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MIS(SED) CONCEPTIONS: MOTHERHOOD THROUGH THE LENS OF INVOLUNTARY CHILDLESSNESS

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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This dissertation project is dedicated to the memory of Emma and Adelaide Brody. Your brief presence in this world and my journey towards you has informed me that the personal experience of motherhood can be both intensely beautiful and painful. It is from my experiences with you that I have chosen to advocate for reproductive justice and a social climate where women can make reproductive choices from a place of agency, authenticity, and autonomy. Emma and Adelaide, *v'yitzror bitzror hachayim et nishmato*, may your souls be forever bound up in the bonds of life. For the shortness of time your hearts beat, you changed me forever, in so many ways, and I am eternally grateful for the time we shared. You taught me how to grieve but also how to grow. Most importantly, you taught me that we are never too small to change anything and everything.

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Table of Contents

List of Tables

Abstract

The present study examined predictors of fertility-specific distress in the experience of involuntary childlessness. One hundred and twelve women took part in this online study. Participants completed a demographic questionnaire, the Fertility Problem Inventory, the Relational Health Indices, the Feminist Perspectives Scale, the Traditional Motherhood Scale, and the Hoffman Gender Scale. A hierarchical regression analysis was conducted to examine how feminist perspectives, traditional mothering values, gender self-confidence, and relational quality related to fertility-related distress. The regression analysis revealed that traditional mothering values, relational quality, age, and income significantly predicted fertility-related distress. Specifically, higher endorsement of traditional mothering values significantly predicted higher levels of fertility-related distress, while higher levels of relational quality significantly predicted less fertility-related distress. Younger age and lower income significantly predicted fertility-related distress. These results may inform counseling strategies when working with women who have experienced reproductive problems and may add to the growing body of literature investigating involuntary childlessness from a feminist perspective. Placing women's reproductive struggles in a sociocultural context may help to increase women's sense of agency, autonomy, and authenticity in negotiating their own perceptions of motherhood as they make reproductive decisions.

Chapter 1

Introduction

Overview

Infertile. Barren. Sterile. These are terms frequently used to refer to a woman who wants a biological child but is unable to have one. They are anything but neutral and tend to conjure feelings of emptiness and inadequacy that serve to reinforce the centrality of the role of motherhood for a woman (Ulrich & Weatherall, 2000). They are additionally reminiscent of *synecdoche*, which occurs when all the connotations assigned to a part become generalized to the whole (Ulrich & Weatherall, 2000). It has been well documented in research on the objectification of women in language that a primary vehicle for this objectifying is the use of synecdoche, or referencing women metaphorically as body parts (Ulrich & Weatherall, 2000). Ulrich & Weatherall provide an example of synecdoche in infertility through one of their study participant's responses, "I always used to say I'm not infertile. I have a very fertile imagination. And I found the word to be half the problem" (p. 331).

In order to reduce this stigmatizing language often associated with reproductive problems, this study used the term *involuntary childlessness* to define infertility. This study utilized terms such as *infertility* only when discussing others' findings using this terminology. Bell (2013) argued that the term *involuntary childlessness* might help to alter the dominant biomedical paradigm of *infertility* that serves to undermine women's agency to a more inclusive paradigm that emphasizes "wholeness, interdependence, diversity, and the broader community context" (p.293).

According to The Centers for Disease Control and Prevention (CDC) (2011), involuntary childlessness affects 10% of women in the United States, which translates to about 6.1 million women. Furthermore, data from The National Survey of Fertility Barriers (Greil, McQuillan, & Slauson-Blevins, 2011c) showed that 51.8% of women aged 25-45 reported an experience of involuntary childlessness at some point in their lives. Involuntary childlessness has increased since the late twentieth century and is expected to continue to rise (Sevon, 2005). Studies have indicated that many women who experience involuntary childlessness report higher levels of depression, anxiety, feelings of insecurity, and dissatisfaction with life (e.g., Miles, Keitel, Jackson, Harris, & Licciardi, 2009). Levels of depression related to involuntary childlessness in women have been found to approach the levels of depression frequently seen in individuals with chronic illness, such as cancer and HIV/AIDS (Galhardo, Pinto-Gouveia, Cunha, & Matos, 2011; Miles et al., 2009).

The Center for Reproductive Psychology (2012) defines *reproductive trauma* as wanting a baby and not having it go as hoped, planned, or dreamed. This may include infertility, pregnancy loss, or stillbirth (Center for Reproductive Psychology, 2012). Recent studies have illustrated the traumatic nature of reproductive problems for some women, including symptoms of re-experiencing, avoidance, intrusion, and arousal (Schwerdtfeger & Shreffler, 2009; Van den Broeck, D'Hooghe, Enzlin, & Demyttenaere, 2010). In fact, approximately 25% of women who experience pregnancy loss exhibit symptoms that meet the full criteria for posttraumatic stress disorder (PTSD) (Schwerdtfeger & Shreffler, 2009). McCarthy and Chiu (2011) suggested that these symptoms can be quite long-lasting, continuing for up to 20 years post trauma.

Regardless of the development of trauma-like symptoms, many women who experienced unplanned childlessness reported symptoms of social isolation, a lowered sense of self worth and wholeness, and feelings of inferiority (McCarthy & Chiu, 2011). These feelings were present over time, even during successful and satisfying adoption processes. Thus, involuntary childlessness may continue to be a life-long and central identity for many women (McCarthy & Chiu, 2011). However, there exists wide variation in how women respond to involuntary childlessness. While there is clear documentation that involuntary childlessness can result in distress for some women, with long-term emotional consequences, it is also important to note that many women heal from the emotional distress that may come with reproductive problems (Jacob, McQuillan, & Greil, 2006).

In regard to the gendered experience of involuntary childlessness, studies have indicated that women tend to experience greater distress and are more directly impacted by reproductive problems than men (Johnson & Fledderjohann, 2012; Miles et al., 2009). Current literature tends to attribute gendered differences to the sociocultural context of infertility, most notably that for women a positive sense of self and power in society often resides in her identity as a mother (Berg, Wilson, & Weingartner, 1991; Exley & Letherby, 2001; Greil, 1991; Johnson & Fledderjohann, 2012; Parry, 2005b).

This pronatalist ideology permeates western society (Forsythe, 2009; Miall, 1986). In a pronatal atmosphere, women are expected to become mothers and, not only is motherhood assumed to be a natural part of being a woman, motherhood is expected to provide a core identity and status for women (Ulrich & Weatherall, 2000). McQuillan, Greil, White, and Jacob (2003) suggested that the role of mother is so

central it is considered a "master status" (p. 1008) because of the shadow it casts on all other female roles. In other words, the role of mother becomes the principal means through which women define themselves and are evaluated by others (Remennick, 2000). A growing body of literature suggests that it is almost impossible to separate ideals of femininity from ideals of motherhood, on both a personal and social level (Woollett & Boyle, 2000; Ulrich & Weatherall, 2000; Sevon, 2005; Choi, Henshaw, Baker, & Tree, 2005; Jacques & Radtke, 2012). This interweaving of motherhood and femininity is exemplified in the following passage by Ashurst and Hall (1989):

> A woman's capacity to create, bear and nurture a child is the very essence of her womanhood, her unique and special capacity- prized, feared, envied, protected, and celebrated. Birth is the only defense against the inevitability of death, an intimation of our immortality, of our new hope for the future. When a woman has a child, she confirms for herself and for others that she is a complete woman, fertile and capable of the biological task of creating and perpetuating life. She rivals her own mother, by becoming a mother of a child in her turn, and completes the reproductive cycle that began with her own conception in her mother's womb. (p. 97)

Many studies have addressed perceptions of motherhood by women who have children and experienced no fertility barriers; however, understanding interpretations of motherhood from those who have experienced infertility, pregnancy loss, or other forms of involuntary childlessness may add a richer and more complete understanding of the importance of motherhood in Western culture. Understanding perceptions of motherhood by those traditionally barred from it may help to further develop theories

on motherhood and inform counseling strategies for working with involuntarily childless women (Haelyon, 2006).

Most studies that address involuntary childlessness fail to position barriers to motherhood in a sociocultural context, show little regard for the social construction of involuntary childlessness, and tend to treat involuntary childlessness as solely a medical problem that happens to have some psychological consequences (Bell, 2009; Greil, McQuillan, & Slauson-Blevins, 2011c; Greil, Slauson-Blevins, & McQuillan, 2010). Thus, society uses the process of social construction to group people, beliefs, and behaviors, and at times uses these groupings to privilege certain people, beliefs, and behaviors (Flores, 2012), including mothers and motherhood. When one considers the sociocultural context of motherhood, there is little wonder that reproductive problems can result in significant distress for women (O'Reilley, 2010). Reproductive problems may be experienced, for a woman as a loss of self, womanhood, status, and power in society. Inhorn (as cited in Haelyon, 2006) asserted, "Infertility, as a barrier to motherhood… throws into question a woman's gender identity, her sexual identity and her very sense of selfhood. Thus the particular situation of infertile women illumines the social construction of gender and politics of identity" (p. 181).

Theoretical Foundations

The current study was based in feminist theories of maternal empowerment. Empowered mothering recognizes that both women and children benefit from maternal narratives that place the mother in a position of agency, authority, authenticity, and autonomy (O'Reilley, 2004). Conversely, O'Reilley (2004; 2010) argued that *patriarchal motherhood* is a male dominated and controlled ideology of mothering by

which all women are regulated and measured. She regarded it as an ideology founded on traditional and binary concepts of gender and gender roles that are embedded in Western cultures and serve an oppressive function for women. O'Reilly (2010) asserted that patriarchal motherhood oppresses women through devaluing the work of mothering at a societal level and establishing ideals of mothering that are impossible to achieve, in part due to the taxing and unending responsibilities associated with motherhood. Not only does patriarchal motherhood limit who and how women can mother, this notion of motherhood may have considerable impact on the experience of involuntary childlessness. For example, women unable to achieve the traditional role of mother through biological pregnancy are left to negotiate an undesirable identity that challenges a sense of femininity, self, power, worth, and inclusion.

Statement of the Problem

The present study was feminist in orientation and aimed to contribute to feminist and reproductive psychology research in two primary ways. First, the study sought to view motherhood through the lens of women who experience involuntary childlessness. Research has only recently addressed the social construction of involuntary childlessness and the sociocultural context of motherhood when investigating involuntary childlessness (Bell, 2009; Greil et al., 2010). Of great importance, this research also hoped to inform counseling strategies when working with women who have experienced reproductive problems. Placing women's reproductive struggles in a sociocultural context may help to increase women's sense of agency, autonomy, and authenticity in negotiating their own perceptions of motherhood as they make reproductive decisions.

The purpose of the present study, informed by feminist theories of maternal empowerment, was to identify predictors of fertility-specific distress in the experience of involuntary childlessness. Specifically, the study examined how feminist perspectives, traditional mothering values, gender self-confidence, and relational quality relate to fertility-related distress. Research examining these relationships will add to the growing body of literature investigating involuntary childlessness from a feminist perspective.

Chapter 2

Literature Review

Involuntary Childlessness

Social construction of involuntary childlessness. Medical authorities define *infertility* as the inability to conceive or carry a pregnancy to term after 12 months of trying to conceive (RESOLVE, 2012). Other definitions of infertility include (a) the inability to have a baby for any reason aside from having gone through a sterilizing operation, such as the inability to carry a baby to term or the lack of a biological child after three or more years of trying to conceive (Shanley & Asch, 2009); and (b) a disease of either the male or female reproductive system that results in abnormal functioning (American Society for Reproductive Medicine, as cited in RESOLVE, 2012). However, biomedical definitions fail to capture the full social reality of infertility (Greil et al., 2010). For example, not all women who experience involuntary childlessness are *infertile*, and fertility can be regarded as a continuum rather than a static or absolute state (Bell, 2013). Some women "may have partners who are medically infertile, some are in social situations in which conventional conception is not possible, and some are not definitively infertile because there is no diagnosable reason for their childlessness" (Bell, 2013, p.293). Medical sociologists have argued that any health and illness issue is best understood as a socially constructed state which must be negotiated by professionals, the sufferer, and the sociocultural context (Greil et al., 2010). Despite this argument, Becker and Nachtigall (1994) asserted that American society has a tendency to turn to medicine for answers to social problems.

Infertility has not been exempted from the trend toward medical reproductive technologies. However, Greil et al. (2011c) asserted that the social construction of health and illness is more pronounced in infertility than in other conditions and provided multiple examples. First, Greil et al. noted that infertility is only considered a problem if parenthood is a desired social role. In the absence of the desire for parenthood, medical treatment would not likely be indicated. Second, while medicine generally treats conditions affecting individuals, infertility is often perceived as a condition that affects couples and sometimes involves family and other social networks. Third, infertility is expressed by the absence of a desired state rather than by a particular symptom complex. Fourth, alternative avenues exist in the case of infertility besides a cure, such as adoption, fostering, choosing a childfree lifestyle, or even changing partners. Greil et al. (2011c) emphasized, "Infertility is best understood as a socially constructed process whereby individuals come to regard their inability to have children as a problem, to define the nature of that problem, and to construct an appropriate course of action." (p. 737)

McQuillan, Stone, and Greil (2007) conducted a study on infertility and life satisfaction among women, which also explored the impact of achievement of motherhood on the experience of infertility. Women who identified as infertile, perceived it as a problem, and had no children demonstrated significantly lower levels of life satisfaction than women who reported no history of infertility. However, there was no significant difference in life satisfaction between women with no history of infertility and women who identified as infertile, had no children, but did not perceive it as a problem. This seems to exemplify the point that meeting the medical definition of

infertility is not the primary problem. Rather, it appears that it is the perception of involuntary childlessness as problematic which has the greatest impact on life satisfaction (McQuillan et al., 2007). In addition to distress being dependent on how the person experiencing difficulty conceiving perceives it, distress often impacts more than the person or couple experiencing it. Hammers-Burns (1999) described the potentially ensuing distress associated with involuntary childlessness as an "intergenerational developmental crisis affecting extended family members and family relationships" (p.97).

Religious infertility is yet another illustration of the social construction of infertility. For example, Halachic infertility occurs when Orthodox Jewish women, who observe the laws of niddah, ovulate too long before mikvah immersion, thus preventing conception (The Hilchot Niddah Guide for Medical Professionals, 2012). Sexual activity is prohibited during a woman's menstruation (i.e., niddah) and for seven days thereafter (Haimov-Kochman, Rosenak, Orvieto, & Hurwitz, 2010). Most women ovulate after ritual immersion (i.e., mikvah immersion), or cleansing, following niddah, which is an optimal time for fertility. So, for women who have shorter cycles and have early ovulation or have longer bleeding, immersion and intercourse will happen too long after ovulation for conception to occur (Jewishinfertility.org, 2013). Treatment is then largely determined by religious doctrine.

Colen (1986) first termed *stratified reproduction* to describe how "reproduction is structured across social and cultural boundaries, empowering privileged women and disempowering less privileged women to reproduce" (Greil et al., 2011c, p. 737). For example, in the United States, as is true in most industrialized countries, the prototypic

infertility patient, as depicted in media and research alike, is a middle-class White heterosexual woman who has delayed motherhood in order to pursue a career (Greil et al., 2011c; Lublin, 1998). The prototypic characterization for women living in poverty and Women of Color, conversely, is the image of being hyperfertile, sexually irresponsible, and unfit mothers with the stereotyped images of the "welfare queen", "crack baby", and "teen mothers" reinforcing this portrayal (Bell, 2009, p.689; Greil et al., 2011c). This construction of Women of Color's and economically disadvantaged women's fertility is inaccurate. In fact, the highest rates of involuntary childlessness occur among economically disadvantaged women and Women of Color (Bell, 2009; Greil, McQuillan, Shreffler, Johnson, & Slauson-Blevins, 2011b). Data from the 1982-2002 National Survey of Fertility Growth depict that the rates of infertility (as indicated by biomedical fertility barriers or failure to conceive after 36 months of regular intercourse) for Black (19.8%) and Hispanic (18.2%) women exceeded the rates for White women (6.9%; Greil et al., 2011b).

Bell (2009) and Greil et al. (2011b; 2011c) highlighted how stratified reproduction often plays out in receipt of medical services. For example, Women of Color and economically disadvantaged women are more likely to be recommended for treatments that impede fertility, such as sterilization and birth control, whereas White middle-class women are more likely to receive treatments that facilitate fertility such as in-vitro fertilization. These racial and class trends in medical care send a clear message about who society deems worthy to be a mother (Greil et al., 2011b). As a result, there is an inverse relationship between the frequency of infertility in a population and that population's use of fertility services (Shanley & Asch, 2009). The class-based framing

of reproduction and motherhood impacts infertility-related policies and responses. As a result, there has been considerable advocacy among several states in the U.S. for mandated private insurance coverage for infertility services. Medicaid, for instance, covers contraception only (Bell, 2009). Stratified reproduction divides women into two groups: "those for whom contraception is available if only they'd just use it and those for whom there are infertility treatments" (Cussins, 1998, p.73). Women of Color and economically disadvantaged women are aware of these social characterizations of themselves. In fact, in one study conducted by Bell (2009), an African American woman reported, when referencing infertility treatments and their expense, that treatment is "way out of my league" (p. 696). Additionally, another respondent in Bell's study expressed fears that medical professionals would convey disapproval for Medicaid recipients to utilize fertility treatments, illustrating how Medicaid reinforces classed notions of fertility.

According to Bell (2009), infertility should be considered a *cultural disorder* because it serves as a reflection of the dominant cultural norms of gender, class, race, sexuality, and reproduction. It is apparent that institutionalized classism and sexism exist within the contexts of the institutions of both medicine and motherhood. Given the deep and complex ways in which infertility is socially constructed (particularly along class lines), it seems important to go beyond the medical management of infertility in addressing treatment options and recovery for all women (Bell, 2009). For example, Currie (1988) investigated reproductive decision-making and found that women's experience of motherhood was tied to the sociocultural context in which the women lived. Illuminating the social process of infertility may help to change the

emphasis from a sole focus on medical treatment and insurance policy issues to alternative support programs and resolutions for involuntary childlessness and motherhood in general, resolutions that do not reinforce oppressive forces for women (Bell, 2009). Schneider and Conrad (1983) poignantly stated that infertility is not something "in which there are 'social factors'; it is itself profoundly social as a phenomenon for study" (p. 227).

Involuntary childlessness and distress. The distress associated with involuntary childlessness has been documented in several studies (Galhardo et al., 2011; McCarthy & Chiu, 2011; McQuillan et al., 2003; Van den Broeck et al., 2010) and suggests that involuntary childlessness is generally regarded as a chronic life crisis that bears influence on later life transitions. Whether the definition of involuntary childlessness comes from a biomedical perspective or a social and human rights perspective, the literature demonstrates that involuntary childlessness is considered one of the most distressing life crises for those who endure it (Bell, 2013).

Quantitative studies on this topic have found mixed results, likely partly attributable to methodological shortcomings (McQuillan, et al., 2011). For instance, because most studies are drawn from a single clinic and have small sample sizes, conflicting findings are likely an artifact of study design and sampling bias (McQuillan et al., 2011). In fact, because many quantitative studies use samples from infertility clinics, they tend to omit those who do not seek or are not currently seeking treatment (McQuillan et al., 2011). These studies are criticized for lack of generalizability and representativeness of women's experiences because there are significant racial and socioeconomic differences between those who seek treatment and those who do not;

less than half of women with involuntary childlessness ever seek treatment (Greil et al., 2010). Jacob, McQuillan, and Greil (2006) noted that while most studies find elevated distress scores of people with infertility in comparison to those who have no fertility barriers, distress levels are typically below clinical relevance. This is important to note because, while it is valuable to understand and explore variable responses of distress, it is equally vital to be aware that women have historically been overpathologized and the experience of distress does not necessitate pathology.

Quantitative studies have suggested that distress is most salient for women who experience a barrier to biological conception and who want to have a biological child (Jacob et al., 2006; McCarthy & Chiu, 2011; McQuillan et al., 2003). For example, McQuillan et al. (2003) addressed some of the shortcomings of previous empirical work by utilizing a random sample of women and a lifetime measure of infertility. They found that infertility was strongly associated with distress, but only for women who had no children, either socially or biologically, and who desired motherhood. Women without children who did not desire motherhood exhibited no distress. They concluded that their results suggested the absence of motherhood for these women threatened a perceived central life role and significantly and negatively impacted well being.

Jacob et al. (2006) found that self-identification as infertile accounted for the largest source of fertility related distress and that women with fertility barriers had higher levels of general distress than did women without fertility barriers. Schwerdtfeger and Shreffler (2009) found that involuntarily childless women who desired a biological child had higher levels of depression and lower levels of life satisfaction as compared to those without fertility barriers. Miles et al. (2009)

additionally found that social pressure to become a mother significantly predicted distress for involuntarily childless women undergoing fertility treatment.

Interestingly, studies have suggested that the achievement of pregnancy for infertile women may not induce a returned sense of normalcy; in fact, some women who achieved a live birth through reproductive technologies reported feelings of anxiety and guilt and an increased pressure for perfection in the mother role (Greil et al., 2010). Several researchers have reported these women may have lower self-evaluations, take longer to embrace the motherhood identity, and feel they cannot complain about the discomforts of pregnancy (Gibson, Ungerer, Tennant, & Saunders, 2000; Greil et al., 2010; Olshansky, 2003).

Olshansky (2003) theorized that infertile women who achieved pregnancy struggled to don a fertile identity and even had difficulty seeing themselves as pregnant women. She asserted that, as a result, previously infertile women disconnected themselves from other pregnant women and new mothers because they did not perceive that they shared the same concerns or worries. Previously infertile women who achieved pregnancy additionally disconnected from other infertile women (Olshansky, 2003). For example, women who struggle with conception may find support in one another but when one person in this support network of women achieves pregnancy, this could be awkward and hurtful for the women who continue to struggle with conception. Thus, Olshansky (2003) believed a woman who achieved pregnancy may distance herself from other involuntarily childless women to avoid the tension and spare their feelings (Olshansky, 2003). Consequently, previously infertile women endure a profound sense of differentness from all other groups of women, struggling to maintain

their relationships while simultaneously yearning for connection (Olshansky, 2003). Olshansky observed that these women sometimes referred to themselves as "infertile fertile" (p. 265), highlighting their ambivalence about taking a fertile identity.

While quantitative studies have shown mixed results, qualitative studies on women's experiences with involuntary childlessness appear quite consistent in findings indicating that involuntary childlessness can be experienced as a distressing and unanticipated life course disruption (McCarthy & Chiu, 2011). For instance, Williams (1997) identified 11 themes that emerged from interviews with women who experienced involuntary childlessness: negative identity, a sense of worthlessness and inadequacy, a feeling of lack of personal control, anger and resentment, grief and depression, anxiety and stress, lower life satisfaction, envy of other mothers, loss of the dream of co-creating, the 'emotional rollercoaster,' and a sense of isolation. Feminist qualitative analyses have also highlighted how the dominant cultural beliefs of Western societies about motherhood served to reinforce beliefs and practices – "namely, the patriarchal nuclear family, heterosexuality, and genetic parenthood" (Ulrich & Weatherall, 2000, p. 334). Furthermore, Whiteford and Gonzales (1995) found that the social pressure for women to have children was so strong that it existed regardless of age, race, religion, ethnicity, and social class.

In their qualitative study investigating perceptions of motherhood from the perspective of women experiencing involuntary childlessness, Ulrich and Weatherall (2000) found that involuntarily childless women often viewed themselves as nonconformists in a society that endorsed the dominant belief that the central role for a woman is that of mother. Three themes emerged regarding reasons for wanting

children: the view of motherhood as (a) a natural instinct; (b) a typical part of the development of a relationship; and (c) expected by society. Involuntary childlessness was then experienced as guilt, inadequacy, and failure (Ulrich & Weatherall, 2000).

McCarthy (2008) investigated the lived experiences of women following unsuccessful medical intervention. The women in this study described involuntary childlessness as an existential challenge to their self, identity, and meaning and purpose of life. Many women reported that the centrality of the role of involuntary childlessness as a life defining experience pervaded their narratives well after unsuccessful treatment. One respondent stated:

> It's like I'm nothing… I really kind of feel like part of me has either died or given up. I guess the thing that has bothered me the most is the kind of emptiness. There is this hollowness about your life. It's like you thought you were this solid chocolate bunny and you're not. You're the hollow chocolate bunny, which is the less expensive version, not quite as good and not what everybody really wanted at Easter. (McCarthy, 2008, p. 321)

Whiteford and Gonzales (1995), in a feminist qualitative analysis on infertility that utilized Goffman's work on stigma, found that some women described involuntary childlessness as shame, guilt, inadequacy, failure, and incompleteness. Interviewees also identified feeling classified as *other* and frequently referred to fertile women as *normals*. Whiteford and Gonzales concluded that women might feel stigmatized by the failure to reproduce as a result of internalizing a socially constructed discourse of gender roles in which women are primarily defined in reproductive terms. They asserted that culturally constructed gender role expectations for men and women result

in differing responses to involuntary childlessness, with women's identities being more likely to be "spoiled" (Whiteford & Gonzales, 1995, p. 30).

Letherby (1999) also identified discourses of stigma, failure, and feeling as other to the feminine ideal among 24 women who identified as involuntarily childless. Respondents expressed feelings of "incompleteness" and being "handicapped" (p. 363), particularly in their sense of femininity. They also expressed feeling a sense of failure both in the specific task of reproduction and to the entirety of womankind.

Only a few studies have interviewed women who had unsuccessful treatments for a decade or longer, and those interviews evidenced a sense of resentment about having to share a private part of themselves with the public (Ferland & Caron, 2013). Additionally, the privacy associated with involuntary childlessness was found to be associated with feelings of despair and isolation (Ferland & Caron, 2013). Many studies have investigated the short-term impact of distress around involuntary childlessness, whereas Ferland and Caron (2013) interviewed postmenopausal women who remained childless to better understand long-term impact.

Four themes emerged to the question of how particapants were now that they were postmenopausal. The first theme was that few experiences in their lives had been as difficult. Participants equated trying to come to terms with involuntary childlessness, even 10 to 20 years later, as very difficult. One participant stated, ''Finding out I was infertile was almost as difficult as when my brother got killed in a car accident.'' The second theme was that the pain never went away.

> I have found that the issue comes up again when I least expect it. At New Year's, I was over at my friend's house and her daughter was home from college and she told her mom she was going to make a special drink just for her because she was such a great mother. It hit me like a ton of bricks—the realization that I would never have that. (p. 186)

Another statement also reflected this theme, ''Several of my friends are now becoming grandparents. It's painful to know I won't have that experience either.'' Participants discussed how menopause and unexpected moments throughout their life trajectory triggered the pain associated with involuntary childlessness and reported that some people in their lives had difficulty understanding and validating that distress.

The third theme was that participant's relationships were closer. Those participants who remained married or remarried discussed that having a strong relationship felt like some consolation for being childless. The fourth theme was, when one door closes another opens. Participants discussed ways in which, despite all the pain, they had become mothers in other ways. Ferland and Caron (2013) noted that the fact that the women they interviewed could remember vivid details of finding out they were infertile or the process of treatments even 25 years later highlighted the magnitude and long term impact of involuntary childlessness. The authors also noted the promising discourse of finding other ways to mother and discussed that finding other nurturing roles may be a way to alleviate some of the distress associated with involuntary childlessness.

Distress and involuntary childlessness due to pregnancy loss. Research regarding the relationship between pregnancy loss and distress appears to have similar

findings as seen in research examining difficulty conceiving and distress (Shreffler, Greil, & McQuillan, 2011). Pregnancy loss refers to the involuntary termination of a pregnancy any time ranging from conception through 28 days following birth (Association of Women's Health, 2006). In the United States, about 14% of clinically confirmed pregnancies end in miscarriage (i.e., the loss of a pregnancy in the first 20 weeks), which represents the most common adverse result associated with pregnancy (Shreffler, et al., 2011; Simmons, Singh, Maconochie, Doyle, & Green, 2006). Another 0.5% of clinically recognized pregnancies in the United States result in stillbirth (i.e., the loss of a fetus following the 20th week of pregnancy) (Shreffler et al., 2011). For some women, involuntary childlessness results not from the inability to conceive but, rather, the inability to maintain a viable pregnancy to term. When these cumulative losses occur for 36 months or more, it is medically considered a form of infertility (Shanley & Asch, 2009).

Research has indicated a variety of psychological outcomes associated with pregnancy loss including, grief, depression, anxiety, guilt, shame, eating disorders, preoccupations with the lost baby, and PTSD (Engelhard, van den Hout, & Vlaeyen, 2003; Lim & Cheng, 2011; Schwerdtfeger & Shreffler, 2009; Shreffler et al., 2011). While these outcomes often diminish by 6 months post-loss, they can continue for several years (Shreffler et al., 2011). In response to stillbirth, women have been found to experience psychological distress for at least 30 months and in some cases distress has been shown to endure throughout the life course (Shreffler et al., 2011). Interestingly, Shreffler et al. also found that women who knew the reason for the pregnancy loss were more distressed than those who did not. Shreffler et al. expected

that knowing the cause would be empowering; however, they surmised that these results suggested knowing the cause facilitated women's self-blame, even when the loss was out of their control. Similar findings have been found in research on other sources of involuntary childlessness. Even when the source of involuntary childlessness is the male partner, women often take responsibility and show greater distress (Shreffler et al., 2011).

Similar to research on other forms of involuntary childlessness, studies addressing pregnancy loss and distress also have found that pregnancy loss is most distressing for women who have no children, place a high importance on motherhood, and perceive themselves as having a fertility problem (Shreffler et al., 2011). When discussing the impact of their findings, Shreffler et al. stated, "These results suggest that the context of women's pregnancy and fertility experiences as a whole and the meaning they attribute to their pregnancies are crucial in shaping the psychological response to pregnancy loss" (p. 352).

Gender and distress. The phenomenon of infertility has shifted from what was once considered a private couples' issue to a medical condition that focuses primarily on women (Greil et al., 2011c). Infertility is now largely positioned as a female problem by Western culture, both physically and psychologically, which has led to the development and maintenance of myths that infertility problems stem solely from the woman (Berg et al., 1991; Domar, 2011). Yet, from a biomedical standpoint, only approximately one-third of infertility cases are related to female factors (Berg et al., 1991; CDC, 2012), another one-third are related to male factors, and the remaining

infertility cases are attributed to combined male and female factors or unexplained factors (CDC, 2012; Shapiro, 2009).

Most gender-focused research in involuntary childlessness has addressed differences in distress levels between men and women (Greil et al., 2009). Distress related to involuntary childlessness has been shown to be consistently greater for women than for men, and women tend to perceive having children as more important; in fact, women reportedly struggle significantly more with relinquishing the intention to have a child (Abbey et al., 1991; Berg et al., 1991; Greil et al., 2009; Johnson & Fledderjohann, 2012; Miles et al., 2009).

Because motherhood is the central role for women in a pronatal society (McQuillan et al., 2003; Ulrich & Weatherall, 2000), men have been found to be significantly less distressed with the notion of not having children, reportedly because their identity is primarily tied to paid employment (Abbey et al., 1991; Berg et al., 1991; Johnson & Fledderjohann, 2012). Galhardo et al. (2011) investigated gender differences in the impact of shame, self-judgment, anxiety, and depression in infertile couples and found that women experienced significantly more shame, self-judgment, and depressive symptoms than their male partners. Other gender differences found in the literature have suggested that women are more treatment oriented than men, find it more difficult to stop treatment, and experience more infertility-related stigma than men (Greil et al., 2010).

Abbey et al. (1991) suggested that women's lives are more disrupted by infertility as compared to men's lives. The authors found that infertile women perceived fertility barriers as more stressful than men and felt more disruption and

stress in their personal, social, and sex lives. Abbey et al. also found that infertile women perceived having children as more important than their husbands. Johnson and Fledderjohann (2012) found similar results. Their results suggested that women who self-identified as infertile and perceived motherhood as important exhibited higher fertility-specific distress, indicating that it was the disruption of the goal of biological motherhood that is most distressing.

In contrast to the bulk of the research on this topic, Berg et al. (1991) did not find significant gender differences in distress among married couples with infertility. However, they reported that the context of distress differed between women and men in their study. For example, women reported significantly higher levels of belief in the importance of having a biological child, which was significantly associated with distress for women but not for men. Women were significantly more likely to want a child for companionship, to have someone to nurture, or to prove adult status and ability to parent while men were significantly more likely to want a child because their spouse did. Greil et al. (2010) also argued infertility more directly impacts women's self-identity, whereas men are impacted more indirectly through the effect it has on their wives. Women reported more use of communication about infertility as a source of coping, both within and outside of marriage. Women also reported more discomfort with fertility-related stimuli, such as baby showers, and also felt a loss of femininity due to infertility more than men felt a loss of masculinity. Finally, women reported significantly more feelings of personal responsibility and guilt regarding infertility than men (Greil et al., 2010).

Most recent studies (Berg et al., 1991; Greil et al., 2009; Johnson & Fledderjohann, 2012) have concluded that gender differences in the experience of infertility are best understood through examining the impact of socialization on gender role expectations and attitudes. More specifically, gender differences in distress are likely linked to a "pronatalist context that emphasizes not only childbearing and motherhood, but a hierarchy of motherhood, placing biological motherhood at the top" (Johnson & Fledderjohann, 2012, p.890).

Involuntary Childlessness and Gender Self-Confidence

Recent literature proposes a paradigm shift in conceptualizing femininity and masculinity, moving from a focus on gender traits and roles to gender self-concept (e.g., Hoffman, Borders, & Hattie, 2000). Movement toward this reconceptualization was largely fueled by laments about the inadequacy of recent and past measurement of femininity and masculinity, with some of those criticisms coming from the author of one of the most popular measures, the Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1974; Hoffman et al., 2000). According to Hoffman et al. (2000), Spence argued that two of the most widely used measures of masculinity and femininity, the PAQ and the Bem Sex Role Inventory (BSRI; Bem, 1974), were essentially measures of instrumentality and expressiveness and that masculinity and femininity should be conceived of differently. Hoffman et al. (2000) argued that it is the obscure conceptual definitions of masculinity and femininity that largely contribute to inadequacy in measurement. Furthermore, they argued that past measures of these constructs were primarily based in stereotypically defined traits, which were originally

established by assessing the prevalence of any given trait or interest among men or women and assumed both bipolarity and unidimensionality of gender.

Hoffman (1996) and Hoffman et al. (2000) focused on gender self-concept as an alternative to current measures of masculinity and femininity and by doing so underscored the diversity of individual versus social perspectives of the meaning of maleness or femaleness. Hoffman's model of gender self-confidence is based in the work of Lewin (1984a, 1984b) and Spence (1985; Spence & Buckner, 1995, 2000), both of which rely on a person's sense of self as the focal point in measuring masculinity and femininity (Hoffman et al., 2000). The focus on the individual as the source of definition for one's sense of maleness or femaleness is an essential feature of Hoffman's model, which is in opposition to previous measurement that focused on socially prescribed and stereotypical gender traits and roles. Hoffman et al. (2000) asserted that, "To describe the nature of an individual's *self-concept* as he or she relates it to masculinity or femininity would indeed be a more fruitful approach to understanding human behavior than counting the ways in which an individual resembles the 'typical' member of his or her own sex" (p.480).

Gender self-concept, which Hoffman et al. (2000) defined as an individual's self-perception as a man or woman, encompasses gender identity. Gender identity reflects the basic sense that one is male or female (Spence & Sawin, 1985). One aspect of gender identity is a construct originally described by Lewin (1984a) as *gender self-confidence*, which Lewin recommended as the focal point of masculinity and femininity assessment. Hoffman et al. (2000) defined gender self-confidence as the strength of an individual's conviction that they meet their own standards for masculinity or femininity.

Hoffman (2006) further stated that gender self- confidence reflects how much one accepts, respects, and values oneself as a male or a female. Hoffman argued that one's gender self-confidence is grounded in gender identity, which is in turn grounded in gender self-concept. A person's gender self-concept may or may not encompass a strong sense of gender identity, and a person's gender identity may or may not encompass a strong sense of gender self-confidence.

The following is an excerpt from Hoffman (2006) illustrating the relationship between gender self-concept, gender identity, and gender self-confidence:

> My theory suggests that one may perceive oneself as female or male and have attitudes, feelings, and behaviors related to that perception (gender self-concept) without necessarily possessing a secure sense of one's femaleness or maleness (gender identity). Furthermore, individual men and women may shun societally prescribed gender roles and still have a strong gender identity. In other words, they may define their masculinity and femininity in a variety of other ways... In addition, an individual may have a secure gender identity but not necessarily be gender self-confident, not necessarily believing that she or he meets personal, self-defined standards for femininity (femaleness) or masculinity (maleness), respectively. (p. 360)

This study utilized the concept of gender self-confidence (i.e., meeting one's own standards for femininity or femaleness) in assessing the relationship between women's gender-related self-perceptions and involuntary childlessness. It seems important to investigate this relationship because no known studies have investigated distress associated with involuntary childlessness utilizing this conceptualization of

femininity, and because femininity and fertility tend to be treated as inextricably linked by pronatal societies.

Involuntary Childlessness and Patriarchal Motherhood

Ideology has been defined as "a set of social, political, and moral values, attitudes, outlooks, and beliefs that shape a social group's interpretation of its behavior and its world" (Schwandt, 2001, p. 123). Pronatalism reflects an ideology regarding men and women's expected roles for, and the importance of, parenthood. (Parry, 2005b). Embedded in a pronatal ideology is the assumption that having children is both a natural and inevitable part of being a woman and that motherhood embodies her central identity (Ulrich & Weatherall, 2000; Parry, 2005b). Pronatalism exists worldwide but can vary in intensity from society to society (Greil et al., 2010). For example, Israel has been described as the "fertility champion of the developed countries" (Haelyon, 2006, p. 178) and has the highest number of fertility clinics per capita in the world (Kanaaneh, 2004). In Israel, the pressure for a woman to bear children is so great that the state offers infertility treatments at no cost to all women who struggle to conceive until there are at least two living children in the home (Haelyon, 2006). Because fertility treatments are so accessible, many women feel that they have no choice regarding utilizing reproductive technology to achieve biological motherhood; they would face the label of deviancy if they chose to forgo treatments and live a childfree lifestyle (Haelyon, 2006).

Pronatalism permeates Western culture and is evident in U.S. society where women's identities are strongly linked to their reproductive capacity and bodies (Forsythe, 2000; Lublin, 1998; Parry, 2005b; Ulrich & Weatherall, 2000). Spelman (as

cited in Lublin, 1998) illustrated the link between women's bodies and their identity:

> The responsibility for being embodied creatures has been assigned to women: we have been associated, indeed virtually identified, with the body: men (or some men) [sic] have been associated and virtually identified with the mind. Women have been portrayed as possessing bodies in ways that men do not. It is as if women essentially, men only accidently, have bodies… (p. 36).

The "motherhood mandate" (Bell, 2009, p. 690) associated with pronatalism necessitates that women become mothers and distinctly parallels motherhood with womanhood. This mandate, illustrative of the ideology of patriarchal motherhood, informs society on both who should mother and how to do so (Bell, 2009).

Patriarchal motherhood is the institutionalization of motherhood, both controlled by and benefitting men (O'Reilly, 2004). O'Reilly (2004) suggested that a form of patriarchal motherhood, labeled *custodial motherhood,* emerged approximately sixty years ago in the post-World War II period as a backlash to the successful emergence of women in the workforce. During the war, women were encouraged to take employment to support the war effort but were then expected to resume their places in the home as soldiers returned with the end of the war (O'Reilly, 2004). O'Reilly argued that a redesign of what constituted good mothering was a primary driving force in getting women back in the home. Bowlby's attachment theory, among other psychological theories, were also emerging at this time and the merging of these forces resulted in two major beliefs underlying custodial motherhood, that full-time mothering is necessary for children and that without it children will suffer from maternal deprivation (i.e., long-

term cognitive, social, and emotional impairment in the infant resulting from separation from the primary care giver, usually the mother) (McLeod, 2007; O'Reilly, 2004).

O'Reilly (2004) stated that a form of patriarchal motherhood termed *intensive motherhood* emerged in the 1970s and remains the dominant Western motherhood ideology. Intensive motherhood bears the hallmarks of custodial motherhood in that it requires full time mothering; however, custodial mothering focused on physical proximity versus the demand for continual attunement of mothers to their children's emotional, cognitive, and psychological needs as seen in intensive mothering. O'Reilly (2004) stated that, as in the case of custodial mothering, intensive mothering operates as a cultural discourse of backlash against feminism. Thus, O'Reilly (2004) purported that the ideology of intensive motherhood was the patriarchal response to women's economic and social independence (e.g., increased workforce representation, divorces initiated by women, rates of education for women, families in which women serve as providers) and was aimed at maintaining the private realm of the home as the natural place for women.

Intensive mothering embodies eight major ideals or expectations: (a) the biological mother is the only caregiver who can appropriately care for the child; (b) mothering must be provided full time; (c) the child's needs should always come before the mother's; (d) mothers need expert instruction on mothering; (e) the mother must feel completely content and confident in her role as mother; (f) mothers must extend copious amounts of time, resources, and effort on raising children; (g) the mother has all the responsibility of mothering but none of the power and; (h) mothering is a private matter and an individual choice that has no political importance (O'Reilly, 2010). O'Reilly

(2004) pointed out that just at the time women made ground in the public realm, along came the new patriarchal ideology of intensive mothering that ensured women would feel inadequate as mothers and view employment and mothering as in conflict due to internalization of the ideology's impossible ideals. These impossible ideals, she argued, were no accident. Rather, they were manufactured, controlled, and used to socially and economically regulate women.

Erika Horwitz (2004) described an alternative to patriarchal motherhood, *empowered mothering*, with the following themes: the importance of mothers having their own needs met, realizing that motherhood does not have to fulfill all a woman's needs or roles, involving others in childrearing, questioning mothering expectations dictated by culture, understanding that mothers do not have the sole responsibility in how a child develops, and challenging the notion that love is the only emotion a mother ever feels toward her child. Empowered mothering distinguishes between the experience and the institution of motherhood, by which the institution represents patriarchal ideologies and experience represents women's experiences with motherhood that are both internally empowering and a potential source of external empowerment (O'Reilly, 2010). Examining the ideals and consequences of patriarchal or intensive mothering should not be confused with a condemnation of family or mothering in general. Rather, empowered mothering calls into question ideals of mothering only as they are regulated by patriarchy and oppressive to women (O'Reilly, 2004).

O'Reilly (2010) argued that gender essentialism is the bedrock of patriarchal motherhood. Patriarchal motherhood thus oppresses women through an ideology defined by rigid and binary concepts of gender roles (masculine/producer and

feminine/nurturer) that result in a public/private dichotomy (O'Reilley, 2010). The work of production is associated with the public sphere while the private sphere is reserved for the work of reproduction. The message of patriarchal motherhood is that men belong in the public sphere where they embody the esteemed masculine traits associated with capitalism and industrialism while women are to remain in the home, a dichotomy that has ultimately resulted in the "invention of full-time motherhood" (O'Reilley, 2010, p.22). Consequently, women are left to measure self worth and importance through motherhood, although motherwork is also given low value within our society (Sevon, 2005).

Congruent with the expectations of patriarchal motherhood, recent research on the transition to parenthood has suggested that parents, and particularly first time parents, tended toward adopting more traditional gender roles after the birth of a child and that mothers tended to adopt more traditional gender roles than non-mothers (Liss & Erchull, 2012). Furthermore, studies (Katz-Wise, Priess, & Hyde, 2010; Johnstone, Lucke, & Lee, 2011) have found that each additional child was associated with increasing endorsement of traditional gender roles and that women, after entering long-term committed relationships and marriage, tended toward part-time versus full-time preference in their career aspirations.

Patriarchal motherhood defines what comprises *good* versus *bad* mothering (Bell, 2009; Jacques & Radtke, 2012). A good mother is exemplified by selflessness, continual sacrifice, and complete child focus. She is White, heterosexual, married, young, middle-class, and stays home with her child. A mother who does not fit within these constructed notions of a good mother is then labeled as bad or selfish (Bell, 2009;

Zimmerman et al., 2008). Women who work, minority women, older mothers, poor mothers, single mothers, and lesbian mothers, are all considered marginal or deviant under this ideology (Bell, 2009; Zimmerman et al., 2008). Furthermore, women who work and women who stay at home are pitted against each other in what has been termed the "mommy wars" (Zimmerman et al., 2008, p. 204), a social debate on who is the better mother. Current research on the issue has evidenced that children who attend high quality day care do as well or better than children who stay at home (Zimmerman et al., 2008).

Pronatalism and patriarchal motherhood ideologies assume that the desire for motherhood by all women is a natural instinct, often referred to as the *maternal instinct* (Nicholson, 1999). Most feminist research roundly rejects the biological determination of desire for motherhood because there is little scientific or historical evidence to suggest that the maternal instinct or even mother-infant bonding is biologically determined (Nicholson, 1999). This study explored whether traditional values of motherhood (i.e. values embedded in the patriarchal motherhood ideology) influence the experience of involuntary childlessness, in view of the literature suggesting that the ideology of patriarchal motherhood is internalized by women and "plays out in policies and practices around infertility where ideological positions are put into action" (Bell, 2009, p. 691).

Involuntary Childlessness and Feminist Perspectives

Focus on the relationship between feminism and reproductive technologies appears to dominate the review of literature on feminism and involuntary childlessness. A full examination of the relationship between feminism and reproductive technologies

is outside the scope of the current project. However, it is important to include a brief summary of this issue as it bears influence on the social context of the study at hand. Reproduction provides a pivotal intersection for both the social construction and regulation of women and is thus, a key area studied by feminist scholars (Woollett & Boyle, 2000). The primary concern appears to center on questions regarding the sociopolitical consequences of these reproductive technologies for women in Western culture.

Scholars arguing against the use of reproductive technologies express concern regarding the medicalization of infertility and how it may prevent focus on issues of social change, such as the sociopolitical forces that shape family formation and the construction of reproductive desires and involuntary childlessness in our culture (Shanley & Asch, 2009; Zimmerman et al., 2008). Feminists who do not support the use of reproductive technologies argue that these technologies represent an oppressive force, an "arm of patriarchy" (Parks, 2009, p. 22); namely, that it gives women's control of their reproductive health and their bodies to the male dominated institution of medicine (Greil et al., 2009; Parry, 2005a). Some feminist scholars are concerned about the issue of choice involved in the use of these technologies, arguing that because these treatments are available, women may feel pressured to use them before accepting involuntary childlessness (Parry, 2005a).

On the other side of the issue are feminist arguments that warn against constructing a woman's desire to have children as either a natural biological instinct or resulting from intense social pressures because both positions hide women's agency and position involuntarily childless women as passive products of their environment (Ulrich

& Weatherall, 2000; Greil et al., 2011). Some feminist scholars feel constructing choices to use reproductive technology as an outcome of decision-making can empower women's agency in reproductive issues and prevent involuntarily childless women as being depicted as "unwitting victims of patriarchal control" (Parry, 2005a, p. 195) or as mad, bad, desperate, obsessed, and irrational (Madeira, 2012; Sandelowski, 1990; Ulrich & Weatherall, 2000). Some feminist scholars additionally point out that reproductive technology, while traditionally used to privilege White, educated, married, heterosexual, middle class family formation, also has the capacity to challenge the traditional construction of family and mother, i.e., the use of these services by lesbians, disabled women, single women, minority women, and post-menopausal women (Parks, 2009).

There appears to be a paucity of research investigating how feminist perspectives impact fertility-related distress in the experience of involuntary childlessness. However, some studies have investigated the influence of personal agency and social pressure for motherhood on fertility-related distress. For example, Haelyon (2006) found discourses of involuntarily childless women that supported their sense of agency and autonomy (described as a rejection of pronatal motherhood mandates), which served as protective factors in the experience of fertility-related distress. A discourse emerged among involuntarily childless Israeli-Jewish women seeking infertility treatments that expressed a sense of taking control of their bodies and reproductive decisions by negotiating with medical experts while simultaneously rejecting idealized maternal practice and the patriarchal notion of the "heroine mother" (Haelyon, 2006, p. 191). Historically, the Israeli government encouraged Jewish

women to have many children by giving a heroine mother award to women who had ten or more children (Kanaaneh, 2004). This concept of the heroine mother also provides an example of how pronatal societies often employ a mother-nation relationship, equating motherhood to nationhood, which reinforces the oppressive function of patriarchal motherhood under the guise of contributing to national agendas by making it women's patriotic duty to bear children (Kanaaneh, 2004). Interestingly, the second discourse that emerged in Haelyon's (2006) study represented themes of distress, the need to submit to any treatment for the sake of a biological child, and a sense that the non-impregnated female body has no rights of it's own accord. Demographic differences between the two groups of women indicated that those who rejected idealized motherhood and felt a sense of inner-agency in their choices had higher education and were less religious.

Ulrich and Weatherall (2000) investigated involuntarily childless women's reasons for wanting children and found dialogues that were consistent with Western sociocultural values regarding motherhood (i.e., motherhood as a natural instinct, as a stage in the development of a relationship, and in response to social expectation). However, a discourse of motherhood as a result of positive decision-making also emerged, which respondents discussed as an active process influenced by many factors rather than a passive decision based on biological drive. Ulrich and Weatherall suggested that the reproductive decision-making discourse highlights women's agency in the decision to have children and can be an empowering strategy, particularly for involuntarily childless women that experience feelings of helplessness. Some women discussed being able to come to terms with involuntary childlessness by understanding

motherhood as an activity with various expressions other than the mother-baby relationship and by challenging the notion that women's only way to contribute to society is through motherhood.

Bell (2013) conducted interviews with 28 Australian women who had in the past or present utilized assisted reproduction. In relation to the impacts of pronatalism, the author noted that while some respondents discussed themes of agency and choice, "others identified strong, basic, almost visceral urges and society's pronatalism as powerful forces" for choosing to use reproductive technologies. One participant responded, "society just expects you to have a child" and another stated, "it's an incredible urge to have children... It's society… It's just a natural desire and a natural instinct to reproduce oneself" (p.290).

Research on feminist attitudes in general have evidenced that a feminist identity is related to more egalitarian expectations for relationships, including division of labor, expectations of education and employment, and beliefs about power and authority in the relationship (Yoder, Perry, & Saal, 2007). In the context of married couples, research has indicated that a more egalitarian division of both household work and childcare was associated with more liberal gender attitudes (Liss & Erchull, 2007). Thus, feminism has affected dialogues about womanhood and motherhood; for example, it may be easier now to voice the desire not to have children or to do so as a single mother (Letherby, 2002). Paradoxically, the advent of reproductive technologies has likely made ambivalence about motherhood less acceptable for involuntarily childless women due to the number of medical treatment options now available (Letherby, 2002). While feminism has added to the dominant discourse of motherhood and womanhood by

discussing the intricacies of both the institutional and personal experience of motherhood, and normalizing ambivalence toward motherhood, stereotypes of childless women remain (Letherby, 2002).

Given that young women today have grown up with these changing feminist dialogues, Jacques and Radtke (2012) explored how young Canadian women constructed their identities, with the possibility that they might articulate new ways to construe womanhood that were resistant to traditional constructions, i.e., wife and mother. By and large, the participants endorsed traditional versions of womanhood though simultaneously positioning themselves as career-oriented and autonomous (Jacques & Radtke, 2012). Participants emphasized personal choice in marriage and motherhood, resisting these choices as stemming from social expectation. Jacques and Radtke found that these accounts also constructed motherhood as intensive motherhood. Participants avoided discussion of how to negotiate traditional concepts of womanhood with the desire for a career and struggled to voice alternative ways of mothering.

Liss and Erchull (2012) investigated the differences in beliefs amongst self-labeled feminist mothers and feminist women who anticipated but did not yet have children. They found that feminist women who anticipated having children expected greater equality in the division of childcare and less traditionalism in child surname choice in comparison to the lived experience of the feminist mothers. The authors surmised that it might be the internalization of the ideology of intensive parenting that contributed to these differences.

It is important to note that recent literature has warned against the dichotomization of passive or fatalistic versus agentic health beliefs in response to

involuntary childlessness (ex., Bell & Hetterly, 2014). This seems relevant given that many studies on feminism and involuntary childlessness position agentic responses (i.e., responses based on a sense of choice and self-determination) as the antithesis to a passive ingestion of dominant pronatal discourses. Bell and Hetterly asserted that, just as involuntary childlessness is constructed along class lines, so too are the constructs of agency and fatalism. For example, fatalism is often associated with the working class while agentic orientation is often associated with middle-class individuals (Bell & Hetterly, 2014).

Bell and Hetterly (2014) found, in a qualitative study of 58 interviews of involuntarily childless women, that women of both high and low social economic status (SES) utilized fatalism as a way to explain and cope with the experience of involuntary childlessness. However, women of higher SES used fatalism as a way to cope only after exhausting other resources to which women of lower SES did not have access. Additionally, women of both high and low SES utilized agentic responses in the face of fertility barriers. Bell and Hetterly (2014) asserted that agency and fatalism are not mutually exclusive and that it is important to rise above the dominant binary and class based notion of these concepts in understanding women's responses to involuntary childlessness or any health-related issue. The authors highlighted that the lines between agency and fatalism are not clear-cut by demonstrating that many women across class groups in their study used agency as fatalism and fatalism as agency. Understanding the complexity of health beliefs is important in making sense of women's experiences with involuntary childlessness. Further research in this area may help to better illuminate the intersection of class, feminism, and reproduction.

Involuntary Childlessness and Relational Quality

Sandelowski (1990) asserted that a patriarchal culture simultaneously promotes and devalues motherhood, a process that consequently undermines meaningful relations between women. She argued that in such a culture, labeling women as infertile defies a sense of female unity by pitting mother against other. Involuntarily childless women experience isolation from other women, with whom they cannot share in the cultural "currency of women" (Sandelowski, 1990, p. 33), including fertile women and other involuntarily childless women who eventually achieve pregnancy. Research has substantiated the feelings of isolation, shame, and otherness that pervade the discourse of involuntary childlessness (e.g. Sandelowski, 1990; Olshansky, 2006; Greil et al., 2009). While research has found social support to be a robust predictor of distress related to involuntary childlessness, few studies have utilized a relational model to investigate the quality of relational connectedness of involuntarily childless women (Sandelowski, 1990; Gibson & Myers, 2002).

A relational model of women's development recognizes that the process of women's identity development is relational in nature, occurs within and toward a sense of connectedness, occurs within and influenced by a sociocultural context, and is central to a sense of well-being (Gibson & Meyers, 2002; Jordan, 1997; Miller, 1976; Patterson, Wang, & Slaney, 2012; Uusimaki, 2013). Relational-Cultural Theory (RCT; Jordan, 1997) has pioneered a shift from conceptualizing identity development as autonomy from others to conceptualizing it as a relational process (Frey, 2013). RCT locates distress and its resolution within relational processes and societal structures (Canadian Women's Health Network, 2009). This stands in opposition to the traditional

Western models of psychological development, which emphasize separation-individuation as the primary vehicle for the development of sense of self (Frey, 2013).

Gibson and Meyers (2002) argued that women's empowering relational experiences might be utilized as a protective factor from distress associated with involuntary childlessness. Understanding the quality of women's relational connectedness seems particularly important in the case of involuntary childlessness due to its isolating influence, long-lasting impact, established ability to negatively influence women's relationships, and intersection with sociocultural influences such as patriarchal motherhood ideologies (Sandelowski, 1990; Schwerdtfeger & Shreffler, 2009). For example, Lechner et al. (2007) found that involuntarily childless women were more likely to be dissatisfied with the social support they received than is seen in the fertile population. Olshansky (2003) also observed dysfunction in the relationships of involuntarily childless women and provided several examples, including difficulty joining in fertile friends' pregnancies and general feelings of isolation and inadequate support from meaningful others who do not grasp the social and psychological sequelae of involuntary childlessness.

Olshansky (2003) argued that RCT is a useful model for understanding infertile women's potential vulnerability to depression. She developed the *grounded theory of identity as infertile* in 1996, which proposed that as women confront infertility they take on an identity as infertile, pushing away other important identities (e.g. friend, partner, worker, family member) and experiencing the identity of infertile as the most salient. Thus, Olshansky (2003) contended that infertile women are at risk for loss of sense of self as they disconnect from other important identities and social connections. She

reasoned that RCT is useful in understanding distress responses in involuntarily childless women because the result of centrality of an infertile identity is isolation and disconnection from others. She further argued that RCT helps to explain why involuntarily childless women who later conceive continue to experience distress; they not only remain disconnected from others but isolate themselves even further with the identity of "infertile fertile" (p. 265) rather than donning a fertile identity with the achievement of pregnancy (Olshansky, 2003).

There is a substantial body of research on social support in the experience of involuntary childlessness (e.g. Jordan & Revenson, 1999; Lechner, Bolman, & van Dalen, 2006; Martins, Peterson, Almeida, & Costa, 2011; Rashidi, Hosseini, Beigi, Ghazizadeh, & Farahani, 2011; Slade, O'Neill, Simpson, & Lashen, 2007), and social support has been found to be a robust buffer for distress in this experience (Malik & Coulson, 2008). However, while positive support may protect against distress, inadequate support may exacerbate the distress response (Malik & Coulson, 2008; Schwerdtfeger & Shreffler, 2009; Slade et al., 2007).

Slade et al. (2007) found that the women who were most likely to perceive their social support as inadequate were those who were more stigma conscious and frequently disclosed fertility problems. It makes sense that involuntarily childless women would seek the support of others to cope with the ensuing distress as women in general have been found to utilize social support as a coping mechanism more frequently than men (Slade et al., 2007). Indeed, involuntarily childless women have been found to seek more social support than involuntarily childless men (Jordan & Revenson, 1999). Slade et al. (2007) suggested that involuntarily childless women may

turn to their social support networks as a coping mechanism but then be confronted with how a stigmatized identity impacts social relationships. Notably, however, Slade et al. investigated the perceived availability of social support rather than quality of relationships.

Martins et al. (2012) investigated the interactive effects of perceived social support and disclosure of involuntary childlessness on fertility-related social, personal, and marital stress. Results indicated that when involuntary childlessness was not disclosed to at least one close relationship, the beneficial effects of social support on fertility-related stress disappeared. When participants felt high levels of perceived social support, those who chose to keep involuntary childlessness secret from at least one close relationship had the highest levels of both personal and social stress. Overall, full disclosure to both close and distant relationships was the disclosure style associated with lowest levels of social and personal fertility-related stress. The authors asserted that these findings suggested those who hide their experiences with involuntary childlessness from important relationships experienced disconnection as they then presented different identities in various life contexts. Additionally, the authors purported that the results reinforced the idea that hiding a highly personal life crisis from important others may stifle the benefits that relationship may serve in adjusting to fertility-related stress.

There have been few studies that have investigated the quality of involuntarily childless women's supportive relationships. Van (2012) conducted a qualitative study to elicit coping processes used by women following pregnancy loss. The primary themes that emerged were being authentic, connecting with others, and avoiding and

pretending. Results indicated that the concept of connectedness was the central theme that facilitated coping with grief, while disconnectedness from self and others inhibited positive coping and led to the use of avoidance and pretending. Finally, Van noted that there was a clear distinction between social support and connectedness in that connectedness necessitated an active and personal connection with another person or groups that fostered comfort and security.

Gibson and Myers (2002) investigated the effects of social coping resources (i.e., the degree to which a person is active in social networks that prove helpful in times of stress) and growth-fostering relationships (i.e., connections with others that are mutually empowering and encourage growth for both parties) on infertility stress for women. They found that both variables significantly contributed to the prediction of infertility-related stress, with infertility-related stress decreasing with increases in social coping resources and growth-fostering relationships. Furthermore, there were significant and positive relationships between social coping resources and growth-fostering relationships with family and partner support. These results suggested that there is a link between growth-fostering relationships and infertile women's well-being, which provides helpful information for developing successful interventions to reduce infertility-related stress.

An interesting development in the experience of involuntary childlessness is the popularity and utilization of the Internet for support, information, and advice, generally via blogs and online support groups focused on involuntary childlessness and treatment (Malik & Coulson, 2008). In fact, survey findings suggest that about half of couples dealing with involuntary childlessness access the Internet for information and/or support

(Malik & Coulson, 2008). The majority of studies on online support and involuntary childlessness have evidenced that while there are some benefits (i.e., anonymity, normalization, and gaining helpful information), online support may also facilitate a disconnection from real world support and increase distress and a sense of isolation (Epstein, Rosenberg, Grant, & Hemenway, 2002; Hinton, Kurinczuk, & Ziebland, 2010; Malik & Coulson, 2008). However, because this study is concerned with how the quality of mutually empowering connections impacts fertility-specific distress, online connections, and the relative anonymity that frequently comes with it, will not be investigated.

Research Questions

The present study, informed by feminist theory of maternal empowerment, sought to identify predictors of fertility-specific distress in the experience of involuntary childlessness. The present study investigated two overarching research questions. The first, regarding the overall model, investigated the influence of relational quality, patriarchal motherhood, gender self-confidence, and feminist perspectives, as a set of variables, on fertility-specific distress. The second question, regarding the individual contribution of each variable, investigated the unique and relative influence of relational quality, gender self-confidence, patriarchal motherhood, and feminist perspectives on fertility-specific distress.

Chapter 3

Methods

Participants

This study obtained an online sample to allow for a representative group across the domains of age, causes of and treatment options for involuntary childlessness, race/ethnicity, education, and household income. Women aged 18-64 who at some point in their lives experienced at least one year of difficulty achieving pregnancy were recruited to complete the online study. Involuntary childlessness could be defined by a medical diagnosis, such as multiple pregnancy loss or stillbirth, religious infertility, or any other participant defined reason. Participants were solicited via online social networking sites, online message boards, flyers distributed at local sexual and reproductive health centers, or indirectly via other participants. The forms of recruitment were chosen in an effort to recruit a larger number of women who were not actively seeking treatment, a criticism of most studies in infertility and pregnancy loss (Greil, McQuillan, & Slauson-Blevins, 2011). It is important to move beyond treatment seekers in understanding the experiences of women with involuntary childlessness in order to reveal the full diversity of this group (Greil, McQuillan, & Slauson-Blevins, 2011).

Participants included one hundred and sixteen women who took the online survey. The mean age was 33.36 (SD = 6.85; range = 22-63). The sample was largely made up of Caucasian participants (88%, n = 102). The remaining sample identified themselves as Native American/Native Alaskan (4.3%, n = 5), Hispanic/Latino(a) (2.6%, n = 3), Biracial/Multiracial (1.7%, n = 2), African American/Black (.9%, n = 1),

Middle Eastern/Arab (.9%, *n* = 1), and Foreign National (.9%, *n* = 1). All participants identified their race/ethnicity.

In terms of annual family income, the distribution was mostly in the middle to the higher end of income brackets provided. Participants income level between $60,000-$99,000 accounted for the largest group (32.8%, *n* = 38), followed by income level between $30,000-$59,000 (29.3%, *n* = 34), and income level between $100,000-$149,000 (20.7%, *n* = 24). The income brackets at both ends had the least number of participants, income level less than $30,000 (9.5%, *n* = 11) and income level greater than $150,000 (6.9%, *n* = 8). Approximately .9% (n = 1) of participants did not report their income level.

Educationally speaking, the majority of participants had at least some college (37.9%, *n* = 44) or greater, followed by a 4 year college degree (31.9%, *n* = 37), master's degree (18.1%, *n* = 21), doctoral degree (1.7%, *n* = 2), and professional degree (MD/JD) (4.3%, *n* = 5). Some participants reported having a high school diploma/GED (4.3%, *n* = 5) or less (1.7%, *n* = 2). All participants indicated their level of education.

In terms of religious affiliation, the majority of the sample (26%, n = 30) identified as Other and was most frequently specified as Christian, Non-denominational, followed by Catholic (21%, *n* = 24), Agnostic (13%, *n* = 15), Methodist (10%, *n* = 12), Baptist (8%, *n* = 9), Atheist (7%, *n* = 8), Lutheran (6%, *n* = 7), Presbyterian (3%, *n* = 4), Jewish (2%, *n* = 2), Church of Christ (1%, *n* = 1), Assembly of God (1%, *n* = 1), Church of Latter Day Saints (1%, *n* = 1), and Pentecostal (1%, *n* = 1). One participant did not identify their religious affiliation.

The women in the sample were predominantly heterosexual (90.5%, *n* = 105), married or partnered (92.2%, *n* = 107), and employed full-time (67.2%, *n* = 78). Four point three percent (*n* = 5) of the sample identified as bisexual, followed by pansexual (2.6%, *n* = 3), homosexual (1.7%, *n* =2), and other (.9%, *n* =1). Following identification as married or partnered, the remaining relationship statuses reported included committed or in an exclusive relationship (4.3%, *n* = 5), single (2.6%, *n* = 3), and divorced (.9%, *n* = 1). Following identification of full-time employment, the remaining sample identified as not employed (19.8%, *n* = 23), employed part-time (6.9%, *n* = 8), and student (6%, *n* = 7). All participants identified their sexual orientation, relationship status, and employment status.

In terms of fertility-related history, the majority of the participants reported a history of a prior pregnancy (58%, *n* = 67), followed by no history of prior pregnancies (42%, *n* = 49). Of the women who reported prior pregnancies, miscarriage was the predominantly identified outcome (35.3%, *n* = 41), followed by a live birth (16.4%, *n* = 19), ectopic pregnancy (8%, *n* = 9), stillbirth (7%, *n* = 8), and abortion (3%, *n* = 3). The majority of the participants reported utilization of medical services (82%, *n* = 95), the remaining participants did not report use of medical services for fertility treatment (17%, *n* = 20). In terms of the presence of children in the home, most participants reported no children, social (i.e., adoption, step-parenting, fosterage) or biological, in the home (76%, *n* = 88), followed by the presence of at least one social or biological child (24%, n = 28). All participants identified their history of pregnancy, outcomes of prior pregnancies, utilization of medical services in fertility treatment, and whether or not there are currently children in the home. Finally, participants predominantly

reported trying to get pregnant for the last 0-5 years (66%, *n* = 76), followed by trying to conceive for the last 5-10 years (22%, *n* = 26), and greater than 10 years (7%, *n* = 8). A few participants did not identify length of time trying to conceive (5%, *n* = 6).

Instruments

The current study utilized a demographic questionnaire designed by this investigator and a total of five measures for the dependent variable and the four predictor variables (Appendix B). The instruments administered included the Fertility Problem Inventory (Newton, Sherrard, & Glavac, 1999), Traditional Motherhood Scale (Whatley, 2004), Relational Health Indices (Liang, Tracy, Taylor, Williams, Jordan, & Miller, 2002), Hoffman Gender Scale (Hoffman et al., 2000), and Feminist Perspectives Scale Short Version (Henley, Spalding, & Kosta, 2000). In order to control for order effects resulting from the order in which participants completed measures, this study randomized the order of the measures in Qualtrics.

Demographic questionnaire. A demographic questionnaire was developed based on factors important to investigating infertility-related distress, such as age, income, education, prior pregnancy outcomes, religion, and presence of children in the home (Newton, Sherrard, & Glavac, 1999; Haelyon, 2006; Mussani & Silverman, 2009; Hare-Mustin & Roderick, 1979; Greil, Johnson, McQuillan, & Lacy, 2011). Furthermore, data on relationship status, sexual orientation, ethnicity, employment status, previous treatment, and length of time trying to conceive was included to help describe the sample.

Fertility Problem Inventory (FPI). The FPI (Newton et al., 1999) was developed to assess important domains of perceived infertility-related distress in both

men and women. It was developed to meet the need for more infertility specific measures of distress and was originally normed on individuals seeking infertility treatment (Peterson, 2002). The FPI is a 46-item questionnaire that utilizes a six-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). It consists of five subscales and one global index of perceived infertility-related distress. The five subscales are social concern, sexual concern, relationship concern, need for parenthood, and rejection of a childfree lifestyle (Newton et al., 1999). The Global Stress score is an overall measure of infertility-related stress, with overall scores ranging from 46 to 276. Sample items include "I would do just about anything to have a child (or another child)", "I find it hard to spend time with friends or family who have young children", and "I feel just as attractive to my partner as before." For the purposes of the current study, the global stress score was utilized as a general measure of fertility-related stress.

The Global Stress score is computed by summing all scale items, or five subscale scores. Higher scores are associated with higher fertility-related psychological stress. The scale has exhibited good internal consistency as indicated by a Cronbach's alpha of .93 (n=1153 women, 1149 men; Newton et al., 1999). Convergent validity was established by comparing correlations of the FPI with other standardized measures (i.e., depression, anxiety, and marital adjustment) and Newton et al. concluded that observed correlations were in the expected direction, moderate in size, and demonstrated adequate convergent and discriminant validity. The mean correlation was .45 with a range of .26-.66. Results indicated that the scale was measuring distinct but related aspects of infertility-related stress. This study found similar reliability statistics for the global score as Newton, et al. (1999). For the overall scale, the Cronbach's Alpha was

.93.

Traditional Motherhood Scale (TMS). The TMS (Whatley, 2004) measures the degree to which an individual holds traditional views of motherhood, and was used to measure patriarchal motherhood. The response format is a 7-point Likert scale with possible responses ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Sample items include "Mothers should stay at home with children" and "Motherhood is an essential part of a female's life." Scoring consists of taking the mean of all responses (range 1-7) and higher scores suggest more traditional views of motherhood.

Factor analysis of the original study sample yielded a one-factor solution of 18 items (Whatley, 2004). Whatley (2004) reported a Cronbach's alpha of .89 with a sample of 106 undergraduate students (86 females and 20 males) and found no differences as a function of ethnicity. However, Whatley found that males were significantly more traditional in their views of motherhood than females. The study indicated that the aggregate undergraduate sample endorsed a higher than average support for traditional motherhood. This study found similar reliability statistics, in adult women, with a Cronbach's alpha of .90.

Relational Health Indices (RHI). The RHI was developed by Liang et al. (2002) to assess growth-fostering relationships and is based on the relational-cultural theory of psychological development. It taps into both subtle and complex qualities of dyadic and group relationships (Gibson, 2000). The RHI is a 37-item self-report questionnaire that operationalizes three major characteristics of relationships theorized to promote growth: mutual engagement (i.e., a shared involvement and experience of the relationship), authenticity (i.e., the capacity and safety to understand and express

oneself sincerely within the relationship), and empowerment/zest (i.e., the experience of feeling invigorated by the relationship (Liang et al., 2002). These three domains of relational health are measured across three types of relationships: peer, community, and mentor.

A sample item from the mentor domain includes, "My relationship with my mentor inspires me to seek other relationships like this one." A sample item from the peer domain includes, "Even when I have difficult things to say, I can be honest and real with my friend." Finally, a sample item from the community domain is, "I have a greater sense of self-worth through my connection with this community."

The response format of the RHI ranges from 1 (*Neve*r) to 5 (*Always*) on a 5-point Likert scale. The possible range for the total score is 36 to 180. Higher scores represent higher levels of relational health. Liang et al. (2002) proposed two ways to score the RHI. Scores of engagement, empowerment/zest, and authenticity can be computed for each of the three relationship domains (mentor, peer, community), thus providing three subscale scores for each of the three relational domains. Alternatively, a composite score can be calculated for each relational domain. Frey, Beesley, and Newman (2005) conducted a principal components analysis on the 37-items of the RHI. Results from the study indicated that the RHI operates most reliably as a measure of a unidimensional construct of relational health within each of the three relationship domains.

Liang et al. (2002) reported that the RHI demonstrated acceptable internal consistency as indicated by Cronbach's alphas for the composite scores of .85 for the peer domain and .90 for the community domain. The authors also reported evidence of

convergent validity by comparing RHI scores with measures of social support, loneliness, depression, stress, and self-esteem. Overall, the patterns of correlations were in the expected directions. All of the scales were positively associated with self-esteem, stress was negatively correlated with the community domain, and depression was negatively correlated with the peer domains.

This study found a Cronbach's alpha of .89 for the total score. For the purposes of this study, the total score was used in the regression analysis. The composite score was used given its optimal reliability.

Hoffman Gender Scale (HGS: Form A). The HGS (Hoffman et al., 2000) was developed as a measure of gender self-confidence. Hoffman (2006) described gender self-confidence as "one's intensity of belief that one meets one's own personal standards for femininity/masculinity" (p. 363). While there are two versions of the HGS, one for men and one for women, this study utilized the version for women, which is comprised of 14 Likert-type items ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), with a total score range of 14-84.

The HGS consists of two 7-item subscales: Gender Self-Definition (HGS-SD) and Gender Self-Acceptance (HGS-SA). For the purposes of this study, the total score measuring gender self-confidence was utilized, with higher scores indicating higher self-confidence. Sample HGS items include, "When I am asked to describe myself, being female is one of the first things I think of" (HGS-SD) and "I am happy with myself as a female" (HGS-SA).

Hoffman et al. (2000) reported a Cronbach's alpha of .94 for the HGS total score in a sample of 273 undergraduate women. Convergent validity was supported by the

significance of predicted correlations between the Gender Self-Definition and Gender Self-Acceptance subscales with the (a) Feminist Identity Development Scale (FIDS) subscales and (b) Womanist Identity Attitudes Scale (WIAS; Hoffman, 2006). This study found a Cronbach's alpha of .91 for the total score for gender self-confidence.

Feminist Perspectives Scale Short Version (FPS3). In pronatal societies, perceptions of motherhood are typically linked to attitudes toward women and their rights, roles, and identities. As seen with recent concerns about, and changes in, assessing gender, a contemporary feminist approach raises questions about previously used measures to assess attitudes toward women and women's issues. Henley, Meng, O'Brien, McCarthy, and Sockloskie (1998) argued that early measures often ignored controversial issues to achieve higher internal consistency; failed to delineate between differing feminist theoretical perspectives (liberal, radical, socialist, etc.); did not recognize the link between race, class, and gender; and did not emphasize women as an oppressed group.

In response to this critical analysis, the FPS3 (Henley et al., 2000) was developed to measure a broad array of beliefs about women and women's issues, tapping into five feminist theoretical perspectives. The FPS3 consists of 36 Likert-type items ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). There are six attitudinal subscales; Fembehave3, a 5-item behavioral subscale; and Femscore3, a composite score. For this study, the composite score (i.e., Femscore3) will be utilized.

Scores for the composite Femscore3 can range from 25 to 175. Femscore3 is scored by summing 5 of the 6 the attitudinal subscale scores (i.e., Liberal, Radical, Socialist, Cultural Feminist, Woman of Color/Womanist). Higher scores on Femscore3

are associated with higher endorsement of feminist attitudes toward women and women's issues. Sample items include, "A man's first responsibility is to obtain economic success, while his wife should care for the family's needs" and "Discrimination in the workplace is worse for women of color than for all men and white women."

Henley et al. (2000) reported a Cronbach's alpha for the composite Femscore3 of .85 and a test-retest correlation of .87, as well as good test-retest and convergent validity between Femscore3 and measures of attitudes toward women. Because several of the subscales (e.g., Fembehave3, attitudinal) had individual Cronbach's alphas less than .70, the authors recommended use of the composite. For this reason, the current study will use the composite Femscore3 as a broad measure of feminist attitudes toward women and women's issues that capture a range of feminist perspectives. This study found a Cronbach's alpha of .80 for the composite score.

Procedure

Data was collected via Qualtrics, an online program that allows for the creation of an Internet-based questionnaire. The survey was created and maintained by the primary investigator through Qualtrics. Only the primary investigator and her advisor had access to data obtained. Data was collected and maintained through the use of a secure server to prevent unauthorized access to confidential information.

Prospective participants received either a recruitment flyer or a post on a social networking site in which they were informed of the purpose and nature of the study and the identity and contact information of the author and her advisor. Flyers and online social networking posts included a link to the online study. Following the link led

participants directly to the online survey, where they were presented with an informed consent document, approved by the IRB at The University of Oklahoma, which again informed of the purpose and nature of the study and informed them of the voluntary nature of their participation. Participants were able to end participation at any time during the process of completing the survey. After the consent document, participants were presented with the survey instruments. First, the demographic questionnaire was presented, followed by the Fertility Problem Inventory (FPI). The following instruments were presented in a randomized order: the Traditional Motherhood Scale (TMS), the Relational Health Indices (RHI), the Hoffman Gender Scale (HGS), and the Feminist Perspectives Scale Short Version (FPS3). After completing the survey instruments, participants were asked if they were interested in participating in a random drawing for a gift card to Amazon. If interested, participants were asked for their name and email address. Identifying information for the purposes of the incentive was separated from participant's data by importing identifying information to a separate panel maintained by a secure server on Qualtrics. Last, participants were thanked for taking the survey and provided contact information for the researcher should they have any questions or concerns. Additionally, contact information for a national support line for involuntary childlessness, Resolve, was provided if taking the survey provoked the experience of distress.

Research Questions

The current study investigated the following research questions: (a) Do relational quality (i.e., RHI), gender self-confidence (i.e., HGS), patriarchal motherhood (i.e., TMS), and feminist perspectives (i.e., FPS3) jointly account for significant

variation in fertility-specific distress (i.e., FPI scores), and (b) Do relational quality (i.e., RHI), gender self-confidence (i.e., HGS), patriarchal motherhood (i.e., TMS), and feminist perspectives (i.e., FPS3) individually and significantly predict fertility-specific distress (i.e., FPI scores)?

Data Analysis

The current study utilized a hierarchical multiple regression model in order to control for relevant demographic variables (i.e., age, income, education) and then to examine the collective and separate influence of the measures (i.e., RHI, HGS, FPS3, TMS) on fertility-specific distress (FPI). Entering the measures in one block at the second step seemed appropriate given the exploratory nature of the study and lack of theoretical basis for entering the predictor variables in any given order.

Chapter Four

Results

Preliminary Analysis

Of the original 155 participants, 39 were eliminated due to noncompletion of the survey, with dropout occurring before completion of any study instruments. Analysis of the patterns of missing data in the remaining cases revealed that 64 (55.17%) exhibited no missing data and 9.6% of all items of all cases were missing data. Little's Missing Completely at Random analysis was conducted and an insignificant chi-square statistic χ^2 (3137.82, p = 1.0) was obtained signifying that data was missing at random. Schlomer, Bauman, and Card (2010) recommend multiple imputation as one of the best methods for handling missing data due to its precision of parameter estimates and accuracy of standard errors. Multiple imputation has been recommended as the best option for handling missing data when greater than 5% of cases are missing at least one data point (Little & Rubin, 1987). Furthermore, Tabachnick and Fidell (2007) recommend linear regression imputation as a more objective estimate of missing values than mean substitution, which is a more conservative estimate, in part by reducing the variance of the variables (Schlomer, Bauman, & Card, 2010). Therefore, linear regression imputation was used to account for missing values to prevent case-wise deletion of missing data. Of note, a comparison of regressions using case-wise deletion and imputed data exhibited almost identical trends and betas, with imputed data reaching statistical significance on one additional predictor variable, likely due to increased power.

The preliminary examination of the data confirmed that all assumptions of the

analyses were met. For all the predictor variables within the regression model, multivariate normality was revealed to be upheld based on the p-p plot and scatterplot of the model's standardized residual values. The p-p plot revealed the model's standardized residual values to be linear as expected and the scatterplot demonstrated a rectangular scatter of residual values. Finally, skewness and kurtosis scores for all model variables were within normal ranges.

The means and standard deviations of the criterion and predictor variables included in the overall model are given in Table 1. Pearson's correlational analyses were conducted to determine the bivariate association between the variables of interest (see Table 2). Demographic variables that showed significant correlation with FPI scores included participant age, education, and household income. Age of participant showed a significant correlation with FPI (r = -.38, p < .01), indicating a trend toward younger participants reporting higher levels of fertility-related distress.

Education showed a significant correlation with FPI (r = -.25, p < .01), indicating that higher education levels were associated with less fertility-related distress. Education also exhibited a significant correlation with income (r = .19, p < .05), denoting that higher education levels were associated with higher income. Finally, household income showed a significant correlation with FPI (r = -.24, p < .01), indicating a trend toward lower income participants showing higher levels of fertility-related distress.

Of the instruments utilized in this study, several exhibited significant correlations with FPI. The TMS was correlated with FPI (r = .40, p < .01). The correlation indicated that higher levels of the criterion variable, FPI, were associated

with higher endorsement of TMS. The HGS was also significantly correlated with FPI (r = -.10, p < .05), indicating that higher levels of gender self-confidence were associated with lower levels of FPI. Finally, the RHI significantly correlated with FPI (r = -.19, p < .01), which indicated reports of greater relational health were associated with lower levels of FPI.

Multicollinearity was not deemed a hindrance to model interpretation as intercorrelations between predictors did not appear to be remarkably high and ranged from small to moderate. Because several demographic variables presented a significant correlation with the criterion variable (i.e., age, income, and education), they were controlled for in the multiple regression analysis.

A t-test found no significant differences in the experience of fertility-related distress between Women of Color and White females, although the lower number of participants who identified as Women of Color may have prevented the ability to detect differences. Additionally, ANOVAs and t-tests found no significant difference in fertility-related distress for women with differing religious identification, between groups of length of time trying, women who have been pregnant and those who have not, or women with children in the home and those without children in the home. However, a t-test indicated a significant difference in the experience of fertility-related distress between participants who have utilized medical services as a part of fertility treatments and those who have not (t = 5.85, p < .01), with women who have utilized medical services as a part of their fertility treatment (n = 95) exhibiting more fertility-related distress than women who have not engaged medical intervention (n = 20).

Multiple Regression Model

A multiple regression model was used to determine the variance in fertility-related distress (i.e., FPI) accounted for by relational quality (i.e., RHI), traditional mothering values (i.e., TMS), feminist perspectives (i.e., FPS3), and gender self-confidence (i.e., HGS). Because the analysis of bivariate correlations indicated a relationship between several demographic variables and fertility-related distress (i.e., age, income, education), they were entered into the first step of the regression model in order to control for their affect on the criterion variable, FPI. The remaining predictor variables (i.e., RHI, TMS, FPS3, HGS) were entered into the second step.

Noted in Table 3, the overall regression model was significant and accounted for 43% (F (7,69) = 7.35, $p < .01$) of the total variance in fertility-related distress, which is considered a large effect size (Cohen, 1988). The last step of the model showed that TMS, RHI, Age, and Income each individually and significantly predicted fertility-related distress (see Table 3) with the relative importance as follows: TMS ($\beta = .41$, $p < .01$), Age ($\beta = -.35$, $p < .01$), RHI ($\beta = -.20$, $p < .05$), and Income ($\beta = -.17$, $p < .05$).

Chapter Five

Discussion

The present study sought to identify predictors of fertility-specific distress in the experience of involuntary childlessness. The study investigated two overarching research questions. The first, regarding the overall model, investigated the influence of relational quality, traditional views of motherhood (i.e., patriarchal motherhood), gender self-confidence, and feminist perspectives, as a set of variables, on fertility-specific distress. The second question, regarding the individual contribution of each variable, investigated the unique and relative influence of relational quality, gender self-confidence, patriarchal motherhood, and feminist perspectives on fertility-specific distress.

The regression analysis indicated that the overall model significantly predicted fertility-related distress. That is, relational quality, traditional views of motherhood, gender self-confidence, and feminist perspectives, as a set of variables, predicted the experience of fertility-related distress. Regarding the second question, results indicated that traditional views of motherhood, relational quality, age, and income exhibited unique and significant influence on the prediction model.

Traditional views of motherhood exhibited a positive and significant relationship in which higher endorsement of traditional motherhood values predicted higher levels of fertility-related distress. Those traditional values reflecting a patriarchal motherhood ideology emerged as the strongest predictor of distress in the regression model. The link between rigid and traditional motherhood values and the endorsement of these higher levels of fertility-related distress is not surprising given

that the role of mother has been associated with a woman's central identity and power within a patriarchal or pronatal ideology (McQuillan et al., 2003; Parry, 2005b; Ulrich & Weatherall, 2000).

Patriarchal values of motherhood not only favor childbearing and motherhood as central roles for women, they are most partial to biological motherhood (Johnson & Fledderjohann, 2012). Research on fertility-related distress has consistently demonstrated that barriers to biological motherhood, particularly if there are no other biological or social children in the picture, is a primary cause of distress (Jacob et al., 2006; McCarthy & Chiu, 2011McQuillan et al., 2003). It makes sense then, that if a woman internalizes these traditional views of motherhood, in which the role of biological mother is perceived as the fundamental identity for a woman, and is then confronted with a barrier to biological mothering, distress may ensue.

Conversely, women who did not endorse high levels of traditional or patriarchal motherhood values reported lower levels of fertility-related distress. A likely explanation may be that these women are more accepting of roles for women outside of the role of mother, find other ways to mother or nurture, or question dominant cultural messages regarding motherhood and thus experience less fertility-related distress around involuntary childlessness. Indeed, research supports that viewing motherhood as an activity with many expressions outside the traditional mother-child relationship (i.e., finding other ways to mother or nurture), developing multiple identities and roles, and challenging the concept of motherhood as defined by patriarchy appears to be protective for women in the experience of involuntary childlessness (Ferland & Caron, 2013; Haelyon, 2006; Ulrich & Weatherall, 2000).

Relational quality had a negative and significant relationship with fertility-related distress, indicating that higher reported levels of growth fostering relationships were associated with lower levels of fertility-related distress. This finding is congruent with previous research on growth fostering relationships and infertility stress, suggesting that there is a link between relationships and women's well-being in the experience of involuntary childlessness (Gibson & Myers, 2002). It may be that the growth-fostering relationships that are integral to women's development and well-being become jeopardized for women facing involuntary childlessness. As they strive to maintain privacy of an undesired identity, they may disconnect from the very relationships that could provide a protective role in coping with that experience. Research has demonstrated that many women perceive involuntary childlessness as a failure, see it as central to their identity, and often disconnect from others in order to maintain privacy (Ferland & Caron, 2013; McCarthy & Chiu, 2011; Whiteford and Gonzales, 1995). This privacy associated with involuntary childlessness has been found to be associated with feelings of despair and isolation (Ferland & Caron, 2013).

Sandelowski (1990) described motherhood in a pronatal society as the cultural "currency of women" (p. 33). This highlights how societal structures can impact relational processes, particularly for women who are unable to share in the "currency" of traditional motherhood. Therefore, it makes sense that the experience of involuntary childlessness, which is often viewed as shameful, stigmatizing, and as a barrier to sharing an essential identity with others, could disrupt relational quality by diminishing a woman's ability to be authentic and feel accepted within important relationships. This withdrawal may be particularly prominent if the relationship is with someone who

embodies the desired identity of a biological mother. Rehner (1989) and Becker (1990) highlighted that women who healed from involuntary childlessness expressed that healing occurs through a "painful reassembly of self" (p. 100) as they begin to construct new views of themselves that allow for reconnection with others.

While gender self-confidence did not emerge as a significant predictor of fertility-related distress, it is notable that a review of the qualitative portion of the Hoffman Gender Scale revealed that many of the participants who defined femininity with a focus on motherhood (i.e., "Someone who is nurturing, sensitive to others and has a maternal instinct, Able to conceive a child.") had lower levels of gender self-confidence than those women who defined femininity with themes of strength and independence, or, "Being happy with who you are." This was an interesting observation given how often femininity and motherhood are linked in Western society.

Feminist perspectives also did not emerge as a significant unique predictor of fertility-related distress. It would seem logical that endorsement of feminist perspectives, which are concerned with social inequalities for women, would translate to less acceptance of patriarchal notions of motherhood and thus, less experience of fertility-related distress. However, it may be that endorsement of feminist perspectives does not necessitate a rejection of traditional motherhood values, perhaps due to the import of the motherhood role in Western society. While a woman may recognize social inequalities for women in many areas, it may still be difficult to challenge the status quo of cultural motherhood expectations. For example, Jacques & Radtke (2012) found that among young college women who have grown up with feminism, participants largely provided discourses of motherhood that were similar to patriarchal

ideologies while simultaneously identifying themselves as agentic individuals with career orientations. Furthermore, the results of the qualitative interviews indicated that participants glossed over discussion regarding women's inequality and criticisms of the traditional workplace and workplace arrangements and how that fit in with career goals. Jacques and Radtke (2012) suggested that there might be a discrepancy between the freedoms that participants intended and the lives they would actually lead.

Finally, demographic variables that correlated with fertility-related distress were entered into the prediction model in order to control for confounding effects. Age and income emerged as negative and significant predictors of fertility-related distress. Age was the strongest of the demographic predictors and the second strongest individual predictor of distress within the regression model. Fertility is a time limited phenomenon and many women may be more likely to seek infertility treatment or be generally concerned with conceiving during their younger "child bearing" years. Thus it is not surprising that age would significantly contribute to the variance explained in fertility-related distress. As women age out of the "child bearing" years, they may have been forced to find ways to cope with fertility-related distress. It may be that older women have developed multiple identities from which they draw their well-being. If motherhood is only one of many well-developed identities (professional, sister, friend, partner, etc.), perhaps it just has less valence on overall well-being.

The findings of Ferland and Caron (2013) in their qualitative study on the long-term impact of involuntary childlessness supported the notion that multiple identities or roles can be protective for women who face barriers to biological motherhood. Ferland and Caron noted that women who were decades past the acute experience of involuntary

childlessness discussed themes of coping by finding other ways to nurture or mother, and some participants discussed the importance of their role as spouse in alleviating fertility-related distress. Income also emerged as a negative and significant predictor of fertility-related distress. Infertility treatments are typically expensive, and it appears logical that lower income might position a woman to experience less hope and more distress by virtue of lack of access to treatment if so wanted.

A comparison of means indicated that those who have utilized medical services experienced more distress than those who have not. This may indicate that those who choose to seek treatment (assuming they can access the resources) are more invested in having a biological child. Thus, they may experience more fertility-related distress in comparison to others who are more accepting of alternative treatments or responses to involuntary childlessness or who are forced to cope with alternatives due to lack of access to treatment. It may also be that medical services themselves may be a source of the distress. Considering the constant focus on one's body, what is or isn't working as it "should" be, side effects from medications, uncomfortable procedures, failed (perhaps multiply failed) treatments, high expenses, numerous doctor's appointments, the sometimes dehumanizing experience of medical treatments, and so on, it is plausible that these factors may contribute to levels of distress. That is, medical services may function as both a cause and/or an outcome of fertility-related distress.

Implications

The strong and significant relationship between the internalization of traditional motherhood values and fertility-related distress has several implications for counseling women facing involuntary childlessness. Women who hold these traditional values are

likely at higher risk for distress and it may be beneficial to help women explore and understand how their beliefs regarding motherhood affect their experience of involuntary childlessness. Exploring these beliefs could help broaden motherhood values and allow for a more empowering and less rigid construction of motherhood and identity. Ideally, this will allow a woman to consider more options to responding to involuntary childlessness, such as adoption, fostering, finding alternative ways to "mother," or choosing a childfree life. The fertility-related distress associated with traditional motherhood values underscores how the negative impact of patriarchal ideologies of motherhood plays out for women experiencing reproductive problems and brings attention to the need for broader discourses on motherhood, such as empowered mothering. Empowered mothering recognizes that both women and children benefit from mothers having their needs met and that motherhood does not have to fulfill all a woman's needs or roles.

A relational understanding of women's development and connectedness also can provide a sense of hope for healing and recovery from the experience of involuntary childlessness. Understanding women's social connectedness from a relational perspective compliments feminist theories of maternal empowerment, as both approaches recognize that Western culture bears influence on the development and socialization of women and men in a manner that maintains narrow gendered behavior and relationship norms (Frey, Beesley, & Miller, 2006; O'Reilley, 2010). Importantly, both theories recognize that as a result of these sociocultural influences, women may surrender authenticity in order to maintain relationships and normed identities (Frey et al., 2006; O'Reilley, 2010).

It is helpful to understand that relational quality may protect against distress in the experience of involuntary childlessness and also has implications for providing counseling services to involuntarily childless women. For example, exploring women's mutual and empowering connections with others and supporting them in maintaining growth fostering relationships may protect against the isolation, self-blame, disconnection, and sense of "otherness" that many women report in the experience of involuntary childlessness.

Relational models of therapy that emphasize interpersonal process and mutual empathy may be particularly salient in working with involuntarily childless women. For example, Gibson (2007) recommended the use of Relational Cultural Theory (RCT) when providing counseling for involuntarily childless women. Gibson suggested that RCT is helpful in deconstructing the concept of fertility and exploring what that label means to the client. This method helps clients to process disruptions in relationships created by incongruencies between their old and new constructions of involuntary childlessness, while the therapist is able to respond empathetically and connect with the client (Gibson, 2007). The experience of empathy and acceptance from the therapist facilitates the opportunity for the client to empathize with themselves and with others. Gibson stated, "In essence, they [clients] are able to deconstruct old beliefs about infertility…in order to create a new identity for themselves. This new identity provides the foundation to accept the experiences of infertility" (p. 285). The same process may be beneficial for the deconstruction and reconstruction of the concept of motherhood in fertility-related counseling. Given the feelings of isolation that many involuntarily childless women report, the importance of relationships and connection may also

suggest the use group therapy as a helpful modality in the treatment of fertility-related distress.

Limitations and Future Research

The present study had several limitations. First, the sample was predominately White (87.9%) and is therefore not generalizable to non-White populations. The study aimed to obtain a more racially and ethnically diverse sample in response to the criticisms of previous research in infertility, i.e., that most study samples are predominantly White. However, this was not achieved because of the overall difficulty in recruiting this population. Research has evidenced that involuntarily childless women frequently report feelings of shame and failure around their experience and regard it as private, which likely contributed to the difficulty in recruitment (Ferland & Caron, 2013; Letherby, 1999; Whiteford & Gonzales, 1995). Future studies would benefit from soliciting a larger and more diverse sample in order to better reflect the experiences of all women who experience involuntary childlessness.

Second, this was a correlational study, which does not allow for making causal inferences. However, it should be noted that the study was supported by a clear a priori theoretical framework, which provides additional support for the study's predictive model. Third, it is possible that, given the amount of missing data, the study survey proved to be too large a time burden, although, it is also possible that some items were emotionally taxing, perhaps evoking memories of past experiences, and a deliberate choice was made to skip those items. Future research in this area may benefit, however, from reducing the time burden of the survey or adding a per person incentive. Last, the online nature of study recruitment may result in limited sampling. Further research may

benefit from recruiting through both online and in-person interview formats.

This study was exploratory in nature and was the first step in examining the impact of several sociocultural factors such as relational quality, traditional motherhood values (i.e., patriarchal motherhood), gender self-confidence, and feminist perspectives on fertility-related distress. It is anticipated that the results of this research will add to the growing body of literature investigating involuntary childlessness from a feminist perspective. Future research should consider investigating the use of relational counseling modalities in the treatment of fertility-related distress. It may also be helpful to continue investigating both the role of gender self-confidence and fertility-related distress and the process by which women are negotiating the dominant cultural mothering values and feminist identity. Future research should continue to consider women's reproductive issues within the context of sociocultural and political influences.

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Table 1

Reliability, Means, and Standard Deviations Table for Predictor and Criterion Variables

Variable	α	*M*	*SD*	*N*
1. Age	-	33.36	6.85	115
2. FPI	.93	174.71	37.11	111
3. RHI	.89	132.85	16.95	77
4. TMS	.90	81.90	17.97	95
5. HGS	.91	58.60	13.88	85
6. FPS3	.80	108.33	23.19	82

Note. Education = highest level of achieved education. Income = Highest level of household income. FPI = Fertility Problem Inventory – higher scores suggest higher levels of fertility-related distress. RHI = Relational Health Indices - peer domain; higher scores indicate higher levels of mutual engagement, authenticity, and empowerment/zest in peer relationships. TMS = Traditional Motherhood Scale – higher scores suggest greater identification with traditional motherhood values. HGS = Hoffman Gender Scale- higher scores indicate higher levels of gender self-confidence. FPS3 = Feminist Perspectives Scale Short Version – higher scores reflect higher endorsement of feminist attitudes toward women and women's issues.

Table 2

Intercorrelations of Predictor and Criterion Variables

Variable	1	2	3	4	5	6	7	8
1. Age	---	.19**	.10*	-.38**	-.02	-.01	.08*	.09*
2. Education		---	.19*	-.25**	.06	-.19**	.05	-.19**
3. Income			---	-.24**	.05	.01	.19**	-.02**
4. FPI				---	-.19**	.40**	-.10*	.00
5. RHI					---	.04	.06	.11*
6. TMS						---	.20**	.04
7. HGS							---	.15**
8. FPS3								---

Note. Education = highest level of achieved education. Income = Highest level of household income. FPI = Fertility Problem Inventory – higher scores suggest higher levels of fertility-related distress. RHI = Relational Health Indices - peer domain; higher scores indicate higher levels of mutual engagement, authenticity, and empowerment/zest in peer relationships. TMS = Traditional Motherhood Scale – higher scores suggest greater identification with traditional motherhood values. HGS = Hoffman Gender Scale- higher scores indicate higher levels of gender self-confidence. FPS3 = Feminist Perspectives Scale Short Version – higher scores reflect higher endorsement of feminist attitudes toward women and women's issues.
*$p < .05$. **$p < .01$.

Table 3

Summary of Multiple Regression Analysis for Variables Predicting Fertility-Related Distress (FPI)

Overall model was significant at $p < .01$, $F(7,69) = 7.35$

Variable	Step Entered	R^2	ΔR^2	F Change	df	B	SE B	β
Age	1	.21	.18	6.53**	(3,73)	-1.74	.41	-.35**
Income	1	---	---	---	---	-6.03	2.71	-.17*
Education	1	---	---	---	---	-2.74	2.58	-.09
RHI	2	.43	.37	6.50**	(4,69)	-1.19	.48	-.20*
TMS	2	---	---	---	---	.94	.18	.41**
HGS	2	---	---	---	---	-.33	.24	-.12
FPS3	2	---	---	---	---	.15	.15	.09

Note. Education = highest level of achieved education. Income = Highest level of household income. RHI = Relational Health Indices - peer domain; higher scores indicate higher levels of mutual engagement, authenticity, and empowerment/zest in peer relationships. TMS = Traditional Motherhood Scale – higher scores suggest greater identification with traditional motherhood values. HGS = Hoffman Gender Scale- higher scores indicate higher levels of gender self-confidence. FPS3 = Feminist *Perspectives* Scale Short Version – higher scores reflect higher endorsement of feminist attitudes toward women and women's issues.
*$p < .05$. **$p < .01$.

Appendix A: IRB Approval Letter

Institutional Review Board for the Protection of Human Subjects

Approval of Initial Submission – Exempt from IRB Review – AP01

Date: February 17, 2014 **IRB#:** 3887

Principal Investigator: Jessica Mckennon Brody **Approval Date:** 02/13/2014

Exempt Category: 2

Study Title: Mis(sed) conceptions: Motherhood through the lens of involuntary childlessness.

On behalf of the Institutional Review Board (IRB), I have reviewed the above-referenced research study and determined that it meets the criteria for exemption from IRB review. To view the documents approved for this submission, open this study from the *My Studies* option, go to *Submission History*, go to *Completed Submissions* tab and then click the *Details* icon.

As principal investigator of this research study, you are responsible to:

- Conduct the research study in a manner consistent with the requirements of the IRB and federal regulations 45 CFR 46.
- Request approval from the IRB prior to implementing any/all modifications as changes could affect the exempt status determination.
- Maintain accurate and complete study records for evaluation by the HRPP Quality Improvement Program and, if applicable, inspection by regulatory agencies and/or the study sponsor.
- Notify the IRB at the completion of the project.

If you have questions about this notification or using iRIS, contact the IRB @ 405-325-8110 or irb@ou.edu.

Cordially,

Aimee Franklin, Ph.D.
Chair, Institutional Review Board

Appendix B: Instruments

Demographic Questionnaire

Please answer the following questions about yourself. All responses are anonymous and confidential.

1. What is your age? _____

2. What is your racial/ethnic background? (Mark all that apply)

_____African-American/Black
_____Asian-American/Pacific Islander
_____Asian-Indian/Pakistani
_____Biracial/Multiracial
_____Hispanic/Latino(a)
_____Middle Eastern/Arab
_____Native American/Native Alaskan
_____White/European American
_____Foreign National (please specify):
_____Other (please specify):

3. What is your highest level of education completed?

Grade school College
High School Graduate School
_____ Other

4. What is your employment status?

_____Not employed _____Employed part-time
_____Employed full-time _____Student

5. What is your annual household income (before taxes)?

_____Less than 30,000
_____30,000-59,999,
_____60,000-99,999
_____100,000-149,999
_____150,000 or higher

6. Please indicate your sexual orientation:

_____Bisexual
_____Heterosexual
_____Homosexual
_____Pansexual
_____Other, please specify: _____:

7. What is your relationship status?

_____Married
_____Remarried (How many times? _____)
_____Engaged
_____Co-Habitating with partner of ____ years
_____Single

8. Are there any children or adolescents currently in your home on a full-time basis?___
If yes, please indicate their relationship to you and their age:
Relationship Age_____
example: stepson 5 years old

_____
_____
_____
_____

9. What do you believe is the cause of your fertility problem:

_____
_____
_____

10. Who provided your fertility problem diagnosis?
_____Infertility specialist
_____Gynecologist/Obstetrician
_____General Practitioner
_____Self-Diagnosis
_____Other, please specify:
_____

11. How long have you been trying to become pregnant? _____

12. Have you utilized medical services as part of your infertility treatment?
(yes/no)____
If no, please skip to question #15

13. How long have you been pursuing infertility treatment from your current and/or previous infertility physicians?

_____

14. What type of treatments have you pursued? (Check all that apply)
_____Intracervical insemination (ICI)
_____IVF
_____Endometrial surgery
_____Surgery to repair a septum
_____Fibroid surgery
_____Tubal surgery
_____Donor eggs

_____Donor sperm
_____ Gamete Intrafallopian Transfer (GIFT)
_____ICSI
_____Ovulation induction medication (e.g., FSH, Clomid, HCG)
_____IUI
_____Zygote intrafallopian transfer (ZIFT)
_____Surrogate or gestational carrier
_____Assisted hatching
_____Cytoplasmic transfer
_____Laparoscopy
_____Immunotherapy
_____Acupuncture
_____Meditation

15. Have you ever been pregnant? (yes/no) _____

16. If yes, what was the outcome? (Indicate the number of times you've had each outcome)
_____Miscarriage
_____Ectopic pregnancy
_____Abortion
_____Live birth
_____Stillbirth
_____Other

17. Have you adopted? (yes/no) _____

18. If yes, how many children have you adopted and what were their ages at time of adoption?_____

19. How did you find out about this study?
_____
_____
_____

Fertility Problem Inventory

Directions: The following statements express different opinions about a fertility problem. Please place a number on the line to the left of each statement to show how much you agree or disagree with it. If you have a child, please answer the way you feel right now, after having a child.

Please mark every item. Use the following response categories:

6 = strongly agree
5 = moderately agree
4 = slightly agree
3 = slightly disagree
2 = moderately disagree
1 = strongly disagree

1. ____ Couples without a child are just as happy as those with children.
2. ____ Pregnancy and childbirth are the two most important events in a couple's relationship.
3. ____ I find I've lost my enjoyment of sex because of the fertility problem.
4. ____ I feel just as attractive to my partner as before.
5. ____ For me, being a parent is a more important goal than having a satisfying career.
6. ____My marriage needs a child (or another child).
7. ____ I don't feel any different from other members of my sex.
8. ____ It's hard to feel like a true adult until you have a child.
9. ____ It doesn't bother me when I'm asked questions about children.
10. ___ A future without a child (or another child) would frighten me.
11. ___ I can't show my partner how I feel because it will make him/her feel upset.
12. ___ Family don't seem to treat us any differently.
13. ___ I feel like I've failed at sex.
14. ___ The holidays are especially difficult for me.
15. ___ I could see a number of advantages if we didn't have a child (or another child).
16. ___ My partner doesn't understand the way the fertility problem affects me.
17. ___ During sex, all I can think about is wanting a child (or another child).
18. ___ My partner and I work well together handling questions about our infertility.
19. ___ I feel empty because of our fertility problem.
20. ___ I could visualize a happy life together, without a child (or another child).
21. ___ It bothers me that my partner reacts differently to the problem.
22. ___ Having sex is difficult because I don't want another disappointment.
23. ___ Having a child (or another child) is not the major focus of my life.
24. ___ My partner is quite disappointed with me.
25. ___ At times, I seriously wonder if I want a child (or another child).
26. ___ My partner and I could talk more openly with each other about our fertility

problem.

27. ___ Family get-togethers are especially difficult for me.
28. ___ Not having a child (or another child) would allow me time to do other satisfying things.
29. ___ I have often felt that I was born to be a parent.
30. ___ I can't help comparing myself with friends who have children.
31. ___ Having a child (or another child) is not necessary for my happiness.
32. ___ If we miss a critical day to have sex, I can feel quite angry.
33. ___ I couldn't imagine us ever separating because of this.
34. ___ As long as I can remember, I've wanted to be a parent.
35. ___ I still have lots in common with friends who have children.
36. ___ When we try to talk about our fertility problem, it seems to lead to an argument.
37. ___ Sometimes I feel so much pressure, that having sex becomes difficult.
38. ___ We could have a long, happy relationship without a child (or another child)
39. ___ I find it hard to spend time with friends who have young children.
40. ___ When I see families with children I feel left out.
41. ___ There is a certain freedom without children that appeals to me.
42. ___ I will do just about anything to have a child (or another child).
43. ___ I feel like friends or family are leaving us behind.
44. ___ It doesn't bother me when others talk about their children.
45. ___ Because of infertility, I worry that my partner and I are drifting apart.
46. ___ When we talk about our fertility problem, my partner seems comforted by my comments.

RELATIONAL HEALTH INDICES
(Liang, Tracy, Williams, Taylor, Jordan, Miller, 2002)

The following questions pertain to your relationships with "mentors" (other than your parents or whoever raised you) who you go to for support and guidance. A mentor is not a peer or romantic partner. By mentor we mean someone who often is older than you, has more experience than you, and is willing to listen, share her or his own experiences, and guide you through some area of your life (e.g., academic, social, athletic, religious).

1. How many (if any) people currently in your life could be considered a mentor to you according to the above definition?
1 None
2 One
3 Two
4 Three
5 Four
6 Five or more

If you have more than one mentor, please answer the following questions regarding the mentor who is most important to you.

OPTIONAL: 2. Is this mentor a _____(insert educational institution) faculty or staff member?
1 No
2 Yes

OPTIONAL: 3. Is this member:
1 Male
2 Female

OPTIONAL: 4. Describe a specific experience you had with your mentor that was especially meaningful to you (positive or negative):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

For each statement below, please indicate the number that best applies to your relationship with this mentor.

1. I can be genuinely myself with my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

2. I believe my mentor values me as a whole person (e.g., professionally/academically and personally).
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. My mentor's commitment to and involvement in our relationship exceeds that required by his/her
social/professional role.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

4. My mentor shares stories about his/her own experiences with me in a way that enhances my life.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel as though I know myself better because of my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. My mentor gives me emotional support and encouragement.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

7. I try to emulate the values of my mentor (such as social, academic, religious, physical/athletic).
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. I feel uplifted and energized by interactions with my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. My mentor tries hard to understand my feelings and goals (academic, personal, or whatever is relevant).
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

10. My relationship with my mentor inspires me to seek other relationships like this one.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I feel comfortable expressing my deepest concerns to my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

The following questions pertain to your friendships with peers (excluding family members or a romantic partner). A close friend is someone whom you feel attached to through respect, affection and/or common interests, someone you can depend on for support and who depends on you. Please answer the next questions regarding just ONE of your closest friends. (Please do not select a family member or romantic partner).

OPTIONAL: 1. Is this friend male or female? 1 Male 2 Female

Next to each statement below, please indicate the number that best applies to your relationship with
a close friend.

2. Even when I have difficult things to say, I can be honest and real with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. After a conversation with my friend, I feel uplifted.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

4. The more time I spend with my friend, the closer I feel to him/her.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel understood by my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. It is important to us to make our friendship grow.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

7. My friendship inspires me to seek other friendships like this one.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. I am uncomfortable sharing my deepest feelings and thoughts with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. I have a greater sense of self-worth through my relationship with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

10. I feel positively changed by my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I can tell my friend when he/she has hurt my feelings.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

12. My friendship causes me to grow in important ways.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

The following questions pertain to the most meaningful community or group with which you have been involved on a day to day basis for the past three months (i.e. academic, social, cultural, religious, etc.) Next to each statement below, please indicate the number that best applies to your relationship with or involvement in this community.

Please identify the type of community or group you have selected:

_____

1. I feel a sense of belonging to this community.
1 Never

2 Seldom
3 Sometimes
4 Often
5 Always

2. I feel better about myself after my interactions with this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. If members of this community know something is bothering me, they ask me about it.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

4. Members of this community are not free to just be themselves.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel understood by members of this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. I feel mobilized to personal action after meetings within this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

7. There are parts of myself I feel I must hide from this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. It seems as if people in this community really like me as a person.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. There is a lot of backbiting and gossiping in this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

10. Members of this community are very competitive with each other.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I have a greater sense of self-worth through my connection with this community.
173
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

12. My connections with this community are so inspiring that they motivate me to pursue relationships
with other people outside this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

13. This community has shaped my identity in many ways.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

14. This community provides me with emotional support.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

Hoffman Gender Scale (Form A) (Revised)

What do you mean by femininity?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate your level of agreement with each of the following statements by rating it a "1,""2," "3," "4," "5," or "6" as follows:

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Agree	Tend to Agree	Agree	Strongly Agree

1. When I am asked to describe myself, being female is one of the first things I think of. ____
2. I am confident in my femininity (femaleness). ____
3. I meet my personal standards for femininity (femaleness). ____
4. My perception of myself is positively associated with my biological sex. ____
5. I am secure in my femininity (femaleness). ____
6. I define myself largely in terms of my femininity (femaleness). ____
7. My identity is strongly tied to my femininity (femaleness). ____
8. I have a high regard for myself as a female. ____
9. Being a female is a critical part of how I view myself. ____
10. I am happy with myself as a female. ____
11. I am very comfortable being a female. ____
12. Femininity (femaleness) is an important aspect of my self-concept. ____
13. My sense of myself as a female is positive. ____
14. Being a female contributes a great deal to my sense of confidence. ____

Feminist Perspectives Scale Short Form

Indicate your level of agreement, using this scale, for the following items. Write the corresponding number after each item.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	somewhat disagree	undecided	somewhat agree	moderately agree	strongly agree

1. A man's first responsibility is to obtain economic success, while his wife should care for the family's needs.
2. Women of color have less legal and social service protection from being battered than white women have.
3. People should define their marriage and family roles in ways that make them feel most comfortable.
4. The government is responsible for making sure that all women receive an equal chance at education and employment.
5. By not using sexist and violent language, we can encourage peaceful social change.
6. Homosexuals need to be rehabilitated into becoming normal members of society.
7. The workplace is organized around men's physical, economic, and sexual repression of women.
8. Rape is best stopped by replacing the current male oriented culture of violence with an alternative culture based on more gentle, womanly qualities.
9. Men's control over women forces them to be the primary caretakers of children.
10. Making women economically dependent on men is capitalism's subtle way of encouraging heterosexual relationships.
11. Men need to be liberated from oppressive sex role stereotypes as much as women do.
12. Putting women in positions of political power would bring about new systems of government that promote peace.
13. Men use abortion laws and reproductive technology to control women's lives.
14. Romantic love supports capitalism by influencing women to place men's emotional and economic needs first.
15. Racism and sexism make double the oppression for women of color in the work environment.
16. Beauty is feeling one's womanhood through peace, caring, and non-violence.
17. Using "he" for "he and she" is convenient and harmless to men and women.
18. It is a man's right and duty to maintain order in his family by whatever means necessary.
19. Being put on a pedestal, which white women have protested, is a luxury women of color have not had.
20. Social change for sexual equality will best come by acting through federal, state, and local government.
21. Romantic love brainwashes women and forms the basis for their subordinations.
22. Women's experience in life's realities of cleaning, feeding people, caring for babies, etc. makes their vision of reality clearer than men's.

23. In rape programs and workshops, not enough attention has been given to the special needs of women of color.
24. It is the capitalism system which forces women to be responsible for child care.
25. Women should not be assertive like men because men are the natural leaders of earth.
26. Marriage is a perfect example of men's physical, economic, and sexual oppression of women.
27. All religion is like a drug to people, and is used to pacify women and other oppressed groups.
28. Bringing more women into male-dominated professions would make the professions less cut-throat and competitive.
29. Capitalism forces most women to wear feminine clothes to keep a job.
30. Discrimination in the workplace is worse for women of color than for all men and white women.

Indicate your level of agreement, using this scale, for the following items. Write the corresponding number after each item.

1	2	3	4	5	6	7
very untrue of me	moderately untrue of me	a little untrue of me	not sure	a little true of me	moderately true of me	very true of me

31. My wedding was, or will be, celebrated with a full traditional ceremony.
32. I actively try to integrate a communal form of work with a communal form of family life.
33. I attend a place of worship that has changed the language of its prayer books and hymnals to reflect the equality of men and women.
34. I use "she" rather than "he" generically, that is, to refer to an unknown person.
35. I take my child to a racially-mixed child care center (or will when I have a child).
36. I often encourage women to take advantage of the many educational and legal opportunities available to them.

Traditional Motherhood Scale

Please answer the following questions regarding your values about motherhood. Read each item carefully and consider what you believe. There are no right or wrong answers, so please give your honest reaction and opinion. After reading each statement, select the number which best reflects your level of agreement using the following scale:

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

_____1. The mother has a better relationship with her children.

_____2. A mother knows more about her child, therefore being the better parent.

_____3. Motherhood is what brings women to their fullest potential.

_____4. A good mother should stay at home with her children for the first year.

_____5. Mothers should stay at home with the children.

_____6. Motherhood brings much joy and contentment to a woman.

_____7. A mother is needed in a child's life for nurturance and growth.

_____8. Motherhood is an essential part of a female's life.

_____9. I feel that all women should experience motherhood in some way.

_____10. Mothers are more nurturing.

_____11. Mothers have a stronger emotional bond with their children.

_____12. Mothers are more sympathetic to children who have hurt themselves.

_____13. Mothers spend more time with their children.

_____14. Mothers are more lenient toward their children.

_____15. Mothers are more affectionate toward their children.

_____16. The presence of the mother is vital to the child during the formative years.

_____17. Mothers play a larger role in raising children.

_____18. Women instinctively know what a baby needs.

Appendix C: Prospectus
Running head: MIS(SED) CONCEPTIONS

Mis(sed) Conceptions: Motherhood Through the Lens of Involuntary Childlessness

Dissertation Prospectus

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TABLE OF CONTENTS

Abstract

The purpose of the present study, informed by feminist theories of maternal empowerment, is to identify predictors of fertility-specific distress in the experience of involuntary childlessness. Specifically, the study will employ a multiple regression model to examine how feminist perspectives, traditional mothering values, gender self-confidence, and relational quality relate to fertility-related distress. Research examining these relationships will add to the growing body of literature investigating involuntary childlessness from a feminist perspective.

Chapter 1

Introduction

Overview

Infertile. Barren. Sterile. These are terms frequently used to refer to a woman who wants a biological child but is unable to have one. They are anything but neutral and tend to conjure feelings of emptiness and inadequacy that serve to reinforce the centrality of the role of motherhood for a woman (Ulrich & Weatherall, 2000). They are additionally reminiscent of *synecdoche*, which occurs when all the connotations assigned to a part become generalized to the whole (Ulrich & Weatherall, 2000). It has been well documented in research on the objectification of women in language that a primary vehicle for this objectifying is the use of synecdoche, or referencing women metaphorically as body parts (Ulrich & Weatherall, 2000). Ulrich & Weatherall provide an example of synecdoche in infertility through one of their study participant's responses, "I always used to say I'm not infertile. I have a very fertile imagination. And I found the word to be half the problem" (p. 331).

In order to reduce this stigmatizing language often associated with reproductive problems, this study will use the term *involuntary childlessness* to define infertility. While this study will utilize terms such as *infertility* when discussing others' findings using this terminology, it is preferred in this study to assert a "willing resistance" (Ulrich & Weatherall, 2000, p. 324) to the dominant and stigmatizing terms often employed.

According to The Centers for Disease Control and Prevention (CDC) (2011), involuntary childlessness affects 10% of women in the United States, which translates

to about 6.1 million women. Furthermore, data from The National Survey of Fertility Barriers (Greil, McQuillan, & Slauson-Blevins, 2011c) showed that 51.8% of women aged 25-45 reported an experience of involuntary childlessness at some point in their lives. Involuntary childlessness has increased since the late twentieth century and is expected to continue to rise (Sevon, 2005). Studies have indicated that many women who experience involuntary childlessness report higher levels of depression, anxiety, feelings of insecurity, and dissatisfaction with life (e.g., Miles, Keitel, Jackson, Harris, & Licciardi, 2009). Levels of depression related to involuntary childlessness in women have been found to approach the levels of depression frequently seen in individuals with chronic illness, such as cancer and HIV/AIDS (Galhardo, Pinto-Gouveia, Cunha, & Matos, 2011; Miles et al., 2009).

The Center for Reproductive Psychology (2012) defines *reproductive trauma* as wanting a baby and not having it go as hoped, planned, or dreamed. This may include infertility, pregnancy loss, or stillbirth (Center for Reproductive Psychology, 2012). Recent studies have illustrated the traumatic nature of reproductive problems for some women, including symptoms of re-experiencing, avoidance, intrusion, and arousal (Schwerdtfeger & Shreffler, 2009; Van den Broeck, D'Hooghe, Enzlin, & Demyttenaere, 2010). In fact, approximately 25% of women who experience pregnancy loss exhibit symptoms that meet the full criteria for posttraumatic stress disorder (PTSD) (Schwerdtfeger & Shreffler, 2009). McCarthy and Chiu (2011) suggested that these symptoms can be quite long-lasting, continuing for up to 20 years post trauma. Regardless of the development of trauma-like symptoms, many women who experienced unplanned childlessness reported symptoms of social isolation, a lowered

sense of self worth and wholeness, and feelings of inferiority (McCarthy & Chiu, 2011). These feelings were present over time, even during successful and satisfying adoption processes. Thus, involuntary childlessness may continue to be a life-long and central identity for many women (McCarthy & Chiu, 2011). However, there exists wide variation in how women respond to involuntary childlessness. While there is clear documentation that involuntary childlessness can result in distress for some women, with long-term emotional consequences, it is also important to note that many women heal from the emotional distress that may come with reproductive problems (Jacob, McQuillan, & Greil, 2006).

In regard to the gendered experience of involuntary childlessness, studies have indicated that women tend to experience greater distress and are more directly impacted by reproductive problems than men (Johnson & Fledderjohann, 2012; Miles et al., 2009). Current literature tends to attribute gendered differences to the sociocultural context of infertility, most notably that for women a positive sense of self and power in society often resides in her identity as a mother (Berg, Wilson, & Weingartner, 1991; Exley & Letherby, 2001; Greil, 1991; Johnson & Fledderjohann, 2012; Parry, 2005b).

This pronatalist ideology permeates western society (Forsythe, 2009; Miall, 1986). In a pronatal atmosphere, women are expected to become mothers and, not only is motherhood assumed to be a natural part of being a woman, motherhood is expected to provide a core identity and status for women (Ulrich & Weatherall, 2000). McQuillan, Greil, White, and Jacob (2003) suggested that the role of mother is so central it is considered a "master status" (p. 1008) because of the shadow it casts on all other female roles. In other words, the role of mother becomes the principal means

through which women define themselves and are evaluated by others (Remennick, 2000). A growing body of literature suggests that it is almost impossible to separate ideals of femininity from ideals of motherhood, on both a personal and social level (Woollett & Boyle, 2000; Ulrich & Weatherall, 2000; Sevon, 2005; Choi, Henshaw, Baker, & Tree, 2005; Jacques & Radtke, 2012). This interweaving of motherhood and femininity is exemplified in the following passage by Ashurst and Hall (1989):

> A woman's capacity to create, bear and nurture a child is the very essence of her womanhood, her unique and special capacity- prized, feared, envied, protected, and celebrated. Birth is the only defense against the inevitability of death, an intimation of our immortality, of our new hope for the future. When a woman has a child, she confirms for herself and for others that she is a complete woman, fertile and capable of the biological task of creating and perpetuating life. She rivals her own mother, by becoming a mother of a child in her turn, and completes the reproductive cycle that began with her own conception in her mother's womb. (p. 97)

Many studies have addressed perceptions of motherhood by women who have children and experienced no fertility barriers; however, understanding interpretations of motherhood from those who have experienced infertility, pregnancy loss, or other forms of involuntary childlessness may add a richer and more complete understanding of the importance of motherhood in Western culture. Understanding perceptions of motherhood by those traditionally barred from it may help to further develop theories on motherhood and inform counseling strategies for working with involuntarily childless women (Haelyon, 2006).

Most studies that address involuntary childlessness fail to position barriers to motherhood in a sociocultural context, show little regard for the social construction of involuntary childlessness, and tend to treat involuntary childlessness as solely a medical problem that happens to have some psychological consequences (Bell, 2009; Greil, McQuillan, & Slauson-Blevins, 2011c; Greil, Slauson-Blevins, & McQuillan, 2010). Thus, society uses the process of social construction to group people, beliefs, behaviors, etc., and at times uses these groupings to privilege certain people, beliefs, and behaviors (Flores, 2012), including motherhood. When one considers the sociocultural context of motherhood, there is little wonder that reproductive problems can result in significant distress for women (O'Reilley, 2010). Reproductive problems may be experienced, for a woman, quite literally, as a loss of self, womanhood, status, and power in society. Inhorn (as cited in Haelyon, 2006) asserted, "Infertility, as a barrier to motherhood… throws into question a woman's gender identity, her sexual identity and her very sense of selfhood. Thus the particular situation of infertile women illumines the social construction of gender and politics of identity" (p. 181).

Theoretical Foundations

The current study is based in feminist theories of maternal empowerment. Empowered mothering recognizes that both women and children benefit from maternal narratives that place the mother in a position of agency, authority, authenticity, and autonomy (O'Reilley, 2004). Conversely, O'Reilley (2004; 2010) argued that *patriarchal motherhood* is a male dominated and controlled ideology of mothering by which all women are regulated and measured. She regarded it as an ideology founded on traditional and binary concepts of gender and gender roles that are embedded in

Western cultures and serve an oppressive function for women. O'Reilly (2010) asserted that patriarchal motherhood oppresses women through devaluing the work of mothering at a societal level and establishing ideals of mothering that are impossible to achieve, in part due to the taxing and unending responsibilities associated with motherhood. Not only does patriarchal motherhood limit who and how women can mother, this notion of motherhood may have considerable impact on the experience of involuntary childlessness. For example, women unable to achieve the traditional role of mother through biological pregnancy are left to negotiate an undesirable identity that challenges a sense of femininity, self, power, worth, and inclusion.

Statement of the Problem

The present study is feminist in orientation and aims to contribute to feminist and reproductive psychology research in two primary ways. First, the study seeks to view motherhood through the lens of women who experience involuntary childlessness. Research has only recently addressed the social construction of involuntary childlessness and the sociocultural context of motherhood when investigating involuntary childlessness (Bell, 2009; Greil et al., 2010). Of great importance, this research also hopes to inform counseling strategies when working with women who have experienced reproductive problems. Placing women's reproductive struggles in a sociocultural context may help to increase women's sense of agency, autonomy, and authenticity in negotiating their own perceptions of motherhood as they make reproductive decisions. In addition, it will further the understanding of the "political economy of reproduction" (Bell, 2009, p. 690) and the various establishments that reinforce it.

The purpose of the present study, informed by feminist theories of maternal empowerment, is to identify predictors of fertility-specific distress in the experience of involuntary childlessness. Specifically, the study will examine how feminist perspectives, traditional mothering values, gender self-confidence, and relational quality relate to fertility-related distress. Research examining these relationships will add to the growing body of literature investigating involuntary childlessness from a feminist perspective.

Chapter 2

Literature Review

Involuntary Childlessness

Social construction of involuntary childlessness. Medical authorities define *infertility* as the inability to conceive or carry a pregnancy to term after 12 months of trying to conceive (RESOLVE, 2012). Other definitions of infertility include (a) the inability to have a baby for any reason aside from having gone through a sterilizing operation, such as the inability to carry a baby to term or the lack of a biological child after three or more years of trying to conceive (Shanley & Asch, 2009); and (b) a disease of either the male or female reproductive system that results in abnormal functioning (American Society for Reproductive Medicine, as cited in RESOLVE, 2012). However, biomedical definitions fail to capture the full social reality of infertility (Greil et al., 2010). Medical sociologists have argued that any health and illness issue is best understood as a socially constructed state which must be negotiated by professionals, the sufferer, and the sociocultural context (Greil et al., 2010). Despite this argument, Becker and Nachtigall (1994) asserted that American society has a tendency to turn to medicine for answers to social problems.

Infertility has not been exempted from the trend toward medical reproductive technologies. However, Greil et al. (2011c) asserted that the social construction of health and illness is more pronounced in infertility than in other conditions. The following is an excerpt from Greil et al. (2011c) regarding the unique expression of the social construction of health and illness in the case of infertility:

> First, no matter how medical practitioners may define infertility, couples do not define themselves as infertile or present themselves for treatment unless they embrace parenthood as a desired social role. Second, while the medical model treats medical conditions as phenomena affecting the individual, infertility is often seen, especially in advanced industrialized nations, as a condition that affects a couple regardless of which partner may have a functional impairment. Thus, defining oneself as infertile involves not simply negotiations between the individual and medical professionals but also negotiations within the couple, and, possibly, larger social networks. Third, the presence of infertility is signaled, not by the presence of pathological symptoms, but by the absence of a desired state. Fourth, it is more obvious in the case of infertility than it is for other medical conditions that other possibilities exist rather than pursuing a 'cure'. Possible alternatives to treatment include self-definition as voluntarily childfree, adoption, fosterage, or changing partners. Infertility is best understood as a socially constructed process whereby individuals come to regard their inability to have children as a problem, to define the nature of that problem, and to construct an appropriate course of action. (p. 737)

McQuillan, Stone, and Greil (2007) conducted a study on infertility and life satisfaction among women, which also explored the impact of achievement of motherhood on the experience of infertility. Women who identified as infertile, perceived it as a problem, and had no children demonstrated significantly lower levels of life satisfaction than women who reported no history of infertility. However, there was no significant difference in life satisfaction between women with no history of

infertility and women who identified as infertile, had no children, but did not perceive it as a problem. This seems to exemplify the point that meeting the medical definition of infertility is not the primary problem. Rather, it appears that it is the perception of involuntary childlessness as problematic which has the greatest impact on life satisfaction (McQuillan et al., 2007).

Religious infertility is yet another illustration of the social construction of infertility. For example, Halachic infertility occurs when Orthodox Jewish women, who observe the laws of niddah, ovulate too long before mikvah immersion, thus preventing conception (The Hilchot Niddah Guide for Medical Professionals, 2012). Sexual activity is prohibited during a woman's menstruation (i.e., niddah) and for seven days thereafter (Haimov-Kochman, Rosenak, Orvieto, & Hurwitz, 2010). Most women ovulate after ritual immersion (i.e., mikvah immersion), or cleansing, following niddah, which is an optimal time for fertility. So, for women who have shorter cycles and have early ovulation or have longer bleeding, immersion and intercourse will happen too long after ovulation for conception to occur (Jewishinfertility.org, 2013). Treatment is then largely determined by religious doctrine.

Colen (1986) first termed *stratified reproduction* to describe how "reproduction is structured across social and cultural boundaries, empowering privileged women and disempowering less privileged women to reproduce" (Greil et al., 2011c, p. 737). For example, in the United States, as is true in most industrialized countries, the prototypic infertility patient, as depicted in media and research alike, is a middle-class White heterosexual woman who has delayed motherhood in order to pursue a career (Greil et al., 2011c; Lublin, 1998). The prototypic characterization for women living in poverty

and Women of Color, conversely, is the image of being hyperfertile, sexually irresponsible, and unfit mothers with the stereotyped images of the "welfare queen", "crack baby", and "teen mothers" reinforcing this portrayal (Bell, 2009, p.689; Greil et al., 2011c). This construction of Women of Color's and economically disadvantaged women's fertility is inaccurate. In fact, the highest rates of involuntary childlessness occur among economically disadvantaged women and Women of Color (Bell, 2009; Greil, McQuillan, Shreffler, Johnson, & Slauson-Blevins, 2011b). Data from the 1982-2002 National Survey of Fertility Growth depict that the rates of infertility (as indicated by biomedical fertility barriers or failure to conceive after 36 months of regular intercourse) for Black (19.8%) and Hispanic (18.2%) women exceeded the rates for White women (6.9%; Greil et al., 2011b).

Bell (2009) and Greil et al. (2011b; 2011c) highlighted how stratified reproduction often plays out in receipt of medical services. For example, women of color and economically disadvantaged women are more likely to be recommended for treatments that impede fertility, such as sterilization and birth control, whereas White middle-class women are more likely to receive treatments that facilitate fertility such as in vitro fertilization. These racial and class trends in medical care send a clear message about who society deems worthy to be a mother (Greil et al., 2011b). As a result, there is an inverse relationship between the frequency of infertility in a population and that population's use of fertility services (Shanley & Asch, 2009). The class-based framing of reproduction and motherhood impacts infertility-related policies and responses. There has been considerable advocacy among several states in the U.S. for mandated private insurance coverage for infertility services, and Medicaid covers contraception

only (Bell, 2009). Stratified reproduction divides women into two groups: "those for whom contraception is available if only they'd just use it and those for whom there are infertility treatments" (Cussins, 1998, p.73). Women of Color and economically disadvantaged women are aware of these social characterizations of themselves. In fact, in one study conducted by Bell (2009), an African American woman reported, when referencing infertility treatments and their expense, that treatment is "way out of my league" (p. 696). Additionally, another respondent in Bell's study expressed fears that medical professionals would convey disapproval for Medicaid recipients to utilize fertility treatments, illustrating how Medicaid reinforces classed notions of fertility.

According to Bell (2009), infertility should be considered a *cultural disorder* because it serves as a reflection of the dominant cultural norms of gender, class, race, sexuality, and reproduction. It is apparent that institutionalized classism and sexism exists within the contexts of the institutions of both medicine and motherhood. Given the deep and complex ways in which infertility is socially constructed (particularly along class lines), it seems important to go beyond the medical management of infertility in addressing treatment options and recovery for all women (Bell, 2009). For example, Currie (1988) investigated reproductive decision-making and found that women's experience of motherhood was tied to the sociocultural context in which the women lived. Illuminating the social process of infertility may help to change the emphasis from a sole focus on medical treatment and insurance policy issues to alternative support programs and resolutions for involuntary childlessness and motherhood in general, resolutions that do not reinforce oppressive forces for women (Bell, 2009). Schneider and Conrad (1983) poignantly stated that infertility is not

something "in which there are 'social factors'; it is itself profoundly social as a phenomenon for study" (p. 227).

Involuntary childlessness and distress. The distress associated with involuntary childlessness has been documented in several studies (Galhardo et al., 2011; McCarthy & Chiu, 2011; McQuillan et al., 2003; Van den Broeck et al., 2010) and suggests that involuntary childlessness is generally regarded as a chronic life crisis that bears influence on later life transitions. Quantitative studies have found mixed results, likely partly attributable to methodological shortcomings (McQuillan, et al., 2011). For instance, because most studies are drawn from a single clinic and have small sample sizes, conflicting findings are likely an artifact of study design and sampling bias (McQuillan et al., 2011). In fact, because many quantitative studies use samples from infertility clinics, they tend to omit those who do not seek or are not currently seeking treatment (McQuillan et al., 2011). These studies are criticized for lack of generalizability and representativeness of women's experiences because there are significant racial and socioeconomic differences between those who seek treatment and those who do not; less than half of women with involuntary childlessness ever seek treatment (Greil et al., 2010). Jacob, McQuillan, and Greil (2006) noted that while most studies find elevated distress scores of people with infertility in comparison to those who have no fertility barriers, distress levels are typically below clinical relevance. This is important to note because, while it is valuable to understand and explore variable responses of distress, it is equally vital to be aware that women have historically been overpathologized and the experience of distress does not necessitate pathology.

Quantitative studies have suggested that distress is most salient for women who experience a barrier to biological conception but who want to have a biological child (Jacob et al., 2006; McCarthy & Chiu, 2011; McQuillan et al., 2003). For example, McQuillan et al. (2003) addressed some of the shortcomings of previous empirical work by utilizing a random sample of women and a lifetime measure of infertility. They found that infertility was strongly associated with distress, but only for women who had no children, either socially or biologically, and who desired motherhood. Women without children who did not desire motherhood exhibited no distress. They concluded that their results suggested the absence of motherhood for these women threatened a perceived central life role and significantly and negatively impacted well being.

Jacob et al. (2006) found that self-identification as infertile accounted for the largest source of fertility related distress and that women with fertility barriers had higher levels of general distress than did women without fertility barriers. Schwerdtfeger and Shreffler (2009) also found that involuntarily childless women who desired a biological child had higher levels of depression and lower levels of life satisfaction as compared to those without fertility barriers.

Interestingly, studies have suggested that the achievement of pregnancy for infertile women may not induce a returned sense of normalcy; in fact, some women who achieved a live birth through reproductive technologies reported feelings of anxiety and guilt and an increased pressure for perfection in the mother role (Greil et al., 2010). Several researchers have reported these women may have lower self-evaluations, take longer to embrace the motherhood identity, and feel they cannot complain about the discomforts of pregnancy (Gibson, Ungerer, Tennant, & Saunders, 2000; Greil et al.,

2010; Olshansky, 2003).

Olshansky (2003) theorized that infertile women who achieved pregnancy struggled to don a fertile identity and even had difficulty seeing themselves as a pregnant woman. She asserted that, as a result, previously infertile women disconnected themselves from other pregnant women and new mothers because they did not perceive that they shared the same concerns or worries. Previously infertile women who achieved pregnancy additionally disconnected themselves from other infertile women (Olshansky, 2003). For example, women who struggle with conception may find support in one another but when one person in this support network of women achieves pregnancy, this could be awkward and hurtful for the women who continue to struggle with conception. Thus, Olshansky (2003) believed a woman who achieved pregnancy may distance herself from other involuntarily childless women to avoid the tension and spare their feelings (Olshansky, 2003). Consequently, previously infertile women endure a profound sense of differentness from all other groups of women, struggling to maintain their relationships while simultaneously yearning for connection (Olshansky, 2003). Olshansky observed that these women sometimes referred to themselves as "infertile fertile" (p. 265), highlighting their ambivalence about taking a fertile identity.

While quantitative studies have shown mixed results, qualitative studies on women's experiences with involuntary childlessness appear quite consistent in findings indicating that involuntary childlessness can be experienced as a distressing and unanticipated life course disruption (McCarthy & Chiu, 2011). For instance, Williams (1997) identified 11 themes that emerged from interviews with women who

experienced involuntary childlessness: negative identity, a sense of worthlessness and inadequacy, a feeling of lack of personal control, anger and resentment, grief and depression, anxiety and stress, lower life satisfaction, envy of other mothers, loss of the dream of co-creating, the 'emotional rollercoaster' and a sense of isolation. Feminist qualitative analyses have also highlighted how the dominant cultural beliefs of Western societies about motherhood served to reinforce beliefs and practices – "namely, the patriarchal nuclear family, heterosexuality, and genetic parenthood" (Ulrich & Weatherall, 2000, p. 334). Furthermore, Whiteford and Gonzales (1995) found that the social pressure for women to have children was so strong that it existed regardless of age, race, religion, ethnicity, and social class.

In their qualitative study investigating perceptions of motherhood from the perspective of women experiencing involuntary childlessness, Ulrich and Weatherall (2000) found that involuntarily childless women often viewed themselves as nonconformists in a society that endorsed the dominant belief that the central role for a woman is that of mother. Three themes emerged regarding reasons for wanting children: the view of motherhood as (a) a natural instinct; (b) typical part of the development of a relationship; and (c) expected by society. Involuntary childlessness was then experienced as guilt, inadequacy, and failure (Ulrich & Weatherall, 2000).

McCarthy (2008) investigated the lived experiences of women following unsuccessful medical intervention. The women in this study described involuntary childlessness as an existential challenge to their self, identity, and meaning and purpose of life. Many women reported that the centrality of the role of involuntary childlessness

as a life defining experience pervaded their narratives well after unsuccessful treatment. One respondent stated:

> It's like I'm nothing… I really kind of feel like part of me has either died or given up. I guess the thing that has bothered me the most is the kind of emptiness. There is this hollowness about your life. It's like you thought you were this solid chocolate bunny and you're not. You're the hollow chocolate bunny, which is the less expensive version, not quite as good and not what everybody really wanted at Easter. (McCarthy, 2008, p. 321)

Whiteford and Gonzales (1995), in a feminist qualitative analysis on infertility that utilized Goffman's work on stigma, found that some women described involuntary childlessness as shame, guilt, inadequacy, failure, and incompleteness. Interviewees also identified feeling classified as *other* and frequently referred to fertile women as *normals*. Whiteford and Gonzales concluded that women might feel stigmatized by the failure to reproduce as a result of internalizing a socially constructed discourse of gender roles in which women are primarily defined in reproductive terms. They asserted that culturally constructed gender role expectations for men and women result in differing responses to involuntary childlessness, with women's identities being more likely to be "spoiled" (Whiteford & Gonzales, 1995, p. 30).

Last, Letherby (1999) also identified discourses of stigma, failure, and feeling as other to the feminine ideal among 24 women who identified as involuntarily childless. Respondents expressed feelings of "incompleteness" and being "handicapped" (p. 363), particularly in their sense of femininity. They also expressed feeling a sense of failure both in the specific task of reproduction and to the entirety of womankind.

Distress and involuntary childlessness due to pregnancy loss. Research regarding the relationship between pregnancy loss and distress appears to have similar findings as seen in research examining difficulty conceiving and distress (Shreffler, Greil, & McQuillan, 2011). Pregnancy loss refers to the involuntary termination of a pregnancy any time ranging from conception through 28 days following birth (Association of Women's Health, 2006). In the United States, about 14% of clinically confirmed pregnancies end in miscarriage (i.e., the loss of a pregnancy in the first 20 weeks), which represents the most common adverse result associated with pregnancy (Shreffler, et al., 2011; Simmons, Singh, Maconochie, Doyle, & Green, 2006). Another 0.5% of clinically recognized pregnancies in the United States result in stillbirth (i.e., the loss of a fetus following the 20th week of pregnancy) (Shreffler et al., 2011). For some women, involuntary childlessness results not from the inability to conceive but, rather, the inability to maintain a viable pregnancy to term. When these cumulative losses occur for 36 months or more, it is medically considered a form of infertility (Shanley & Asch, 2009).

Research has indicated a variety of psychological outcomes associated with pregnancy loss including, grief, depression, anxiety, guilt, shame, eating disorders, preoccupations with the lost baby, and PTSD (Engelhard, van den Hout, & Vlaeyen, 2003; Lim & Cheng, 2011; Schwerdtfeger & Shreffler, 2009; Shreffler et al., 2011). While these outcomes often diminish by 6 months post-loss, they can continue for several years (Shreffler et al., 2011). In response to stillbirth, women have been found to experience psychological distress for at least 30 months and in some cases distress has been shown to endure throughout the life course (Shreffler et al., 2011).

Interestingly, Shreffler et al. also found that women who know the reason for the pregnancy loss were more distressed than those who did not. Shreffler et al. expected that knowing the cause would be empowering; however, they surmised that these results suggested knowing the cause facilitated women's self-blame, even when the loss was out of their control. Similar findings have been found in research on other sources of involuntary childlessness. Even when the source of involuntary childlessness is the male partner, women often take responsibility and show greater distress (Shreffler et al., 2011).

Similar to research on other forms of involuntary childlessness, studies addressing pregnancy loss and distress also find that pregnancy loss is most distressing for women who have no children, place a high importance on motherhood, and perceive themselves as having a fertility problem (Shreffler et al., 2011). When discussing the impact of their findings, Shreffler et al. stated, "These results suggest that the context of women's pregnancy and fertility experiences as a whole and the meaning they attribute to their pregnancies are crucial in shaping the psychological response to pregnancy loss" (p. 352).

Gender and distress. The phenomenon of infertility has shifted from what was once considered a private couples' issue to a medical condition that focuses primarily on women (Greil et al., 2011c). Infertility is now largely positioned as a female problem by Western culture, both physically and psychologically, which has led to the development and maintenance of myths that infertility problems stem solely from the woman (Berg et al., 1991; Domar, 2011). Yet, from a biomedical standpoint, only approximately one-third of infertility cases are related to female factors (Berg et al.,

1991; CDC, 2012); another one-third are related to male factors and the remaining infertility cases are attributed to combined male and female factors or unexplained factors (CDC, 2012; Shapiro, 2009).

Most gender-focused research in involuntary childlessness has addressed differences in distress levels between men and women (Greil et al., 2009). Distress related to involuntary childlessness has been shown to be consistently greater for women than for men and women tend to perceive having children as more important; in fact, women reportedly struggle significantly more with relinquishing the intention to have a child (Abbey et al., 1991; Berg et al., 1991; Greil et al., 2009; Johnson & Fledderjohann, 2012; Miles et al., 2009).

Because motherhood is the central role for women in a pronatal society (McQuillan et al., 2003; Ulrich & Weatherall, 2000), men have been found to be significantly less distressed with the notion of not having children, reportedly because their identity is primarily tied to paid employment (Abbey et al., 1991; Berg et al., 1991; Johnson & Fledderjohann, 2012). Galhardo et al. (2011) investigated gender differences in the impact of shame, self-judgment, anxiety, and depression in infertile couples and found that women experienced significantly more shame, self-judgment, and depressive symptoms than their male partners. Other gender differences found in the literature have suggested that women are more treatment oriented than men, find it more difficult to stop treatment, and experience more infertility-related stigma than men (Greil et al., 2010).

Abbey et al. (1991) suggested that women's lives are more disrupted by infertility as compared to men's lives. The authors found that infertile women

perceived fertility barriers as more stressful than men and felt more disruption and stress in their personal, social, and sex lives. Abbey et al. also found that infertile women perceived having children as more important than their husbands. Johnson and Fledderjohann (2012) found similar results. Their results suggested that women who self-identified as infertile and perceived motherhood as important exhibited higher fertility-specific distress, indicating that it is the disruption of the goal of biological motherhood that is most distressing.

In contrast to the bulk of the research on this topic, Berg et al. (1991) did not find significant gender differences in distress among married couples with infertility. However, they reported that the context of distress differed between women and men in their study. For example, women reported significantly higher levels of belief in the importance of having a biological child, which was significantly associated with distress for women but not for men. Women were significantly more likely to want a child for companionship, to have someone to nurture, or to prove adult status and ability to parent while men were significantly more likely to want a child because their spouse did. Greil et al. (2010) also argued infertility more directly impacts women's self-identity, whereas men are impacted more indirectly through the effect it has on their wives. Women reported more use of communication about infertility as a source of coping, both within and outside of marriage. Women also reported more discomfort with fertility-related stimuli, such as baby showers, and also felt a loss of femininity due to infertility more than men felt a loss of masculinity. Finally, women reported significantly more feelings of personal responsibility and guilt regarding infertility than men (Greil et al., 2010).

Most recent studies (Berg et al., 1991; Greil et al., 2009; Johnson & Fledderjohann, 2012) have concluded that gender differences in the experience of infertility are best understood through examining the impact of socialization on gender role expectations and attitudes. More specifically, gender differences in distress are likely linked to a "pronatalist context that emphasizes not only childbearing and motherhood, but a hierarchy of motherhood, placing biological motherhood at the top" (Johnson & Fledderjohann, 2012, p.890).

Involuntary Childlessness and Gender Self-Confidence

Recent literature proposes a paradigm shift in conceptualizing femininity and masculinity, moving from a focus on gender traits and roles to gender self-concept (e.g., Hoffman, Borders, & Hattie, 2000). Movement toward this reconceptualization was largely fueled by laments about the inadequacy of recent and past measurement of femininity and masculinity, with some of those criticisms coming from the author of one of the most popular measures, the Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1974; Hoffman et al., 2000). According to Hoffman et al. (2000), Spence argued that two of the most widely used measures of masculinity and femininity, the PAQ and the Bem Sex Role Inventory (BSRI; Bem, 1974), were essentially measures of instrumentality and expressiveness and that masculinity and femininity should be conceived of differently. Hoffman et al. (2000) argued that it is the obscure conceptual definitions of masculinity and femininity that largely contribute to inadequacy in measurement. Furthermore, they argued that past measures of these constructs were primarily based in stereotypically defined traits, which were originally

established by assessing the prevalence of any given trait or interest among men or women and assumed both bipolarity and unidimensionality of gender.

Hoffman (1996) and Hoffman et al. (2000) focused on gender self-concept as an alternative to current measures of masculinity and femininity and by doing so underscored the diversity of individual versus social perspectives of the meaning of maleness or femaleness. Hoffman's model of gender self-confidence is based in the work of Lewin (1984a, 1984b) and Spence (1985; Spence & Buckner, 1995, 2000), both of which rely on a person's sense of self as the focal point in measuring masculinity and femininity (Hoffman et al., 2000). The focus on the individual as the source of definition for one's sense of maleness or femaleness is an essential feature of Hoffman's model, which is in opposition to previous measurement that focused on socially prescribed and stereotypical gender traits and roles. Hoffman et al. (2000) asserted that, "To describe the nature of an individual's *self-concept* as he or she relates it to masculinity or femininity would indeed be a more fruitful approach to understanding human behavior than counting the ways in which an individual resembles the 'typical' member of his or her own sex" (p.480).

Gender self-concept, which Hoffman et al. (2000) defined as an individual's self-perception as a man or woman, encompasses gender identity. Gender identity reflects the basic sense that one is male or female (Spence & Sawin, 1985). One aspect of gender identity is a construct originally described by Lewin (1984a) as *gender self-confidence*, which Lewin recommended as the focal point of masculinity and femininity assessment. Hoffman et al. (2000) defined gender self-confidence as the strength of an individual's conviction that they meet their own standards for masculinity or femininity.

Hoffman (2006) further stated that gender self- confidence reflects how much one accepts, respects, and values oneself as a male or a female. Hoffman argued that one's gender self-confidence is grounded in gender identity, which is in turn grounded in gender self-concept. A person's gender self-concept may or may not encompass a strong sense of gender identity, and a person's gender identity may or may not encompass a strong sense of gender self-confidence.

The following is an excerpt from Hoffman (2006) illustrating the relationship between gender self-concept, gender identity, and gender self-confidence:

> My theory suggests that one may perceive oneself as female or male and have attitudes, feelings, and behaviors related to that perception (gender self-concept) without necessarily possessing a secure sense of one's femaleness or maleness (gender identity). Furthermore, individual men and women may shun societally prescribed gender roles and still have a strong gender identity. In other words, they may de- fine their masculinity and femininity in a variety of other ways... In addition, an individual may have a secure gender identity but not necessarily be gender self-confident, not necessarily believing that she or he meets personal, self-defined standards for femininity (femaleness) or masculinity (maleness), respectively. (p. 360)

This study will utilize the concept of gender self-confidence (i.e., meeting one's own standards for femininity or femaleness) in assessing the relationship between women's gender-related self-perceptions and involuntary childlessness. It seems important to investigate this relationship because no known studies have investigated distress associated with involuntary childlessness utilizing this conceptualization of

femininity, and because femininity and fertility tend to be treated as inextricably linked by pronatal societies.

Involuntary Childlessness and Patriarchal Motherhood

Ideology has been defined as "a set of social, political, and moral values, attitudes, outlooks, and beliefs that shape a social group's interpretation of its behavior and its world" (Schwandt, 2001, p. 123). Pronatalism reflects an ideology regarding men and women's expected roles for and the importance of parenthood. (Parry, 2005b). Embedded in a pronatal ideology is the assumption that having children is both a natural and inevitable part of being a woman and that motherhood embodies her central identity (Ulrich & Weatherall, 2000; Parry, 2005b). Pronatalism exists worldwide but can vary in intensity from society to society (Greil et al., 2010). For example, Israel has been described as the "fertility champion of the developed countries" (Haelyon, 2006, p. 178) and has the highest number of fertility clinics per capita in the world (Kanaaneh, 2004). In Israel, the pressure for a woman to bear children is so great that the state offers infertility treatments at no cost to all women who struggle to conceive until there are at least two living children in the home (Haelyon, 2006). Because fertility treatments are so accessible, many women feel that they have no choice regarding utilizing reproductive technology to achieve biological motherhood; they would face the label of deviancy if they chose to forgo treatments and live a childfree lifestyle (Haelyon, 2006).

Pronatalism permeates Western culture and is evident in American society where women's identities are strongly linked to their reproductive capacity and bodies (Forsythe, 2000; Lublin, 1998; Parry, 2005b; Ulrich & Weatherall, 2000). Spelman (as cited in Lublin, 1998) illustrated the link between women's bodies and their identity:

> The responsibility for being embodied creatures has been assigned to women: we have been associated, indeed virtually identified, with the body: men (or some men) [sic] have been associated and virtually identified with the mind. Women have been portrayed as possessing bodies in ways that men do not. It is as if women essentially, men only accidently, have bodies… (p. 36)

The "motherhood mandate" (Bell, 2009, p. 690) associated with pronatalism necessitates that women become mothers and distinctly parallels motherhood with womanhood. This mandate, illustrative of the ideology of patriarchal motherhood, informs society on both who should mother and how to do so (Bell, 2009).

Patriarchal motherhood is the institutionalization of motherhood, both controlled by and benefitting men (O'Reilly, 2004). O'Reilly (2004) suggested that a form of patriarchal motherhood, labeled *custodial motherhood,* emerged approximately sixty years ago in the post-World War II period as a backlash to the successful emergence of women in the workforce. During the war, women were encouraged to take employment to support the war effort but were then expected to resume their places in the home as soldiers returned with the end of the war (O'Reilly, 2004). O'Reilly argued that a redesign of what constituted good mothering was a primary driving force in getting women back in the home. Bowlby's attachment theory, among other psychological theories, were also emerging at this time and the merging of these forces resulted in two major beliefs underlying custodial motherhood, that full-time mothering is necessary for children and that without it children will suffer from maternal deprivation (i.e., long-term cognitive, social, and emotional impairment in the infant resulting from separation

from the primary care giver, usually the mother) (McLeod, 2007; O'Reilly, 2004).

O'Reilly (2004) stated that a form of patriarchal motherhood termed *intensive motherhood* emerged in the 1970s and remains the dominant Western motherhood ideology. Intensive motherhood bears the hallmarks of custodial motherhood in that it requires full time mothering; however, custodial mothering focused on physical proximity versus the demand for continual attunement of mothers to their children's emotional, cognitive, and psychological needs as seen in intensive mothering. O'Reilly (2004) stated that, as in the case of custodial mothering, intensive mothering operates as a cultural discourse of backlash against feminism. Thus, O'Reilly (2004) purported that the ideology of intensive motherhood was the patriarchal response to women's economic and social independence (e.g., increased workforce representation, divorces initiated by women, rates of education for women, and families in which women serve as providers) and was aimed at maintaining the private realm of the home as the natural place for women.

Intensive mothering embodies eight major ideals or expectations: (a) the biological mother is the only caregiver who can appropriately care for the child; (b) mothering must be provided full time; (c) the child's needs should always come before the mother's; (d) mothers need expert instruction on mothering; (e) the mother must feel completely content and confident in her role as mother; (f) mothers must extend copious amounts of time, resources, and effort on raising children; (g) the mother has all the responsibility of mothering but none of the power and; (h) mothering is a private matter and an individual choice that has no political importance (O'Reilly, 2010). O'Reilly (2004) pointed out that just at the time women made ground in the public realm, along

came the new patriarchal ideology of intensive mothering that ensured women would feel inadequate as mothers and view employment and mothering as in conflict due to internalization of the ideology's impossible ideals. These impossible ideals, she argued, were no accident. Rather, they were manufactured, controlled, and used to socially and economically regulate women.

Erika Horwitz (2004) described an alternative to patriarchal motherhood, *empowered mothering*, with seven themes: the importance of mothers having their own needs met, realizing that motherhood does not have to fulfill all a woman's needs or roles, involving others in childrearing, questioning mothering expectations dictated by culture, understanding that mothers do not have the sole responsibility in how a child develops, and challenging the notion that love is the only emotion a mother ever feels toward her child. Empowered mothering distinguishes between the experience and the institution of motherhood, by which the institution represents patriarchal ideologies and experience represents women's experiences with motherhood that are both internally empowering and a potential source of external empowerment (O'Reilly, 2010). Examining the ideals and consequences of patriarchal or intensive mothering should not be confused with a condemnation of family or mothering in general. Rather, empowered mothering calls into question ideals of mothering only as they are regulated by patriarchy and oppressive to women (O'Reilly, 2004).

O'Reilly (2010) argued that gender essentialism is the bedrock of patriarchal motherhood. Patriarchal motherhood thus oppresses women through an ideology defined by rigid and binary concepts of gender roles (masculine/producer and feminine/nurturer) that result in a public/private dichotomy (O'Reilley, 2010). The

work of production is associated with the public sphere while the private sphere is reserved for the work of reproduction. The message of patriarchal motherhood is that men belong in the public sphere where they embody the esteemed masculine traits associated with capitalism and industrialism while women are to remain in the home, a dichotomy that has ultimately resulted in the "invention of full-time motherhood" (O'Reilley, 2010, p.22). Consequently, women are left to measure self worth and importance through motherhood, although motherwork is also given low value within our society (Sevon, 2005). Congruent with the expectations of patriarchal motherhood, recent research on the transition to parenthood has suggested that parents, and particularly first time parents, tended toward adopting more traditional gender roles after the birth of a child and that mothers tended to adopt more traditional gender roles than non-mothers (Liss & Erchull, 2012). Furthermore, studies (Katz-Wise, Priess, & Hyde, 2010; Johnstone, Lucke, & Lee, 2011) have found that each additional child was associated with increasing endorsement of traditional gender roles and that women, after entering long-term committed relationships and marriage, tended toward part-time versus full-time preference in their career aspirations.

Patriarchal motherhood defines what comprises *good* versus *bad* mothering (Bell, 2009; Jacques & Radtke, 2012). A good mother is exemplified by selflessness, continual sacrifice, and complete child focus. She is White, heterosexual, married, young, middle-class, and stays home with her child. A mother who does not fit within these constructed notions of a good mother is then labeled as bad or selfish (Bell, 2009; Zimmerman et al., 2008). Women who work, minority women, older mothers, poor mothers, single mothers, and lesbian mothers, are all considered marginal or deviant

under this ideology (Bell, 2009; Zimmerman et al., 2008). Furthermore, women who work and women who stay at home are pitted against each other in what has been termed the "mommy wars" (Zimmerman et al., 2008, p. 204), a social debate on who is the better mother. Current research on the issue has evidenced that children who attend high quality day care do as well or better than children who stay at home (Zimmerman et al., 2008).

Pronatalism and patriarchal motherhood ideologies assume that the desire for motherhood by all women is a natural instinct, often referred to as the *maternal instinct* (Nicholson, 1999). Most feminist research roundly rejects the biological determination of desire for motherhood because there is little scientific or historical evidence to suggest that the maternal instinct or even mother-infant bonding is biologically determined (Nicholson, 1999). This study explores whether traditional values of motherhood (i.e. values embedded in the patriarchal motherhood ideology) influence the experience of involuntary childlessness, in view of the literature suggesting that the ideology of patriarchal motherhood is internalized by women and "plays out in policies and practices around infertility where ideological positions are put into action" (Bell, 2009, p. 691).

Involuntary Childlessness and Feminist Perspectives

Focus on the relationship between feminism and reproductive technologies appears to dominate the review of literature on feminism and involuntary childlessness. A full examination of the relationship between feminism and reproductive technologies is outside the scope of the current project. However, it is important to include a brief summary of this issue as it bears influence on the social context of the study at hand.

Reproduction provides a pivotal intersection for both the social construction and regulation of women and is thus, a key area studied by feminism (Woollett & Boyle, 2000). The primary concern appears to center on questions regarding the sociopolitical consequences of these technologies for women in Western culture.

Feminists against the use of reproductive technologies express concern regarding the medicalization of infertility and how it may prevent focus on issues of social change, such as the sociopolitical forces that shape family formation and the construction of reproductive desires and involuntary childlessness in our culture (Shanley & Asch, 2009; Zimmerman et al., 2008). Feminists who do not support the use of reproductive technologies argue that these technologies represent an oppressive force, an "arm of patriarchy" (Parks, 2009, p. 22); namely, that it gives women's control of their reproductive health and their bodies to the male dominated institution of medicine (Greil et al., 2009; Parry, 2005a). Some feminists are concerned about the issue of choice involved in the use of these technologies, arguing that because these treatments are available, women may feel pressured to use them before accepting involuntary childlessness (Parry, 2005a).

On the other side of the issue are feminist arguments that warn against constructing a woman's desire to have children as either a natural biological instinct or resulting from intense social pressures because both positions hide women's agency and position involuntarily childless women as passive products of their environment (Ulrich & Weatherall, 2000; Greil et al., 2011). Some feminists feel constructing choices to use reproductive technology as an outcome of decision-making can empower women's agency in reproductive issues and prevent involuntarily childless women as being

depicted as “unwitting victims of patriarchal control” (Parry, 2005a, p. 195) or as mad, bad, desperate, obsessed, and irrational (Madeira, 2012; Sandelowski, 1990; Ulrich & Weatherall, 2000). Some feminists additionally point out that reproductive technology, while traditionally used to privilege White, educated, married, heterosexual, middle class family formation, also has the capacity to challenge the traditional construction of family and mother, i.e., the use of these services by lesbians, disabled women, single women, minority women, and post-menopausal women (Parks, 2009).

There appears to be a paucity of research investigating how feminist perspectives impact fertility-related distress in the experience of involuntary childlessness. However, some studies have investigated the influence of personal agency and social pressure for motherhood on fertility-related distress. For example, Haelyon (2006) found discourses of involuntarily childless women that support their sense of agency and autonomy (described as a rejection of pronatal motherhood mandates), which serve as protective factors in the experience of fertility-related distress. A discourse emerged among involuntarily childless Israeli-Jewish women seeking infertility treatments that expressed a sense of taking control of their bodies and reproductive decisions by negotiating with medical experts while simultaneously rejecting idealized maternal practice and the patriarchal notion of the “heroine mother” (Haelyon, 2006, p. 191). Historically, the Israeli government encouraged Jewish women to have many children by giving a heroine mother award to women who had ten or more children (Kanaaneh, 2004). The concept of the heroine mother also provides an example of how pronatal societies often employ a mother-nation relationship, equating motherhood to nationhood, which reinforces the oppressive function of patriarchal

motherhood under the guise of contributing to national agendas, by making it women's patriotic duty to bear children (Kanaaneh, 2004). Interestingly, the second discourse that emerged in Haelyon's (2006) study represented themes of distress, the need to submit to any treatment for the sake of a biological child, and a sense that the non-impregnated female body has no rights of it's own accord. Demographic differences between the two groups of women indicated that those who rejected idealized motherhood and felt a sense of inner-agency in their choices had higher education and were less religious.

Ulrich and Weatherall (2000) investigated involuntarily childless women's reasons for wanting children and found dialogues that were consistent with Western sociocultural values regarding motherhood (i.e., motherhood as a natural instinct, as a stage in the development of a relationship, and in response to social expectation). However, a discourse of motherhood as a result of positive decision-making also emerged, which respondents discussed as an active process influenced by many factors rather than a passive decision based on biological drive. Ulrich and Weatherall suggested that the reproductive decision-making discourse highlights women's agency in the decision to have children and can be an empowering strategy, particularly for involuntarily childless women that experience feelings of helplessness. Some women discussed being able to come to terms with involuntary childlessness by understanding motherhood as an activity with various expressions other than the mother-baby relationship and by challenging the notion that women's only way to contribute to society is through motherhood. Miles et al. (2009) additionally found that social

pressure to become a mother significantly predicted distress for involuntarily childless women undergoing fertility treatment.

Research on feminist attitudes in general have evidenced that a feminist identity is related to more egalitarian expectations for relationships, including division of labor, expectations of education and employment, and beliefs about power and authority in the relationship (Yoder, Perry, & Saal, 2007). In the context of married couples, research has indicated that a more egalitarian division of both household work and childcare was associated with more liberal gender attitudes (Liss & Erchull, 2007). Feminism has affected dialogues about womanhood and motherhood; for example, it may be easier now to voice the desire not to have children or to do so as a single mother (Letherby, 2002). Paradoxically, the advent of reproductive technologies has likely made ambivalence about motherhood less acceptable for involuntarily childless women due to the number of medical treatment options now available (Letherby, 2002). While feminism has added to the dominant discourse of motherhood and womanhood by discussing the intricacies of both the institution and experience of motherhood and normalizing ambivalence toward motherhood, stereotypes of childless women remain (Letherby, 2002).

Given that young women today have grown up with these changing feminist dialogues, Jacques and Radtke (2012) explored how young Canadian women constructed their identities, with the possibility that they might articulate new ways to construe womanhood that was resistant to traditional constructions, i.e., wife and mother. By and large, the participants endorsed traditional versions of womanhood though simultaneously positioning themselves as career-oriented and autonomous

(Jacques & Radtke, 2012). Participants emphasized personal choice in marriage and motherhood, resisting these choices as stemming from social expectation. Jacques and Radtke found that these accounts also constructed motherhood as intensive motherhood. Participants avoided discussion of how to negotiate traditional concepts of womanhood with the desire for a career and struggled to voice alternative ways of mothering.

Liss and Erchull (2012) investigated the differences in beliefs amongst self-labeled feminist mothers and feminist women who anticipated but did not yet have children. They found that feminist women who anticipated having children expected greater equality in the division of childcare and less traditionalism in child surname choice in comparison to the lived experience of the feminist mothers. The authors surmised that it might be the internalization of the ideology of intensive parenting that contributed to these differences.

Involuntary Childlessness and Relational Quality

Sandelowski (1990) asserted that a patriarchal culture simultaneously promotes and devalues motherhood, a process that consequently undermines meaningful relations between women. She argued that in such a culture, labeling women as infertile defies a sense of female unity by pitting mother against other. Involuntarily childless women experience isolation from other women, with whom they cannot share in the cultural "currency of women" (Sandelowski, 1990, p. 33), including fertile women and other involuntarily childless women who eventually achieve pregnancy. Research has substantiated the feelings of isolation, shame, and otherness that pervade the discourse of involuntary childlessness (e.g. Sandelowski, 1990; Olshansky, 2006; Greil et al., 2009). While research has found social support to be a robust predictor of distress

related to involuntary childlessness, few studies have utilized a relational model investigating the quality of relational connectedness of involuntarily childless women (Sandelowski, 1990; Gibson & Myers, 2002).

A relational model of women's development recognizes that the process of women's identity development is relational in nature, occurs within and toward a sense of connectedness, occurs within and influenced by a sociocultural context, and is central to a sense of well-being (Gibson & Meyers, 2002; Jordan, 1997; Miller, 1976; Patterson, Wang, & Slaney, 2012; Uusimaki, 2013). Relational-Cultural Theory (RCT; Jordan, 1997) has pioneered a shift from conceptualizing identity development as autonomy from others to conceptualizing it as a relational process (Frey, 2013). RCT locates distress and its resolution within relational processes and societal structures (Canadian Women's Health Network, 2009). This stands in opposition to the traditional Western models of psychological development, which emphasize separation-individuation as the primary vehicle for the development of sense of self (Frey, 2013).

Gibson and Meyers (2002) argued that women's empowering relational experiences might be utilized as a protective factor from distress associated with involuntary childlessness. Understanding the quality of women's relational connectedness seems particularly important in the case of involuntary childlessness due to its isolating influence, long-lasting impact, established ability to negatively influence women's relationships, and intersection with sociocultural influences such as patriarchal motherhood ideologies (Sandelowski, 1990; Schwerdtfeger & Shreffler, 2009). For example, Lechner et al. (2007) found that involuntarily childless women were more likely to be dissatisfied with the social support they received than is seen in the fertile

population. Olshansky (2003) also observed dysfunction in the relationships of involuntarily childless women and provided several examples, including difficulty joining in fertile friend's pregnancies and general feelings of isolation and inadequate support from meaningful others who do not grasp the social and psychological sequelae of involuntary childlessness.

Olshansky (2003) argued that RCT is a useful model for understanding infertile women's potential vulnerability to depression. She developed the *grounded theory of identity as infertile* in 1996, which proposed that as women confront infertility they take on an identity as infertile, pushing away other important identities (e.g. friend, partner, worker, family member) and experiencing the identity of infertile as the most salient. Thus, Olshansky (2003) contended that infertile women are at risk for loss of sense of self as they disconnect from other important identities and social connections. She reasoned that RCT is useful in understanding distress responses in involuntarily childless women because the result of centrality of an infertile identity is isolation and disconnection from others. She further argued that RCT helps to explain why involuntarily childless women who later conceive continue to experience distress; they not only remain disconnected from others but isolate themselves even further with the identity of "infertile fertile" (p. 265) rather than donning a fertile identity with the achievement of pregnancy (Olshansky, 2003).

A relational understanding of women's development and connectedness appears to provide a sense of hope for healing and recovery from the experience of involuntary childlessness. For example, the work of Rehner (1989) and Becker (1990) highlighted that women who heal from involuntary childlessness express that it occurs through a

"painful reassembly of self" (p. 100) as they begin to construct new views of themselves that allow for reconnection with others. Understanding women's social connectedness from a relational perspective also compliments theories of maternal empowerment because both approaches recognize that Western culture bears influence on the development and socialization of women and men in a manner that maintains narrow gendered behavior and relationship norms (Frey, Beesley, & Miller, 2006; O'Reilley, 2010). Importantly, both theories recognize that as a result of these sociocultural influences, women may surrender authenticity in order to maintain relationships and normed identities (Frey et al., 2006; O'Reilley, 2010).

There is a substantial body of research on social support in the experience of involuntary childlessness (e.g. Jordan & Revenson, 1999; Lechner, Bolman, & van Dalen, 2006; Martins, Peterson, Almeida, & Costa, 2011; Rashidi, Hosseini, Beigi, Ghazizadeh, & Farahani, 2011; Slade, O'Neill, Simpson, & Lashen, 2007) and social support has been found to be a robust buffer for distress in this experience (Malik & Coulson, 2008). However, while positive support may protect against distress, inadequate support may exacerbate the distress response (Malik & Coulson, 2008; Schwerdtfeger & Shreffler, 2009; Slade et al., 2007).

Slade et al. (2007) found that the women who were most likely to perceive their social support as inadequate were those who were more stigma conscious and frequently disclosed fertility problems. It makes sense that involuntarily childless women would seek the support of others to cope with the ensuing distress as women in general have been found to utilize social support as a coping mechanism more frequently than men (Slade et al., 2007). Indeed, involuntarily childless women have

been found to seek more social support than involuntarily childless men (Jordan & Revenson, 1999). Slade et al. (2007) suggested that involuntarily childless women may turn to their social support networks as a coping mechanism but then be confronted with how a stigmatized identity impacts social relationships. Notably, Slade et al. investigated the perceived availability of social support rather than quality of relationships.

There have been few studies that have investigated the quality of involuntarily childless women's supportive relationships. Van (2012) conducted a qualitative study to elicit coping processes used by women following pregnancy loss. The primary themes that emerged were being authentic, connecting with others, and avoiding and pretending. Results indicated that the concept of connectedness was the central theme that facilitated coping with grief, while disconnectedness from self and others inhibited positive coping and led to the use of avoidance and pretending. Finally, Van noted that there was a clear distinction between social support and connectedness in that connectedness necessitated an active and personal connection with another person or groups that fostered comfort and security.

Gibson and Myers (2002) investigated the effects of social coping resources (i.e., the degree to which a person is active in social networks that prove helpful in times of stress) and growth-fostering relationships (i.e., connections with others that are mutually empowering and encourage growth for both parties) on infertility stress for women. They found that both variables significantly contributed to the prediction of infertility-related stress, with infertility-related stress decreasing with increases in social coping resources and growth-fostering relationships. Furthermore, there were

significant and positive relationships between social coping resources and growth-fostering relationships with family and partner support. These results suggested that there is a link between growth-fostering relationships and infertile women's well being, which provides helpful information for developing successful interventions to reduce infertility-related stress.

An interesting development in the experience of involuntary childlessness is the popularity and utilization of the Internet for support, information, and advice, generally via blogs and online support groups focused on involuntary childlessness and treatment (Malik & Coulson, 2008). In fact, survey findings suggest that about half of couples dealing with involuntary childlessness access the Internet for information and/or support (Malik & Coulson, 2008). The majority of studies on online support and involuntary childlessness have evidenced that while there are some benefits (i.e., anonymity, normalization, and gaining helpful information), online support may also facilitate a disconnection from real world support and increase distress and a sense of isolation (Epstein, Rosenberg, Grant, & Hemenway, 2002; Hinton, Kurinczuk, & Ziebland, 2010; Malik & Coulson, 2008). However, because this study is concerned with how the quality of mutually empowering connections impacts fertility-specific distress, online support and the relative anonymity that frequently comes with it will not be investigated.

Research Questions

The present study, informed by feminist theory of maternal empowerment, seeks to identify predictors of fertility-specific distress in the experience of involuntary childlessness. The present study will investigate two overarching research questions.

The first, regarding the overall model, will investigate the influence of relational quality, patriarchal motherhood, gender self-confidence, and feminist perspectives, as a set of variables, on fertility-specific distress. The second question, regarding the individual contribution of each variable, will investigate the unique and relative influence of relational quality, gender self-confidence, patriarchal motherhood, and feminist perspectives on fertility-specific distress.

Chapter 3

Methods

Participants & Procedures

Eligibility for this study includes being female, age 18-64, and identifying sometime in adulthood as having experienced infertility or involuntary childlessness as defined by a medical diagnosis, multiple pregnancy loss or stillbirth, religious infertility, or any other participant defined reason. Heppner, Wampold, and Kivlighan (2008) suggested a minimum of 84 participants to ensure power to detect a medium effect size in a multiple regression model with 4 predictors, but the current study will aim for 160- 200 participants.

The study intends to recruit via several methods. Research flyers will be distributed at a local reproductive treatment center and a local support group, to recruit those individuals currently seeking treatment. Research flyers will also be distributed at local sexual and reproductive health centers, such as Planned Parenthood, in order to access participants who may not be seeking treatment and to recruit a broader diversity of socioeconomic status than would be seen in treatment seekers alone. Additionally, a link to the online study questionnaire will be posted to multiple online support groups (e.g., Resolve), blogs, and sites dedicated to issues around reproductive issues (e.g., Oklahoma Coalition for Reproductive Justice). Finally, this study will utilize the snowball technique, both by posting a link to the survey on Facebook and by allowing for distribution of the research flyer. These forms of recruitment were chosen because they will ideally recruit a larger number of women who are not actively seeking treatment, a criticism of most studies in infertility and pregnancy loss (Greil,

McQuillan, & Slauson-Blevins, 2011). It is important to move beyond treatment seekers in understanding the experiences of women with involuntary childlessness in order to reveal the full diversity of this group (Greil, McQuillan, & Slauson-Blevins, 2011).

Data will be collected via Qualtrics, an online program that allows for the creation of an Internet-based questionnaire. The survey will be created and maintained by the primary investigator through Qualtrics. Only the primary investigator and her advisor will have access to data obtained. Data will be collected and maintained through the use of a secure server to prevent unauthorized access to confidential information. Participants will complete informed consent and the study questionnaire online via Qualtrics. Participation will be voluntary and no identifying information will be collected.

Instruments

The current study will utilize a demographic questionnaire designed by this investigator and a total of five measures for the dependent variable and the four predictor variables (see appendices for complete measures). The five measures will include the Fertility Problem Inventory (Newton, Sherrard, & Glavac, 1999), Traditional Motherhood Scale (Whatley, 2004), Relational Health Indices (Liang, Tracy, Taylor, Williams, Jordan, & Miller, 2002), Hoffman Gender Scale (Hoffman et al., 2000), and Feminist Perspectives Scale Short Version (Henley, Spalding, & Kosta, 2000). In order to control for order effects resulting from the order in which participants complete measures, this study will randomize the order of the measures in Qualtrics.

Demographic questionnaire. A demographic questionnaire was developed based on factors known to impact infertility-related distress, such as age, income, education, prior pregnancy outcomes, religion and its importance, political affiliation, and presence of children in the home (Newton, Sherrard, & Glavac, 1999; Haelyon, 2006; Mussani & Silverman, 2009; Hare-Mustin & Roderick, 1979; Greil, Johnson, McQuillan, & Lacy, 2011). Furthermore, data on relationship status, sexual orientation, ethnicity, employment status, any previous treatment, and length of infertility experience will be included to help describe the sample.

Fertility Problem Inventory (FPI). The FPI (Newton et al., 1999) was developed to assess important domains of perceived infertility-related distress in both men and women. It was developed to meet the need for more infertility specific measures of distress and was originally normed on individuals seeking infertility treatment (Peterson, 2002). The FPI is a 46-item questionnaire that utilizes a six-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). It consists of five subscales and one global index of perceived infertility-related distress. The five subscales are social concern, sexual concern, relationship concern, need for parenthood, and rejection of a childfree lifestyle (Newton et al., 1999). The Global Stress score is an overall measure of infertility-related stress. Sample items include "I would do just about anything to have a child (or another child)", "I find it hard to spend time with friends or family who have young children", and "I feel just as attractive to my partner as before." For the purposes of the current study, the global stress score will be utilized as a general measure of infertility-related stress.

The Global Stress score is computed by summing all scale items, or five

subscale scores. Higher scores are associated with higher infertility-related psychological stress. The scale has exhibited good internal consistency as indicated by a Cronbach's alpha of .93 (n=1153 women, 1149 men; Newton et al., 1999). Convergent validity was established by comparing correlations of the FPI with other standardized measures (i.e., depression, anxiety, and marital adjustment) and Newton et al. concluded that observed correlations were in the expected direction, moderate in size, and demonstrated adequate convergent and discriminant validity. The mean correlation was .45 with a range of .26-.66. Results indicated that the scale was measuring distinct but related aspects of infertility-related stress.

Traditional Motherhood Scale (TMS). The TMS (Whatley, 2004) measures the degree to which an individual holds traditional views of motherhood, and will be used to measure patriarchal motherhood. Factor analysis of the original study yielded a one-factor solution of 18 items (Whatley, 2004). The response format is a 7-point Likert scale with possible responses ranging from 1(*strongly disagree*) to 7(*strongly agree*). Sample items include "Mothers should stay at home with children" and "Motherhood is an essential part of a female's life." Scoring consists of taking the mean of all responses, which ranges from 1 (i.e., absence of traditional views of motherhood) to 7(i.e., extreme view of traditional motherhood); higher scores suggest more traditional views of motherhood. Whatley (2004) reported a Cronbach's alpha of .89 with a sample of 106 undergraduate students (86 females and 20 males) and yielded no differences as a function of ethnicity. However, Whatley found that males were significantly more traditional in their views of motherhood than females. The study indicated that the aggregate undergraduate sample endorsed a higher than average

support for traditional motherhood.

Relational Health Indices (RHI). The RHI was developed by Liang et al. (2002) to assess growth-fostering relationships and is based on the relational-cultural theory of psychological development. It taps into both subtle and complex qualities of dyadic and group relationships (Gibson, 2000). The RHI is a 37-item self-report questionnaire that operationalizes three major characteristics of relationships theorized to promote growth: mutual engagement (a shared involvement and experience of the relationship), authenticity (the capacity and safety to understand and express oneself sincerely within the relationship), and empowerment/zest (the experience of feeling invigorated by the relationship (Liang et al., 2002). These three domains of relational health are measured across three types of relationships: peer, community, and mentor.

A sample item from the mentor domain includes, "My relationship with my mentor inspires me to seek other relationships like this one." A sample item from the peer domain includes, "Even when I have difficult things to say, I can be honest and real with my friend." Finally, a sample item from the community domain is, "I have a greater sense of self-worth through my connection with this community."

The response format of the RHI ranges from 1 (*Neve*r) to 5 (*Always*) on a 5-point Likert scale. The possible range for the total score is 0 to 148. Higher scores represent higher levels of relational health. Liang et al. (2002) proposed two ways to score the RHI. Scores of engagement, empowerment/zest, and authenticity can be computed for each of the three relationship domains (mentor, peer, community), thus providing three subscale scores for each of the three relational domains. Alternatively, a composite score can be calculated for each relational domain. Frey, Beesley, and

Newman (2005) conducted a principal components analysis on the 37-items of the RHI. Results from the study indicated that the RHI operates most reliably as a measure of a unidimensional construct of relational health within each of the three relationship domains. Therefore, this study will use the composite relational health scores for the peer and community relationship domains, which consist of 12 and 14 items, respectively. The mentor scale will be administered for instrument integrity, but will not be used in the study. Liang et al. (2002) reported that the RHI demonstrated acceptable internal consistency as indicated by Cronbach's alphas for the composite scores of .85 for the peer domain and .90 for the community domain. The authors also reported evidence of convergent validity by comparing RHI scores with measures of social support, loneliness, depression, stress, and self-esteem. Overall, the patterns of correlations were in the expected directions. All of the scales were positively associated with self-esteem, stress was negatively correlated with the community domain, and depression was negatively correlated with the peer domains.

Hoffman Gender Scale (HGS: Form A). The HGS (Hoffman et al., 2000) was developed as measure of gender self-confidence. Hoffman (2006) described gender self-confidence as "one's intensity of belief that one meets one's own personal standards for femininity/masculinity" (p. 363). While there are two versions of the HGS, one for men and one for women, this study will only utilize the version for women, which is comprised of 14 Likert-type items ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

The HGS consists of two 7-item subscales: Gender Self-Definition (HGS-SD) and Gender Self-Acceptance (HGS-SA). For the purposes of this study, each subscale

score will be utilized. HGS-SD measures how strongly a woman's self-defined sense of femaleness or femininity impacts her overall sense of identity (Hoffman et al., 2000), meaning that higher scores are associated with higher importance of femaleness to overall identity. HGS-SA measures a woman's comfort with her internalized and self-defined sense of femaleness or femininity (Hoffman et al., 2000). Individuals who score higher on self-defined sense of femaleness may or may not consider gender to be an essential part of their identity. Sample HGS items include, "When I am asked to describe myself, being female is one of the first things I think of" (HGS-SD) and "I am happy with myself as a female" (HGS-SA). Scoring consists of calculating total scores for each subscale, each subscale yielding a score that ranges from 7-84. Higher scores represent higher levels of that particular construct.

Hoffman et al. (2000) reported a Cronbach's alpha of .94 for the HGS total score, .88 for the HGS-SD, and .90 for the HGS-SA in a sample of 273 undergraduate women. Hoffman et al. additionally reported a Cronbach's alpha for women of .88 for the HGS-SD and .90 for the HGS-SA. In a separate study, Hoffman (2006) obtained a Cronbach's alpha of .90 for the HGS-SD and .87 for HGS-SA in a sample of 361 female students at a large university in California. Convergent validity was supported by the significance of predicted correlations between the Gender Self-Definition and Gender Self-Acceptance subscales with (a) Feminist Identity Development Scale (FIDS) subscales and (b) Womanist Identity Attitudes Scale (WIAS; Hoffman, 2006).

Feminist Perspectives Scale Short Version (FPS3). In pronatal societies, perceptions of motherhood are typically linked to attitudes toward women and their rights, roles, and identities. As seen with recent concerns and changes in assessing

gender, a contemporary feminist approach raises concerns about previously used measures to assess attitudes toward women and women's issues. Henley, Meng, O'Brien, McCarthy, and Sockloskie (1998) argued that early measures often ignored controversial issues to achieve higher internal consistency; failed to delineate between differing feminist theoretical perspectives (liberal, radical, socialist, etc.); did not recognize the link between race, class, and gender; and did not emphasize women as an oppressed group.

In response to this critical analysis, the FPS3 (Henley et al., 2000) was developed to measure a broad array of beliefs about women and women's issues, tapping into five feminist theoretical perspectives. The FPS3 consists of 36 Likert-type items ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). There are six attitudinal subscales; Fembehave3, a 5-item behavioral subscale; and Femscore3, a composite score. For this study, the composite score (i.e., Femscore3) will be utilized.

Scores for the composite Femscore3 can range from 25 to 175. Femscore3 is scored by summing 5 of the 6 the attitudinal subscale scores (i.e., Liberal, Radical, Socialist, Cultural Feminist, Woman of Color/Womanist). Higher scores on Femscore3 are associated with higher endorsement of feminist attitudes toward women and women's issues. Sample items include, "A man's first responsibility is to obtain economic success, while his wife should care for the family's needs" and "Discrimination in the workplace is worse for women of color than for all men and white women."

Henley et al. (2000) reported a Cronbach's alpha for the composite Femscore3 of .85 and a test-retest correlation of .87, as well as good test-retest and convergent

validity between Femscore3 and measures of attitudes toward women. Because several of the subscales (e.g., Fembehave3, attitudinal) had individual Cronbach's alphas less than .70, the authors recommended use of the composite. For this reason, the current study will use the composite Femscore3 as a broad measure of feminist attitudes toward women and women's issues that capture a range of feminist perspectives.

Research Questions

The current study will investigate the following research questions: (a) Do relational quality (i.e., RHI), gender self-confidence (i.e., HGS), patriarchal motherhood (i.e., TMS), and feminist perspectives (i.e., FPS3) jointly account for significant variation in fertility-specific distress (i.e., FPI scores)? (b) Do relational quality (i.e., RHI), gender self-confidence (i.e., HGS), patriarchal motherhood (i.e., TMS), and feminist perspectives (i.e., FPS3) individually and significantly predict fertility-specific distress (i.e., FPI scores)?

Data Analysis

The current study will utilize a simultaneous regression model in order to examine the collective and separate influence of the predictor variables on fertility-specific distress. Simultaneous regression seems appropriate given the exploratory nature of the study and lack of theoretical basis for entering the predictor variables in any given order.

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APPENDIX A

Demographic Questionnaire

In order to successfully complete this study, I would like to know more about you. All responses are anonymous and confidential, the information you provide will not be used to identify you in any way.

1. What is your country of residence? _____

2. What is your age? _____

3. What is your racial/ethnic background? (Mark all that apply)

____African-American/Black
____Asian-American/Pacific Islander
____Asian-Indian/Pakistani
____Biracial/Multiracial
____Hispanic/Latino(a)
____Middle Eastern/Arab
____Native American/Native Alaskan
____White/European American
____Foreign National (please specify):_____
____Other (please specify):_____

4. What is your highest level of education completed?

_____ Less than High School
_____ High School Diploma/GED
_____ Some College
_____ 4 year College degree (BA/BS)
_____ Master's Degree
_____Doctoral Degree
_____ Professional Degree (MD/JD)

5. What is your employment status?
Not employed __ Employed part-time
Employed full-time Student_____

6. What is your annual household income (before taxes)?
_____Less than 30,000
_____30,000-59,999
_____60,000-99,999
_____100,000-149,999
_____150,000 or higher

7. Please indicate your sexual orientation:
_____Bisexual
_____Heterosexual
_____Homosexual
_____Pansexual

_____Other, please specify: _____:

8. What is your relationship status?

____Single
____In committed/exclusive relationship
____Married/Partnered
____Divorced
____Other, please specify: _____

9. What is your religious affiliation?

___Agnostic	___Assembly of God	___Atheist
___Baptist	___Buddhist	___Catholic
___Church of Christ	___Church of Latter Day Saints	___Hindu
___Jewish	___Lutheran	___Methodist
___Muslim	___Pentecostal	___Presbyterian

___Other, please specify: _____

9. Please indicate the number of years that you have been in your current relationship (round to the nearest year):_____ Years

10. Are there any children or adolescents currently in your home on a full-time basis?___
If yes, please indicate their relationship to you and their age:
Relationship Age_____
example: stepson 5 years old
_____
_____
_____
_____

11. What do you believe is the cause of infertility:_____
_____
_____
_____
_____
_____

13. If there is one, what is the medically diagnosed cause of the fertility problem? (Check one only)
_____ Male factor
_____Female factor

_____Combined male-female factor
_____Unexplained cause
_____Other, please specify:_____

14. Who provided the infertility diagnosis?
_____Infertility specialist
_____Gynecologist/Obstetrician
_____General Practitioner
_____Self-Diagnosis
_____Other, please specify:
_____

15. How long have you been trying to become pregnant?
_____

16. Have you utilized medical services as part of your infertility treatment? (yes/no)____
If no, please skip to question #18

17. If yes, please indicate how you are paying for your infertility treatment: (Check one only)
_____ Insurance covers all cost
_____Insurance plus out-of-pocket payment
_____No insurance, all out-of-pocket
_____Other, please specify: _____

18. How long have you been pursuing infertility treatment from your current and/or previous infertility physicians?
_____

19. What type of treatments have you pursued? (Check all that apply)
_____Intracervical insemination (ICI)
_____IVF
_____Endometrial surgery
_____Surgery to repair a septum
_____Fibroid surgery
_____Tubal surgery
_____Donor eggs
_____Donor sperm
_____ Gamete Intrafallopian Transfer (GIFT)
_____ICSI
_____Ovulation induction medication (e.g., FSH, Clomid, HCG)
_____IUI
_____Zygote intrafallopian transfer (ZIFT)
_____Surrogate or gestational carrier
_____Assisted hatching

_____Cytoplasmic transfer
_____Laparoscopy
_____Immunotherapy
_____Acupuncture
_____Meditation
_____Other, please
specify:_____

20. Have you ever been pregnant? (yes/no)
_____

21. If yes, what was the outcome? (Indicate the number of times you've had each outcome)
_____Miscarriage
_____Ectopic pregnancy
_____Abortion
_____Live birth
_____Stillbirth
_____Other, please specify:_____

22. Have you adopted? (yes/no) _____

23. If yes, how many children have you adopted and what were their ages at time of adoption?_____

30. How did you find out about this study?
_____
_

APPRNDIX B

FERTILITY PROBLEM INVENTORY

Directions: The following statements express different opinions about a fertility problem. Please place a number on the line to the left of each statement to show how much you agree or disagree with it. If you have a child, please answer the way you feel right now, after having a child.

Please mark every item. Use the following response categories:

6 = strongly agree
5 = moderately agree
4 = slightly agree
3 = slightly disagree
2 = moderately disagree
1 = strongly disagree

1. ___ Couples without a child are just as happy as those with children.
2. ___ Pregnancy and childbirth are the two most important events in a couple's relationship.
3. ___ I find I've lost my enjoyment of sex because of the fertility problem.
4. ___ I feel just as attractive to my partner as before.
5. ___ For me, being a parent is a more important goal than having a satisfying career.
6. ___ My marriage needs a child (or another child).
7. ___ I don't feel any different from other members of my sex.
8. ___ It's hard to feel like a true adult until you have a child.
9. ___ It doesn't bother me when I'm asked questions about children.
10. ___ A future without a child (or another child) would frighten me.
11. ___ I can't show my partner how I feel because it will make him/her feel upset.
12. ___ Family don't seem to treat us any differently.
13. ___ I feel like I've failed at sex.
14. ___ The holidays are especially difficult for me.
15. ___ I could see a number of advantages if we didn't have a child (or another child).
16. ___ My partner doesn't understand the way the fertility problem affects me.
17. ___ During sex, all I can think about is wanting a child (or another child).
18. ___ My partner and I work well together handling questions about our infertility.
19. ___ I feel empty because of our fertility problem.
20. ___ I could visualize a happy life together, without a child (or another child).
21. ___ It bothers me that my partner reacts differently to the problem.
22. ___ Having sex is difficult because I don't want another disappointment.
23. ___ Having a child (or another child) is not the major focus of my life.
24. ___ My partner is quite disappointed with me.
25. ___ At times, I seriously wonder if I want a child (or another child).
26. ___ My partner and I could talk more openly with each other about our fertility

problem.
27. ___ Family get-togethers are especially difficult for me.
28. ___ Not having a child (or another child) would allow me time to do other satisfying things.
29. ___ I have often felt that I was born to be a parent.
30. ___ I can't help comparing myself with friends who have children.
31. ___ Having a child (or another child) is not necessary for my happiness.
32. ___ If we miss a critical day to have sex, I can feel quite angry.
33. ___ I couldn't imagine us ever separating because of this.
34. ___ As long as I can remember, I've wanted to be a parent.
35. ___ I still have lots in common with friends who have children.
36. ___ When we try to talk about our fertility problem, it seems to lead to an argument.
37. ___ Sometimes I feel so much pressure, that having sex becomes difficult.
38. ___ We could have a long, happy relationship without a child (or another child)
39. ___ I find it hard to spend time with friends who have young children.
40. ___ When I see families with children I feel left out.
41. ___ There is a certain freedom without children that appeals to me.
42. ___ I will do just about anything to have a child (or another child).
43. ___ I feel like friends or family are leaving us behind.
44. ___ It doesn't bother me when others talk about their children.
45. ___ Because of infertility, I worry that my partner and I are drifting apart.
46. ___ When we talk about our fertility problem, my partner seems comforted by my comments.

APPRNDIX C

RELATIONAL HEALTH INDICES
(Liang, Tracy, Williams, Taylor, Jordan, Miller, 2002)

The following questions pertain to your friendships with peers (excluding family members or a romantic partner). A close friend is someone whom you feel attached to through respect, affection and/or common interests, someone you can depend on for support and who depends on you. Please answer the next questions regarding just ONE of your closest friends. (Please do not select a family member or romantic partner).

OPTIONAL: 1. Is this friend male or female? 1 Male 2 Female

Next to each statement below, please indicate the number that best applies to your relationship with a close friend.

2. Even when I have difficult things to say, I can be honest and real with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. After a conversation with my friend, I feel uplifted.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

4. The more time I spend with my friend, the closer I feel to him/her.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel understood by my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. It is important to us to make our friendship grow.
1 Never
2 Seldom
3 Sometimes

4 Often
5 Always

7. My friendship inspires me to seek other friendships like this one.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. I am uncomfortable sharing my deepest feelings and thoughts with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. I have a greater sense of self-worth through my relationship with my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

10. I feel positively changed by my friend.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I can tell my friend when he/she has hurt my feelings.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

12. My friendship causes me to grow in important ways.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

The following questions pertain to the most meaningful community or group with

which you have been involved on a day to day basis for the past three months (i.e. academic, social, cultural, religious, etc.) Next to each statement below, please indicate the number that best applies to your relationship with or involvement in this community.

Please identify the type of community or group you have selected:

_____

1. I feel a sense of belonging to this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

2. I feel better about myself after my interactions with this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. If members of this community know something is bothering me, they ask me about it.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

4. Members of this community are not free to just be themselves.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel understood by members of this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. I feel mobilized to personal action after meetings within this community.
1 Never
2 Seldom

3 Sometimes
4 Often
5 Always

7. There are parts of myself I feel I must hide from this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. It seems as if people in this community really like me as a person.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. There is a lot of backbiting and gossiping in this community.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

10. Members of this community are very competitive with each other.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I have a greater sense of self-worth through my connection with this community.
173
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

12. My connections with this community are so inspiring that they motivate me to pursue relationships
with other people outside this community.
1 Never
2 Seldom
3 Sometimes

4 Often
5 Always

13. This community has shaped my identity in many ways.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

14. This community provides me with emotional support.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

The following questions pertain to your relationships with "mentors" (other than your parents or whoever raised you) who you go to for support and guidance. A mentor is not a peer or romantic partner. By mentor we mean someone who often is older than you, has more experience than you, and is willing to listen, share her or his own experiences, and guide you through some area of your life (e.g., academic, social, athletic, religious).

For each statement below, please indicate the number that best applies to your relationship with this mentor.

1. I can be genuinely myself with my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

2. I believe my mentor values me as a whole person (e.g., professionally/academically and personally).
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

3. My mentor's commitment to and involvement in our relationship exceeds that required by his/her
social/professional role.
1 Never
2 Seldom

3 Sometimes
4 Often
5 Always

4. My mentor shares stories about his/her own experiences with me in a way that enhances my life.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

5. I feel as though I know myself better because of my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

6. My mentor gives me emotional support and encouragement.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

7. I try to emulate the values of my mentor (such as social, academic, religious, physical/athletic).
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

8. I feel uplifted and energized by interactions with my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

9. My mentor tries hard to understand my feelings and goals (academic, personal, or whatever is relevant).
1 Never
2 Seldom
3 Sometimes

4 Often
5 Always

10. My relationship with my mentor inspires me to seek other relationships like this one.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

11. I feel comfortable expressing my deepest concerns to my mentor.
1 Never
2 Seldom
3 Sometimes
4 Often
5 Always

APPENDIX D

Feminist Perspectives Short Form 3.

Please answer the following items regarding various social attitudes according to your level of agreement. Use the following legend:

1-Strongly Disagree
2-Moderately Disagree
3-Somewhat Disagree
4-Undecided
5-Somewhat Agree
6-Moderately Agree
7-Strongly Agree

____1. A man's first responsibility is to obtain economic success, while his wife should care for the family's needs.
____2. Women of color have less legal and social service protection from being battered than white women have.
____3. People should define their marriage and family roles in ways that make them feel most comfortable.
____4. The government is responsible for making sure that all women receive an equal chance at education and employment.
____5. By not using sexist and violent language, we can encourage peaceful social change.
____6. Homosexuals need to be rehabilitated into becoming normal members of society.
____7. The workplace is organized around men's physical, economic, and sexual repression of women.
____8. Rape is best stopped by replacing the current male oriented culture of violence with an alternative culture based on more gentle, womanly qualities.
____9. Men's control over women forces them to be the primary caretakers of children.
____10. Making women economically dependent on men is capitalism's subtle way of encouraging heterosexual relationships.
____11. Men need to be liberated from oppressive sex role stereotypes as much as women do.
____12. Putting women in positions of political power would bring about new systems of government that promote peace.
____13. Men use abortion laws and reproductive technology to control women's lives.
____14. Romantic love supports capitalism by influencing women to place men's emotional and economic needs first.
____15. Racism and sexism make double the oppression for women of color in the work environment.
____16. Beauty is feeling one's womanhood through peace, caring, and non-violence.
____17. Using "he" for "he and she" is convenient and harmless to men and women.
____18. It is a man's right and duty to maintain order in his family by whatever means necessary.
____19. Being put on a pedestal, which white women have protested, is a luxury

women of color have not had.
____20. Social change for sexual equality will best come by acting through federal, state, and local government.
____21. Romantic love brainwashes women and forms the basis for their subordinations.
____22. Women's experience in life's realities of cleaning, feeding people, caring for babies, etc. makes their vision of reality clearer than men's.
____23. In rape programs and workshops, not enough attention has been given to the special needs of women of color.
____24. It is the capitalism system which forces women to be responsible for child care.
____25. Women should not be assertive like men because men are the natural leaders of earth.
____26. Marriage is a perfect example of men's physical, economic, and sexual oppression of women.
____27. All religion is like a drug to people, and is used to pacify women and other oppressed groups.
____28. Bringing more women into male-dominated professions would make the professions less cut-throat and competitive.
____29. Capitalism forces most women to wear feminine clothes to keep a job.
____30. Discrimination in the workplace is worse for women of color than for all men and white women.

Please answer the following statements according to how true or not true they are of you.
Use the following legend:

1-Very untrue of me
2-Moderately untrue of me
3-A little untrue of me
4-Not sure
5-A little true of me
6-Moderately true of me
7-Very true of me

____31. My wedding was, or will be, celebrated with a full traditional ceremony.
____32. I actively try to integrate a communal form of work with a communal form of family life.
____33. I attend a place of worship that has changed the language of its prayer books and hymnals to reflect the equality of men and women.
____34. I use "she" rather than "he" generically, that is, to refer to an unknown person.
____35. I take my child to a racially-mixed child care center (or will when I have a child).
____36. I often encourage women to take advantage of the many educational and legal opportunities available to them.

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APPRNDIX E

Hoffman Gender Scale (Form A) (Revised)

What do you mean by femininity?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate your level of agreement with each of the following statements by rating it a "1,""2," "3," "4," "5," or "6" as follows:

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Agree	Tend to Agree	Agree	Strongly Agree

____1. When I am asked to describe myself, being female is one of the first things I think of.
____2. I am confident in my femininity (femaleness).
____3. I meet my personal standards for femininity (femaleness).
____4. My perception of myself is positively associated with my biological sex.
____5. I am secure in my femininity (femaleness).
____6. I define myself largely in terms of my femininity (femaleness).
____7. My identity is strongly tied to my femininity (femaleness).
____8. I have a high regard for myself as a female.
____9. Being a female is a critical part of how I view myself.
____10. I am happy with myself as a female.
____11. I am very comfortable being a female.
____12. Femininity (femaleness) is an important aspect of my self-concept.
____13. My sense of myself as a female is positive.
____14. Being a female contributes a great deal to my sense of confidence. ____

APPENDIX F

TRADITIONAL MOTHERHOOD SCALE

Please answer the following questions regarding your values about motherhood. Read each item carefully and consider what you believe. There are no right or wrong answers, so please give your honest reaction and opinion. After reading each statement, select the number which best reflects your level of agreement using the following scale:

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

_____1. The mother has a better relationship with her children.

_____2. A mother knows more about her child, therefore being the better parent.

_____3. Motherhood is what brings women to their fullest potential.

_____4. A good mother should stay at home with her children for the first year.

_____5. Mothers should stay at home with the children.

_____6. Motherhood brings much joy and contentment to a woman.

_____7. A mother is needed in a child's life for nurturance and growth.

_____8. Motherhood is an essential part of a female's life.

_____9. I feel that all women should experience motherhood in some way.

_____10. Mothers are more nurturing.

_____11. Mothers have a stronger emotional bond with their children.

_____12. Mothers are more sympathetic to children who have hurt themselves.

_____13. Mothers spend more time with their children.

_____14. Mothers are more lenient toward their children.

_____15. Mothers are more affectionate toward their children.

_____16. The presence of the mother is vital to the child during the formative years.

_____17. Mothers play a larger role in raising children.

_____18. Women instinctively know what a baby needs.