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How do Perceived Gender Roles Influence the Number of Attempted Medical Interventions of Infertile Couples?

Erin Aiello
University of Kentucky, em_aiello@sbcglobal.net

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Erin Aiello, Student

Dr. Ronald Werner-Wilson, Major Professor

Dr. Hyungsoo Kim, Director of Graduate Studies

HOW DO PERCEIVED GENDER ROLES INFLUENCE THE NUMBER OF ATTEMPTED MEDICAL INTERVENTIONS OF INFERTILE COUPLES?

THESIS

A thesis submitted in partial fulfillment of the
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By

Erin Aiello

Lexington, Kentucky

Director: Ronald J. Werner-Wilson, Professor of Family Sciences

Lexington, Kentucky

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ABSTRACT OF THESIS

HOW DO PERCEIVED GENDER ROLES INFLUENCE THE NUMBER OF ATTEMPTED MEDICAL INTERVENTIONS OF INFERTILE COUPLES?

Infertility affects 1 in 8 couples and the literature discusses the emotional effects infertility has on an individual. One option for infertility is to attempt medical interventions and the literature in the field does not explain why some people attempt more interventions than others. Using data from the 2002 National Survey of Family Growth (NSFG), Cycle 6, this quantitative study aims to understand the relationship between traditional gender roles and values and the attempted number of medical interventions by individuals within a relationship experiencing infertility. The results from this study indicate that both males and females that are in relationship experiencing infertility are more likely to attempt medical interventions when they highly value the meaning of family, rather than their views on traditional gender roles and values for men and women.

KEYWORDS: Couples, Family, Gender roles, Infertility, Medical interventions

Erin Aiello

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By

Erin Aiello

Ronald J. Werner-Wilson, Ph.D.

Director of Thesis

Hyungsoo Kim, Ph.D.

Director of Graduate Studies

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Chapter One: Introduction

Infertility can be a lifelong experience for those who don't seek medical interventions or have unsuccessful medical treatments. At each stage in the family life cycle, couples living with infertility may re-experience the pain of their infertility (Ferland & Caron, 2013), which may prompt them to attempt medical interventions. Much of the literature already written is about women and their experiences with infertility, rather than from a male's experience or the couple as a whole. Women may experience more distress than men if they are the infertile member within a relationship; much of this distress is attributed to social pressures of what it means to be a woman, which includes the ability to have biological children. These perceived gender roles and views may play a role as to why someone who is in a relationship experiencing infertility would seek medical help.

Literature Review

Infertility is defined as "the inability to conceive a pregnancy after one year of engaging in sexual intercourse" (Jordan & Revenson, 1999, p. 342). According to Resolve (2013), the National Infertility Association, 7.3 million people in the U.S. are affected by infertility which is equivalent to 1 in 8 couples. Of those infertile couples, one-third of infertility cases are caused by female infertility, one-third are from male infertility, and the remaining one-third is a combination of both partners or a result of unknown causes. Of the infertile women, 44% receive medical assistance and 65% of those women go on to give birth with the help of medical resources. It remains unknown how many males receive medical intervention for infertility.

Infertility and the Family Life Cycle

The family life cycle provides a framework for the typical trajectory of a family. People who deviate from the norm may experience isolation because a majority of people are following this cycle; therefore this creates different stressors that may be difficult to relate to given the factors of one's life. Couples living with infertility may experience feelings of grief or sadness and social isolation at each stage of the family life cycle (Ferland & Caron, 2013). As couples experience these feelings of isolation and desire parenthood, they may be more inclined to attempt medical interventions for their infertility.

McGoldrick, Carter, and Garcia-Preto (2012) have identified seven stages of the family life cycle: (a) leaving home: emerging young adults; (b) joining of families through marriage/union; (c) families with young children; (d) families with adolescents; (e) launching children and moving on at midlife; (f) families in late middle age; and (g) families nearing the end of life. When families join through marriage/union, there is the expectation that the new couple will have children and become parents, and their parents will become grandparents. During this time, the young couple may experience many questions from their social support system about when they will have children. This is a difficult time for the infertile couple because they may not know how to answer those questions and may not feel comfortable disclosing their infertility outside of their marriage.

When families reach the life cycle stage of "families with young children" (McGoldrick et al., 2012) infertile couples may feel social isolation from their friends who are now becoming parents (Ferland & Caron, 2013). Children provide a way for

families to connect, therefore if a couple does not have children, they may no longer be invited to birthday parties or events that are specifically for children. The infertile couple may begin to wonder who will take care of them in later life (Ferland & Caron, 2013). This continues on through the family life cycle stage of "families with adolescents". When the infertile couple reaches the life cycle stages of "families in late middle age" and "families nearing the end of life" they may once again experience social isolation as others are now becoming grandparents.

As couples experiencing infertility pass through different stages of the family life cycle, they may change their attitudes towards being a parent. When people around them are starting to become parents, the infertile couple may feel more pressure from each other and their social support to become parents. As previously mentioned, the family life cycle provides a normative trajectory for how families should be, and when infertile couples don't meet these standards in a timely manner, this could potentially influence the number of medical interventions they try in order to become biological parents.

Symbolic Interactionism

There are three themes of this theory, all of which come from Herbert Blumer. The first theme is: people will react to something according to the meaning that the thing has for them, we learn about meaning through interactions with others, and as people come into contact with different things and experiences, they interpret what is being learned (Smith & Hamon, 2012, p. 15-16). The second theme is: a human infant is asocial and once individuals develop a sense of self, this will provide motivation for future behavior (Smith & Hamon, 2012, p. 16). The final theme is: individuals are influenced by society and people learn the rules and values of society through everyday interactions

(Smith & Hamon, 2012, p. 17). In other words, individuals create their own meaning of objects. Individuals are also mindful of how they appear to others and this mindfulness is a learned approach. Meanings can come from society and interactions with others.

Mogobe (2005) stated that:

> Meanings are acquired during an individual's experience in the group, and these meanings lead to the development of self or an identity. Therefore, the underlying assumption in this study, derived from symbolic interactionism, is that identity of self is constructed and maintained with the social interaction that occurs between the individual and the environment" (p. 28).

Symbolic interactionism is important for understanding infertility because the well-being and levels of distress may differ depending on the meaning individuals within a couple place on their infertility as a whole and their inability to be a biological parent. If an individual believes that their meaning as a male or a female is to be a biological parent, then they may value that belief differently than someone who believes the meaning of their gender is to be a parent, whether it is through biological means or adoption services. Individuals place meaning to roles, such as husband, wife, mother, or father. Additionally, they may place meaning onto how they assumed those roles. For some people experiencing infertility, it might be important for them to be a biological parent, which could influence how many medical interventions they attempt. For others, they may feel that medical interventions are not an option for them and would find the same meaning of being a parent to an adopted child.

Medical Family Therapy

A couple that is experiencing infertility might benefit from going to a medical family therapist, rather than a different mental health professional because of their specialized training for medical issues. A medical family therapist bridges the gap between mental health and physical health for the client, and therefore could better understand the client's medical situation because of their emphasis on specific medical issues in addition to their systemic training through family therapy. Medical family therapy provides a different clinical experience for clients and those experiencing infertility could benefit from this developing field.

According to the Bureau of Labor and Statistics (BLS) as of 2012, there are 166,300 jobs for mental health counselors and marriage and family therapists. Of those jobs, marriage and family therapists fill 37,800 positions. Twenty-five percent of marriage and family therapist work in individual and family services, 24% work in outpatient care centers, 22% work for the government, 8% work in offices of health care practitioners, and 5% work in nursing and residential care facilities (Bureau of Labor and Statistics, 2014, "Work Environment").

Medical family therapy is the "biopsychosocial treatment of individuals and families who are dealing with medical problems" (McDaniel, Hepworth, & Doherty, 1992, p.2). The biopsychosocial model refers to the "hierarchical, interdependent relationships of biological, psychological, individual, family, and community systems (McDaniel et al., 1992, p. 14). Medical family therapy is a branch of marriage and family therapy and was developed in the 1980s and 1990s (Doherty, McDaniel, Hepworth, 2014).

There are three levels of medical care: primary, secondary, and tertiary (McDaniel et al., 1992). Primary care providers are the initial place for individuals and families to consult with at a health care facility. Examples of primary care providers include family physicians and pediatricians. Secondary care refers to a more specialized healthcare provider such as a cardiologist, chiropractors, and private practice family therapists. Typically, secondary care providers work with patients that have been referred to them by a primary care provider. Tertiary care applies to medical issues that are highly specialized. In tertiary care, family therapists may specialize in specific illnesses and conditions in order to work with families to meet their needs.

Doherty et al. (2014) identify four areas that medical family therapists can contribute to in the health care system: the patient experience of health care, the health of the population, the containment of health care costs, and enhanced practice environments. To enhance the patient's experience of health care, medical family therapists can help patients build connections amongst the splits in four areas: the mind/body, the individual and the family, the family and institutional systems, and clinical healthcare and the larger community. Medical family therapists are trained to help patients understand the relationship between the psychological components of the brain and the bodily system as a whole unit.

The second split, the individual and the family, stems from the systemic perspective of family therapy or family systems theory (Doherty et al., 2014). Family systems theory has the assumption that the whole is greater than the sum of the part and that all family members have a role in the system (Smith & Hamon, 1012). A medical

family therapist would acknowledge the patient's experience and illness as an aspect of the system and understand the role of each family member within that system.

When a family experiences a chronic illness, doctor's visits and health checkups become part of their routine. In order to help patients and their families navigate the third split, the family and institutional system, medical family therapists work to understand patterns within the family that then extend into their relationship with the healthcare system (Doherty et al., 2014). Doherty et al. (2014) mentions family secrets and triangulation between the family members and health care providers (p. 531).

The final split, clinical health care and the larger community, means that medical family therapists need to look at their patients' community as a whole, which includes their cultural base, faith organizations, and government systems (Doherty et al., 2014). Health care providers tend to work in an isolated area, such as a hospital or a medical facility that does not take into account other contextual factors of their patients.

Gender Identity

Gender identity is a construction of biological and social factors (Garcia-Preto, 2011) and may contribute to more efforts and medical interventions for couples experiencing infertility. As individuals learn and construct their own views of their gender, they may find themselves to be set in these roles. Their perceived gender roles may make individuals feel stuck, therefore they may be more inclined to attempt medical interventions to fulfill their gender norms.

There is an assumption that mothers hold a more dominant role in parenting because they tend to stay at home with their children and that mothers parenting styles for sons and daughters differ. Mothers remain close to their daughters and teach them how to

nurture others and have emotional connections whereas sons are supposed to be more distant from their mothers in order to create autonomy, which may play a role in one's desire to maintain traditional gender roles later in life. Maccoby (1990, as cited by Garcia-Preto, 2011) has done research that shows sex roles appear as early as childhood and that these behaviors are learned by peers. As children age, they continue to remain close with their socially constructed gender norms.

Historically, men have always been more in control than women, which is a characteristic that could stem from the socially constructed view that men should be the head f the household. Men were supposed to prove their manhood by becoming autonomous from their family and working. This left women in charge of the home and raising children (Garcia-Preto, 2011). By watching adults and media sources, children learn these roles gender roles and the assumption that "men have more power and privilege than women" continues to live on (Garcia-Preto, 2011, p. 235).

Within traditional expectations, men have more power outside of the home and women's power remains in the home (Hare-Mustin, 1978). Men's power comes from having a job and earning a paycheck; society associates money with power. Women gain power by having a nice home and well behaved children. However the family is losing its importance in society, therefore making it less powerful (Hare-Mustin, 1978). Women may feel powerless and at a loss for their identity when much of their effort has been put towards the traditional roles as a housewife and mother and the value is decreasing.

Women who strive to break free of the traditional views of staying at home and raising children run the risk of being seen as unfeminine (Garcia-Preto, 2011). To be feminine, a woman is kind, patient, and nurturing. A woman needs to be assertive and

competent in order to be successful, but if she shows any signs of feminine traits, her competency is diminished. This concept makes it seem like women have to be either feminine or successful, rather than blending both views together.

Women are typically the ones to give up a career in order to start a family (Hare-Mustin, 1978). When women confine themselves to the role of housewife and mother, they struggle to have a personal sense of identity. There are two styles of identity: a personal sense of identity and a reflected sense of identity (O'Connell, 1975). A personal sense of identity refers to one's skills or strengths; it builds self-esteem and feelings of worth. An individual with a personal sense of identity has achieved autonomy by recognizing their value intrinsically and what they have to offer. A reflected sense of identity refers to other members within one's life. Rather than focusing on the individual self, instead the focus is on the group. It is similar to the inclusion of a group; the overall well-being of the group makes the individual feel good, therefore a reflected sense of self is external.

Infertility as an Identity

A study conducted by Olshansky (1987) concluded that infertility becomes an identity because it becomes a core part of their life. There are three stages to this identity formation: symbolic rehearsals, informal identity of self as infertile, and formal identity of self as infertile.

Symbolic rehearsals. Symbolic rehearsals refer to the imaginative act of becoming a parent (Olshansky, 1987). An individual might imagine being pregnant or what it would be like to take care of a baby. Symbolic rehearsals oftentimes reflect the dominant cultural beliefs and are experienced by the individual as early as childhood.

Young girls play house and take care of dolls, and this form of play emerges into the symbolic rehearsals seen later in life as an adult (Ulrich & Weatherall, 2000).

The symbolic rehearsals lead to actions taken by the couple to attempt pregnancy (Olshansky, 1987). Some couples are more active in pursing pregnancy, whereas others are more relaxed and let things happen. A couple that is more active might schedule more routine sex to ensure conception. On the other hand, the laid back couple may stop using contraception and see where that takes them. The couple's approach to conception may be a factor in their coping and perceptions of infertility.

Informal identity of self as infertile. After some time has passed and the couple realizes their attempts of pregnancy are not working, they begin to make modifications within their daily lives (Olshansky, 1987). They may change their diet, exercise regime, or pattern of sexual intercourse. At this point, the couple is reluctant to accept the reality of their situation as being infertile. This is partially due to the stigma of infertility, which will be discussed in depth later in this paper, and the biological factors of having children. The couple recognizes a problem with their attempts and infertility may be a possibility in their minds, which leads to their informal identity of infertility. Many people look to outside sources for recommendations or advice on what to do. Until the infertility has been diagnosed, the identity is still informal.

Formal identity of self as infertile. At this stage, more couples seek the help of a medical professional. From here, the couple can be diagnosed and their identity of self as infertile has become formalized. Some choose to proceed with medical treatments (Olshansky, 1987). Medical treatments cause anxiety for both men and women. In regards to in-vitro fertilization (IVF), women worry about the effects the hormone

injections will have on their body and moods. It is usually the husband's responsibility to administer the IVF injection and their anxiety stems from accidently injecting in the wrong place or hurting their wife (Jordan & Revenson, 1999).

Because the couple is unwilling to accept their infertility, they constantly work towards removing that label from themselves (Olshansky, 1987). By doing so, they end up unintentionally reinforcing their identity as infertile. Finding a solution eventually becomes the core of their relationship. When a couple continuously schedules sexual intercourse and has many moments of false hope of pregnancy, they are working at relieving themselves of infertility as their label, only to reconfirm it. The more work a couple puts towards becoming pregnant, the more times they must acknowledge the reality of their infertility.

Social Construction of Infertility

In a study by Miall (1986), respondents revealed a stigma of infertility. Many respondents thought of infertility as a failure or that they didn't work normally as humans. Miall (1986) discusses a concept called *courtesy stigma* which is defined as stigma that "is based on their association with someone who has a stigmatizing attribute, and not on their own personal attributes" (p. 271). In other words, people base their views of infertility on those around them, in this case, it is the view or stigma of infertility.

Furthermore, when women were contemplating the possibility of being infertile, they took an extra step to keep their doctor appointment secret from others. Infertility is often an avoided topic of conversation for the couple and the couple's family and friends. Infertile women in the study felt that they weren't a "whole person" because they couldn't reproduce (Miall, 1986).

There are many places where individuals and couples can get information about infertility. A Swedish study about where women get their perceptions about infertility revealed that many women turn to peers for information (Lampi, 2011). A peer base oftentimes leads to an overestimation of infertility risks. Information from peers isn't as accurate as the information from a medical professional. Typically older women receive more information from a health care professional, whereas younger women rely on the media for information about pregnancy and infertility. At the end of the study, a majority of the women stated they would prefer that their information came from a healthcare professional (Lampi, 2011). Based on the findings from Lampi (2011) it would seem that a majority of the general population does not have accurate information about infertility and that this misinformation is part of how people shape their views towards infertility.

Coping Styles

Individual coping styles could play an important role in a couple's decision to attempt medical interventions for their infertility. Lechner et al. (2007) refer to two coping styles: active coping style and emotional and passive coping style. Active coping style is used "to solve the underlying problem" (Lechner et al., 2007, p. 289). Emotional and passive coping style is used "to influence the emotions or results that are caused by the problem" (Lechner et al., 2007, p. 289). Couples that are living with infertility may find both coping styles to be beneficial for different aspects of their experience, although passive coping is associated with more distress or depressive-related symptoms (Kelly et al., 2008; Lechner et al., 2007). Men tend to use problem-focused coping or active coping, whereas women use emotion focused coping (Jordan & Revenson, 1999; Kelly,

Tyrka, Price, & Carpenter, 2008). Bell (2013) found that some women avoid situations that involve babies, pregnancy, childbirth, and even Mother's Day.

Infertility and Grief

Oftentimes infertile couples experience complicated grief, which may affect their decision to attempt medical interventions. Complicated grief occurs when a person cannot move forward after a loss and cannot resume their life (Mayo Clinic, 2014, "Definition"). Symptoms of complicated grief include "preoccupation with thoughts of the deceased, disbelief, feeling stunned, and lack of acceptance of the death" (Horowitz, Siegel, Holen, Bonanno Milbrath, & Stinson, 1997, p. 905).

Infertility may not be seen as an actual loss by society, therefore people experiencing infertility may not feel like it is acceptable to grieve. When they do grieve, it may be over the loss of potential or what could have been, rather than over a physical loss of a person dying (Lechner et al., 2007). The social support system of the couples or individuals working through infertility should acknowledge it as a loss and understand that it is difficult for the infertile couple to accept. Women who engage in other roles similar to that of a mother or find meaning in their lives are able to work through some of their grief (Ferland & Caron, 2013).

The Effects of Infertility on a Relationship

The decision to attempt medical interventions for infertility can cause strain within a couple's relationship because it can become a focal point of the relationship (Olshansky, 1987). Communication and sexual problems create strain on the relationship (Volgsten, Svanberg, & Olsson, 2010). Sexual intercourse becomes meaningless to couples, as they strive to remove their identity as infertile (Olshansky, 1987). It becomes

more scheduled with a goal in mind, instead of a gesture of affection and intimacy (Volgsten et al., 2010).

On the other hand, some couples feel closer because of their infertility. In a study conducted by Ferland and Caron (2013), infertile women reported that their relationships strengthened with their husbands because they were all each other had. Referring back to the family life cycle, many couples experience stress while launching young adults. Children are the focal point in relationships for aduration of at least 18 years. Once children leave the household, the couple may not connect in ways they used to. However, childless couples may not experience that stress because they have more time to focus on their relationship.

Findings from a study by Greil, Leitko, and Porter (1988) concluded that women think about infertility more often, whereas men are more likely to accept their experiences and move on. This difference is perspective towards infertility may create more problems in a relationship.

Purpose

Based on the literature, which suggests that individuals base their identity around their gender and the effects of infertility on a couples' relationship, the purpose of this study is to determine if participants who reported an experience of infertility sometime in their life seek more medical help based on their gender roles and values. Infertility, gender roles and values, and medical interventions are the variables of this study that will be analyzed.

Hypotheses

There are two hypotheses for this study: (H1) females with traditional gender roles and values will report having tried more medical interventions than females with nontraditional gender roles and values; and (H2) there will not be a significant difference in the number of attempted medical interventions between males with traditional gender roles and values and males with nontraditional gender roles and values.

Chapter Two: Methodology

Sample

Data for this study is from the 2002 National Survey of Family Growth (NSFG), Cycle 6. According to the Centers for Disease Control and Prevention (CDC), the NSFG "gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health" (CDC, 2015). Data collection for Cycle 6 was conducted by the National Center for Health Statistics and was funded by nine programs within the U.S. Department of Health and Human Services (CDC, 2015). During Cycle 6, 7,643 women between the ages of 15-44 and 4,928 men between the ages of 15-44 participated in the study. The study consists of in-person interviews and Computer-Assisted Self-Interviewing (CASI). Of the female respondents, 569 reported receiving medical help to get pregnant. Of the male respondents, 224 reported receiving medical help to have a baby. It will first be determined if the respondent is infertile, then their response to a series of attitude questions will be analyzed, followed by their attempted medical interventions. See Table 2.1 for descriptive information.

Measures

To determine if the respondents have experienced infertility in their relationship, the following questions were used for analysis: males were instructed to respond to the following statement: "(Did you or your wife ever go / Have you or your wife ever been / During any of your relationships, have you or your (wife or) partner at the time ever been) to a doctor or other medical care provider to talk about ways to help you have a baby?" Male participants had the option to answer yes or no.

Table 2.1 Descriptive Characteristics of Cycle 6 from NSFG and Present Study

Characteristic	Cycle 6	Present Study
Sex		
Male	4928 (39.2%)	224 (28.2%)
Female	7643 (60.8%)	569 (71.8%)
Race/Ethnicity		
Hispanic/Latino	2712 (21.6%)	138 (17.4%)
American Indian or Alaskan Native	455 (3.6%)	20 (2.5%)
Asian	422 (3.4%)	21 (2.7%)
Native Hawaiian or Pacific Islander	80 (0.6%)	10 (1.3%)
Black or African American	2706 (21.5%)	129 (16.3%)
White	8893 (70.7%)	612 (77.3%)
High School Degree		
No	9458 (85.1%)	65 (8.2%)
Yes	1662 (14.9%)	723 (91.8%)
Education Beyond High School		
Associates	848 (6.7%)	95 (25.3%)
Bachelors	1726 (13.7%)	179 (47.6%)
Graduate	669 (5.3%)	102 (27.2%)

Female participants were asked "(during any of your relationships,) have you or your (husband or) partner at the time ever been to a doctor or other medical care provider to talk about ways to help you become pregnant?" Female participants were instructed to answer yes or no.

The analyses focused on gender roles and values and the attempted medical interventions for infertility. Gender roles and values were based on the following questions: "it is much better for everyone if the man earns the main living and the woman takes care of the home and family" (achieve), "a working mother can establish just as warm and secure a relationship with her children as a mother who not work" (warm), "a young couple should not lie together unless they are married" (cohab), "it is okay for an unmarried female to have a child" (chsupport), "the rewards of being a parent are worth it, despite the cost and the work it takes" (chreward), and "it is more important for a man to spend a lot of time with his family, than to be successful at his career" (family). Responses ranged from strongly agree, agree, disagree, strongly disagree, and if respondent insists: neither agree nor disagree. These responses were reverse coded, with strongly disagree having the lowest value, and strongly agree as the highest value. Respondents who answered "neither agree nor disagree" or did not respond were be used for analysis.

Female participants were asked to respond to the statement "which of the services shown on Card 52 (have/did) you or you (husband/partner/previous partner (had/have) to help you become pregnant?" Female participants were instructed to enter all options that apply: advice, infertility testing, drugs to improve your ovulation, surgery to correct blocked tubes, artificial insemination, or other types of medical help.

Male participants were asked to respond to the statement “which of the services shown on Card 44 (did/have) you or your (wife/partner) (have/had) to help you have a baby together?” Male participants were instructed to enter all options that apply: advice, infertility testing, drugs to improve ovulation, surgery to correct blocked tubes, artificial insemination, treatment for varicocele, or other types of medical help.

Chapter Three: Results

Hypothesis 1

Hypothesis 1: Females with traditional gender roles and values will report having tried more medical interventions than females with nontraditional gender roles and values

A correlation between gender roles and values and the outcome variable as medical interventions was used for the second hypothesis (see Table 2.1). For gender roles and values, males and females responded to the following statements about attitudes: “it is much better for everyone if the man earns the main living and the woman takes care of the home and family” (achieve), “a working mother can establish just as warm and secure a relationship with her children as a mother who not work” (warm), “a young couple should not lie together unless they are married” (cohab), “it is okay for an unmarried female to have a child” (chsupport), “the rewards of being a parent are worth it, despite the cost and the work it takes” (chreward), and “it is more important for a man to spend a lot of time with his family, than to be successful at his career” (family). Responses ranged from strongly agree, agree, disagree, strongly disagree, and if respondent insists: neither agree nor disagree. These responses were reverse coded, with strongly disagree having the lowest value, and strongly agree as the highest value. Respondents who answered “neither agree nor disagree” or did not respond were not used for analysis.

Female participants were asked to respond to the statement “which of the services shown on Card 52 (have/did) you or you (husband/partner/previous partner (had/have) to help you become pregnant?” Female participants were instructed to enter all options that

Table 3.1. Correlation of Gender Roles and Views and Medical Interventions for Females

	Medical Interven.	Achieve	Warm	Cohab	ChSupport	ChReward	Family
Medical Interven.	1.00						
Achieve	-.024	1.00					
Warm	-.012	-.324**	1.00				
Cohab	-.008	.412**	-.205**	1.00			
ChSupport	-.004	-.299**	.251**	-.424**	1.00		
ChReward	.087*	.017	.046	.119**	.036	1.00	
Family	.096*	.180**	.006	.122**	-.058	.109*	1.00

apply: advice, infertility testing, drugs to improve your ovulation, surgery to correct blocked tubes, artificial insemination, or other types of medical help.

For females, the view that it is much better for everyone if the man earns the main living and the woman takes care of the home and family" (achieve) and the number of attempted of medical interventions are not correlated, $r(541) = -.024$, $p = .569$. The view that "a working mother can establish just as warm and secure a relationship with her children as a mother who not work" (warm) and the number of attempted medical interventions are not correlated, $r(560) = -.012$, $p = .781$. The view that "a young couple should not lie together unless they are married" (cohab) and the number of attempted medical interventions are not correlated, $r(541) = -.008$, $p = .848$. The view that "it is okay for an unmarried female to have a child" (chsupport) and the number of attempted medical interventions is not correlated, $r(539) = -.004$, $p = .919$. The view that "the rewards of being a parent are worth it, despite the cost and the work it takes" (chreward) and the number of attempted medical interventions are correlated, $r(555) = .087$, $p = .039$. The view that "it is more important for a man to spend a lot of time with his family, than to be successful at his career" (family) and the number of attempted medical interventions are correlated, $r(528) = .096$, $p = .027$. Based on these results, hypothesis 1 was not supported.

Hypothesis 2

Hypothesis 2: There will not be a significant difference in the number of attempted medical interventions between males with traditional gender roles and values and males with nontraditional gender roles and values.

A correlation between gender roles and values and the outcome variable as medical interventions were used for the second hypothesis (see Table 2.2). For gender roles and values, males and females responded to the following statements about attitudes: “it is much better for everyone if the man earns the main living and the woman takes care of the home and family” (achieve), “a working mother can establish just as warm and secure a relationship with her children as a mother who not work” (warm), “a young couple should not lie together unless they are married” (cohab), “it is okay for an unmarried female to have a child” (chsupport), “the rewards of being a parent are worth it, despite the cost and the work it takes” (chreward), and “it is more important for a man to spend a lot of time with his family, than to be successful at his career” (family). Responses ranged from strongly agree, agree, disagree, strongly disagree, and if respondent insists: neither agree nor disagree. These responses were reverse coded, with strongly disagree having the lowest value, and strongly agree as the highest value. Respondents who answered “neither agree nor disagree” or did not respond were not used for analysis.

Male participants were asked to respond to the statement “which of the services shown on Card 44 (did/have) you or your (wife/partner) (have/had) to help you have a baby together?” Male participants were instructed to enter all options that apply: advice infertility testing, drugs to improve ovulation, surgery to correct blocked tubes artificial insemination, treatment for varicocele, or other types of medical help.

For males, the view that it is much better for everyone if the man earns the main living and the woman takes care of the home and family” (achieve) and the number of attempted of medical interventions are correlated, $r(214) = -.146$, $p = .032$. The view that

Table 3.2. Correlation of Gender Roles and Views and Medical Interventions for Males

	Medical Interven.	Achieve	Warm	Cohab	ChSupport	ChReward	Family
Medical Interven.	1.00						
Achieve	-.146*	1.00					
Warm	.036	-.255**	1.00				
Cohab	-.098	.293**	-.081	1.00			
ChSupport	.007	-.295**	.208**	-.383**	1.00		
ChReward	.190**	.016	.098	.134*	-.099	1.00	
Family	.058	.115	.142*	.202**	-.118	.218**	1.00

"a working mother can establish just as warm and secure a relationship with her children as a mother who not work" (warm) and the number of attempted medical interventions are not correlated, r(221) = .036, p = .593. The view that "a young couple should not lie together unless they are married" (cohab) and the number of attempted medical interventions are not correlated, r(217) = -.098, p = .148. The view that "it is okay for an unmarried female to have a child" (chsupport) and the number of attempted medical interventions is not correlated, r(213) = .007, p = .915. The view that "the rewards of being a parent are worth it, despite the cost and the work it takes" (chreward) and the number of attempted medical interventions are correlated r(222) = .190, p = .004. The view that "it is more important for a man to spend a lot of time with his family, than to be successful at his career" (family) and the number of attempted medical interventions are not correlated, r(209) = .058, p = .402. Based on these results, hypothesis 2 was not supported.

Male participants were asked to respond to the statement "which of the services shown on Card 44 (did/have) you or your (wife/partner) (have/had) to help you have a baby together?" Male participants were instructed to enter all options that apply: advice infertility testing, drugs to improve ovulation, surgery to correct blocked tubes artificial insemination, treatment for varicocele, or other types of medical help.

Analysis for both females and males focuses on the relationship between their gender roles and views and the number of attempted medical interventions. When any of the six questions based on gender roles and views were combined, there was not a significant relationship between gender roles and views and medical interventions. When an analysis of each question based on gender roles and views and the number of

attempted medical interventions, the results showed some correlations between the variables.

Chapter Four: Discussion

Infertility is a medical issue that affects millions of people. Much of the previous literature focuses on individual effects of infertility, rather than from a systemic perspective. The research that has focused on infertility as a couples' issue tends to look at couples where females are experiencing infertility, and there is an uneven distribution of literature focusing on males and females that have reported themselves as being infertile. Previous literature has also focused on the distress or dissatisfaction of the infertility, rather than asking why some people medical interventions.

There were two hypotheses for this study: (H1) females that are experiencing infertility in their relationship and have traditional gender roles and values will report having tried more medical interventions than females that are experiencing infertility in their relationship and have nontraditional gender roles and values; and (H2) there will not be a significant difference in the number of medical interventions attempted between males that are experiencing infertility in their relationship and have traditional gender roles and values than males that are experiencing infertility in their relationship and have nontraditional gender roles and values. The results of this study did not support the hypotheses. Both females and males make the decision to attempt more medical interventions based on how much they value the meaning of family, rather than set gender roles for men and women.

There are two coping styles commonly associated with individuals: active coping style and emotional and passive coping style (Lechner, 2007). It would seem that the individuals within this study who attempted medical interventions assumed a more active

coping style because they took action to solve their problem of infertility, regardless of the end result of their medical intervention.

Olshanksky (1978) identified three stages of infertility as an identity formation: symbolic rehearsals, informal identity of self as infertile, and formal identity of self as infertile. During formal identity of self as infertile, the couple has sought the help of a medical professional. It can be assumed that the participants within this study were in this stage of identity because they reported going to the doctor for their infertility.

Clinical Implications

While the focus of this study was about the relationship between gender roles and values and attempted medical interventions of people within a relationship experiencing infertility, there are some clinical implications of the findings. It would be ideal for fertility clinics to have a tertiary care model, where patients could easily access a family therapist to help them cope with their experience. However, a majority of marriage and family therapists are not working in medical settings therefore their scope of practice when it comes to working with their client's medical issues may be limited.

For marriage and family therapists that are unable to collaborate with healthcare providers, a narrative approach to therapy may be beneficial to help them work with clients that are experiencing infertility within their relationship, which also incorporates aspects of symbolic interactionism because it allows clients to create a new meaning of their experience. Being mindful of the medical family therapy framework is beneficial as well, with an emphasis on communion and agency (Breen Ruddy & McDaniel, 2008). Communion refers to feeling loved and cared for and agency focuses on aspects of the illness or medical issues that patients can control. Previous literature on infertility has

often used a qualitative approach, which has concluded that coping is a process which involves acceptance of one's situation (Ferland & Caron, 2013; Lechner, 2007; Miall, 1986).

Narrative therapy gives clients the opportunity to share their story (Nichols, 2013). People tend to blame themselves for issues or problems they have; however the reasoning for their problems may stem from a social or cultural constructed perspective. These constructions force people to view problems and solutions in a narrow way. Instead of giving people the freedom to look at their problem from all perspectives, social and cultural constructions hinder exploration of solutions. Essentially, people are not the cause of their problems; rather the narrow view of cultural and societal barriers causes problems because people do not have the resources to work towards an effective solution.

A main component of narrative therapy is externalizing the problem (Nichols, 2013; White, 2007). Externalizing the problem is when an individual stops labeling and categorizing themselves as having a problem, and instead works towards defeating their problem. Additionally, White (2007) describes externalizing as a way for people to "unravel some of the negative conclusions they have usually reached about their identity under the influence of the problem" (p. 26). A couple with infertility may not be able to be fertile through medical intervention, but they can work towards making infertility an aspect of their life, rather than the definition of who they are. Ferland and Caron (2013) discussed three themes from their study about infertility: finding out, living with it, and coming to terms. Within these three stages, Ferland and Caron (2013) identified common themes such as why me, I am to blame, and what good am I, which could be associated with negative conclusions that White (2007) mentioned. Externalizing problems makes

solutions seem more attainable and relieves people of the stigmas associated with their problem.

Conflict within a relationship or family occurs when the narratives people have are problem-saturated stories (Nichols, 2013). Problem-saturated stories can lead to blame and dispute against other people's stories. A study by Miall (1986) concluded that infertile individuals may self-label, which refers to when an individual assumes other people may label deviant attributes as such. Part of self-labeling comes from perceptions of other's thoughts, but also societal and cultural stigmas and views. Problem saturated stories can come from self-blame and blame from others within a system. Breen Ruddy and McDaniel (2008) states that people should "put the illness in its place", which encourages families to maintain routines and traditions; in the instance of infertility, a therapist could help clients continue old rituals and create new routines.

The foundation of progress in narrative therapy is built on the common enemy family members have. While listening to the narratives, the therapist should pick out common themes within each story and consult clients about them. When members see they are fighting the same battle, they can hopefully work together to conquer it.

Narrative therapists work on deconstructing their client's story and then restructuring it in a positive way (Nichols, 2013). In order to start this process, the therapist will gather information about the client's experiences and assumptions, which White (2004) refers to as relative influence questioning. Once the problem is recognized the therapist will "map the influence of the problem on the family and then map the influence of the family on the problem" (Nichols, 2013, p. 274; White & Epston, 2004).

When looking at how the problem influences the family, the therapist will explore the impact of the problem in each member's life. To understand the influence of the family on the problem, the therapist will look into the attempts the client's made towards defeating their problem. Lechner (2007) concluded that there is an association between coping styles and social support; when people experience more social support, they tend to have a more active-coping style, which allows people to explore the underlying problem they are currently experiencing.

After determining the problem in a person's story and understanding the role of the problem in their life, a narrative therapist can help the client reauthor their life (Nichols, 2013). This is done by gathering information about previous moments of competency in the client's life. From there, the therapist can reframe questions that allow the client to think in a future-oriented mindset.

It would be helpful for a couple with infertility to understand the social and cultural expectations and understand the narrow tunnel they have been working in to accept their situation. When the couple recognizes the role these constructions have played in their patterns of thinking, they can externalize themselves from the problem and work towards shaping a new identity for themselves.

Limitations

The data used for this study was collected by the NSFG and it is important to identify the areas that limit the findings of this study. Because this study used data that was already collected, formatting research questions that match the interview questions provided limitations to the depth of analysis. Originally, this study had four hypotheses however upon further investigation some of the questions from the NSFG data were not

clear about which person within the participants' relationship was experiencing infertility. Furthermore, correlations between gender roles and value sand attempted medical interventions were single item correlations, which limit the strength of the value.

The data was non-dyadic, so while the there were responses from both male and female participants, it is difficult to analyze and make meaning of how a couple experiencing infertility may respond to gender roles and values and attempted medical interventions. Additionally, there were 7,643 women between the ages of 15-44 and 4,928 men between the ages of 15-44 that participated in the data collection, but only 569 female participants reported receiving medical help to get pregnant and 224 male participants reported receiving medical help to get pregnant. The ratio of female to male participants who reported receiving medical help to get pregnant is consistent with the literature, in that females tend to be the focal point of infertility, but having a larger, more equal spread of data would be beneficial to identify gender difference of roles and values, if any exist.

Future Directions

A theme from the data is the meaning behind having a family. Future research should focus on active coping styles and emotional and passive coping styles to better understand if there is a relationship between personal values and the coping mechanism used for such situations.

Much of the previous research studying infertility has focused on how stressed an individual is, usually a female. Future directions for research include interviewing couples and their experiences as well as their meanings, and differences or similarities

amongst infertile males or females within those couples. Furthermore, research should also look into those couples that are not in the formal identity of self as infertile stage.

Another approach for future research on this topic would be a longitudinal analysis assessing infertile couples at each stage of the family life cycle. At each stage, questions about grief and coping could be better understood. From a lifecourse perspective, future researchers could better understand how couples experiencing infertility perceive their options in terms of medical interventions.

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Vita

Erin Aiello

EDUCATIONAL INSITUTIONS

B.S., Family and Consumer Sciences, 2012
Emphasis in Family Resources
Illinois State University
Normal, Illinois

PROFESSIONAL POSITIONS HELD

Research Assistant, University of Kentucky, 2014-2015
Intern Therapist, University of Kentucky Family Center, 2014-2015
Intern Therapist, Garden Springs Elementary School, 2012-2014
Intern Therapist, Tates Creek High School, 2014
Teaching Assistant, University of Kentucky, 2013-2014
Undergraduate Intern, Illinois State University, 2012-2013

SCHOLASTIC AND PROFESSIONAL HONORS

Secretary, Student Association of Marriage and Family Therapy, 2014-Present
Member, American Association for Marriage and Family Therapy, 2013-Present
Member, National Council on Family Relations, 2014-Present