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Personal, Interpersonal, Biomedical, Textual

Vignettes on Infertility and Fertility Privilege

ABSTRACT The following is an autoethnographic account of the experience of infertility, constructed as a dialogue representing personal, interpersonal, biomedical, and textual voices. The dialogue includes excerpts from other autoethnographic work on infertility, medical records, voicemail messages and interviews, medical texts and brochures, and memoir. The body of this dialogue is a series of vignettes reflecting the lived experience of an infertile patient during and after treatment, and a collection of statements elucidating the specifics of fertility privilege. The essay highlights the conflicting voices and messages surrounding infertility treatment and identity. KEYWORDS Infertility; Identity; Autoethnography; Fertility privilege

> The physics of narration, by which stories are drawn together, like atoms with a positive charge. . . a story we will all hear, and that, as it moves through our bodies, will change us.[1]

This is a portion of "my" story—more specifically, the recent biomedical experience of infertility within my embodied narrative. And yes, the diagnosis of infertility and infertility treatment moved through my body and changed me. Previous to learning I was infertile at 30 years old, I was not sure I wanted to have children at all, which was something I discussed openly with my partner—before and after our marriage. I support the choice not to have children. However, I thought that is what it was—a choice. After meeting with a Reproductive Endocrinologist and Infertility (REI) specialist, I suddenly understood this would not be a choice for me in the traditional biological sense.

Throughout four physically, emotionally, and economically painful years of infertility treatments with no resulting pregnancy, my personal identity expanded to include the label of "infertile." Surrounded by both condescending and supportive communication during treatment from medical professionals, and loving friends and family (bystanders) whose perspectives at times inadvertently wounded me, I often felt confused, unheard, and unmoored.[2] Even the

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most supportive members of my community were fertile, and as a result, I sought the camaraderie of other infertile individuals who could commiserate with me on the specifics of treatment(s).

Finding my voice in the midst of various treatments, in a society colored by fertility privilege and built around the social construct of pronatalism, initially prompted me to create a list of pieces of advice and "support" to avoid when communicating with infertile, cisgender women, or a list of "what not to say" to folks undergoing infertility treatment(s). In a body that could not conceive, creating a tool for further dialogue became empowering and healing. I imagined a piece that individuals could share with family members and friends who wanted to provide emotional support but lacked a roadmap. In the silence around infertility, what *not* to say seemed the most efficient place to begin.[3]

Driven to understand my experiences and the experiences of other infertility patients, my interest blossomed into a qualitative study on practitioner–patient communication in REI practices. During infertility treatment, when so much remains unknown by both doctor and patient, hearing someone else's journey anchored me. Studying interview data, listening to dozens of individual stories (collected in my own research and through studying women's history, women's health and reproduction, as well as autoethnographic work on pregnancy, miscarriage, and infertility), and gathering medical information and textual excerpts from my own experience became a cathartic, meaning-making process.[4] In constructing a new identity I sought other voices and perspectives—largely textual, though some of the most comforting discussions occurred during interviews on practitioner–patient communication at REI practices. Of course, there is real comfort in solidarity—in the "body politic" of infertility.[5] By exploring my experiences with friends, family, and the medical establishment, and analyzing my qualitative work, the sense of my journey as a series of dialogues emerged, and the initial "list" became the series of vignettes below.

This collection of vignettes attempts to illustrate the contours of fertility privilege from the perspective on an infertile, cisgender woman undergoing fertility treatment(s). It is common that while seeking a diagnosis and undergoing treatments, patients find solace in interpersonal relationships.[6] I sought this support, but as those interactions were often fraught with fertility privilege, I turned to texts as an alternative source of comfort. Susan Griffin's *What Her Body Thought* was particularly helpful in voicing the inchoate reality of my diagnosis as "unexplained."[7] I found solace reading autoethnographic and qualitative work with which I identified. While Jennifer J. Bute, Diana C. Parry,

DeAnna H. Chester, and Caryn E. Medved's stories are unique from mine, reading them validated much of what I experienced: physical and emotional turmoil, fertility treatment(s) complicating my professional life, a public that misunderstands infertility, and the difficulties of dealing with an indeterminate diagnosis.[8]

I found it relatively easy to find autoethnographic and qualitative research with which I identify because I am an educated, white, cisgender woman. The working-class, economic instability of my childhood ended with my first full-time job after graduate school. I am conscious that my experience benefits from race and class privilege (rooted in access to higher education and stable employment), but is simultaneously complicated by gender-based oppression and, at this stage of my life, the lack of acknowledgement of fertility privilege in a largely pronatalist society.[9] How does one hold all of this in balance? As Medved notes, "privilege does not make my pain less real, but it must be put in perspective."[10] This autoethnography attempts to both acknowledge my privilege and give voice to a privilege unavailable to me—that of a fertile body. My story is a vital part of and participant in the body politic, but it is only one voice, one perspective. Someone with every gender expression and orientation, of every racial background, from every socioeconomic status could share their unique stories to reflect the wide variety of childless/infertile experience and end the cultural silence around infertility.[11]

To reconstruct my experience accurately, I engaged with various texts, including: my medical records, my interview transcripts for a qualitative study, voicemail transcriptions, and medical research and materials provided by my REI clinics. Throughout this journey, identifying the influence of the textual (or internal) and audible (or external) voice became part of the process of understanding my diagnosis, treatment, and shifting identity. Deciding which voice to give credence to (and when and how) parallels my embodied experience, my medical treatment, and my perception of the medical hierarchy to which I felt beholden.

The decision to frame my experiences as a series of vignettes is informed by ethnographic work such as Moises Kaufman's *The Laramie Project* and inspired by ethnodrama, including Arthur W. Frank's conceptualization of the "coda," and "holding one's own" within a narrative.[12] Below is a "cast" list and following that, the actual vignettes in which we all played a role. The reader might imagine the Author attempting to navigate the information, advice and directions provided in the midst of treatment(s), work, and a family and social life.

THE "CAST"

THE "CHORUS" (LISTED ALPHABETICALLY): BERNSTEIN, BUTE, CHESTER, GRIFFIN, LEAVITT, MEDVED, PASCH, DUNKEL-SCHETTER, AND CHRISTENSEN, PARRY, SHAW, VIC[13]: These academics comprise my "chorus," modeled after ancient Greek plays. Although they appear as a group at the close of a vignette to offer the reader a deeper analysis of what is happening, or simply to validate the infertile voice and/or the Author with their ministrations, each time the Chorus speaks, it is quoting just one of the members.

BYSTANDER(S): Friends, family, acquaintances, strangers, and the reader. This general category provides some anonymity, but also suggests that most fertile individuals, including those closest to you, cannot fully enter the experience with you.

A STUDENT, A COLLEAGUE, A PARTNER: While these are references to specific (yet still anonymous) bystanders, each demonstrates a particular moment during my treatment that complicated my relationship with that individual.

A DRUGSTORE CHECKOUT CLERK OR PHARMACY TECHNICIAN: As stated.

AUTHOR: Diagnosed with infertility, unexplained.

AN INFERTILE VOICE[14]: This voice represents the larger net of my qualitative research, inspired by twenty-four voices; it does not always reflect my particular experiential knowledge, but it does reflect what I have observed at a support group for women with infertility or learned in my research. This voice should help orient the reader to the particularities of infertile experience or offer background information that may not be readily apparent.

VOICE OF MEDICINE: This is a voice and also a category representing the wide range of medical information individuals receive before and during infertility treatment(s). At times, particular individuals within medicine "break away" from the category to speak directly to the Author. These individuals are as follows:

> **RECEPTIONIST:** Representing all receptionists with whom I have interacted at REI offices and quoting one directly.
>
> **DOCTOR:** Representing all REI specialists I have seen and quoting one directly.
>
> **INFERTILITY NURSE:** Representing all the REI nurses with whom I have interacted and quoting three directly.
>
> **BLOOD-DRAW TECH:** As stated.

INFERTILITY VIGNETTES

To discover whether or not I could have a child, I visited an REI specialist. I would visit three over the years, and after this visit I changed practitioners.

During a Treatment Consultation

DOCTOR: *Looking down at my bulky medical file, with sarcasm* Thanks for all the homework. . . you guys are real pros, huh?[15]

INFERTILITY NURSE: I don't email.[16]

THE CHORUS: Deprived of your own authority, you will be tempted to look toward another authority to tell you what you think. The same process that occurs between parents and a child or governments and citizens also occurs in a doctor's office. Whether the attitude of your doctor is abusive or simply paternalistic, if you are not seen and heard, [then] your faith in yourself will be shaken. Somewhere in the breach between your own knowledge and medicine's ability to apprehend it, you cease to trust the knowledge of the body.[17]

The outcome of my consultation appointment was a clear understanding that reproduction would not be a choice for me in the traditional biological sense—I would need intervention. Just before my 30th birthday I learned that my best chance for conception and pregnancy was in vitro fertilization (IVF).[18] The diagnosis? "Unexplained." Shortly thereafter, I attended a baby shower for a family member.

At a Baby Shower

BUTE: Women have reported confessing a fertility problem to avoid the even greater stigma associated with voluntary childlessness. Such revelations not only reveal a particular health condition, but also position women as trying to fulfill the societal expectation of motherhood.[19]

BYSTANDER(S): So! When is it your turn?!
I bet you are getting the baby itch seeing all this!
All your friends are having children! You're next I bet!
Careful! I hear pregnancy is catching!
Do you want some of my [husband's/partner's/boyfriend's] sperm? It works REALLY well!
You want kids? You can have mine!

THE CHORUS: People don't think before they talk; partly because becoming a parent isn't always a conscious choice, unless, of course, you experience difficulty.[20]

I considered simply informing bystanders of my recent diagnosis, but as it was "unexplained," I felt that would provoke further questions I did not want to answer.

Each time I walked into my treatment facility, I read a sign posted on the bulletin board in the elevator. It states that the practice does not accept Medicaid and therefore, all bills must be paid in full to receive treatment. There is an alarm bell inside me, a voice from long ago in my childhood: poor people are not welcome here. An old op-ed is even more direct: "imagine this one. . . the government has been paying for fertility drugs given to Medicaid patients."[21] The social construct is clear: the poor should not be having children; don't they have enough? The fecund poor person is as well-worn a trope as it is inaccurate. The inherent classism in access to treatment is deeply unsettling. Your care and thus, your fertility/menstrual cycle are virtually taken hostage if you cannot pay. I reached again and again for Griffin's work, as it helped me understand the inequity in treatment and the historical perception of female patients in Western medicine, both of which seemed to influence my treatment under certain doctors.

At the REI Office, Before, During, and After an Appointment

AN INFERTILE VOICE: Depending on the state and the insurance company, fertility coverage varies wildly. Even where fertility coverage exists, both states and insurance companies have the legal right to arbitrarily limit the range and quantity of treatments. For example, an insurance program might cover intrauterine insemination (IUI) cycles, but only two. If the first two do not work, the individual or couple will have to pay out-of-pocket, go into debt, or forego treatment altogether. State laws and insurance policies can change at any time and infertile patients have little to no recourse regarding these changes. Moreover, the infertile community has no powerful lobbying arm.

VOICE OF MEDICINE: *via a pamphlet in the waiting room* The World Health Organization defines infertility as: "a disease of the reproductive system defined by a failure to achieve a clinical pregnancy after 12 months or more of regular unprotected intercourse."[22]

RECEPTIONIST: *with affected sweetness* Sweetie—that is not how it works here.[23]

DOCTOR: *rolls eyes*

AUTHOR: *abruptly stops talking*

AUTHOR, TO READER: I have never not gotten along with a nurse before but I brought all of our files to Dr. X and [the nurse] has lost them twice,

accidently put them in the basement once, and was indignant when I said, "Well Dr. X would know that if she looked at our file," and she was like, "I don't know what you are talking about." And I said, "I handed you all of your files, do I need to make you another copy of all our files and bring them to you?" And she said, "clearly that's what you need to do because I don't have them."[24]

VOICE OF MEDICINE: DO NOT leave messages for your IVF nurse on weekends, holidays or after 5:00 p.m.[25]

THE CHORUS: Still [we] can feel the dead weight of an earlier impression even now. Women depicted as ignorant of our own bodies, our own desires, prey to our own thoughts.[26]

So treatment(s) began, weekends and holidays notwithstanding. As I entered treatment, I became the receiver of a host of well-intentioned advice and confusing medical information, including a long litany of treatment directions. Being "in treatment" felt like being in a maze.

During Treatment(s)

AUTHOR, TO READER: I remember the Medicaid sign in the elevator. I feel relieved and then ashamed as I slide my health savings account card to the receptionist.

HEAD INFERTILITY NURSE: Please feel free to email me whenever you want. Or call—keep trying until you get me.

INFERTILITY NURSE: Hi. . . this is V--- calling from the doctor's office, I uh, have your orders we're just waiting on your financial obligation to be taken care of. I will go ahead and give you your weekend orders, and just go ahead and um, give your nurse a call on Monday to get the rest of your orders. Uh. . . go ahead and start taking 5 mg of the Letrozole tonight and tomorrow night and, like I said just give your um, nurse a call on Monday with the rest of your orders. Uh, if you have any questions, give us a call. . . thank you.[27]

BYSTANDER(S): Just relax!

INFERTILITY NURSE: Hi. . . my name is A--- I'm calling from Dr. T---'s office, calling with your instructions. Dr. T--- wants you to take your Ovidrel [injection] this evening, sometime between 6 and 8 p.m., and then the IUI procedure is going to take place on Tuesday, uh, that's January the 28th, so that morning we'll need you and your husband to come into the clinic by 7:30. You will go upstairs and have a progesterone level drawn, your husband will provide a, uh, sample, and then we'll need

you to come back to the clinic later that morning at 11 a.m. for the actual IUI procedure with Dr. T---. [pause] Um, your blood work, ah looks great, your lining today was 11.6, which is great we want to see that over 8, and um, the two follicles you have that are mature, on your right ovary—you had one that was 23 and one that was 20.9. On your left you had two follicles, but they're not mature—one was at 13.3 and one was 12.1. So again. . . hope you have a nice day. Take care. Bye-bye.[28]

BYSTANDER(S): Have a glass of wine!

VOICE OF MEDICINE: *in my folder of treatment information* Your pregnancy test will be performed approximately 12 days after the embryo transfer. These 12 days will pass by very slowly because you're waiting to see if pregnancy has occurred. Try to keep yourself busy with personal projects and go on with your life as normally as you can. If you would like to discuss anything with the staff or a counselor, please do not hesitate to call. . . . If a pregnancy does occur, two more hormone levels will be repeated at three-day intervals. We will then schedule your first ultrasound to ascertain the location of the pregnancy. Patients will return to their obstetrician once pregnancy growth and viability have been confirmed by ultrasound to continue their prenatal care. . . . We remind you that IVF is [a] stressful, time-consuming, costly process with no guarantee of success; however it offers the only option for some infertile couples. IVF is a team effort.[29]

AUTHOR: and it was perfect, which is the word they like to use. "Perfect" or "beautiful," they say you have a beautiful uterus or beautiful follicles.[30]

INFERTILITY NURSE: I don't understand what it is you don't understand.[31]

AUTHOR: Once, during the implant procedure of an IVF cycle, I looked at the screen and watched the doctor insert two embryos. Heavily medicated and cotton-mouthed I mumbled, "They look like Christmas lights."

BYSTANDER(S): At least you are having fun trying!

THE CHORUS: Paul Farmer calls such distinct points of view "positioned rhetoric" and demonstrated in his anthropological studies how multiple points of view are logically situated in particular historical contexts and necessary to construct a full remembrance of past events.[32]

For me, a "full remembrance" included: the rolled eyes, the well-intentioned advice, the supportive nurse, the classist flyer in the elevator, and the perspectives

gleaned from my research. The problem with infertility treatment is that it follows you everywhere, as does the advice and medical dictates. The intersection of my experience and my research provided both an outlet and an uncomfortable level of overlap.

At the Office

BYSTANDER(S): You should adopt! I had a [relative/friend/co-worker] who adopted a child and she was pregnant a [week/month/year] later!

BUTE: I myself was uncertain about motherhood and wondered how my choice to return to graduate school in my late twenties would affect my options for becoming a parent.[33]

AUTHOR, TO READER: I also returned to graduate school in my late twenties, but like so many cis-women I assumed I would be able to conceive when I chose and instead focused on prevention instead of conception.

MEDVED: I'd be lying to you (and myself) if I said my infertility at this time wasn't troubling. . . . Yet I also consciously wouldn't let it be the only issue defining my life.[34]

A COLLEAGUE: Autoethnographies should be left to anthropologists.

AUTHOR: A graduate assistant sat in an evening exam for five minutes while I raced upstairs, pulled a cooler out of the tiny faculty refrigerator and gave myself a "trigger" shot called Ovidrel (this tells your body to ovulate). I tucked an ice pack into my pants and put on a thin sweater to return to class. The next morning, I went in to have my (egg) retrieval; only one colleague knew. This was also my most professionally productive period thus far—I refused to be defined by our repeated failures to conceive with treatment and my disappointment became fuel for research and writing.

VOICE OF MEDICINE, TO AUTHOR:

- Begin Doxycycline 100mg when you get home from the retrieval and again that night. Take one pill twice a day (a.m. and p.m. until finished)
- Begin Medrol (Methylprednisolone) 16mg the night of retrieval. Take as directed on the bottle every night for six nights.
- Begin Progesterone in oil 50mg (1cc or 1 ml) IM 2 days after your retrieval. Then continue once daily until pregnancy test. You will be given further instructions after pregnancy test results.
- Begin Dostinex 0.5 mg 1 pill by mouth for 6 days.

- Endometrin 100mg three times daily starting the day after your embryo transfer.
- Progesterone capsules 200mg twice daily starting the day after your embryo transfer.
- Ganirelix 250mcg sub-Q.
- Cetrotide 0.25mg/Cetrotide 3mg sub-Q.[35]

A COLLEAGUE: I'm here for you—whatever you need. Do you need me to go with you to the surgery? I'll drive you home afterward.

MEDVED: My body was sore and overweight from years of IVF hormone injections.[36]

AUTHOR, TO READER: Mine too.

STUDENT: Why don't you have children?

AUTHOR, TO STUDENT: That's a personal question that I'm not sure fits into the lecture or class discussion on American medical history today. Try me again next week!

A COLLEAGUE: Well, I wouldn't include an autoethnography on your CV for a serious position in a history department.

THE CHORUS: How will my altered positionality guide my future work, and how can I honestly and thoughtfully reflect on the lens through which I now view the world? Should I engage the possibility of putting subjectivity at the forefront of intellectual inquiry?[37]

The bulk of my treatment experience occurred in my home, in the kitchen where I monitored and administered my medications and gave myself nightly injections. I rested at home after outpatient procedures and while I awaited test results.

At Home, Mostly in Front of the Refrigerator

VOICE OF MEDICINE: *from a handout on injections* With a dart-like motion, pierce the skin with the needle into the muscle completely, leaving none of the needle exposed. Draw back the plunger. If you are accidentally in a blood vessel, blood will appear in the syringe. If so, pull the needle out and replace it with a new needle. Start the injection process again.[38]

AUTHOR: Could you do the progesterone shots in my hips when we get there? They don't do the pills at this place.

VOICE OF MEDICINE: Your nurse will estimate and prescribe the quantity of medication you need. It is your responsibility to keep track of your medications and acquire refills as needed.[39]

PARTNER: *shuddering* No, no I really don't think I could do that. I would be really nervous and all I would think about is hurting you. Is there any way a nurse could help us? I don't want to make a mistake.

AUTHOR, TO READER: I went in on all six days, presenting the opposite hip each time. Each time the ache grew until I felt I had the flu. To her credit, this nurse (perhaps she emails?) was very supportive and empathetic.

THE CHORUS: This too is in my body. . . [a] leaning out as if to catch what can never be caught. . . . Loss and longing move from body to body, expressed in one place as sorrow, in another as illness, then as destruction, and everywhere as desire.[40]

I did whatever I could to "run away" from home, to do the work I love and to see new places; I refused to stop living. I brought my reading, my restrictions (only *one* cup of coffee, eat healthy, avoid toxins) and my medications with me, even on vacation. Often, vacation without children is perceived as a luxury.

Before and During a Vacation

BYSTANDER(S): *earnestly* You're going where? Wow! Must be nice not to have kids!

VOICE OF MEDICINE: If flying, call your airline and ask about their policy on traveling with injectable medications. You should take them with you on the plane in case you get separated from your luggage. However, you may need a doctor's note detailing what your prescriptions are. We will be happy to provide this for you.[41]

BYSTANDER(S): I had a [relative/friend/co-worker] who planned their dream vacation and had to cancel it because she found out she finally got pregnant! Perhaps you should plan something you've been meaning to do and it will happen!

VOICE OF MEDICINE: If you are planning a vacation this summer, don't forget about your medications. . . . Don't forget a container for proper disposal

of your needles. You may need to fill your prescriptions early if you will run out prior to coming home from your vacation.[42]

BYSTANDER(S): *noticing we are eating alone and after asking if we have kids* Get a dog! That's the same thing, except easier and cheaper. Just think—you won't have to pay for college!

VOICE OF MEDICINE: Possible side effects: bleeding (i.e., gums), local irritation, redness, mild pain and itching at site of injection. . . nausea, vomiting, chills and fever (rare).[43]

BYSTANDER(S): Every time my [husband/partner/boyfriend] sneezes/breathes/touches/looks at me, I get pregnant.

VOICE OF MEDICINE: Take into consideration what medications need to be refrigerated and pack appropriately with frozen ice packs and coolers. An insulated lunch bag works great. . . . If you are on progesterone vaginal suppositories—keep in mind these will melt in hot temperatures. So, don't pack them in your checked luggage![44]

- Leuprolide 4 mg = 0.8 ml
- Your cost: $78.00
- Ovidrel 250 mcg
- Your cost: $79.50
- Cetrotide 0.25 mg and 3 mg
- Cetrorelix acetate for injection
- Your Cetrorelix cost: Covered[45]

One trip, enjoyable in spite of the medications, restrictions, side effects, and bystander chatter, renewed my hope in the future. Two weeks later I received the bad news.

After Failed Treatment

BLOOD-DRAW TECH: Well. . . you will have to come in for the test so we can confirm a pregnancy or not.

MEDVED: To top it off, it's a painful requirement that I go into the clinic for one more blood test just to confirm that I'm not pregnant.[46]

BYSTANDER(S): Have you considered [alternative medicine/medical treatment]?

AUTHOR: So many times I've lost count.

BYSTANDER(S): You are so lucky. . . you can [sleep in/have date nights/travel/etc.].

CHESTER: When you admit such thoughts, people bring up miracles. Yes, miracles happen, but we don't all get one. Hadn't so far.[47]

INFERTILITY NURSE: *defensively* Well I still believe in miracles and I'm going to hope for one for you.

AUTHOR: *long pause, then, wryly* Thanks.[48]

VOICE OF MEDICINE: Infertility generates disability (an impairment of function), and thus access to health care falls under the Convention of the Rights of Persons with Disability. . . . Infertility in women was ranked the 5th highest serious global disability (among populations under the age of 60).[49]

INFERTILITY NURSE: Your HCG level was 1.23. I'm sorry.

AUTHOR: So it was positive?

INFERTILITY NURSE: Yes. But 1.23 was the level. I'm sorry.

AUTHOR: What is it supposed to be?

INFERTILITY NURSE: At least 50. I'm sorry.

HANDWRITTEN CARD: Find the silver lining!

PARTNER: I'm on my way home. Let's open that special bottle of wine we've been saving and we'll make a fire. Great wine can be opened for sad things too, right?

BYSTANDER(S): *brightly* When you stop trying it will happen!

THE CHORUS: The most common, seemingly innocuous procedures of medicine serve to strip a patient, not only of dignity, but also of the capacity for autonomous judgment. The disenfranchisement only continues in the process of diagnosis. But here the problem is not just with medical procedure. Trying to express what you feel in your body, you will confront a paucity of words. . . . This alone will leave you fumbling in a fog of vague impressions, certain that what you feel remains unnamed.[50]

This "fog of vague impressions" became overwhelming in stores, particularly when shopping for baby gifts or pregnancy tests. These were gifts for another baby, my baby was just an idea in time, an impression in my mind.

While Shopping

BYSTANDER(S): So—do you have children?
Is this for your son or daughter?
Your son or daughter will love this.

A DRUGSTORE CHECKOUT CLERK OR PHARMACY TECHNICIAN: *seeing ovulation kits or pregnancy tests* Oh, how exciting!
Well I hope it turns out how you want.
Good luck! I'm rooting for you!

AN INFERTILE VOICE: Infertile/childless people often loathe explaining to fertile people that taking ovulation and pregnancy tests—repeatedly—can be part of their diagnostic journey. Patients who have undergone IUI or IVF often take a pregnancy test before the official test at the doctor, only to find out that a brutal, exhausting, six-week treatment has failed. If you are infertile, trying to make emotional space for yourself during these purchases can be a nearly insurmountable task. The assumption that the person is taking these tests as a sign of their fertility is part of the blindness resulting from fertility privilege.

The intrusion of infertility treatment into my marital partnership was terrible and wonderful. It upset our expectations, our communication, our schedules, our bank account; it created a closeness, camaraderie, and collection of comedic phrases and anecdotes we continue to recall to this day.

In an Intimate Partnership

BYSTANDER(S): Have you tried _____ position?

PASCH, DUNKEL-SCHETTER, AND CHRISTENSEN: More so than most medical problems, infertility is truly a couples' issue. Infertility is a characteristic of a couple who is attempting pregnancy, in addition to the individual, even in cases in which only one member appears to have the biological problem. Treatment attempts require the participation of both partners. . . . Because infertility affects couples as a unit, it presents unique challenges for the couple relationship.[51]

VOICE OF MEDICINE: Between 2006 and 2010, approximately 12% of women in America between the ages of 15 and 44 had ever used infertility services, or 7.3 million people.[52] Among women aged 25–44, the percentage is 17%, and among men in the same age group, 9.4%.[53] These statistics do not necessarily reflect the number of people who are infertile—they merely speak

to the percentage of people actively seeking treatment for or advice regarding becoming and staying pregnant.

AN INFERTILE VOICE: Infertility and secondary infertility are a major cause for difficulty (emotional, physical, and economic) in intimate partner relationships and they are a major cause for the end of intimate relationships, including engagements and marriages.[54]

PASCH, DUNKEL-SCHETTER, AND CHRISTENSEN: On average having children was very important to both husbands and wives, and both were involved in and wanted to talk about trying to have a baby.[55]

DOCTOR: They do have a counselor you can pay $175 per hour. . . if you really need to talk to somebody.[56]

AUTHOR: My partner has always been involved in our treatment because male factor infertility is part of our story together. As with many issues, infertility highlights our culture's double standards, rooted in gender stereotypes: historically men could leave women who were barren, but women could not leave men who were impotent because men were thought to be universally fertile.[57]

AUTHOR, TO READER: We were often given instructions of when and when not to have intercourse as an infertile couple.[58] We were not alone.

CHESTER: We soon turned my body and our sex lives over to medical science.[59]

VOICE OF MEDICINE: Intercourse: in general, you will be asked to refrain 3–4 days prior to egg retrieval but no more than 6 days should elapse between intercourse or ejaculation.[60]

INFERTILITY NURSE: Hello, Hi. . . it's S--- over at the doctor's office, just giving you a call back in regards to your message. Sometimes irritation. . . just monitor, um, what you're having. You may have it for about 24 hours and then it should go away, but that can be very normal. If you have any questions, feel free to call me back, and just a reminder that you and [your partner] will need to have intercourse tonight and tomorrow. Thank you! Good luck! I look forward to hearing from you soon, hopefully with good news. Thank you.[61]

BYSTANDER(S): Have you tried _____ supplement?

VOICE OF MEDICINE: *the sexless reproductive act* Slowly push the plunger all the way to inject the medication, and pull the needle straight out.[62]

PASCH, DUNKEL-SCHETTER, AND CHRISTENSEN: Husbands' perceptions of the effect of infertility on their marriage was only related to how much they thought infertility had affected their own self-esteem.[63]

AUTHOR, TO READER: In our case, we felt discouraged but our self-esteem stayed largely intact. A miracle? Perhaps.

BYSTANDER(S): Oh, you are still young! You have plenty of time!

AUTHOR: The month after our third failed IVF, my doctor ordered a DNA fragmentation test for my partner and advised me to go through another round of IVF drugs just to cut out a tiny bit of uterine tissue during an office visit and send it to Yale. The test at Yale would determine if I have "implantation issues," because none of the doctors could figure out why I don't get pregnant. I look at my partner one night in the kitchen, tearfully: "I can't," I say emphatically. "I simply cannot."

THE CHORUS: While I could not exercise agency in relation to my ability to have a biological child, I [could] take control of when to stop this medically assisted pursuit.[64]

In moments of uncertainty about when, if or how to proceed, I continued to attend family gatherings and visited the worship spaces of friends and family. During one visit I was still (surreptitiously) taking injections.

A Holiday, with Family and Friends

BYSTANDER(S): When you stop trying it will happen!

AN INFERTILE VOICE: Many infertile/childless couples choose periods of self-isolation to avoid the judgments of well-intentioned friends or family who question or challenge an individual or a couple's choices regarding treatments, testing, procedures, or a refusal to do some or all of those things. Those choosing not to share their fertility status at all avoid the added stress and pain of an open commentary on their (very personal) choices and the complicated nexus of factors that lead to those choices.

BYSTANDER(S): Why don't you just adopt?

VOICE OF MEDICINE: Hold the Follistim pen with the needle pointing upwards. Tap the cartridge holder gently with your finger to help air bubbles rise to the top of the needle. The small amount of an air bubble will not affect the amount of medicine you will receive. Look for a droplet forming at the tip of the needle. If you see a droplet, go to the next step.[65]

BYSTANDER(S): As soon as you stop thinking about it, you will get pregnant!

PARRY: On another note, at the family Thanksgiving dinner there were some REALLY painful comments made. . . . I wish I hadn't been such a blabbermouth and told everyone about our attempts to conceive. I find my feelings get so hurt because my family just doesn't get how deep this goes.[66]

BYSTANDER(S): We are having trouble conceiving too—it's hard, I know. We lost a pregnancy at eight weeks; what surprised me most is how attached I got.

Every social setting is a landmine during treatment, and in our case, we stalled treatment for a year, and then considered discontinuing it altogether. After moving to a Southern city, visiting a place of worship often included discussions about children, or when/if we would have them.

In a Place of Worship

BYSTANDER(S), AT COFFEE HOUR: You will never guess who is pregnant!

AN INFERTILE VOICE: Some individuals and couples will share their infertile status and seek the support of a faith community, though this can be complicated as well. Sometimes well-intentioned members of the community will commit to support these individuals or couples. Different prayers or rituals may be used, but if conception is not forthcoming, those who are infertile may experience grief, isolation, and possibly a deep sense of personal failure. If there are community events celebrating the arrival or dedication of children, infertile couples must navigate their feelings in public or avoid participating.

BYSTANDER(S): Can we pray for you/think good thoughts, etc.?
Any progress to report?
I/we believe in miracles!
Maybe it is not [God]'s will?

Ultimately

THE CHORUS: We thrashed inside our conditions as in cocoons.
The cottony white webbing clumped in our throats.
Our arms were useless and aching. Our eyes, black
With staring into the future.
We couldn't tear ourselves away.
. . . .
Coupled or alone, leaning on sticks,
you pick your way through the serious, uninhabited
mountains.[67]

A CODA FOR THE BYSTANDER(S): MUSINGS ON FERTILITY PRIVILEGE

Similar to other forms of privilege, fertility privilege exists on a continuum. Individuals can move in and out of this form of privilege throughout their childbearing years.[68] However, many individuals or couples will not experience primary, secondary, short-term, or long-term infertility. This collection of statements attempts to reconstruct the experience of fertility privilege.

Because I have been able to conceive, I have not been the receiver of a wide range of unsolicited, unscientific advice about infertility and conception. Moreover, I may not realize that much of this advice, though well-intentioned, shows a complete lack of understanding of reproductive endocrinology, the complex nexus of infertility causes, and the uncertainties of diagnosis infertile people face.

Because I have been able to conceive, I have not been expected to manage other's expectations about our choice of treatment, or our choice to forego treatment, nor do I have to entertain and respond to well-meaning friends and family members who openly question our choices and/or the timeline of our infertility journey.

I do not consider the added stress of completing daily tasks with infertility treatment on my mind. I do not have to consider the painful, often expensive medical treatment(s) that infertile individuals and couples experience. I do not have to think about taking out loans to have these treatments, having surgeries, taking shots, or being devastated emotionally (and sometimes economically) if these treatments and interventions do not work. I do not have to find a space to grieve failed medical treatments, nor do I have to balance those treatments with my personal and/or work life. I do not have to deal with the reality that I cannot have children simply because I do not have the resources to attain fertility treatments.

If I am insured, I can assume that my state requires my insurance company to offer some coverage for maternity care and/or delivery, even if it is not what I prefer. I do not have to worry that I will be denied coverage for the entirety of the treatments, nor do I have to worry that subsequent pregnancies and deliveries will not be covered. I do not worry whether or not I can sufficiently "prove" my pregnant status to my insurance company to receive coverage.

I feel comfortable noting the economic benefits of childlessness to childless/infertile friends. I may note the quality of their living quarters, their luck in being able to take a vacation, buy a new car, and replace worn or older clothing, or own updated technology. I do not have to constantly manage the economic weight of infertility, including considering adoption and/or making my living

quarters meet the standards of home visits required for foster care and/or adoption. Alternatively, I do not have to be reminded that I have the income to replace or update items in my living quarters because I do not have to provide for children I cannot have or am unable to welcome into my home at that time.

I feel comfortable making comments about my life before having had children, particularly about when I used to have free time, personal goals, or "a life." I often refer back to that time, which I remember with fondness, though I would never trade that life for my life with children. When my childless/infertile friends mention they are stressed, busy, or overwhelmed, I remind them that I didn't even know what busy *was* until I had children. I am confident I can make these kinds of statements and the majority of my fertile peers will commiserate.

I can (if I wish) easily arrange to be in the company of other people who can have children, particularly among my peer group. If I am in a certain age range, I can assume that the majority of those around me will have children.

I can avoid spending time with my peers who do not have children with few social consequences. If I do want time away from my children, I expect that my childless/infertile friends will be able to make time for me easily because they do not have children.

I can travel without having to worry about transporting fertility medicines, many of which have to be kept cold. I do not have to navigate the difficulty and inconvenience of having to get a note from my doctor, and then share that note, revealing my infertile status at the security checkpoints, at the gate, and with the flight attendants in each direction. If I can become pregnant, I can confidently assume that my refusal to take a flight will go unquestioned and/or be publicly sanctioned.

I enjoy baby showers. They are not a painful reminder of a rite of passage I may never experience. At baby showers, I can talk freely about my own experience with pregnancy, delivery, and child-rearing, secure in the knowledge that I am not an outsider. If I invite childless/infertile friends to my own baby shower, I may have difficulty understanding their reluctance to attend and/or I may be offended if they refuse, wondering if their commitment to our friendship is waning. Furthermore, I may consider their decision not to attend a selfish one.

I enjoy strolling through the baby departments of stores or looking at maternity clothes. Buying toys for the children of close friends and/or nieces, nephews, or other young family members is less likely to be emotionally fraught.

If I am a cisgender man partnered with a cisgender woman and I have been able to conceive and have a child, I can celebrate with friends and professional peers. I do not have to struggle to find men with whom to grieve infertility. Nor do I have to fear being pitied for not being "man enough" to produce children.

If I am a fertile cisgender woman partnered with a cisgender man, I do not have to fear that my male partner will take offense at my request that he be tested for infertility. Nor do I have to fear that a refusal to be tested will prevent me from having children. Moreover, I will not have to fear the end of my relationship because of my inability to conceive.

If I am fertile and have a religious or spiritual practice that is precious to me, I do not fear a crisis of faith because of my inability to conceive or carry a child to term. I do not worry that other members of my faith community will ask questions about my fertility status. I do not have to consider how my standing in the community will change if I reveal my infertility. I do not have to worry that someone will point to my spiritual practice, commitment to my faith, or strength of belief as the reason for my infertility. I do not have to fear that individuals will try to turn my infertility into a kind of spiritual journey or lesson, provoking further guilt and shame.

If I am a fertile individual and I celebrate cultural events or holidays, these celebrations are not painful reminders of my inability to conceive. During holidays, I do not have to think about childhood traditions, or unpack decorations I have saved without being able to share these traditions and memories with my child.

I do not dread upcoming holidays, family gatherings, birthdays, anniversaries, or reunions at which family members may announce their pregnancies, nor do I have to navigate my reactions in these settings carefully.

When I enter a drugstore or supermarket to buy an ovulation or pregnancy test, I may feel a sense of nervous excitement and anticipation. I do not dread these purchases and the immense emotional energy it takes to navigate bystander comments/questions.

I do not have to consider the consequences of how and when I reveal my pregnancy publicly. I feel comfortable posting belly pictures, assuming that everyone is fertile. I may need and want support for and celebration of pregnant bodies—and this must be available to pregnant women. I may not be aware that if someone has not revealed their infertile status, that person has no place (publicly) to process their pain, confusion, and social discomfort.

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Assuming that a couple wants to have children or does not want to have children is itself part of fertility privilege. While some women and men will fail to conceive throughout the entirety of their productive years (primary infertility), others will eventually have children with or without fertility treatment(s). Still others will easily have one child and then for known or unknown reasons, be unable to conceive again (secondary infertility). Often, those with fertility privilege will tell those with secondary infertility that they should be thankful they were able to have one child, and that the desire or struggle to have more children is "selfish." This too is fertility privilege—it makes one unable to understand the pain that comes with infertility—be it primary, secondary, short-term, long-term, or permanent. Individuals who are infertile and choose to welcome a child into their lives through fostering, adoption, surrogacy, or by some other arrangement are often expected to "get over" their grief regarding infertility because they are no longer childless. This, too, springs from fertility privilege.

EPILOGUE

> In my own way I am attempting what could be called a rescue. Or, to put it more modestly, I am trying to express a longing that, though it is not often articulated in contemporary life, I can sense at the margins of desire. . . the wish for a less brutal, more caring world.[69]

At the close of this project, "infertile" is only one part of my larger identity—not the center. Ultimately, I want this essay and my qualitative research to help create a "less brutal world" for all those who receive infertility treatment(s) after me. I would like to prompt fertile individuals to rethink (if necessary) their approach with friends, family, and colleagues who struggle with infertility. I would like medical practitioners to understand the weight of their language beyond each visit and look closely at the power dynamic that can both soothe and wound patients.

There is a long, plodding nature to fertility treatment(s), including forced breaks between procedures, varying gaps between test results and decisions, and a kind of "hurry up and wait" to it all. Including two blank pages in the middle of this collection of vignettes might not create these impressions for the reader, though they would be evocative of my experience. The emotional rollercoaster of the experience—the deep lows and extraordinary highs, the hope attached to any positive news—remains difficult to depict (visually). During treatment, I mentally collected scraps of good news and chained them together like an

invisible talisman—an imaginary trail of little lights behind me as I approached the stirrups and ultrasound machine yet again.

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NOTES

1. Susan Griffin, *What Her Body Thought: A Journey into the Shadows*, (San Francisco: Harper, 1999), 277.

2. Jennifer J. Bute and Tennley A. Vik describe both the choice of infertility as an identity, and the shifting communication needs and expectations of infertile women throughout treatment in "Privacy Management as Unfinished Business: Shifting Boundaries in the Context of Infertility," *Communication Studies* 61, no. 1 (2010): 1–20.

3. Angela L. Palmer-Wackerly and Janice L. Krieger, "Dancing around Infertility: The Use of Metaphors in a Complex Medical Situation," *Health Communication* 30, no. 6 (2015): 612–23; Bethany Johnson and Margaret M. Quinlan, "Insiders and Outsiders and Insider(s) Again in the (In)fertility World," *Health Communication* (in press): doi: 10.1080/10410236.2016.1138384.

4. Maxine Birch and Tina Miller, "Inviting Intimacy: The Interview as Therapeutic Opportunity," *International Journal of Social Research Methodology* 3, no. 3 (2000): 189–202; Vicki Drury, Karen Francis, and Ysanne Chapman, "Taming the Rescuer: The Therapeutic Nature of Qualitative Research Interviews," *International Journal of Nursing Practice* 13, no. 6 (2007): 383–84.

5. Griffin, *What Her Body Thought*, 90.

6. Bute and Vik, "Privacy Management as Unfinished Business."

7. Griffin, *What Her Body Thought*.

8. Jennifer J. Bute, "'Nobody Thinks Twice about Asking': Women with a Fertility Problem and Requests for Information," *Health Communication* 24, no. 8 (2009): 752–63; "When Public and Private Intermingle. . . Reflections on (Re)production," *Health Communication* 26, no. 1 (2011): 104–106; Diana C. Parry, "Understanding Women's Lived Experiences with Infertility: Five Short Stories," *Qualitative Inquiry* 10, no. 6 (2004): 909–22; DeAnna H. Chester, "Mother. Unmother: A Storied Look at Infertility, Identity, and Transformation," *Qualitative Inquiry* 9, no. 5 (2003): 774–84; Caryn E. Medved, "Infertility, Professional Identity, and Consciousness-Raising," in *Communicating Pregnancy Loss: Narrative as a Method for Change*, ed. Rachel E. Silverman and Jay Baglia (New York: Peter Lang, 2014), 103–16.

9. Judith Daniluk, "Helping Patients Cope with Infertility," *Clinical Obstetrics and Gynecology* 40, no 3. (1997): 661–72; Julia Moore and Patricia Geist-Martin, "Mediated Representatives of Voluntary Childlessness, 1900–2012," in *The Essential Handbook of*

Women's Sexuality: Meanings Development, and Worldwide Views, Vol. 1, ed. Donna Castañeda (Santa Barbara, CA: Praeger, 2013), 233–52.

10. Medved, "Infertility, Professional Identity, and Consciousness-Raising," 115.

11. In this manuscript, the terms "childless" and "infertile" are often used together, which illustrates the reality that some individuals or couples choose to withhold their fertility status from friends and family, obfuscating the (in)voluntary nature of their childlessness. I define "childless" as an involuntary state, in keeping with Julia Moore's contention that the term "childfree," which emerged in the 1970s as an alternative to "voluntary childlessness," is more useful for describing those who choose to be childfree. The social difference between voluntary and involuntary childlessness must not be overlooked. I agree with Julia Moore and Patricia Geist-Martin and Judith Daniluk, who argue that voluntary childlessness and the stigma faced by voluntarily childless individuals and couples is distinct from that faced by temporary and involuntarily childless individuals and couples. Voluntary childlessness provokes a particular form of prejudice, while involuntary childlessness provokes pity. However, this is not a (re)construction of pronatalist essentialism—one can grieve infertility without assuming that having children is the highest aim of an individual or couple or questioning the choice not to have children. See Julia Moore, "Reconsidering Childfreedom: A Feminist Exploration of Discursive Identity Construction in Childfree LiveJournal Communities," *Women's Studies in Communication* 37, no. 2 (2014): 159–80; Moore and Geist-Martin, "Mediated Representatives of Voluntary Childlessness"; Daniluk, "Helping Patients Cope with Infertility."

12. Moises Kaufman, *The Laramie Project* (New York: Vintage, 2001); Arthur W. Frank, "Practicing Dialogical Narrative Analysis," in *Varieties of Narrative Analysis*, ed. James A. Holstein and Jaber F. Gubrium, (Thousand Oaks, CA: Sage, 2012), 33–52.

13. Carole Bernstein, "Infertility Group," *Poetry* 179, no. 1 (2001): 12–13; Bute, "'Nobody Thinks Twice about Asking'"; "When Public and Private Intermingle"; Bute and Vick, "Privacy Management as Unfinished Business"; Chester, "Mother. Unmother"; Griffin, *What Her Body Thought*; Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston: Beacon Press, 1996); Medved, "Infertility, Professional Identity, and Consciousness-Raising"; Laurie A. Pasch, Christine Dunkel-Schetter, and Andrew Christensen, "Differences between Husbands' and Wives' Approach to Infertility Affect Marital Communication and Adjustment," *Fertility and Sterility* 77, no. 6 (2002): 1241–47; Parry, "Understanding Women's Lived Experiences with Infertility"; Charla L. Markham Shaw, "Personal Narrative: Revealing Self and Reflecting Other," *Human Communication Research* 24, no. 2 (1997): 302–19.

14. Elliot G. Mishler, "The Struggle between the Voice of Medicine and the Voice of the Lifeworld," in *The Sociology of Health & Illness: Critical Perspectives*, 8th ed., ed. Peter Conrad (New York: Worth Publishers, 2009), 358–69.

15. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

16. Ibid.

17. Griffin, *What Her Body Thought*, 290–91.

18. The Mayo Clinic defines in vitro fertilization (IVF) as "a complex series of procedures used to treat fertility or genetic problems and assist with the conception of a child. During IVF, mature eggs are collected (retrieved) from your ovaries and fertilized by sperm in a lab. Then the fertilized egg (embryo) or eggs are implanted in your uterus.

One cycle of IVF takes about two weeks." "In vitro Fertilization," *Mayo Foundation for Medical Education and Research*, accessed 15 April 2014, http://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/basics/definition/prc-20018905.

19. Bute, "'Nobody Thinks Twice about Asking.'"

20. Medved, "Infertility, Professional Identity, and Consciousness-Raising."

21. Ellen Goodman, "Poverty and Fertility," *The Baltimore Sun*, 22 March 1995, accessed 14 March 2015, http://articles.baltimoresun.com/1994-03-22/news/1994081149_1_fertility-drugs-welfare-mothers-medicaid.

22. "Infertility Definitions and Terminology," *World Health Organization*, n.d., accessed 8 March 2015, www.who.int/reproductivehealth/topics/infertility/definitions/en/.

23. Bethany Johnson, interviewed by Margaret M. Quinlan, 4 September, 2014. In fall 2014, Margaret M. Quinlan (University of North Carolina at Charlotte, Department of Communication Studies) and I started a qualitative study titled "Practitioner–Patient Communication: Women's Experiences with Reproductive Endocrinology and Infertility."

24. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

25. *Injection Instructions* (n.p.: IntegraMed America, 2006), 1.

26. Griffin, *What Her Body Thought*, 204.

27. REI Practice, voicemail to author, January 2014. In an effort to maintain anonymity of doctors and nurses, I have replaced the legal name of the fertility clinic with "REI Practice."

28. REI Practice, voicemail to author, 2014.

29. *IVF Patient Information Booklet* (Publisher details redacted for IRB confidentiality, n.d.), Personal Medical Records.

30. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

31. Ibid.

32. Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2007), qtd. in Leavitt, *Typhoid Mary*, 233.

33. Bute, "When Public and Private Intermingle," 105.

34. Medved, "Infertility, Professional Identity, and Consciousness-Raising," 107.

35. *IVF Patient Information Booklet* (Publisher details redacted for IRB confidentiality, n.d.), Personal Medical Records.

36. Medved, "Infertility, Professional Identity, and Consciousness-Raising," 109.

37. Bute, "When Public and Private Intermingle, 104.

38. *Injection Instructions*, 23.

39. Personal Medical Records, 2014.

40. Griffin, *What Her Body Thought*, 313.

41. Nicole O, "Traveling with Infertility Medications," *Center of Reproductive Medicine*, last modified 18 July 2011, accessed 2014, http://infertilitytexas.com/infertility-texas/traveling-with-infertility-medications/.

42. Ibid.

43. *Injection Instructions*, 25.

44. Nicole O, "Traveling with Infertility Medications."

45. Personal Medical Records, April–May 2014.

46. Medved, "Infertility, Professional Identity, and Consciousness-Raising," 110.

47. Chester, "Mother. Unmother," 778.

48. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

49. "Infertility Definitions and Terminology," *World Health Organization*.

50. Griffin, *What Her Body Thought*, 281.

51. Pasch, Dunkel-Schetter, and Christensen, "Differences between Husbands' and Wives' Approach to Infertility Affect Marital Communication and Adjustment," 1241.

52. Anjani Chandra, Casey E. Copen, and Elizabeth Hervey Stephen, "Infertility Service Use in the United States: Data from the National Survey of Family Growth, 1982–2010," *National Health Statistics Reports*, 73 (2014): 1, accessed 28 May 2014, http://www.cdc.gov/nchs/data/nhsr/nhsr073.pdf.

53. Ibid., 1.

54. Jennifer J. Bute, "Discursive Dynamics of Privacy and Disclosure: Evidence from a Study;" *Western Journal of Communication* 77, no. 2 (2013): 164–85; Daniluk, "Helping Patients Cope with Infertility"; Andrew C. High and Kelly Ryan Steuber, "An Examination of Support (In)Adequacy: Types, Sources, and Consequences of Social Support among Infertile Women," *Communication Monographs* 81, no. 2 (2014): 157–78; Kelly Ryan Steuber and Denise Haunani Soloman, "Factors that Predict Married Partners' Disclosures About Infertility to Social Network Members," *Journal of Applied Communication Research* 39, no. 3 (2011): 250–70.

55. Pasch, Dunkel-Schetter, and Christensen, "Differences Between Husbands' and Wives' Approach to Infertility Affect Marital Communication and Adjustment," 1244.

56. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

57. Margaret S. Marsh and Wanda Ronner, *The Empty Cradle: Infertility in America from Colonial Times to the Present* (Baltimore, MD: Johns Hopkins University Press, 1996).

58. Bethany Johnson, interviewed by Margaret M. Quinlan, 5 September 2014.

59. Chester, "Mother. Unmother," 777.

60. *IVF Patient Information Booklet* (Publisher details redacted for IRB confidentiality, n.d.), Personal Medical Records.

61. REI practice, voicemail to author, 2014.

62. *Injection Instructions*, 23.

63. Pasch, Dunkel-Schetter, and Christensen, "Differences Between Husbands' and Wives' Approach to Infertility Affect Marital Communication and Adjustment," 1246.

64. Medved, "Infertility, Professional Identity, and Consciousness-Raising," 111.

65. *Injection Instructions*, 23.

66. Parry, "Understanding Women's Lived Experiences with Infertility," 917.

67. Bernstein, "Infertility Group."

68. Patricia Beattie Jung and Ralph F. Smith, *Heterosexism: An Ethical Challenge* (Albany: State University of New York Press, 1993); Jodi Kaufman and John O. Wamsted, "White Male Privilege: A Conversation," *Qualitative Inquiry* 21, no. 1 (2015): 77–82; Peggy McIntosh, "White Privilege: Unpacking the Invisible Knapsack," *Peace and Freedom* Magazine, (July–August 1989): 10–12; Paula S. Rothenburg, ed., *Race, Class, and Gender in the United States: An Integrated Study*, 6th ed. (New York: St. Martin's Press, 1998); Tim Wise, *White Like Me: Reflections on Race from a Privileged Son: The Remix*, (Berkeley, CA: Soft Skull Press, 2011).

69. Griffin, *What Her Body Thought*, 12.