CHAPTER 8

POSITIONING GENDER IDENTITY IN NARRATIVES OF INFERTILITY: SOUTH INDIAN WOMEN'S LIVES IN CONTEXT

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INTRODUCTION

How do women construct gender identities when they cannot be mothers, in a context such as India where strong pronatalist attitudes mandate motherhood? 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). 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 static, 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 and listening/questioning, human actors generate definitions that are, in turn, taken for granted as "real" (Bamberg, 1997; Davies, 1989; Harre and Van Langenhoven, 1999). Gender identity in particular is accomplished interactionally, continually renegotiated in

linguistic exchange and social performance (Davies, 1989; Cerulo, 1997; Kessler and McKenna, 1978). Narratives developed during research interviews provide a window into the process. When we tell stories about events our lives, we interpret the past to perform our preferred identities (Langellier, 2001).

I examine the personal narratives of three South Indian women who are in their 40s and 50s, selected from a larger corpus of interviews with married childless women completed during fieldwork in Kerala in 1993-4. Interviews, conducted at a single point in time, were tape recorded and subsequently transcribed and translated where necessary. My research assistant (Liza) and I conducted them (seven were in English and the rest in Malayalam[1]). We encouraged women to give extended accounts of their situations, including the reactions of husbands, other 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 are salient issues for them.

Study of personal narrative is a form of case-centered research, often described as narrative analysis (Riessman, 1993, 2001). 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 and 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 and Van Langenhove, 1999:7). 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 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

<u>"I think that it must be because I am so old"</u>

Asha, who has never been pregnant, is a 42-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 where 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 26 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 12 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 asks, "What do you think is the reason why you do not have children?" Excerpt 1 begins here.

[Transcript 1 about here]

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 40 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 for women in Kerala is 22 (L. Gulati, Ramalingam, I.S. Gulati, 1996).

Looking at 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, 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—she would be viewed as a "good historian" and "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 didn't work, and 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 alright." 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 45 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 other family members; 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, 2000a), and with Indian views of familial identity (Roland, 1988).

Information from later in the interview contextualizes Asha's identity 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, 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 women and historically disadvantaged castes (Gulati, Ramalingam, Gulati 1996; Jeffrey 1993). Without parents, however, arranging a marriage was difficult and, 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 in order to have children—necessary in a country without social welfare programs for the aged. Instrumental views about having children to insure parental caretaking are common in India (P. Jeffery, R. Jeffery, Lyon, 1989; Uberoi, 1993).

Asha went to a marriage broker to fix a marriage at age 38—an unusual move, necessitated by the fact that her brothers had left the region. The arranged inter-caste marriage (Asha married "down") concealed a significant age discrepancy —Asha was 12 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, 2000a), the 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 42, 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 re-positioning herself as a single woman? A reader might be tempted to read her story as one of victimization—a South Indian woman who faces divorce because of infertility--but her narrative performance as a competent “solo self” suggests a more complex reality. There is a consistency to her identity before marriage, and the one she puts forward as the marriage is ending.

“I think I was overworking”

My interview with Sunita took place in a different context than the one with Asha and her life circumstances are also very dissimilar. Sunita is 46-year-old Hindu woman from a Brahmin sub-caste. She works as a university professor and has a Ph.D. Her husband owns an established business. Married for 22 years, they had planned to have “at least 2 children.” I interviewed Sunita alone, in her home, in English; she was totally fluent, even using a western argot. She was obviously familiar with the conventions of western research interviewing, succinctly answered my beginning demographic questions, until I asked one (“And have you ever been pregnant?”) that immediately

prompted a lengthy narrative about a sequence of events that led to a miscarriage 20 years previously—the only time she had been pregnant. The context of the miscarriage was crucial to Sunita's understanding of infertility: she elaborated the circumstances several times during our long interview.

Excerpt 2 begins here. I have represented the structure of the narrative thematically in stanzas (a series of lines that are about the same topic, adapted from Gee, 1991).

[Transcript 2 about here]

Sunita, unlike Asha, positions her infertility in a web of family obligations that result in "overworking." She was 26 years old at the time of the miscarriage, several years into a "choice"—not arranged—marriage, and her in-laws were not "amenable to the whole situation." Sunita attempts to be the good daughter-in-law: going "to their place to cook in the evening for a family of seven," after she has worked "the whole day" at a job, and before she returned home with food prepared for her husband. (Double shifts are typical for employed South Indian women, although the triple shift Sunita reports is unusual—a consequence of the couple's decision to live apart from the joint family and also have her perform the cooking duties expected of a new daughter-in-law.) In the context of heavy physical demands made by her mother-in-law, a miscarriage occurs, which Sunita attributes to "overworking."

Sunita structures the narrative in ways that insure her attribution will be shared by the listener/reader. In the dialogic process she places her audience—me—in a dual position: a sympathetic woman listener, who understands about the heavy demands of combining career and family, but also an outsider who may not understand the additional

demands placed on Indian women. She invites me into an Indian narrative world in stanzas 2 and 3, by providing orientation about "choice" marriage, family hierarchy, and the obligations of brides towards in-laws. Understanding that I am being educated, I ask questions. In lines deleted from the transcript, I ask ("You were living separately from your in-laws?"); she responds by clarifying that she and her husband were "living some distance away." They chose not to become part of a joint family, yet she performed cooking responsibilities as the newest bride, as if she had become part of the joint family. The audience positions Sunita as the dutiful daughter-in-law, and enters into her point of view.

With cultural context and an alliance between teller and audience established, Sunita commences the narrative plot in earnest in stanza 4. Time shifts from the general to the particular ("<u>that</u>" day). She positions key characters in her drama: a demanding mother-in-law ("she insisted that I carry it"), an attentive personal physician ("she said 'You just lie down…'"), and a concerned husband (after the miscarriage, he says going to cook everyday for the in-laws is "ridiculous"). Sunita's positionings offer clues about her preferred identity—she represents herself as an Indian woman who observes tradition and family authority relations, deferring to mother-in-law and husband.

Sunita and Asha position characters in their performances in distinctive ways. Both are first-person accounts, and consequently privilege the "I." But Sunita's voice exists in the context of meaningful relationships—with a mother-in-law, husband, and personal physician. The physician, for example, is given a spoken role ("You just lie down…") and a gender ("she"), in contrast to Asha's anonymous physicians ("they"). In Sunita's account, the physician is represented as a supportive advocate concerned with the life

world of her patient ("I think you need to rest…you have to put on weight"), not simply the gynecological expert who relies on one medical technology after another—Asha's representation. Attending to emotions connected to the events also varies: there is no mention of physician response when Asha refers to "disappointment" when treatment failed; when Sunita "was so frightened" as she began spotting, her physician offers reassurance ("you're okay"). These differences probably reflect the contrasting class positions and related medical experiences of the two women: Sunita had a personal physician she "rang up," and Asha got treatment at a local hospital clinic, where she probably saw a different doctor every visit. Asha positions herself economically throughout her "solo" life story: she explicitly mentions paying for treatment and her belief that a child would provide security in old age. Sunita's "collective" life story takes class privilege for granted: she never mentions money explicitly, and appears to want a child for "completeness," instead of economic security.

Sunita returns to the miscarriage and the role her physician played much later in the interview. We had been talking for more than an hour, and I was asking about the reaction of others to her childlessness, including "your husband's family." She responded by saying she thinks her mother-in-law has "always felt guilty…she has always felt she has been the cause of that miscarriage." When I asked "because of the traveling and bringing all the food?," Sunita agreed, and immediately returned to the storyworld (Young, 1987) to elaborate the earlier narrative. New information emerges: when her doctor learned of the heavy physical work Sunita had done at her mother-in-law's insistence, and her mother-in-law's statement ("I've had 5 children, I've done the same work as you, I've carried things such as these"), the physician expressed anger:

"Don't you do such stupid things." Sunita interpreted the statement as a clear message to take care of herself, not her mother-in-law. As Sunita performs the role of the woman physician, she appears to identify with her young patient, who is caught in a web of obligations and authority relations typical in Indian families, with which the physician must have been familiar. New daughters-in-law are expected to provide household services in their mother-in-law's homes, until the time that they achieve full status as women, that is, have a child. Sunita positions her physician as an ally against inequality—ironically, in the case, between a mother- and daughter-in-law, both women, but separated by age and status in a hierarchical family system. Sunita's representation suggests she was empowered by the medical relationship. The physician's authority enabled her to break away from traditions of generational deference. Together with her husband, the physician enabled her to say "no."

Yet, there is something missing from the narrative: no explicit reference to blame. In accounting for infertility, Sunita never expresses anger, holds her mother-in-law responsible, nor does she fault herself for "overworking." Can such thoughts and emotions even be imagined in the South Indian context? The issue of blame must remain implicit. My interpretation here is supported by material from elsewhere in the interview, and also a letter Sunita wrote me. (I had sent her a draft of a book chapter [Riessman, 1997], which drew heavily from our interview conversation, and asked for her reactions to my interpretation of her narrative account.)

Sunita performed a conversation with her mother-in-law as our interview was drawing to a close. To elaborate why her mother-in-law might feel "guilty," Sunita related a conversation the two women had on a long train ride as they returned from the

funeral of a close family member; Sunita had repositioned herself as a valued daughter-in-law in the 20 years that had passed since the miscarriage. She reconstructs their conversation: Her mother-in-law said, "I've never had the courage to ask you…You had conceived so why couldn't you conceive again?…It shouldn't have happened that way." Sunita says to me, "I tried to tell her 'I don't blame you.'" In the brief exchange, Sunita refers to the conversational rules the two women observed: they went "round and round," she says, circling the question of blame. Still positioning herself as a traditional Indian woman and dutiful daughter-in-law, Sunita follows her mother-in-law's lead about how to conduct herself ("since she went round and round I also had to go round and round"), just as 20 years earlier she had followed her mother-in-law's instructions, leading (she implies) to miscarriage . Elsewhere (Riessman, 1997), I interpret the exchange by arguing that generational tensions cannot be addressed openly in contemporary India. Political issues about women's proper place in modern Indian families still remain private—cast as interpersonal conflicts between women. Because the only discourse available is interpersonal, the two women go "round and round" about blame and forgiveness.

Sunita's letter, written in response to my draft manuscript, ignored my political interpretation and concurred with my interpersonal one. Here's precisely what she wrote:

> Till you interviewed me I had not reflected very deeply about the events in my life. On reflection I think that your interpretations about the blame-forgiveness is quite right, though I had not consciously perceived it in that way before. My ability to deal with my not having children was because I know there was nothing medically wrong with me or my husband.

> Moreover, my husband's acceptance of me as a complete woman facilitated my own acceptance of myself as a complete person. This has enabled me to enjoy all the children in my life.

Sunita puts forward several identities in the letter. First, it is typed on university letterhead, which brings her professional self into our exchange. Second, she emphasizes that there is nothing "wrong" with her medically. Like Asha, she claims an identity without medical fault and consequent blame. Unlike Asha, however, Sunita can claim a secure identity as a wife, even without progeny. She says her husband's acceptance of her as a "complete woman" has enabled her to accept herself as a "complete person." Her word choice here is puzzling: it could suggest some continuing uncertainty about gender identity in the absence of motherhood, or it could be read as a statement about the superiority of "personhood" over motherhood/womanhood. Finally, she refers to enjoying "all the children in my life." Here, Sunita is recalling a continuing theme in our interview—the many non-biological children with whom she has important relationships (the children of servants and colleagues and nieces and nephews). Sunita chooses to locate herself in a "complete" life—how she wants to be known.

I now turn to a third, and final interview, which contrasts with the first two in identity construction processes.

<u>"You are perfectly- [normal], no defect at all"</u>

Gita, who had two miscarriages, is a 55-year-old Hindu woman from a lower caste (Ezhava—agricultural and industrial workers). She completed a law degree and practices family law in a municipality. Her high educational attainment is not unusual in Kerala,

where women have the highest levels of education (and literacy) in all of India (L.Gulati, Ramalingam, I.S.Gulati, 1996). Gita's husband is also professionally educated, now retired. They invited us into their home, after Gita had been asked by an intermediary if she was willing to be interviewed for a research project on childless women. She readily consented, greeted me at the door in fluent English, and consequently I conducted the interview (my research assistant was also present, as was Gita's husband for the first half-hour of the long interview).

The topic of my research--infertility and its consequences for women--was not particularly salient for Gita. I did not realize this at the time, but it became clear when working later with the transcript. She gave many hints about her preferred identity early in the interview that I missed: when asked demographic questions about educational attainment, for example, she responded with a lengthy account that included the name of each school she had attended, from primary school through postgraduate, and the history of her career since. When I asked how long she had been married and the number of children they had expected ("one boy, one girl"), she began a story about the first miscarriage, but quickly switched topics: it was a "late marriage" (at 35), because she had "not wanted to marry." In a lengthy "aside" (my formulation at the time), Gita said that "so many proposals" came because of her professional status as a "lady lawyer," but she refused them. She told me she was "active in politics, you know, the liberation struggle movement," referring to the time when the Communist Party came to power. She vividly performed a conversation with her mother that occurred after her brothers married and her father died: "I am old," her mother said, "very old, I cannot safeguard you, so get married." A year passed before Gita agreed, and then she asked the family to "fix my

marriage." She had decided she "wanted a companion." Gita brought out photograph albums of the wedding celebration, naming the judges in the pictures, and "all the lady lawyers—all in good positions."

At this point in the trajectory of the interview, I request that we "go back" to the pregnancy and miscarriage, my interest—I positioned Gita as an infertile woman. Looking back, I am embarrassed at the abruptness, and also my formulation at the time of the "digressions." Excerpt 3 occurs at this point. (Deleted from it are brief exchanges between us—I ask questions to clarify—that are marked " =".)

[Transcript 3 about here]

Positioning is a vivid point of entry into the narrative, and our interaction generally. Gita performs her preferred gender identity--"lady lawyer" and "political leader"--and minimizes the importance of motherhood, over the objections of husband, in-laws, and interviewer. Like the family (but for different reasons), I attempt to position Gita in a world of fertility. In the opening lines she briefly obliges, mentioning two pregnancies—the outcomes of which I have to clarify (deleted from the transcript). She quickly changes topics to what "I already told you"—the primacy of her political world. The two worlds are linked by a miscarriage. Ignoring her doctor's advice "to take bed rest" during the second pregnancy, she "had to" participate in a major demonstration against Indira Gandhi who was seeking re-election. Traveling from Kerala to New Delhi to participate in the protest probably involved a 3-day train trip in 1975. Despite her return by plane and a 16-day nursing home stay for "bleeding," we infer that Gita lost the pregnancy (a fact I confirm with a question a few lines later).

Gita shifts topics to the response of various family members. Her husband was "very angry" and ordered her not to "be active." Her in-laws "brought" her for infertility treatment to a specialist in a major South Indian city. In both instances, she positions herself as the object of others' displeasure, without responsibility herself. Yet, readers might question this attribution: she had ignored her physician's advice, and she was "40 or 41" years old when evaluated subsequently by the specialist who, Gita says, found "no defect." As with Asha's infertility, age may have been a factor. Gita had conceived twice, but could not sustain pregnancies—also suggesting a possible "defect." Instead, she locates responsibility in her husband, who refused to be examined by a "lady doctor," and will not allow his sperm to be tested. Gita returns several times in the interview to his refusal to be tested.[3] By these actions, she can enact the gender identity of a "perfectly" normal woman, with "no defect at all."[4]

Gita's narrative contrasts with both Asha's and Sunita's by its multitude of characters. The performance is richly peopled—with political figures, "lady" lawyers and doctors, concerned in-laws, a helpful sister-in-law, and an involved husband. Gita's positioning of characters puts forward a relational identity, complete without motherhood. Later in the interview, she supports my interpretation here. Resisting (once again) my positioning of her in the world of biological fertility, she says explicitly: "Because I do not have [children], I have no disappointments, because mine is a big family." She continues with a listing of many brothers, their children, and particular nieces who "come here every evening…to take their meals." Here she explicitly challenges bipolar notions of parental status—either you have children or you don't. She performs a gender identity that challenges the normative script for women in India. She

is constructing a life that explicitly resists the master narrative--biological motherhood is supposed to be the central axis of gender identity.

CONCLUSION: RETHINKING IDENTITY

Throughout the world, adult identity for women is normatively organized around the milestone of motherhood, and the norm is particularly strong in India. To be sure, there are currents of change in the motherhood mandate with economic liberalization, which is influencing ideas about marriage and reconfiguring family forms. Nevertheless, arranged marriage continues to be the dominant form and pronatalism remains, even if diversity is possible in the timing of marriage and childbearing, especially among India's growing middle class. While "delay" may be tolerated, women are ultimately expected to marry and reproduce (Riessman, 2000a).

Married women who cannot bear children must construct gender identities around other principles than motherhood. Three case studies suggest diverse possibilities for women as they age in South India. I examined the identity work women did in interviews to communicate how they wanted to be known—positively, not as victims, but as agents of lives that had accommodated infertility. The stories women developed were my focus, because narratives "are a particularly significant genre for representing identity and its multiple guises in different discursive contexts" (Mishler, 1999:pg). Social positioning in the stories—how narrators chose to position audience, characters, and themselves—was my point of entry because "fluid positionings, not fixed roles, are used by people to cope with the situation they find themselves in" (Harre and van Langenhove 1999:17).

However difficult events may have been in the past, all three women performed positive identities in the present that transcended stigma and victimization. Significantly, none of the women blamed themselves for infertility in their interpretive accounts: fault lay with age (Asha), a husband's refusal to be tested (Gita) and, implicitly, a mother-in-law's demands for heavy housework (Sunita). Whatever the "truth" may be, each woman had constructed an explanation that left her without blame and responsibility. The women's age is hugely significant also: all were beyond the typical childbearing years—and consequently could look back on their reproductive lives. As all narrators do, they recast the past in light of present concerns and values. All three had developed subjectivities apart from motherhood. Social location is also significant: the women were employed, although they differed considerably in social class (and caste) origins. Elsewhere (Riessman, 2000a, 2000b), I analyze age and social class as important mediators of women's experiences of the stigma of infertility. The case studies here represent women who are economically comfortable (Gita and Sunita) and/or occupationally secure (Asha, Gita, and Sunita)—certainly not representative of Indian women in general or women in Kerala, even with their relative advantage in literacy and status. My point is not to generalize from cases to populations but to extend boundaries theoretically about possibilities for identity construction among childless women as they age, even in contexts such as India where pronatalism strongly shapes constructs of adult female status and identity. In Kerala, possibilities for "modern" women are considerable, given the political-economic context and women's historic access to education. Schooling enlarges interpretive capacities, self-concept, women's bargaining power in marriage, and it encourages social participation—taking action.

The case studies reveal diversity and a plurality of identities that develop over time, even in the same woman. Kristeva expresses it well: female identity is "subject in progress", "always becoming" (cited in Ireland, 1993: 108). The case studies provide yet another challenge to psychological theories of adult identity that emphasize a universal trajectory (Erikson, 1959) and to some feminist theorizing that essentializes women's development. As Mishler (1999:pg) states, a "notion of identity as socially distributed or as existing only within a matrix of changing relationships is not easy to grasp, particularly since it runs counter to traditional deeply-entrenched view of identity as coterminous with and 'belonging' to the individual person."

My analysis here raises questions for social research on infertility and identity construction processes. Past work emphasizes infertility as a disruption in the expected life course (Becker 1994). But this is true only "if we think of identity formation as a progressive development from childhood to adulthood and of personal narratives as functioning primarily to provide a sense of continuity by reframing and smoothing over the impact of discontinuities and disruptive events" (Mishler, 1999, citing Cohler, 1982). The narratives of women I interviewed certainly emphasized bodily disruption—miscarriages—but the case studies do not suggest identities organized around metaphors of disruption.

Previous research has examined young couples in the midst of (often desperate) fertility searches, where discontinuities in the expected life course may be particularly difficult. Not much is known about the interpretive accounts of women past childbearing age who are involuntarily childless. The case studies here present some beginning insights about pathways of adult identity when motherhood cannot be the central axis of

self-definition. They begin to suggest that South Indian women might find other ways of interpreting infertility and constructing identities more easily than U.S. women professionals (represented in Greil, this volume)—an intriguing possibility that challenges cultural stereotypes. Pathways of gender identity are always influenced by cultural context, in western countries and developing ones alike. Despite constraints, however, women do not simply follow cultural plots in restorying their lives. Encountering infertility, they interpret it and compose lives that adapt to, resist, and sometimes reach beyond the master narrative of motherhood. Infertility is positioned differently in older women's lives, compared to younger ones'. Research needs to examine further the contrasting meanings of infertility over the life course. .

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FOOTNOTES

[1] Malayalam is a member of the Drividian family of languages spoken in South India. My representation of the translated interviews has benefited from conversations with Liza while in India, and with India specialists since my return to the U.S. (See Riessman, 2000b, for a fuller discussion of translation and interpretation issues.)

[2] Kerala, located along the extreme southwestern coast of India, is an exceptional state on a variety of indicators: a 75 % literacy rate for women (vs. 39 % for India), a life expectancy at birth of 73 for women (vs. 57), and a sex ratio of 1036 females per 1000 males (vs. 929). The "effective" female literacy rate in Kerala, which excludes 0-6 year olds, approaches 86 percent. (L.Gulati, Ramalingam, and I.S.Gulati 1996). There is debate about the precise causes of the state's advantaged position (New York Review of Books 1991). On the political economy, special ecology and unique history of Kerala, see Jeffrey 1993; Nag 1988.

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4 For a detailed structural analysis of Gita's narrative, see Riessman (2001).

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TRANSCRIPT 1 (ID22:3-4)

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 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 5 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 Infertility Clinic]

If God is going to give, let him.

TRANSCRIPT 2 (ID 26:2-4)

C: And have you ever been pregnant?

S: Yeah I think it was the second or third year of marriage
that I was pregnant.
then in the third month I started spotting.
I think I was overworking.

And uh since it was a choice marriage, I had a lot of-
We were trying to get my in-laws
to be more amenable to the whole situation.
In-laws were against the marriage.

And uh so I used to work the whole day,
then go to their place to cook in the evening for a family of seven.
Then uh pack the food for two of us and bring it home [laughs]

== [interaction about living separately and traveling between 2 households]

I think uh that uh was over doing it.

And then I carried some of the food stuff you know,
the grains and things, the monthly stuff, groceries,
from that place,
because my mother-in-law insisted that I carry it that day.

And the next day I started spotting
and I was so frightened because uh, you know,
I didn't know really what to do.

So I rang up my doctor and told her
and she said, "You just lie down, and come in, you're okay,

but only thing I think you need to rest."
You know, “don't move around” and things like that.

===   [tells of miscarriage]
So uh it <u>was</u> quite traumatic at that point.

But the doctor- in fact I was very thin.
I weighed under 100 pounds.
So the doctor said, "Look you have to put on weight
before you uh decide to get pregnant again…"

And after that I stopped going everyday to my in-laws
because my husband said "this is ridiculous, I mean you know"

TRANSCRIPT 3 (ID 27:8-9)

C: Now I am going to go back and ask some specific questions. Were you ever pregnant?

G: Pregnant means-- You see it was 3 years [after the marriage]
Then I approached [name of doctor]
Then she said it is not a viable—[pregnancy]
==
So she asked me to undergo this operation, this D&C
And she wanted to examine him also

Then the second time in 1974-in 75,
Next time--four months
==
Then she wanted [me] to take bed rest
Advised me to take bed rest

Because I already told you
It was during that period that [name] the socialist leader
Led the gigantic procession against Mrs. Indira Gandhi,
The Prime Minister of India, in Delhi

And I was a political leader [names place and party]
I had to participate in that

So I went by train to Delhi
But returned by plane
After the return I was in [name] Nursing Home
For 16 days bleeding

And so he was very angry

He said "do not go for any social work
Do not be active" this and that
But afterwards I never became—[pregnant]
==
Then my inlaws, they are in [city]
They thought I had some defect, really speaking
So they brought me to a gynecologist,
one [name], one specialist

She took three hours to examine me
And she said "you are perfectly- no defect at all"
Even though I was 40 or 41 then
"So I have to examine your husband"

Then I told her "You just ask his sister"
She was- his sister was with me in [city]
So I asked her to ask her to bring him in
He will not come

Then we went to the house
So then I said "Dr. [name] wants to see you"
Then he said "No, no, I will not go to a lady doctor"
Then she said she would not examine him
They had to examine the-what is it?--the sperm in the laboratory
But he did not allow that.

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