

Parenthood as Privilege: The Cultural Tensions of Acceptable Reproduction

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**PARENTHOOD AS PRIVILEGE:
THE CULTURAL TENSIONS OF ACCEPTABLE REPRODUCTION**

a dissertation

by

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The cultural tensions of acceptable reproduction**

by Gretchen Sisson

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Parenthood is one of the most salient, fundamental roles that adults adopt cross-culturally, yet, as this dissertation will show, the process of becoming a parent is culturally fraught with both meaning and privilege. In particular, I focus on the cultural tensions of biological parenthood, exploring what the biological relationship between parent and child means for various groups, and how the concept of biological parenthood is judged differently for those different populations. Specifically, I focus on young parents (who society deems unfit to both reproduce and to parent) and teen pregnancy prevention efforts, birthparents who relinquish infants for adoption (who society deems fit to reproduce, but unfit to parent) and the consequences for their lifecourses, and individuals experiencing infertility (who society deems fit to both reproduce and parent – but challenges their ways of achieving either) and their interactions with the biomedical model and healthcare system. From each population, we can gain more nuanced insight into the role of biology in framing parenthood, and how society determines whose parenthood is “acceptable,” allowable, and supported. Finally, I draw specific recommendations from each piece, hoping to gain insight into how changes to sexual education, reproductive health advocacy, adoption policy, and the healthcare system can improve the outcomes for vulnerable, marginalized populations and legitimate the pathways to parenthood for all.

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Chapter 1
Introduction
The Meanings, Challenges, and Privileges of Biological Parenthood

Parenthood in contemporary culture is a tricky, contradictory concept. It is alternately glorified, condemned, avoided, pursued, presumed, and commodified. And, of course, within the tricky term “parenthood” there is both motherhood, and fatherhood, which we know are very different. There are attachment parents, helicopter parents, free-range parents (all of whom are invested in espousing their theory of raising children); there are working mothers and stay-at-home moms (who are often said to be “at war” with one another); there are deadbeat dads and unwed mothers (though rarely are those qualifiers inverted). There are movements devoted to the pursuit of parenthood for same-sex parents, for single-parents-by-choice, and for those experiencing infertility; there are movements devoted to conditional avoidance of parenthood through birth control and abortion; there is even a movement directly eschewing parenthood – the “childfree movement” (and do *not* refer to them as *childless*). In the end, there are “good” and “bad” parents (based on the way they are labeled by society at large), as well as good parents and bad parents (based on their skill as caregivers), and what makes them either good or bad rarely has anything to do with their race, class, gender, age, sexuality, religion, while what labels them “good” or “bad” frequently has everything to do those demographic categories most salient to their family.

Yet, before most individuals can spout their various parenting philosophies or demonstrate their abilities in childrearing, they must first become parents. Seemingly, this is a straightforward process: find a partner (or, at least, someone with a

complementary gamete to yours), have a sexual relationship, wait thirty-six to forty weeks (perhaps assembling a crib in the meantime), and then gaze adoringly at your new, genetically related offspring. This trite script will vary in infinite different ways, but for each person on this planet there was a corresponding pregnancy, and two corresponding genetic parents. Whether those parents will actually *parent* the child is an unknown, but biological reproduction is a mandate. And, when beginning with an absolute (sperm meets egg) and ending with infinite possibility (any conceivable family structure), there are bound to be culturally constructed ideals, privileges, and complications along the way.

I argue that current the contemporary script of biological parenthood (the genetic relationship of a parent to a child) carries two burdensome tensions: Parenthood is a commonly accepted mark of transition to adulthood, and children are the way of making a “couple” a “family” – as such, it is viewed as nearly universally desirable. Biological, genetic reproduction is the presumed way of achieving parenthood; it is the easiest way of becoming a parent, and it is the most desirable way of forming a family. However, because a genetic relationship assumes children will “become” their parents, those “undeserving” of reproduction should be discouraged from becoming pregnant and, if they do, from parenting their child (Tension 1). Furthermore, because we value the biological bond, it becomes selfish to “want” it too blatantly – in the same way Americans value money but (at least purport to) abhor greed and excess. Consequently, those who, in the face of infertility, pursue biological parenthood too eagerly are

similarly condemned (Tension 2). The consequences of these tensions, as well as additional challenges, are considered in Table 1.

Let us deconstruct the components of this cultural model, and its consequent cultural tensions. First, the idea of parenthood as necessary to the transition to adulthood. Parenting has long been viewed as central to adult development in American society (Tyler May, 1995; Gutmann, 1975; Duval, 1962). In a study on voluntarily childless individuals, Park (2002) identified many stigmas associated with those who do not have – and, more importantly, do not want – children. These individuals believe themselves to be viewed as self-centered, selfish, cold, materialistic, sad, inadequate, and deprived by their decision not to be a parent (2002: 30). While these stigmas may be changing – more neutral and positive opinions of childlessness are held by younger people, more educated people, and never-married people – the majority of people (57 percent) disagreed with the statement that childless people can have a “fully satisfying life” (Koropeckyj-Cox & Pendell, 2007). Many of these characteristics, such as selfishness, materialism, inadequacy, and lack of fulfillment imply a certain amount of immaturity, and, by extension, imply that either becoming a parent would force one to mature and abandon these traits, or that people who choose parenthood are inherently more mature than those who choose childfree lives. Either way, voluntarily childlessness is seen as either a cause or symptom of failing to successfully assume the full adult role.

These stigmas are at least part of the reason that voluntarily childlessness is very rare, with estimates of its recent incidence somewhere between 2.2 and 9.6 percent of women (Park, 2002). When parenthood is framed as a necessary part of the adult

transition, much like leaving one's parents' home, many do not question their reasons for becoming a parent; it is simply what's done. As one voluntarily childless man explained:

People are asking me, "why don't you have children?" and I would sometimes turn it around and ask them, "Well, why did you decide to have children?" And they'll look at me strangely. "I didn't decide to have children; you get married, you have kids!" And just try to get them to think about, this is a choice. And then explain to them that my choice was to not have kids. And yours was. And they usually go away looking confused. Sometimes I think they understand what I'm trying to say and other times they don't. (Park, 2002, p. 36)

This example reveals that for many, parenthood may not even be a "choice" – it is simply the desired, presumed norm that signals healthy adult development. This assumption, coupled with the fact that having children is seen as necessary to life fulfillment, contribute to a culture where parenthood is either pursued with conscious desire or, at least, accepted without much conscious realization.

The second part of contemporary parenthood scripts is the idea of biological parenthood as easily achieved and, consequently, presumed.¹ Essentially half (49 percent) of all pregnancies in the United States are unplanned, with 44 percent of this half resulting in a live birth (42 percent of unintended pregnancies end in abortion, 14 percent

¹ Of course, there are many families for whom biological reproduction is *not* the presumed pathway to parenthood, including sex-same couples and single individuals hoping to become parents. Indeed, the presumption of biological reproduction is a coupled, heteronormative ideal. Yet, I have chosen to limit my scope to discussing this heterosexual, coupled reproduction specifically *because* it is the presumption, even if the result is an exclusionary discussion. This decision is because *same-sex parenthood and single-parenthood-by-choice always involve extra "work."* As long as it takes a sperm and an egg to create new life, it will require a man and a woman to create a child. This conclusion by no means requires that a man and a woman are necessary to raise a child, but it does mean that same-sex couples and individuals are already operating at a disadvantage when they decide to become parents. (It could, of course, also be argued they have an advantage because they are less likely to stumble into an unplanned pregnancy, and thus more likely to be making careful, prepared decisions to become parents). These potential parents must either a) pursue adoption, and meet the social and legal criteria for doing so; b) pursue infertility treatment – regardless of whether or not they are medically considering infertile. In fact, by virtue of not having a partner with complementary gametes, such cases are usually referred to as "situational infertility." Regardless of what pathway they choose, these potential families are already violating the presumption of two-parent biological reproduction, so these cases are of minimal utility when trying to deconstruct that presumption.

in pregnancy loss). Ultimately, approximately 22 percent of births in any given year are the result of unintended pregnancies – over 1.4 million children annually (Finer & Henshaw, 2006). Additionally, infertility affects only 11.8 percent of women in the United States – a significant minority, but a small minority nonetheless (CDC National Center for Health Statistics, 2005). Biological parenthood is presumed because, looking at the numbers, it *ought* to be presumed; it is, by far, the most common way of becoming a parent. In fact, for most, it requires a significant amount of awareness and work to simply avoid biological parenthood, let alone to challenge it as the primary mode of family building.

Table 1.

Challenges to Biological Parenthood Model

Childlessness	<i>Challenges parenthood as necessary rite of passage and children as essential to definition of family</i>
Adoption	
Adoptive Families	<i>Denies presumption and desirability of biological relationship</i>
Birthparents	<i>Challenges biological basis for parent-child bond or reveals the extent to which social factors overcome that bond</i>
Infertility	<i>Denies ease of biological parenthood and reveals when the desirable can be desired “too much”</i>
Socially “Unfit” Parents	<i>Reveals the desire to want children like yourself to be a privilege based on social constructs rather than reproductive capacity</i>
Alternative Families	<i>Dismisses the presumption of biology through family structure (same-sex couples, single parent reproduction)</i>

The third premise worth examining is the desirability of biological reproduction, as opposed to other pathways to parenthood, primarily adoption. Adoption is still subjected to significant stigma and skepticism in today's society. Studies have shown that, in community-wide surveys not focused on those with direct personal experiences with adoption, 25 to 30 percent of respondents question the mental health of adoptees, and only 32 percent of respondents express unqualified support for adoption (Evan B. Donaldson Adoption Institute, 1997). Furthermore, 30 percent of adoptees believe that "people expect adopted kids to have problems," and 21 percent of adoptive parents report that "society in general does not understand adoptive families" (Benson, et al., 1994, p. 85). These biases are not limited to those within the community, but are also expressed by professionals involved in adoption research and practice (Wegar, 2000).

However, the most telling concerns are those expressed by prospective adoptive parents – individuals experiencing infertility, who are considering adoption. Miall (1987) revealed that these potential parents believed 1) that a biological (genetic) relationship is critical for love and bonding, and thus parent-adopted child relationships are lessened on these dimensions; 2) adopted children are "second rate" because of their unknown (and, sometimes unknowable) genetic and hereditary past; and 3) quite simply, that adoptive parents are not "real" parents.

In addition to these stigmas around adoption, there are logistical obstacles to its desirability. Adoption is usually very expensive. Private adoptions in the United States (for either domestic or international adoptions) range in cost from \$5,000 to over

\$40,000² (Child Welfare Information Gateway, 2004), making it prohibitively expensive for many families. Tax credits, which vary significantly by state, will go some way towards reimbursing adoption expenses, by never far enough to make them a non-factor. Such barriers make it less likely that potential parents will consider adoption as a “first choice” pathway to parenthood, thus making it more uncommon and doing little to help deconstruct the negative assumptions that continue to accompany adoption. Adoption then becomes a back-up plan when biological parenthood is denied, most frequently through infertility.

Thus, adoption and infertility are inextricably linked,³ leading to adoption being haunted by the “dual stigmata of infertility and illegitimacy” (Haines & Timms, 1985). Society is skeptical of both adoptive parents (because of the stigma of infertility, and the belief that they are not “real” parents), and adoptive children (because they have been “rejected” by biological families, and because birth parents are more likely to be of lower socioeconomic status than – and thus, genetically inferior to – potential adoptive parents). Furthermore, Kressler and Bryant (1996) argue that the history of secrecy and deception around adoption, as well as the decision of some adoptees to later search for their

² Foster care placements and adoptions are significantly less, ranging from \$0-2,500. However, these placements are not necessarily permanent, and frequently involve older children. Adoptive parents generally prefer infants and very young children.

³ Adoption and infertility are linked in popular conception, even when not in circumstance. Because the system of adoption has developed as a response to infertility, many of the same stigmas endure even if a particular adoption for a specific family is not a means of achieving parenthood after infertility. Furthermore, as previously mentioned, families led by same-sex couples or single-parents-by-choice are often considered as having “situational infertility.” Sex columnist, humor writer, and adoptive parent with his husband, Dan Savage writes of their first group meeting with other potential adoptive parents: “I opened my ten-pound notebook and peeked at the agenda: ‘Grieving Your Infertility.’ ‘Coping with Infertility.’ ‘Infertility and Its Impact on Adoption’ ... Infertility was never an issue for us, just a fact, so we hadn’t spent much time thinking about it, let alone learning to cope with it.. At this point, we were positive we should have skipped the first day. The boyfriend and I had accepted our infertility a long time ago, and sitting with the straight couples, we felt our very presence was mocking their ‘loss’” (Savage, 2000, p. 22).

biological parents, both contribute to the idea of adoptive families as “less than” biologically related families. Secrecy and search are thus both easily misconstrued to falsely conclude that adoptive families themselves recognize the inadequacies of their relationships: parents believe the adoption *should* be hidden, and adopted people remain unsatisfied with only knowing their adoptive parents. More likely, secrecy is derived from the stigma (to which is also contributes) and search is derived from a curiosity that does not challenge the legitimacy of the adoptive parent-child relationship. Following this faulty logic, however, it is best to legitimize the parent-child relationship and reduce the unknown by forming that relationship through biological reproduction.

Having found evidence for its ease, presumption, and desirability, we must then carefully consider these tensions pursuant to concepts of biological parenthood. As discussed, one of the common reasons that that this form of parenthood is desired is the hope of having children biologically similar to oneself; and, if not oneself, similar to the partner that one has chosen to be the other genetic parent of one’s children. For those that society deems unworthy of biological parenthood (largely because they themselves are deemed “undesirable” – based on their race, ethnicity, social class, etc. – and because of the view that children will essentially *become* their genetic parents), their path to parenthood is filled with roadblocks of scrutiny.

While very blatant eugenicist policies seem to have faded from prominence, practices consistent with these ideas remain. For example, King and Harrington Meyer (1997) found that women of varying socioeconomic statuses had greatly varying access to reproductive health services: poor women (particularly those on Medicaid) had broad

access to contraception, but frequently no access to infertility treatments; their middle class counterparts had much more access to infertility treatment, but sparse coverage of contraception. Furthermore, poorer women are more likely to receive from their physicians long-acting contraceptives such as Norplant and other implantable devices (Thomas, 1998). While social class clearly is a predominant factor, race and ethnicity also have significant effects: low-income black and Latina women of color were much more likely to have their motherhood discouraged by physicians who discussed the importance of limiting family size and options such as vasectomy and sterilization – although, in this study, the white comparison group was also more middle class (Downing, et al., 2007). These discriminatory medical practices, in addition to being against poor women, women of color, and women receiving public assistance, are against unmarried mothers and young mothers (Thomas, 1998). Frequently, these demographics are not even viewed as distinct descriptors – a mother can be described as young, black, poor, single, or on welfare, and any of the five will serve as a euphemistic stand-in for the others as well. This stereotype is the undeserving mother, one who should be discouraged from reproducing. I argue that this rejection is based in part on the belief that she cannot adequately support her potential offspring, but in part because such offspring will be – because they are biologically and genetically hers – like *her*, and like her similarly undeserving.

This tension deserves even further unpacking, particularly because strictly biological arguments are less and less likely to be made to keep this “undeserving” mother from reproducing. Such premises sound very much like heavily eugenicist, racist,

and classist assertions (probably because they are). If, instead, they can be cloaked as moral or economic arguments, they are more likely to carry more weight in contemporary discourse. Thus, arguments about “welfare queen” mothers costing taxpayer dollars, deadbeat fathers neglecting their moral obligations to their children, and out-of-wedlock childbearing rife with language of sexual promiscuity crop up. The most effective arguments, however, are those that manage to frame preventing reproduction as better for the mother and child (though, of course, prevention who leave us with only a woman – no mother, no child). Among those most susceptible to having their reproduction targeted as deviant are young mothers. The rhetoric of blame and tragedy around teen pregnancy masks the reality that most teen pregnancy prevention efforts are merely disguised ways of keeping poor women and women of color from having children in a way consistent with the cultural conditions under which they’re making such childbearing choices. Beyond infertile couples – who must justify the *way* they are pursuing parenthood, without necessarily justifying the *reasons* for doing so – these parents are routinely portrayed as undeserving of any form of parenthood.

To return to the explicit discussion of biological parenthood: the second tension – that of desiring biological parenthood, without over desiring it – is particularly fraught. This tension is most brought to light in the case of infertility patients, who continue to pursue pregnancy even as biology denies it to them. Popular discourse surrounding infertility is generally not accepting of individual’s right to pursue treatment, and resolutely opposed to providing insurance coverage for such procedures. In an online

discussion on *The Washington Post's* website specifically discussing coverage (Mundy, 2009), comments included:

It's a choice, not a right, to seek these treatments. I'd really like my insurance company to pay for a Botox treatment because I'm older and getting wrinkles. It's cosmetic, not life threatening. To many women, like me, who do not want children, it almost seems like a vanity project that is fed by emotion, the fertility industry and now TV... What happened to Darwinism and survival of the fittest?

Enough already! ... Here's a novel idea -- sometimes you can't have EVERYTHING you want in life and you should count your blessings.

Having your own biological children is not a right and I really wish more people would choose adoption or even becoming foster parents. It may be a more difficult route but it's also one that is very rewarding in the end.

If someone has tried for one whole year to get pregnant, that's not significant. The human body doesn't always work exactly on schedule, and rushing off to spend tens of thousands of dollars on specialists and invasive procedures because one doesn't get pregnant the instant one wishes to, is ludicrous.

Society doesn't accept infertility as a legitimate disease. That is because for most recipients, it isn't a disease -- they've just aged beyond the point were conception is supposed to occur.

These arguments are at the least judgmental, if not ignorant or simply incorrect. For example, infertility is based on biological factors other than age (or else it is not considered "infertility), and medicine has concluded that one year of failing to conceive does reflect an extremely low likelihood that that couple will conceive without intervention. Yet, regardless of their inaccuracies, these comments do reflect the many challenges that couples reported hearing from others while they attempted to resolve their infertility: Why don't you just adopt? Why do you really want to be a parent? Why

does this deserve to be covered by insurance?⁴ The accusatory tone of these questions suggests not only that this tension is real – with real consequences – but also that the larger culture does not *like* it has structured biological parenthood as desirable. In a society where alternate family structures are increasingly common and adoption (itself a challenge to biological parenthood) is seen as panacea for other social ills (particularly other challenges, such as the previously discussed “undesirable” parents). If adoption is to be celebrated, then taking great lengths to avoid adoption is to be vigorously condemned, even if it is consistent the presumed model of achieving parenthood. As a society, we desire a biological relationship between parent and child, but we do not like that we do so. However, only those who highlight that desire through their ongoing, active pursuit, feel the consequences of this tension.

Yet, for adoption to be an option at all, there must be some biological parents who either relinquish a child, or have that child taken away. What does this say for their biological relationship, for their parental rights? For parents whose children are removed for their own safety after demonstrated abuse or neglect, their rights are severed as a direct consequence of their actions, but not usually because of their expressed desire to no longer rear that child.⁵ However, for parents who place a child for adoption, that is

⁴ These are legitimate questions, and the infertility community does provide answers to them. Yet, widespread misinformation about infertility, along with high profile misuses of infertility treatments (such as “Octomom,” Nadya Suleman, a mother of 14 children born within seven years, including octuplets; or even Jon and Kate Gosselin, parents of twins and sextuplets, whose marriage very publicly dissolved on their reality television show) (Mundy, 2009), structure these challenges in a judgmental way that does not recognize the true experience of those with infertility.

⁵ Determinants of abuse and neglect (as well as institutional scrutiny of both) will vary greatly by race and class, so this is not to assert that all parents who face losing custody or parental rights are guilty in doing so – or that there are not a great many abusive and neglectful parents who maintain custody of their children without ever having their rights questioned. Regardless, *most* parents who lose their parental rights in this way attempt to regain them. *Most* parents who relinquish their rights through adoption do not.

frequently the only thing they are expressing: they cannot, at this time, parent this child in the way in which they believe this child deserves, or they do not feel that external factors are allowing them the option of parenting. Many times (but certainly not always, and certainly less frequently today), it has extraordinarily devastating consequences. The unique situations of birthparents can reveal two things: 1) *Why* would an individual relinquish their biological child to be parented by others? 2) What social forces are at play when this decision is made? If there are social influences encouraging adoption placement, why do these influence these parents? 3) What are the consequences of the legal severing of the biological parent-child bond? Solinger (2001) writes that adoption, particularly the “baby scoop” adoptions in the mid-twentieth century in the United States, amount to a denial of the birthmother’s motherhood:

The language these women use to express their anguish is powerful. In many cases it seems to suggest that what surrenders suffered was a near-fatal blow – a blow that struck at their *biologically grounded right* [emphasis in original] to be mothers of the children they bore and were forced to “give away.” Today many people are uncomfortable with or simply reject the idea that motherhood is essentially a biological phenomenon or status. Yet the stories here press us to consider the implications of this: women who become mothers in other-than-biological ways very often do so by depending on *other mothers* to provide them with children... We have seen that economic and cultural degradation can cancel a woman’s ability to assert the biological claim to motherhood. (pp.74-95)

These women have the right to biological motherhood *because they are biological mothers*. They may choose to waive that right; they may lack the power to assert that right; or they may have that right violated in coercive adoptions. However, the right to parenthood established by virtue of the biological relationship. The consequences for violating this right and for separating the biological parent and child do, as we will see, have enduring effects on the lives of those parents. While a person might become a

parent without a biological relationship with their child, if there is biological parent-child relationship, the experiences of birthparents show us that it is difficult – if not impossible – to not want to assume a parenting identity, if not a parenting role.

Clearly, birthparents are not the same as the “undesirable” parents due to the biological connection their children are presumed to be similar to them *and their children are desired*. In this way, birthparents are acceptable as biological parents, but not as social parents. Infertility patients are acceptable as the latter, but not the former. And adolescent parents are accepted as neither.

Given that biological parenthood is the (desired, presumed) norm for building families, should we, as a society, accept that, by constructing and enforcing these levels of scrutiny, it also becomes a privilege? If so, what are appropriate bases for allotting this privilege? And if not – is parenthood truly a right for everyone? To explore the meaning and privilege inherent in parenthood, particularly given the tensions of biological parenthood that have been discussed, I will use three discrete groups: adolescent parents, who face much ridicule and discrimination in response to their early childbearing; birthparents, who relinquished the parenting role of their biological children, and the consequences for their life courses; and couples facing infertility, for whom the pursuit of parenthood is continually challenged. Each of these populations falls within the gray area of one or more contradictions and must work to earn their parenthood in various ways – and not all of them do.

Chapter 2

Finding a Way to Offer Something More: Reframing Teen Pregnancy Prevention

Advocacy organizations have consistently framed adolescent pregnancy as profoundly and enduringly detrimental for young women, their families, and their communities, despite equivocal evidence about the causal relationship between young maternal age and poor outcomes. Without this attribution, logic mandates that such organizations find more evidence-based justifications for teen pregnancy prevention that still address the lived experiences of populations most at risk for early parenthood. If such evidence-based justifications continue to be lacking, it is unlikely that these well-intentioned efforts will truly have a beneficial impact on the communities with which they are concerned. This paper presents such justifications, including recognition of the challenges inherent in parenting and protection of adolescence as a developmental stage; the need to make pregnancy prevention more accessible for those who chose it; and overall investment in adolescent sexual health. From this new paradigm, sexual health advocates can build a class-conscious model of sexual health that recognizes the necessity of providing more options for at-risk youth, the appeal of models of conjoint agency, and the necessity of comprehensive health resources and sexuality education. By adopting a new framework for teen pregnancy prevention, the promise of prevention within a social justice movement can begin to be discussed.

KEYWORDS: Adolescents, Social justice, Public health policy, Pregnancy prevention, Sexuality education, Adolescent health

Traditional debates surrounding adolescent pregnancy prevention have focused on the means to the end: do we promote abstinence-based strategies or teach contraceptive use? What role should parents play and what role should schools play? How can we make messaging more salient to different racial and ethnic groups? Each of these dilemmas examines *how* teen pregnancy is best prevented, without questioning the *why*. In policy and advocacy discourses, *why* is somehow understood: teen pregnancy is

risky for all of those involved. Compared to women who delay childbearing, teen mothers are more likely to end up on welfare. The children of teen mothers are at significantly increased risk of low birthweight and prematurity, mental retardation, poverty, growing up without a father, welfare dependency, poor

school performance, insufficient health care, inadequate parenting, and abuse and neglect. (The National Campaign to Prevent Teen Pregnancy, 2001, p. 1)

Similarly, the teen pregnancy prevention organization The Candie's Foundation states it more succinctly: "the mission of The Candie's Foundation is to educate America's youth about the *devastating consequences* of teenage pregnancy [emphasis added]" (The Candie's Foundation, 2010). With such a slew of undesirable outcomes presumably following closely on expectant teens' heels, it seems no wonder that the motivations for prevention remain largely unquestioned. Unfortunately, however, this discourse – widely embraced by well-meaning, liberal-seeming nonprofit organizations – is largely unsupported by academic research.

Research findings reveal that when appropriate comparison groups (such as sister, one of whom became a teenaged parent, and the other who did not) are chosen, there is no association between poor infant and child outcomes based on young maternal age (Geronimus, 2003; Geronimus & Korenman, 1993; McCarthy & Hardy, 1993; Furstenberg, et al., 1987). In high poverty communities, where adolescent motherhood is most common, young maternal age was a *protective* factor against low birthweight (Rich-Edwards, 2003; Rauh, et al., 2001; Geronimus, 1996) and infant mortality (Geronimus, 2001). Some evidence indicates that children of teen mothers score as well, if not better, on measures of cognitive development from preschool through early adolescence (Moore, et al., 1997; Geronimus, et al., 1994); other research shows some disadvantage, but estimates the magnitude of early childhood effects at "only about one-tenth of a standard deviation" below outcomes of children born to mothers in their early twenties (Manlove,

et al., 2008). Yet still: “when social, economic, or demographic factors are controlled, many findings diminish or go away” (Manlove, et al., 2008, p. 196).

If consistent adverse effects for children are lacking, what about the impact on the future of the young parents? Furstenberg (2007) writes: “popular accounts in the media, the views often expressed by advocates, and even professional writings, overstate the costs to young mothers when taking fuller measure of their circumstance prior to parenthood” (p. 53). When compared to all youth, young parents *are* markedly disadvantaged – however, not all young people come from background placing them at risk for young parenthood, making the comparison an inherently flawed one. When women who were teen mothers are compared to either their sisters who were not teen mothers (Geronimus & Korenman, 1992) or to young women who had miscarriages as teenagers (Ashcraft & Lang, 2006; Hotz, et al., 2005), the results are much different. Hotz, et al. (2005) found no effects on future fertility, marital status, or hourly wages; significant effects on number of hours worked and incidence of living in poverty were *beneficial* for young parents: “estimates indicate that the incidence of poverty for women who began their childbearing as teens would have been 0.58 times *more* likely to live in poverty over this period of their lives [twenties and early thirties] if they delayed their childbearing until adulthood” (p. 709). Furthermore, estimates show that earlier childbearing does not necessarily increase net public assistance expenditures; once young mothers are over the age of 22, they show a slightly *lesser* participation public assistance compared with peers who were not teen parents (Hoffman, 2008; Hotz, et al., 2005). Additionally, for young mothers who later marry, spousal and family incomes are

significantly higher (compared with non-mothers who later marry) (Hoffman, 2008; Ashcraft & Lang, 2006). However, young mothers are slightly less likely to earn a high school diploma, a deficit they compensate for with increased completion rates of graduation equivalency degrees (GEDs) and increased number of work hours in early adulthood (Hotz, et al., 2005, p. 713). These findings hold true even for teens with multiple pregnancies (Ashcraft & Lang, 2006). Thus, even with modest adverse effects on education, young mothers' GED completion and work experience eliminates any adverse effects on wages, public assistance, or poverty later in life. Hoffman (2008) does suggest that for more recent cohorts of young mothers, the beneficial effects of earlier childbearing are minimized and completion of a GED is not fully offsetting to the adverse effect on high school completion. What these data tell us is that while some adverse effects may exist immediately after a teen birth, the effect of early childbearing over the life course is relatively benign, if not beneficial – although these more recent cohorts of young parents are less likely to experience beneficial effects.

And what about the fathers? Considerably less data are available on young fathers and their outcomes, though the research that has been done indicates similar outcomes to those of young mothers: “early entry into fatherhood is associated with lower levels of schooling, lower actual occupational income, and fewer hours worked in the labor market” (Brien & Willis, 2008, p. 148), though these negative effects are significantly mitigated when controlling for background characteristics. These results aside, considerations of early fatherhood are complicated by two factors. First, young men have more varied levels of relationships with their children than young women do.

A father can improve his outcome in terms of lifetime earnings by never establishing legal paternity and providing no support for his child, or even by not marrying the child's mother, not establishing residence with the child, and providing minimal (or lessened) support (Brien & Willis, 2008). However, this outcome results in lesser resources for the child and a greater cost for society. The second complicating factor is that most teen mothers are not partnered with other teenagers: 65 percent of teen mothers have male partners over 20 years old; in 1988, 12 percent of births were to teen mothers, but only 5 percent to teen fathers. Furthermore, fathers are quite often older than mothers, even when they are both teens (Landry & Forrest, 1995). The implications here are that there are fewer teen fathers; they are likely to become parents later than teen mothers (and thus have any disruption due to parenthood later in their schooling or job experience); and they have the greater ability to "walk away" from the situation and feel even fewer costs to themselves. Each of these factors complicate a straightforward understanding of the impact of young fatherhood, but make clear the implications for interventions which will be discussed later.

Overall, these data reveal that many of the negative outcomes presumed to be inherent in adolescent pregnancy are better attributed to the effects of family poverty (Dodson, 1996; Furstenberg 1991), racial health disparities (Rauh, et al., 2001), and other sociocultural factors. Furstenberg (2007) writes: "Rather than being a primary source of social disadvantage, early childbearing is better understood as a product of disadvantage" (p. 73). Over half of teen mothers grow up in families with very low socioeconomic status, and more than 80 percent live in poverty or near-poverty before even becoming

pregnant (Luker, 1996; Alan Guttmacher Institute, 1994). Adolescents living in high poverty neighborhoods are more than twice as likely to experience teen pregnancy than those living in low poverty neighborhoods, even when controlled for factors such as family income, race, and parental education level (Harding, 2003), an effect which is exacerbated by proximity to more advantaged neighborhoods (South & Crowder, 2010). Poverty and its correlates of low-level education and high unemployment all make adolescents significantly more likely to become parents (Kirby, et al., 2001).

As always, issues of class disparity are further complicated by racial disparity. As of 2006, when compared to their non-Hispanic White peers, the birth rate for non-Hispanic Black teenagers was 2.3 times higher and the rate for Hispanic teenagers was 3.0 times higher. Furthermore, babies born to non-White mothers are less likely to receive comprehensive prenatal care and are at an increased risk for prematurity, low birthweight, and low Apgar scores (National Vital Statistics Report, DHHS, 2009). Such disparities cannot appropriately be attributed to low maternal age. True to the dictum that correlation does not prove causation, the underlying structural factors that make a young woman both more likely to become a young mother *and* more likely to face health risks and long term challenges should be examined.

Of course, not all teen pregnancies lead to teen parenthood, and the rates of abortion among teen pregnancies tend to further compound the levels of disadvantage among teen parents. Young women from more privileged backgrounds, as well as higher-achieving young women from disadvantaged backgrounds, are both more likely to choose abortion (rather than parenthood) as a response to unintended pregnancy; they are

also less likely to have an unintended pregnancy in the first place (Luker, 1996; Blum & Resnick, 1982). Even while overall abortion rates have declined, the abortion rates for all women making below 200% of the poverty level increased, with the abortion rate among poor teenagers increasing the most substantially (Jones, et al., 2002). This finding is because poor women have much higher pregnancy rates (including higher unintended pregnancy rates), resulting in both higher abortion rates and higher rates of unintended birth. Finer and Henshaw (2006) found that women living below 100% of the poverty level, when compared to women living above 200% of the poverty level, had a pregnancy rate 2.3 times higher, an unintended pregnancy rate 3.8 times higher, an abortion rate 3.2 times higher, and an unintended birth rate 5.2 times higher (p. 93). Thus, more affluent women (including privileged young women) avoid unintended birth through both pregnancy prevention and abortion, while still maintaining lower abortion rates than their disadvantaged peers. Consequently, the socioeconomic disparities found in rates of teen pregnancy are – by virtue of which young women are most likely to terminate a teen pregnancy – exacerbated even further in rates of teen parenthood.

Even closer examination of these disparities reveals that, for the profoundly disadvantaged, young childbearing might even be an adaptive response to the high health risks and available life courses (Furstenberg, 2007; Furstenberg, 1991; Geronimus, 1990). Indeed, following the “weathering” hypothesis, Geronimus’s research (2001, 1996, 1992*b*) has shown that the reproductive health of poor women, particularly poor Black women, begins to decline earlier than their more advantaged counterparts. For these women, teen parenthood actually provides their children with a survival advantage

(Geronimus, 1992*b*) and lowered odds of low birth weight (Geronimus, 1996). Such disparities are the result of lifelong social and economic disadvantage, and structural barriers to preventative healthcare and well-being (Geronimus, 2001). Furthermore, expectant young mothers tend to have very extensive backgrounds of childcare experience, caring for younger siblings, cousins, nieces and nephews; similarly, they expect other family members to take on active roles in caring for their children (Geronimus, 1992*a*). This integrated family care structure (providing both social and material support) may, in fact, be reduced for women who choose to delay parenting. A full understanding of the ways in which earlier parenting can be understood as adaptive for truly disadvantaged populations forces one to recognize the myriad of social, cultural, and economic factors that influence the reproductive decisions of young people.

Why then, given this substantial evidence – little of which is new – are advocates (who purport to have the best interests of adolescents at the core of their work) so devoted to casting adolescent pregnancy as inevitably devastating for young parents, children, and communities? Luker (1996) details the lengthy history of the construction of teen pregnancy as problematic. She identifies three keys frameworks for the prevention models: 1) the presentation that teenagers most at risk of childbearing are, by virtue of their age, race, or socioeconomic status, not ready to be parents, and preventing pregnancy protects society from having to compensate for less than fully-prepared parents (the “fitness” argument); 2) most teenaged parents are not married, and the appropriate forum for creating families is solely within the context of marriage (the “bastardy” argument); and 3) adolescence as a developmental stage is an inappropriate

phase during which to make the decisions required of autonomous adults and parents, and teenagers should be protected from needing to assume such roles too early (the “adolescence” argument). Historical analysis reveals many key tenets of these motivations for prevention to be flawed.

Regarding the fitness argument (Luker, 1996), the variables that diminish fitness are either immutable (such as race) or unlikely to vary (such as social class), rendering judgments of fitness truly discriminatory. If a woman is poor, and in America therefore likely to be low-income for the duration of her life, does she not have the right to bear children? Jencks and Edin (1995) examine precisely this question, evaluating various myths that influence policy: that if teen mothers delayed childbearing, those same women would not need public assistance when they had their children later; that if single mothers got married, they would not need assistance; and finally, if teen mothers completed high school, that they would be able to access employment that paid them well enough to not need assistance. The authors find all of these conclusions to be faulty. The common bottom line here is money: if we believe that young parents cost taxpayers more money, we are more likely to judge them to be less fit parents. Yet, as discussed, the evidence here is equivocal, and few would actually advocate that poor people should be permanently childless. Fewer still would advocate enforcing measures necessary to prevent those who want to parent from doing so – such as the historical practices of forced sterilization or contraception, or coerced relinquishment for adoption – and certainly the Supreme Court would have something to say about it if they did. Thus, we cannot evaluate fitness based on poverty, as morality, practicability, and constitutionality

all defy it (Jencks & Edin, 1995). If teen parents are judged to be “unfit” for reasons other than being poor, it certainly should not be by virtue of their age, as young parenting has been the social norm for far longer than delayed parenting has been. The best response to the fitness argument is to equip parents with the resources necessary to assist them in parenting, not deny them the opportunity to ever have children.

The bastardy argument (Luker, 1996) may seem of greater irrelevance in contemporary American society, where 38.5 percent of births (1.6 million babies in 2006) are by unmarried women, with the rate increasing every year (National Vital Statistics Report, DHHS, 2009). However, motherhood before marriage has long been viewed by poor women as adaptive, thus making the stigma attached to illegitimacy inapplicable to their circumstances. The delaying of marriage (and most single mothers do marry at some point, if not to the father of their first child) comes from a number of factors: the belief that the mother-child bond is paramount and married relationships with the child’s father are secondary; the (often accurate) view that marriage will *not* increase economic stability or even solidify the relationship; the diminished number of marital partners in poor – and predominantly Black – communities, due to high levels of violence and incarceration amongst young men; and finally, the idea that marriage can be postponed into ones mid- to late-thirties, but motherhood cannot (Edin & Kefalas, 2005). These patterns represent more than different social norms amongst low-income and racial minority communities, revealing very different lived realities for these groups, which are reflected in their reproductive strategies. Furthermore, children born to unmarried parents do not necessarily have less parental involvement than children whose parents

divorce. Never-married fathers see their children more frequently than divorced fathers who have subsequently remarried (McLanahan & Sandefur, 1994). Other than a vestigial and fading social stigma attached to illegitimacy, the bastardy argument as a motivation for prevention has less relevance than ever before, while it already had very little relevance for poor women.

Of the three historical foundations for preventing young childbearing, the adolescence argument seems to carry the most legitimacy. Certain aspects of this motivation will be discussed and incorporated into new models later in the paper, but there are noteworthy caveats to the execution of this model that should be avoided. Adolescence, as a developmental phase, is a historically new model developed only within the past century (Luker, 1996). For young women especially, adolescence was defined as time in which they were in need of protection. As sexual and social mores began to change, “young unmarried women had become potent symbols for the dangers of uncontrolled sexuality” (Nathanson, 1983, p. 75). The “need” to control this sexuality led to narrow ideas of purity, chaste courtship, and prohibitive levels of stigma surrounding premarital sexuality and non-marital motherhood (Fessler, 2006; Nathanson, 1983). While the overt discourse was about protecting youth, the subtext was more concerned with fears of sexuality and the upholding of male-led marriages and families.

Yet, the concept of adolescence, and the idea that young adults are characteristically – physically, psychologically, and emotionally – distinct from adults, has taken root so thoroughly because it is, in many ways, absolutely true. Psychological research indicates that adolescents are at a distinct stage of neurological, cognitive, and

emotional and affective development compared to adults, with younger teenagers, of course, being even further from developmental maturity (Johnson, et al., 2009; Giedd, 2008; Steinberg, 2005; Steinberg & Cauffman, 1996). Furthermore, laws to protect teenagers by regulating work force participation or by raising ages to consent to marriage and sexual relationships have taken strides to preserve the youth of the country from having to assume adult responsibilities before they should have to. However, such protections also undermine the capabilities of teenagers who do assume such responsibilities, and lose sight of the fact that young parenting has been the norm for a much longer proportion of human history than it has not. If contemporary culture has (with good reason) determined that adolescence is not an appropriate phase during which to parent, that reasoning should not be used to cast young parents as inept or incapable as a means of encouraging prevention. Instead, it should be used as a means of encouraging more widespread social support for those parents, whom society has determined are more in need of it by virtue of their youth.

History shows that many of these strategies for prevention are, at best, out of touch with the lived realities of the young women most likely to become young mothers and, at worst, subversive towards the efforts of young parents and low-income families. Many of the justifications are rooted in sexist notions about controlling young *girls'* sexuality, about regulating young *motherhood*, and about the stereotypes of hyper-fertile, sexually permissive, welfare-dependent (Black) *women*. Both the burden to prevent teen pregnancy, and the blame when it is not, are frequently placed on the shoulders of the female partner. This social construction of adolescent sexual relationships has

traditionally excluded, or least not focused as much upon, the roles of young men in pregnancy prevention. Ultimately, the desire to prevent such pregnancies is rooted in concerns about appropriate sexuality, poverty and class, accountability and deservedness, and, ultimately, racism, classism, and sexism.

Given this history, is preventing teen pregnancy the right goal? Should we abandon the goal of prevention entirely? The evidence previously cited would lead us to conclude that there is little to be gained from prevention, as there are extremely minimal adverse effects to young parenthood for those that actually become young parents (and, for some young people, adverse effects to delaying parenthood). Given the prevalence of narratives on the detriments of teen pregnancy, it seems truly counterintuitive for well-meaning advocates and policymakers to fundamentally question this focus. Yet, the conclusion is inevitable: *teen pregnancy prevention is not the most important goal*. Indeed, prevention is only useful if it is subsumed within broader discussions of overall reproductive health and anti-poverty efforts. When properly framed, what the idea of “prevention” (although inadequate in and of itself) offers is a way of bringing these dialogues together, a point of intersection for discussing adolescence, reproductive health, and poverty. Were prevention goals abandoned entirely – instead of being reframed in ways the following discussion will detail – it is possible that the needs of those most at risk, marginalized populations would be ignored.

In order to help disadvantaged youth (whether or not they become young parents), efforts must both reflect the realities of youth in poor America and attempt to influence their lives in a constructive way; sexual health models must break with the rigid

prevention-centric framework and come up with productive ways of offering something more by delaying parenthood. Tentative models are as follows:

1. All parenting is challenging; parenting in poverty is extremely difficult. *These challenges and hardships are worth trying to delay; adolescence, both as a developmental stage distinct from adulthood and as a social phase for exploring one's potential future pathways, is worth protecting.* Contrary to conventional wisdom, young parents have proven themselves capable of meeting many of the challenges of parenting. That ability does not mean they should have to. The challenges of raising a low-income family: negotiating work-family conflict; navigating public benefits; protecting one's family from more dangerous neighborhoods, less safe childcare and schools, and high surveillance from protective services – the list goes on. While such challenges will never be easy, and will be difficult for the populations at risk of adolescent pregnancy to ever avoid (regardless of when they become parents), we can still argue that adolescents ought to be able to live more years of their lives without these challenges.

Such a model parallels the adolescence argument analyzed and found wanting by Luker (1996). However, if the paradigm is shifted so that teens are protected not because of their incapacabilities, irrationality, or immaturity, or because of fears of their sexual development, but because they deserve the opportunity to experience adolescence free from the responsibilities of parenthood, the messaging becomes more salient to teens themselves. It

becomes liberating rather than limiting, a positive message rather than a negative one.

There are, however, arguments to be made that childbearing – regardless of age – brings more joy than challenges, and that having children serves as a motivating factor for young parents to achieve academically and professionally (Lipper, 2003; Dodson, 1999). What, then, is there to protect them from? Here, the challenge is not one for the potential young parent, but rather for the advocates working to prevent pregnancy: what additional joys, motivations, and opportunities can we offer youth instead? This point will be discussed later in the paper.

2. *In ways far less significant than those commonly understood, young parenthood can potentially limit the future prospects of the young parent and their child.* Though evidence is mixed, some research indicates that children of teen parents show small, but significant, disadvantages in regards to early cognitive development and behavioral outcomes (Manlove, et al., 2008). Furthermore, young mothers complete about two fewer years of schooling than women who delay childbearing at least until thirty years old (Hofferth, et al., 2001). Furthermore, these years are frequently lost at critical early stages, preventing a young person from earning a high school diploma, technical school degree, or having any college education, (rather than the less economically-consequential loss of not having an advanced degree beyond college). The earlier the childbearing is, the earlier the potential loss of

schooling and the more profound the consequences. Presumably, these limitations could be overcome by better social support for young parents, but as such supports are not currently in place – and are unlikely to be in the near future – the limitations are worth acknowledging and avoiding, while still being kept in perspective.

3. In the attempt to offer adolescents a full range of choices regarding their sexual health and lifecourse, *educating about ways to prevent young pregnancy will make delaying childbearing a more accessible option for those who recognize pregnancy prevention as the most adaptive decision for themselves*. This model most readily applies to middle and upper social class adolescents, who can immediately recognize the ways in which early childbearing would disrupt their determined (and often, prescribed) life courses through adulthood (Geronimus 2003). Additionally, for the majority of poor teenagers who see delaying parenthood as a means to class mobility, as a way of preserving a wider range of future options for themselves, or as simply the best decision for themselves at the time, prevention efforts must provide them with all the requisite information to do so.

It must also be recognized that, with nearly half of all pregnancies and a quarter of births in the United States being unplanned (Finer & Henshaw, 2006), “most teens do not want to become parents and are not ready to take on the responsibility of raising children” (Furstenberg, 2007, p. 161). Beyond that, most couples, regardless of age, do not want to be risking pregnancy on a

continual basis. These young people must be given the skills and resources needed to control their reproduction, so that they can continue to prevail upon that knowledge throughout the rest of their lives.

4. Because the means of pregnancy prevention often endorse less risky sexual behaviors, *preventing pregnancy becomes a way of preserving overall reproductive health and investing in the health of a vulnerable population.* For example, practices such as using barrier methods of contraceptives (particularly condoms), practicing abstinence, or delaying sexual debut not only prevent pregnancy, but lower risk for sexually transmitted illnesses, including HIV. Thus, efforts should be framed as a way of encouraging overall more healthful behaviors.

Each of these frameworks attempts to provide a way of thinking about preventing (or, perhaps more positively worded, “delaying”) pregnancy that is both constructive and goal-oriented, and more relevant to the lives of contemporary teenagers.

Prevention efforts demand a drastically different paradigm, one that will recognize the realities of contemporary adolescence, broaden options available to all teenagers, increase their capacity to make healthy decisions for themselves, and still empower them in their roles as parents if childbearing is not delayed. Such an outlook is a distinct change from current conceptualizations, and a new model – of which prevention is only a part – is necessary to improve outcomes and protect youth.

Towards a Class-Conscious Model of Adolescent Sexual Health

In trying to disentangle the complex questions of adolescent sexual health, Luker (1996) offers this complication:

The short answer to why teenagers get pregnant and especially to why they continue those pregnancies is that a fairly substantial number of them just don't believe what adults tell them, be it about sex, contraception, marriage, or babies. They don't believe in adult conventional wisdom – not because they are defiant or because they are developmentally too immature to process the information (although many are one or the other and some are both), but because the conventional wisdom does not accord with the world they see around them... Unless we can begin to understand that world, complete with its radically new circumstances, most of what adults tell teenagers will just be blather. (Luker, 1996, p. 11)

This gap – between the education adults offer and the world teenagers know – dilutes even the best intentioned efforts to communicate with teens about their own sexual health. For the youth most at risk for adolescent pregnancy, this gap is further accentuated by the fact that models of sexual health and appropriate reproduction are predicated upon middle class value systems and life courses (Geronimus 2003).

Tolman, et al. (2003) discuss the ways in which understandings of gender dynamics are critical to comprehensive models of adolescent sexuality: “how we conceptualize gender and sexual health influences research, education, and services for adolescents. Gendered conceptions of sexuality challenge the basic premise of equal access to the psychological, social, and material resources required to interact

[healthfully]. By not acknowledging unequal access, the model overlooks crucial barriers” (p. 7). For Tolman, these barriers are created by gender; she demonstrates that without a clear understanding of unequal access, models of sexual health are woefully inadequate. In regards to teen pregnancy, one of the most critical barriers is social class, but an understanding of sexual health that consider social class has yet to be fully developed. Consequently, reframing prevention efforts requires not just a shift to more empowering motivations, but a more class-conscious model of understanding adolescent sexuality.

Dominant American value systems adhere to the idea of the Protestant work ethic (Weber, 1930) and the American Dream, in which success is linked with motivation, competence, and morality; a lack of success implies a deficiency in one of these capacities: “success [is combined with] self-interest... the idea that the greatest good is to be as individually successful as possible” (Plaut & Markus, 2005, p. 471). Not only does this structure innately condemn those who fall short of ideas of privileged success, the focus on individualism is inconsistent with models of decision-making adopted by those in working class or poor communities.

Stephens, et al. (2007) discuss the ways that differing material conditions, available resources, and potential opportunities promote differing normative actions according to social class. Indeed, the high value placed on choice – as something determinative of personal agency and thus happiness – is, while overestimated by most individuals (Iyengar & Lepper, 2000), also inherently classed. Working class subjects were less likely to “choose to choose” (when presented with an option to accept a given

reward, or to choose from a selection of other possible rewards, none of which were known), and were more likely to respond to appeals that structured choice as an interdependent or social process. This interdependence is not meant to imply that working class individuals are less agentic, but rather that they understand agency in a very different way. Middle class individuals are more likely to adopt a *disjoint model of agency* that assumes action emanates from the individual, that “good” actions influence the environment according to personal interests, and that situations can and should be controlled by independent choice and action. In contrast, working class individuals are more likely to follow a *conjoint model of agency*, where agency is reflective of the obligations to and responses of others, and decisions are made more interdependently (Stephens, et al., 2009). This difference becomes problematic when those more empowered by the class hierarchy – who are more likely to adopt the disjoint model – perceive those following the conjoint model as more passive, less motivated, less effective, and consequently, less capable of making their own decisions. Stephens, et al. (2009) examine the ways these disparate models of agency can create unrecognized prejudice, as differing cognitive models are unlikely to be understood as the functions of class that they are. These differences have important policy implications: models of prevention that appeal to disjoint models of agency (primarily individual interests and personal advancement) are less likely to have resonance for the low-income adolescents that are most at risk for early childbearing and parenthood.

In addition to discrepancies in how choice is perceived and structured, there is a gap in the role sexuality and reproduction play for poor women and their middle class

counterparts. For example, Gregory (2007), in a work appropriately entitled *Ready*, describes the phenomenon of “new later motherhood” among the professional class of women. In the past three decades, the number of women aged 35 to 40 having their first child has increased ten-fold, for ages 40 to 44, it has increased thirteen-fold. For these women, delaying parenthood is a highly adaptive function; it allows them to a chance to establish themselves as individuals, complete their education, find an appropriate partner (or be empowered to choose single parenthood), achieve financial security, and make career choices that enable them to parent in a way they desired. All of these variables are viewed as *essential* to making them “ready” to be mothers, to the point that “the overwhelming majority of women viewed the choice to have children after 35 as *one of the most positive choices they had made in their entire lives* [emphasis in original]” (2007, p. 4). Moreover, the few women in this population who had working class upbringings consider delaying motherhood as critical to their upward mobility. This trend of later motherhood among the more privileged of society accomplishes two things: 1) it makes teenage mothers seem even younger by comparison, and thus even less competent and more in need of protection; and 2) it establishes that older motherhood is better without recognizing that, while delaying motherhood can be adaptive for some women, earlier motherhood may be adaptive for those that choose that as well. Most critically, this class divergence ensures a policy divergence from the realities of lower-income lives, as policy is always a better reflection of more privileged outlooks.

In contrast to these middle-upper class women, for whom delayed childbearing is a prescribed part of their lifecourse, poor women face very different realities. Their

future prospects are already diminished by the fact of their poverty. Less is compromised by young parenting, and there few readily available opportunities for them other than motherhood. This difference is not lost on the young women themselves. Describing her focus group interviews with low-income young women, Dodson (1999) writes:

In these discussions about early motherhood, I often asked young women and girls, “If you wait to get pregnant, wouldn’t that make a big difference? Wouldn’t that be much better?” One young girl, perhaps tired of my reiteration, answered, “Wait for what, what’s coming anyway?” Her companions watched me and waited for my answer. (p. 90)

This “what’s coming?” phenomenon is unfortunately fairly accurate. Few of these young women have been counseled about college or taken the SATs; they have not been taught about financial aid and need-blind admissions (Lipper, 2003). Post-secondary education is rarely an option that they even see, let alone for which they can hope and strive. They have little hope of accessing well-paying jobs or well-employed partners, and if they do, such ideas are far-off dreams, not realities that can be achieved by delaying a baby a few years: “There is another powerful force which shapes their acceptance of that future, and *that is the degree to which these millions of girls in poor America can imagine another life...* What if [other options] seem out of reach and foreign? Love here and now, family ties, and a baby envisioned are real to these young women” (Dodson, 1999, p. 89).

While their options may be narrowed to motherhood, this final option does not seem to be such a negative one. Motherhood provides (or at least is believed to provide) unconditional love, a new identity, a cemented relationship with the child’s father, and “a

sense of self-worth that comes from being vital to the survival of a tiny human being” (Lipper, 2003, p. 42). Though some of these reasons may be flawed, for many of these young women, “mother” is the most important role they will ever assume, and they see little reason to delay it. Why should they? What’s coming?

These arguments – about the Protestant work ethic, about cognitive modeling, about the “new later motherhood,” about the limited options available in low-income communities – may seem disjointed. In concert, however, they function to create the social realities in which teenagers make the choices they do, and in which young parenting is perceived the way it is. Each piece of the puzzle (and indeed, there are plenty more pieces to be considered) brings with it a way of understanding teen pregnancy and parenthood, and only by better understanding it can models be developed to better prevent it.

Based on all this seemingly disparate evidence, it becomes apparent that in order for sexual health models to effectively influence the behaviors they hope to influence, they must be more conscious of social class. Incorporating class recognizes *how* the young women most at risk for teenaged parenthood understand their options and shape their choices, and thus has far greater capacity to impact their behaviors. Strategies need to extend beyond traditionally understood sexuality education and prevention efforts to incorporate the following approaches:

1. *Find a way to offer something more; give low-income young women more options.* When they have grown up in communities where few opportunities for post-secondary education or well-paid (or even merely living-wage) jobs

exist, and where motherhood has become a way for women to assert themselves and assume more importance within that community, there is little incentive for delaying parenthood. There is real joy to be found in parenting, in addition to the challenges; in order to prevent pregnancy, young people must see that potential for joy in other available endeavors. When society makes an investment in their future, not merely by simplistically telling them to not get pregnant, but by offering them realistic routes out of poverty and into quality schooling and productive employment, these young people will have something to lose and will thus be more motivated to make the choices necessary to delay parenting until they have moved more towards self-sufficiency. When they ask the question “What’s coming?” the answer should be a resounding and realistic “something good.” As a means of prevention, this seems to be exceptionally broad in scope and slightly tangential: when young women have the potential for better futures, they will delay parenting in order to protect their own potential.

2. *Recognize and appeal to models of conjoint agency.* Disjoint models, which focus on individual agency and preserving future self-interests, are less resonant in low-income communities where decisions are made differently. This difference is critical. Effective efforts should engage communities and families as much as possible, so that communal agency supports the goal of prevention for the betterment, not just individual women, but the community as a whole. Additionally, when discussing the challenges associated with

young parenting, the impact on the entire family should be examined, as it will likely be a more persuasive presentation than appealing to individual interests for these most at risk youth. Indeed, it is frequently entire family networks that absorb the responsibility and financial cost of additional children (Furstenberg 2007), so the inclusion of a broader scope fits well with youth's experiences.

3. *Constructively work towards improving access to sexuality education (both in and out of school settings), reproductive health information, and health services including contraception and safe abortion.* Health and healthcare disparities are one of the primary reasons that low-income teenagers do not have necessary means to practice prevention in their sexual relationships. All teenagers must have access to the necessary information, both through comprehensive school curricula (see below) *and* through their families. Low-income families need to be able to provide their young people with accurate information, which includes not only having access to accurate information themselves, but having work environments that enable them to spend time with their children in order to establish trust and share their insights and beliefs. Furthermore, all teenagers should have ready access to affordable and effective contraception, regular interaction with healthcare providers regarding their reproductive health, and the ability to obtain legal abortions should they so choose. These are fundamental questions of reproductive rights and social justice, and without them, efforts to prevent any unintended

pregnancies – of which teenage pregnancy is only a small fraction – will essentially be moot.

Importantly, the mere availability of health services is not necessarily sufficient to reduce rates of teen parenthood. It does, however, provide young couples, as well as adults, with the resources they need to make the best, most adaptive plans for themselves and their families. Again, with 49 percent of all pregnancies in the country being unplanned (Finer & Henshaw, 2006), the greater availability of health services could lead to more informed intentionality about pregnancy and family planning – without dictating what those plans out to be.

4. *Make comprehensive sexuality education, including information about safe behaviors, relationships and communication, and sexual desire, a reality for all teenagers.* While the previous argument focuses on improving access to sex education, this goal is concerned with the quality of that education. This point applies equally to middle- and upper- income teens, whose class advantage does not necessarily ensure better sex education. Sex education must incorporate not only basic information on contraceptive and protective methods, but also help teens be able to communicate and negotiate with potential sexual partners in a way that ensures mutual respect and safety. Finally, education should recognize the unquestionable component of sexual desire. By empowering teens – especially teenaged girls, whose desire is often denied or stigmatized – to recognize and take control of their own desire, they will be more in control of their sexual behaviors (Tolman, 2002).

This idea, which seems almost intuitive in many ways, still makes (American) adults very wary. However, until desire becomes a part of the discussion, teenagers will have a less than fully comprehensive education, and consequently will be less prepared to make the best decisions for themselves.

These goals extend far beyond the typical scope of prevention models and, not only attempt to address the deficient class awareness of previous models, but to also create a more equitable environment in which youth develop as healthy, responsible adults and decision-makers. Class-consciousness requires understanding delayed parenthood as means of working towards social equality and justice – however, it is only one small piece of such an effort.

What, then, should such interventions look like? By broadening the scope of what is meant by “prevention,” advocates must similarly broaden the scale of the interventions themselves. To date, evidence on larger scale interventions has been mixed, but youth development programs and community-based education efforts provide insight into what is needed to build more class-conscious interventions. For example, vocational education and employment programs have not been found to reduce contraceptive use or teen childbearing (Kirby, 2007; Schochet, et al., 2000; Cave, et al., 1993; Allen, et al., 1990), however service learning programs (including engaged volunteerism in the community, paired with reflection on the experience, usually as a component of classroom learning) *did* reduce pregnancy during the school year in which students were enrolled in the program (Kirby, 2007; Melchior, 1998; Allen, et al., 1997; Philliber & Allen, 1992). The reason for this difference might be best attributed to the concept of “finding something

more.” When youth assessed that they were receiving training for low-wage jobs with limited potential for upward mobility, they had little to gain from delaying childbearing. However, when youth were engaging their community in new ways, forming new mentoring relationships, and reflecting on their ability to contribute to society, they chose to take greater measures to prevent pregnancy.

Additionally, community-level initiatives (which focus on both pregnancy and sexually transmitted diseases) have shown mixed results (Kirby, 2007), with the most successful programs being the most intensive ones. For example, one community in South Carolina pursued an initiative that

included the following components: teachers, administrators, and community leaders were given training in sexuality education; sex education was integrated in all grades in the schools; peer counselors were trained; the school nurse counseled students, provided male students with condoms, and took female students to a nearby family planning clinic; local media, churches, and other community organizations highlighted special events and reinforced the message of avoiding teen pregnancy. (Kirby, 2007, p. 157)

This intensive program *was* effective at reducing the teen pregnancy rate for the duration of the time that it was able to sustain interest and momentum in the program (Kirby, 2007; Vincent, et al., 2004; Koo, et al., 1994; Vincent & Schluchter, 1987). Similar programs with even more intensive school nursing components have also shown success (Vincent, et al., 2004), but the results of less intensive community-based initiatives has been mixed (Paine-Andrews, et al., 1999; Hughes, et al., 1995). Although even equivocal

progress in high risk communities, such as low-income housing developments, indicates the potential of such programs (Sikkema, et al., 2005) – if the community is willing to make a strong commitment to the continuation of such initiatives. The success of such programs appeals to the conjoint model of agency; when young adults see their families and communities as invested in their future – and, conversely, see their childbearing decisions as impacting their families and communities – that model of agency is prevailed upon.

An additional virtue of community-level interventions is that they include non-school age adolescents in the conversation. Basing community efforts outside of the schools broadens the conversation to include not only parents of teenagers and other adults with the power to influence teens' decisions, but older teens – 18 and 19 year olds still at risk for young parenthood, recent high school graduates successfully modeling non-parenting roles, and – most importantly – partners of younger teens. As Landry and Forrest (1995) have shown, the fathers of most children born to teen mothers are not teenagers themselves, and are thus out of reach of the public school system. By establishing the intervention on a community level, these partners – critical to the decision-making processes involved in preventing pregnancy – are brought into the ongoing conversation.

Beyond greater involvement and investment, Ashcraft (2008) shows how community-based programs have the potential to become a “powerful resource for better preparing students to participate in democratic life” (p. 637). She argues that sex education can be used as a vehicle to model personal responsibility, participatory citizenry, and a justice-based orientation, while also opening up discussions of race, class, gender, sexual

orientation, and, consequently, of privilege. Ashcraft finds that students involved in a program with this approach showed greater academic involvement and achievement, began the transition from “apathetic to activists” (p. 652). She writes: “Researchers would do well to challenge this frame and make clear the futility of talking about teen sexuality as if it were somehow separate from rather than integral to teens’ academic achievement, civic engagement, and future life chances” (Ashcraft, 2008, p. 662). This paradigm shift makes sex education a critical part of young people’s academic career. While Ashcraft does not address the program’s efficacy delaying childbearing, the potential for a class-conscious model to impact the lives of youth (beyond any knowledge of pregnancy prevention) is inherent in this broader understanding of sex education.

Finally, the most difficult factor to address is the intangible gain to be made from becoming a parent. There is real joy to be had in raising a child – even with whatever challenges that parent must face – and there is real motivational capacity that can be focused towards achievement when an individual must provide for someone else’s welfare. For the youth who experience this, what can we offer instead, if we are encouraging them to delay parenting? It is, perhaps, the most difficult aspect of young parenthood to counter, and it is one of the fundamental reasons some proportion of young women will always choose to be mothers earlier than others. Advocates can only hope that by creating a society in which real educational and career opportunities are available to youth, that the incentive to delay parenting is sufficient to influence young people’s behavior. Then again, if the incentive is not great enough, and the opportunities are not

real enough, youth will continue to place little in jeopardy by choosing young parenthood.

Ultimately, the most promising interventions look very little like straightforward prevention efforts: service learning programs and youth involvement, educated and passionate community leaders, an accessible and engaged healthcare system, and the development of active, democratic citizens. These are not simple sex education classes and condom demonstrations. These interventions are the basis for real social change.

Prevention as Social Justice, Social Change as means of Prevention

Recasting prevention efforts to better reflect the lived experiences of those most at risk for early childbearing will not only make them more effective, but will provide a basis for prevention other than the derision of young parents. We know that the young parents who are most successful are those that receive support – primarily from their families, but also from public programs that help capitalize that family support (Furstenberg & Crawford, 1978). When prevention is framed in a way that demonizes these individuals, support is less likely to be forthcoming, and the challenges of early parenthood are compounded. Thus, reframing prevention benefits all young people, regardless of whether or not they are already parenting.

There is strong evidence showing that as material conditions improve and more options are made available, the age of new mothers rises. The less poverty in a society, the lower the rates of teen pregnancy (Low, et al. 2008; Singh & Darroch, 2000; Jones, et al., 1985). Harder to examine is the inverse relationship: delaying parenting may serve as a means of class mobility for both individuals and their families. However, if prevention

models do strive to assume a more class-conscious approach, creating opportunities and empowering young people, it seems logical that those same teenagers will have more potential to achieve more for themselves.

Delaying pregnancy and alleviating poverty should not be viewed as distinct goals: working towards the latter may ensure former, and working towards the former *could* better accommodate the latter. While Furstenberg (2007) writes that traditional prevention efforts “could not deliver on [fighting poverty or strengthening families]” (p. 162), it is precisely *because* “policymakers failed to account for the fact that the timing of first births among highly disadvantaged women is largely a marker of, not an important causal factor in shaping, the life course of low-income women and their children” (p. 162). Thus, efforts have previously failed to achieve this goal precisely because they failed to fully respond to the class-based realities that lead to early childbearing in the first place. Only by reframing prevention within the context this class-conscious model can advocates hope to be effective in either delaying pregnancy *or* contributing to upward social mobility.

Furthermore, pursuing the two goals simultaneously sidesteps the concern that young childbearing might be healthier (Furstenberg, 2007, 1991; Geronimus, 2001, 1996, 1992*b*, 1990), as ameliorating poverty would minimize adaptive advantages of early pregnancy. However, advocates and policymakers must recognize that without addressing the concerns of poverty and disadvantage, traditional pregnancy prevention efforts are not only unlikely to work – they have the potential to do a grave disservice to the population they are attempting to serve. Such work is not productive social change,

and it will not move society towards greater reproductive justice. It is not, then, simply more useful to include a class-conscious model: it is imperative if advocates hope to create positive change and improve the lives of young people.

In extension, true social change is the best way to prevent young pregnancy. Better employment conditions allow low-income parents to more effectively manage work-family conflict, providing them with more opportunities to mentor their children on their options. Improving healthcare access makes the range of options more available to all people, including teenagers, so that they may better execute pregnancy prevention. Increasing affordable options for post-secondary education or job training programs that youth are actually passionate about allows youth to invest in their futures, and provides them with internal motivation to delay parenting. Teen pregnancy is not as isolated issue and it must be understood within the wider context of social complexities and inequities, all of which need to be effectively addressed. The point of these arguments is not to make teen pregnancy prevention seem to be an insurmountable challenge, but rather to cast it within its appropriate scope. Efforts must empower rather than disparage young people, they must consider (if not directly address) the underlying social causes, and they must always remember that preventing teen pregnancy is only one step in finding a way to offer teens something more.

Chapter 3

Birthparents on Adoption: Trauma, Openness, and New Definitions of Family

Within the adoption triad of adoptees, adoptive parents, and birthparents, the latter are least frequently given an ongoing opportunity to voice their lived experiences within the adoption system. Through 42 in-depth interviews and qualitative analysis, this paper provides insight into the evolving birthparent experience, on both a historical timeline that documents changes to the system of adoption as a whole, and a personal timeline that documents individuals' experiences as a birthparent over their lifecourse. From their narratives of adoptions spanning nearly fifty years, these birthparents provide insight into the traumatic potential of coercive, closed adoptions, the evolution of openness in adoption, and what elements of openness are truly protective of birthparents' well-being. Their insights and policy recommendations require both a new concept of adoption, and a new idea of kinship relationships following adoption.

KEYWORDS: Adoption, Trauma, Open adoption, Parenthood, Motherhood, Family structure

History of Domestic Infant Adoption

Between 1945 and 1973, 1.5 million infants in the United States were surrendered for non-family adoption (Fessler, 2006), with over 170,000 being placed in the peak year of 1970 alone (Stolley, 1993). During these several decades, rates of premarital intercourse rose from 39 percent in 1950 to 68 percent in 1972 (Hofferth, et al., 1987), while contraception remained largely inaccessible for unmarried couples, and abortion remained illegal (May 1999). Unsurprisingly, these combined factors led to an increase in non-marital pregnancies as compared to previous generations. In response, the postwar era showed the establishment of maternity homes for unwed mothers (Solinger, 2000), which made adoption a much more common option for families. The sum of these factors, themselves heavily culturally determined, combined with cultural ideals of conformity, acceptable sexuality, and appropriate parenthood, led to astonishingly high domestic adoption rates that have not been seen since.

At this time, non-marital pregnancy – as a marker of premarital sex – was viewed as shameful and secretive. From this stigma and fear, expectant young women were left with few options *other* than adoption, which became the culturally-dictated means for addressing such pregnancies. As one unmarried mother commented: “I was from a small town, so I didn’t tell anybody because in 1968 you were considered trash if you were pregnant. The symbol of being a good, white, middle class family was a lily-white daughter” (Fessler, 2006, p. 31). The adoptions resulting from these pregnancies were always closed (meaning there was no ongoing contact between birthparent and adoptive family post-adoption), frequently coercive, and usually traumatic for the young woman.

Yet, as troubling as this recent history is, does it have much relevance when discussing adoption today? Nearly 4 in 10 births in 2007 were to unmarried women, a rate 2.5 times higher than in 1980 and 19.0 times higher than in 1940 (Ventura, 2009). Abortion is legal nationwide, and has been for nearly forty years; contraception is legal and far more accessible than in the past. Young women today have more opportunity to avoid unintended pregnancy, have options besides giving birth if they do become pregnant, and would not be considered particularly deviant if they did become mothers before (or without) marrying. Despite these changes, however, in many ways adoption has not similarly evolved with the changing historical context.

It is important to look at who relinquishes children, both in the past and today. Between 1945 and 1973, when an unmarried woman became pregnant, the most frequent response was to get married. Before 1973, of the number of children *conceived* out of wedlock, 47.7 percent were *born* to married women. Among the remaining percentage

born to never-married women, 8.7 percent were relinquished for adoption. Notably, there are tremendous racial disparities in both of these rates: 64.2 percent of White women who became pregnant out of wedlock married before birth, compared to only 20.9 percent of Black women. Black, unmarried women surrendered only 1.5 percent of the time; White unmarried women surrendered 19.3 percent of the time (Bachrach, et al., 1992). These differences provide insight into why women were led to surrender and the cultural forces that influenced, if not determined, their choices.

The post-World War United States was, of course, a tremendously racist and racially segregated society. It is not surprising then that, when faced with White, unmarried pregnant women and Black, unmarried, pregnant women, the culture had two drastically different responses:

White women in this situation were defined as occupying a state of “shame,” a condition that admitted rehabilitation and redemption. The pathway was prescribed: casework treatment in a maternity home, relinquishment of the baby for adoption, and rededication of the offending woman to the marriage market... Black women, illegitimately pregnant, were not shamed but simply blamed, blamed for the population explosion, for escalating welfare costs, for the existence of unwanted babies, and blamed for the tenacious grip of poverty on blacks in America. There was no redemption for these women, only the retribution of sterilization, harassment by welfare officials, and public policies that threatened to starve them and their babies. (Solinger, 2000, p. 25)

Unmarried and pregnant Black women were viewed as sexually uncontrolled and deviant, but by no means a challenge to the cultural hegemony, as they were considered beneath concern (beyond serving as a scapegoat, of course). For this reason, while hardly a *protective* factor, race excluded Black women from the cultural pressure to surrender. Relinquishment was almost exclusively a White phenomenon.

It continues to be so today. Between 1973 and 1981, the first eight years after the nationwide legalization of abortion, only 0.2 percent of children born to Black women were relinquished for adoption, as opposed to 7.5 percent of children born to White women. Between 1982 and 1988, the disparity lessened slightly to 1.1 percent of children born to Black women and 3.2 percent of children born to White women, but by 1989 to 1995 *virtually zero percent* of children born to Black women were relinquished, as opposed to 1.7 percent of children born to White women (Chandra, et al., 1999). Women who relinquish for adoption today continue to be disproportionately White (Moore & Davidson, 2002; Miller & Coyl, 2000). Additionally, when controlled for age, birthmothers are more likely to have college-educated, never-divorced, higher-income parents than women who choose to raise their child (Namerow, et al., 1997; Namerow, et al., 1993; Cushman, et al., 1993). They themselves are more likely to have completed more years of schooling (Bachrach et al., 1992) and have a greater future-orientation (Donnelly & Voydanoff, 1991). As markers of social class, both education and income indicate that women who relinquish for adoption are more likely to be middle or upper-middle class than women who choose to parent. Thus, it is those social factors, which we most often consider racial, and class privilege that place a woman at a greater likelihood of relinquishing a child for adoption.

While the face of adoption has not greatly changed over the past fifty years, the system of adoption certainly has. In contrast to the coercive, closed adoptions of the “baby scoop” era, adoptions have become more open, allowing for some degree of continuing contact between the birthparents and the adoptive family. Most of these

changes have been largely the result of adoptee and birthparent activists, who lived the experience of a closed system of adoption and fought to see it changed (Solinger, 2001; Grotevant & McRoy, 1998). However, some adoption advocates argued that open adoption placed the needs of birthparents ahead of adoptive families, leading to a sense of instability and threatening the permanence of the adoptive family (Kraft, et al., 1985a,b,c). Research on early open adoptions showed that openness eases birthparents' adjustment post-adoption and does not adversely affect adoptive families (Chapman, et al., 1987a,b; Champman, et al., 1986); most birthparents and adoptive parents were satisfied with the interactions they had (Etter, 1993; Gross, 1993); and adoptive families in open adoptions felt advantages outweighed any disadvantages (Siegel, 1993). However, other studies concluded that birthmothers in open adoptions felt *more* isolated and felt *more* despair (Blanton & Deschner, 1990), and showed that 75 percent of potential adoptive families preferred closed adoptions, with 25 percent preferring semi-open and none choosing open adoption (Smith 1991). From these beginnings, open adoption had a rocky start: it indicated some promise in increasing satisfaction with adoption on the part of birthparents, but was seen as threatening to the adoptive family. It was clear that openness could be done in a way that did not benefit birthparents.

Despite these challenges, open adoption continued to become more and more of the norm (Grotevant, et al., 1994), and increasing evidence indicated that this was for the best. Contact led to increased empathy and trust between adoptive and birthparents (Sykes, 2000). Among adoptive parents, openness contributed to an increased sense of confidence in their relationship with their child (Grotevant, et al., 1994), and more

adoptive parents began to view openness as in the best interest of their child (Logan & Smith, 1999). Siegel (2003) found that, seven years into an open adoption, no adoptive parents regretted that their adoptions were open, 86 percent were comfortable with the amount of contact they had with their child's birthparents, and 96 percent agreed with the statement that "knowing his/her birthparent comforts my child." Most adoptive parents were pleased, even enthusiastic, about the amount of openness in their adoptions. Similarly, Ge, et al. (2008) found that the degree of openness in an adoption was significantly correlated with overall satisfaction with the adoption for both adoptive parents and both birthparents; additionally, for birthmothers, openness was correlated with post-adoption adjustment and well-being.

What, though, does the lived experience of openness mean? What kind of openness is most beneficial for birthparents, and what does it serve to protect them from? Perhaps most importantly: what do these open adoptions look like, and how do they require a shift from previously developed notions about adoption and family? This article examines these questions through in-depth interviews with birthparents with a range of adoption experiences.

A note on language used in this paper: there is much contention within the adoption community over the language used to express the relationships between those within the adoption triad, which includes both sets of parents and the child. Some of my participants, for example, will object to my use of the term "birthparent" (preferring instead "first parent" or "natural parent"), and would rightfully argue that diction such as "decisions" or "choices" about "adoption placement" would not accurately reflect the

degree of coercion they felt in surrendering their child. When possible, I refer to my participants simply as “parents” and try to limit the word “birthparent” to situations where their role might be confused with the adoptive parent. I did so to logistically situate them within a discussion of adoption in a way that the term “mother” or “parent” does not inherently do. By doing so, I do not mean to reduce the relationship that birthparents have with their children solely to their birth or genetic relationship. Additionally, when discussing the birthparents’ adoption experiences, I have tried to use words that best reflect the level of choice and agency that they communicated in their own narratives; indeed, as much as possible, I have tried to use the language that they chose in telling their own story.

Methods

Participants were recruited from various birthparent support groups, both in-person and online. Additionally, participants immersed in this usually closed community frequently referred other birthparents to the project, either through personal communications or online message boards. In total, participants found out about the project through personal referral, one local Concerned United Birthparents (CUB) chapter, or one of six different online postings (only one of which I arranged). I believe the willingness of participants to refer others reflects on the eagerness of birthparents to share their stories, which they feel are frequently overlooked.

When possible, interviews were arranged in person; when prohibited by geographic distance, interviews were conducted over the phone. All participants were interviewed individually, even when both parents involved in an adoption chose to

participate. Interviews lasted an average of 80 minutes and included discussion of the participants' personal experiences with adoption, as well as their reflections on the system of adoption more generally. Interviews were then transcribed and coded for themes such as social factors influencing adoption decisions, long term impact of adoption on the emotional health and lifecourse of the birthparent, and thoughts on whether or how adoption should be changed.

Table 1. Timeline of Study Participants.

	Year	Age	Adoption Type		Year	Age	Adoption Type
1	1962	22	Closed	22	1990	16	Open; closed by adoptive family
2	1963	20	Closed	23	1996	19	Semi-open; closed by adoptive family
3	1965	19	Closed	24	1999	26	Semi-open
4	1965	19	Closed	25	2000	18	Semi-open
5	1965	18	Closed	26	2000	18	Open
6	1965	17	Closed	27	2000	19	Open
7	1968	18	Closed	28	2001	17	Open
8	1969	19	Closed	29	2003	19	Open
9	1972	23	Closed	30	2003	20	Semi-open
10	1976	16	Closed	31	2003	22	Semi-open
11	1976	18	Closed	32	2004	23	Open
	1981	23	Closed		2005	24	Open
12	1978	18	Closed	33	2006	18	Open
13	1979	18	Closed	34	2006	26	Semi-open
14	1980	15	Closed	35	2006	21	Semi-open; opened by both sides
15	1982	18	Closed	36	2006	26	Open
16	1983	17	Closed	37	2006	23	Open
17		18					
18	1984	14	Closed	38	2007	42	Open
	1987	17	Closed	39		49	
19	1987	18	Closed (selected adoptive family)	40	2007	43	Open
20	1987	18	Closed (selected adoptive family)	41	2009	19	Semi-open; opened by both sides
21	1988	20	Closed (selected adoptive family)	42	2009	23	Open

In total, 42 birthparents were interviewed individually, including 40 mothers and two fathers. When accounting for both partners involved in an adoption participating, birthparents with multiple adoptions, and multiples births, these 42 participants represent

43 domestic adoptions of 45 children over a period of 47 years, in twenty different states and Canada.

Findings

Social factors influencing adoption decisions. Given the wide range of date and location of the participants' adoptions, one might expect a similarly wide range of demographic characteristics. Yet, while their experiences and personal opinions vary greatly, these parents do have much in common. With only one exception (who identified as part Native American) all participants were White, although some of the mothers noted that their children were biracial, implying that the birthfathers were not. This racial demographic is reflective of what we know about women who decide on adoption. Additionally, all participants were unmarried at the time of the adoption, and none were between the ages of 27 and 41 when the adoption took place, thus falling outside of their 30s – the age range which has increasingly become the time for upper-middle class women – and women realistically aspiring to that class – to become mothers. Over the past 30 years, the number of women having their first child between the ages of 35 and 40 has increased ten-fold (Gregory, 2007). Only three participants were *above* 41 years old; with them included the average was 21.1 years old, without them the average was 19.4 years old. Finally, most participants spoke of coming from middle to upper-middle class families, in which an unplanned, non-marital pregnancy was viewed with shock, disappointment, or shame.

Indeed, even as their stories varied, it is important to realize the extent to which the social factors influencing the decisions to place for adoption *have not changed*.

Regardless of the year of the adoption, most participants spoke of the same factors: youth, lack of financial resources, families unwilling (or unable) to support a new child, shame and disappointment surrounding an unplanned pregnancy, the desire for their child to be brought up in a two parent family, and the stigma of single motherhood. While not all of these factors contributed to each parent's experience with the same intensity, they were consistent across 47 years of stories. Such consistency indicates that, while as a society we have perhaps become more accepting of single mothers (as indicated by, or perhaps because of, their increasing prevalence), those who choose adoption today are choosing it because of the same pressures that led women of earlier generations down the same path – it is simply that fewer women feel those pressures.

Most birthmothers do want to parent their children. Of the 42 interviewed, only four indicated that, all things considered, they preferred not to parent: one whose pregnancy was the result of a traumatic sexual assault, one who had already been a single mother and was uninterested in “starting over” in that role, and two who said they had never really wanted to be parents and continued to feel that way. Except for these few women, the rest of the birthmothers did wish they were able to parent their children, some desperately so. Again, regardless of when they began their adoption, the reasons were very similar:

In 1962: I would have needed to have had a job and have some kind of money and a place to have babysitting, daycare... I also would have felt somewhat of a need to have my family accept my son.

In 1965: Money. That's what I would have needed. Yeah. That's all I would have needed, financial assistance... There was such a shame to being unmarried and pregnant. And there were no single parents – every child absolutely needed a mother and father.

In 1972: Well, first of all, [I would have needed] a job so I could get some money. And a place to live. An apartment... But also my dad was not going to allow it.

In 1976: [I would have needed] a secure house, a house where I had support and love.

In 1987: That is when I kind of just decided, “You know what? My child deserves the best. My child deserves a mother and a father.”

In 1999: All along my mother... was saying what I needed to do was choose adoption. Because she didn't feel like I was responsible enough, in her view, to be a mom... And she also thought that any baby needed a dad. So I would be selling the baby short if I didn't provide him with a father.

In 2003: I think it's mostly just because I didn't have the support that I would have needed to feel like I was doing a good job. I would have always felt like I was failing at it ... Also, I thought people would have judged me for being a single mom and I don't know how you change that.

In 2003: Without my parents behind me saying, “Ok, yes, we support you guys, whatever you are going to need we're going to help you.” I knew we couldn't do it without them. So I knew that if my mom said this is what I had to do, I was going to have to do it, I didn't feel like I had any other choice.

The same stories, told over and over again: not enough money, not enough support, no partner, too much stigma against single mothers. Perhaps one of the birthmothers said it best:

I don't know, I've never met anyone in this world – they might exist, but I've never met any, and I know a lot of birthmothers – who wouldn't have, if they had the power to, change the other things about their lives. More support, more cash, more something, so they wouldn't have to do that. I don't know anybody who, all things considered, choose to place their kid for adoption. It has a lot to do with external factors that are not with their control. So, if I had a choice to choose external factors, I would have changed those up and parented.

However, without the power to change the external factors, they changed the one thing they could: the people who would parent their children.

Classifying adoption type. For the purposes of this paper, “closed adoptions” are defined as adoptions in which the birthparents have no input or knowledge of the adoptive family, and no communication with the child or adoptive parents after the adoption is completed. In contrast, I have defined “open adoptions” as adoptions in which the birthparent(s) chose the adoptive parents and have regular, ongoing contact with their child and the adoptive family. The amount and type (in person, email, telephone) of contact varies based on geographic distance between the birthparents and adoptive families, but it is the comfort level and the ability of both parties to initiate communications that are the best indicators of a truly open adoption.

Falling somewhere in between closed and open adoption are those I have classified as “semi-open.” While some parents used this term, others referred to their adoptions as open, and then described something very different from the above definition. Included in these semi-open adoptions are ones in which birthparents might receive regular letters or pictures of their child on a set schedule (such as every year on the child’s birthday and at the holiday season) or have an annual visit. Often, they do not know the personal contact information of their child’s adoptive parents (or even their last name or state of residence), and communication is done through the adoption agency. While they do provide ongoing contact and allow for a continuing relationship between birthparent and child, semi-open adoptions do not have the same level or type of contact as open adoptions.

Neither semi-open nor open adoption contracts have any legally enforceable degree of openness; openness is upheld only by the continuing relationship between the

birthparents and adoptive parents. Indeed, two participants had had open or semi-open adoptions where the adoptive parents stopped communicating with them, effectively closing the adoption. Conversely, one semi-open adoption was later opened up further as the birthmother and adoptive parents became more comfortable sharing with one another.

The historical shift towards greater openness in adoption began taking place in the late 1980s and early 1990s. This change marks the conclusion of the era of coercive closed adoptions in which young women had astonishingly little control over their reproductive lives in general, and the decision to surrender their child specifically.

Traumatic impact of closed adoptions. With few exceptions, women involved in closed adoptions described their experiences as traumatic. Similar to victims of prolonged physical or sexual abuse, they displayed diagnostic characteristics of Post-Traumatic Stress Disorder as described by Herman (1997), including

- 1) *Alterations in affect regulation, including persistent dysphoria:* But you know the grief doesn't really subside. I could make the grief come up right now and I could be a pile on the floor and basically be in the same exact place that I was 23 years ago... There's no peace.
- 2) *Alterations in consciousness, including amnesia for traumatic events:* I don't remember leaving the hospital. I don't remember saying goodbye to him. I don't remember... did he leave before I left? I don't remember anything. Nothing. I remember his father holding him and I remember the room that I was in. But nothing else.... I never saw the baby again. I don't remember signing the papers. I don't remember when it was, where I was, who was with me – I don't remember anything like that. The only reason I know when I signed was – since we've been in reunion – we went back to Catholic Social Services, and they gave me my relinquishment papers.
- 3) *Reliving experiences, in the form of intrusive symptoms or ruminative preoccupation:* Every March is hard for me, around his birthday. It just all comes back. I think your body remembers a lot of stuff, you know? I think about it all the time – what could I have done differently? Why didn't I think I could do

it? I get almost flashbacks, but who knows if they're real, because I don't remember that much, actually.

- 4) *Alterations in self-perception, including shame, guilt, and self-blame:* The feelings that came out of having to surrender him was that I had... killed him, that I had done something so awful by separating ourselves. It was like a crime that I had done this thing. It was such a black place that I hadn't ever gone to, but it was there.
- 5) *Alterations in relations with other, including disruption of intimate relationships:* I think this does leave you with craziness, and that's the only way I can describe it. Insecurity, fear, fear that you're gonna lose again, because you've already lost it once. I can remember after my [second] son was born, I can remember sitting in the hospital thinking, "Are you really mine?" Almost doing that same detachment. I felt that surreal – "Is this real? Am I really gonna get to keep this one?" Almost like I didn't deserve it. To be happy. To have this beautiful baby.
- 6) *Alterations in systems of meaning, including sense of hopelessness and despair:* It was beyond depression. I was oblivious. With my son, so much was repressed and I was traumatized, I couldn't even open my mouth about what happened with me.

Additionally, accounts of nightmares, prolonged detachment, and shifted lifecourses were frequently shared, consistent with previous findings on birthparents' mental health post-adoption (Fessler, 2006). These various symptoms indicate a high level of post-traumatic stress, even decades after the relinquishment.

Jones (1993) even goes so far as to propose a "birthmother syndrome" that, beyond symptoms of PTSD, includes unresolved grief, dual identities that express outer perfection and inner shame, arrested emotional development, self-punishment, and unexplained secondary infertility (p. 272). While the idea of the birthmother syndrome remains undeveloped, it does reflect the universality of the post-relinquishment closed adoption experience; it resonates in all aspects of the birthmothers' lives, quite frequently for the rest of their lives.

Compounding the initial trauma of coerced relinquishment was the ongoing ambiguous loss of their child. Boss (2004) describes ambiguous loss as the loss of a person who is physically present but psychologically absent (as in cases of dementia, illness, or addiction), or physically absent but psychologically present (as in missing person cases). Clearly, the relinquished children fall into this latter category. Boss writes that “ambiguous loss is the most stressful loss because it defies resolution” (p. 553). This lack of resolution provides insight into why so many birthmothers in closed adoptions struggle with the aftermath of surrender for so much of their lives. Not knowing what happened to their missing children, where they are, whether they are safe and happy: all contributed to ongoing guilt and confusion, and compounded trauma.

However, all of the interviewed birthparents involved in closed adoptions have had reunions with their adult children. For these parents, the reunions meant their losses were no longer ambiguous; they knew where their lost children were and what their lives had been like. Fessler (2006) interviewed one mother, who had surrendered her first daughter and then lost her second daughter to cancer as a teenager, who stated:

I’ve been asked the question “What is worse, adoption or death?” Before I found Madlyn, I thought adoption was worse, because I knew where my second daughter was – she was in heaven – but I still worried about Madlyn and where she was. After I found Madlyn, I now know death is worse because I’ll never see my second daughter again. (p. 236)

Even this small resolution – of simply knowing what happened to her relinquished daughter – seemed to bring some lasting relief from the enduring trauma, if only by eliminating the ambiguity. This resolution seemed to be one of the only ways birthparents felt able to move past the surrender, “undo” the trauma, and begin to feel

healed: “I had my moments of sadness but, truly, when I lay my head down at night now, I’m thankful. I know where my baby is. She’s all grown up. She’s a beautiful woman. I’m blessed and I feel healed” (Fessler, 2006, p. 278). That birthmothers can, so many, many years later, find consolation in reconnection, perhaps speaks to the resilience of the human psyche and the hope of moving past even the most fracturing of traumas. As one participant stated, “At first [reunion] was very difficult. But it was freedom. I call it freedom. Freedom to talk about it. I don’t care who knows now.”

But was it the closed nature of these adoptions that made them so traumatic?

While the ambiguity of loss certainly compounds trauma, most of the closed adoptions were also coerced. Most participants in early closed adoptions desperately wanted to parent their children, but felt they had no, or very limited, choice:

I was forced into it. I had no choice. Even though I was 18, I was naïve, I never knew. Back then, I guess welfare was available, but I never knew anything about it. And my mother wouldn’t let me live there. She was worried about what people would say. I think that’s what it came down to.

I do feel that I received subtle pressure from society in general and from my parents. No one ever – not a single person – ever said to me, “Are you sure this is what you want to do? Have you considered options?” I didn’t have options. I felt like my child would be ostracized, there was no way I could give to my child the things that I wanted.

Given these accounts, it is likely that the both the coercive nature of the adoption, in addition to the closed structure, contributed to the long-term traumatic effects on some birthmothers. It is difficult to draw conclusions on this distinction, however, because as the social pressures that contributed to adoption decisions lessened, adoptions were simultaneously becoming more open. While there are examples of open adoptions that were made under very limited, possibly coercive circumstances, there are very few

women in closed adoptions who feel that they were not pressured or forced into the adoption.

Only one participant in a closed adoption showed no indication of trauma and seemed truly pleased with the adoption. Her experience differed from most other birthmothers in closed adoptions in that her adoption occurred later than most closed adoptions (in 1987); she had the support of her family should she choose to parent; she was able to pick her daughter's adoptive family and meet them once immediately after placement; and she has had a very positive, ongoing reunion with her daughter beginning when she was 16 years old. She switched doctors when her felt her obstetrician was being disrespectful of her decision, was specific with the agency about the type of adoptive family she wanted, and refused to accept anything else even when she was told that they could not find a family that met her criteria:

I [had] peace in my heart and feeling that I had done everything the way that was right for me. There were no "could've, would've, should've" moments for me. I had set out with a goal and I had accomplished it. I felt so good and proud about my decision and going on with life ... I had the resources to [advocate for myself]. I was lucky... I think that I did my job as a mother. I think that that mother lion instinct took over. That I was driven to find her exactly what I would have wanted to give her, and anything less is not an option. I did my job as a parent, in my eyes. And if that job is letting her go, then that's what it is. That's what it was at the time.

This is not to say that her adoption was not without grief; this mother went through counseling and also struggled with secondary infertility, which she hypothesized might have had something to do with the adoption. It does suggest, however, that the degree of control, choice, and agency that a mother feels when approaching adoption will heavily influence her feelings on the adoption afterwards.

The participants' stories suggest that trauma can originate from both the ambiguous loss of closed adoption, as well as the lack of agency or amount of coercion that a mother experiences when faced with adoption. While it could be one or the other for some women, most often both factors contribute to the trauma. However, both factors likely contribute to one another: the more closed the system of adoption is, the more secrets surround adoption, the more likely the women will feel less agency within the system. The shift towards greater openness in adoption not only concerns the amount of contact between birth family and adoptive family, but also the lessening stigma surrounding adoption and being adopted – changes which both emerged over the same historical period. How, then, have these greater degrees of openness impacted the experiences of birthmothers? To what extent does openness protect birthmothers from the trauma experienced by their earlier counterparts?

Impact of open adoptions. Openness seems to be a necessary, but not sufficient, condition to prevent birthparents from experiencing trauma. Some of the open adoption narratives were ones of depression, regret, or shame, but others contained aspects of gratitude, peace, or even joy that were absent from the closed adoption narratives. This is not to say that open adoption stories are without pain; most birthmothers who were pleased with their adoption decision still described periods of intense grief or mourning, and times at which the pain was compounded by continually interacting with their child.

Historically, the transition to more open adoptions was not a smooth one, as reflected by the timeline of participant experiences. The two earliest adoptions with any degree of openness (occurring in 1990 and 1996) were both closed by the adoptive family

within the first two years. For one of these mothers, her narrative of loss at the closing of the adoption sounds very similar to the initial response of birthmothers in adoptions that had been closed from the start:

I felt like my life wasn't worth anything. I felt like I'd been placed on this earth for one purpose, and that was to have those boys. It was a very, very dark time.

When open adoptions are closed, it seems to merely compound the loss by highlighting the lack of control that the birthparents have once they relinquish their parental rights.

Stories such as these place birthparents and adoptive parents in opposition to one another, as if their interests were incompatible.

Also problematic were semi-open adoptions in which the spirit of openness was seemingly neglected, even if contact was maintained. For example, one birthmother describes her annual lunch with her son and his adoptive mother, which, along with emails or letters about three or four times a year, constitute the extent of her contact with her son. However, at seven years old, her son does not know that she is his birthmother; he has not been told by his adoptive parents who she is:

It's really hard for me to visit knowing that I know the whole story and his mother knows the whole story and my daughter who is three can tell you, "This is Benjamin, he grew up in my mom's tummy a long time ago." She knows, she just turned three and she knows. He doesn't know... So I don't know this summer if we'll visit or not because I don't really know if it's fair to him to be coming and not knowing. And then, the purpose of the visit is not for his benefit, right? It's for my benefit... and he doesn't even know who I am.

Situations such as these, where contact is continued but an open relationship between birth family and adoptive family is not achieved, suggest that adoptive families once again view their interests in opposition with the birthparents'. Furthermore, they view openness as solely beneficial to the birthparent (instead of to both families, including the

child), which then leads to secrets that, ironically, negate any continuing benefit to that birthmother.

In contrast, the most successful open adoptions are ones in which the adoptive parents see a benefit to the child and themselves in maintaining contact with the birth family. Birthparents told stories of babysitting their children, going on family vacations with the adoptive family, attending their child's soccer games, having their child and her adoptive sister as flower girls in their weddings. These are open adoptions in which knowledge and acceptance of the birthparent are always present for that child:

They talk to my son about it – they say “birthmom;” they call me his birthmom when they're introducing me to people. Obviously everyone in the family knows. When his mom tucks him in at night, it's “Mommy loves you, Daddy loves you, Lindsay loves you.” They talk about me to him. There're pictures of me in their house.

The first year, I saw him just about every month, but then it got to be too much. So, now it is down to four times a year, which is plenty too, because they're also on Facebook and they post pictures there. They have a blog. [His adoptive mother] calls me. She sends me pictures on my cell phone. We have become friends. As a matter of fact, she called me the other night and she put him on the phone, and he didn't say anything, but she said he was smiling when I was talking to him. So, he recognizes me, and has every time that I go up there. They are really open. They are really open with the boys, so he will know that I am his birthmom. Right now, he is just too young, but he knows that I am someone special.

These were the adoptions that seemed most protective of birthmothers; they were allowed ongoing contact with their child in a way that acknowledged their motherhood, without putting them in conflict with the adoptive family. As one birthmother said,

I think ultimately it only validates your own parenthood to recognize and understand my motherhood, too. If everything about your adoptive parenthood is predicated on my absence – I'm always out there in the world. I'm never gone. I always birthed your child. If those worlds are always separated, it's always this fearful, artificial relationship you have with your kid. But if we all are present to

each other, literally and psychologically, I feel like we're all working in reality and working with what we have.

Yet, the ability to have this kind of openness, to accept the presence of another parent in your child's life, is still not the norm.

Many of the birthmothers involved in open adoptions did not have this same level of positive experience. Whether because of unclear expectations, their perception that the adoptive family was not following through on their commitment to openness, or their regret surrounding the adoption more generally, several experiences fell far short of the ones previously described:

Maybe if there was a schedule, or if there was some sort of facilitation around the openness, it maybe could have had a more positive outcome. I have before told them I'd like pictures and they did send them. Then they stopped. So, it's kind of like that lukewarm acceptance. They're always very kind to me, but I think that they wish that I would just go away.

Preceding that visit was a bit of disappointment because his adoptive parents did not engage John [the birthfather] and myself as much as they promised they would. They said they would contact every week for the first three months, and after the first three weeks we got an email saying, "Oh, we can't do this anymore. We can't keep you updated. We're very tired right now and we can't promise updates every week. We'll let you know when we can." And that was the last email they ever sent us... They hardly ever call or try to connect with us, even though they visit our city often. They might be in the area five times a year, and only call us twice.

These less than satisfactory open adoptions often reveal the same regret and sadness that is heard in closed adoption narratives. Without a consistent sense of openness – a clear definition of what that very ambiguous, various term means – open adoption seems to have little protective value.

Conceptualizing openness. How does a prospective birthparent begin a conversation with prospective adoptive parents about openness? Many birthmothers

commented on the inherent awkwardness: “Here I am. I have something that they want. Yet we are forming this relationship that is not organic,” and, “Even in our first meeting, they came in and sat down and they’re like ‘It’s just really weird to walk into a room and know you’re going to be meeting somebody who’s going to be in your life for the rest of it.’” Most conversations began as specific ideas about number phone calls per month or visits per year – but as the previous stories have shown us, these sorts of guidelines are of little value in determining what kind of relationship birthparent and adoptive family will share.

What is more important – indeed, what is critical to the foundation of an open adoption – is building a concept of openness not dependent upon pictures sent during the holidays or semi-annual visits. The most successful open adoptions, where birthparents were most content with their decision and felt that the best outcome had been achieved for all parties, were adoptions in which the adoptive family considered the birthparent a part of their family. This consideration was the single most consistent indicator of whether a birthparent would feel positively about the adoption:

I could tell that they really cared about me, and it wasn’t just about [the baby]. It’s just a level of respect. They’re kind of like my older brother and sister. Their relationship with me is not based on my relationship with my daughter... Every time we’re on the phone – I’d say 9 times out of 10 – not that we don’t discuss [our daughter], if she’s in the back she’ll put her on the phone, but we don’t talk about the adoption. It’s more like, “Oh, what are you doing today?”

I believe they do think that I’m part of their family, and they have told me that. They told me that from the very beginning. That they weren’t just adopting this baby, we were just going to be like extended family to them. So they’ve welcomed my whole family in, with open arms.

They don’t consider me part of their family, I’m sure, because there are references when they message me, like “We’re busy with family that day, so we can set up a

visit for the next day.” Saying that they’re busy with family and that makes them unavailable... then obviously they don’t consider me to be family. I don’t think most of their friends and family know who I am at all.

I don’t think they consider me part of their family. I think they might through lip service, but I don’t know if this is how they treat their other family members. It just seems like they are fulfilling an obligation that they have.

These accounts show the contrast between the birthmothers who feel as if they are an acknowledged part of their child’s adoptive family, and those who do not. It is no surprise then that the birthmothers in the former two excerpts felt comfortable telephoning the adoptive family, joining them for holidays, and had little worry that they would be cut out of their children’s lives. Just as most parents would not feel the need to limit the contact that loving aunts or uncles have with their children to twice a year, or feel burdened by an obligation to include an older cousin in family activities, these adoptive families view birthparents as part of their family. Here, the birthparents do not represent a threat to the adoptive parents’ role in the child’s life, or an obligation that the parents must begrudgingly meet simply because they said they would. Instead birthparents are part of an extended kinship circle.

To build such a relationship requires prospective adoptive families to recognize that they are not only becoming parents, but that they are forging a life-long relationship with at least one birthparent. This concept is not the way most people think of building their families when they decide to have children, and it is not the way most of society thinks about adoption. One participant told the story of meeting with her son’s adoptive parents around his first birthday, in order to see how they were feeling about the adoption

and whether everyone's expectations were being met. When the adoptive mother told her she did not understand why they were meeting, she responded:

I'm scrambling to justify this conversation because I think it's self-evident that we might just want to check in with each other. I drew the three Olympic rings, interconnected and said, "I conceive of our adoption like this, where you are one circle, [the birthfather] and I are another circle, and [our son] is the third." And [his adoptive mom] drew an entirely different diagram, which is one circle with another circle in the middle – that's their family, with [my son] in the middle – and I am this other, unconnected circle off to the side. Literally, visual representations of how we perceive this relationship totally differently. I backpedal and don't even know what to do, and then go home and have a total nervous breakdown. Essentially, it was a second loss. I had taken the open relationship as a second consolidated relationship with my son, and then I had lost that.

This birthmother had gone through the checklist with the adoptive parents and agreed on the type and amount of contact that they wanted, a conversation that – while worlds apart from closed and secretive adoptions – was essentially just concerned with logistical details, rather than the building of an open relationship:

In living out the open adoption, we've come to find out that our philosophies about how we feel about adoption were very different... I imagined openness as that we were all connected. I loved them because they were the parents of my son. That, while I wasn't expecting to be a part of the everyday family life, but that I conceived of them as being a part of my larger family. I don't feel like they feel that way. I feel like they, in some ways, participate in the open adoption as a favor to me because they said they would, or because maybe I needed it for my grieving processes – as opposed to conceiving of it as something that really benefits everyone... The adoptive family, even within the context of open adoption, couldn't really conceive of family dynamics where birthparents were actually really involved. Openness, even though it's more popular in the adoption community, is still kind of an oddity in the larger scheme of things. I think that worked against me.

These kinds of open adoptions are very different from what society expects of adoption.

Miall and March (2005) found that, while 77 percent of the general population approves of the exchanging of cards and letter post-adoption, only 62 percent approved of ongoing

personal contact, and 85 percent of the population supported the continued option of fully closed adoption. Open adoptions represent a significant shift in how most of society thinks about adoption. However, this openness does not just constitute a new idea of adoption; *it constitutes a new idea of family*, a family that extends beyond its nuclear core in the belief that what is good for the birthparent will be good for the entire adoption triad.

Indeed, the birthmothers that were most happy with their adoptions were matched with adoptive parents whose commitment to birthparents' rights and openness were truly exceptional. Most adoptive families have experienced infertility for many years, are paying lots of money to the adoption agency, and are focused solely on having a child and becoming parents. One participant told the story of her first encounter with her son's adoptive mother: "She said, 'If you ever try to change your mind or ever try to take him away from us,' she didn't mean this literally, but she was like, 'I will kill you.' She just was trying to say don't disappoint us. But he wasn't [theirs yet]. Nobody understands that." Even if these words were taken as a sort of joke – which they were by this birthmother – they reveal the fear of disappointment and lost hope that many prospective adoptive parents feel when they begin interacting with a potential birthmother who is considering them. Remembering the desire of adoptive parents makes these anecdotes all the more resonant:

When I was leaving the hospital it was kind of one of those critical points. We were all crying. I really didn't know if this is the right thing or if this is going to work. And when I gave her [adoptive] mom a hug when I was leaving, she said, "You know, this can go two ways. You can parent her or we will parent her. Either way, she's going to be loved. We'll go with us parenting her because that's the way we planned, but if that doesn't feel right, call me and I will bring her back

to you.” I had no idea where she found the strength to say that, but it was one of those things where it gave me some control when I felt so completely out of control.

Here, the question is not about openness, but about recognizing that the birthmother owes the adoptive family nothing. Indeed, she is not even a birthmother until she signs the relinquishment papers – until then, she is just a mother trying to make a decision. One birthmother said, “The entire time I was in the hospital, I just wanted to run. I just wanted to grab him and disappear. It’s a totally different thing once the baby’s here – any decision you thought you made, you have to totally make all over again.” Being given the space and opportunity to make that decision free from the burden of potential adoptive parents’ expectations was something very few birthmothers were given; when they were, they felt it helped them be much more confident in the decision and helped ensure a trusting, open start to their relationship.

None of these arguments in support of open adoption are meant to say that open adoption is easy. Indeed, most birthmothers in closed adoptions expressed very strongly that they believed openness was not a solution to the problems that they faced in their adoptions. They vehemently believed that seeing one’s child being raised by someone else would compound the trauma. Birthmothers in open adoption did agree that initial visits did bring up a lot of grief: “As much as I love openness, I think it forces you into the grief earlier. You don’t really get that period of peaceful denial... I think that a few weeks of denial or even a few months is maybe healthy. Just being able to give yourself some time to separate that.” Some birthmothers avoided in-person contact for the first several months up to a year, until they felt strong enough. Many phrased the resumption

of contact not for their own benefit, but for the benefit of the child. For example, one birthmother pumped breast milk and delivered it to her son's adoptive family on a regular basis – even though, that early on in the adoption, she says she would have preferred less contact. For her, though, it was a way to directly benefit her son, to show that she was committed to openness not only to ease her own pain, and to provide something that she, as his biological mother, could offer that his adoptive mother could not. It both benefitted her son and helped her to validate her motherhood. For those with positive open adoptions – and again, not all open adoptions were – openness ultimately provided a way of recapturing some of the joy that is lost in adoption: “It felt like I had gone through hell and back. But, it's worth it, for her. Seeing her happy and loved and getting hugs from her. She has the life that I wish that at that time I could have given her.” For those with less positive experiences with open adoption, the openness was more of a sort of consolation prize – less joyful, but still better than going without contact: “[The adoption] is definitely the worst thing that's ever happened to me – that is mitigated by the fact that my son is the best thing that's ever happened to me.”

Then, given the emotional labor that goes into maintaining an open adoption, what about birthmothers who enter an adoption and want it to be closed? Four participants did initially want closed adoptions, all of them ended up in open ones either at the requirement of the adoptive family they had chosen, the counseling of the adoption agency, or the result of an evolving relationship with the adoptive parents. None of them regretted having an open adoption:

I did not [initially want an open adoption]. I did not. I wanted nothing, because I thought it would be too hard. I thought that knowing something about him, seeing

pictures, would just make it harder for me to go on, but that was not true. The more you know about adoption, you kind of realize, you're going to change your mind. And I did. I did.

I think at that point it opened up without me knowing it, because I was reaching out to them. They were giving me pictures and there was a little more correspondence than just through the agency and getting those pictures and letters. So I think when I first reached out to them, that was openness without me even knowing it... I think that the option should be given as open. Specifically they want that, the adoptive families want it. So when they're leaving that on the table for the birthmother to take advantage of, I think that it's enough for the birthmother to know the pros and cons of closed versus open, and them being able to reach out to the family if she does want to see the child and having that on the table, but not really forced.

Given this evidence, it seems that closed adoption should be discouraged; even if the birthmother is initially wary of ongoing contact, the door should be left open for a greater relationship to evolve. Without undermining the agency of a woman seeking a closed adoption, perhaps the best evidence in favor of open adoption is this: no birthmother reported wanting less contact with their child.

Real openness in adoption, then, is a very tall order. It requires a new understanding of what adoption looks like; it requires the acceptance of the birthparent into the adoptive family's kinship circle; it requires prospective adoptive parents to place their desire for parenthood second to respecting the rights of the prospective birthmother prior to relinquishment; and, in order to be maintained, it requires ongoing logistical and emotional work, particularly on the part of the birthparent. Such a commitment to this type of adoption – which is, essentially, a commitment to the health and long term well-being of birthparents and adoptees – will not be something all potential adoptive parents will be willing to commit to. However, the laws, policies, and practices of adoption agencies must somehow be accountable to all members of the adoption triad.

Birthparent policy recommendations. In many regards, birthparents' opinions on adoption policy reform are diverse, sometimes even contradictory. For example, some believed more women with unplanned pregnancies should be presented with the option of adoption; some were adamant that "everyone in the world knows adoption exists" and it should not be presented as an option unless the expectant mother brings it. Some believed the potential birthmothers should absolutely meet and form a relationship with potential adoptive parents prior to the child's birth, in order to feel confident and comfortable with her decision; others believed this created an expectation and put pressure on the mother to give her child to other parents.

Yet, on all the following points, nearly all were in adamant agreement:

1. Adoption should be a nonprofit industry, and adoptions should be less expensive for adoptive families. Many felt the profit motive led adoption agencies to encourage adoption over other options and to build an expectation that potential adoptive families had the "right" to a specific child.
2. Adoption should be rare, and it should be considered a last resort for women who are certain they cannot or do not want to parent. In order to ensure that women have fully examined all options, they should receive non-biased counseling from the adoption agency. Furthermore, many birthparents told stories of receiving pre-adoption counseling from counselors who were adoptive parents (sometimes, whose only qualification was being an adoptive parent), who they felt were biased toward encouraging adoption.

3. An expectant mother considering adoption should be encouraged by the adoption agency to create both an adoption plan and a parenting plan, so that she is able to choose which plan to follow after giving birth. By doing so, she will not feel that adoption is her only option when the time comes to make the final decision.
4. When adoptions do take place, they should be open. Adoption contracts should have some legally enforceable degree of openness, with minimum birthparent visitation or contact rights that can only be removed under circumstances that would usually remove parental rights.
5. Adoption agencies have a responsibility to provide ongoing support for birthparents, adoptive parents, and adoptees, and to encourage a sense of true, positive openness in adoptions that is protective of birthparents and beneficial for all parties.
6. Adoption records should be open and accessible to adult adoptees and birthparents, and birth certificates should not be altered to indicate that adoptive parents gave birth to the adopted child. Instead, a secondary “adoption certificate” should be issued to indicate that the adoption had occurred.

Besides these specific, executable policy recommendations, birthparents wished to see adoption agencies fostering a greater environment of openness and working to communicate that commitment to openness with potential adoptive parents.

Discussion

When considering the long-term effects of adoption, it is important to note the two contrasting timelines. Firstly, there is the historical timeline, over which adoption has become less secretive, more open, and seemingly more concerned with meeting the needs of birthparents. Secondly, there is the personal timeline; that is, the way a birthparent feels about their adoption as they move through their life. It is this second timeline that presents a challenge when discussing the impact of adoptions on birthparents' lives.

Most of the women in closed adoptions were very unhappy with their adoption experiences. All of them, however, were at least twenty years removed for their adoption placement. Some of them acknowledge that, after the intense grief immediately after the adoption subsided, they felt somewhat positive about the adoption. One birthmother, who now strongly believes that adoption should be a rare, last resort, remembers: "I was giving speeches back then [five years after the adoption] on why adoption was a good thing." However, the progress of time changed how she felt. This speech-giving was not unique, and, in fact, seems to be part of the adoption system:

What I find really exploitive that they do at agencies is that they take these stories from women that placed a year or two years or three years ago, and they pump them up because these women are really happy to talk about this honeymoon period; and it's really great, and why don't you just choose this, and everything will work out really good.

In contrast to the older closed adoptions, all of the birthparents in open adoptions had placed within the previous ten years. Indeed, many participants in open adoptions that occurred longer ago felt the least positively about the adoption.

Are, then, the happiest accounts of open adoptions – all very new – merely the product of a “honeymoon period” that many birthparents seem to experience once their initial mourning period has passed? Or are these new adoptions qualitatively different? Has the progress of the historical timeline ensured enough legitimate change that the long-term positive effect will endure for individual birthparents? One birthmother in a ten-year-old open adoption was skeptical:

I’ve been talking to a girl who has an open adoption right now. She’s definitely in an adoption honeymoon, and I hope it will last forever. I hope what’s going on now with her adoption really does work. I don’t think it’s inevitable that adoptions will fail or turn sour. I think it’s common.

Only long-term, longitudinal research will show whether the honeymoon period and eventually souring will continue to occur in more recent, more fully open, adoptions.

There is also the question of who chose to participate in this project by sharing their adoption stories. Clearly, the vast majority of participants were women, and the two men that chose to participate did so because they were still partnered with the birthmother, and did so at her encouragement. Indeed, most of the groups through which I recruited, most of the message boards on which participants encouraged others to contact me, and both conferences where I met directly with birthparents were comprised of, trafficked by, and attended by solely women. Birthfathers were largely missing from the discussion. When asked, most participants believed that men had less connection to the pregnancy, experienced less loss, faced less trauma, and consequently felt less of a need to be involved in activism or the adoption community later in life. Based on the two men who did participate, they did seem to experience the loss less profoundly than their partners, but there was still a loss. Furthermore, for the one birthfather in a closed

adoption, he did express a fair amount of regret at having “gone along” with the adoption. It does not seem, for these men, that they were experiencing the adoption in a qualitatively different way than their partners, although the extent of the impact was perhaps slightly less.

However, there were also many women who intentionally tried to remove the father from the adoption process. More than one woman told a judge the sexual relationship with the father had been coercive (although one acknowledged this as an outright lie, and two others said they “weren’t sure” if it had been rape) in order to avoid needing their consent on the relinquishment papers. (This does not include three other women whose pregnancies were unequivocally the result of rape, who clearly did not include the birthfathers in their decision-making process.) For some, it was easy to avoid the father’s input – a few women in closed adoptions simply did not tell their partners they were pregnant and kept the adoption a secret from them. For women in open adoptions who wanted to avoid the birthfather, they use the agency as a sort of mediator: “I would refer him to the agency so he could get contact. He’s completely out of the picture because I forced him out.” Because adoption agencies are often willing to work solely with birthmothers, the birthfathers become a sort of dispensable inconvenience. It does not matter that they chose the adoptive family, or that they have met them – what matters is that they sign the relinquishment papers when the time comes. That birthmothers who wanted to force birthfathers out of adoptions seemed to be given no pushback from the agencies is worth considering: what are the long term impact on these fathers, who are given so little choice in their child’s adoption? While it may be true that

some are uninterested in such choice, and in such cases should have the chance to waive it, excluding birthfathers who do want to be involved seems tantamount to coercion; coercion in adoption is never worth protecting.

But for each of these cases in which a birthfather was pushed out of the process by a birthmother (or kept in the process because of their continuing relationship with that birthmother), there were other men who had visits with their child in open adoptions, who enjoyed reunions with their children in closed adoptions, and who the birthmothers believed had similar emotional reactions to the adoption that they themselves had had. Why, then, did these men not participate in this study? Again, because recruitment was done through adoption-centric communities, it seems that men have not found an ongoing space for themselves within those communities. While many birthmother activists have worked very hard to create safe environments (either real or virtual) for birthmothers, there has been less focus on incorporating men into those spaces (or less initiative by men to create their own spaces).

Developing spaces for birthparents and taking measures within the adoption system to protect them and their rights requires expanding the focus from the adoptive family, specifically the child. Critics of open adoptions have argued that openness places the needs of birthparents before the needs of adoptive families (Kraft, 1985*a,b,c*), but have failed to acknowledge that the system of adoption *should* have an obligation to protecting the interests of all parties to the extent that they do not conflict. One birthmother said:

That's kind of the larger rhetoric of adoption, that it needs to be child-centered. But it also needs to account for the experiences of the women who will be living

out for the rest of their lives, too, and you need to prepare yourself and even give yourself permission to think about what would be good for yourself as a person. I think that that sometimes gets lost in the adoption preparation – you try to remove yourself and only think about the baby.

The system of adoption has not long been accountable to birthparents, but the rights of birthmothers, are in many ways simply variants on the rights of all parents and all women. As Solinger (2001) writes: “I am willing to go out on a limb with this hypothesis about adoption: that the incidence of adoption, that is, the transfer of babies from women of one social classification to women in a higher classification or group... may be a very accurate index of the vulnerable status of women in the country of the birthmothers” (p. 67). When it does not allow birthmothers real choice, real control, and real respect, adoption is less a way of creating families and more a mechanism of preserving hierarchy.

Finally, there is the question of reunion, and the fact that all participants in closed adoptions had had reunions with their adult children. What about the birthmothers not in reunion, who chose not to participate? Did they indeed walk away from their adoptions, move on with their lives, and feel not feel the need to become part of the adoption community or continue to share their stories? It is possible, but highly unlikely. Firstly, given the very profound impact on many in the same situation, it seems unlikely many individuals would walk away wholly unscathed. Secondly, participants did mention others in their support groups who were not in reunion, who did not feel comfortable sharing their story with someone who had not gone through the same thing. One said, “I don’t blame her. I couldn’t talk about this before reunion. Now I tell everyone. Reunion gave me my voice back.” Now that so many birthmothers have found their voices, it

behoves the rest of the adoption community to listen to their stories and recommendations and to improve that system which has the capacity to so fundamentally change so many lives.

Chapter 4

Conceiving Infertility: Negotiating the Biomedical Model

Assisted reproductive technologies have transformed medicine's response to infertility and the ways those with difficulty conceiving understand their bodies and experiences. In many capacities, the biomedical model is insufficient: recognition is contingent upon attempts to conceive; diagnosis is imprecise or unexplained; treatments striving for solutions without cures are frequently incapable of providing either. In-depth interviews with 26 patients, conducted in 2009, revealed negotiations of this model: (1) complying; (2) supplementing medical treatment; (3) pursuing alternative treatments; (4) playing active roles in determining treatment; (5) using religion and spirituality as non-bodily ways of controlling infertility; (6) infusing the objective idea of "disease" with subjective purpose; (7) building personal, alternate models; and (8) directly challenging the scientific authority of the biomedical model and resisting the terms of treatment. Understanding these negotiations provides a better concept of patient identity and the "illness" experience, and can inform policy regarding prevention, education, and insurance mandates.

KEYWORDS: Infertility, Alternative treatments, IVF, Reproductive health, Biomedical model

Infertility treatments, and those individuals who pursue them, are alternatively viewed with fascination and scorn by the general American public. These narratives are shown in public discourse around the television program *Jon and Kate Plus Eight*, about a family with twins and sextuplets, both pregnancies the result of *in vitro* fertilization (IVF), as well as around Nadya Suleman – the "Octomon" – who conceived fourteen children, including one set of octuplets through IVF. With public knowledge of assisted reproductive technologies (ART) and the experience of infertility being quite low, many couples pursuing ART face judgment, indignation, and outright ridicule for making this reproductive choice (Mundy, 2009). In contrast, individuals are also exposed to the medical model for understanding infertility, which creates a very different narrative around this condition. Caught between these two narratives are, of course, the couples

and individuals trying to both navigate and to justify the role of an ART patient – all while trying to build a family.

Infertility as Disease: The Implications of the Medical Model

Throughout history, infertility has been modeled as a condemnation by religion (where “barrenness” was a sign God’s displeasure or a test of faith), a “woman’s problem” (when it was thought to be best handled through self-help treatments), a social concern (which was rooted in inappropriate female behavior or “unwomanliness”), and finally a medical ailment (Marsh & Ronner, 1996). The emergence of the biomedical model as the primary way of understanding infertility did not occur independently from these earlier models; these models not only illustrate alternate epistemologies for understanding, but also show the dramatic ways that medicine is influenced by historical and social values.

The crux of the biomedical model is in the presentation of infertility as a disease in need of medical treatment. However, infertility resists our predominant ways of understanding illness and treatment in several ways:

1. Infertility generally has no physical pain or suffering, represents no threat to ongoing health or quality of life, and is only recognized as problematic under very specific conditions – namely, after approximately twelve months of unprotected sexual intercourse without conception. Thus, a person who is unable to conceive but not trying to conceive would not recognize this condition as problematic at all, let alone as a disease. It would not only be inappropriate to diagnosis this condition a disease, it would be impossible.

2. Infertility is identified, like most forms of disability, as a deviation from a norm. In this way, it is comparative, and by being comparative, it is social (Rothman, 1989). As such, infertility is only a deficit under specific circumstances.
3. Infertility as a primary diagnosis groups together a wide range of possible physiological impairments that affect fertility differently. It becomes a nonspecific term that encompasses a multitude of possible complications in areas of anatomy, hormones, gametes, and timing – all of which are necessary for conception. Additionally, within an “infertile couple,” the possibility exists that one individual has minimal or no impairment, yet the diagnosis is still extended to both parties. Thus, impairment in one individual that prevents conception creates infertility in the other, as they are also now unable to conceive in the way they want.
4. Most fertility treatments do not represent a cure; in fact, most treatments merely minimize the causes of infertility in favor of increasing the odds of conception, without resolving the original problem. A couple that successfully conceives as a result of new reproductive technologies is not likely to have an easier time conceiving again in the future, should they chose to do so; the infertility is not “fixed” or “cured” as a result of the treatment. Barbara Katz Rothman (1989) goes so far as to suggest that such procedures are the equivalent of “important, non-medical ways of managing disability, ways that address the handicapping effects of the disability – like learning sign language, having wheelchair ramps” (p. 144). Instead of fixing the underlying cause, reproductive technologies make the sources of infertility less important to fertility.

5. Many variations of treatment do not even try to achieve what for most couples is the original goal: to have a child that is genetically theirs through a gestation of the biological mother. Although treatments do, in a variety of ways, accommodate conception, many options (donor gametes, surrogacy) change this goal. In such cases, not only does the treatment neglect to address the source of the problem, it changes goal to accommodate what is possible.

Despite these various inconsistencies between infertility and how we typically understand disease and treatment, the framework of the biomedical model does direct society's beliefs about infertility. Sandelowski (1987) writes that "the recent rediscovery of infertility by clinicians, researchers and the general public has not caused the etiology, treatment or prognosis of infertility to be substantially more definitive than they ever were... [it] has engendered a crisis of ambiguity in the infertile whose expectations from medical management far exceed its capabilities" (p. 73). The high amount of confidence in biomedicine in fact represents an additional obstacle to those actually confronting infertility. A deficit of the biomedical model is its inability to acknowledge, on a social level, its own limitations, so that when individuals addressing infertility first interact with medical treatment, they must discover on their own that it does not necessarily offer them any answers.

Further criticisms of the biomedical model have challenged its framework of infertility as an individual problem. Dorothy Roberts (1997) rejects the liberal market solution for reproductive technologies and is hesitant to adhere to the distributive solution. Faced with the abundant inequity in access to ART and the implications their

use creates for determining who is deserving of parenthood, Roberts argues that the best way of eradicating the harmful and disparate effects of reproductive technologies may require deterrence of their use. Rather than the individual-focused diagnosis and treatment, many women would be better served by interventions to preserve fertility through preventative healthcare. Instead of (or in addition to) being a *medical* problem, infertility is a *public health* problem – a model which allows for a more comprehensive approach to the issue and consequently more comprehensive, equitable proposed solutions. Using ART as a way to overcome these possible causes of infertility allows society to “in fact mask the social and economic structures and inequities that give rise to the problem” (Shanley & Asch, 2009: p. 852).

Given the nearly absolute authority that the biomedical model has been ceded in contemporary culture, it becomes difficult to recognize that it is just that – a model, a way of understanding that is contingent upon historical context and current limits of knowledge. Engel (1977) writes that “the historical fact we have to face is that in modern Western society biomedicine not only has provided a basis for the scientific study of disease, it has also become our own culturally specific perspective about disease, that is, our folk model” (p. 196). In any culture, a single model will not encompass the lived experiences of diverse individuals. We should not expect it to do so for infertility.

Negotiating the Biomedical Model

The dominance of the biomedical model has forced infertility patients to find alternate ways to negotiate this model in the creation their identities as both infertile individuals and couples. These negotiations have the potential to represent “everyday

resistances” against what Foucault (1978) conceptualized as biopower: “in contrast to large-scale, collectively organized, and visible resistance movements, forms of everyday resistance are manifest in ‘subjugated knowledges’... This suggests shifting attention from the sites of biopower, that is the institutions that develop and sustain discourses on the regulation of the social body” (Kielmann, 1998). These resistances not only have the capacity to redefine individual experiences, but also shift the locus of control within the power dynamic.

The idea of negotiating with the biomedical model is not a new one for gynecological patients, particularly in the field of obstetrics. Davis-Floyd (2003) argues that the “conceptual outcome” of a woman’s birthing experience is determined by the degree of correspondence between the biomedical model and the woman’s self-concept of her own body and her goals for treatment (p. 187). A natural corollary is that the conceptual outcomes for infertility patients will similarly vary, perhaps even more profoundly given that birthing is generally completed within the span of a few days, whereas infertility treatments span many months and can be influenced by the additional stress associated with damaged self-concepts. Indeed, Sandelowski (1995) comments on the process of “reconstruction” that former infertility patients undergo after having achieved parenthood, encompassing the “epistemic stances toward infertility over time, adopting various combinations of scientific, historic, folk and/or metaphysical orientations to causation and proof” (p. 129).

In a study on agency in infertile patients, Greil (2002) noted that “the biomedical model and the body as machine metaphor carry with them a clear ideological justification

for medical intervention, that is to say, for treatment. If a machine is broken, the natural response is to repair it. The infertile women I spoke with found the medical interpretation of infertility plausible” (p. 109). Most patients *will* accept the biomedical model; so the question then becomes how they maintain agency and control within the pursuit of treatment once they have accepted that model.

Methodology

Setting. This research was conducted in Massachusetts, one of only fifteen states with mandated insurance coverage (Massachusetts General Law, Chapter 175, Section 47H) and one of only four states that mandate comprehensive coverage, defined as at least four cycles of assisted reproductive technologies (Henne & Bundorf, 2008). Such a mandate fundamentally changes the experience of seeking infertility treatment. In the United States, assisted reproductive technologies (ART) cost on average between \$7,000 and \$11,000 per cycle when using the couple’s own gametes (the use of donor eggs or sperm can drastically increase the price). Because it often takes a couple multiple cycles in order to achieve a viable pregnancy, the average cost per infant ranges from \$38,000 to \$50,000 (Henne & Bundorf, 2008). Clearly, such steep costs are prohibitive for a substantial proportion of the US population. For those who can access treatment without insurance coverage, the cost has a tremendous influence on their options and their decision-making processes. Insurance mandates significantly increase utilization of ART, significantly reduce the number of multiple births per ART birth (and the consequent health risks and healthcare costs) (Henne & Bundorf, 2008), and significantly increase fertility rates (Schmidt, 2006). Compared to the high price tag in most of the

United States, most participants reported spending \$100 or less per cycle, depending on their drug protocol, insurance co-pay, and whether or not they pursued non-covered alternative treatments. Two participants had specifically moved to Massachusetts to be able to afford treatment; one additional couple had postponed treatment until a previously anticipated move to the commonwealth. The impact of the insurance mandates on these participants' experiences cannot be overestimated.

Subjects. Subjects were individuals who have histories of difficulty conceiving, and have sought either treatment or support for that challenge. Participants were recruited from the Massachusetts chapter of RESOLVE, a national infertility association, through e-newsletters. Respondents showed an extremely wide variation in involvement with RESOLVE; several limited their involvement to receiving emails, others (a minority) were active in support groups.

In total, 26 participants were included in the research; twenty women and six of their partners. At the time of the interview, the female participants' average age was 34.8 years old; however, their average age when they began trying to conceive was 30.8 years old, well within the age range in which women can expect to be fertile. Nineteen of the women were partnered with men, and one with a woman, and the couples had been together an average of 9.2 years (eighteen of the couples were married; the remaining two intended to be).

Racially, all of the participants were White, and ethnically, none were Hispanic/Latino. Although this homogeneity is not desirable, as it limits the scope of lived experiences available in the sample, it is not entirely inconsistent with the

population seeking infertility treatment. Indeed, 80.9 percent of those seeking infertility care at Brigham and Women's hospital in Boston are listed as "Caucasian" (Jain & Hornstein, 2005). Contrasted with the Massachusetts 2000 census data, Chinese and Asian/Pacific Islanders populations are overrepresented in the patient population; Hispanic/Latinos are far underrepresented. Blacks were underrepresented, though not statistically significantly (5.4 percent versus 4.5 percent). The proportions of the remaining patient population did not differ significantly from their proportions in the general population (Jain & Hornstein, 2005). These disparities are *in spite of* the fact that Black and Hispanic women are just as likely or *more* likely to suffer from most types of infertility (Wellons et al., 2008; Jain, 2006; Bitler & Schmidt, 2006). Additionally, infertility treatments have been shown to be less effective for Black patients (Dayal et al., 2009; Seifer et al., 2008), further suggesting the market for treatment is not designed to serve these populations. It is important to remember, however, that the racial and socioeconomic disparities in accessing medical treatment are by no means unique to infertility; instead, they are the unfortunate norm in the American healthcare system. While insurance mandates may increase access to advanced reproductive technologies, they have not been found to reduce these disparities (Jain, 2006; Bitler & Schmidt, 2006). Consequently, a representative sample of those pursuing infertility treatments should be predominantly White; however, contrasting the entirely White sample with both the patient population (80.9 percent White) and the general population (84.5 percent White) indicates that while the patient population is already disparate from the general population, the research sample was further pronounced in this disparity.

Furthermore, despite the insurance mandates, large disparities exist between the patient population and the general population based on highest level of education and annual household income – both strong indicators of socioeconomic status. While income information was not collected, the sample proportion of women with at least four-year college degree (85.0 percent) and the patient population proportion (84.9 percent) were virtually identical. Both contrast distinctly with 31.4 percent of women with four-year college degrees in the Massachusetts general population (Jain & Hornstein, 2005). Using education level as an indicator of socioeconomic status, we can infer that the infertility patient population is of a higher status than the general population, and that the sample was appropriately reflective of these characteristics.

Of the twenty couples, six couples had no diagnosis in either partner and were relegated to the “unexplained” category; another six couples had ambiguous, partial diagnoses which were not made until *after* treatments had failed. Of the remaining eight couples that had diagnoses, only six were diagnosed with conditions not considered fully prohibitive of conception. For only two couples did medicine offer no potential solution, save donor gametes (for the treatment of azoospermia) and/or surrogacy (for the treatment of premature ovarian failure). Fifteen of the twenty couples represented had undergone IVF; all but one of the remaining five had gone through between three and eight cycles of intrauterine insemination (IUI). Thus, nineteen of the twenty couples have had very prolonged treatment experiences (the final couple had a very prohibitive prognosis and abandoned treatment after two failed IUI cycles), and have been living the

patient experience at an intense level for quite a long time. Indeed, the average time spent trying to conceive was 3.7 years, ranging from four months to ten years.

Interviews. Subjects were interviewed in a location of their choosing to ensure ease of participation; the interviews lasted on average eighty minutes. All research was conducted in accordance with the Health Insurance Portability and Accountability Act (HIPAA) for maintaining confidentiality and removal of Protected Health Information (PHI).

Analysis. Interviews were transcribed and organized following an analytic inductive process which included data reduction along emergent themes, data clustering to derive conclusions, and conclusion drawing to make sense of the participants' stories (Miles & Huberman, 1984; McGuffey, 2008). The data clusters were grouped according to general themes, aspects of the patient experience, and ways of making meaning. From these clusters, ways of coping, practices of resistance, and new models of understanding infertility became apparent. These findings are not meant to suggest that *beliefs* divergent from the biomedical model necessarily promote *behaviors* that are resistant to that model; instead, both beliefs and behaviors become ways of making meaning of a challenging experience.

Findings

The Patient Identity. Under the biomedical model, individuals experiencing infertility assume the patient identity and follow a treatment protocol that frequently requires daily medication and injections, regular medical appointments, and constant

lifestyle alterations. Kimberly, who had been trying to conceive for four years, described the consuming nature of the experience:

[Infertility] affects every single aspect of your life, in a million, trillion different ways. It's financial, it's emotional, it's medical, it's physical, it involves your family, your friends, every single thing – I can't walk down the street without dealing with it. It involves everything.

Frequently, assuming the patient identity comes at the cost of other identities. Charlotte was one of three women to give up her career while pursuing treatment; she justified this decision as a way of transitioning into the identity she hoped to ultimately assume, as a mother:

I'm not doing a good job at work and I'm not getting pregnant, probably because I'm stressed at work... I took a decent step down purposefully to be able to not have to devote as much time to my job so I could focus on trying to have a kid... I love the job right now, and I actually, because I think I've mellowed out in so many other ways... I don't need a career.

Many couples reported feeling stalled, as they delayed major decisions while waiting to see how their infertility would be resolved, and trying to be prepared for all options. Julia reflects:

You feel very stagnant in your life. For two years, I felt like I couldn't make a job change, it was hard to plan vacations, it was scary to spend big amounts of money – for example, a car, or a kitchen renovation, because I didn't know if we'd be paying for an adoption. I just felt sort of stuck. You didn't want to feel three, four, five years have gone by, and you haven't redone the kitchen, and you haven't gotten your new car, because you've been waiting for five years to figure out if you're gonna have a baby.

The sacrifices, the waiting, the inability to plan – these represent the larger struggles of living as a patient indefinitely.

Participants also struggled with the daily reality of being constantly medicated.

Beyond the challenges of physical side effects (though those certainly took their toll),

these women did not feel like themselves; they felt like their identities were compromised by the medications:

Sarah: This drug [Clomid] made me crazy. I usually am a pretty even-keeled person, and I would cry at the drop of a hat... I remember lying in the living room downstairs and I would lie on the couch under a blanket, weeping the entire time. Just for no particular reason... I think I just need a break from it. And I really thought I'd never get to this point... But I really finally reached a point where I need a break. I need to breathe. I keep saying, I need to get back to me. Mentally and physically. Mentally it's made me a much more bitter and angry person, that I *hate*.

The physical and emotional toll of a daily medication regimen, paired with the logistical challenges of fundamentally rearranging schedules to accommodate doctor's visits, make it impossible to not be constantly aware of one's patient identity.

For Karen, the toll of treatment became too much. The patient identity was too burdensome, and she began to give up her goal of being a mother rather than assume it again:

Just the thought of having to go through that again just literally exhausted me. It had been the worst six months of my life, emotionally, physically, mentally. It was so draining, and I just – I couldn't do it. So I thought, well, I'll just take the summer off. And then when summer passed and fall came and I was back on my antidepressants and I was feeling good and I was exercising everyday and I had lost the weight I had gained, and I thought, oh my god, I can't go through that again... So I just never went back.

For most, however, the elusive goal of parenthood was what maintained most couples' strength to continue in the process, while still managing the other aspects of their lives.

As Robert said, "This whole process happened, and in the meantime, you've gotta keep living." Though perhaps Sarah, in her third year of treatment, stated it best: "I absolutely want a family. And that's why we keep going."

The Need to Negotiate. Living within the patient identity dictated by the medical framework requires sacrificing a large amount of control and losing the ability to plan.

This disempowerment is not just the result of the illness, but of the treatments; Amy commented that, instead of giving her some sense of control, the “treatments are taking control away on another whole level.” To regain control, participants showed a wide range of behaviors that allowed them to feel more empowered in the course of treatment.

It is vital to remember that the majority of couples began treatment with no definitive diagnosis as to why they were having difficulty conceiving. Those with unexplained infertility truly struggled with this ambiguity:

Charlotte: I would say globally, not having a diagnosis [was the hardest part]. That made me crazy, that really bothered me. That was a thing that I kept just being like... “Why aren’t you more curious about this? Why don’t you want to find out what this is?” to doctors. So that was a global stress – we can’t fix this because we don’t know what’s wrong and no one wants to know.

Even Meredith, who was diagnosed with premature ovarian failure, was able to acknowledge the benefits of having an answer: “As shitty as [the diagnosis] was, you could kind of move right on to the grieving part, and not waste a whole lot of time.” In a world where an answer – any answer, even a bad one – is a luxury not always provided by Western medicine, it is no wonder patients frequently seek to challenge the biomedical model.

Participants exhibited eight strategies of varying compliance, negotiation, and resistance to the biomedical model: 1) outright compliance; 2) going beyond medical treatment and making lifestyle changes; 3) pursuing alternative treatments; 4) seeking information and advocating for themselves as patients; 5) using their religion, spirituality, or magical thinking to develop other, non-bodily ways of controlling infertility; 6) extracting meaning and learning lessons from the experiences; 7) building personal,

alternate models that encompass a wide range of ways of thinking about infertility; and 8) directly challenging the scientific authority of the biomedical model, resisting the terms of treatment, or questioning the ability of medicine to offer them solutions. No participants showed pure compliance and none showed full resistance. Rather, they built their own strategies and models for maintaining control while operating under the patient identity and interacting with the biomedical model.

Compliances. Compliance with the biomedical model would seem to be the default choice for those seeking medical treatments, and for many it was – at first. Negotiations and resistances were gradually integrated; there was always a point at which the medical treatments were no longer viewed as sufficient.

Men were far more likely to show higher levels of compliance and faith in medicine than their female partners. While women felt a higher degree of control because most treatments focused on their bodies as site of virtually all intervening procedures, men reported feeling slightly more removed from the process (physically, if not emotionally). Consequently, they did not seem to view the negotiating behaviors as likely to improve the outcome. While his wife sought information about alternative treatments, Joseph resolutely stated: “I personally try to collect my information from the doctor, because there’s a lot of opinions online. You don’t know where the information’s coming from, and if it’s valid or not.” In this construction the doctor is the highest authority, and the best possible hope of solution. Again, Andrew illustrated this gender difference:

I haven’t looked up much, I haven’t read much. Yeah... it’s not really like me, though, ‘cause I’m just kind of trusting the doctor that he knows what he’s doing. And I don’t

really want to know too much. I can only cope with so much. I trust Kelly and the doctors... It's too much. It's just so much. It is overwhelming. I think we [husbands] have to be [more optimistic].

For him, trusting the doctors, trusting his wife, and having a high level of optimism that treatments will work is the best way to deal with the absence of another possible solution.

Andrew is fully accurate in his statement that husbands are more optimistic – all participants in heterosexual relationships commented that the male partner was more confident that medicine would provide a solution. When Sarah was asked how certain she was that she would be a mother one day, she said fifty percent; when her husband was asked the same question, he said “mid to high nineties.” For most male partners, this optimism did not necessarily seem to be best attributed to their gender, but rather their perception of themselves in a supportive role through treatments. They felt adopting an upbeat and optimistic stance was the best way they could support their partners. Regardless of the reason for this increased optimism, however, this gender difference indicates that women will be more likely to seek other negotiations of the biomedical model; lack of faith in the model is the first prompting to seek other solutions.

For most, following medical treatments meant ceding control, and negotiations became a way to attempt to regain it. However, Janet stated that “[her] coping mechanism was to give up control.” After moving across the country in order to benefit from Massachusetts’ insurance mandate, she felt tremendous relief to be able to hand over her care to her doctor:

The idea of somebody with a professional degree being in control of this process instead of me – and then the fact that they’re in control also means that they’re responsible for it if it goes wrong – was a huge relief. It just made it feel like I could continue... It made me feel like if something went wrong, it would not be my fault. The clinic was

responsible for the process. I'm sure some people find that disempowering, but for me, I found it a huge relief.

For Janet, compliance was the best solution. By constructing the medical model as blameless, compliance becomes a relief, and relinquishing control a way of relinquishing burden.

Furthermore, the construction of infertility as a disease justified treatment as a primary means of resolution. Participants suggested other ways of resolving, such as adoption or living without children, but for many, the pursuit of treatment was justified by understanding their infertility as a disease deserving of treatment:

Kimberly: There's all these arguments of "Why would you do IVF anyway, you can just adopt!" I say that infertility is a disease, and that you should have a right to treat it the way you treat any other disease... There are instances where it's untreatable, like any disease, and I understand that. I don't know what I say to those people. I say, "Are you kidding me?" I believe that having children and not having children is an inherent right.

Seeking medical treatment for a disease is more easily constructed as a right than pursuing expensive, stressful interventions (which may not work) to become parents.

The disease model simplifies the debate by removing other complicated questions.

Broadly, we expect medicine to provide solutions for diseases, we expect people to have access to these treatments, and we do not question patients' right to pursue such treatments. Here, conceptual compliance with the biomedical model and the disease construction removes the burden of determining who is worthy of intervention (and consequently, questioning whether oneself is) because, quite simply, everyone who has the disease has the right to treat it.

Negotiation: Lifestyle Changes. Even those patients who had high levels of faith in the biomedical model felt the need to go beyond medical treatments, often by

making lifestyle changes that were seen as ways to gain more control over one's fertility. They become ways of negotiating, without denying, the determinative authority of the medical model. Most frequently, these changes involved modifications in diet and exercise:

Kate: We have changed our lifestyle. We've been cooking at home more and eating out less. We dusted off the treadmill. I hate to run, so my husband's been running. I bought a yoga tape. Never thought that I would, but I really like it... I think it actually does relax me. So at night now, instead of watching TV, I am doing that and then I read. And it seems to work out.

Kate's account is very consistent with the stories of most participants, at least early on in the treatment process. Most participants reached a point, however, when the rigor of upholding such self-conscious lifestyles became too burdensome. The strength of this negotiation is that it gives participants many variables they can control; the weakness of this negotiation is that it places a tremendous amount of pressure on participants to maintain the high standards of behavior. Ultimately, when treatments continue to fail, most participants abandon this negotiation. As Mary said, "At one point I just said... screw it." Ultimately, lifestyle changes are an early negotiation that most readily fulfills the need to "do everything" possible to ensure conception. These efforts do not deny the potential of Western medical treatments, but recognize that medicine will work best under "optimal" conditions that they can work to ensure.

Negotiation: Alternative Treatments. Alternative treatments were viewed by most participants as an extension of the lifestyle changes that they were making. Unlike the lifestyle changes, alternative treatments involved the introduction of another

practitioner or practices specifically discouraged by physicians, making them something entirely different.

For some, alternative therapies and practices represented valid treatments that, through their own therapeutic properties, would improve their chances of conceiving:

Amy: The yoga and the acupuncture have helped, absolutely. Definitely with stress reduction, but I think also with my temperature. My temperature is getting more steady. And I can tell, after a treatment, my temperature will go up. I'm definitely a believer on that. And I think the yoga is really important for the relaxation and concentration and trying to get back to being calm and getting out of my head a little bit.

Like Amy, many believed that treatments improved basal body temperature cycles and led to more blood flow to their reproductive organs. Other participants remained skeptical of the potential of alternative therapies to induce bodily changes, but viewed them as invaluable ways to help them relax, reduce stress, and alleviate side effects of various medications. Meredith, diagnosed with premature ovarian failure and left with extremely few medical options, used alternative treatment before ultimately moving on to adoption:

Meredith: I did not expect [the acupuncture and herbal remedies] to restore my fertility necessarily. They were very effective at addressing symptoms I was having... Also, there was definitely just feeling like, because I basically was told that there was not anything that I could do medically, it made me feel like I was doing something. So, that was a big motivator. It was just something concrete to do, to channel the energies. And, it had these positive, these therapeutic effects as well.

Almost all of the participants who used alternative therapies had extremely positive experiences with them, and viewed them as an integral part of treating their infertility.

By far the most common alternative treatment was acupuncture, with 18 of the 20 participants pursuing it. The prevalence of this treatment raises the question: can acupuncture truly be called “alternative” if such a large majority of participants engage in

it? Given the context in which participants framed their use of acupuncture, yes. While no reproductive endocrinologists discouraged patients' use of acupuncture, none encouraged it, and most responded to their patients' use of acupuncture with indifference. Pursuing such therapies was truly patient-driven. In some cases, participants framed their use of acupuncture as definitively resistant to their doctor's approach:

Charlotte: [Acupuncture] made me feel like I was doing something... It felt like something I could be in control of and make the appointments myself, and be like "I'm doing acupuncture, doctor, I don't care what you say." It was satisfying.

From this approach, it does not matter how common acupuncture is. If participants *view* it as resistant to Western medicine, it *becomes* resistant; it becomes a way for them to negotiate by working outside the medical treatments that are failing them.

Negotiation: Information Seeking and Patient Advocacy. In contrast to actively pursuing non-Western medical treatments, advocating within the medical setting may seem to be a less challenging means of negotiating. However, recognizing that *all* participants pursued medical treatment, regardless of the extent to which they also incorporated alternative therapies demonstrates that working within the system as their own personal advocate becomes a critical way of responding to the biomedical model.

The most frequently means of advocacy was seeking a second opinion (eleven of the twenty couples had switched doctors at some point). Changing doctors was rarely done simply because the participant did not like the doctor, but instead because, after educating themselves about their care, they fundamentally disagreed with how they were being treated. As a negotiation, however, seeking a second opinion is relatively

unchallenging – it attributes the lack of answers to the individual doctor or medical practice – but it does encourage them to think more critically about their care.

The second level of patient advocacy was information seeking, not simply for their elucidation, but as way for them to find new protocols to try. Julia suggested a couple different treatment protocols to her doctor, who actually followed through with those suggestions. She describes her process of seeking information and requesting these treatments:

I felt like I need to go into this with as much knowledge as I could. As much as I loved, and still do love, my doctor, they don't give you all the answers. A lot of what we did along the route was stuff that I read about and mentioned. I had read that some clinics will do, when you're doing an IUI, they'll actually do two. I remember talking to my doctor about it... and she let us do it. She never volunteered that information, but I had read about it.... That kind of stuff, you have to just be your own advocate. For me, the way to do that was just to read as much as I could.

Julia was not alone in embracing this advocate role; after being repeatedly let down by the medical treatment, advocating for themselves seemed intuitive to most women: as Laura said, "I used to put a lot of stock in doctors' knowledge and doctors as knowing. Over the years, I've learned that I know myself better than anybody else and I know my body, and I need to be an advocate for myself." Adopting this role enabled them to take responsibility for their treatment. They did not cede the authority to their physicians, but instead delegated themselves as capable of directing their own treatment from the position of the empowered patient advocate.

Negotiation: Religion, Spirituality, and Magical Thinking. While all previous negotiations have functioned in different ways, they have shared a focus on the body as the site of infertility and different ways of maximizing the impact of treatments. Yet, as

in all important experiences, religion and spirituality became a way of understanding infertility for half of the sample (13 of 26 participants). For most, it was a simple practice of praying more, or having faith in God's plan for their families:

Meredith: Personally, I'm not surprised this is how it's unfolded. I never really necessarily pictured myself as having children biologically. I just kind of always had this feeling. I kind of feel like, for me, it's a spiritual thing, trying to discern what God's will might be for your life and trying to go with it and not fight against what life is offering you... My thing isn't that I need to be pregnant or I need to have a baby, but I want to be a parent with Robert. I just think that's how it's meant to be.

As a negotiation, religious and spiritual models do not negate the capacity of the biomedical model, but instead hearken back to earlier understandings, in which infertility and its potential solutions are out of human hands. Thus, spiritual models provide hope: there is a plan, even if it cannot be realized at this moment; with patience, a solution will be found. If treatments fail, it is because they were not meant to succeed. From this perspective, spiritual models can alleviate self-blame.

For some, religion was less a solace and more a challenge: does God want me to suffer? The struggle with these blame-based religious understandings may seem self-punitive, but they are in many ways a natural extension of the "doing everything" approach to treatment: Am I truly doing *everything*? Am I being a good enough person? Am I deserving of this? These challenges are another example of where the biomedical model, despite the tremendous burden it can place on patients, can in many ways be less blaming than alternatives.

The final extension of spiritual-type understandings of infertility was through types of magical thinking. In these cases, the participants recognized that their reasoning

was irrational, but were still seeking order from the seeming randomness of treatments continual failure:

Cynthia: There's a couple times when someone's pregnant, and not that I get jealous, but I think... oh, they're pregnant so that means I'm not gonna get pregnant. That crosses my mind. There's a pregnant person so that means I'm not. Also, where there's three... I'll do that too. Someone will tell me someone's pregnant, and there's one, and then the second one, and then the third, and I missed it!

This break from logic, which was readily acknowledged by all women who mentioned it, does not necessarily represent a negotiation. Instead, it illustrates the extent to which the need to find meaning, no matter how irrational it may be, drives the experience of infertility.

For those participants who felt that their spirituality or religion influenced their understandings of infertility, it was often a very significant factor in how they handled the experience. However, for the majority of people – 14 of the 26 interviewed – there was little or no relationship between this medical diagnosis and their faith. Kimberly assertively states:

To say that any higher power, whoever it may be, makes these kind of decisions... it's not. I believe that my body, for some reason, there's something going on. There's a medical reason for it, it's not because God has so chosen me to be barren... I don't believe that it has anything to do with a higher power... I find it kind of ignorant.

For Kimberly, and many others who shared her reasoning, seeking spiritual models meant that a higher power had judged her not worthy of being a parent, which she refused to accept.

Negotiation: Extracting Meaning and Reaching Others. Participants also sought meaning in many other ways, outside of the religious and spiritual spheres. This approach serves as a negotiation by imbuing a medical diagnosis, which is typically

conceived as objective – with subjective meaning; it becomes a catalytic and transformative experience for those going through it. Given the extent to which treatment protocols dominate the schedules, bodies, and minds of patients, by framing it as a “learning experience,” participants were able to feel they were getting something from failed treatments. Most participants felt that they were better able to approach the experience as not *merely* a biomedical process, but more holistically as a meaningful, subjective, and frequently transformative, experience.

The most common lesson learned was repeated, almost word for word, by many of the women interviewed: “I’m stronger than I ever thought I could be.” Several also said that, despite many challenges to their relationships, they felt that their marriages were stronger than they had previously been, and that they and their partners were better prepared to be parents than they would have been had they not gone through infertility. Michelle, pregnant with twins through egg donation at the time of her interview, reflected how infertility had made her a “much more open, and flexible” person. Generally, participants considered themselves to have grown through the experience. Frequently, these lessons were framed as being in service of the ultimate goal: parenthood. For example, they were now more patient, more flexible, more prepared for the unexpected, which was interpreted as being better prepared psychologically, emotionally, and spiritually for the experience of raising a child.

Many participants also created meaning by reaching out to others. The simplest form of reaching out was increasing education amongst women about their own fertility. Many viewed this increase in information as imperative, suggesting venues for sharing,

such as high school health classes, early conversations with gynecologists, and increased willingness on the part of infertility patients to speak about their experiences. Indeed, this desire to make issues of infertility more visible was often one of the primary motivating reasons why individuals elected to participate in this research.

Beyond sharing information, some participants suggested an alternate way of reaching out to other patients – while at the same time subverting what they viewed as an unjust insurance system – by sharing unneeded medication. Even though Kimberly is still pursuing treatment, she receives more drugs per cycle than she needs to use, a surplus that can safely be passed on to women without such generous coverage. She shared her unused medications with her sister-in-law, who lives in a state without mandated insurance coverage. Medication sharing (and Kimberly was not the only participant to engage in it) is not only a way of creating personal and social meaning, but also a way of addressing an inherent inequity between those with insurance coverage and without. Beyond negotiating with the biomedical model, then, this behavior attempts to subvert the structure of the American healthcare system.

Negotiation: Building Alternate Models. It is not merely the adherence to a single negotiation that helps address the inadequacies of the biomedical approach, but the gradual building of a model which incorporates a wide range of understandings. Often, biology plays a significant part in this explanation, but within a framework that makes it quite different from the medical model. Meredith, who has stopped treatment and is pursuing adoption, describes her model:

I feel like why, on the one hand – just, biological fluke. Sometimes I really seriously do wonder why. I always come back to the greater idea of why... you know, this is God's

plan for our life. We have so many great things in our life, we have so many blessings, maybe this is what we're destined to do, to provide a nice life for some poor kid or a couple of kids who are living in some shitty orphanage somewhere. Maybe there is some greater purpose to it all.

Although biology is the primary variable she mentions, she couples it with the word "fluke," implying a large amount of randomness and reducing it to little explanatory value. She moves on to incorporate her religion and her sense of a greater purpose – explanations which reaffirm her decision to follow through with adoption.

Other participants built models similarly, while coming to drastically different conclusions:

Laura: I think I'm always looking for what I did wrong. I was on the birth control pill for years, I was on depo-provera for a long time. I thought maybe it was drugs and alcohol from when I was younger... Maybe stress, I've thought.

Kimberly: When I look at it as my disease... I don't think that they have found the reason. I think there's a reason. They just don't know what it is. So, one, it's not unexplained... I guess it's unfound more than unexplained, because they just don't know. I feel like there is a medical reason... They haven't figured it out yet. They might never, but there is a reason.

Both women recognize the deficits of current medical knowledge; Laura negotiates by offering her own, complementary possible explanations, while Kimberly negotiates the same inadequacies by recognizing the limitations of knowledge as temporary and focusing on the capacity of biomedicine to accumulate further knowledge. These alternate models represent the incorporation of participants' histories, belief systems, and social realities *with* their medical diagnoses and treatment prognoses to build explanatory models for infertility most relevant to them, so that they might move forward with a comprehensive approach that best addresses their needs.

Challenges and Resistances. Participants were often acutely aware of the shortcomings of interventions and the limits of medical knowledge, an awareness that reflects the lack of explanations or solutions they were given. For many participants asked to make seemingly minute changes cycle-by-cycle, the alterations signified a large amount of randomness and guesswork on the part of physicians, which felt inconsistent with their ideas of what “science” and “medicine” should be. Amy and Hannah reflect:

Amy: There’s no answer, it’s almost more like an art verses a science... Some days I’m like, I don’t even know if they know what they’re doing. They’re just guessing. And that part is, like, oh my god, you don’t know what you’re doing and you can’t give me an answer and you’re a doctor.

Hannah: It makes me really believe that, if you’re an infertility patient and you manage to get pregnancy, it’s 80% luck. I very strongly believe that. Because they never figured out what was wrong.

The diction in these narratives (“art,” “luck”) does not merely signify frustration or pessimism; it goes beyond that to reveal an entrenched criticism and skepticism that Western medicine has the capacity to provide answers not just to their own cases, but infertility more broadly.

Mary, who works as an occupational therapist with patients with brain injuries, grapples with the limits of Western medicine on both personal and professional levels:

I just think it just makes you realize how little we know about the human body... Because I deal with stroke patients, and families ask you, “Oh, will they recover?” I don’t have a magic ball. I think the same thing goes for fertility. It’s an art. It’s not a science. It’s not black and white. Nothing in Western medicine is black and white.

This model, like many of the others before, represents a critical deconstruction of the authority, objectivity, and capacity of Western medicine. Given the profound cognitive dissonance that results from the *behaviors* of actively pursuing medical treatment, despite

the *beliefs* that the biomedical model is deficient in knowledge and insufficient in practice, the negotiating behaviors in which patients engage seem intuitive ways of coping with a conceptual model that does not fully meet their needs as patients, who want a solution, or people, who want an answer.

Regaining Control. Ultimately, the goal of negotiations and resistances is to regain control within the patient experience. It was through adapting the biomedical model that they were able to recapture their sense of empowerment:

Hannah: I felt like I didn't have enough control. Well, you have no control. So, I wanted control wherever I could find it. I mean, if it's only reading or surfing the net, or becoming involved with RESOLVE, or joining a support group – it was something that made me feel like, at least if I'm not in control of what happens, at least I'm in control of my care... Towards the very end [I felt like I gained control]. I feel like by choosing the doctor I chose, and by choosing to consult with another doctor, and by making the choice to adopt... I feel like I was taking back control of the situation.

For all of the participants, the need for greater empowerment was palpable. To not have control over one's own pursuit of parenthood is a startling and disempowering experience, and only through the negotiations previously described were participants able to maintain hope and regain not only their control, but their sense of themselves.

Resolutions: Moving beyond the Patient Identity. For those participants who had ended treatment – either because they had successfully conceived, moved on to adoption, or decided they no longer had the emotional or financial resources to continue – there was a gradual return to their former selves. These participants gladly shed the patient identity, while still recognizing the enduring changes that going through infertility had made to their lives and personalities:

Hannah: Now I feel like my old self. I feel like things come out of my mouth that I haven't even considered saying in so long. It's like there was this blockage in there, and it's so much... it's so different now that I've reached this point in my pregnancy.

Additionally, many felt that they would be (or were) different parents than they would have been, had they not gone through infertility:

Kelly: When you're initially thinking about [having a baby], you're like... Oh, babies are so cute. And then the longer you have to wait you think of the crappy moments too. And I'm so ready for that, too. When we have to bring it to the emergency room, or having it get hurt or sick – I'm ready to stay up all night with a sick baby. I want it all.

Meredith: Infertility takes all of the romantic notions... to this whole other realm of "Would you take a baby with half an arm?" [when filling out adoption paperwork.] It's an ultra-realistic approach to parenthood, if not somewhat more focused on the negative aspects.

Infertility changes family-building from the joyous experience that these participants expect it to be into an ongoing struggle that involves many challenges and much compromise. When looking at something as important as how a family is formed or how a mother understands parenthood, the impact can be profound – not just for the impacted family, but for how society conceptualizes of the idea of the family.

These changes are long-lasting. Nicole and Janet, both of whom have successfully had children, still feel the repercussions of infertility in their daily lives:

Nicole: I always get choked up thinking about anything that I ever went through, and I always feel like it's just so fresh, like it was just the other day. And it's been years.

Janet: I feel like I'm not comfortable with the reality that the world works that way. I don't understand why this really unfair thing happened to me... The world is not as trustworthy of a place as it had been.

For Nicole, Janet, and the rest of the participants, infertility had fundamentally changed the way they understood themselves, the way they imagined their families, how they

interacted with their partners, the way they envisioned parenthood, and how they understood the world around them.

Discussion

Despite the overwhelming authority of the biomedical model, these participants have shown a complex understanding of their infertility by building alternate ways of understanding. However, there are benefits to many of these couples as a result of having such a model available. Most powerfully, medicine provides the framework for presenting infertility as a straightforward illness or condition requiring comprehensive treatment. Popular discourse on infertility is generally not accepting of individuals' right to pursue treatment, and resolutely opposed to providing insurance coverage for such procedures:

It's a choice, not a right, to seek these treatments. I'd really like my insurance company to pay for a Botox treatment because I'm older and getting wrinkles. It's cosmetic, not life threatening. To many women, like me, who do not want children, it almost seems like a vanity project... What happened to Darwinism and survival of the fittest? (Mundy 2009)

Society doesn't accept infertility as a legitimate disease. That is because for most recipients, it isn't a disease -- they've just aged beyond the point where conception is supposed to occur. (Mundy 2009)

These arguments are at the least judgmental, if not ignorant or simply incorrect.

However, they do reflect the many challenges that couples reported hearing from others while they attempted to resolve their infertility: Why don't you just adopt? Why do you really want to be a parent? Why does this deserve to be covered by insurance? Citing the biomedical model and explaining infertility as a disease becomes a simple way of transferring the authority of medicine to what is, in popular discourse, a questionable and undeserving diagnosis. Thus, even those that are skeptical and challenging of the strict

application of the medical model to infertility are still reliant on it to provide a legitimacy which society seems reluctant to cede.

Yet, because the biomedical model remains focused on the individual, any benefits derived from its use (like the argument for insurance mandates) still structure the problem on a microcosmic level. Because insurance mandates have not been shown to reduce racial and socioeconomic disparities (Jain 2006), they do not truly represent a social justice-based solution. Instead, social justice efforts should focus on (1) reducing public health disparities in access to all healthcare, in rates of sexually transmitted infections, in access to safe birth control, abortion, and childbirth; (2) improving the safety of workplaces and the environment by reducing potential exposure to toxins that compromise fertility; and (3) improving the structure of the American workplace and the gendered division of family labor, so that couples would be better able to accommodate child-rearing earlier in their careers, should they so choose (Shanely & Asch, 2009). The social justice perspective recognizes the interconnectedness of overall wellbeing and the capacity to reproduce, without denying the biomedical model as a solution for those cases where infertility does arise. The two models – the prevention-focused, social justice-oriented, public health framework, and the treatment-focused, (re)distributive-oriented use of medicine to justify insurance coverage – are not mutually exclusive. However, employing the former will only strengthen the case of the infertility community in their use of the latter, while at the same time reducing both the scale and disparity of infertility.

An additional benefit of the social justice framework is its attention to the varying experiences of infertility based on race and ethnicity. The racial/ethnic homogeneity of

this sample is a disappointing deficit, as cultural variation is extremely likely to lead to different meanings of parenthood, pregnancy, Western medicine, and, consequently, infertility. The greater the cultural variation, the less accessibility to the biomedical model, and the more disparate the models (van Balen, 2009):

1. Black women are less likely than their White peers to pursue treatments (despite being more likely to experience infertility) (Jain, 2006) and more likely to mark their experiences with self-reliance, unspokenness of the problem, and reliance on religion and faith (Inhorn et al., 2009; Ceballo, 1999), and the internalization of the idea of the hyperfertile Black woman. For those who do pursue medical treatments, race becomes another ground for conflict with the medical model; providers seemed incredulous when they insist they have no history of sexually-transmitted infection, abortion, or previous pregnancy to which they could attribute infertility (Ceballo, 1999). Race appears to be another motivation for negotiating with the authority of the medical model, with the most profound negotiation being the drive to avoid treatment all together.
2. Due to socioeconomic, language, and cultural barriers that made them far less likely than non-Hispanic couples to pursue medical treatment, Latina women showed high reliance on models involving religion (particularly Catholicism) and cultural values of *familismo* and *marianismo* (which dictate that marriages without children are unsuccessful, and that women's self-esteem is derived from her ability to mother) (Inhorn, Ceballo, & Nachtigall, 2009). They also made use of humoral medicine, massage by a *sobadoro*, and "hot" remedies (to fix a "cold" womb) which were

designed to raise body temperature (Inhorn, Ceballo, & Nachtigall, 2009; Becker, Castrillo, Jackson, & Nachtigall 2006). As medical treatment becomes more logistically and conceptually inaccessible, individuals become significantly more likely to pursue negotiations.

3. Beyond similar economic constraints and language barriers, Arab Americans experience Islamic doctrine as an additional prohibitive factor. Scriptures are quite limiting in regards to what treatments they will allow: infertility is understood as “God given,” and gamete donation and adoption are disallowed (Inhorn, Ceballo, & Nachtigall, 2009; Inhorn & Fakih, 2006). Thus, while many Arab Americans prevail to religious models due to the inaccessibility of the medical model, they find little solace in the very limited solutions that Islam allows. For them, the religious model does not supplement the biomedical model, it supplants it; this example is perhaps the most direct conflict between models, in which an earlier model directly creates a barrier to treatment. It is worth nothing further that, while strict Catholicism could present the same barrier that strict Islam does to the use of some reproductive technologies (particularly IVF), it did not present as a barrier to any of the Catholic participants, who chose simply to ignore their church’s objects. Whether Muslim Americans would be similarly willing to pursue treatments that are denied by their faith remains to be examined.

While broader incorporation of more a more diverse patient population will provide greater insight into an even wider spectrum of negotiations, resistances, and alternate models; the diversity of responses that emerged from these participants reveals the

complexity and struggle of the infertility experience, even within a relatively similar segment of the population. Their experiences provide not only insight into their personal challenging of the biomedical model as a means of regaining control, but also the acceptance of this deficient model on a community level, as a means of presenting infertility with legitimacy. The key to better addressing the shortcomings of the biomedical model is not to refute the biological basis for infertility or to deny the medical setting as a place for treatment, but instead to build a more holistic approach which (1) acknowledges infertility as a public health, and not just individual problem, which is often preventable; (2) returns control to the individual and the couple, helping to make all options for family-building – including treatment – more accessible to all groups; and (3) incorporates individuals' beliefs and needs as valid and valuable contributions to the treatment process. Most importantly, the legitimacy of infertility must be derived from the suffering and challenges inherent in the experience, and *not* from a biomedical model that neglects to meet the needs of those who must operate under its constraints.

Chapter 5

Towards a Social Justice Approach to Family Building

When dealing with issues as complex as rights and moral obligations and as fundamental as parenthood and family structure, there are extremely few areas that are appropriately clear-cut. However, it is my hope that these pieces will begin to illustrate, each their own way, a few enduring truths that are critical to resolving the cultural tensions of biological parenthood.

First, we must recognize that the desire for parenthood is, on a social level, essential for the continuation of society. We must also recognize that biological parenthood will always be the most common way of building a family. Consequently, we should not strongly ridicule those willing to go to great lengths to achieve parenthood and maintain a parenting relationship with their child. Such drives have both evolutionary and social motives, and should be accessible even if there are biological hindrances (such as infertility) or logistical challenges (such a single-parent or same-sex parent families). Demonizing these prospective parents for not making adoption their primary pathway to parenthood would require a criticism of all families who pursue conception over (or at even simply before) adoption. If adoption is the “better” route for parenthood, either by virtue of its asserted moral superiority or society’s need for competent adoptive parents, then it is the “better” route for all potential parents. If we criticize any individuals for pursuing conception over adoption, we must criticize all individuals who do so – even though they are the overwhelming majority.

Second, we must recognize and respect the potential of all parents *to parent* their children, unless they have proven themselves incapable of or unwilling to do so. This recognition requires an active investment in families, through support – not only mental and emotional support and practical guidance, but material and financial support when needed to move towards self-sufficiency. No one parents alone, and we should not expect those most lacking in resources to do so. Truly, it takes a village. Investing in parents is not only protective of their individual rights, but will necessarily lead to an investment in children, families, and communities.

Additionally, we must expand reproductive rights discourses to *always* including means of family building (and not only means of *avoiding* family building), acknowledging that not all options are best for all women or all families. I mention women specifically here because reproductive decision-making is largely relegated to their domain, particularly decisions about most contraception (including all post-coital contraception), abortion, and adoption, and because their bodies are always the site of reproduction and frequently the site of the most intensive infertility treatments. Within the familiar discourse of “choice” we must acknowledge and incorporate more reproductive options: the choice to pursue assisted reproductive treatments, the choice to place a child for adoption, the choice to become a single mother, and the choice to become a parent before others might judge her to be ready. For couples, we must recognize the options of surrogacy, donor gametes, adoption, childlessness, and same-sex parenting. Not all of these options will be right for a given individual, and the number of variables that go into making such a decision would be too innumerable to

comprehensively detail. They include personal moral and religious beliefs, financial situations, levels of social support, current needs of the individual or family, assessments of future options, and levels of personal comfort with any given choice. These options can (and should) be regulated to ensure the safety of those involved: adoption regulation should offer protection for both birthparents and adoptive families; surrogacy contracts should acknowledge the rights of the surrogate and the intended family; and abortion is never a true choice if it is not medically safe and accessible. Beyond these necessary protections, regulation that limits family building options should be avoided, as only individuals should make decisions such as these for themselves and their potential family.

It is important to note that these populations, whose stories I have tried to tell, are not mutually exclusive – if not assuming both roles themselves, they are always interacting with one another. There was the birthmother who later suffered from secondary infertility and became an adoptive mom; a teen mother who has raising the son she had at age 15 and who had placed the son she had at age 19 for adoption. There was the woman struggling to conceive who worked as a sex educator, treating young people how to prevent pregnancy. There was the young mother who told me how she struggled with the narrative around adoption as a “loving option,” feeling as if she was being criticized for raising her daughter.

In a rare set of circumstances, I met one participant, Margaret, for the study on infertility at RESOLVE’s annual conference, and ran into her a year and a half later at ACONE’s (Adoption Community of New England) conference. She spoke at the former conference as someone who had gone through infertility, and at the latter as an adoptive

mom. I later interviewed her daughter's birthmother, Caroline, for the study on adoption. Having heard both sides of their story, I realized the careful balance that must be maintained. On one side is a White, upper-middle class, professional, married couple who wanted more than anything to be parents. After going through infertility treatments, they whole-heartedly embraced the idea of adoption; they paid "over \$30,000" to a private adoption agency to adopt a newborn girl, Nicole. Witnessing the excitement with which she speaks about becoming a mother, and the glowing words she uses to describe her daughter, I have no doubt she is a loving, wonderful parent. On the other side is Caroline, who I interviewed late at night after she was finished attending classes for the day and working at one of her two jobs. Margaret's motherhood was gained at the expense of Caroline's, who spoke of struggle, grief, and the process of building a relationship with the adoptive family. Caroline seems proud of her decision – she spoke excitedly about the trips that Margaret and her husband were able to take Nicole on, and the opportunities she believed Nicole would have that Caroline herself had not – but she also seems almost wistful, and in some ways defeated. She described the fresh grief she went through when she learned Margaret and her husband were adopting a second child: "I don't know why I was surprised. I guess I just figured she would be enough. She would have been enough for me." But she is pleased to know her daughter, and to know that Margaret refers to her as "someone very special to us" when she talks about Caroline to their shared daughter.

Did Margaret and her husband have the right to be parents? Even knowing the outcome, and hearing from Caroline about the life they're providing for their child, and

witnessing their excitement and joy, the answer must be no. If there was a right to parenthood, society would have an obligation to meet that right, and there seems to be no way to do so without violating the rights of others. The right to free speech exists, and continues to exist even when the speaker is being truly offensive, because there is no right to be free from offense. The right to parenthood cannot exist because, when it cannot be achieved biologically, it places a demand on others' parenthood – *and the right of parents to their own children does exist.*

These are the rights that I do feel comfortable asserting, based on this research:

1. There is a right to treatment for a potentially treatable medical condition, though not all infertility is a potentially treatable medical condition. Furthermore, as long as the limits of medicine do not offer reliable solutions to unexplained infertility, there should be no right to indefinite interventions once they have been repeatedly demonstrated to be unsuccessful. However, as long as a right to treatment exists, albeit limited in some capacities, there is an obligation of society to make that treatment accessible regardless of ability to pay.⁶ Whether this is achieved through cost regulation of the artificial reproduction industry, or insurance mandates, or both, treatment for medically caused infertility should have be a privilege.
2. There is a right for individuals to control their own reproductive health and reproductive lives. This right requires that individuals be given the knowledge to preserve their health, the skills and resources to prevent unintended pregnancy or

⁶ This right, however, would require that the United States recognize a broader right to affordable medical care – and make a broader effort to ensuring that right – than it has in any arena, not just infertility.

pursue conception, and an environment free from coercion or ridicule for making the decisions best for them given their circumstances. If we, as a society, feel invested in influencing the reproductive decisions of some populations (namely, young people), we must work to change those circumstances which influence individuals' decisions. Furthermore, we must employ a high level of scrutiny and examine any motivations for wishing to intervene in the reproductive decisions of specific groups: are those motivations eugenicist? Are there any valid reasons for one groups discourage parenthood amongst another group, whether the division is based on age, or race, or class, or some other social factor? I have not found evidence that such reasons exist.

3. Parents have a right to their own biological children, and unless proven abusive, neglectful, or otherwise harmful, they have the right to raise their children. If they choose to waive that right, then the conditions under which they do so should be fully informed by the best knowledge available. Finally, the terms of that waiving should be honored, otherwise violations would represent a retroactive violation of their parental rights. For example, if a birthparent places a child for adoption with the understanding that the adoption is open and will allow ongoing contact with that child, those are the conditions under which she chose to waive her parental rights. He or she might not do so if open adoption were not available (in fact, many birthparents said that, if only closed adoption were available, they would be parenting). To not have legally enforceable openness, to allow for the

fact that the conditions under which they waived their parental rights can be changed, violates those right.

4. Children have the right to be raised in safe homes give them as much opportunity as possible to thrive. When children do not have homes, or have been removed from homes that were unsafe, they should be given every chance to join an adoptive (or temporary foster) family that will provide a loving, permanent home, and that will validate their biological relationships by preserving connections and contact when it is safe and possible to do so. To maximize the number of potential parents willing to become adoptive families, adoption – even infant adoption – should be considerably more affordable for most families. The couples I spoke with who decided to adopt all struggled with and were frustrated by the cost of adoption, money they felt would be better spent on providing for their future child once they were in their home. Additionally, every birthparent agreed that the cost of adoption was problematic, and that the structure of adoption as a for-profit business was reprehensible. The high cost not only limits children’s rights to a home, but was a strain for adoptive families and a pressure for birthparents. It seems there is no justification for a profit-based adoption industry.

In addition to these rights are the ones which clearly already exist: an individual’s rights to their own body, an adoptive parent’s legal rights as the guardian of and provider for their children, and the rights of all individual’s to be safe and protected when making the choices they believe are best for themselves and that do no harm to others.

Ultimately, while it would be incorrect to assert a “right” to parenthood, parenthood should not be a privilege awarded to those deemed most deserving within social hierarchies. We must expand the scope of our understanding about family building to recognize it, essentially, as a social justice issue. The cultural tensions illustrated here are primarily rooted in fundamental inequalities based on gender, poverty, race, sexuality, marital status, and the stigma associated with non-traditional (that is, not genetically-related) families. These are entrenched prejudices that can only partially be addressed by insurance mandates or comprehensive sex education or open records laws. Instead, sexism, classism, racism, homophobia, and unfounded fears of sexuality, new technology, and social change must be deconstructed to resolve these tensions in order to build healthy, supported, and loving families. It is both as simple and as critical as how the future generations of our world brought into and brought up in this world.

Bibliography

- Alan Guttmacher Institute. (1994). *Sex and America's Teenagers*. New York: Guttmacher Institute.
- Allen, J., Philliber, S., Herrling, S., & Kuperminc, G. (1997). Preventing teen pregnancy and academic failure: Experimental evaluation of a developmentally-based approach. *Child Development, 64*(4), 729-742.
- Allen, J., Philliber, S., & Hoggson, N. (1990). School-based prevention of teen-age pregnancy and school dropout: Process evaluation of the national replication of the Teen Outreach Program. *American Journal of Community Psychology, 18*(4), 505-524.
- Ashcraft, C. (2008). So much more than "sex ed": Teen sexuality as a vehicle for improving academic success and democratic education for diverse youth. *American Educational Research Journal 45*(3), 631-667.
- Ashcraft, A., & Lang, K. (2006). The consequences of teenage childbearing. *National Bureau of Economic Research Working Paper Series*, Working Paper 12485.
- Bachrach, C. A., Stolley, K. S. & London, K. A. (1992). Relinquishment of Premarital Births: Evidence from National Survey Data. *Family Planning Perspectives, 24*(1).
- Becker, G. (2000). *The Elusive Embryo: How Men and Women Approach New Reproductive Technologies*. University of California Press: Berkeley.
- Becker, G., Castrillo, M., Jackson, R., & Nachtigall, R. (2006). Infertility among low-income Latinos. *Fertility and Sterility, 85*(4), 882-887.
- Benson, P., Sharma, A., & Roehlkepartain, E. (1994). *Growing Up Adopted: Portrait of Adolescents and Their Families*. Minneapolis: The Search Institute.
- Bitler, M., & Schmidt, L. (2006). Health disparities and infertility: impacts of state-level insurance mandates. *Fertility and Sterility, 85*(4), 858-865.
- Blanton, T., & Deschner, J. (1990). Biological mothers' grief: The postadoption experience in open versus confidential adoption. *Child Welfare, 69*(6), 525-535.
- Blum, R., & Resnick, M. (1982). Adolescent sexual decision-making: contraception, pregnancy, abortion, and motherhood. *Pediatric Annals 11*, 797-805.
- Boss, P. (2004). Ambiguous Loss Research, Theory, and Practice: Reflections After 9/11. *Journal of Marriage and Family 66*, 551-566.
- Brien, M., & Willis, R. (2008). Costs and consequences for the fathers. In S. Hoffman and R. Maynard, *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy (Second Edition)*. Washington, DC: Urban Institute Press.

- Candie's Foundation, The. (2010). History. Available: <http://www.thecandiesfoundation.org/history>. Accessed November 2010.
- Cave, G., Bos, H., Doolittle, F., & Toussaint, C. (1993). *JOBSTART: Final Report on a Program for School Dropouts*. New York: Manpower Demonstration Research Corporation.
- Ceballo, R. (1999). The Only Black Woman Walking the Face of the Earth Who Cannot Have a Baby. In M. Romero, & A. Stewart (Eds.), *Women's Untold Stories: Breaking Silence, Talking Back, Voicing Complexity* (pp. 3-19). Routledge: New York.
- Centers for Disease Control and Prevention. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth." National Center for Health Statistics, U.S. Department of Health and Human Services.
- Chandra, A., (1999). Adoption, adoption seeking, and relinquishment for adoption in the United States. *Advance Data*, 306. National Center for Health Statistics, Centers for Disease Control and Prevention.
- Chapman, C., Dorner, P., Silber, K., & Winterberg, T. (1986). Meeting the needs of the adoption triangle through open adoption: The birthmother. *Child and Adolescent Social Work*, 3(4), 203-213.
- Chapman, C., Dorner, P., Silber, K., & Winterberg, T. (1987a). Meeting the needs of the adoption triangle through open adoption: The adoptee. *Child and Adolescent Social Work*, 4(1), 78-91.
- Chapman, C., Dorner, P., Silber, K., & Winterberg, T. (1987b). Meeting the needs of the adoption triangle through open adoption: The adoptive parent. *Child and Adolescent Social Work*, 4(2), 3-12.
- Child Welfare Information Gateway. (2004). Costs of adopting. Administration on Children, Youth, and Families, U.S. Department of Health and Human Services.
- Cushman, L. F., Kalmuss, D., & Namerow, P. B. (1993). Placing an infant for adoption: The experiences of young birthmothers. *Social Work*, 38, 264-272.
- Davis-Floyd, R. E. (2003). *Birth as an American Rite of Passage*. University of California Press: Berkeley.
- Dayal, M., Gindoff, P., Dubey, A., Spitzer, T., Bergin, A., Peak, D., & Frankfurter, D. (2009). Does ethnicity influence in vitro fertilization (IVF) birth outcomes? *Fertility and Sterility*, 91(6), 2414-2418.
- Dodson, L. (1996). *We Could Be Your Daughters: Girls, Sexuality and Pregnancy in Low-Income America*. Cambridge: Radcliffe Public Policy Institute.
- Dodson, L. (1999). *Don't Call Us Out of Name: The Untold Lives of Women and Girls in Poor America*. Boston: Beacon Press.

- Donnelly, B. W., & Voydanoff, P. (1991). Factors associated with releasing for adoption among adolescent mothers. *Family Relations*, 40, 404-410.
- Downing, R., LaVeist, T., & Bullock, H. (2007). Intersections of ethnicity and social class in providers' advice regarding reproductive health. *American Journal of Public Health* 97(10), 1803-1807.
- Duvall, Evelyn. (1962). *Family Development*. New York: Lippincott.
- Edin, K. & Kefalas, M. (2005). *Promises I Can Keep: Why Poor Women Put Motherhood Before Marriage*. Los Angeles: University of California Press.
- Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science*, 196(4286), 129-136.
- Etter, J. (1993). Levels of cooperation and satisfaction in 56 open adoptions. *Child Welfare*, 72, 257-267.
- Evan B. Donaldson Adoption Institute, The. (1997). *Benchmark Adoption Survey: Report on the Findings*. Princeton: Princeton Survey Associates.
- Fessler, A. (2006). *The Girls Who Went Away: The Hidden History of Women Who Surrendered Children for Adoption in the Decades Before Roe v. Wade*. New York: Penguin Press.
- Finer, L., & Henshaw, S. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health* 38(2), 90-96.
- Foucault, M. (1978). *The History of Sexuality*. Knopf Publishing Group: New York.
- Furstenberg, F. (1991). As the pendulum swings: teenage childbearing and social concern. *Family Relations*, 40(2), 127-138.
- Furstenberg, F. (2007). *Destinies of the Disadvantaged*. New York: Russell Sage Foundation.
- Furstenberg, F., Brooks-Gunn, J., & Morgan, S. P. (1987). *Adolescent mothers in later life*. New York: Cambridge University Press.
- Furstenberg, F. & Crawford, A. (1978). Family support: helping teenage mothers to cope. *Family Planning Perspectives*, 10(6), 322-333.
- Ge, X., Natsuaki, N., Martin, D., Neiderhiser, J., Villareal, G., Reid, J., Leve, L., Shaw, D., Scaramella, L., & Reiss, D. (2008). Bridging the divide: Openness in adoption and postadoption psychosocial adjustment among birth and adoptive parents. *Journal of Family Psychology*, 22(3), 529-540.
- Geronimus, A. (1990). Why teenage childbearing might be sensible: Research and policy implications. Paper for the American Association for the Advancement of Science. New Orleans, Louisiana.

- Geronimus, A. (1992). Clashes of common sense: On the previous child care experience of teenage mothers-to-be. *Human Organization*, 51(4), 318-329.
- Geronimus, A. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease* 2(3), 207-221.
- Geronimus, A. (1996). Black/White differences in the relationship of maternal age to birthweight: A population-based test of the weathering hypothesis. *Social Science and Medicine*, 42(4), 589-597.
- Geronimus, A. (2001). Understanding and eliminating racial inequalities in women's health in the United States: The role of the weathering conceptual framework. *Journal of the American Medical Women's Association*, 56(4), 1-5.
- Geronimus, A. (2003). Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Social Science and Medicine*, 57, 881-893.
- Geronimus, A., & Korenman, S. (1992). The socioeconomic consequences of teen childbearing reconsidered. *Quarterly Journal of Economics*, 107, 1187-1214.
- Geronimus, A., & Korenman, S. (1993). Maternal youth or family background? On the health disadvantages of infants with teenage mothers. *American Journal of Epidemiology*, 137(2), 213-225.
- Geronimus, A., Korenman, S., & Hillemeier, M. (1994). Does young maternal age adversely affect child development? Evidence from cousin comparisons. *Population and Development Review*, 20(3), 585-609.
- Giedd, J. (2008). The teen brain: insights from neuroimaging. *Journal of Adolescent Health* 42, 335-343.
- Gregory, E. (2007). *Ready: Why Women Are Embracing the New Later Motherhood*. New York: Basic Books.
- Greil, A. L. (2002). Medicalization, Metaphor, and Agency. In M. C. Inhorn, & F. van Balen (Eds.), *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies* (pp. 101-118). University of California Press: Berkeley.
- Gross, H. (1993). Open adoption: A research-based literature review and new data. *Child Welfare*, 77(3), 269-284.
- Grotevant, H., & McRoy, R. (1998). *Openness in Adoption: Exploring Family Connections*. Thousand Oaks: Sage Publications.
- Grotevant, H. D., McRoy, R. G., Elde, C. L., & Fravel, D. L. (1994). Adoptive family system dynamics: Variations by the level of openness in the adoption. *Family Process*, 33, 125-146.
- Gutmann, D. (1975). Parenthood: A key to the comparative study of the life cycle. (167-184). In N. Datan & L. H. Ginsberg (Eds.) *Life-Span Development Psychology*:

Normative Life Crises. New York: Academic Press.

- Haimes, E., & Timms, N. (1985). *Adoption, Identity and Social Policy: The Search for Distant Relatives*. Aldershot: Gover.
- Harding, D. (2003). Counterfactual models of neighborhood effects: The effect of neighborhood Poverty on dropping out and teenage pregnancy. *American Journal of Sociology*, 109(3), 676-719.
- Henne, M. B., & Bundorf, M.K. (2008). Insurance mandates and trends in infertility treatments. *Fertility and Sterility*, 89(1), 66-73.
- Herman, J. (1997). *Trauma and Recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.
- Hofferth, S., Kahn, J. & Baldwin, W. (1987). Premarital Sexual Activity among U.S. Teenage Women Over the Past Three Decades. *Family Planning Perspectives*, 19(2), 46-53.
- Hofferth, S., Reid, L., & Mott, F. (2001). The effects of early childbearing on schooling over time. *Family Planning Perspectives*, 33(6), 256-267.
- Hoffman, S., Foster, E. M., & Furstenberg, F. (1993). Reevaluating the costs of teenage childbearing. *Demography*, 30(1), 1-13.
- Hoffman, S. (2008). Updated estimates of the consequences of teen childbearing for mothers. In S. Hoffman and R. Maynard, *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy (Second Edition)*. Washington, DC: Urban Institute Press.
- Hotz, V. J., Williams Elroy, S., & Sanders, S. (2005). Teenage childbearing and its life cycle consequences: Exploiting a natural experiment. *The Journal of Human Resources* 40(3), 683-715.
- Hughes, M., Furstenberg, F., & Teitler, J. (1995). The impact of an increase in family planning services on the teenage population of Philadelphia. *Family Planning Perspectives*, 27(2), 60-65.
- Inhorn, M. C., & Fakh, M. H. (2006). Arab Americans, African Americans, and infertility: barriers to reproduction and medical care. *Fertility and Sterility*, 85(4), 844-852.
- Inhorn, M. C., Ceballo, R., & Nachtigall, R. (2009). Marginalized, Invisible, and Unwanted: American Minority Struggles with Infertility and Assisted Conception. In L. Culley, N. Hudson, & F. van Rooij (Eds.), *Marginalized Reproduction: Ethnicity, Inferility, and Reproductive Technologies* (pp. 181-198). Earthscan: London.
- Iyengar, S., & Lepper, M. (2000). When choice is demotivating: Can one desire too much of a good thing? *Journal of Personality and Social Psychology*, 79(6), 995-1006.

- Jain, T. (2006). Socioeconomic and racial disparities among infertility patients seeking care. *Fertility and Sterility*, 85(4), 876-881.
- Jain, T. & Hornstein, M. D. (2005). Disparities in access to infertility services in a state with mandated insurance coverage. *Fertility and Sterility*, 84(1), 221-223.
- Jencks, C. & Edin, K. (1995). Do poor women have a right to bear children? *The American Prospect*, Winter 1995.
- Johnson, S., Blum, R., & Giedd, J. (2009). Adolescent maturity and the brain: The promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health* 45, 216-221.
- Jones, E., Darroch, J., Goldman, N., Henshaw, S., Lincoln, R., Rosoff, J., Westoff, C., & Wulf, D. (1985) Teenage pregnancy in developed countries: determinants and policy implications. *Family Planning Perspectives* 17(2), 53-63.
- Jones, M. (1993). *Birthmothers: Women Who Have Relinquished Babies for Adoption Tell Their Stories*. Chicago: Chicago Review Press.
- Jones, R., Darroch, J., & Henshaw, S. (2002). Patterns in the socioeconomic characteristics of women choosing abortions. *Perspectives of Sexual and Reproductive Health* 34(5), 226-235.
- Kielmann, K. (1998). Barren ground: contesting identities of infertile women in Pemba, Tanzania. In M. M. Lock, & P. A. Kaufert (Eds.), *Pragmatic Women and Body Politics* (pp. 127-163). Cambridge University Press: Cambridge.
- King, L. & Harrington Meyer, M. (1997). The politics of reproductive benefits: U.S. insurance coverage of contraceptive and infertility treatments. *Gender and Society* 11(1), 8-30.
- Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kirby, D., Coyle, K., & Gould, J. (2001). Manifestations of poverty and birthrates among teenagers in California zip code areas. *Family Planning Perspectives*, 33(2), 63-69.
- Koo, H., Dunteman, G., George, C., Green, Y., & Vincent, M. (1994). Reducing adolescent pregnancy through school and community-based education: Denmark, South Carolina, revised 1991. *Family Planning Perspectives*, 26(5), 206-217.
- Koropecjy-Cox, T. & Pendell, G. (2007). Attitudes about childlessness in the United States: Correlates of positive, neutral, and negative responses." *Journal of Family Issues* 28(8), 1054-1082.
- Kraft, A., Palombo, J., Mitchell, D., Woods, P., & Schmidt, A. (1985a). Some theoretical considerations on confidential adoptions: Part I, The Birthmother. *Child and Adolescent Social Work*, 2(1), 13-21.

- Kraft, A., Palombo, J., Mitchell, D., Woods, P., & Schmidt, A. (1985b). Some theoretical considerations on confidential adoptions: Part II. *Child and Adolescent Social Work, 2*(2), 69-81.
- Kraft, A., Palombo, J., Mitchell, D., Woods, P., & Schmidt, A. (1985c). Some theoretical considerations on confidential adoptions: Part III. *Child and Adolescent Social Work, 2*(3), 139-153.
- Kressier, D. K., & Bryant, C. D. (1996). Adoption as deviance: Socially constructed parent-child kinship as a stigmatized and legally burdened relationship. *Deviant Behavior (17)*, 391-415.
- Landry, D., & Forrest, J. D. (1995). How old are U.S. fathers? *Family Planning Perspectives 27*(4), 159-161+165.
- Lipper, J. (2003). *Growing Up Fast*. New York: Picador.
- Lloyd, M. (1996). Condemned to be meaningful: Non-response in studies of men and infertility. *Sociology of Health and Illness 18*(4), 433-454.
- Logan, J., & Smith, C. (1999). Adoption and direct post-adoption contact. *Adoption & Fostering, 23*(4), 58-59.
- Low, B., Hazel, A., Parker, N., & Welch, K. (2008). Influences on women's reproductive lives: Unexpected ecological underpinnings. *Cross-Cultural Research, 42*(3), 201-219.
- Luker, K. (1996). *Dubious Conceptions: The Politics of Teenage Pregnancy*. Cambridge: Harvard University Press.
- Manlove, J., Terry-Humen, E., Mincieli, L., & Moore, K. (2008). Outcomes for children of teen mothers from kindergarten through adolescence. In S. Hoffman and R. Maynard, *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy (Second Edition)*. Washington, DC: Urban Institute Press.
- Marsh, M. & Ronner, W. (1996). *The Empty Cradle: Infertility in America from Colonial Times to the Present*. The Johns Hopkins University Press: Baltimore.
- Massachusetts General Law. Chapter 175, Section 47H. 1987. Infertility; pregnancy related benefits.
- May, E. T. (1999). *Homeward Bound: American Families in the Cold War Era*. New York: Basic Books.
- McCarthy, J. & Hardy, J. (1993). Age at first birth and birth outcomes. *Journal of Research on Adolescence, 3*, 373-392.
- McGuffey, C. S. (2008). Saving masculinity: Gender, reaffirmation, sexuality, race, and parental responses to male child sexual abuse. *Social Problems 55*(2), 216-237.
- McLanahan, S. & Sanefur, G. (1994). *Growing Up with a Single Parent: What Helps, What Hurts*. Cambridge: Harvard University Press.

- Melchior, A. (1998). *National evaluation of Learn and Serve America school and community-based programs*. Waltham: Brandeis University Center for Human Resources.
- Miall, C. (1987). The stigma of adoptive parent status: Perceptions of community attitudes toward adoption and the experience of informal social sanctioning. *Family Relations* 36(1), 34-39.
- Miall, C. & March, K. (2005). Open adoption as a family form: Community assessments and social support. *Journal of Family Issues*, 26, 380–410.
- Miles, M. & Huberman, A. M. (1984). *Qualitative Data Analysis: A Source Book of New Methods*. Sage Publications: Beverly Hills.
- Miller, B. C., & Coyl, D. D. (2000). Adolescent pregnancy and childbearing in relation to infant adoption in the United States. *Adoption Quarterly*, 4, 3-25.
- Moore, K., Morrison, D., & Greene, A. (1997). Effects on the children born to adolescent mothers. In R. Maynard (Ed.), *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy (First Edition)*. Washington, DC: Urban Institute Press.
- Moore, N. & Davidson, J. (2002). A profile of adoption placers: Perceptions of pregnant teens during the decision-making process. *Adoption Quarterly* 6(2), 29-41.
- Mundy, L. "Jon and Kate Plus Healthcare." *The Washington Post*. June 29, 2009. Online discussion available: [washingtonpost.com/wp-dyn/content/discussion/2009/06/26/DI2009062603401.html](http://www.washingtonpost.com/wp-dyn/content/discussion/2009/06/26/DI2009062603401.html)
- Namerow, P. B., Kalmuss, D. S., & Cushman, L. F. (1993). The determinants of young women's pregnancy-resolution choices. *Journal of Research on Adolescence*, 3, 193-215.
- Namerow, P. B., Kalmuss, D. S., & Cushman, L. F. (1997). The consequences of placing versus parenting among young unmarried women. *Marriage & Family Review*, 25, 175-197.
- Nathanson, C. (1983). *Dangerous Passages: The Social Control of Sexuality in Women's Adolescence*. Philadelphia: Temple University Press.
- National Campaign to Prevent Teen Pregnancy, The. (2001). *Halfway There: A Prescription for Continued Progress in Preventing Teen Pregnancy*. Washington, DC.
- Paine-Andrews, A., Harris, K., Fisher, J., Lewis, R., Williams, E., Fawcett, S., & Vincent, M. (1999). Effects of the replication of a multi-component model for preventing adolescent pregnancy in three Kansas communities. *Family Planning Perspectives*, 31(4), 182-189.
- Park, K. (2002). Stigma management among the voluntarily childless. *Sociological Perspectives* 45(1), 21-45.

- Philliber, S. & Allen, J. (1992). Life options and community service: Teen Outreach Program. In B. Miller, J. Card, R. Paikoff, & J. Peterson (Eds.) *Preventing Adolescent Pregnancy*. Newbury Park: Sage Publications.
- Plaut, V. & Markus, H. (2005). The 'inside' story: A cultural-historical analysis of being smart and motivated American-style. In A. Elliot & C. Dweck (Eds.), *Handbook of Competence and Motivation*. New York: Guilford Press.
- Rauh, V., Andrews, H., & Garfinkel, R. (2001). The contribution of maternal age to racial disparities in birthweight: A multilevel perspective. *American Journal of Public Health, 91*, 1815-1824.
- Rich-Edwards, J., Buka, S., Brennan, S., & Earls, F. (2003). Diverging associations of maternal age with low birthweight for Black and White mothers. *International Journal of Epidemiology, 32*, 83-90.
- Roberts, D. (1997). *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage Books, Random House: New York.
- Rothamn, B. K. (1989). *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. W. W. Norton & Company: New York.
- Sandelowski, M. (1995). A theory of the transition to parenthood of infertile couples. *Research in Nursing and Health 18*(2), 123-132.
- Sandelowski, M. (1990). Failures of Volition: Female Agency and Infertility in Historical Perspective. In J. O'Barr, D. Pope, & M. Wyer (Eds.) *Ties That Bind: Essays on Mothering and Patriarchy*. University of Chicago Press: Chicago.
- Sandelowski, M. (1987). The color gray: Ambiguity and infertility. *Image: Journal of Nursing Scholarship 19*(2), 70-74.
- Savage, D. (2000). *The Kid: What happened after my boyfriend and I decided to go get pregnant*. New York: Penguin.
- Schmidt, L. (2006). Effects of infertility insurance mandates on fertility. *Journal of Health Economics 26*, 431-446.
- Schochet, P., Burghardt, J., & Glazerman, S. (2000). *The short-term impacts of Job Corps on participants' employment and related outcomes*. Washington, DC: United States Department of Labor, Employment, & Training Administration.
- Seifer, D., Frazier, L., & Grainger, D. (2008). Disparity in assisted reproductive technologies outcomes in black women compared with white women. *Fertility and Sterility 90*(5), 1701-1710.
- Shanely, M. & Asch, A. (2009). Involuntary childlessness, reproductive technology, and social justice: The medical mask on social illness. *Signs: Journal of Women in Culture and Society 34*(4), 851-874.
- Siegel, D. H. (1993). Open adoption of infants: Adoptive parents' perception of advantages and disadvantages. *Social Work, 38*(1), 15-23.

- Siegel, D. H. (2003). Open adoption of infants: Adoptive parents' feelings seven years later. *Social Work*, 48, 409–419.
- Sikkema, K., Anderson, E., Kelly, J., Winett, R., Gore-Felton, C., Windsor, R., Heckman, T., Graves, K., Hoffman, R., & Brondino, M. (2005). Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. *AIDS*, 19(14), 1509-1516.
- Singh, S., & Darroch, J. (2000). Adolescent pregnancy and childbearing: Levels and trends in developed countries. *Family Planning Perspectives* 32(1), 14-23.
- Smith, J. (1991). *Attitudes of prospective adoptive parents toward agency adoptive practices, particularly open adoption*. Paper presented to the National Committee for Adoption. April 1991. Washington, DC.
- Snibbe, A., & Markus, H. (2005). You can't always get what you want: Educational attainment, agency, and choice. *Journal of Personality and Social Psychology*, 88, 703-720.
- Solinger, R. (2000). *Wake Up, Little Susie: Single Pregnancy and Race Before Roe v. Wade*. New York: Routledge.
- Solinger, R. (2001). *Beggars and Choosers: How the Politics of Choice Shapes Adoption, Abortion, and Welfare in the United States*. New York: Hill and Wang.
- South, S. & Crowder, K. (2010). Neighborhood poverty and nonmarital fertility: Spatial and temporal dimensions. *Journal of Marriage and the Family*, 72(1), 89-104.
- Steinberg, L. (2005). Cognitive and affective development in adolescents. *TRENDS in Cognitive Sciences* 9(2), 69-74.
- Steinberg, L., & Cauffman, E. (1996). Maturity of judgment in adolescence: psychosocial factors in adolescent decision making. *Law and Human Behavior* 20(3), 249-272.
- Stephens, N., Hamedani, M., Markus, H., Bergsieker, H., & Eloul, L. (2009). Why did they “choose” to stay? *Psychological Science*, 20(7), 878-886.
- Stephens, N., Markus, H., & Townsend, S. (2007). Choice as an act of meaning: A case of social class. *Journal of Personality and Social Psychology*, 93(5), 814-830.
- Stolley, K. (1993). Statistics on Adoption in the United States. *The Future of Children*, 3(1), 26-42.
- Sykes, M. (2000). Adoption with contact: A study of adoptive parents and the impact of continuing contact with families of origin. *Adoption and Fostering*, 24(2), 20–33.
- Thomas, S. (1998). Race, gender, and welfare reform. *Journal of Black Studies* 28(4), 419-446.
- Tolman, D. (2002). *Dilemmas of Desire: Teenage Girls Talk about Sexuality*. Cambridge: Harvard University Press.

- Tolman, D., Striepe, M., & Harmon, T. (2003). Gender matters: Constructing a model of adolescent sexual health. *The Journal of Sex Research*, 40(1), 4-12.
- Tyler May, E. (1995). *Barren in the Promised Land: Childless Americans and the Pursuit of Happiness*. New York: Basic Books.
- United States Department of Health and Human Services. (2009). Births: Final data for 2006. *National Vital Statistics Report*, 57(7).
- Van Balen, F. (2009). Infertility and Culture: Explanations, Implications, and Dilemmas. In L. Culley, N. Hudson, & F. van Rooij (Eds.), *Marginalized Reproduction: Ethnicity, Inferility, and Reproductive Technologies* (pp. 34-48). Earthscan: London.
- Van den Akker, O. (2001). The acceptable face of parenthood: the relative status of biological and cultural interpretations of offspring in infertility treatment. *Psychology, Evolution, and Gender* 3(2), 137-153.
- Ventura, S. (2009). Changing patterns of nonmarital childbearing in the United States. *NCHS Data Brief*, 18. National Center for Health Statistics, Centers for Disease Control and Prevention.
- Vincent, M., Clearie, A., & Schluchter, M. (1987). Reducing adolescent pregnancy through school and community-based education. *Journal of the American Medical Association*, 257(24), 3382-3386.
- Vincent, M., Drane, W., Joshi, P., Shankarnarayan, S., & Nimmons, M. (2004). Sustained reduction in adolescent pregnancy rates through school and community based education, 1982-2000. *American Journal of Health Education*, 35(2), 76-83.
- Weber, M. (1930). *The Protestant Ethic and the Spirit of Capitalism*. New York: Routledge Classics.
- Wegar, K. (2000). Adoption, family ideology, and social stigma: Bias in community attitudes, adoption research, and practice. *Family Relations* 49(4), 363-370.
- Wellons, M., Lewis, C., Schwartz, S., Gunderson, E., Schreiner, P., Sternfeld, B., Richman, J., Sites, C., & Siscovick, D. (2008). Racial difference in self-reported infertility and risk factors for infertility in a cohort of black and white women: The CARDIA Women's Study. *Fertility and Sterility* 90(5), 1640-1648.
- Zelizer, V. (1985). *Pricing the Priceless Child: The Changing Social Value of Children*. Basic Books, Inc.: New York.