about why some embryos make it and some don't that would be an improvement. But, there is no research money to put towards this so I don't think it will happen anytime soon, if at all. I think we've done a great job considering.

These comments again stressed the competitive side of the infertility field. Because there were no guarantees with fertility treatments and infertility medicine blurred the line between medicine and business, fertility specialists had to find ways to maintain their competitive edge. Additionally, they differentiated themselves from colleagues in order to attract patients. Although fertility specialists were loyal to the field of reproductive endocrinology and infertility as a whole, they were often competitive with each other individually, each claiming to be the "best" at what they do. This competitiveness

resulted in the wide variation of quotes, often contradictory, from fertility specialists themselves included in the magazine articles analyzed in my study.

All of the fertility specialists whom I interviewed were less interested in talking about collaborative reproduction compared to *in vitro* fertilization. Perhaps, this is because collaborative reproduction is not as technologically straightforward as *in vitro* fertilization and involves more psychosocial aspects involving several different personalities. Franklin (1997) said that fertility clinics center on high-tech options when fertility specialists have the most control. However, all the clinics represented in my interviews included sperm donation, egg donation, and surrogacy as a necessary part of their overall “business model” to provide comprehensive fertility care. Through her research, Becker (2000) suggested that most fertility specialists are ambivalent toward sperm donation which my study confirmed as well. Although fertility specialists performed artificial inseminations, all of the fertility specialists whom I interviewed expressed that they did not really enjoy doing this. Artificial insemination was a relatively simple procedure, often done by ob/gyns resulting in somewhat of a turf battle as to who is responsible for infertility treatments. Dr. Carter explained, “I don’t know why anyone would choose to have their ob/gyn do an IUI [intrauterine insemination, also known as artificial insemination]. They don’t know what they are doing.” Dr. Appleton said that insemination by an ob/gyn was “a step up from doing it yourself.”

Although fertility clinics used donor sperm, these fertility clinics themselves were not responsible for obtaining the sperm. Instead, women had to get their own sperm from a handful of frozen sperm banks throughout the United States shipped directly to the clinic. When asked why the lack of interest in sperm donation, Dr. Baker admitted, “I did not go into this field to work with men.” Dr. Appleton said, “I went into this field because I enjoy working with women.” These doctors’ ambivalence toward men also appeared in their descriptions of their “sperm collection” facilities. Dr. Davis explained,

At first we made men provide their [sperm] samples in the bathroom. Then we gave them a small room with a chair. Now we supply them with some “reading” material to help them along.

Despite the statistics showing that infertility affects men equally, men were definitely marginalized by these fertility specialists during infertility treatments. Additionally, men were often reduced to their ability to produce sperm, another consistent narrative throughout my study.

Surrogacy was another difficult topic for these fertility specialists. They viewed surrogacy as “complicated” and “messy.” Similar to the my analysis of popular media, Dr. Appleton explained,

Whenever I bring up the possibility of surrogacy to a patient, they will almost always bring up the Baby M case, even today all of these years later. Everyone has heard of it, and it still causes a lot of fears among parents thinking about surrogacy. This was the first big media story about infertility treatments and probably affected the way most people think about infertility treatments, especially surrogacy. You can obviously see its long-term effects.

All of the clinics represented did not recruit their own surrogates or handle the “matching” process between surrogates and intended parents. Instead, they referred patients to independent surrogacy agencies and oversaw only the medical aspects of a surrogacy pregnancy. Dr. Elliott explained, “Surrogacy is relatively easy given the surrogate is not infertile herself. In most cases, a simple embryo transfer and she’s pregnant. There really isn’t much I need to do.” Likewise, Dr. Davis stated “I always try to encourage egg donation or embryo donation first when I can. However, surrogacy is usually easier for families than adoption. In both cases, there is a lot that can go wrong. ” These fertility specialists maintained an overwhelming interest in the high- tech components of infertility as well as defining what is “easy” versus “difficult” when it comes to family building. However, this determination was often based on medical reasons with no consideration to psychosocial issues or structural factors.

Unlike sperm donation and surrogacy, all of these fertility specialists were very much involved with egg donation by actively recruiting and screening their own egg donors. Dr. Davis explained, “Because the success of egg donation depends heavily on the egg donor’s ability to follow directions and adhere to protocol, it is critical that we know who these women are and pick the right ones.” To ensure

the success of the egg donation process, doctors felt they needed to control all aspects of egg donation, especially the egg donors. Given the difficulty expressed in the magazine articles about recruiting egg donors, I asked about how egg donors are typically recruited by their clinics. All of the fertility specialists whom I interviewed said that recruitment was difficult for them too. Recruitment methods often included, radio commercials, flyers, advertisements in papers, and Internet advertising. One fertility specialist admitted to “going places with young women would frequent, like bars and nightclubs to find young, pretty, smart donors.” Unlike the media portrayals, egg donors used by the clinics were exclusively anonymous. Dr. Davis described having a separate entrance for donors and recipients so they would never run into each other. Dr. Appleton staggered appointments so donors and recipients are at his clinic at completely different times. Overall, none of the fertility specialists recommended patients telling others, including their children, of their egg donation. Dr. Baker said, “That’s the beauty of egg donation. You can be pregnant and no one needs to know.” Similar to my media analysis, pregnancy was portrayed as more important than genetics in a pregnancy via egg donation. However, through my other research (Glazer and Sterling 2005), parents via egg donation usually struggle with unresolved issues related to genetics after their baby is born. As with my previous analysis, genetics continues to be important regardless of new methods for family formation.

Most of fertility specialists interviewed in my study involved some type of mental health professional with the initial egg donor screening. However, ultimately the fertility specialist decided who was an appropriate donor or recipient emphasizing their power and patriarchal control over all aspects of fertility. While all the fertility specialists agreed that money was not a motivating factor for donors, all paid donors between \$7,000 and \$10,000 for a single donation. In addition, in Dr. Elliot’s office, there was a flyer posted stating at the top in big bold letters, “Let us pay for your college tuition this semester” highlighting the financial benefit of donating eggs. Recruiting “good” egg donors was a

priority for most of these clinics to again maintain their competitive edge as I discussed before. Dr.

Appleton explained,

Most of the women I see now are older—usually over 40. Of course, they all want to get pregnant using their own eggs. But, often this is impossible. I let them try however many times they want. I tell them the realities that it is unlikely. At some point, they will become interested in egg donation. Sometimes it takes a while, but we need to be able to offer them a good alternative or we will lose them to another clinic. (Dr. Appleton)

As cited in the NSFG statistics, older women seeking fertility care were a main priority for all of these clinics and their marketing tactics reflected this, as well as maintaining a certain narrative about age and fertility which I discussed in Chapter 4.

Similar to portrayals in popular media about egg donation, many of the fertility specialists also looked forward to the day when women could preserve their fertility longer and egg donation would not be necessary. When asked about whether or not egg donation would eventually be replaced by one of these newer technologies, all the doctors interviewed thought this was plausible.

I could see it happening. The demand is certainly there. Women want to have their own babies, not someone else's. This has always been a big issue. No matter how many times we tell women that this is their baby, some never feel that way no matter what. If women demand it, someone will figure it out that is a sure thing. That's the way this field has typically worked. There is not much more we can do, but this would be a huge breakthrough and would put egg donation out of business which would not be such a bad thing. (Dr. Baker)

Two of the fertility specialists I interviewed were also working on establishing their own frozen egg banks. Dr. Davis explained, "Egg banks are the future." Drs. Davis and Appleton explained that egg banks were especially appealing because they further promoted anonymity and further separated donors from their eggs. Again, this minimized any psychosocial issues or structural factors that fertility specialists would confront during the egg donation process. These fertility specialists were more interested in the eggs than the donor, creating a business transaction rather than personal relationships. Additionally, none of the fertility clinics represented conducted any formal follow-up with donors. Dr. Davis said, "Sometimes we contact them later if the recipient family is interested in using her specific eggs again. We don't pressure them. We just ask if they are interested." Dr. Appleton offered free

annual gynecological exams for donors until their 30th birthday, the cut-off age for “his” donors as if he “owned” them. Given the age cut-off as well as the difficulty in recruiting egg donors, I wondered these exams were more a method to keep tabs on the donors to use again, like Dr. Davis did, rather than for purely altruistic or health-related reasons. Because “good” egg donors were hard to find (in terms of both their appeal to potential parents and ability to comply with the egg donor process), fertility specialists were incented to retain as many as possible for additional donations, again emphasizing the business side of procreative medicine.

As I also discussed in the previous chapter, all the physicians agreed that frozen embryos were the biggest unaddressed challenge regarding procreative technologies. Although frozen embryos offered families additional cost-effective opportunities to become pregnant, the sheer number of embryos now frozen was a problem for both patients and fertility clinics alike. When asked about the status of nearly half a million frozen embryos and what the future holds for embryo disposition in general.

The number of frozen embryos has gotten out of control. I really don't think we have the space for much more. I'm not sure what our alternatives are. I would not be surprised if some company took charge of storing all these frozen embryos somewhere off site and centralized. It's hard for us to keep up with them all. It's not at all cost-effective for us anymore. It's going to be a big problem very soon. (Dr. Carter)

Frozen embryos are a big problem for us. They take up too much room and cost a lot. We have to have many procedures in place to keep up with them. I wish we had better options. Patients want them as do the fertility clinics. Embryo donation is a good idea theoretically, but I'm not sure how you change the perception that it is selling babies. That's why only the religious groups have taken it up. When a for-profit business gets involved, it just sends the wrong message about embryos for sale. I'm not sure how to get past this. I will tell you....if someone doesn't find something soon, some business will take it over. I think this is what we are seeing with those embryo banks. To my knowledge, none of them have worked so far, but it's just a matter of time. (Dr. Grant)

Note that the biggest concern about frozen embryos was how much they were costing clinics. There was no mention of any psychological, social, or ethical considerations of having so many embryos frozen indefinitely which were described in the media portrayals. Since embryo adoption received attention in

the media, especially by religious publications, I asked if embryo donation was a viable option. Dr.

Carter said,

Even the President of the United States went on television and said how great embryo adoption was, especially over stem cell research. I think it was Bush that put aside millions to be used towards educating the public about embryo adoption. It was millions I think. I remember many local meetings about this with politicians wanting to meet with fertility doctors about how to get the word out. This kept the media's attention for a while. (Dr. Carter)

I don't really know how many families really want embryo adoption. Parents of frozen embryos usually do not want to give up their genetic materials. Those that were the result of donor gametes, then there is a whole mess of legal and ethical considerations as to whose embryos are these and how much say does the donor have in what happens to them. Our hands are tied with them. And families who decide to adopt embryos, I don't know what to say to them. Yes, it is cheaper. But, there is so much variability in terms of clinics and labs where they were created that I can't be confident as to their quality. I would not recommend families go through with this without more information. (Dr. Grant)

Although embryos remained a problem for fertility specialists, they predicted no improvements any time soon. In fact, all but one of the physicians interviewed did not know how patients were educated about the fate of their frozen embryos since they did not typically discuss this topic with patients directly. Moreover, these physicians had even less knowledge about more complicated situations such as donating to research, shipping across state lines, or "ownership" of embryos created through collaborative reproduction. Additionally, no standard policies, informed consent, or contracts were used with regard to embryos. Most of the fertility specialists were reluctant to destroy embryos, even with the patient's consent, due to liability risks. For the most part, fertility specialists expected patients to navigate through the limited choices for embryo disposition on their own without any professional advice.

Multiple births were also a major challenge to the infertility field identified by these fertility specialists. They agreed most families actually seek out multiples, especially twins, with a kind of "two-for-one" type attitude. Dr. Grant told me that he had had several patients who were perinatologists or neonatologists who also did not want to limit the number of embryos transferred even though they fully understood the risks involved with multiples. Similar to the media representations above, many

patients, regardless of educational background or experience, did not think multiples will ever happen to them. The doctors whom I interviewed blamed these false perceptions about multiples strictly on the media. Dr. Davis explained,

If the media would concentrate more on the horror stories of multiples, it might be a different story today. It's all beautiful babies. Everyone is happy. After struggling with infertility, this is all families that come to me see. And this is exactly what they want....an instant family. A house full of children. Boys and girls. This is what they want me to give them. They don't want to hear the realities. They never think it will happen to them. Did you know that even having twins is five times more risky than one?

Other than more accurate media portrayals, none had any suggestions about lowering multiple births.

Dr. Baker explained, "Our goal is one healthy baby. But, if a family wants to hedge their bets, I support them within reason." While "single embryo transfers" were available and even recommended by the American Association of Reproductive Medicine, no one wanted to stress this option to patients given the high costs of *in vitro* fertilization and the additional burden this would place on patients. They were also very quick to distance themselves from selective reduction, telling me that they were not involved with this activity and referred patients to perinatologists if needed. Ultimately, the decisions resulting in multiple pregnancies lied with the women. As seen throughout my study, fertility specialists saw their role as supporting a woman's procreative choice, not influencing it. While they might not have directly dictated women's choices, many structural factors, such as power, patriarchy, and gendered expectations exerted by the fertility specialists severely limited women's agency in being able make choices.

All of these fertility specialists also agreed that procreative technologies were completely safe and the public did not need to worry about adverse outcomes. They explained any major study producing results on either side was unlikely since infertility patients were challenging to include in major studies like this, especially due to the privacy issues surrounding their experiences. Similar to my media analysis, Dr. Grant informed me, "I don't even know what we would do with data like that. How do you tell a woman—you can either have a baby or risk a small chance of getting cancer decades from

now. I don't see how this is helpful to anyone." However, all knew other fertility specialists who decided to use procreative technologies as well as those who declined these methods for building their own families suggesting some type of uncertainty as to the long-term outcomes.

Also in my interviews, the fertility specialists mentioned the growing trend for designer babies, mainly sex selection. In fact, a couple of the clinics were specializing in this now. Dr. Elliott explained, "I expect a growing demand for sex selection. It doesn't help with success rates overall, but I have no problem giving patients what they want." Dr. Baker said, "The vast majority of patients are average suburban parents who have two or three children of one sex and say they want another of the opposite sex. What's wrong with that?" However, they did not expect technology to be able to deliver "designer" babies based on other characteristics anytime soon. Dr. Grant said, "I guess it could happen, but I don't see the reality of it at all. It's not something people should really worry about." However, when asked about the connection between fertility treatments and cloning, a major fear expressed in the media, Dr. Cooper explained,

People are always concerned about cloning. It's actually not a stretch. The same people who are involved with reproductive technologies are also doing the cloning experiments. This has been a mixed blessing for the media. Nearly all the doctors interviewed set the record straight about why this wouldn't happen. But, you always have some big-mouthed fraud that tells the media it can be done.

These types of conflicting views expressed by experts were apparent whenever a new procreative technology was introduced. As a result, it provided fodder for critics looking to raise fear and concerns among the public. By focusing on the best interests of the fertility specialists to promote new technologies, it also further inhibited agency in terms of true procreative choice.

After over three decades, the fertility specialists whom I interviewed agreed that they think the attention towards procreative technologies has plateaued. They already sensed changes as many who made up the original "establishment" started to die off, infertility treatments became routinized, and expectations increased, especially in terms of desired outcomes and how much patients were willing to

pay for treatments. I am interested in seeing what is next for infertility, what other technologies will emerge, and how these new family building methods will be introduced into public consciousness by the fertility specialists themselves. According to my analysis, previous procreative technologies followed similar scripts: anticipating the technology with both excitement and uncertainty; criticizing the technology through moral and ethical concerns; lauding the technology as a miraculous breakthrough; and finally normalizing the technology and making it seem commonplace, and in some cases reaching celebrity status (with the exception of egg donation which was never really normalized). In general, the ways in which procreative technologies were portrayed allow these options to simply become an expected “a way of life” for many women experiencing infertility (Franklin 1997). In fact, many consider women who do not choose procreative technologies deviant (Spar 2006). Most likely, the infertility-industrial-complex employs a specific marketing strategy in accordance with these narratives that will be used again with upcoming technologies. Regardless of what will come next, it will surely continue to include the complicated interplay between structure and agency and appeal to basic tenants of parenthood, genetics, and production as I have discussed throughout this chapter.

CHAPTER 7

CONCLUSION

Between 1960 and 2010, media depictions of infertility rose from just a handful of mentions to hundreds of articles. Options for families experiencing difficulty getting pregnant grew exponentially during this time as well. A whole host of procreative treatments aimed at fulfilling dreams of having a child replaced limited hope for overcoming infertility. Given the expansion of fertility-related information and available services, many believed that the experience improved for those struggling to get pregnant. However, did the culture of infertility truly change or was it just a different version of the same? Both Letherby (2003) and Greil (2010) stated that infertility is legitimized by both individual experiences and culture. In my study, I reviewed three major topical areas which occurred with the greatest frequency within the data set and had the most sociological relevance to the study of culture. My analysis of defining infertility, controlling fertility, and treating infertility through procreative technologies provided insight into journalists' perceptions of what was important to communicate about infertility to vast audiences of women and men. Because infertility was a reflection of cultural norms, infertility was best understood through socially constructed categories. Moreover, the infertile, professionals, and others within a sociocultural context regularly negotiated these categories.

Mathieson and Stam (2008) suggested that individuals develop meanings related to infertility within the context of organized social relationships, particularly the medical system. As a result, I also included interviews with fertility specialists to supplement my media analysis. My study indicated a tremendous amount of patriarchal control exerted by fertility specialists through the media. Most importantly, the fertility specialists literally defined "infertility." Since no definitive tests for infertility existed, fertility specialists developed their own medical definitions which circulated throughout popular media. Furthermore, fertility specialists also valued their autonomy within the field. No specific

standards of care or guidelines for treatments developed. Treating infertility was perceived as more of an art than a science. As a result, fertility specialists decided who was infertile, who could be treated, which treatments were accessible, and even which ones were “successful.” They constructed the definition of infertility in such a way that allowed individual fertility specialists to further limit or expand this definition at their discretion, including the “socially” infertile like older women, single women, lesbians, and same-sex couples.

Given the fluidity of defining infertility, many journalists suggested that women had more choices. However, according to my analysis, medical control actually replaced biological control. Instead of increasing agency, a patriarchal and capitalistic structure controlled women’s choices about procreation. Disguised as individual choice, decisions about infertility treatments were anything but. Overall, fertility specialists sold a “product” or “service” by way of procreative procedures. Specific medical necessity was rarely established, and treatments held no guarantees. Additionally, many women forgave or ignored inappropriate or even abusive behavior due to hope for a potential end-result of a baby. A woman’s ability to get pregnant depended heavily on her relationship with a fertility specialist, something that was not accessible to everyone. Similar to what Rothman (1991) described as “guidance-cooperation,” fertility specialists appeared in the media as counselors and coaches while a good patient listened to the doctor and cooperated with his suggestions. However, because the capitalist system that commodified infertility treatments and promoted competition, women could obtain treatment elsewhere. Fertility specialists attempted to appease patients under the guise of agency. If something did not work out as expected (as seen many times in my study), fertility specialists held women responsible for knowing and accepting the risks. Women simply considered any difficulties with treatment as the price they had to pay for a child (Malin et al. 2001). In turn, women seeking infertility treatments experienced what Weber (2002) described as the “iron cage of modernity.”

Women become trapped in the “infertility-industrial-complex” which controlled procreation through technological efficiency and rational calculation.

Ginsberg and Rapp (1995) used the concept of “stratified reproduction” to explain the role of power and structure in the social construction of procreation. The infertility-industrial-complex clearly allowed some people to procreate while discouraging others. Defining infertility as a medical condition also involved ascribing appropriate treatment or management. If one could not (or did not want to) receive treatment, the meaning of infertility changed. Through their articles’ content, journalists reflected these changing social and cultural boundaries. Generally, these new groups supported (and could afford) a neoliberal view of increased “production” and deregulation through procreative technologies. Another level of stratification existed within the infertility field itself. Fertility specialists created an internal hierarchy with regard to treating infertility as well. Fertility specialists regularly differentiated themselves regarding their ability to successfully treat infertility. Likewise, journalists portrayed primary care physicians and ob/gyns as having a much lower status on this social hierarchy. Identifying only a small, elite group of physicians who could successfully overcome infertility further restricted agency. While fertility specialists often competed with each other on an individual level, they also maintained a strong loyalty to their profession in order to protect their collective autonomy and power.

Even though men experienced infertility equally (at least statistically), infertility remained predominately a woman’s issue. Researchers showed that women are usually the ones who initiate treatment, receive treatment, and cope with the difficulties associated with infertility regardless of the diagnosis (Greil 2011; Becker 2000). Journalists reinforced this narrative as well. For example, journalists defined men’s fertility mainly through their contribution of sperm. Additionally, men typically experienced infertility only through their partners. Further complicating matters, most of the fertility specialists (especially among the “older” and more experienced doctors) were men. As a result,

gender inequality shaped the experience of infertility on many levels. Traditional gender roles dictated that women should have children and shaped men's experiences and lack of involvement. Likewise, these gendered expectations influenced when women should have children, what lengths women should undergo to have children, and how women should react when faced with infertility. Eventually, the reach of traditional gender roles with regard to procreation extended to "non-traditional" women such as single women and the LGBT community through procreative technologies. Although journalists suggested that new opportunities for women changed attitudes, women without children experienced a "silent stigma" due to the multiple social factors still controlling procreative choices which limited agencies.

Although procreative technologies challenged traditional family formation, heteronormativity prevailed. Despite increased attention toward childlessness in popular magazines, journalists still promoted children (or at least an accepted feminine alternative) as the expected ideal. Procreative technologies even allowed those who did not fit within traditional gender roles to have children, therefore assimilating single women, lesbians, and same-sex couples into heteronormativity. Additionally, procreative technologies made it possible to experience pregnancy or genetic connections in a variety of circumstances previously unimaginable. In fact, journalists stressed connections with genetics, or at least pregnancy, attained via procreative technologies over other family-building options like adoption. Journalists portrayed children, particularly genetically related children, as the ultimate reward (or holy grail *per se*) for persistence with procreative treatments. As a result, families should be willing to endure whatever means necessary for however long it takes to reach this end.

7.1 Theoretical Implications

Snow (2004) explained that one does not just develop new theories through qualitative research but rather extends and builds on pre-existing theoretical concepts. In my study, I applied the basic

framework and ideas from social constructionist and feminist theories about infertility to my new findings. Overall, my research further supported that infertility is a flexible social process rather than a rigid medical ailment. Because knowledge and “truth” were not fixed, social constructionist theory radically challenged positivism traditionally used to describe infertility and its treatments from a medical perspective. However, the social construction of infertility was complex, probably more so than other health-related issues in that fertility specialists controlled not on the definition of infertility but also those who fit this definition which changed repeatedly. For instance, infertility could not be determined definitively through medical testing or treatments and was not life-threatening or even life-limiting, creating confusion around its legitimacy and impact as a disease. The diagnosis of “infertility” was not the result of pathologic symptoms or an ailment, but rather the absence of pregnancy or a baby. According to Koropatnick et al. (1993:163), infertility is a “non-event” transition that must be acknowledged by one who embraces the desired social role of parenthood. As my study found, patients (and non-patients) defined their own experiences as well as constructed their own reality with regard to infertility.

Greil (2009:140) stated that health and illness are “socially constructed categories negotiated by professionals, suffers, and others in a sociocultural context.” Heritage, Clayman and Zimmerman (1988) and Maynard (1988) also found the social organization of media presentations shape public perceptions of social problems. Through my research, I concluded that infertility specialists actively controlled the transfer of knowledge about infertility and access to treatments through the media. Because few resources existed regarding accurate information about infertility, the media played a critical role in establishing meanings for infertility as well as the medicalization of fertility. Due to the fertility specialist’s expert status and superior competence, journalists and reporters did not question them and rarely offered any alternative opinions, analyses, or conclusions to this homogenous medicalized view. Further complicating matters, fertility specialists routinely disagreed with each other in the media,

sometimes adamantly. As a result, stories about infertility were fraught with contradictions. For instance, infertility was defined as a medical condition, yet women were ultimately responsible for their choices. Getting pregnant was easy except for when it was not, and then an expert was needed. Articles described the proliferation of new family-building options emphasizing hope, but in reality, very few people could access these options and success rates were low. Increased media coverage about infertility suggested that stigma surrounding infertility was lessening, but women continued to experience this stigma all the same. Articles included information about both the safety and risks of infertility treatments side-by-side. Journalists presented widely varying information about age and fertility. The infertility field was both a medical specialty and a business, and patients viewed fertility specialists as both god and devil, sometimes simultaneously. The status of embryos with regard to infertility treatments remained unclear. As I found, not all aspects of infertility could be addressed through the scientific methods or study purported by the fertility specialists. Instead, infertility should be addressed collaboratively and dynamically, especially through the inclusion of a variety of independent voices and perspectives. However, the information shared by the media about infertility engaged limited concepts, models and schemes needed to make sense of the experience. As a result, the ways in which people go about socially constructing their behaviors around infertility on a day-to-day basis were heavily influenced by factors promoting the infertility field's best interests with little variation or virtually no objections.

Divisions within feminist philosophies about procreation also existed. More specifically, a consistent feminist response to infertility treatments has not yet been established (Petchesky 1995). For many, whether procreative technologies designed to treat infertility support individual rights, progress, and the freedom of choice or are they oppressive and immoral remained unclear (Klawiter 1990). Infertility presented a problem for which there does not seem to be a nice feminist answer. The

technological solutions to infertility challenged feminism because they offered new options for women while at the same time threatened reproductive freedoms (Sandelowski 1990).

My study uncovered several major points that may inform the feminist perspective on infertility. First, Rothman (2000) pointed out there are problems with holding women accountable for their own fertility. For instance, how much fertility is actually lost is unclear, and the social factors that contribute to delayed childbearing are ignored (Rothman 2000). In reality, women were constantly blamed for infertility or their inability to conceive at nearly every level. Journalists strongly suggested that poor decision-making, lifestyle choices, past sexual behaviors, health habits, diet and exercise, environmental toxins and stress all lead to infertility, at all ages. Media rarely included specific medical causes of infertility. Even patient advocacy groups stressed prevention efforts. In turn, infertility became a scapegoat for many social problems. Moreover, journalists held women responsible for the fertility of their children and partners as well. Fertility specialists denied infertility treatments completely at their discretion. Unlike other health issues, no insurance company or regulatory agency which a woman could report to existed. Because infertility treatments were often unsuccessful, the blame was placed on women again, both directly and indirectly, for this “failure.” Feeding their feelings of desperation, fertility specialists informed women that it was their choice alone whether or not to take these risks. Little transparency existed with regard to the treatment processes so women often had no other choice than to accept personal fault for their infertility and any unsuccessful treatments.

Secondly, I found that infertility field clearly blurred the line between medicine and business, even more than I expected. Although biological processes were involved, fertility care consisted of very little “health” per se. The goal of infertility medicine was not to “manage,” “cure,” or even “treat” any type of specific health concern. In fact, many women received infertility treatments without proper diagnosis, particularly in the case of “unexplained” infertility. Insurance usually did not cover the costs of procreative treatments, and families had to pay out-of-pocket, as with any other service. Also,

reasons for infertility included several social issues, such as being single, gay, or older. Whether or not infertility was really a disability or handicap that needed prevention and immediate treatment concerned feminists, but infertility specialists were not interested in preventing, immediately treating, or even providing women with choices. As with all businesses, they wanted to find more “consumers” for their particular service or product, which in this case was the chance to have a baby, by any means possible. While many fertility specialists worked ethically within this unique capitalist medical environment, some did not. Whether doctors were motivated by greed or the intense desires to help patients, the aftermath was the same when bad outcomes occurred.

Finally, feminists worried about exploitation and the long-term effects of infertility treatments on all women and their families. However, my study revealed that obtaining better data about possible dangers was unlikely. Based on the complex interactions between social forces as I discuss above, women were expected to want children and be willing to do anything to have them. For fear of limiting choices and restricting access to care, fertility specialists and their patients (who were influenced by their experiences at the hands of the infertility field) had no interest in collecting these data. No one encouraged further research in this area, and finding an appropriate sample population to make results generalizable was unrealistic. Thus, true risks of treating infertility will not be known until it is too late.

Despite 50 years of procreative advancements, women were still unfairly saddled with the burden of procreative responsibility while at the same time isolated from any type of clear answers or supportive structures (Klawiter 1990). As Harwood (2007) stated, infertility is the truly last frontier for procreative choice. As a result, feminist input regarding these complicated issues is desperately needed more than ever.

7.2 Applied Implications

In terms of applications for my findings, I found the information about age and fertility shared by the media as especially problematic. Journalists changed their narrative about this topic with each decade, mirroring both social changes and the needs of the infertility field. Because no treatments options existed for delayed pregnancies, journalists first encouraged younger motherhood. When fertility specialists made egg donation available, journalists wrote articles promoting older motherhood as a new choice. However, journalists did not share the details of egg donation and only told women vaguely that “treatments” existed to help older women achieve pregnancy. After clinics became overrun with new patients while success rates remained low creating disappointment, fertility specialists backed off their original message that age was no longer a detriment to fertility. At the same time, journalists wrote about the “return of younger motherhood,” although little was known about details of age and fertility.

Overall, the most effective treatment for age-related infertility is egg donation, which is associated with its own set of problems even now. “Desirable” egg donors are hard to find. Risks related to fertility medications and surgical procedures used in egg donation exist, especially among women who donate multiple times. Success rates remain relative low and costs high. Marketing tactics targeting both potential donors and recipients are exploitive. Financial incentives are clearly offered to egg donors. Questions arise regarding exactly whose interests were being protected. Secrecy around egg donation abounds. And no research on the children born via egg donation is available. However, for older women wanting to become pregnant, egg donation is the only viable option. Although egg freezing is on the horizon, its future potential is unknown, creating unrealistic hope among women wanting to maintain genetic connections regardless of age.

As I mentioned before, obtaining reasonable data to inform these questions is unlikely. Doctors and patients alike did not want to know the answers for fear of further complicating the decision to use

donor eggs. However, older motherhood is here to stay. As a result, information that will actually help women make educated decisions is desperately needed. Because of the interplay between structure and agency discussed in my study, fertility specialists cannot effectively supply this information. Unfortunately, women's organizations and feminist groups have been reluctant to take on this issue of educating women about the inequitable impact of age on fertility. Delayed motherhood remains an unresolved issue for both clinicians and feminist scholars requiring intentional application of theories and critiques.

7.3 Policy Implications

According to my media analysis, the state of embryos is still one of the biggest unresolved issues facing the fertility field, patients, and society at large. Without an effective resolution, politics will eventually limit family building options. Cahn (2009) suggested that controversies surrounding excess embryos can be divided into conservative and liberal and right and left positions. Although the fertility field has a long history of autonomy and self-regulation, this status-quo perpetuated inconsistency and fragmentation. As I discussed in my study, fertility specialists were publically unclear as to the status of embryos allowing tacit support for embryo-as-personhood legislation. Given the growing number of frozen embryos available throughout the United States, this controversy will only worsen raising complex issues related to appropriate storage, options for disposition, availability for research, and genetic siblings being raised by different families through embryo "adoption," adding more fodder for those interested in "saving" embryos.

A second policy recommendation is to provide more unbiased data and transparency regarding the realities of procreative treatments. Decision-making about family building choices is difficult. Not long ago, biology controlled procreative outcomes. Today, many choices exist. However, as I discussed earlier, it was difficult for women and men to exercise agency in the midst of such strong social forces.

Those with a vested interest in either encouraging fertility care or preventing controlled the majority of information about infertility shared with the public. Even government statistics promoted by the Centers for Disease Control and Prevention were suspect since they were all self-reported by fertility specialists with no oversight or accountability. As a result, families were left to make their own decisions based on severely biased knowledge about the realities, benefits, and risks.

7.4 Future Research

In his article “The Experience of Infertility: A Review of the Literature,” Greil (2009) identified several gaps in infertility research: learning more about men’s infertility, long-term consequences of infertility, relationships between infertility and stress, the effectiveness of psychological interventions, and the underrepresentation of economically deprived and culturally distinct populations which I agree with as well. However, based on my own research, I would add a few more areas of sociological interest. First of all, as I discussed throughout my study, fertility specialists need to find new populations in order to grow their businesses. While social science researchers primarily focused on women and men who embrace the “infertility” identity, I am interested in those groups that are not “technically” infertile by definition, but still need fertility care. This includes, single women, same-sex couples, and patients purposely seeking fertility care to improve genetics, select sex, preserve fertility, or other non-medical reasons. How do these groups identify with “infertility” and how do their experiences differ from others who seek fertility care and procreative technologies because of medical necessity?

Secondly, since sex was very much separated from procreation by the fertility field, how does “procreative sex” differ from other sex? Journalists portrayed procreative sex as not enjoyable, equating it to more “work” than fun, especially for men. Likewise, fertility specialists (and most likely other physicians) have no interest or skills in effectively relaying information about sex and sexuality to

patients. Additionally, differences exist between procreative sex among fertility couples versus the medicalized infertile. Gaining more insight into this issue would be helpful, especially from a sociological perspective rather than simply as a biological process.

Thirdly, most of the families included in the popular magazine articles that I analyzed all resolved their infertility in the end. Very few families still actively pursuing infertility treatments shared their experiences with the media. As a result, journalists—across time—ignored the reality that many families do not go home with a baby. Moreover, definitions of procreative “success” varied, ranging from a pregnancy to a baby. I am curious to learn more how those who are not successful with treatments compare to those families who are. Similarly, many families interviewed in these articles maintained their connections with infertility beyond the birth of their child, sometime for years or decades. As most health conditions are moving towards “person first” language which explains that people are not synonymous with their diseases, many people experiencing infertility continue to identify as “infertile.” Exactly how long the infertility “identify” lingers is unclear. Some researchers suggested that infertility is only temporary (Deveraux and Hammerman 1998; Harwood 2007), but my research indicated it continues long past its resolution, even after family-building is completed or ceases. After one has a child, is she still considered “infertile” and on what basis, biologically or socially?

Finally, stories about infertility portrayed in the media all included families that were well into their infertility journeys or had completed treatment. As a result, little data existed as to the early decision-making process of those experiencing infertility. It is important to ascertain how people initially identify with infertility, what prompts them to seek care and from whom, and how decisions about pursuing certain treatments are made from the very beginning before they are influenced by the infertility field.

Over the past 50 years, journalists suggested that women's procreative choices expanded (although probably not to the extent reflected in the media), including if, when, and how they wanted to have children. While procreative technologies changed the landscape of family building, the underlying social forces influencing decisions about procreation did not. Overall, issues of power, patriarchy, gendered expectations, social stratification and heteronormativity continued to limit agency with regard to decisions about infertility. To conclude, although women faced different situations throughout the decades, the culture of infertility did not change that much, resulting in similar challenges for all women facing infertility between 1960 and 2010.

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APPENDICES

Appendix A

A Summary of Key Infertility Advances and Events 1960-2010

1960s

- 1960 Clomid was tested as an infertility treatment at Rock Reproductive Center and Free Hospital for Women.
- 1960-5 Infertility specialists began to report their pregnancies to the public.
- 1960s Big increases in knowledge of ovarian stimulants, how eggs mature, ovulation, fertilization, and the growth of the embryo *in vitro*, safer and better laparoscopy.
- 1960s Pergonal, a gonadotropin, is introduced through the Serono Company.
- 1962 Landrum Shettles claims that he transplanted a fertilized egg into a woman's uterus, resulting in pregnancy (however, this claim is never substantiated).
- 1963 The first public announcement of a successful birth from frozen sperm is made.
- 1965 Baby boom generation begins to come of age, delays childbearing (birth rates decrease).
- 1968 Pope Paul VI issues *Humanae Vitae* ("Of Human Life") which requires the linkage of intercourse and procreation.
- 1969 A Harris poll shows that the majority of Americans believe techniques like IVF are "against God's will."
- 1969 Human fertilization *in vitro* is achieved for the first time by Dr. Edwards in the United Kingdom and documented publicly, including in the journal *Nature*.

1970s

- 1970 Nation's first commercial sperm bank opens in Minnesota.

- 1970 *Look* magazine publishes an article entitled “Motherhood—Who Needs It?” which discusses the opinion that it “doesn’t make sense any more to pretend that women need babies.” The very next year, *Look* magazine runs a cover story announcing “The Test Tube Baby is Coming.”
- 1971 A Washington conference on the biomedical ethics states that IVF research will necessitate infanticide.
- 1972 National Association of Non-Parents formed to promote “child-free” living.
- 1972 The American Medical Association urges a moratorium on IVF research involving humans while the American Fertility Society urges further work in the field.
- 1973 The Supreme Court issues the decision in *Roe v. Wade*. Anti-abortionists express opposition to IVF because it involves the destruction of embryos.
- 1973 Landrum Shettles attempts the first IVF procedure on Doris Del-Zio at Columbia-Presbyterian, which is blocked by university politics and is ultimately unsuccessful.
- 1973 The first pregnancy achieved following IVF was reported in *The Lancet* from the Monash team, although it only lasted a few days and would today be called a biochemical pregnancy.
- 1973 The volunteer group RESOLVE formed in Massachusetts to help infertile people.
- 1973 The Commissioners on Uniform State Laws, and a year later, the American Bar Association, approved the Uniform Parentage Act. This act provides that if a wife is artificially inseminated with donor semen under a physician's supervision, and with her husband's consent, the law treats the husband as if he were the natural father of the DI child.
- 1975 Robert Edwards and Patrick Steptoe have the first successful IVF pregnancy among their patients in the UK. However, it is an ectopic pregnancy.
- 1976 A tubal ectopic pregnancy via IVF from Steptoe and Edwards in Britain was reported.
- 1977 Louise Brown, the first “test tube” baby was conceived in November.
- 1978 Louise Brown, first “test tube” baby is born by *in vitro* fertilization in England.
- 1979 Alastair MacDonald, England’s second test tube baby is born.

1980s

- 1980 Two Australian teams succeed in IVF deliveries after drug-induced super ovulation in the mother (Candice Reed in Melbourne).
- 1981 Elizabeth Jordan Carr is born, the first *in vitro* baby in the US.
- 1982 Vatican Radio condemns IVF immoral, although public opinion has shifted to support treatments for infertile couples.
- 1982 Six other American universities open IVF clinics in the U.S.
- 1982 The Washington Post reports that 54 test tube babies have been born in England, and another 33 have been born in Australia.
- 1982 Dr. Alan Trounson develops the 5-day embryo culture which will enhance the IVF process and increase implantation rates.
- 1983 First embryo donation pregnancy achieved.
- 1986 First ZIFT pregnancy achieved.
- 1987 Donor ova are available in the US.
- 1987 The Vatican issues an official statement opposing IVF.
- 1988/9 GIFT introduced and the first successful pregnancies achieved.
- 1989 First successful attempts using PGD (Preimplantation Genetic Diagnosis) were successful with babies born in 1990.
- 1989 The ASRM reports that there are approximately 4,000 frozen embryos in the United States.

1990s

- 1990 Human Fertility and Embryology Act in the UK and the setting up of the Human Fertility and Embryology Authority.
- 1990 First blastocyst transfer reported by Scholtes and Zeilmaker.

- 1990 Dr. Mark Hughes develops Preimplantation Genetic Diagnosis (PGD).
- 1992 Rosanna della Corte gives birth to a son, Ricardo, at the age of 62 after IVF treatment by Severino Antinori in Italy.
- 1992 Researchers in Belgium report pregnancies using a technique to inject a single sperm cell into an egg. This procedure, known as ICSI, revolutionized the treatment of male infertility.
- 1992 The Fertility Clinic Success Rate and Certification Act of 1992 requires that the Secretary, HHS, through the CDC, develop a model program for the certification of embryo laboratories, to be carried out voluntarily by interested States.
- 1995 The Centers for Disease Control and Prevention begins to collect statistics on ART success rates and makes this information available to the public.
- 1995 The first formal InterNational Council on Infertility Information Dissemination (INCIID) was launched.
- 1996 Cytoplasmic transfer was performed for the first time at St. Barnabas Fertility Clinic in New Jersey.
- 1997 Atlanta infertility clinic reports first successful pregnancy in US using an egg that had been frozen.
- 1997 The birth of Dolly the sheep, the first cloned mammal.
- 1999 The American Fertility Association is founded to raise awareness and fight for social and legislative change around infertility issues.

2000s

- 2000 The culture of embryonic stem cells, some from “spare” embryos donated by couples who have had successful IVF treatment, opens the way to “made-to-order” tissue for transplant.
- 2001 Teams in the US and Italy announce that they are working on producing the first human clone.
- 2001 Fertile Hope is founded which is dedicated to providing reproductive information, support, and hope to cancer patients and survivors whose medical treatments present the risk for infertility.

- 2001 The FDA bans the use of cytoplasmic transfer in the United States.
- 2002 Severino Antinori, best known for his work in enabling post-menopausal women to have babies, claims that three human cloned pregnancies are taking place, two in Russia and one in an “Islamic country.”
- 2004 The first child is born from ovarian tissue that was removed from her mother, frozen and transplanted back.
- 2004 Conceive Magazine and Fertility Today Magazine make their debuts as the first consumer-g geared publications addressing infertility.
- 2004 Over 450 IVF clinics are in the U.S. alone.
- 2005 The ASRM reports that there are over 500,000 frozen embryos currently in the United States.
- 2005 FDA establishes new recommendations regarding the collection, handling, and storage of human sperm, eggs, and embryos.
- 2010 Robert Edwards of Britain wins the 2010 Noble Prize in medicine for developing *in vitro* fertilization, a breakthrough that has helped millions of infertile couples have children.

Appendix B**Magazine Articles by Decade**1960-1969

Keywords: STERILITY

Number of Articles: 15 (analyzed 15)

1970-1979

Keywords: STERILITY

Number of Articles: 35 (analyzed 35)

1980-1989

Keywords: STERILITY; INFERTILITY

Number of Articles: 135 (analyzed 75)

1990-1999

Keywords: INFERTILITY; INFERTILITY CLINICS; REPRODUCTIVE TECHNOLOGY; FERTILITY; FERTILITY DRUGS; FERTILIZATION *IN VITRO*

Number of Articles: 296 (analyzed 150)

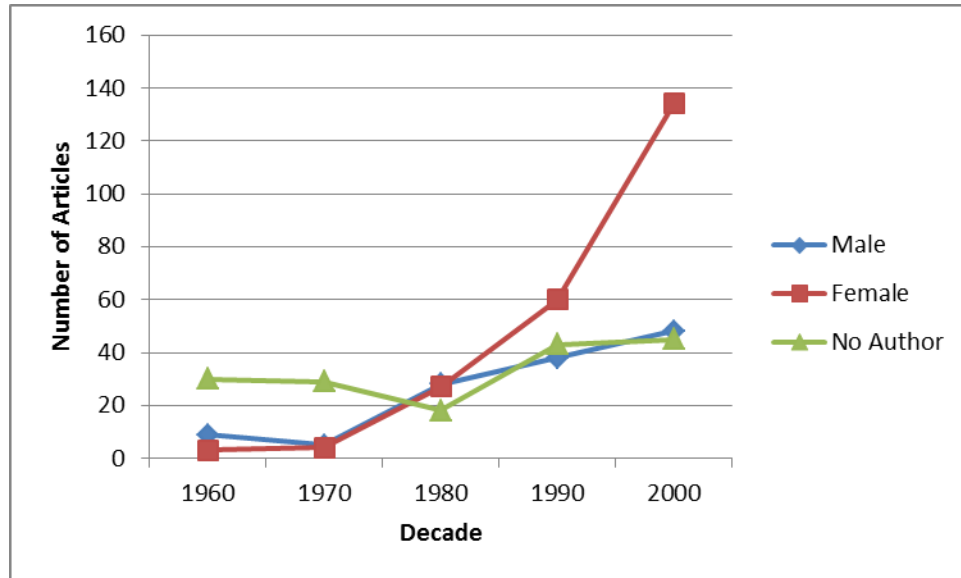
2000-2010

Keywords: INFERTILITY; INFERTILITY CLINICS; REPRODUCTIVE TECHNOLOGY; FERTILITY; FERTILITY DRUGS; FERTILIZATION *IN VITRO*

Number of Articles: 346 (analyzed 225)

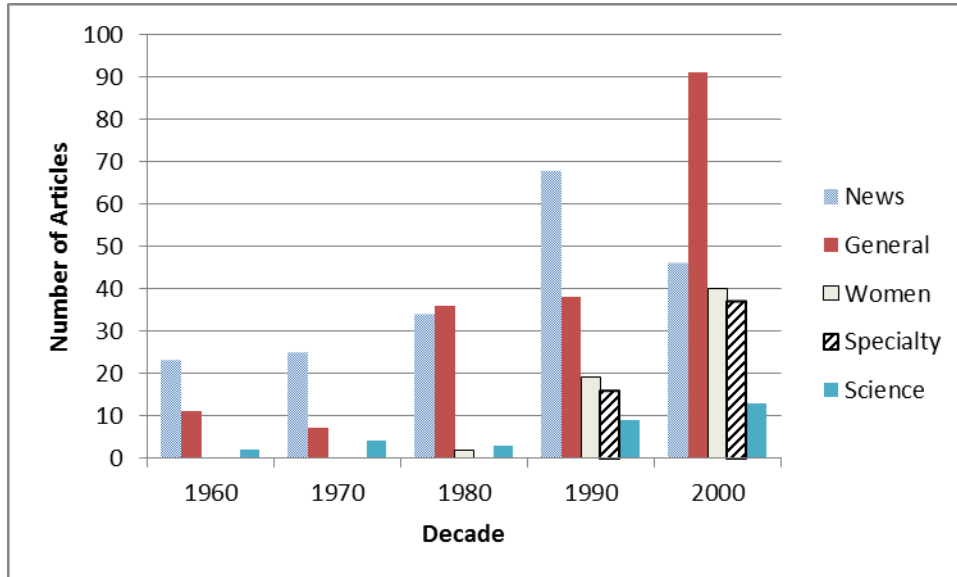
Appendix C

Authors by Gender



Appendix D

Articles by Type of Magazine



Appendix E

Semi-Structured Interview Guide for Physician Interviews

1. **Demographic** Information
 - Gender
 - Age
 - Years in practice
 - Training and experience
 - Geographic area

2. Why did you **go into the specialty reproductive medicine/infertility**?
 - What interested you the most about this field of medicine?
 - What do you like most about the field?
 - What are the challenges of practicing reproductive medicine?
 - How have these challenges changed over the years?

3. What were the **early days** of reproductive medicine/infertility like?
 - What did you think you would be doing when you went into this field?
 - How did these expectations compare to what you actually did?
 - How has the public viewed the field of infertility over the years?
 - Positive viewpoints
 - Negative viewpoints
 - How have these viewpoints changed over the years?

4. Describe how things **have changed** over the past five decades (1960-2010)?
 - What are the most important changes in treatments and techniques that you have seen over your career?
 - How do you think patients have changed over time?
 - Their needs
 - Their expectations
 - How have your interactions with patients changed over time?
 - How do patients learn about infertility? Where do they get their information typically? (IVF, egg donation, sperm donation, surrogacy, embryo donation/adoption)
 - How have you dealt with conflicts with patients over the years?
 - What about the “business” of infertility?
 - Why is infertility treatments so expensive?
 - How have practice regulations/guidelines changed over the years?
 1. Do you think regulations are needed?
 2. Why or why not?
 - What are reporting procedures and success rates?
 - How do you typically “recruit” patients?

5. Describe **the field today**.

- What are the major benefits in the field today?
 - For professionals
 - For patients
- What are the major challenges in the field today?
 - For professionals
 - For patients
- How do you think things will continue to change in the future?

6. How do you think the **media has portrayed infertility** 1960-2010?

- What has it been like working with the media when it comes to infertility?
- What have been the biggest news stories related to infertility?
- What types of popular media messages about infertility do you think are most accurate?
- What types of popular media messages about infertility do you think are inaccurate?
- What types of messages do you wish the media would portray?
 - What do you wish readers would know about infertility?
- How does the media influence patients?
 - Positively
 - Negatively
- How does infertility fit with other issues related to reproductive rights?
- Do you think infertility and reproductive medicine are feminist issues?

Appendix F

Description of the National Family Growth Survey

Cycle 1: 1973

Sample

NCHS established a target sample size of 3600 black women and 6400 women who were white or of other races, in order to have a large enough sample of black women for analysis of subgroups. A four-stage stratified probability sampling method was used to identify 32,818 dwelling units; 3820 of these were either vacant or not dwelling units. Of the remainder, 26,028 (89.8 percent) completed household screeners. A fifth stage of the sampling process identified one eligible respondent from households that had more than one. Of the 10,879 eligible women thus selected, 9817 (90.2 percent) completed interviews. Twenty women were later eliminated from the sample because their ages fell outside the 15-44 age range.

Field Work

A few interviews were conducted in early 1973, but the bulk of the fieldwork was begun in July and completed by December.

Data Collected

The survey reports background information about the respondent and her husband, such as education, religion, ethnic origin, occupation, and earnings. Complete marital history, birth history and pregnancy history information are recorded. For pregnancies ending after January 1, 1970, a complete history of contraceptive methods used in the interval is available, including the reason the last method was stopped. The wantedness and timing of each pregnancy was ascertained. Finally, there are detailed questions about the woman's ideal family size, desired, intended and expected number of children. A monthly calendar of contraceptive use from January 1, 1970 until the date of the survey is provided; the information was recorded in the form of dates, and transcribed to the calendar by the interviewer.

Cycle 2: 1976

Sample

NCHS established a target sample size of 4000 black women and 6000 women who were white or of other races, in order to have a large enough sample of black women for analysis of subgroups. A four-stage stratified probability sampling method was used to identify 32,652 dwelling units; 5490 of these were either vacant or not dwelling units. Of the remainder, 25,479 (93.8 percent) completed household screeners. A fifth stage of the sampling process identified one eligible respondent from households that

had more than one. Of the 10,202 eligible women thus selected, 8611 (94.4 percent) completed interviews.

While the survey was in the field, Westat realized that the sample was falling short of the target. This was due to a larger than expected refusal rate, population shifts resulting in fewer than expected dwelling units in some strata, and a lower than expected proportion of white and other women in some strata. Westat increased the sampling ratio for some strata during the fieldwork to compensate for this. In spite of this, the sample of black women (3009) is 25 percent short of the target of 4000 and the sample of white women (5488) is 9 percent short of the target.

Field Work

The interviews were conducted by trained women interviewers over the course of six months centered on April, 1976. The interview took about an hour to complete.

Data Collected

The survey reports background information about the respondent and her husband, such as education, religion, ethnic origin, occupation, and earnings. Complete marital history, birth history and pregnancy history information are recorded. For pregnancies ending after January 1, 1973, a complete history of contraceptive methods used in the interval is available, including the reason the last method was stopped. The wantedness and timing of each pregnancy was ascertained. Finally, there are detailed questions about the woman's ideal family size, desired, intended and expected number of children. A monthly calendar of contraceptive use from January 1, 1973 until the survey is provided; the information was recorded in the form of dates, and transcribed to the calendar by the interviewer.

Cycle 3: 1982

Sample

This is the first nation-wide fertility survey to include childless never-married women. Black women and teenage women were over-sampled to produce numbers large enough to perform analyses for small subgroups. A special supplementary sample was drawn of women living in college dormitories and sororities. Permission of the respondent and a parent or guardian was required for never-married respondents aged 15-17. A four-stage stratified probability sampling method was used to identify 34,630 dwelling units; 3559 of these were either vacant or not dwelling units. Of the remainder, 28,817 (92.7 percent) completed household screeners. A fifth stage of the sampling process identified one eligible respondent from households that had more than one. Of the 9804 eligible women thus selected, 7969 (81.3 percent) completed interviews.

Data Collected

The survey reports background information about the respondent and her husband, such as education, religion, ethnic origin, occupation, and earnings. Complete marital history, birth history and pregnancy history information are recorded. For pregnancies ending after January 1, 1979, a complete history of contraceptive methods used in the interval is available, including the reason the last method was stopped. The wantedness and timing of each pregnancy was ascertained. There are questions about the woman's ideal family size, desired, intended and expected number of children. Women are asked their age at the first time they had intercourse. This survey has expanded questions about the respondent's use of health services, including PAP tests, pelvic exams, and tests for STD's. There are also detailed questions about child care. A calendar of contraceptive use, recorded at six-month intervals, is provided for the period from January 1st, 1979, until the date of the survey.

Cycle 4: 1988/1990**Sample**

The National Center for Health Statistics (NCHS) selected eligible women from households in which a member had responded to a National Health Interview Survey (NHIS) between October, 1985 and March 1987. If more than one eligible woman was in a household, only one was selected for the National Survey of Family Growth (NSFG) interview. Women who had moved since the NHIS were tracked to their new addresses. Black women were over-sampled to produce numbers large enough to perform analyses for small subgroups.

The response rate for the NHIS, from which the NSFG sample was drawn, was 96 percent. Of the women selected for the NSFG sample, 80 percent completed interviews. In an intensive follow-up, NCHS did sub sampling for nonresponse. Taking account of this sub sampling, as NCHS does, produces a response rate of 82 percent. The response rate is thus the product of 96 percent (for the NHIS) and 82 percent (for the NSFG) or 79 percent overall.

Data Collected

The survey reports background information about the respondent and her husband, such as education, religion, ethnic origin, occupation, and earnings. Complete marital history, birth history and pregnancy history information are recorded. For pregnancies ending after January 1, 1982, a complete history of contraceptive methods used in the interval is available, including the reason the last method was stopped. The wantedness and timing of each pregnancy was ascertained. There are questions about the woman's ideal family size, desired, intended and expected number of children. Women are asked their age at the first time they had intercourse. This survey has expanded questions about the respondent's

use of health services, including PAP tests, pelvic exams, and tests for STD's. There are more questions about precautions the respondent was taking to avoid AIDS and other STD's, although many of these responses are not included in the data because of concerns about confidentiality. There are also detailed questions about child care.

Additional Information

The NSFG Cycle IV telephone reinterviews have been divided into two files. The Respondent File (Part 1) contains one record for each woman in the survey, while the Interval File (Part 2) contains one record for each completed pregnancy experienced by a woman in the survey. An interval can be defined as any of the following: the time between a first intercourse at last contact (in 1988) and a pregnancy that ended after last contact, or the time between a pregnancy that ended before last contact and one that was in progress at the time of the interview. Part 1 offers data on the respondent's marital history/update, education, family background, sex education, births and pregnancies, first sexual intercourse, sterilizing operations, contraceptive history/update, family planning services, infertility services, births intended and expected, adoption, sexually transmitted diseases/AIDS, religion, race/ethnicity, employment/occupation, income, and insurance. Part 2 supplies information on outcomes of pregnancies and other pregnancy-related information, use of birth control methods during intervals, and "wantedness" of pregnancies.

Cycle 5: 1995

The NSFG Cycle V includes data from 10,847 women. The interviews have been divided into two files. The Respondent File (Part 1) contains one record for each woman in the survey, while the Interval File (Part 2) contains one record for each completed pregnancy experienced by a woman in the survey. An interval can be defined as one of the following: the time between a first intercourse at last contact (in 1988) and a pregnancy that ended after last contact, or the time between a pregnancy that ended before last contact and one that was in progress at the time of the interview. Part 1 offers data on respondents' marital histories, education, family background, sex education, births and pregnancies, first sexual intercourse, sterilizing operations, contraceptive histories, family planning services, infertility services, births -- intended and unexpected, adoption, sexually transmitted diseases/AIDS, religion, race/ethnicity, employment/occupation, income, and insurance. Part 2 supplies data on outcomes of pregnancies and other pregnancy-related information, use of birth control methods during intervals, and "wantedness" of pregnancies.

Cycle 6: 2002

Survey of Men and Women, 2002: Cycle 6 of the National Survey of Family Growth (NSFG) was conducted by the National Center for Health Statistics (NCHS), with the participation and funding support of nine other programs of the U.S. Department of Health and Human Services. Cycle 6 was based on an area probability sample. The sample represents the household population of the United States, 15-44 years of age. The survey sample is designed to produce national data, not estimates for

individual States. The contractor for the survey, the Institute for Social Research of the University of Michigan, hired and trained over 200 female interviewers for the 2002 NSFG. In-person interviews were completed with 12,571 respondents 15-44 years of age--7,643 females and 4,928 males. The interviews were voluntary and confidential. The response rate was 79 percent overall--80 percent for females and 78 percent for males. The questionnaire for males averaged about 60 minutes in length, while the female interview averaged about 80 minutes.

Cycle 7: 2006-2010

The NSFG interviewed a national sample of men and women 15-44 years of age living in households in the United States. Interviews were done 48 weeks of every year for 4 years—from June, 2006 to June, 2010. In each year, a nationally representative sample of men and women in 33 areas (Primary Sampling Units or PSUs) was interviewed. By the end of 4 years of interviewing, in June 2010, over 22,600 interviews had been completed in 110 areas. The first public use data files were released in May 2010, and included 13,495 interviews conducted between 2006 and 2008 (7,356 female and 6,139 male). A second set of data files will be released in 2011, containing all 22,600 interviews conducted from 2006-2010—over 10,000 interviews with men and more than 12,000 interviews with women.

Questionnaires, Datasets, and Related Documentation for Cycles I - VII

http://www.cdc.gov/nchs/nsfg/nsfg_questionnaires.htm