# Infertility around the Globe

*New Thinking on Childlessness, Gender, and Reproductive Technologies*

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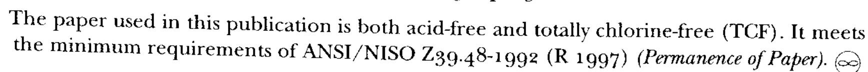

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EIGHT

# Positioning Gender Identity in Narratives of Infertility

## *South Indian Women's Lives in Context*

*Catherine Kohler Riessman*

How, in a context such as India where strong pronatalist attitudes mandate motherhood, do women construct gender identities when they cannot be mothers? Making babies is how women are expected to form adult identities the world over, and in non-Western "developing" societies the gendered consequences of infertility can be grave (Inhorn, 1994; Unisa, 1999). Psychological theories consider maternity the central milestone in adult female development (Ireland, 1993). Yet women find ways to compose lives that accommodate, and sometimes resist, dominant definitions. How is this identity work done as women move into and beyond the childbearing years?

Recent work on adult identity development questions formulations about identity as singular and continuous (Mishler, 1999). Building on these ideas and drawing on a social constructionist perspective, I show how identities are constituted in and through spoken discourse. In symbolic exchanges—conversations being the most basic—individuals interpret their pasts to communicate how they want to be known. By talking, listening, and questioning, human actors generate definitions of their situations that are in turn taken for granted as "real" (Bamberg, 1997; Harre & van Langenhove, 1999). Gender identity in particular is accomplished interactionally, continually renegotiated in linguistic exchange and social performance (Davies, 1989; Cerulo, 1997; Kessler & McKenna, 1978). Narratives developed during research interviews provide a window into the process. When we tell stories about events in our lives, we perform our preferred identities (Langellier, 2001).

I examine the personal narratives of three South Indian women who are in their forties and fifties, selected from a larger corpus of interviews with married childless women completed during fieldwork in Kerala in 1993–1994. Interviews, conducted by me and my research assistant, Liza George, were tape recorded and subsequently transcribed and translated where necessary (seven interviews were in English, the rest in Malayalam).[1] We encouraged women to give extended accounts of their situations, including the reactions of husbands, family members, and neighbors. We did not interview husbands, so their perceptions of infertility are not included except as wives represent them. (For a full description of method, see Riessman [2000a, 2000b].) The three women chosen for analysis here are among the oldest in my sample and probably past childbearing age. Constructing gender identities and meaningful lives without biological children is a salient issue for them.



Study of personal narrative is a form of case-centered research, often described as narrative analysis (Riessman, 1993, 2002). Investigators from several theoretical perspectives have adapted the methods to study issues of health and illness (Bell, 2000, 1999; Frank, 1995; Langellier, 2001; Mattingly, 1998; Mattingly & Garro, 2000). I use the approach pioneered by Mishler (1986a, 1986b, 1991, 1999), which includes the following distinctive features: presentation of and reliance on detailed transcripts of interview excerpts; attention to the structural features of discourse; analysis of the co-production of narratives through the dialogic exchange between interviewer and participant; and a comparative approach to interpreting similarities and differences among participants' life stories. I compare narratives the women develop to explain infertility, and analyze positioning in relation to identity claims. "The act of positioning . . . refers to the assignment of fluid 'parts' or 'roles' to speakers in the discursive construction of personal stories" (Harre & van Langenhove, 1999, p. 7). I analyze how narrative structure, positioning, and performance work together in women's constructions of their identities as childless women.

Several levels of positioning are my analytic points of entry into the "personal stories." First, they developed in an immediate discursive context, an evolving interview with a listener-questioner. At this level, women position themselves in a dialogic process. They perform their preferred identities for a particular audience—my research assistant and me in this case. We are also located in social spaces and bring views about infertility to the conversations, positioning the women. Second, the narratives are positioned in a broader cultural discourse about women's proper place in modern India, a "developing" nation that is developing new spaces (besides home and field) for women to labor. I show how attention to the shifting cultural context and the proximate interview context assists interpretation. Third, the women position themselves in relation to physicians (and medical technology) and vis-à-vis powerful family members in their stories. Taken together, the angle of vision of positioning in narrative provides a lens through which to explore how middle-aged women construct positive identities when infertility treatment has failed.

I now turn to the case studies, beginning with a brief description of each woman and the contexts of conversation. Detailed transcriptions of excerpts of interviews are included so that readers can examine the narratives in dialogic exchange.

## THE NARRATIVES

### *"I think that it must be because I am so old"*

Asha, who has never been pregnant, is a forty-two-year-old Hindu woman. She completed secondary school and is employed as a government clerk. Typical of women in Kerala, she has benefited from the state's educational policies: girls attend school as often as boys, and, because of similar levels of education, secure government jobs are occupied by both women and men, in contrast to other states in India.[2] Asha and her husband, from a "backward" (Dalit) caste, receive some food and housing assistance from the government. On the day we met her, she was making her second visit to the infertility clinic of a government hospital. She had previously gone for biomedical treatment for infertility in another hospital, as her narrative describes. Biomedicine is widely available in Kerala, and the hospital to which she came this time is the tertiary care center for a large district. We learn Asha had come reluctantly in the excerpt (below), but she was not reluctant to be interviewed; we spent nearly an hour talking together in a private room while she was waiting to be seen by the doctor. Liza, my twenty-six-year-old research assistant, told Asha we wanted to understand "the experience of being childless from women's points of view." The open-ended interview was in Malayalam, translated periodically for me, and Asha said she felt "comforted" by it. Although our questions focused mostly on issues of infertility and societal response, Asha directed the interview to other topics of importance to her. During the first few minutes, for example, when asked about the composition of her household and other demographic "facts," Asha's extended responses hint at complexities in gender relations: her husband is twelve years her junior and will become unemployed shortly ("we will be managing on my income alone"). The meaning of these issues only became clear later. At this point, Liza asked her about not having children.

L: What do you think is the reason why you do not have children?

A: I think that it must be because I am so old.
That is my opinion.
Other than that, no other problem.
There is this [name] hospital in Alleppey
there— I had gone there for treatment.



Then the doctor said that— after doing a scan
the way through which the sperm goes
there is some block.
And so they did a D&C.
When the results came—when we gave money to the lab
they said they did not see any problem.
After that they said I must take five pills.
I took them.
Then that also did not work.
Then they said that I must have an injection.
I had one.
They said I must come again after that.
After I had the first injection
I was disappointed when it did not work
I had hoped that it would be all right after the first injection.
When that did not happen
then I was very much disheartened.
Then when they said to come again—
then I didn't go after that. . . .

*[describes how a neighbor persuaded her to go to the infertility clinic]*

If God is going to give, let him.[3]

Asha's explanation for infertility takes a classic narrative form: she emplots a sequence of events related to medical treatment, which she locates in time and place, and she provides evaluation or commentary on their meanings. Typical of "fully formed" (Labov, 1982) narratives, hers is tightly structured and uninterrupted by the listener. Asha was forty years old at the time of the events, had been married two years, and could not get pregnant. We do not know, at this point in the conversation, why she married so late; the average age at which women in Kerala marry is twenty-two (Gulati, Ramalingam, & Gulati, 1996).

In terms of how Asha positions herself, she answers our question directly and offers her present understanding of "the reason" for infertility ("it must be because I am so old"), which contrasts with the technical diagnosis offered by a physician she consulted in the past ("there is some block"). It is her location in the life course, she says, not some internal flaw, that is responsible for the infertility. The narrator is agent, the real expert, wise and realistic about the meaning of age for fertility; she positions the physicians as "they"—the other—who depend on medical technology (a scan, a D&C, pills and injections). As the knowing subject, Asha deflects blame; age is not something she is responsible for. Her positioning aligns the listener with the narrator in a moral stance: the "I" knows better than the "other."

Asha carefully names every procedure and reports how she followed the

prescribed regime, perhaps because of the setting of the interview and her expectations about us. She positions herself for the medical context, so that she will be viewed as a "good historian" and a "compliant patient." But biomedicine failed her. It also failed to make room for emotions: no one relates to her disappointment in the narrative performance. Asha became "disheartened" when treatment did not work, and she did not return to the hospital.

In a lengthy episode (not included here) Asha performs a conversation with a neighbor in her village, who got pregnant after treatment at the infertility clinic where our interview took place. "She told me if I came here [to clinic] it will be all right." Asha said to the neighbor, "I will still have this problem of my age." The neighbor responded by saying she had seen "people who are forty-five years" in the waiting room of the clinic. Asha then agreed, very reluctantly, to try the clinic as "a last resort." As she reasoned, "there will be no need to be disappointed" because she will have tried everything.

Asha concludes the narrative with a coda that looks to religion rather than science ("If God is going to give [children], let him"). Like the first line of the narrative or abstract ("I think it must be because I am so old"), the coda acknowledges that health involves more than narrow technical problems in the body that doctors can fix. A theodicy frames the account of infertility—beginning and ending it—suggesting resistance to the biomedical model and secular beliefs about health (Greil, 1991).

There are several puzzlements in Asha's sparse narrative. Because the interview was translated from Malayalam, close examination of word choice is not appropriate, but other narrative strategies can be examined, for example, the characters she introduces in the performance and the way she positions herself in relation to them. Absences are striking: there is no mention of husband or family; only once does she use a plural pronoun ("when we gave money to the lab"). She does not say that her husband accompanied her for treatment or if he was examined by doctors—customary in Indian infertility clinics. In contrast to the richly peopled stories about infertility told by other South Indian women, there are few characters in Asha's: anonymous doctors ("they"), a neighbor, and Asha herself. We get the impression of an isolated, singular "self," negotiating infertility treatment on her own—a picture that is at odds with the typical family-centered fertility search I observed in fieldwork (Riessman, 2000b) and with Indian views of familial identity (Roland, 1988).

Information from later in the interview contextualizes Asha's performance in the excerpt and informs understanding of the process of her adult identity formation. Her life story is in some ways typical of the life course of women from the rural areas of Kerala, although in key respects it is unique. She relates that her natal family was large and very poor, and when marriage proposals came, her parents could not raise the dowry. Asha also says she was not interested in marriage ("married life, I did not want it from childhood on, I was one of those who did not like it"). Both of her parents died when she was a young woman, and she received a small inheritance when the property was divided among the siblings. She bought a little gold, took out a loan, got a job, won some money in the lottery, and eventually accumulated enough to buy a small piece of land with a thatched hut ("all of it I bought by myself"). Such autonomous actions contrast with stereotypes about women in India, but Asha's actions are not atypical in Kerala. Government policies are fostering women's power and economic independence as part of rural development efforts, including micro credit schemes and enterprises, in addition to affirmative action policies for historically disadvantaged castes (Gulati et al., 1996; Jeffrey, 1993). Without parents, however, arranging a marriage was difficult. In response to a question I asked about "her change of heart about marriage," Asha educated me: "If you want to get ahead in the future you must have a husband . . . when we become old there must be somebody to look after us." Like Indian women generally, she was constrained by gender ideology; Asha needed a husband to move forward and receive social recognition—to "get ahead"—and to have children—necessary in a country without social welfare programs for the aged. Instrumental views about having children to ensure parental caretaking are common in India (Jeffery, Jeffery, & Lyon, 1989; Uberoi, 1993).

At thirty-eight Asha went to a marriage broker to fix a marriage—an unusual move that was necessary because her brothers had left the region. The arranged intercaste marriage (Asha married "down") concealed a significant age discrepancy—Asha was twelve years older than her husband—which she discovered later. Because of her education and the context of women's employment in South India, she has secure earning capacity as a government clerk, while her husband faces unemployment. He wants children, however, and she fears she will be on her own again ("If we do not have children, the marital relationship will break up"). Like other rural women (Riessman, 2000b), Asha's in-laws blame her for the fertility problems and pressure her to get treatment. Constructing a positive gender identity without children is extremely problematic for Asha because of ideologies about compulsory marriage and motherhood.

In this context, the narrative excerpt above makes sense: "as a last resort" Asha decides to begin infertility treatment again, at age forty-two, even as she wisely knows she is "too old." The absence of family and husband in the excerpt masks their role in the decision. The husband's absence raises other questions, however. Given the complexities of their gender relations—she is significantly older and the primary wage earner—and the precarious status of their marriage, we might ask: Is Asha repositioning