

BECOMING ADOPTIVE PARENTS

BECOMING ADOPTIVE PARENTS:  
SHIFTS IN IDENTITY FROM BIOLOGICAL PARENTHOOD  
TO ADOPTIVE PARENTHOOD AMONG INFERTILE COUPLES

By

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## ABSTRACT

This research is based on a sample of 76 couples experiencing a fertility problem. Recruited through a medical fertility clinic and several adoption agencies, the response rate was 43%. Data were collected by means of written questionnaires and semi-structured interviews.

The focus of this research is on the way that parenthood identity changes for couples who are unable to have biological children and who therefore pursue adoption as an alternate route to parenthood. Conceptualized as a "transformation of identity", the analysis traces the process by which couples relinquish identification with biological parenthood and assume identification with adoptive parenthood.

Several key issues are explored in the study: the impact of infertility on the taken-for-granted meaning of parenthood; critical incidents that initiate the transition to adoptive parenthood; objective and subjective indicators of what it means to be ready to take on adoptive parenthood; and finally, the resocialization process involved in shifting from biological to adoptive parenthood. Also examined is the relationship between infertility resolution and adoption readiness. The findings suggest that this is not always a sequential relationship as usually assumed, but rather, may be experienced as a concurrent commitment to both biological and adoptive parenthood.



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## INTRODUCTION

AN OVERVIEW OF THE TRANSITION TO ADOPTIVE PARENTHOOD

## Introduction

### THE TRANSITION TO ADOPTIVE PARENTHOOD: AN OVERVIEW

Parenthood has taken on many new meanings in light of recent changes in the norms and structures of families. Where once one could more easily place the identity of parents as spouses living together to create and raise their own biological children, one must now take into account a much wider situational variation in the way that this role identity is taken on and carried out. In Canada, for example, it is currently estimated that less than half of all families fit with this biologically rooted, monolithic image of what it means to be a parent (Eichler, 1983:238). As a result, the majority of parents carry out their roles within different contexts and with different contingencies. Adoptive parents, unmarried single parents, divorced single parents and blended parent families are representative of the divergent ways that the parenthood role is carried out.

In light of the diversity of parenthood roles, a concept like the "transition to parenthood" (Rossi, 1968) loses some of its ability to fully explain the process of taking on the role identity of parenthood because of its

tendency to gloss over the different kinds of parenthood that people take on. If we are to adequately understand the transition to parenthood in all its forms, then it is important that the transition be examined in light of the unique features of each kind of parenthood. Even in instances where couples wish to become parents but do not, the transition is of central importance. Matthews and Martin-Matthews (1986), for example, focussed attention on the importance of this approach when they examined the "transition to non-parenthood" among the involuntary childless. In this study, the focus is on the transition to another kind of parenthood: namely, the transition to adoptive parenthood by infertile couples.

Although the process of becoming an adoptive parent involves a different set of experiences from that of becoming a biological parent, they both occur against the backdrop of a common set of values and norms for what parenthood should be. As Blake (1974) has pointed out, pronatalist values underlie our beliefs about family. The pronatalist value that couples should have children is manifested through a set of expectations and pressures that are exerted on a couple to have children soon after they are married. In fact, in our culture, parenthood holds the central place in identifying a family as a family. For, "to become parents" is to "have a family" suggesting that to be married without children is to not be a family at all. In

this sense, taking on family identity occurs when a couple begins to have children, rather than at the time of marriage itself. From this perspective, parenthood, not marriage, is the critical transition into "family-hood".

Given the importance of parenthood for family identity within our culture, couples typically invest heavily in the role identity of parenthood. As one indication of this, 95% of newly married couples anticipate that they will have children at some point in their lives (Glick, 1977). For many couples, becoming parents, and in so doing becoming families, is non-problematic insofar as they are able to choose to have biological children and then simply proceed to do so without difficulty. For other couples, however, taking on this family identity is blocked by an inability to take on the parenthood role. Because of a fertility problem, some couples are unable "to have a family" when they set out to do so. With parenthood blocked by infertility, couples find themselves caught in a tension between their own urgent desire to have children, the expectations of family and friends that they do so, and on the other hand, their increasing powerlessness in overcoming their fertility problem.

In light of this block to parenthood, couples are faced with the problem of defining and redefining what both parenthood and family mean to them. The re-evaluation of the



parenthood role is usually unexpected. Before there is any awareness of infertility, becoming a "normal" biological parent is simply taken-for-granted. Perhaps because of a greater emphasis on controlling fertility through contraception, the prospect of having difficulty in "turning on" fertility is remote for most couples. Most couples presume that they are fertile. As a result, it usually comes as quite a surprise when the decision is made to start having children and there is no immediate result. At the outset, this may be easily rationalized as some minor problem or at very most, something that will be easily fixed by the medical profession. However, as time progresses and various tests and treatments are tried without success, couples may become increasingly concerned about their chances of having a biological child of their own. Seen in these terms, infertility is an ongoing social process whereby couples continue to hope for a pregnancy in the face of an increasingly gloomy medical prognosis.

For couples who are faced with this unexpected obstacle of infertility, there is a gradual loss of control over their life plans. Whereas at first they may have been concerned that they did not have as much control over the timing of having children, this may gradually deepen into a concern over whether or not they will be able to have biological children at all. This loss of control is manifested in a loss of autonomy in decision making. This

autonomy is in large part surrendered to the experts to whom they turn for help, leaving them increasingly dependent on them in their drive to become parents. Decisions regarding tests and treatments are guided by the advice of their doctor who becomes the controlling player in the ebb and flow of the infertility process.

Although the chances for biological parenthood diminish in the face of infertility, for many couples parenthood itself continues to be an important and desirable role. In light of this, couples begin to examine alternate ways of becoming parents. Although there are now more options than ever because of the various reproductive technologies, adoption continues to be one of the main alternate ways for becoming parents. Choosing adoption, however, necessarily involves a redefinition of what it means to be a parent. For those couples who choose adoption, this redefinition involves letting go of the physical, hereditary or biological aspects of parenthood in favour of the social aspects of the parenting experience. The decision to pursue adoptive parenthood can therefore be seen as a shift in their subjective perceptions of what it means to be a parent.

In addition, becoming an adoptive parent involves a different set of preparatory experiences than is encountered in becoming a biological parent. Foremost among these

experiences are coming to terms with the difference of the adoptive relationship and gaining support and legitimation for the new role identity. A couple may begin by entertaining the idea of adoption, fantasizing themselves as adoptive parents, soliciting support from others and making concrete steps to become legitimated as adoptive parents. Like the loss of control they encounter in dealing with infertility, taking steps to become adoptive parents also takes away control. Whereas couples surrender control to doctors in the infertility investigation, they must also surrender control to the official agents of the adoption process. Seeking parenthood in this way is no longer the relatively simple matter of getting pregnant and having a child, but instead involves applications, meetings, interviews and other evaluation procedures that are designed to judge their eligibility to become parents.

The transition to adoptive parenthood for couples faced with a fertility problem is thereby conceptualized as a process whereby couples begin to identify less with biological parenthood and identify more with adoptive parenthood. Couples remain committed to the identity of parenthood throughout the process but must redefine for themselves what parenthood means to them. This redefinition represents a "transformation of identity" that reflects the relinquishment of the biological parenthood identity on the one hand and an increasing identification with adoptive

parenthood on the other hand.

The way that couples redefine themselves from biological parenthood to adoptive parenthood has received scant, if any, attention in the scientific literature. Although there is a growing body of literature that deals with infertility as a life crisis, and another body of literature that deals with preparation for adoption from a social case work perspective, none deal specifically with the critical link between infertility resolution and adoption readiness from a social-psychological perspective. This research proposes to fill this gap.

To this end, phenomenology and symbolic interaction provide the theoretical tools for examining this process. Focussing on the transformation of identity as the central concept, the related issues of identity salience, commitment and socialization are drawn on. In keeping with the social-psychological approach, an emphasis is placed on understanding the dynamic aspects of this identity transformation process. As a result, the methodology was designed to capture the subjective perceptions that couples have of their situation.

The research design for understanding this process consisted of two phases. First, a preliminary study was carried out in order to be sensitized to the predicament of infertility and adoption consideration. Although the

researcher had personal experience with both infertility and adoption (the significance of which will be discussed in greater detail in Chapter 4), it was necessary to check out subjective perspectives of the experience with the experiences of others in a similar situation. The preliminary study consisted of attendance at five infertility support group meetings followed by open-ended, unstructured interviews with five couples. In the support group setting, data were not recorded for use in the study, but rather, the situation was used as a way of coming to a cursory understanding of what some of the salient issues were for the couples who participated. This activity was useful for giving some sense of direction to the five unstructured interviews that followed. These interviews were used as a way of exploring in greater detail what infertility meant to these people in their day-to-day lives and as a way of identifying some of the main issues in their consideration of adoption.

The second phase of the research was the main study and this consisted of giving questionnaires and conducting semi-structured interviews with a randomly selected sample of seventy-six couples who were experiencing a fertility problem. The information from the preliminary interviews was used as a grounded basis for constructing the questionnaire and the interview schedule. In this regard, the approach was largely inductive, although not entirely, for a review of

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the literature also suggested avenues to explore. Whereas the preliminary study was entirely qualitative in its methodology, the main study combined qualitative and quantitative techniques. This was achieved through the use of fixed questions that were quantifiable but open-ended in order to allow respondents maximum flexibility in their response.

In order to gain insight into the fullest range of events in the transition to adoptive parenthood, couples were sampled for the main study from several different sources. Some couples were recruited from a fertility clinic at a large teaching hospital and other couples from the adoption lists at two Children's Aid Societies. Couples were deliberately recruited from these different sources in order to ensure that there were couples at various stages of their consideration of adoptive parenthood. For example, many couples from the fertility clinic had considered adoption as an option but had not taken concrete steps towards adoption. On the other hand, all couples recruited from the adoption agencies were actively pursuing adoption. By sampling in this way, an effort was made to "catch the process" of transformation of identity from biological parenthood to adoptive parenthood.

The chapters which follow are laid out in the following order. In Chapter 1, there is a review of the

literature that deals with infertility and adoption as separate, yet related processes. By far the bulk of the literature that focusses on these topics deals with them as two separate issues. Given the focus of this research, which is to look at how the two topics are related, an effort was made to elaborate, where possible, the links between infertility and adoption as related and interpenetrating processes. Although the orientation of this research is sociological, this review encompasses work that comes out of many different disciplines. Some was sociological while other research came from psychology, medicine, demography, social work and psychiatry.

In Chapter 2, the transition to adoptive parenthood is placed within a theoretical framework. Using the concepts of a social-psychological perspective, parenthood is examined as a "problematic". Because infertility blocks the expected transition to biological parenthood, couples must re-evaluate and redefine the meaning that the parenthood identity has for them as a desired role identity. The process of reshaping the parenthood identity to accommodate the unique contingencies of adoption is examined as a socialization experience that is different from what is otherwise encountered in the normal transition to parenthood.

A discussion of the methods and findings of the preliminary study is the substance of Chapter 3. The

preliminary study was, in a sense, "the mucking around" stage of the research. During this phase, the emphasis was on exploring what issues were important to the people who were faced with parenthood as a "problematic". The issues, as they emerged in this phase, were the foundation for setting out some formalized propositions to examine in the main study.

The methodology that was used in the main study is described in Chapter 4. Included in this section is a discussion of the formal propositions that were constructed in order to focus attention on specific aspects of parenthood as a problematic. The sampling design and some of the difficulties that were encountered in obtaining a sample are examined. Other methodological issues specifically pertaining to this research are also discussed. For example, the advantages and disadvantages of using the couple as the unit of analysis are examined. Also, the researcher has had personal experience with both infertility and adoption and the implications of being an "insider" in this sense are explored in some detail.

Chapters 5, 6, 7 and 8 represent an analysis of the data that were collected from the main study. It is in these chapters that the theory, methodology and data come together to illustrate the process of transformation of identity from biological parenthood to adoptive parenthood.



Chapter 5 provides a general orientation to the analysis of the transition to adoptive parenthood. Included here is a discussion of the demographic and fertility-related characteristics of the people who go through this transition. In addition, there is a discussion of the three groups that are used in the analysis of the transition to adoptive parenthood.

Chapter 6 examines the manner in which the taken-for-granted identity of biological parenthood comes to be defined as problematic both within the marital dyad and with the significant others with whom they interact. The issues of loss of control and relinquishment of identification with biological parenthood are also discussed.

Chapter 7 focusses on adoption readiness and the rudimentary features of making the transition to adoptive parenthood. Of particular interest in this chapter are the critical incidents that initiate the transformation of identity, the subjective and objective indicators that one is ready to assume the identity of adoptive parenthood, and finally, the obstacles that block identification with adoptive parenthood.

In Chapter 8, there is an examination of the resocialization process that is involved in becoming an adoptive parent. Both informal and formal agents in this resocialization process are examined. On the informal level, spouses, significant others and media all influence the way

that the adoptive parenthood identity is constructed. On the formal plane, adoption agency personnel play a key role in reshaping the parenthood identity. When pieced together, these four chapters provide some insight into the overall process involved in becoming an adoptive parent.

This study was undertaken to strengthen our understanding of this transition in two different domains. First and foremost, this research set out to examine the transition to adoptive parenthood as a social-psychological issue. In this respect, the goal has been to analyze the process within the conceptual framework of identity transformation and to identify some of the social-psychological attributes of adoption readiness. Second, and no less important, it is hoped that this research will provide valuable practical information about infertility resolution and adoption readiness. Information about these issues can benefit not only those couples who encounter these unexpected life contingencies, but also the medical and social work professionals with whom they are in contact.

On a much broader level, it is hoped that this study will bring into sharper relief the issues of the meaning of parenthood, the meaning of "family-hood" and the value of children. Since parenthood is so often taken for granted by those people who can readily have children, it's meaning and importance in our culture tends to be more sharply brought

into focus by talking to people who have difficulty becoming parents.

Furthermore, in recent years, greater attention has been focussed on the meaning of parenthood in light of advances in reproductive technology. Because these procedures often involve a biological contributor who will not end up parenting the child, the question arises as to the relative importance of biological parenthood versus social parenthood. This most often occurs in procedures like artificial insemination by donor and to a lesser extent, surrogate motherhood and the insemination of a donor ovum. By examining in this study those people who choose to adopt, the social significance of biological parenthood and social parenthood may be better understood. By looking at the importance that is attributed to each of these aspects of parenthood, it is hoped that this work will make a contribution to the "sorting out process" that is typically involved when parenthood is problematic in a variety of contexts.

## CHAPTER 1

### A REVIEW OF THE LITERATURE

## Chapter 1

### REVIEW OF THE LITERATURE

The literature that deals with the link between infertility resolution and adoption can be examined according to the following categories: a) prevalence of infertility; b) prevalence of infertiles seeking to adopt; c) infertility and adoption as separate processes; d) the importance of infertility resolution in the adoption process; and e) adoptive parenthood identity.

#### Prevalence of Infertility

There is tremendous variation in the reported incidence of infertility. This variation can primarily be attributed to two factors. First, there is some conceptual ambiguity with regard to the meaning of infertility, and second, there is tendency in the demographic study of childlessness to overlook the distinction between voluntary and involuntary childlessness.

As Sherris and Fox (1983:L-116) have pointed out, the conceptual ambiguity of infertility arises as a result of the different meanings accorded to it in medical,

demographic and popular circles. From these perspectives, other related terms are often used interchangeably. These include infecundity, subfecundity, sterility, primary and secondary infertility and childlessness (McFalls, 1979b:4). Differences in the estimates of the incidence of infertility therefore reflect differences in the definitions used.

Failure to distinguish between voluntary and involuntary childlessness has been a perennial problem in demographic circles. This problem was first identified almost 50 years ago by Kiser (1937:50) who stated:

Despite the age old character of the problem, we know little about the incidence of actual sterility today. There are some data regarding proportions childless among marriages of completed fertility, but such figures leave unanswered the question concerning the extent to which it represents physical inability to bear a child.

More recently, Poston (1976:198) lamented the same problem, pointing out that data concerning childlessness in the demographic literature continue to obscure the prevalence of infertility in the population by failing to distinguish between voluntary and involuntary childlessness (see for e.g., Grindstaff, Balakrishnan & Ebanks, 1981; Hastings & Robinson, 1974; Kunz, Binkerhoff & Huntley, 1973; Ritchey and Stokes, 1974). Furthermore, this failure overlooks some preliminary evidence (Veevers, 1980; Wolowyna, 1977) which suggests that there are socio-demographic differences between voluntary and involuntary

childless couples.

In spite of these difficulties, there appears to be some consensus that the incidence of infertility in North America is between 10 and 15% of the married population (Kraft, Polombo, Mitchell, Dean, Meyers and Schmidt, 1980:620). Using the most commonly accepted, medically based definition of infertility which is "failing to conceive after one year or more of marriage during which contraceptives were not used," Mosher (1982:22) calculates from census data that 10% of all U.S. couples are infertile. Comparable statistics are indicated for Canada, with 1 in 10 marriages or 10% being considered involuntarily childless (Hepworth, 1980:169) Likewise, Cooke, Sulaiman, Lenton and Parsons (1981:532) report that, on the basis of life table analysis, after 12 months of unprotected intercourse, 90% of couples will achieve pregnancy. Waller, Rao and Li (1973:138) suggest that 11% of the population are "sterile," meaning that they have no offspring because of infertility. Others put the figure considerably higher, suggesting that 15% of the childbearing population are infertile (Bernstein & Mattox, 1982:309; Menning 1975, 1977, 1980; Griffin 1983:597). Burgwyn (1981:93) and Mazor (1979:101) go even higher suggesting that one out of every six couples (approximately 17%) are infertile.

Other studies give rates of involuntary childlessness that are radically different. Rao (1974:156),

for example, estimates that only 4% of his sample of 555 women were childless involuntarily. This figure is suspect given that only women in the age categories of 30-49 were included. The researcher himself puts little confidence in the figure indicating that it is only a "reasonable" and "tentative" estimate of the actual incidence of involuntary childlessness. A report by the World Health Organization (1976:15) indicates that the frequency of infertility varies widely as a result of cultural, medical and environmental factors such that:

It seems that up to 5% of all couples are infertile for complex reasons that are difficult to diagnose and for which present day treatment is therefore largely ineffective. Superimposed on this, "hard core" additional factors may raise the prevalence of infertility to 30% or even higher in some communities. (cited in McFalls, 1979a:230)

There is evidence to suggest that the incidence of infertility may be on the increase. Aral and Cates (1983:2327), for example, point to increases in the demand for medical infertility services as an indication of an escalating problem. Menning (1977) suggests that increases in abortions, venereal diseases and pelvic inflammatory disease, along with delayed childbearing, may account for this increase.



### The Prevalence of Infertiles Seeking Adoption

Adoption is only one alternative among many for resolving involuntary childlessness. Other options include remaining childfree with an emphasis placed on careers and even pets (Van Keep & Schmidt-Elmendorff, 1974:46-7), artificial insemination, surrogate parenthood and in vitro fertilization (Zimmerman, 1982). Therefore, it is important to get some perspective on the proportion of infertile couples who actually seek to adopt.

Based on an analysis of American national survey data from 1976, Bachrach (1983:862) calculates that, among noncontraceptively sterile women with no live births, the rate of those adopting ranges from 17.5% for those women 15 to 29 years to 45.8% among those 30 to 44 years. The fact that older women are more likely to be adoptive mothers than younger women is explained by the amount of time that is necessary in which to institute and carry out the lengthy procedures necessary for infertility investigation and adoption. Consistent with these results, Humphrey and MacKenzie (1967:95) calculated that 30% of couples attending an infertility clinic had adopted (where the woman was aged 20-39 years). A more recent estimate, also consistent with these results, is that one in four infertile couples in the United States seek to adopt (Burgwyn, 1981:105).

Although these data give some perspective on the

proportion of infertile couples seeking adoption, they are suspect insofar as they do not account for two recent trends which brings their reliability into question. First, the alternate medical options such as in vitro fertilization and artificial insemination are becoming more commonplace and acceptable (Zimmerman, 1982). Given the greater accessibility of these alternatives, one can speculate that fewer infertile couples would pursue adoption. Second, there have been dramatic changes in the number of children available for adoption. In Canada, there is an excess of adoptive applicants over the supply of adoptable babies. This is reflected in a decline of adoptions in Canada from a high in 1970-1 of 20,500 adoptions to 14,600 in 1975-6 (Hepworth, 1980:132). Similar trends have been observed in the U.S. (Bonham, 1977:296).

In Ontario, adoptions decreased from 7,245 in 1971 to 5,105 in 1976. More recent statistics show an even more dramatic decline with 1264 children being placed in 1982 dropping to 1193 in 1983 and 923 in 1984 (Ministry of Community and Social Services, Ontario, 1984). Of these placements, approximately only one half were infant adoptions (e.g., 656 in 1983 and 484 in 1984).

In light of these trends, it is not surprising that adoption agencies are officially discouraging many would-be applicants from applying (Hepworth, 1980:137). Furthermore, as the demand for adoptable babies exceeds the supply, the

criteria by which couples become eligible to adopt tend to become more stringent (Hepworth, 1980:169). One of these criteria is that couples demonstrate that they are infertile. For example, in Alberta, Newfoundland and many agencies in Ontario, demonstrated infertility or a completed medical infertility work-up are required for approval of adoption applications (Hepworth, 1980:232-238). In Saskatchewan, adoption policy is tied to supply and demand for when the waiting period for infants exceeds three years then only infertile couples remain eligible for adoption (Hepworth, 1980:174). Given these divergent requirements, it is difficult to obtain accurate statistics on the proportion of couples who apply for adoption that are infertile. However, in the face of more stringent requirements because of the acute shortage of adoptable children, it would seem that most couples who are on adoption waiting lists are infertile.

In spite of the lack of good empirical data on the proportion of infertile couples seeking adoption, two conclusions can be drawn. First, there is a decrease in the proportion of couples who choose adoption as the way to alleviate their involuntary childlessness because there are now more accessible "alternatives in human reproduction" (Zimmerman, 1982). Second, it would appear that most, if not all couples on adoption waiting lists are infertile due to

the shortage of adoptable babies.

### Infertility and Adoption as Separate Processes

A subtle but important distinction must be made between the resolution of infertility per se and the resolution of the childless state through adoption. Although these are two processes that can be conceptually distinguished, they are two processes that are considerably less separable when experienced in reality.

Conceptually, the resolution of infertility involves the working through of the feelings of loss, frustration, anger and grief that occur with the emergent realization of reproductive incapacity. Various stage models, which will be discussed later, have been proposed to describe this process of coming to some emotional reconciliation of infertility. By contrast, the resolution of involuntary childlessness, as the resultant status of infertility, can be achieved through several means (e.g., AID, IVF, childfree lifestyle), of which adoption is one alternative. Adoption, then, becomes the process by which the couple resolves their childless state and not necessarily their emotional feelings about infertility. Hence, on a conceptual level, coming to terms with infertility and the decision to adopt can be seen as two separate and distinct processes.

Parenthood is the common denominator that brings the

two processes together, with the loss of biological parenthood due to infertility affecting and being affected by the effort to come to some acceptance of adoptive parenthood. There is little, if any, empirical work that contributes to an understanding of how these processes are experienced together, and so it is to this task that this research directs itself. By way of establishing the groundwork for this task, a review of what is known about infertility and adoption as separate processes is relevant.

### The Process of Infertility

Infertility can be seen as a "life crisis" (Bresnick, 1981; Bresnick and Taymor, 1979:156; Goodman and Rothman, 1984:81; Pfeffer and Woollett, 1983:2) or a "stressful life event" (Zaslove, 1978:2) that evokes a series of social-psychological responses. As a life crisis, infertility takes it's toll on the relationship, on individual self-esteem, the ability of individuals to function, to communicate and to feel normal (Mai, Munday & Rump, 1972). It results in:

injury to self-esteem, self-image ... and deviates from social expectation and as such may have deleterious consequences for mental health because of the pressures of social disapproval. (Rosenfield and Mitchell, 1979:178)

For some couples, the crisis of infertility precipitates a

reorganization of self in order to cope with the lost ideal of biological parenthood and the corresponding desire for immortality (Kraft et al, 1980:623). Although infertility tends to have a detrimental impact on self-esteem, there is some indication that it has the opposite effect on the marriage relationship. Bierkens (1975:179), for example, reports that in 72% of cases, infertility had a strengthening effect on the marriage relationship.

Various stage-based models of infertility resolution are proposed in the literature. Menning (1977) and Shapiro (1982) have applied Kubler-Ross' stages of dying to the process of resolving infertility and delineated the stages of surprise, denial, isolation, anger, guilt, depression, grief and finally resolution. Renne (1977) identifies the four stages of the process as shock, protest, despair and resolution. Mazor (1979) describes the process as involving denial and disbelief, helplessness and loss of control over life plans, feelings of being "damaged and defective" which give rise to anger and fear, a period of mourning and finally, an acceptance based on a reassessment of "how to best realize their own creative, generative and nurturant potentials in the absence of biologic children" (p.108). Hertz (1982:98) suggests that couples go through a period of astonishment, fear and anxiety, a sense of losing control over one's life plans, concern about bodily integrity, worries about sexuality, guilt and punishment and finally

anger.

Although there is some agreement that there are definite, identifiable periods or stages that infertile couples experience in resolving their infertility, there is certainly less clarity regarding the order of progression of these stages. The above models suggest a neat and linear progression from the shock of the initial awareness to some form of resolution. But as Kraft et al (1980:622) point out, a "complete" or "final" resolution of infertility is not absolute, for the issue continues to reverberate and can be revived even though it may essentially be worked through. Likewise, Menning (1977) suggests that it is a process that may not have a distinct end point. Zaslove (1978:2) suggests that some couples may experience "chronic depression, frustration, guilt, anger, feelings of isolation, alienation and inadequacy." Rosenfeld and Mitchell (1979) also point out that alienation and isolation may be prevailing symptoms of infertility.

This non-resolution of the infertility crisis may be the result of a number of factors: the loss associated with infertility may be ambiguous and unrecognizable which makes it difficult to grieve; the loss may be "socially unspeakable;" and a social support system may be absent due to the "uncertain" nature of the loss (Menning, 1980:317). In addition, as Bierkens (1975:179) points out, "acceptance

of childlessness is sometimes impaired by the persistent hope for a miracle."

As a process, the resolution of infertility occurs over time. As a result, attempts to understand how people socially and psychologically respond to the biological reality of their infertility depends to a very large extent on the amount of time that they have been aware of their fertility problem. The importance of time as a factor in the resolution of infertility becomes apparent upon examination of studies which have undertaken to understand reactions to infertility regardless of how long the couples had been aware of their fertility problem. For example, Kirk (1964) and Andrews (1970) characterized infertile couples as reacting to infertility with feelings of depression and disappointment. Subjects in these studies had known about their infertility for between 2 and 10 years and had already adopted a child at the time of the study. By contrast, Wiehe (1976b) studied infertile couples who had known about their infertility for only 2 to 6 months, and these subjects' reactions to infertility were neutral with a slight leaning in a positive direction. This discrepancy in reactions can be explained as a function of time, with those subjects in Wiehe's study exhibiting denial of the infertility at such an early stage and those in Kirk's and Andrews' studies reflecting the feelings of depression and loss that emerge over time as infertility becomes more established as a



reality in their lives.

These discrepancies in the response to infertility as a function of time point to the need to move away from static and monolithic measures of social-psychological reaction to infertility to a more fluid and multidimensional assessment of that response. This may be achieved by using multi-stage sampling techniques and qualitative methodologies that are designed to capture the process.

#### The Process of Adoption

For infertile couples, adoption is a social process that acts as a means of family formation (Bachrach, 1983). In this sense, adoption does not refer to the simple "act" of placing a child with a family, but it too is a process that occurs over time. It would appear that there are two different dimensions to this process which Kent and Richie (1974:519) have referred to as "legal adoption" and "emotional adoption." Legal adoption brings into play the influence and decisions of a variety of community institutions. These institutional influences are embodied in the work of lawyers, judges, physicians, clergy and social workers who, in varying degrees of directness, affect the adoption process (Katz, 1964). Emotional adoption, by contrast, concerns the couples' subjective experience of

adoption which begins with the psychological preparation for adoptive parenthood and continues into adoptive parenthood as couples continue to seek to "resolve their loss [of a biological child] and make their wholehearted commitment to the [adopted] child" (Kent and Richie, 1974:520).

As the distinction between legal and emotional adoption would suggest, there are both formal and informal aspects to the adoption process. Although there is a considerable body of literature that deals with the formal and legal aspects of the adoption process, there is considerably less material that deals with the informal aspects of this process. This includes a set of preparatory experiences whereby the couple comes to an emotional readiness to engage the more formal aspects of adoption. For example, couples come to an emotional readiness for adoption by fantasizing themselves in the role of adoptive parents, discussing such concerns with each other as "will I love an adopted child?", talking to friends and family about the possibility of adoption, preparing a baby's room and by observing the experiences of those who have adopted. These aspects, which no doubt play a crucial role in the process of coming to identify with adoptive parenthood, have not been adequately researched.

For most couples, it would seem there is some emotional preparation before setting into motion the legal

adoption process. However, as Kent and Richie (1974:519) point out, there is not always a sequential connection between the emotional commitment to adoption and the legal adoption. Likewise, Renne (1977) points out that, contrary to the popular belief that most couples approach the adoption agency when they have come to some resolution of their feelings about infertility, most in fact are seeking adoption at a time when their feelings of protest and despair over infertility are still unresolved.

There is little empirical evidence regarding the process through which couples pass until they reach a stage of readiness to accept adoption. However, Humphrey (1969:50) suggests that length of marriage may be one of the best predictors indicating readiness for adoption. Taking into account that there is usually an initial period of contraception, a delay in seeking fertility advice, and then a period of infertility of investigations, most adoptions occur in the seventh, eighth and ninth years of marriage. Similar findings are reported by Maas (1960) who suggests that ten years is the average length of marriage for first adoptions.

From a different perspective, Bradley (1967) emphasizes the importance of medical diagnosis in the decision to enter into the adoption process. She investigated the time that had elapsed between the

confirmation of their inability to have a child naturally and their initial contact with an adoption agency. The median amount of time that elapsed was 16 months which led the researcher to conclude that

some time is necessary, a moratorium of a sort, for couples to begin to come to terms with their infertility and to accept the idea of adopting a child, or at least to reach the point where they can directly act on that idea. (Bradley, 1967:93)

Although this situation may still hold true for some couples, it's validity is somewhat questionable due to the critical shortage of adoptable babies. In light of the prospect of waiting for several years to adopt a baby, couples are less likely to afford themselves the luxury of waiting until they come to terms with their infertility. Instead, they may be more likely to make an intellectual decision to put in their name for adoption "just in case" they don't get pregnant during the infertility treatment.

Adoption as a formal legal process includes contacting the agency, filling out applications, being on a waiting list, going through the home study, the placement of the child, and the legal finalization of the adoption. The home study is no doubt the central feature in this formal process, for it is the primary instrument by which couples are assessed for their readiness to adopt (Davis and Bouck, 1955). In Ontario, the home study is defined as:

a reciprocal process of evaluation and education, whereby the applicants and their social worker exchange information and work together to assess the suitability of the applicants for adoptive parenthood. (Ministry of Community and Social Services, 1979:6)

Although the home study is defined as a "reciprocal process," it does overlook the power of the agency to give or withhold a child (Rothenberg, Goldey and Sands, 1971:591). This makes the home study the source of considerable stress for adoptive couples (Robinson, 1973). For many infertiles, the home study invokes resentment, fear or rage because they feel that they must "prove" their parental fitness where other couples do not:

For couples who have gone through the hope and disappointment of fertility testing, further probing by an adoption worker may be like rubbing salt in the wound, yet they are usually loath to complain for fear of losing their last chance at parenthood. (Joe, 1979:20)

Although infertile couples have tended to focus on the evaluative aspects of the home study, Wiehe (1976a:126) argues that there has been a shift in adoption practice from evaluating to preparing couples for adoptive parenthood. By empirically demonstrating that there is change in adoption attitudes as a function of the adoptive study, Wiehe supports the contention that the home study does in fact act as a socialization experience whereby couples are prepared for adoptive parenthood. Interestingly, however, the home study did not affect attitudes toward infertility. In fact, subjects tended at the beginning of the adoptive study to

view their infertility more positively than at the end (Wiehe, 1976a:132). This finding may in fact support Renne's claim that "adoption is not the most appropriate sequel to a diagnosis of infertility. A period of grieving is" (1977:465).

Like the infertility process, the adoption process is characterized by a loss of control over one's life plans. Where this control is given over to the physician in the infertility work-up, it is given over to the child welfare agency once the adoption process has begun. In commenting on this transference of control, McCormick (1980:206) suggests that

the couple must adapt to this shift, changing their focus from the physical regimen of timing, medications and tests to the psychosocial burden of investigation and home study.

There is little doubt that couples who experience infertility and adoption give up some control over their life plans. However, contrary to McCormick's suggestion above that there is a sequential transfer of control from the physician to the social worker, it is no doubt frequently the case that couples experience the loss of control in these areas of their lives concurrently. In other words, couples may go through infertility resolution and adoption at the same time, and in so doing, experience this loss of control concurrently in two realms of their lives. This may in fact be a recent development due to the

long waiting period that couples must now go through in order to adopt.

In light of this, a particular interest to this research is not how infertility and adoption are experienced as separate and distinct, but how they are experienced as two processes that interpenetrate one another. In this regard, infertility and adoption can be seen as having a reciprocal relationship that is characterized by a tension between coming to terms with infertility and coming to a state of readiness for adoption. The resolution of infertility as a factor in determining readiness for adoption has received some attention in the literature. It is to this issue that I now turn.

#### The Importance of Infertility Resolution in the Adoption Process

There are two kinds of literature that examine the linkages between the process of infertility resolution and the process of adoption. By far the bulk of this literature is rooted in a professional, practice-based framework that conjectures to link nonresolution of infertility with adoption failure. This body of literature consists primarily of professional adoption workers' anecdotes, reflections and speculations on the one hand and non-randomly selected case analyses on the other hand. On a considerably smaller scale,

there is a body of literature that has sought to empirically demonstrate a link between the resolution of infertility and adoption success or failure. This body of literature is characterized by a number of empirical control problems that bring the validity of the results into question.

The purpose of this section is to review these two bodies of literature. Although much of this literature has limited empirical validity, it does have relevance for the central thesis of this proposal which is to examine the shifts in identity from biological to adoptive parenthood. However, given the questionable validity of this material, it's greatest value may be seen as the highlighting of empirical weaknesses that can be avoided in the present research. In addition, it points to a gap in our understanding of the reciprocal relationship between infertility resolution and readiness for adoption. Therefore, I will first discuss these two bodies of literature and then discuss their implications for the present research.

In the social work practice literature, the resolution of infertility has been emphasized as an important factor for successful adoption outcomes. This emphasis no doubt stems from a set of criteria outlined by the Child Welfare League of America (1978:60-61) which are used to evaluate a potential adoptive couple's readiness for adoption. Among other criteria such as the strength of the



marital relationship and emotional maturity, feelings about infertility is used as a basis for evaluation. Although infertility resolution is identified as only one factor among six in the adoption evaluation process, it can be seen as being the basis for a discussion that touches on many other aspects of the couple's reality. For example, it is suggested that feelings about childlessness can be the take-off point for workers to explore a couple's feelings about unmarried parents, children born out of wedlock, about inherited traits, and motivations and attitudes about adoption (Child Welfare League of America, 1978:61,70; Zober, 1967:400). Although there is no parallel set of national standards in Canada that are used in adoption placements, it would appear that these guidelines are widely used (Brieland, 1984:79).

Stemming from these guidelines, there is an abundance of conjecture in the professional, practice-oriented literature that the resolution of infertility is the most crucial factor in the evaluation of an applicant's suitability or readiness for adoption. For example, Castle (1982:10) suggests that "the ideal [adoptive] couples are those who are able to talk in some depth about the pain of finding that they are infertile but who seem now to have resolved this." Menning (1975:458) points out that nonresolution of infertility feelings may be a leading cause

questioned about the link between infertility resolution and adoption, they admitted that:

they had no evidence ... that failure to work through feelings about infertility had any negative effects on subsequent placements. (Joe, 1979:21)

Furthermore, research on adoption outcomes is problematic because of difficulties in establishing criteria for defining adoption success or failure, lack of control groups, middle-class bias, and a tendency towards the use of purely descriptive rather than quantitative data (Joe, 1979:63-76).

Nevertheless, there has been some effort in retrospective studies to link infertility with adoption failure. However, the results of these studies are largely inconclusive. For example, Zwimpfer (1983:171) was unable to link the infertility attitudes and feelings of adoptive applicants with adoption failure because of the difficulty in measuring these in an "objective" manner. Consequently, only demographic correlates of success or failure are examined. Similarly, Kadushin and Seidl (1970:37) acknowledge the potential importance of feelings towards infertility as a factor in adoption failure, but did not test for it because of a lack of relevant details in files regarding these feelings and the subsequent low reliability coefficient on this item. In an exploration of caseworkers' perceptions of adoptive applicants, Bradley (1966:441)

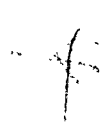
identified "acceptance of infertility" and "non-neurotic motivation for adoption" as key evaluative factors used in the psychosocial appraisal of couples' positive potential for adoptive parenthood. "Psychosocial appraisal" was a cluster variable that incorporated several factors and, as a result, it is not clear how significant the acceptance of infertility is in the assessment of their prospect for adoptive parenthood. Another study indicates that there is a relationship between the ability to talk about infertility and post-adoption functioning, but this relationship was established on the basis of caseworkers' subjective perceptions of what "post-adoption functioning" is or should be (Lawder, Lower, Andrews, Sherman & Hill, 1969:104, 117). As Joe (1979:71-2) has clearly demonstrated, these perceptions of "favourable post-adoption functioning," "good parenting" or "parental success" usually reflect the middle class value bias of professional social workers. In a review of literature focussing on adoption outcomes, Kellmer Pringle (1967:23) concludes that the attitudes of adoptive parents towards adoption, illegitimacy and infertility are far more important than factors like age, income and social class for predicting successful adoption outcome, but it is unclear how important infertility is in the total scheme of things.

Although the vast majority of the adoption literature emphasizes the importance of infertility

resolution for successful adoption, there are exceptions. For example, Starr, Taylor and Taft (1970:497) report no relationship between the nature of the infertility problem for the adoptive couples and their performance as adoptive parents. In light of the bulk of evidence to the contrary, the researchers suggest that

there is a need for future research to assess the relationship between the degree of resolution of feelings about infertility and performance as adoptive parents ... but until the relationship is resolved, it might be appropriate to de-emphasize its importance as part of the home study. (Starr et al, 1970:497)

As the preceding discussion would suggest, the importance of infertility resolution for "successful" adoption is open to question. This can be attributed to empirical weaknesses such as non-randomized sampling procedures, ambiguities with respect to operationalizing concepts like "infertility resolution" and "successful adoption," and biased assessments by adoption workers of these phenomena. Perhaps more important than these empirical problems is a fundamental weakness in the way that this relationship has been conceptualized. There is a tendency in all of this literature to conceptualize "infertility resolution" as having a neat and tidy end point that must be reached before adoptive parenthood can be successfully experienced. Yet, as was discussed in a preceding section, infertility is often experienced as an ongoing process that may not have a specific end point. Thus, this literature



tends to ignore the fact that infertility resolution may, and in fact is likely to, continue on well into the adoption process.

Similarly, adoption is not a process that begins with the formal agency process. Rather, from a social-psychological perspective, there is a set of preparatory experiences that a couple goes through in order to come to a stage of readiness to even begin the formal process. In this sense, the identity of adoptive parenthood may often be rehearsed long before a couple goes through the official steps of adoption. Therefore, not only does infertility resolution carry over into the formal adoption process, but the initial preparatory experiences of the adoption process reach back into the period when the experience of infertility is most salient.

The conceptual shortcomings of previous work in this area form the point of departure for the proposed research. Instead of focussing on two static empirical concepts like "infertility resolution" and "adoption success", this research proposes to examine the relationship between two processes. Specifically, the focus is on the resolution of infertility as an ongoing process and adoption as a process, which, when experienced concurrently, result in a shift in the meaning of parenthood. This shift in the meaning of parenthood reflects a change in identity whereby

the identification with biological parenthood gives way to an identification with adoptive parenthood. By approaching the topic in this manner, the emphasis shifts from looking at infertility resolution as a "cause" of adoption success or failure, and rather, emphasizes the reciprocal relationship between the two processes.

### Identity

Identity, as it relates to biological and adoptive parenthood, is the focus of the proposed research. Yet, there is little, if any, information in the literature on this issue. While identity does receive attention in the adoption literature, the focus is on post-placement conflicts in identity among adoptive parents, adoptees and birth mothers (Sorosky, Baran & Pannor, 1975). In that research, there is little attention paid to questions of identity among adoptive parents and considerably more paid to adoptees and biological parents. This may well reflect a bias in the literature that is rooted in the tendency to see adoptive parents as the chief benefactors of the adoption process whose lives have been "enriched" by the experience (Dukette, 1984:241), whereas adoptees and biological parents face the more precarious task of working through problems of identity that stem from feelings of loss and ambivalence over the severing of their biological tie (Dukette,

1984:243). As a result of this emphasis on adoptees and biological parents, the adoption literature has not sufficiently recognized the identity dynamics that beset the adoptive parents (Rothenberg et al, 1971:592).

Kirk's work on adoptive relationships comes closest to dealing with the problems of identity for adoptive parents (Kirk, 1984). Although Kirk does not deal specifically with issues of identity, he does examine the implications of taking on the "role" of adoptive parenthood, and the extent to which couples accept or reject the "difference" of adoptive parenthood from biological parenthood. Although this approach to adoptive parenthood has been widely recognized, it does emphasize the experiences and dilemmas of adoptive parenthood after adoption placement, as opposed to the preliminary shifts in identity leading up to adoptive parenthood.

There remains a considerable gap in our knowledge of how infertile couples shift their identification from biological parenthood to adoptive parenthood. It is precisely this gap that this research proposes to fill.

## SUMMARY

In spite of a dwindling supply of adoptable babies and new technological reproductive alternatives, there are

still a significant number of infertile couples who seek to adopt. Although infertility and adoption can be conceptualized as two separate and distinct processes, when experienced, they have a reciprocal relationship.

There is a considerable body of literature that emphasizes the importance of infertility resolution for "successful adoption." However, this literature is of questionable validity because of empirical weaknesses. Furthermore, this literature tends to view infertility resolution and adoption readiness as sequential processes, which overlooks the more likely possibility that these processes are experienced concurrently and reciprocally.

Identity, as it pertains to adoptive parenthood, has received little research attention. This gap is especially acute with respect to the preparation for the adoptive parent identity before the adoption occurs. Thus, in response to this deficiency, this research proposes to look at how the experiences of infertility resolution and adoption preparation are at the base of a shift in identity from biological parenthood to adoptive parenthood.



## CHAPTER 2

SOCIAL PSYCHOLOGICAL PERSPECTIVES ON PARENTHOOD  
AS A PROBLEMATIC: A THEORETICAL FRAMEWORK

## Chapter 2

### THEORETICAL FRAMEWORK

This research takes it's theoretical direction from phenomenology and symbolic interactionism. Phenomenology is concerned with the subjective experience of everyday reality with reference to a "certain structure of consciousness" (Schutz, 1971:117). Symbolic interactionism shares with phenomenology the same concern with subjective understandings of the world. Blumer (1969:35), for example, emphasizes the importance of the "meanings" that people attach to their actions and interactions. Berger and Luckmann (1966) link together phenomenology and symbolic interactionism in their theoretical discussion of the social construction of reality. Society exists as both objective and subjective reality, with an emphasis on the process whereby the individual attaches meaning to and internalizes a shared, and therefore "objective" form of reality.

The subjective understanding of the social world, which holds a central place in both of these theoretical orientations, is of primary importance to the present research. Specifically, this research will be concerned with

the way that couples subjectively perceive parenthood in the face of infertility. How do couples apprehend, interpret, or otherwise make subjectively meaningful the events associated with the processes of infertility and adoption? What are the implications of these events for the meaning of parenthood? It is expected that these perceptions of parenthood change over time as couples gradually relinquish hopes of having their own biological children and begin to consider themselves in the role of adoptive parents.

The "objective" reality of parenthood, represented by a set of normative expectations, is also important to the present research insofar as it influences a couple's subjective view of parenthood. As an objective reality, parenthood is shaped by pronatalist prescriptions that exert a pressure on married couples not only to have children but to be "on-time" with having children. Through socialization, this objective reality is "internalized" by couples and this lies at the basis of values and attitudes that manifest themselves in the desire to be parents in order to be "just like everyone else." However, for couples who are going through the process of infertility, these normative expectations become problematic. Unable to conform to these expectations because of infertility, couples may consider adoption as the means to bring their behaviour into line with this objective reality. It is the subjective

perceptions of infertile couples as they bring themselves into line with this normative, objective reality through adoption that is the central thesis of this research.

The alignment of a couples' subjective view of parenthood in the face of infertility and the objective reality of parenthood involves a transformation in identity. That is, when infertility blocks a couple's ability to meet the normative expectation of biological parenthood and adoption is used as the alternate means of meeting these expectations, then there is an underlying shift in the way that couples define themselves as parents. As part of this transformation, some infertile couples identify themselves less in the role of biological parents with pregnancy, birth and a genetically similar child, and more in the role of adoptive parents who must endure waiting lists, home studies and a genetically different child.

Other concepts and theoretical tenets from phenomenology and symbolic interactionism are illuminating for understanding the transformation of identity from biological parenthood to adoptive parenthood. The phenomenological concepts "taken-for-granted reality" and "problematics" are particularly relevant to this analysis. Fertility and the assumption of "automatic" biological parenthood lie at the basis of couples' taken-for-granted reality. Infertility is problematic to this taken-for-

granted reality insofar as it interrupts the expected course of action which is to have their own biological children when they want them.

The symbolic interactionist concepts of "identity," "socialization," "definition of the situation," "career," "transformation of identity" and "status passage" are particularly important for the present research. Couples are "socialized" to think about the "identity" of parent as involving a biological tie. Therefore, in the absence of a fertility problem, couples think about their own "career" as parents as involving this biological link. However, infertility precipitates a process whereby the "situation" must be redefined. This involves a redefinition of what it means to be a parent. This process is at the basis of a "transformation of identity" from biological parenthood to adoptive parenthood. Because this shift in identity has some common elements for all couples who go through it, it can be characterized as a "status passage."

The phenomenological and interactionist orientations provide a perspective for coming to an understanding of the "meanings" that people attach to parenthood. Although infertility brings into question the normative aspects of parenthood, this research does not propose to examine infertility and adoption within a "deviance" perspective. This is an attempt to move away from psycho-pathologically oriented biases that are often found in studies of

infertility and adoption (Allison, 1976). Instead, by looking at shifts in identification from biological to adoptive parenthood identity, we can hopefully come to an understanding of the process without the implicit value assumptions of these other approaches.

The purpose of this chapter is to discuss in detail how these theoretical orientations can guide an inquiry into the transformation of identity from biological parenthood to adoptive parenthood. The discussion of the relevant concepts has several dimensions: definition of the concepts as they appear in the theory; relevance of the concepts to the processes of infertility and adoption; and finally, how the concepts can direct the research to understanding a particular aspect of the empirical world.

Identity is the pivotal concept for understanding the shift in identification from biological parenthood to adoptive parenthood. However, identity can be best understood in the present context against the backdrop of subjective and objective views of parenthood with infertility as a problematic that brings the parenthood identity into question. Therefore, this analysis will first examine these other concepts before focussing on identity, transformations of identity and resocialization.

### The Subjective View

This research is fundamentally concerned with how couples subjectively perceive their predicament of infertility and the implications that it has for the meanings that they attach to parenthood. Subjectivity, or the subjective meaning inherent in conduct,

is always the meaning that the acting person ascribes to his own conduct: it consists of his motives..., his immediate or long-range plans, his definition of the situation and of other persons and his conception of his own role in the given situation...The only direct source of subjective information is the observed individual himself (Wagner, 1970:322).

In this research, infertile couples are the "direct source" of subjective information. Interviews with couples have been chosen as the means for accessing these subjective perceptions. On a general level, this research is interested in tapping into such issues as: "How do couples define the various social situations in which they find themselves?"; "How do they assess their own and their partners actions throughout the infertility process?"; "What do various events in the infertility process mean to them?"; "How do they see themselves in the role of parents?"; "How do their interactions with others affect how they define parenthood?"; "How does the meaning of adoption change throughout the process?" These questions and others are geared towards eliciting the way that couples perceive parenthood in the face of infertility.

An understanding of how infertile couples subjectively perceive themselves as parents is further illuminated by the concepts "intersubjectivity" and "typification" which form the basis of a "taken-for-granted reality" (Schutz, 1971). Individuals operate in the everyday world on the assumption that symbols are shared and understandable only when one knows what the symbols stand for in the mind of the person who uses them. In this respect, understanding and knowledge are not private, but are by nature, "intersubjective." Not only do individuals operate on the assumption that symbols and meanings are shared among themselves at a point in time, but they operate on the assumption that this intersubjectivity will carry on into future experiences. This anticipation of familiar experiences in the future on the basis of pre-aquaintanceship with the everyday world is referred to as "typification." In other words, based on typical experiences in the past, individuals expect similar experiences in the future. In this sense, intersubjectivity and typification give every day reality a "taken-for-granted" quality that is characterized by predictability. On the basis of this typicality, individuals plan projects of action whereby they take into account what is known about "typically similar actions in the past" in order to weigh the means, ends or possible outcomes of the projected action (Schutz, 1971:67).

Plans for parenthood are projected on the basis of a



taken-for-granted reality of what it "means" to be a parent. For most married couples, the taken-for-granted reality is that they will have their own biological children when they wish to have them. They make their plans to have children on the assumption that they will be no different from a family member, friend or other peer who had children when they wanted them. These are the "typical" experiences that give shape to a couple's taken-for-granted reality concerning fertility. This research proposes to examine this taken-for-granted reality as it pertains to the meaning of parenthood. Given the primary objective of this research, which is to understand the transformation of identity from biological parenthood to adoptive parenthood, an understanding of this taken-for-granted reality is necessary as a way of establishing a baseline for observing the transformation. For it is this taken-for-granted reality that forms the basis of the biological parenthood identity. Two particular interests in this regard concern the meaning of parenthood as a taken-for-granted reality for couples, and second, the way in which couples come to have this definition of parenthood as a taken-for-granted reality. It is expected that before there is any recognition of a fertility problem, couples will believe that they are fully in control of when and how they have children. This belief arises as a result of observing the experiences of people around them who have

children when and how they want them. It is on the basis of this observation that couples expect the same experience for themselves.

The concept "career" provides an appropriate context for understanding the formation of parenthood as a taken-for-granted reality. Hughes (1937:409), for example, introduced the notion of "life career" which is a dynamic perspective for looking at how an individual actively interprets, throughout the whole of his life, the meanings of his attributes, actions, values as well as the things that happen to him. Stebbins (1970:34) elaborates this perspective by drawing attention to the "subjective aspects of career." Subjective career refers to a "predisposition" to act in a certain way. Past experiences are activated by situational stimuli which thereby impinge upon present awareness which in turn guides behavior in the immediate present (Stebbins, 1970:35). Subjective career, as a predisposition, provides a framework from which to study the "personal evaluation of the more objective facets of career life and associated meanings at the situational level where behavior predicted by these approaches may be modified by environmental forces" (Stebbins, 1970:41).

Parenthood, then, can be seen as a taken-for-granted reality which, from a career perspective, predisposes the individual to act on the basis of the presumption of fertility. Of course, this view of parenthood is modified

as a result of situations where infertility becomes apparent. A career perspective provides a way for looking at how infertile couples actively interpret and redefine their meanings of parenthood in light of their situation of infertility and the prevailing "objective" reality of parenthood.

Insofar as parenthood is based on an intersubjective set of shared meanings, it can be considered to have an "objective" quality to it. That is to say, parenthood takes on a habitualized and obdurate character as a result of the fact that it means the same thing to a number of people in the same culture. From this perspective, then, parenthood is an objective reality that embodies a set of social and normative expectations. This is important for understanding how couples subjectively perceive parenthood throughout their life careers, for individuals internalize these expectations of parenthood through the process of socialization. The nature of parenthood as an objective reality is the focus of the next section.

### The Objective View

Parenthood has an objective social meaning that is rooted in a set of norms and prescriptions that dictate whether, how and when people become parents. Therefore,

these norms and prescriptions influence how couples define or attach meaning to parenthood. For couples who are facing infertility, these norms play a significant part in the way that they subjectively perceive themselves in the role of parents.

Most central among these norms is the pronatalist expectation that married couples should have children (Blake, 1974). Veevers (1980) elaborates on this pervasive cultural press towards parenthood when she says that "parenthood is almost universally lauded as an intrinsically desirable social role." It is seen as a "moral obligation" (Laurence, 1982) that has its roots in both religious beliefs and cultural norms (Pohlman, 1970:7-8). Davis (1978) suggests that not only are there coercive norms to have children, but couples are expected to acquire children and cope without assistance from the state or other institutions and individuals.

This expectation for parenthood is so strong that there is hesitancy to define a childless couple as a family. For example, several centuries ago, John Donne preached that for "a couple to contract before that they will have no children makes it no marriage, but an adultery" (cited in Bernard, 1982:55). Although perhaps severely stated by today's standards, the same principle still seems to be held by many. Ball (1972), for example, points out that the taken-for-granted definition of the normal family is a

married couple with their children residing together, and all other forms of family, including childless ones, constitute a social problem.

Not only are couples expected to have children, but they are expected to have children "on-time." Neugarten, Moore and Lowe, (1968:22-3) highlight the prevalence of norms governing age appropriate behavior:

Expectations regarding age appropriate behavior form an elaborated and pervasive system of norms governing behavior and interaction, a network of expectations that is imbedded throughout the cultural fabric of adult life. There exists what might be called a prescriptive timetable for the ordering of major life events: a time in the life span when men and women are expected to marry, a time to raise children, a time to retire. This normative pattern is adhered to, more or less consistently, by most persons in the society. Men and women are aware not only of these social clocks that operate in various areas of their lives, but they are aware also of their own timing and readily describe themselves as "early," "late," or "on time" with regard to family and occupational events.

The normative prescription for the proper time for childbearing is currently reflected in the admonition to young couples to have children "before its too late" (Rindfuss and Bumpass, 1976:227). The normative expectation for parenthood tends to be related more to length of marriage than it is to the wife's age. Usually two years after marriage, people begin to expect that the couple will have children (Veevers, 1980). Infertility can be seen as a disturbance in this normative schedule of life events by the fact that the transition becomes ill-timed and off schedule

according to these prevailing norms.

These strong pronatalist pressures influence the meaning of parenthood in the minds of couples. In the same way that the actions of their significant others shape their expectations for parenthood, so too these normative expectations shape their taken-for-granted or typified view of what it means to parent. Pronatalist pressures and age expectations make parenthood a desirable and necessary identity for couples at a specified point in their marital career. As Stebbins (1970:36) points out, one's subjective awareness of passage through stages in life career is brought into sharper relief when one falls behind one's reference group. When the transition to parenthood is delayed on account of a fertility problem, there is a heightened awareness by couples of their subjective movement through this career line. This emerging sense of being "late" in comparison to their reference group stimulates greater subjective career awareness.

On the most fundamental level, one can project that because of these pressures, parenthood comes to be highly valued in the minds of married couples. Accordingly, failure of infertile couples to become parents has many negative consequences. One such consequence of not having children is to risk missing out on adult status. Erikson (1968) viewed generativity as one of the primary maturation tasks that individuals face in adulthood. Given that having and

rearing children is one of the primary means of accomplishing this task, then infertility threatens the "full" achievement of maturity (Goodman and Rothman, 1984:82). Likewise, Hill and Aldous (1969:923-5) point out that "parenthood rather than marriage appears to be the crucial role-transition point that marks the entrance into adult status in our society." As Blake (1974:279) explains, the pronatalist pressure is so strong that parenthood is an explicit part of the definition of masculinity and femininity and is therefore seen a necessary condition for adequately carrying out adult sex roles.

This research proposes to look at the prevalence of these normative expectations throughout the process of infertility. Normative expectations for parenthood influence couples' decisions to try and have children in the first place. When infertility reduces the possibility of achieving parenthood biologically, these normative expectations again prevail and couples look for alternate means of meeting them. Adoption thereby becomes the way that couples align their actions with pronatalist pressures in order to re-establish a "degree of symmetry between objective and subjective reality" (Berger and Luckmann, 1966:183).

Of particular interest in this regard are couples' perceptions of this pressure throughout the process. Specifically, to what extent do couples feel this pressure

to have children even when they have a limited chance of bearing their own? Do couples experience the pressure to adopt in the same way as they experience the pressure to have biological children? Who are the significant persons who relay this expectation for parenthood? It is expected that the pressure to be parents not only prevails throughout the processes of infertility and adoption but it intensifies as the prospects of having their own biological children diminish and they fall farther behind their reference group. Also, it would seem likely that at some point there is a shift in emphasis from the expectation that they have their own children to the expectation that they adopt. In other words, they start with pressure to have their own biological children and when this is not forthcoming, there is a renewed set of pressures that are exerted on them to adopt.

Although adoption is one alternative for bringing actions into line with normative pressures, it still has an objectively different meaning from biological parenthood. As Kirk (1981:31-34) points out, these objective differences between adoptive and biological parenthood are the result of a set of "situational discrepancies." For example, biological parenthood is characterized by a presumption of fertility, no need to demonstrate eligibility for parenthood and independence in the procurement of their child. By contrast, adoptive parenthood is characterized by no



preparation for infertility, eligibility for parenthood must be demonstrated, and there is dependency on a middle person to carry out the transaction of adoption. How individuals identify and describe these differences and the way that these differences enter into their subjective definitions of parenthood is of interest to the present research.

It would also appear that parenthood has a different "objective" reality for men and women. Most evidence would suggest that motherhood is more salient to the female identity than fatherhood is to the male identity. This is discussed by Veevers (1980:7):

Whereas masculinity can be affirmed by occupational success or sexual prowess, femininity has traditionally been closely linked with bearing and caring for children, with other roles remaining relatively peripheral.

This would suggest that women are more likely than men to feel these pronatalist expectations throughout the experience of infertility.

There is empirical support for this view of the greater importance of parenthood to women than to men. Mulford and Salisbury (1964), using the Twenty Statements Test, found that the position of mother is more important to the woman than father is to the man. In a study of involuntary childlessness, Bierkens (1975:179) found that, among both men and women, childlessness is considered easier for men to bear than for women. Consistent with this,

Brennan (1977) found that wives tend to assume more of the negative aspects of the responsibility for psychological maintenance of the infertility than the husbands.

As Hollingworth (1916:28) astutely pointed out many years ago, women have been the targets of many more social devices compelling them to have children: "belief, law, public opinion, illusion, education, art and bugaboos [i.e., threats of evil consequence] have all been used to reinforce maternal instinct." For women, more so than men, parenthood may be the "raison d'etre" or the most centrally integral part of the female gender role. As Humphrey (1977:747) points out, women will tend to view motherhood as

a source of fulfillment and childlessness as a state of emotional deprivation; men, for their part, will regard fatherhood primarily as a mark of sexual identity and only to a lesser extent as fulfilling their emotional needs.

Male-female differences in the attitude toward parenthood may result in conflicts in the marriage about pursuing children through adoption. As Berger (1977:142) has pointed out, husbands may be more reluctant but may comply with their wife's wishes to have children. Although it would appear that parenthood is a more salient identity for women than for men, this must be considered in light of the recent trend for women to enter the paid labour force. In the face of this trend, one can speculate that parenthood takes on lesser importance for women.

This research proposes to examine the differences in

the meanings that men and women attach to parenthood. As the above suggests, it is expected that women will more intensely feel the loss of biological parenthood due to infertility. Why is this so? What are the unique pressures that are brought to bear on women to have children? How important is the motherhood role in comparison with other roles that the woman carries out? Similarly, it is expected that, because women are the primary targets of pronatalist pressures, they will have the strongest desire to become a parent through adoption. Do women initiate the adoption process? What are the pressures to adopt that they experience?

Although it would appear that men and women attach different meanings to parenthood, this research is also concerned with the "shared meaning" of parenthood that a couple constructs for themselves. This is especially critical in light of their decision to initiate the formal adoption process for one would expect at least some level of agreement between spouses before they approach an agency for adoption. An effort will be made to obtain information about the dynamic interplay between husband and wife as they try to reconcile their differing meanings of parenthood in order to come to a mutually agreed upon course of action. It is important in this regard to determine where spouses may differ in their feelings about biological and adoptive

parenthood, and to investigate how they come to some agreement regarding the decision to adopt.

In light of the strong pressures coming to bear on couples to have children and the "objective" differences between biological and adoptive parenthood, infertility takes on a critical significance as the event which disrupts the taken-for-granted reality of biological parenthood. It is expected that couples who are early on in the infertility process will hold on strongly to biological parenthood as their taken-for-granted reality. This reflects a sense of optimism early in the infertility process which is indicative of couples' beliefs that their fertility problem will be solved. However, as time goes on and the "solutions" do not work, infertility becomes increasingly problematic for their taken-for-granted reality. The disruption of biological parenthood, as the "taken-for-granted reality," by the "problematic" of infertility, is the subject of the next section.

#### Infertility as a Problematic

Problematics arise when an individual's current stock of knowledge (based on typifications) is insufficient to explain a new experience (Schutz & Luckmann, 1973:8-10). The taken-for-granted flow of experience is interrupted. As Mead (1938:82) has put it, a "problematic" is the

"checking or inhibition of some more or less habitual form of conduct, way of thinking or feeling... due to an exception to an accepted rule or manner of thought or some object that calls out opposing emotions." Infertility is problematic for the taken-for-granted reality of biological parenthood. It is a new and unexpected experience that is not easily explained by past experiences. All socializing efforts, including those from family, friends and normative expectations, by focussing on biological parenthood, leave the couple unprepared for the experience of infertility. Therefore, they cannot draw on experiences in the past that help them to deal with infertility.

In the face of a problematic, "hitherto sufficient typifications appear insufficient" and as a result, "new explications" must be advanced until "the solution seems to be sufficient for the problem under consideration" (Schutz & Luckmann, 1973:14). Infertility, as a problematic, calls out for new explications. Initially, couples seek these explanations from family doctors and fertility clinics. However, as time goes on and the problem of infertility remains, then couples may turn to another solution for their problem which is to achieve parenthood through adoption.

Infertility as a problematic, does precipitate a process whereby couples must come to a new shared meaning of their reality. Of particular interest for the present

research is to examine how couples react to this problematic. Specifically, there will be a focus on how couples come to accept adoption as the way of dealing with their disturbed taken-for-granted reality. In this regard, questions will focus on how infertility affects the couples taken-for-granted reality of themselves as biological parents at different stages in the infertility process; how explications are sought from the medical profession; and most importantly, how adoptive parenthood is considered as a "new solution" to the problem of infertility.

"Motives" are used in problematic situations where the taken-for-granted reality is disrupted. In the face of this disrupted action, motives become the answers to questioned conduct. Motives are essentially social, rather than psychological phenomena. They are not fixed elements "in" an individual, but are verbalizations that emerge in situationally specific interactions. As Mills (1981:326) explains, motives are the "words" that are "imputed or avowed as answers to questions, interrupting acts or programs." "Accounts" (Scott & Lyman, 1981) are one kind of motive that are used to explain unanticipated or untoward behavior. Accounts can be in the form of either "justifications," where the actor accepts the responsibility for the action, or in the form of "excuses" where the responsibility is externalized to some other source.

In the case of infertility and adoption, motives

become the verbal means by which couples "explain" their situation. When "explaining" infertility, one would expect that the accounts given by couples would be in the form of excuses because of the inability to control or take responsibility for the biological problems that are contributing to the infertility. Conversely, one would expect explanations of adoption to be in the form of "justifications" because couples are more likely to accept responsibility for that which they have freely chosen. The proposed research will examine questions such as: How do infertile couples account for their childlessness with friends, family or work associates? Who do they tell? What are the excuses that are used? How do they account for adoption to these people? What kinds of situations arise that precipitate a need for these responses?

Infertility, as a problematic, affects how people identify themselves in the role of "parent." As a result, infertility precipitates a series of redefinitions and changes in the parenthood identity. It is to this central issue of parenthood identity that this research now turns.

### Identity

The focus of the present research is on identities related to "parenthood." Specifically, this means looking at

the identities of "biological parenthood" and "adoptive parenthood."

Identity is a key element of subjective reality (Berger & Luckmann, 1966:194). In symbolic interactionist thought, identity has both biographical and situational dimensions. From a biographical perspective, the self is a structure of identities comprised of "socially recognized categories which are firm, deep and real parts of what he feels himself to be" (Rosenberg, 1981:12). Each person has as many "role-identities" as social positions he occupies (McCall & Simmons, 1978:65). Each role identity has two dimensions: first, the "conventional" which is the structural framework of role identity which holds the cues for what is appropriate and proper; and second, the "idiosyncratic" which accounts for the individual modifications, elaborations or embellishments which arise from the situation (McCall and Simmons 1978). As the preceeding discussion suggests, the conventional demand for the parenthood identity is shaped by a set of pronatalist expectations. When infertility blocks the possibility of achieving biological parenthood, adoption introduces an idiosyncratic dimension insofar as couples must in some way align the new contingencies of the adoptive parenthood identity with the conventional demands of pronatalism. Preparation for the role identity of adoptive parenthood can therefore be examined in light of both the conventional



demands for the role and it's idiosyncratic features.

Identities can also be seen as being arranged according to a hierarchy of salience such that the "higher the identity in the hierarchy, the more likely that the identity will be invoked in a given situation" (Stryker, 1980:61). Factors that affect the salience of a given role identity include its prominence, its need for support, the persons need for intrinsic and extrinsic gratification gained through it's performance, and finally, the perceived degree of opportunity for it's profitable enactment in the presentation circumstances (McCall & Simmons, 1978:81-2).

Parenthood is one such identity that can be seen as fitting into this hierarchy of salience. For married couples who have yet to discover a fertility problem, this identity is important insofar as couples are exposed to the normative expectations that they have children at a certain age. Therefore, as they get closer to this age or time period, the parenthood identity becomes more important because the pressure to be a parent intensifies. In light of this, parenthood becomes more salient in the identity hierarchy. With the discovery of infertility, parenthood not only maintains it's importance in the hierarchy, but may in fact, intensify and become more prominent. Bierkens (1975:179) lends empirical support to this view when he reports that as time passes in the infertility process, the uncertainty

and the fear of forever remaining childless increase.

As the process of infertility progresses and minimizes the chances of achieving the identity of parenthood biologically, the salience of parenthood comes under question. It is at this point that couples make decisions about either remaining child free or trying to realize this identity by some other means. It is expected that, for those for whom parenthood continues to hold a prominent place even in the face of infertility, adoption is likely to be chosen as the way that this prominent identity can be fulfilled.

Identity, then, is not a static element in the hierarchy of salience but is changeable as a result of the influence of "situated activity" (Alexander & Wiley, 1981:273). Identities are modified and shaped through the process of situated activity or interaction. Identity is defined in the situation which "establishes what and where the person is in social terms" (Stone, 1981:188). This involves the "identification of" and "appraisal of" one's own and other's identity in the situation (Strauss, 1959:47). Identity is established in the situation when others 'place' the self as a social object by assigning the same words of identity that the self 'announces' (Stone, 1981). From this perspective, then, it is possible to look at the changes in the identity of parenthood as a result of the variety of situations that are encountered throughout

the process of infertility and the process of adoption. For example, throughout the process of becoming adoptive parents, a couple may change their "identification of" themselves from biological parents initially, to a being a childless couple, to finally being adoptive parents. Ultimately, taking on the identity of adoptive parent would also reflect an "identification with" other adoptive parents.

The concepts "commitment" and "situational adjustment" are useful in further illustrating the biographical and situational aspects of identity. Whereas commitment refers to "personal stability in the face of changing situations," in the process of situational adjustment "individuals take on the characteristics required by the situations they participate in" (Becker, 1981:308). Commitments in adult life can take many forms and these include such things as "choosing an occupation, getting a job, starting a family" (Becker, 1981:314). These commitments also constrain the person's behavior in order to bring about some personal consistency in varying situations. However, as the individual moves in and out of new social situations, there is a need to deal with the unique requirements of every situation. In this respect,

if he has a strong desire to continue, the ability to assess accurately what is required, and can deliver the required performance, the individual turns himself into the kind of person the situation demands (Becker,

1981:310).

The notions of commitment and situational adjustment are particularly relevant when considering the impact of infertility on identity for the involuntary childless couple. When parenthood is a salient identity underlying the involuntary childless state, then there is a "commitment" to parenthood. As such, parenthood becomes "the consistent line of activity in a sequence of varied situations" (Becker, 1981:313). For the infertile couple, this commitment to parenthood persists in the face of a variety of situational adjustments. These situations, which require adjustment include the initial awareness of their infertility problem, subsequent realization that they may not be able to have their own children, a period where they may question their commitment to parenthood, and finally, a consideration of adoption as an alternate route for realizing their commitment to parenthood.

The establishment of identity is contingent upon the responses of others in the situation. In this regard, "significant others" and "reference groups" shape the formation of identity. A reference group is

that group whose outlook is used by the actor as a frame of reference in the organization of his organizational field ... they constitute the structure of expectations imputed to some audience for whom one organizes his conduct. (Shibutani, 1978:11)

Reference groups, then, act as the basis by which people define the situation so that identity may be established and

action can proceed. In looking at how reference groups shape the formation of parenthood identity in various situations, it is important to determine first who these "others" are, and second, how it is that these people contribute to the parenthood identity.

In keeping with this, the process by which individuals take on a new role identity is characterized by an ongoing search for support and legitimation (McCall & Simmons, 1978). For infertile couples who are preparing themselves for adoption, this support and legitimation is sought on many fronts. On the most fundamental level, spouses seek to gain support from one another by means of an ongoing negotiation and construction of what parenthood means to them. Friends, family and the potential grandparents also bring the parenthood identity into focus in interaction, quite often in the form of "dropped hints" which subtly remind the couples that a new grandchild or a new niece or nephew are being waited for. Support is also sought from these significant others for the adoptive parenthood identity. Doctors also play a significant role in shaping parenthood identity by outlining the couple's chances of biological parenthood, and in some cases, suggesting that couples pursue adoptive parenthood. In addition to seeking informal support for the new role identity of adoptive parenthood, couples must also seek

legitimation through the formal adoption process. Social workers, as the formal agents in the adoption process, are, in a sense, the gatekeepers who control access to this new identity. By entering the formal adoption process, couples submit themselves to a set of evaluation procedures that will determine whether or not they are fit to be adoptive parents. In this way, support and legitimation act as important socialization mechanisms in moving couples towards an identification with adoptive parenthood.

Of particular importance in determining the way these others influence the parenthood identity is the extent to which infertile couples have an "open" or "closed awareness context" (Glaser and Strauss, 1981) about their infertility, their interest in adoption and the non-parental role that they occupy. Whereas in an open awareness context each interactant is aware of the other's true identity and his own identity in the eyes of the other, in a closed awareness context one interactant does not know either the other's identity or the other's view of his identity (Glaser and Strauss, 1981:54). If couples maintain a closed awareness context about their infertility, then their reference groups will continue to identify them in the role of biological parents. If, on the other hand, they are open about their infertility and their interest in adoption, then their reference group may begin to identify them not as biological parents but as potential adoptive parents. For

some couples, the announcement of adoption plans may be the first open statement to others that there is a fertility problem. Thus, not only do they open the awareness context for adoption, but they open the awareness context for infertility at the same time.

Coming to a shared meaning through the definition of the situation is important for establishing parenthood identity. Defining the situation is an active process whereby the actors are "engaged in" and "doing" definition of the situation (McHugh, 1968:40). As such, definition of the situation is essentially a subjective endeavour whereby the actors involved interpret the situation. The centrality of subjective definition is reflected in Thomas' famous dictum which states that "if men define situations as real, they are real in their consequences" (in Stryker, 1980:31). Seen in this light, the actors can be seen as the authors of an agreement that emerges through a process of searching out a common definition. Only when there is a shared definition of the situation whereby each makes an identification of the other and an identification with the other's role, can identity be established and interaction proceed in an unproblematic manner (Stone, 1981).

With infertile couples, interaction is sometimes problematic because of difficulties that they and the others in the situation have in coming to a shared definition of

the situation. Infertile couples are sometimes heard to lament that "no one understands what we are really going through." This sense of isolation is indicative of a non-shared definition of the situation. In this regard, this research proposes to examine examples where there are incompatible definitions of the situation. It is expected that this is largely due to the 'others' being unable to identify with the infertile person's position, and as a result, interaction is likely to be awkward and strained. Equally important here are the situations where adoption is at issue. Again, because of the unfamiliarity that others have with the adoption process, one would expect that the interaction may be characterized by uneasiness.

Parenthood, then, is one identity within a hierarchy of salience. As with all identities within this hierarchy, it's position of salience fluctuates according to such factors as stage of the lifespan, motivation for it's enactment and degree of gratification to be gained by entering into it. For infertile couples, parenthood is a prominent identity within this hierarchy because of couples' high commitment to becoming parents and the greater likelihood that this identity would be invoked in the many situations that they encounter in trying to become parents.

The salience of the parenthood identity also fluctuates according to the immediate situation in which the infertile person finds himself. Through the maze of tests



and treatments that are involved in an infertility work-up and the comments and questions from various reference groups, couples encounter a wide spectrum of situated activities that modify their self-perceptions of what it "means" to be a parent. For example, a diagnosis of blocked fallopian tubes or endometriosis may be significant situations out of which couples further identify themselves as infertile and therefore unable to achieve or realize biological parenthood. Or, as couples reach the end of an unsuccessful treatment regimen, again infertility becomes more real and biological parenthood more remote. There are also situations where adoption is mentioned, such as by well wishing friends or family, as an alternative for infertile couples to consider. These, and other situations such as reading an article about adoption or seeing a newsclip, begin to move people towards an identification with adoptive parenthood. There is, then, a period of transition during which couples begin to identify themselves less with biological parenthood and more with adoptive parenthood.

This research proposes to come to an understanding of the identities of "biological parenthood" and "adoptive parenthood" by examining the subjective definitions of the situation that underlie the establishment of these identities. Of particular interest are the kinds of situations couples see as being important in their

experience for the re-evaluation of parenthood identity. What kinds of situations make couples start to think about adoptive parenthood as an option? How are events in the "formal" adoption process, such as contacting the agency, meeting with a social worker, going through the home study or attending a group meeting seen as affecting the infertile couple's perception of themselves as adoptive parents? What kinds of "informal" situations with co-workers, friends or family do they encounter that cause them to think about adoptive parenthood rather than biological parenthood? A related concern here is how couples establish a shared meaning and a common definition of their situation. Are there situations where one partner influences the other in terms of redefining themselves as adoptive parents? What are these situations and how are they subjectively perceived?

Definitions of the situation are critical for understanding how couples identify themselves as biological or adoptive parents. These definitions, when pieced together, can be seen to represent a process whereby couples shift their identification from biological parenthood to adoptive parenthood. This shift in identification can be seen as a "transformation of identity."

### Transformation of Identity

Strauss (1959) argues that change in adult life can be seen as a series of related "transformations of identity." Arguing against a view of human development that purports a movement along a continuum according to fixed norms or goals, Strauss (1959:91) suggests that these are inadequate because they do not take into account "the open-ended, tentative, exploratory, hypothetical, problematical, devious, changeable and only partly-unified character of human courses of action." Within this context, changes in adult life can be seen as a series of related transformations that involve perceptual change, coming to new terms and evaluations of self and others.

Taking on a new identity involves "dismantling, disintegrating the preceding nomic structure of subjective reality" and constructing a new subjective reality (Berger & Luckmann, 1966:177). Through resocialization, "old identities, beliefs and values may have to be abandoned in the process of creating a new self-concept and world view" (Gecas, 1981:168). In this sense, subjective reality is "ongoingly maintained, modified and reconstructed" (Berger and Luckmann, 1966:172) on the basis of conversations and interactions with significant others. This is an ongoing process of personal change that occurs against the backdrop of a taken-for-granted reality.

Although the shift in identity from biological to adoptive parenthood involves a process of resocialization and a reconstruction of identity, it can be differentiated from other more radical forms of self-change. For example, "conversion" (Travisano, 1981) is often used to describe sudden or dramatic changes in a master status or core identity (Bankston, Forsythe and Floyd, 1981). In the case of infertiles seeking adoption, however, there is typically a more gradual or incremental change in identity because of the characteristic sense of ambiguity that prevails throughout the process of both resolving one's fertility problem and coming to some acceptance of adoption. Since very few people ever receive a diagnosis of absolute sterility, most couples maintain hope for the possibility of a pregnancy and biological parenthood. This makes the relinquishment of biological parenthood and the identification with adoptive parenthood a slow and gradual process of identity change.

In addition, because couples have so little control over the processes of both resolving infertility and pursuing adoption, there are many unique and unpredictable contingencies that arise in the reshaping of parenthood identity. These contingencies make the transformation from biological parenthood to adoptive parenthood not so much a rationally developed sequence of events, but rather, more like a process of "creative bumblng" (Straus, 1976:254-56)

whereby couples seek solutions to the many obstacles they encounter in their attempts to become parents. As part of this meandering process, couples might also encounter periods where parenthood loses importance as the central role identity in their lives. With this in mind, the transformation from biological parenthood to adoptive parenthood may not be a neat linear process, but rather, one that is characterized by periodic digressions into "non-parenthood."

The changes in parenthood identity precipitated by infertility are especially acute in light of "critical incidents" which constitute "turning points in the onward movement of personal careers" (Strauss, 1959:93). Similar to the "problematic" discussed earlier, these incidents are the result of changes in the expected roles or institutionalized paths of one's taken-for-granted reality, and force the individual to take stock, re-evaluate, revise and re-judge the direction of one's personal career. In this regard, one must "gain, maintain and regain a sense of personal identity" in light of "unexpected places and novel experiences" (Becker and Strauss, 1956:263).

In the process of infertility tests and treatments, it is expected that there is one or more such "critical incidents" which can be seen as precipitating a "transformation of identity." One can speculate as to the

nature of these critical incidents. For example, receiving the results of tests which indicate a very low sperm count or badly obstructed fallopian tubes drastically reduce the prospect of achieving a pregnancy. Because of the very significant effect that such a diagnosis has on the possibility of achieving biological parenthood, it can be seen as a critical incident. For those couples who do not receive such drastic diagnoses, the critical incident may be in a more subtle form. For example, couples might establish in their minds a certain time limit for trying a treatment, and once finished they must re-evaluate their position. Again, this can be seen as a critical incident. For other couples with no definite diagnoses, contact with an adopted child or friends who adopt might also comprise such a critical incident. Through these critical incidents, which reflect the increasing realization that they cannot have their own children, there is a transformation from an identification with biological parenthood to an identification with adoptive parenthood. In this sense, they begin to dismantle the image of themselves as biological parents and slowly start to construct for themselves a new parenthood identity based on adoption.

When individuals experience these critical incidents and the accompanying changes in identity in a fashion similar to other members of a group, then these transformations become institutionalized. This is referred

to as "status passage" because members of the group move from one status to another in an orderly and somewhat predictable sequence (Glaser & Strauss, 1971). Status passage can be analyzed along the following dimensions: desirability; inevitability; reversibility; repeatability; whether done alone, collectively or in aggregate; degree of awareness that others are going through it; opportunity to communicate with these others; degree of choice in going through the passage; degree of control; degree of legitimation; clarity of the signs of passage; and degree of disguise of the passage (Glaser & Strauss, 1971:4-5).

The pattern of transition from relinquishing biological parenthood to taking on adoptive parenthood can be seen as a status passage. It involves a predictable set of events that couples go through in order to be adoptive parents. With the awareness of infertility, couples go through a series of tests and treatments that are accompanied by a set of emotional stages that may include surprise, denial, isolation, anger, guilt, depression, and grief (Menning, 1977). These stages are part of the process whereby couples try to come to some acceptance of the increasing threat of lost biological parenthood. At some point in this process, adoption is considered, realistically assessed and finally acted on by some as an alternate way of achieving parenthood. The consideration of adoption

initially involves fantasizing themselves in the role of adoptive parents. As Schutz (1970:142) has pointed out, such fantasy is at the root of carrying out a project of action. Fantasizing adoptive parenthood is shaped by looking closely at instances of adoption among family and friends, gathering information about adoption from books, articles and professionals, and finally, approaching the agency to determine their eligibility and potential for adopting a child. Once contact is made with the adoption agency, there are other events that bring the possibility of adoptive parenthood into sharper relief for the couple. This includes filling out application forms which require statements of preference and personal thoughts about adoption, going on a waiting list for several years, going to group meetings, and finally, having a home study. These ordered events, beginning with the realization of infertility and ending with the adoption placement, represent a status passage.

Although one can conceptually think of infertility and adoption as two distinct processes, when experienced in reality, they are intermeshed. In some respects the two processes can be seen as having mutually reinforcing relationships that are characterized by a tension between "letting go" of biological parenthood on the one side, and coming to some acceptance of adoptive parenthood on the other. This research proposes to look at these processes, not as separate and distinct, but as they are experienced



together. Specifically, this means looking at the events that influence how couples come to some identification of themselves in the adoptive parenthood role while at the same time, mourning the loss of their biological capacity.

Underlying this transformation of identity is a process of resocialization. This process of resocialization is the key to coming to an empirical understanding of the transformation of identity from biological parenthood to adoptive parenthood.

#### The Process of Resocialization

Most socialization for parenthood is directed towards when and how people are to bear children. In this sense, biological parenthood is the basis for people's taken-for-granted reality. When the "critical incident" of infertility blocks biological parenthood, couples must redefine for themselves the meaning of parenthood in the face of this "changed" situation. In this regard, infertility initiates a process of resocialization.

Whereas there are numerous socialization guidelines for how one should be a biological parent, there are considerably fewer guidelines for the resocialization process necessary to become an adoptive parent. On the socialization of parents to the adoptive parenthood role,

Kellmer Pringle (1967:25) points out some of the dimensions that are involved in the socialization process:

Perhaps the biggest of all fallacies is the assumption that to adopt is little different from having children of one's own. In many respects, which may or may not prove to be important, it is manifestly different. Socially, adopting parents are a minority or 'deviant' group; emotionally, they have to face the reasons for being unable to have a family of their own; and to come to terms with their own and their children's attitudes to illegitimacy; biologically, the adoptive mother will not experience pregnancy and birth in relation to the child. And from all three points of view, parents undergo a series of quite different preparatory experience before assuming the role of 'adoptive' parents.

As this clearly points out, the socialization for adoptive parenthood is distinctly different from socialization to biological parenthood.

In this light, an important focus of this research is to examine the resocialization process whereby couples prepare themselves to take on the identity of adoptive parent. In this process, individuals are not passive recipients but are active participants in shaping and defining their role in the face of the changing situations (Bush & Simmons, 1981:135). The "preparatory experience" for adoption is likely to include a period of mourning for the loss of their potential biological children, explanations or 'accounts' of their infertility to friends, family and work associates, discussions about the possibility of adoption with these same people, and contact with the adoption agency which sets into play a formal process that further

socializes couples to adoptive parenthood. This contact with the adoption agency involves the additional stages of being on a waiting list for a long period of time, a home study, group educational sessions, and finally, placement.

This research proposes to explore both the formal and informal aspects of this resocialization process. Specifically, what kinds of events and experiences with their reference group stand out as being important to the couple in the process of re-defining themselves as adoptive parents? It is predicted that the informal process, where infertile couples talk through their infertility and adoption with others, will be critical in coming to an identification of themselves as adoptive parents. Through this process of "talking through" their infertility they will at some point approach the agency to begin the 'official' adoption process. For some, this may be a calculated manouver that occurs at an early stage, regardless of their social-psychological identification with adoptive parenthood, because of their awareness of long waiting lists for adoption. For others, the initiation of the formal adoption process may not occur until there is a strong sense of identification with adoptive parenthood that has already been established on an informal level. Of course, once begun, it is expected that this formal process will further solidify the infertile couple's identification with adoptive parenthood.

**SUMMARY**

Phenomenology and symbolic interactionism provide a set of useful conceptual tools for guiding an analysis of how infertile couples shift their identification from biological parenthood to adoptive parenthood. The concepts that are of central importance in examining this process are identity, transformation of identity and resocialization.

## CHAPTER 3

### IDENTIFYING THE ISSUES: THE PRELIMINARY STUDY

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There were essentially two phases in carrying out the research: the preliminary study and the main study. This chapter deals specifically with the first phase of the research. It focusses on the preliminary study giving attention to how this was carried out and the nature of the substantive theory that emerged from it. The next chapter deals with the second phase of the study and examines the manner in which the main study was designed in order to get a more structured understanding of the themes that emerged from the preliminary study.

However, before discussing the preliminary study, some comment is warranted on the rationale for proceeding with the research in two phases. The difference between the first phase and the second phase can be seen to correspond with the distinction between generating and verifying theory. Using the tenets of "grounded theory" (Glaser & Strauss, 1967), the preliminary study was carried out in an effort to generate substantive themes as a basis for designing the main study. This preliminary study was

essentially unstructured, exploratory and qualitative. It served as a means for sensitizing the researcher to the social reality of parenthood as a problematic and was the basis for identifying the issues that were considered most salient for those couples experiencing it. This approach allowed for the emergence of various themes, categories and hypotheses.

The second phase of the research consisted of the main study which aimed to verify a number of propositions. These propositions were generated largely from the data of the preliminary research but were also shaped and remolded according to the data and theory that currently exist in the literature. In this respect, this research started as an inductive endeavour in order to generate "substantive theory" (Glaser & Strauss, 1967) on parenthood as a problematic, and ended as a deductive endeavour aimed at testing and verifying various theoretical propositions by looking again at the data of social reality. These propositions and the methods that were used for testing these propositions are discussed in detail in Chapter 4.

#### The Preliminary Study

The people who provided the data for the first phase of the research consisted of couples who, in a variety of situations and circumstances, were blocked from biological

parenthood because of a fertility problem. Their participation in the preliminary study came about as a result of having been registered with an infertility support group that was being run through a city hospital. The researcher had access to this group as a result of himself being a participant in the group. During the preliminary study, the researcher began by simply participating as a group member in the support meetings and concluded with intensive, unstructured interviews with several couples.

At the outset, the group meetings were useful in providing a general orientation to the experiences of other couples who were faced with parenthood as a problematic. Although the researcher was able to make many observations about their experiences, this information was not recorded or used specifically as data in the study. This decision was made primarily on the grounds that the researcher did not wish to disrupt the support group process by telling participants they were being observed or researched. Given that the goal at this stage of the research was to get an orientation to the problem in as natural a form as possible, it was felt that this was the best way to proceed. Five such meetings were attended and in all, over 30 couples participated.

Participation by the researcher in the support group meetings was useful for getting an understanding of the



range of issues that couples encountered when faced with parenthood as a problematic. However, in order to get a more in-depth understanding of the issues, intensive interviews were carried out with individual couples. The guiding criterion by which they were selected was to get couples from a wide variety of circumstances in order to get the greatest possible scope of experiences. The support group leader was consulted in this regard and in combination with my own contacts through the group, five couples were selected and approached for interviews.

Although the background of each of the couples was not exactly known before hand, the five couples who were selected did represent a wide range of circumstances. For example, as it turned out, the amount of time that they had experienced infertility ranged from three to nine and a half years. In three of the couples the biological problem was with the female, in one the male, and in the other, it was undiagnosed. Two couples had adopted. One couple was experiencing secondary infertility (meaning that they had a biological child of their own but were having difficulty having a second) while the rest were experiencing primary infertility (no biological children). In addition, there were a variety of ages and social backgrounds.

The interviews were essentially unstructured and were tape recorded. Following the principles of grounded theory, issues, concepts and categories were allowed to

emerge from the interviews. In other words, this preliminary study did not set out to "prove" a set of pre-determined hypotheses. In order to identify those phenomena that were considered most important by the infertile couples themselves, it was essential to avoid using pre-determined questionnaires and variables that might interfere with the more spontaneous emergence of these phenomena. Instead, an unstructured format was used so that recurrent phenomena that emerged in the data could be identified and categorized. This is the essential nature of generating "substantive theory" which focuses on empirical or substantive issues, rather than conceptual or formal theoretical ones (Glaser & Strauss, 1967).

Of course, it is never fully possible to enter into such a situation as a "tabula rasa" or without any sense of direction. Collecting data from a grounded approach is essentially an emergent process, which in this instance, began with very general observations in the support group setting. Arising out of this participation experience were some general issues that were used as a basis for guiding the line of questioning in the interviews. The researcher was able to get some sense of the salience of various issues by the amount of time that was devoted to talking about those issues in the group meetings. The general issues that were identified and used as a basis for exploration in

the interview included: couples' perceptions of being blocked from parenthood; the effect of non-parenthood on the marriage relationship; the meaning of parenthood for them as individuals; the effect of being blocked from parenthood on relations with significant others; and finally, their thoughts about adoption as an alternative. These broad categorizations were identified, not so much to rigidly dictate the format of the interview, but rather, to give it a loose sense of structure within which to proceed.

Questions used in the interview were made as general as possible in order to allow couples the maximum freedom in the way that they responded to them. For example, the interviews usually began with a question like, "Can you tell me where you are in all the tests and treatments?" Examples of other questions used are: "How has all of this changed you?" or "Do you talk to other people about your infertility?" or "Have you considered adoption?" In addition to these, other questions which were even more general were asked in order to allow couples to identify for themselves the most salient aspects of the experience. For example, "What do you find to be the most difficult thing about having a fertility problem?" or at the end, "is there anything about this whole experience that is important to you that we haven't talked about yet?"

Interviews in the preliminary study were tape recorded and later transcribed. The interviews lasted

approximately one and a half to two hours.

### Generating Substantive Theory: Parenthood as a Problematic

The data of the interviews in the preliminary study, as they are presented here, have been subject to substantive analysis. They have been arranged into categories (Glaser & Strauss, 1967), each of which includes descriptions of the "typical" cases. Empirical data are therefore included in order to illustrate these substantive categories. The primary aim for including these data, however, is not to present a comprehensive picture of what it is like to be blocked from biological parenthood because of a fertility problem, but rather, to show the "grounded" roots of the more formal conceptual theory that is tested in the main study. In this respect, the emergence of these substantive categories has both methodological significance and theoretical significance because they are the building blocks for constructing the formal theory that is to be tested in the main study. Hence, the primary significance of the substantive categories, as they are outlined below, was to suggest avenues that the main study could follow.

The data of the preliminary interviews are organized into six broad categorizations. These categories represent the central issues that were encountered by couples in their

experience of infertility and their consideration of adoption. The categories are identified as: the normative expectations for parenthood; the greater salience of motherhood versus fatherhood; parenthood as a problematic; defining parenthood as a problematic in interactive situations; patterns of resolution in reconciling blocked parenthood; and finally, adoption readiness.

### 1. Normative Expectation for Parenthood

No doubt one of the strongest issues to emerge in the interviews was the nagging sense expressed by couples that they should be parents. Being blocked from parenthood because of a fertility problem seemed to heighten their awareness of this prescription. This was most often expressed as a vague feeling that the people around them expected that they would have children. This expectation that they have children was engendered in a variety of situations ranging from potential grandparents dropping hints about wanting someone to spoil, to friends and family members asking them the simple question "Any kids yet?". In none of the interviews did anyone report that someone suggested directly that they should have children, but rather, in all cases it was implicit in the way the question was asked or the statement made that they should have children.

The strength of the normative expectation that couples be parents is highlighted by the deviant feelings that it engenders for couples who are blocked from parenthood. The fact that couples expressed deviant feelings stemming from their childless state would seem to reflect the strong pronatalist values that prevail in our culture. One woman expressed how these values and expectations were conveyed:

Yah, like its just NATURAL or something that a woman gets pregnant - so you feel like you are abnormal or something. Especially when you go out to these woman things and thats the first that they talk about is what they did in the hospital when they had their babies and how they got pregnant. (F-INT #2)

Interactions with peers seemed to play an important role in highlighting the expectation for parenthood. One woman describes how meeting an old friend focussed attention on parenthood as a problematic:

I couldn't believe it. I saw a friend of mine the other day from high school who I had not seen for 5 years. She was with her little daughter and practically the first thing she said to me was "Have any kids?" I couldn't believe it. So I said no and she goes "what? No kids?" It was like "heh whats going on?" - as if I were abnormal or something. (F-INT #4)

Couples pointed to socialization as an important factor for understanding the amount of emphasis that was put on parenthood as a desirable and important role in adult life. As several couples demonstrated, even as children we learn how important it is to be parents. As a result, when blocked from parenthood in adulthood, feelings of being less

than fully normal were engendered. As one woman expressed it:

I have this feeling of inadequacy because I can't have any children. As a little girl, you're playing with dolls and all this and you're prepared right from when you are a little one. You're prepared to be a mother - role playing and the whole bit. And then all of a sudden I can't. Like its a whole switch in your mind. You're prepared for this whole thing and then Bingo! - you can't and you have to start thinking differently. (F-INT #4)

The expectations for the parenthood role also appear to be patterned by age expectations. In this regard, couples were not only exposed to the expectation that they should be parents, but it appeared that this expectation intensified as time went on. For most couples, there was a sense that there was an appropriate time to become parents. This tended to be transmitted by a concern that was aroused when one was late for the transition. Age was often an important factor in this transition. As one man pointed out, there was very little pressure for the first months or years after marriage, but as time passed, the pressure mounted:

For a while you can get away with it ... people will think, "hey, you don't want to have children until later on in life or until you have your own or until you get your house or save your money or whatever." You can do that when you are 25, 26, or 27 - till you're 30. Then people start saying, like for example my father, he said like "is there a problem? Are you planning on having children?" It comes to a point where people no longer say that they are just getting their lives in order or that they are just saving this or that because once you start your 30's most people don't want to have 2 and 3 year olds when they are 55. (M-INT #2)

Clearly, the data of the preliminary interviews suggest that couples perceived parenthood to be an expected role that they should take on. Specifically, the data illustrate that:

- \* there is a normative expectation for parenthood.
- \* non-parenthood engenders deviant feelings for the childless.
- \* there is strong socialization that one "should" be a parent.
- \* the transition to parenthood is normatively scheduled to occur several years after marriage.

## 2. The Salience of Motherhood versus Fatherhood

Although both men and women were exposed to the pronatalist prescription that they become parents, women were more often than men to be the direct targets of these expectations. The desire for parenthood and the frustration at being unable to be parents was more intensely felt by women. In this regard, being blocked from the motherhood role was perceived to be more problematical than being blocked from the fatherhood role. Regardless of who had the medical problem, both men and women shared the perception that being blocked from parenthood had a greater impact on the woman than on the man. No doubt the fact that women have traditionally had more invested in the parenthood role would partially explain this phenomenon. As one man explained it:



I don't think a lot of people realize what we have been through. I don't think people realize how much it bugs her - and it bothers me on occasion. But I think that I have more outside interests and I am more active through my job. I don't live with it all the time as she does. (M-INT #2)

The greater investment in the parenthood role by women may be a result of the greater societal expectation that women be mothers. Not only do women seem to have more invested in the parenthood role than men, the greater importance of the role of motherhood tends to be reinforced by societal expectations. A woman described her feelings of failure arising from this expectation:

I feel that somewhere along the line I have failed and I know that other people say that that isn't right. You can't help it. People just expect women to have babies. That's what we were put here for! (laughing) It's people who make you feel like a failure. It will never go away because people will never let you forget. (F-INT #2)

The societal expectation that women should be mothers is sometimes perceived to occur in more immediate spheres of interaction. In this regard, significant others convey the expectation for motherhood. For example, one man expressed how he perceived his wife's guilt at not being a mother:

Sometimes she has this feeling that she was put on this earth to produce children and that's it and there is a frustration that she can't fulfill her need to - with respect to that - and that really upsets her because she feels like she is letting me down, she is letting her daughter down, her mother down... (M-INT #3)

Conversely, women tended to perceive that their husbands were considerably less concerned about the prospect

of not becoming parents. Although this may be related to the lesser emphasis placed on fatherhood for men, women frequently commented about the apparent lack of emotional response by their husbands. For example:

It doesn't bother him as much. He doesn't have heart.  
He doesn't have a heart. He's got a rock in there!  
(laughing). (F-INT #5)

Another indication that being blocked from parenthood was a more salient issue for women than men emerged in discussions about the impact of infertility on the marriage relationship. In this regard, several men indicated that being unable to have children didn't really bother them directly, but only indirectly because their wives would get upset about it. One man suggested that he gets upset with infertility only when his wife is upset, suggesting that it may not be the infertility per se, but the subsequent impact on their relationship that is most disturbing:

I'm fairly optimistic that something is going to happen and that it will come. And the only time that I really get down is when I see her really getting down and not so much that its me but that she gets down on herself.  
(M-INT #3)

Another possible explanation for the greater importance of motherhood was that the loss of the motherhood role also included the loss of the pregnancy experience. In this regard, pregnancy was considered to be a unique and distinct role in itself that was as important as parenthood. One woman expressed it this way:

We're happy with our adopted son. Very, very, happy. But there is still this need to get pregnant. There is that need no matter how many children we adopt. I think that I will always have that need inside of me. That I won't be fulfilled until I get pregnant. Even if I was to lose the baby or if the baby was to die after birth. But I do feel that I have that need and the only way to fulfill that need is to get pregnant. (F-INT #5)

As another indication of the greater salience of motherhood over fatherhood, women were more likely than men to talk about parenthood. Although men generally talk less frequently than women about personal or family issues, the relative frequency with which they talked about parenthood gives some insight into the centrality of the parenthood role in their interactions with others. And although one cannot say with complete certainty that the greater frequency with which women talk about parenthood represents a greater importance of parenthood, it does seem to suggest that it is an experience more intensely experienced by women. One man, in describing the couple's relationship with their friends who now have children, explained that men simply don't talk about such matters as often as women, and related to this, don't find the experience as difficult:

Fortunately, its easier for the guy because you can talk about sports or whatever ... they don't just sit and talk about their children as much... she probably finds it a lot more difficult than I do. (M-INT #1)

Women seemed to concur with this view:

People tell me...women talk about these things more than men... I don't know, maybe I'm wrong, but I certainly do... (F-INT #5)

When the subject of infertility did arise, men seemed to be

much more evasive than women in dealing with the subject. As one man explained:

Well, they [ie. his family] obviously know but I still have problems talking about it. In fact, I don't think that I have ever told anyone. Its through her or someone in her family ... I guess you've talked to my mother about it because she has mentioned it to me. My problem is that I don't just come right out and talk about it. I just "yah, yah" and change the subject as soon as possible. (M-INT #1)

When the biological problem rested with the man, there was a often a greater attempt to keep it private. As the wife of a man with a very low sperm count explained:

I think it is very personal for him. Somehow I think that if it was a tubal problem it wouldn't be that personal. Somehow I don't think so. Like usually everybody thinks that its the woman's problem. But in our case it is very personal. You don't tell everybody what the problem is and I wouldn't want anybody to think that he is any less of a man than his brothers are because its a big thing. (F-INT #5)

Even in the relationship itself, women expressed a greater need to talk about parenthood than men:

I don't think that infertility has changed me other than the fact that we have far more arguments than we usually do because I didn't want to talk about it too much, just for the sake of bringing it up whereas she wanted to talk about it all the time. (M-INT #4)

There was also a considerable difference between men and women in the extent to which being blocked from parenthood was discussed in the work place. In general, women were much more open when talking about it at work. Again, this seems to suggest that infertility is a more difficult experience for women. For example:

For her, there's always someone pregnant in her office so its harder on her because they talk about that kind of thing all the time. Whereas when I go to work, you say to guys, guys that I work closest with and you say "well we can't have children." And they say "thats too bad" and go back to their office and keep working. (M-INT #4)

Clearly, parenthood was perceived to hold a more central place in the lives of women than men. The data of the preliminary interviews support this notion insofar as they indicate that:

- \* there is a much stronger societal expectation that women be mothers, and related to this, women invest more than men in the role of parenthood.
- \* men have a heavier investment in other roles, especially paid work, which lessens the salience of fatherhood.
- \* loss of fatherhood elicits less of an emotional response for men.
- \* men were less likely to experience the loss of the parenthood role directly, but rather as something that upset their wives.
- \* greater salience for women because loss of motherhood also means the loss of the pregnancy experience.
- \* women were much more likely to talk about being blocked from parenthood than men.

### 3. Parenthood as Problematic: When Infertility Blocks the Normal Transition to Parenthood

Couples indicated a very acute awareness of the societal expectation that they be parents. However, when they were unable to do so on account of a fertility problem,

transition to this expected and anticipated role identity became problematical. In light of this, most couples talked about having to realign their expectations for parenthood when they encountered a fertility problem. One woman commented on the importance of age in the realization that she might be unable to become a parent:

I guess everyone has certain plans when they are younger. Like I'm going to get married and have so many kids and things just didn't work out the way you had planned. I always thought that I would like to have 3 kids by the time that I'm 30. Well, I'm going to be 30 next month and I guess its just that your dreams haven't come true. (F-INT #3)

The manner in which parenthood was identified as being problematical was usually a slow and gradual process that was marked by several significant events. For most couples, the societal expectation that they have children was so internalized that there tended to be a reluctance to even entertain the possibility that they might never become biological parents. Going to the doctor for the first time after suspecting a problem was one such event in the identification of oneself as a person with a fertility problem. The decision to go to the doctor was often the first overt recognition that was given that there might be a problem:

We had been trying for a good year I guess, close to it anyway, and still nothing was happening and then it was, you better go to the doctor. You know, you try for a couple of months and you think oh its just on our minds, calm down and you try and tell yourself this and ah ... you know that there could be something seriously wrong. (F-INT #1)

Relationships with significant others also played an important role in the way that couples realigned the meaning of parenthood in the face of infertility. Couples indicated that when parenthood was problematic, it tended to take on a more prominent place in their lives. This was in part due to the way that others responded in the situation. One woman expressed how the desire for parenthood became even more central in her life:

People say, "Oh just forget about." I think its a lot easier said than done. Like you think about it all the time and just to say "well I'm going to forget about it..." I don't know, I can't put it out of my head anyway. (F-INT #3)

For some, the greater importance of parenthood is reflected in the prevailing nature of having a fertility problem:

I don't think that it will ever go away. I think that when I'm 65 years old it will still bother me. I don't think that any woman could sit there and honestly say "Well thats OK that I don't have a child" unless you really really don't want one. But if you really want one, I don't think the hurt will ever go away. For me anyway. (F-INT #2)

The way that parenthood was defined as a problematic tended to be shaped to a large degree by the way that infertility as a medical problem was defined in the relationship. In this regard, the person who had been identified as having the fertility problem tended to be the one who took greater responsibility and had greater guilt for being blocked from the parenthood role. For one woman who was identified as having the fertility problem, this was

manifested in feelings of inadequacy as a marriage partner:

I was thinking to myself that maybe that he's really disappointed in himself, now that he's married me ... if he had married someone else he could have had children. (F-INT #4)

Similarly, an important distinction emerged between being blocked from parenthood as a couple problem and having the biologically-rooted medical problem as an individual problem. One man expressed how his wife has taken on a greater sense of responsibility for parenthood as a problem because of having the biological problem:

I think that it is tougher on the partner that supposedly has the problem. You know, like her problem is OUR problem but I think that I would probably find it more difficult if the infertility was with me. I'm sure that I would find more of a guilt feeling with her saying "Gee I'm sure that you would like to have children but because of my problem, I'm depriving you." And on several occasions she has said that to me. I'm saying that that doesn't change our relationship but I know that if the shoe was on the other foot that I would probably feel the same way and I think because of that it has been a lot more difficult on her. (M-INT #2)

Consideration of adoption was an important event for the identification by self and others of parenthood as a problem. The adoption was both a private and public announcement that there was something wrong. In other words, the announcement of adoption was instrumental in socially defining parenthood as a problem. One man explained how this occurred:

And once we put in for adoption then you have to start [to talk about it]. Then its not a secret and I think that probably made us more open with people that really didn't know. Before we really didn't offer explanations



and people wondered. But once you say you are going to adopt, then people realize that there is a problem of some sort. (M-INT #2)

When parenthood was defined as a problem, couples typically re-evaluated its meaning and importance in their lives. In addition, couples tended to examine other aspects of their lifestyle as a result of the parenthood identity being called into question. For example:

There are times when she can't understand why we have this stupid house because we're not going to have kids anyway. We moved here to start our family. There were times that I felt that way myself - like why not just rent an apartment instead of paying for a large mortgage? Its a waste ... but I guess in the long run its not. (M-INT #1)

In some instances, the commitment to parenthood itself is brought into question. After a variety of treatments, one couple began to question whether it was all worthwhile:

Husband: Well you're taking Clomid or you're taking this... and all of a sudden you're entering all kinds of foreign substances into your body, into my wife's body. To think of all the things that she has done to have another child - like going under anesthetic and all the testing and all the frustrating parts and all this and still ... nothing. So you wonder, why are you doing all this?

Wife: I guess if at the end of it all we'll be successful and have a child, then its worth it. But I keep thinking of going through it more and more and NOT being successful and its frustrating and sometimes I feel like just saying "forget it ... sera ... sera."  
(INT #3)

To summarize, in the face of a fertility problem, parenthood came to be defined as problematical. The manner in which it came to be defined as such occurred along several different dimensions:

- \* age is an important marker for determining whether certain life goals have been met - parenthood being one such goal.
- \* going to a doctor defines parenthood as a problem.
- \* parenthood as an identity increases in importance because it is problematical.
- \* desire for parenthood intensified by the expectations of others.
- \* infertility tends to be defined as an individual problem, blocked parenthood as a couple problem.
- \* greater sense of guilt and responsibility for non-parenthood by the person with the biological problem.
- \* consideration of adoption is an important event in defining parenthood as a problem.
- \* When parenthood is called into question, there is a re-evaluation of other aspects of life.

#### 4. Defining Parenthood as a Problematic in Interactive Situations

When the transition to parenthood does not occur as it should according to normative expectations, couples must somehow account for this problem in their interactions with significant others. In this regard, parenthood was not only defined as a a problem within the marital dyad, but came to be defined as a problem by the members of their social network, including friends, family or work associates. In keeping with this, they were faced with a variety of decisions regarding who to tell about their blocked parenthood, when to tell them, how much to tell, under what

circumstances to tell, and how to go about telling them.

A dominant trend that emerged in the interviews was that over time, couples seemed to become more open about discussing the reasons for non-parenthood. Two explanations emerged regarding this increased openness. First, over time couples learn how to talk about infertility by developing a vocabulary that enables them to reveal as little or as much information to outsiders; and secondly, after a time of dealing with these people, the couple reaches the stage of being unwilling to put up with pretenses in the interaction situation.

The tendency towards greater openness over time was explained this way by one man:

A couple of years ago I was saying oh it'll happen I suppose whenever its time - or maybe at that time I was saying "oh we're still waiting - you know, the old stand-by early on - but you can use that only so long. The longer it goes on, the more open you are because maybe you're more frustrated. Now we're saying that we would love it to happen but that it just isn't happening. (M-INT #3)

For another man, the decision to pursue adoption provides an easy way of explaining their childlessness, where once there was not the same readily available vocabulary:

Like before we would get snide remarks, like "you wouldn't do that if you had children," or "What's the matter? Don't you like children?" and I wouldn't say anything. I would just sort of smile and leave it as is and let them think what they wanted to think. Now I just don't say no, I say we can't and that we are in the process of adopting. (M-INT #4)

Similarly, one woman indicates how she has learned what the

most effective responses are in situations where the issue of infertility arises:

Interviewer: How do you react now to people when they say those kinds of things? (ie. Friends told her she is lucky that she doesn't have to go through the discomfort of labour and losing her figure.)

Wife: Before I didn't but I'm more bold now, I speak more. Last time someone said that I said "Do you want to switch?" And then I just left the person hanging there and she wasn't able to answer back. It gave her food for thought and she didn't say anything.... she didn't answer my question... so I thought, well that's a good one, because it worked on her and it must work on other people too and so I'll keep trying. And if they can answer that, then I'll give them another one! Just give them food for thought... let them know what it's like to be in our shoes. (F-INT #5)

In some cases, friends and family of the infertile couple began to create excuses in order to explain why there were no children. In this regard, childlessness was seen as an untoward behavior which was in need of explanation. One couple describes their experience:

We sort of sat back and had the comments and the jokes like "we can't imagine Richard ever being a father anyways" or "Becky enjoys her job and she doesn't want to quit work anyway. What are you going to do? What are you going to say to people? (M-INT #2)

In interactions with significant others there were differences in extent to which there was a shared definition of parenthood as a problem. For many couples, the perceived inability of others to share in the definition of their situation resulted in them being very closed about their situation. For example, one woman described the underlying assumptions that interfered with others coming to a shared definition of non-parenthood as a problem:

People don't understand what you are going through. A vacation will not do the trick. They have the assumption that you just have to get away. You just have to forget about it and get it off your mind. They would like to see you have a child and they are worried about it and concerned for you but they don't ask questions like "Is there a problem?" I find that they don't think that there is a real problem. They just think that it is something that is going to come in time. (M-INT #1)

One man commented on the unlikelihood of there being a shared definition of the problem unless the other had the problem:

You just don't know. You don't understand what people are like on the other side and most people never do understand or take the time to and they don't really give a damn. And until you're there and forced into the situation (ie. being infertile) - everyone believes that it will not happen to them. Until then, they will never really understand the people on the other side. (M-INT #2)

For most couples, there was a very clear distinction between those who could and those who could not share in the definition of their blocked parenthood:

Interviewer: What do you find is the reaction of people when you tell them that you have a fertility problem?

Husband: I guess there are two. One is that understanding and the other is from those that don't understand and that haven't been through it.

Wife: Yah, like I find that people really can't understand what you are going through. Like with comments like "Go on a cruise. Get drunk." or something like that, you know that they don't know what you're really going through. Especially if they've had no problem then they can't understand what the problem is. People who have had the problem can sympathize with you. They are usually quite understanding and they will tell you what they have gone through. (INT #3)

When couples did encounter other people who had the problem, there was reassurance in the shared definition of

the situation. As one woman pointed out after attending a support group meeting:

It was good for me. It was good to see that there are other people out there. Not that I like to see people who have problems but its just nice to know that other people in this world do have the same problem. (F-INT #2)

To summarize, the data of the preliminary interviews indicated that the way parenthood was defined as a problematic varied across the different interactive situations. Specifically:

- \* there is an increased openness over time in talking of parenthood as a problematic due to developing a vocabulary and tiring of the pretense.
- \* adoption becomes one way of explaining parenthood as a problematic.
- \* there is a perception that people can't share the definition of the situation if they don't share the problem.
- \* when definition of the situation is non-shared, there was a greater tendency to be closed about the problem.

## 5. Reconciling Blocked Parenthood - Patterns of Resolution

Coming to terms with blocked parenthood seemed to consist of patterned sequences of events. There were two distinct perspectives that emerged when couples described the patterned changes that they experienced. From one perspective, couples described the changes as a series of

mood shifts that recurred in every cycle. From another perspective, however, these changes were described in terms of shifts in thoughts and feelings in the time period from when they first detected a problem to their present feelings.

For some couples, the loss of parenthood was tied to every menstrual cycle. Couples tended to describe a pattern of renewed hope at the beginning of every cycle, a sense of mounting excitement throughout the cycle if they hit the timing of intercourse correctly, followed by a big let down or depression at the end of the cycle when the period confirmed that again they would not be parents. As one man described the experience:

I think that the stage is a repetitious thing, whether it be monthly or bi-monthly or whatever. You have the hope and then the not knowing and then the hoping again and then the depression because its not happening... the first couple of weeks after she has her period you're not that depressed because its over, you're starting off the new month and there is nothing that you can do about it for the first couple of weeks because she won't be ovulating anyway. So everything runs fairly smoothly and then she ovulates and it builds up and it builds up and you're excited and hopeful and then it comes crashing down again and the cycle starts all over again. (M-INT #1)

Menstrual periods were perhaps the most significant time of the cycle for dealing with the block to parenthood. Typically, some very intense feelings emerged at this time of the cycle. The helplessness that was encountered at this time was described by one man:

When you had a period, it was just devastating - nobody knows. I felt helpless. Numerous battles that we have had over it - I would try to rationalize - how do you rationalize that? It didn't happen this month. It's when the extreme bitterness would come out. It was just really, really difficult. Here I am - that helpless feeling that I'm being cheated in life. Nobody knows the kinds of discussions that we had and you know - she would cry endlessly. Nothing in the world would make the hurt go away except being pregnant and it never happened. (M-INT #2)

Although this change of emotion that corresponded with the cycle was common among many couples, there was a definite tendency for couples to become "hardened" to the emotional changes as time went on. In fact, in many cases, couples began to accept it as "part of life." In a sense, there was a typification formed that the cycle will end with a period and not a pregnancy which seemed to gradually lessen the emotional impact of periods over time:

We're now in the stage where when it comes, it comes (the period). I'm not quite as upset about it. I guess because you go through it so often you realize that getting yourself so upset and crying and being down and depressed for 2 or 3 days is not going to do you any good. You realize that this is bound to happen and is going to happen. (F-INT #1)

Similarly, one woman described how the time before the period was the most difficult because she came to expect that it was definitely going to come.

The most difficult time is from the time I ovulate to the time I have my period. I am depressed then. For the two weeks before, I know I'm going to get my period and it's depressing because it's feeling like it's going to take for ever and you know - I just want to get it over with and start again. Mainly because I figure, ahn, it didn't work again. Once my period comes, then I guess I just figure, well OK, maybe next time and then things are different. (F-INT #3)



From quite another perspective, feelings about non-parenthood changed over the course of the entire process of trying to get pregnant. From this view, couples described themselves going through a series of stages which reflected a progression of their response to being blocked from parenthood. One couple identified how these feelings changed for them:

Interviewer: You mentioned that you go through different stages?

Wife: What I meant by stages was just really accepting it. Like you have to first realize that there is a problem... and the first thing you say is "why?" Why me? Why do I have to go through this? This is terrible. And then you get to the point where you say, "Yeah, someday I'll have kids and you kind of get your hopes up for awhile and then its depression and you go through that for awhile.

Husband: And then you get thinking that you are getting so old and its been going on so long and you've only got so much time left. (INT #1)

One couple who has been blocked from biological parenthood for nine years described going through stages of hope, shock, bitterness, helplessness and isolation:

Wife: I think when you first start out having a fertility problem you sort of have hope. You go a year or two - I think we were a year and a half before we finally went to the doctor. You just expect that you go off the pill and you are going to get pregnant and you just don't think that you are going to have a problem and so you know, the first few years it didn't really bother us. But as the years go on you get more bitter - like why us? Why us? And then like you feel that you are the only people in the world who have the problem.

Husband: I think overall it gives you a very helpless feeling that just becomes - and I hate to use the word - despairing. You get to the point where it doesn't matter what you do and you suddenly realize how little control you have. And I'm not sure that other people out there really know what that feeling is like. (INT #2)

One woman described the experience of mentally bargaining for a pregnancy while she was going through a number of tests:

I sort of felt that well I'm going through all this and the reward at the end is that I'm going to get pregnant. In a way, I had that in my head. If I'm a really good girl, then I'll get pregnant. (F-INT #4)

For others, there was sense of guilt for some wrong-doing in the past that one is now being punished for with infertility:

She felt like she was being cheated or punished. You know like everyone in the world stole 2 chicklettes when they were 6 years old and they got away with it. But she feels like she is being punished for the rest of her life. However you rationalize it, she had the feeling that she was being punished and that indirectly she was punishing me. (M-INT #2)

Perhaps one of the most prevailing dimensions of being blocked from parenthood was the strong sense of uncertainty about when or whether they will become parents. This uncertainty was seen as a real impediment to their acceptance of being blocked from parenthood. In light of this, finding definite answers played an important role in coming to some resolution of parenthood as a problematic. The way that couples sought these answers varied considerably. For one couple, simply wanting a definite yes or no answer in the medical process was the key:

Husband: See, the problem is, we get caught in the gray area. It would have been so much easier, and I hate to say it, and I'm glad they didn't - that you're told in black and white - "you can't have children." Then there would have been none of this that we have gone through

for nine years - being told that there is nothing wrong and you can have children and all this hoping and then every month, hopes would be shattered. If they had said right from the start, "well you are infertile" - its a callous way to look at it but if we had been told no... Wife: Its a little easier to accept it. (INT #2)

For other couples, coming to some acceptance meant not centering their entire life on the need to become parents:

You come to a point where you realize that you have to go on with your life. Like you have to realize that you can't center your whole life on trying to have children. It just doesn't work that way. (F-INT #1)

For others, adoption is the key for overcoming the uncertainty of parenthood that accompanies infertility. For these couples, adoption is perceived as a 'better bet' for becoming parents because it is seen as something that can work when other avenues are unsuccessful. As one woman explained:

You just get fed up with it. Thats why I didn't want to go for any more tests or any more surgery. I've just had it. You get to your saturation point and you just don't want anymore of it. Now I'm going to concentrate on adoption and hope that that works. (F-INT #4)

Various patterns emerged with respect to the way that couples experienced their blocked parenthood. As the data suggest, these can be summarized as follows:

- \* feelings regarding the loss of parenthood are tied to every menstrual cycle for some couples.
- \* some of the stages in the overall experience of reconciling blocked parenthood include: shock, denial, hope, bargaining, guilt, bitterness, helplessness and isolation.
- \* ambiguity of infertility interferes with acceptance of blocked parenthood.

- \* the search for definite answers is important in coming to some resolution of non-parenthood.
- \* adoption is an important event for overcoming the uncertainty of parenthood that accompanies infertility.

## 6. Adoption Readiness

Against the backdrop of parenthood as a problematic, couples tended to perceive adoption as a way of bringing their behavior into line with the normative expectations that they be parents. The couples interviewed were at various stages of readiness to take on adoptive parenthood. Several factors emerged as important for when adoption became a viable alternative. For some couples, adoption only became a real alternative after all other avenues for becoming a biological parent had been explored. In this sense, biological parenthood seemed to be the preferred way out of parenthood as a problematic. However when this was no longer likely, adoption became the way out of parenthood as problematic. One couple explained it this way:

Wife: Adoption is kind of on the back burner. With all the tests its like, try this, try that so adoption gets put in the back of your mind. I feel like I would much sooner have children of my own if thats what we can have - rather than adopting. But by all means I would adopt - a child is a child. But it does mean more to me (to have my own) because I can be pregnant and have his baby.

Husband: I would like to be as positive or as positive as possible that we cannot have our own children. Not that I would want adoption to be a last resort or

anything but I would like to get working on that before I am too old. (INT #1)

Taking on adoptive parenthood seems to be related to the costs that are incurred in trying to become biological parents. At some point, the cost of trying again to be biological parents becomes too high and as a result, adoption becomes a more realistic alternative. One couple explained their decision not to go ahead with another treatment and instead to pursue adoption:

The doctor said that if we don't try surgery then we might as well forget it. Well, this has been going on for a long time. For me to have the surgery - well its a year before you are over it completely and have a chance again. I'm going to be 34 by then and I thought to myself "no way!" I can't take any more of this stuff. I felt like I'd rather go straight for adoption and see if that works. So a few days after I got out of the hospital (from the laparoscopy) we applied for adoption because everything takes so gall darn long I thought that I better get this thing rolling. (F-INT #4)

Perhaps one of the most significant events in coming to a readiness to take on adoption was the acceptance that there was a problem. This was not only acceptance that there was a medical problem, but acceptance that there was a lessened chance of biological parenthood. As a result, adoption became a more viable alternative for becoming parents. One woman explained:

I think you come to the conclusion that there is definitely something wrong - that you may just never have children of your own. There are other ways. You can adopt. I know now that I can take that a little easier. (F-INT #1)

The decision to pursue adoption was seen as a way of

putting an end to some of the uncertainty associated with infertility. Whereas the prospect of pregnancy was uncertain, at least with adoption there was a more definite sense that they would get a child. For one couple, the certainty that was afforded by adoption made their lives considerably less stressful.

I found the whole thing very hard on me. With all the tests and everything my nerves were shot, I gained 15 pounds just worrying. I don't want that anymore. I can handle adoption a lot better. We know what we're going after. There is no more guessing. We are going to try for adoption and concentrate on that. I find that a lot easier. (F-INT #4)

Significant others also played a role in the decision to pursue adoption. Although most couples were supported in their decision to pursue adoption, some were discouraged:

A girl was visiting our house and I was telling her about adopting and she said "Oh no! I would never do that. If I can't have my own baby then I won't have children." You know I don't need any one telling me that if I can't have his baby then you shouldn't adopt because to me we wanted children one way or the other. (F-INT #2)

In other instances, significant others tended to have uninformed notions about what it meant to adopt, and on this basis discouraged the prospect of adoption. One couple explained how their parents discouraged the adoption:

My parents are upset about us adopting. I think they are thinking in terms of the olden days. Things like who are you going to get? What race? Or are the parents of the child going to live 3 blocks away and they know that you have their child? So much has changed with adoption but they are centuries behind in their thinking. (M-INT #4)

Age also seemed to be an an important consideration in the decision to pursue adoption. There seemed to be a sense that time was getting on and that if one waited too long, the age gap between parent and child would be too great, or there would be difficulty in getting a child at all:

I have this friend who is 53 and his child is 8. The age gap between them is so obvious that it is incredible. Whats it going to be like when the kid is a teenager and my friend is into old age? This age gap is pretty serious stuff. Also, because of my age and how long it takes, chances are that we will only get one. So for me, age is the big factor and we have to get going on it (adoption.) (M-INT #4)

In some instances, couples expressed resistance to adoption. This resistance seemed to stem in part from a sense of uncertainty for what was involved in becoming an adoptive parent. A lack of familiarity with the adoption process also tended to give rise to some reservations about taking on this option. One man who had already adopted explained the reservations he had going into adoption:

Even to the very day that we picked up our little girl I was very tentative about it. I really went along with it because I knew how much it meant to her. I guess I was in agreement with it but in all honesty I was very tentative about it. Like I envisioned picking up a little - well now I don't know what I envisioned. (M-INT #2)

Through the preliminary interviews, a number of factors emerged that seemed to be significant for the initiation of the adoption process. These can be seen as indicators of adoption readiness and can be summarized as

follows:

- \* for some there is a need to explore all avenues for biological parenthood before pursuing adoptive parenthood.
- \* when costs of continuing to seek biological parenthood become too high, then adoption tends to be pursued.
- \* acceptance that there is a problem is sometimes important for initiating the adoption process.
- \* the decision to adopt puts an end to some of the uncertainty of seeking biological parenthood.
- \* age is an important factor in initiating the process.
- \* significant others have both a positive and negative influence on the decision to pursue adoption.

## SUMMARY

The data of the preliminary study, as they are presented above, have been subject to substantive analysis. Although the information that is presented represents the main issues as they were expressed by participants, the analysis is by no means fully comprehensive in its scope. The issues that are presented here represent those concerns and experiences that were common to most couples. Of course, what gets overlooked are all the idiosyncratic features of each couple's experience that give the data a richness and a depth that can not be fully represented in this kind of analysis. However, these unique features did serve to broaden the researcher's orientation to the subject



matter thereby laying the groundwork for teasing them out in the main study.

In the next chapter, the main study is discussed. Included in this is a discussion of how the data of the preliminary study have been used in the design of a set of propositions for systematically examining the the transition from biological parenthood to adoptive parenthood.

## CHAPTER 4

### THE MAIN STUDY: PROPOSITIONS, METHODOLOGY AND IMPLICATIONS

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This chapter focusses on the way that the main study was designed and carried out. Included here are discussions of how the propositions were constructed for testing in the main study, how the data were collected, how the participants were recruited for the sample and finally, some of the unique methodological issues that were involved in this particular research project.

### CONSTRUCTING THE PROPOSITIONS

A set of propositions was set up as a way of systematically guiding the analysis in the main study. These propositions were molded on the basis of information taken from several sources. These included the preliminary study, the review of the infertility and adoption literature and finally, a set of relevant theoretical concepts and ideas drawn from symbolic interactionist and phenomenological thought. The process of pulling all of these threads together and prioritizing specific aspects is not one that is

easily described. However, some discussion of how these were all brought together is warranted.

As described in the preceding chapter, the first step in constructing the propositions was to go into the field being as open as possible to the varied experiences of couples who were experiencing parenthood as problematic. The result of this preliminary study was to construct a "substantive theory" that represented those issues that emerged as being most important for understanding the social psychological reality of parenthood as a problematic and the consideration of adoption as one way of reconciling this problematic. The main features of this substantive theory are summarized into six categories and are described in detail in Chapter 3.

Using these issues as a footing, the basic research problem was formulated as 'the shift in identification from biological parenthood to adoptive parenthood.' With this basic problem identified, the substantive and theoretical literature were examined. The search of the substantive literature focussed on the prevalence of infertility as a problem, the prevalence of infertiles seeking adoption, the separate processes of infertility and adoption, and the importance of infertility resolution in the adoption process. The theoretical literature was examined with a view to extracting concepts useful in explaining the relationship between infertility resolution and adoption

readiness. Key concepts were deemed to be those related to salience of and commitment to identity, transformation of identity, accounts and re-socialization.

Based on the preceding investigation, a set of propositions was developed as follows:

1. Normative expectation for parenthood.

Biological parenthood is the basis for a couple's taken-for-granted reality. It is proposed that this taken-for-granted reality is shaped through socialization experiences with parents, friends and others. As a result, couples feel the expectation, not only from these others but from themselves, that they have their own biological children soon after they are married.

2. Infertility as a problematic - accounts.

Infertility is problematic, insofar as it disrupts the normative expectation for parenthood. It is proposed that couples experience infertility as a problem that requires explanation to others of their motives. It is expected that these explanations are in the form of "accounts", or more specifically, excuses (because the responsibility for the infertility is externalized).

3. Adoption accounts.

When adoption is chosen as the alternate means of achieving parenthood, it too deviates from the usual manner in which people become parents and therefore requires explanation to others. It is expected that "accounts" of adoption will be in the form of justifications (because the couple takes responsibility for their action).

4. Shared versus non-shared definitions of the situation.

Interactions with significant others or one's reference group involves coming to shared definitions of the situation in order that identity be established in the situation. It is proposed that when infertility or adoption are at issue, the infertile couple will perceive that their significant others who do not share the problem will not be able to share their definition of the situation and will be unable, therefore, to adequately "place" their identity of involuntary childlessness. This results in feelings of isolation for the infertile couple. By contrast, those significant others who do share in the problem of infertility and/or adoption will be able to place the

identity of the couple.

5. Commitment to parenthood.

As the chances of biological parenthood diminish in the face of infertility, the degree of "commitment" by the couple to parenthood is brought into question. It is proposed that, if commitment to parenthood is high, then couples will make a situational adjustment and pursue adoption, whereas if commitment to parenthood is low, couples will continue "trying", or choose a childfree lifestyle.

6. Salience of parenthood identity.

Parenthood is one identity in a hierarchy of salience. It is proposed that when infertility calls into question the parenthood identity, it takes on added importance in the hierarchy because of the energy and effort that is directed toward it.

7. Salience of motherhood versus fatherhood.

Motherhood is considered to be more salient to female identity than fatherhood is to male identity. It is proposed that women will experience childlessness more intensely than men. In keeping with this, it is proposed that women may be the initiators of the adoption process whereas men may be more reluctant.

8. Shifts in identification from biological to adoptive parenthood.

The dominant issue of this research is the shift in identity from biological parenthood to adoptive parenthood. Although infertility is problematic for achieving biological parenthood, medical tests and treatments offer hope to couples for overcoming this problem. It is proposed that early on in the infertility process, when tests and treatments are actively being administered, that couples will continue to identify themselves with biological parenthood. Later in the infertility process, when treatments have been unsuccessful, couples may begin to "let go" of biological parenthood and begin to identify with adoptive parenthood. It is proposed that this may include a period of shock and anger at the prospect of losing biological parenthood, a critical incident that shifts attention to adoption, a period of fantasizing about adoption, and finally the initiation and carrying through of the formal adoption process.

9. Critical incidents.

At some point in the process of infertility, there are one or more "critical incidents" that make adoption a realistic option for the couple involved. It is proposed that these critical incidents are significant in the minds of couples

for letting go of biological parenthood and identifying with adoptive parenthood. These can be seen as "turning points" that mark the beginning of a more serious consideration of adoptive parenthood.

10. The importance of parenthood as a shared reality between spouses.

Although spouses may attach different meanings to infertility, parenthood and adoption, there is also a shared reality that they construct for themselves in order that action may proceed. It is proposed that in order to proceed with adoption, there must be some level of agreement, or shared construction of reality between spouses. However, the level of agreement that is necessary to proceed with adoption will vary from couple to couple.

11. Resocialization to adoptive parenthood.

The identification with adoptive parenthood involves a process of resocialization. It is proposed that there are few guidelines for becoming an adoptive parent, and as a result, couples are socialized by looking at the experiences of other adopting couples, reading books and magazines and by going through the formal adoption process which includes such things as applications, adoption information meetings and interviews with adoption workers.

## COLLECTING THE DATA

With the major issues identified, the next step was to construct a research instrument to collect data on these issues. Whereas the preliminary study was primarily exploratory and therefore qualitative in nature, the main study used both qualitative and quantitative techniques in order to come to an understanding of the shift in identity from biological parenthood to adoptive parenthood. Specifically, both structured interviews with open-ended questions and individual written questionnaires were used. The quantitative approach of the structured interview and

the written questionnaire had the advantage of uniform structure and direction which allowed for clearly defined measures and statistical comparisons. By contrast, the qualitative approach of open-ended questions allowed for probing and wandering into areas that couples considered to be important which allowed for a better understanding of how couples uniquely perceived their predicament.

In carrying out the research, each spouse was first given a self-administered questionnaire to fill out. The purpose of the questionnaire was twofold: to obtain demographic data and to obtain quantifiable measures of individual attitudes in order to determine where spouses might differ. These questionnaires were filled out independently by each spouse. These were administered before the interview in order to minimize the contaminating effect that spouses might have on each other in the interview. Subsequent to this, the interview was conducted with both spouses together, and the implications of this are discussed later in this chapter.

## RECRUITING PARTICIPANTS

This section focusses on the original sampling design for the study and it's subsequent modification as a result of some emergent sampling quandries. Specifically,



there will be a discussion of the sample with reference to procedures, sources, and size. This will include a discussion of some of the problems that were encountered in obtaining a sample of this sort and the strategies that were used to overcome these difficulties. In addition, potential sources of sampling bias will be examined in order to determine the limitations that these impose on generalizability.

### The Sample Design

The primary objective of this research was to look at the transformation of parenthood identity from the perspective of the infertile couple. This transformation is a process, and as such, required a research design capable of capturing the dynamic nature of this process. The method of sampling was critical in this regard.

The sampling design was shaped by the desire to intercept couples at various stages in the process of redefining parenthood. The parameters for this process were, at one end, those who were early on in the infertility process, and at the other end, those who were late in the pre-placement adoption process. To this end, it was necessary to obtain the sample from several different sources. In order to be sure that the sample had some couples who had experienced infertility and some who had

experienced adoption it was necessary to recruit couples from both a medical center that treats infertility and an agency that does adoptive work. The original design called for those in the early stages of infertility investigation to be obtained through several gynecologists working out of the McMaster University Medical Center. Those in other stages of an infertility investigation were to be recruited from those attending the Fertility Clinic at McMaster University Medical Center. To get respondents who were at various stages in the adoption process, it was originally proposed to obtain the sample through the Waterloo Region Child and Family Services in Kitchener, Ontario.

The initial goal of the research was to get a total sample of 120 couples. This figure was the result of several considerations. First, it was considered necessary to have at least this number in order to delineate several stages in the process and to then make meaningful statistical comparisons across these stages. Second, based on the preliminary qualitative data, it was believed that this many interviews would be adequate to arrive at a phenomenological understanding of the process.

When the sample was actually selected, it was discovered that this number would be a difficult ideal to realize. First, there were insufficient numbers of patients who were seeing the gynecologists at McMaster University

Medical Center. (The reasons for this are discussed in a later section entitled "Emergent Problems in Obtaining the Sample", p. 147). Consequently, after the research was begun, additional participants were recruited from the Fertility Clinic in order to compensate for this. Also, it was necessary to approach another adoption agency in order to increase the the number of people who were active in the adoption process. Family and Children's Services of Guelph and Wellington County was selected because of geographical proximity. They agreed to cooperate with the research and assisted in the recruitment of more participants who were active in the adoption process.

It was expected that there there would be some overlap of infertility and adoption experiences from the various sample sources. For example, it was considered quite possible that some participants selected from the infertility sources would already be on an adoption waiting list. Conversely, it was reasonable to expect that some selected from the adoption sources would still be actively pursuing infertility tests and treatments. However, since the sample from the infertility sources was selected from a different geographical location from the adoption sources, it was unlikely that there would be any overlap in terms of the same couple appearing on both lists. Furthermore, since it is the focus of this research to look at how the two processes of infertility resolution and adoption

readiness are experienced concurrently, it was not in the best interest of the research to exclude persons from the sample if they were chosen from the infertility group and had their name on an adoption list. The overriding concern was not that the groups be homogeneous in terms of their experiences, but that they be representative of stages in the transformation of identity.

In sampling this way to "catch the process," an assumption was made that the experiences of the couples who were recruited would represent various stages in the transition to adoptive parenthood. Ideally, given unlimited time and resources, one would do a longitudinal study and examine couples as they go through the transition from beginning to end. However, given the constraints on time in which this study had to be carried out, the assumption was made that the composite picture of couples at various stages in the transition would be representative of the typical patterns that are involved in the transition to adoptive parenthood.

In addition to their status regarding infertility or adoption experience, other criteria were used in the sample selection procedure. However, some of these criteria changed as a result of changes in social policy between the time of the proposal and the data collection. The first criterion was that couples had to be married. At the time of the

proposal, one of the requirements for adoption in Ontario was that couples had to be married. However, with the new Canadian Charter of Rights, it was no longer legally possible for agencies to discriminate on the basis of marital status. Consequently, agencies removed this as a criterion for adoption, and correspondingly, it was removed as a criterion for eligibility for the study. Second, couples had to be childless and have experienced a fertility problem in the present marriage in order to be eligible for the study. This excluded any couples who were at the time of the sampling pregnant, or who already had a biological or adopted child living with them. It did not, however, exclude those who were not presently pregnant but who had had a miscarriage or stillbirth in the past. Also, there were several couples who had children from a previous marriage who were not living with them, and these were included in the study. Third, couples in all groups had to be of an age such that they were eligible to adopt. Again, at the time of the proposal for the research, the adoption agency required that the youngest spouse must be no older than 36 years of age at the time of application to the agency. This too changed as a result of the Charter of Rights, for agencies could no longer discriminate on the basis of age. As a result, some couples were on the adoption list who exceeded these age criteria. Consequently, couples were not excluded from the analysis on the basis of age as

originally proposed.

Although one would expect that the kind of diagnosis and prognosis that one receives throughout the infertility tests would have an impact on the transformation of identity, this was not taken into account for the purposes of sampling. Couples, when selected, were included in the sample regardless of their diagnosis. Of course, the impact that this has on the meanings assigned to parenthood was taken into account when interviewing the couples. For example, one would logically expect that, in cases where a definite diagnosis had been made and the prognosis for pregnancy was poor, these couples would more quickly 'mourn the loss' of biological parenthood. In cases where the prognosis was ambiguous, one might expect that the transformation from biological parenthood to adoptive parenthood would be a much slower one. From this perspective, the type of diagnosis was more appropriately used as a variable for coming to a better understanding of transformation of identity, than for selecting the sample.

### Sampling Procedure

According to the original research design, couples were to be randomly selected for inclusion in the study. At the beginning of the research, this was the procedure that

was followed. For those couples who were being investigated by their gynecologist or who were attending the Fertility Clinic, they were asked at the time they were seeing their doctor whether they were willing to participate in the study. The assumption was made that by intercepting couples as they came in, the result would be a randomized cross-section of couples from all possible types of fertility problem. This assumption was based on the fact that there is no intake structure for appointments that would make them in any way non-random.

For couples from the adoption agencies, a random selection of couples (using a table of random numbers) was to be taken until there were enough couples for the sample. However, in the course of selecting couples from the first adoption agency's list, all couples were ultimately sent a letter because there was not an adequate response from the initial sample selection. In fact, even after all people on the list were sent letters, there were still not enough couples in these two groups. It was at this point that it was decided to approach the second adoption agency as described above. In the case of the adoption list from this agency, it was decided to send a letter of invitation to all childless couples on the waiting list. This was based on the assumption that the low rate of response from the first agency would be repeated with this agency. Given this approach, the sampling procedure for the adoption sample

shifted from being a probability sample of the adoption agency population, to a study of the entire population of both agencies.

#### Ethical Considerations in Sample Selection

As the sample was drawn from several sets of confidential records, several procedures were necessary to ensure that confidentiality was protected. Several methods of recruitment were used to get participants and, as a result, there were several different measures used to protect confidentiality. In the case of getting subjects from the gynecologists, it was necessary for the physicians themselves, or a member of their staff, to approach the eligible patients. Patients who were eligible were given a letter from the researcher which invited them to participate (see Appendix A). This letter described the nature of the study and the kind of commitment that was required of them. In addition, there was a letter from the researcher's supervisor which was intended to help legitimate the study (see Appendix B). These letters directed the patients, if they were willing to participate, to return the Eligibility Form (see Appendix C) directly to the researcher. Once this form was received, the researcher could then make contact with the couple in order to set up an interview. With this



procedure, the researcher only had access to patients' names after they themselves contacted the researcher.

In selecting patients from the Fertility Clinic, it was necessary for a member of the clinic staff to first select eligible patients who were then approached to participate in the study. Patients were considered eligible if they were seeing the physician for a fertility problem regardless of whether or not they had considered adoption. At the outset, this was achieved by giving patients a letter from the researcher (similar to that given to the gynecology patients described above) which invited them to participate in the study. However, after 8 letters were handed out with only one response to the researcher over the course of several weeks, a decision was made, on the suggestion of the clinic physician, to have the researcher personally attend the clinic to extend invitations to participate. After the physician had asked for the patients permission to be introduced to the researcher, the researcher then met the couple, explained the study and asked them to participate. In this way, patient-physician confidentiality was protected because couples had to consent to see the researcher. This proved to be a much more effective method of recruiting participants.

In recruiting participants from the adoption agencies, agency staff selected clients that had applied for their first adoption. These clients were then sent a

covering letter from the agency (see Appendices G and H) that included an invitation letter from the researcher, a legitimating letter from the researcher's supervisor and an Eligibility Form with a return envelope (see Appendices B, C and D). Again, couples who wanted to participate were instructed to return the Eligibility Form with their name and address to the researcher who would then contact them to set up an interview.

In addition to protecting confidentiality of records in the sampling procedures, it was necessary to set into place other measures that would ensure the confidentiality of responses once the couple agreed to participate. In setting up the interviews and describing the purpose of the research to the participants, it was necessary to emphasize that the research was being conducted independently from the Fertility Clinic and the adoption agencies through which they had been recruited. That is, although the clinic and the agencies were cooperating with the research by providing access to a sample, it was stressed that the findings and the results of the research were to be analyzed independently from the medical personnel at the clinic or the staff at the adoption agency. In this regard, participants were assured that their responses were kept in strict confidence from these personnel. This was perhaps most critical with respect to the adoption sample, for

questions were asked regarding their readiness for adoption. There was thus a danger that they would be unlikely to participate or respond truthfully if they felt the agency was going to know about their possible reservations concerning adoption.

In addition, because the letter which requested their permission to participate in the study was coming from the agency, there was a possibility that couples may have seen their participation in the study as having some bearing on their eligibility for adoption. In this sense, they might have believed that their refusal to participate in the study could possibly be used against them because of their vulnerable position with the agency. With this possibility in mind, the letters to potential participants directly addressed this issue (see Appendix D). Specifically, couples were informed that: the research was independent from the clinic or the agency; that the results of the research would not be given to these agencies except in a non-identifying and aggregate form; and that their participation in the research was voluntary. This final point was again emphasized in the initial phone contact in order to establish with certainty that the couples were not entering into the study under any misperceived feeling of duress.

### Sample Size

In carrying out the project, the researcher met with and talked to approximately 110 couples. This figure includes both the couples who were interviewed and observed in the preliminary study and couples who were given the formal questionnaires and interviews in the main part of the study. In the preliminary study, five couples were interviewed and approximately 30 couples were observed in their interactions over the course of five support group meetings. In the main part of the study, 76 couples participated.

The formal analysis in Chapters 5, 6, 7 and 8 focusses on the experiences of the 76 couples in the main study. Of these 76, two couples sent in the questionnaire only and were not interviewed. The overall participation rate was 43%. This varied by sample group as indicated in Table 1. For example, the sample group recruited from the Fertility Clinic had the highest participation rate (70.9%). This is no doubt attributable to the manner in which participants were recruited. In this group, couples were personally approached at the Fertility Clinic, whereas in all other groups couples were sent letters. This personal contact seemed to make a significant difference in the willingness of couples to participate (for a fuller discussion of this, see the next section on "Emergent

Problems", p. 147). By contrast, the lowest participation rate was encountered in recruiting participants from Family and Children's Services of Guelph and Wellington County. In this group, contact was made by mail and there were no follow-up letters. The result was a participation rate of only 15.4%.

Table 1. Response and participation rates

	Fertility Clinic	Waterloo CAS	Guelph CAS	TOTAL
Number approached	55	107	58	220
Number responding	55	87	22	164
Number eligible	55	69	52	176
Number who agree to participate	39	29	8	76
Response rate (%) [No. responding by No. approached]	100	79.8	37.9	74.5
Participation rate (%) [No. participating by No. eligible]	70.9	42.0	15.4	43.2

#### Emergent Problems in Obtaining Participants

When the effort was made to recruit couples for the study, some difficulties were encountered. Most significant

among these was the difficulty of getting early infertile couples from the gynecologists. No couples were successfully recruited to this group. In the first six weeks, only one patient was considered eligible by physicians and approached for participation in the study. In discussing this lack of eligible patients with several gynecologists, two possible reasons were offered as to why there were so few infertility patients. First, many couples who are very early on with infertility may still be seeing their family doctors for preliminary tests and are therefore not yet ready for their gynecologist. Second, since the gynecologists were located in the same hospital as the Fertility Clinic, it was suggested that there may have been a tendency for patients to go directly to the Fertility Clinic from their family doctor, rather than going to the intermediary, the gynecologist. In response to these difficulties, efforts were concentrated on recruiting early infertility patients from the Fertility Clinic, rather than the gynecologists.

Although patients were more readily recruited from the Fertility Clinic, even here there was some reluctance to participate. Those who were very early on in the infertility investigation were particularly difficult to recruit. One possible explanation for this is that many of these couples may not yet have identified themselves as actually having a fertility problem, and as a result, they do not see themselves participating in a study about infertility and

adoption. By way of illustration, one woman was approached in the Fertility Clinic to see if she would be interested in participating in the study. This woman and her husband had been trying to have a child for just over a year. When the study was explained to be about how having a fertility problem affects people in their lives, she curtly interrupted and said: "Please don't put that label on me (referring to "fertility problem"). I am just here for the first time to get something checked." This was an obvious example of someone who was very early on in the process and who resented being identified as "infertile." The woman did not agree to participate. Another couple expressed their reservations about the study after they were interviewed, which may illustrate why others did not participate. The wife expressed it like this:

When the doctor first mentioned this study to us he said it was about infertility and adoption and all of a sudden we felt like he was writing us off. Like we felt like the message was that there wasn't much else he could do for us. Like we were there to have someone help us with our fertility problem, not to have someone tell us that we were ready to be included in a study about infertility and adoption. We don't consider ourselves infertile - a problem, yes; infertile, no.

Here again, couples are particularly sensitive to the labels that are attached to them. Although other couples were not as direct as this in stating their feelings, it seems quite plausible that refusal to participate in these early stages can be partially accounted for by this lack of

identification with, or acceptance of, an infertile identity.

For other couples, the role of researcher may have been a source of confusion that may have resulted in non-participation. Near the end of an interview with one couple, the conversation went this way:

Wife: You know, he [her husband] didn't want to do this [the interview].

Researcher: Can you tell me why you were hesitant? I'm interested to know why some people don't get involved in a study like this.

Husband: I guess I just wasn't sure who you were. I knew you weren't a doctor and I really didn't like that. You (turning to his wife) said that the doctor told you that this guy could help us if we helped him and because we had inquired at one point about a psychologist maybe I thought you were a psychologist or something. I'm still not exactly sure what you are, but it has been good to talk to you about it, even though I didn't want to come here in the first place.

This lack of familiarity with sociologists specifically, or researchers generally, may have been an obstacle to participation for some couples.

In recruiting participants from the adoption agencies, one of the chief problems seemed to stem from concerns about confidentiality. For these couples, there seemed to be a lot of concern about how their decision to either participate or not participate might influence their chances of adoption. Although the couples were given written and verbal assurances that the the research was completely confidential and separate from the agency, the fear that it might jeopardize their chances of adopting was in some cases



a reason for participating, and in others for not participating. For example, one couple participated because they still believed that it had something to do with the agency homestudy. After briefly introducing what the study was about and reassuring them again that it was confidential, the husband said "I'm still not convinced that they (the adoption agency) won't find out what we say." More reassurances were given, but the gentleman was still suspicious as evidenced by him interrupting the interview after several minutes. He said: "Why do you and the agency need to know how often I go to church?" I explained that I wasn't sure why the agency needed to know but gave him the reason why I needed to know. At this point I confronted him with the fact that I didn't think it was worth proceeding with the interview if he was going to continue to suspect that I was an agency representative. This time he said he believed me and said he would answer honestly. The interview was then completed without further interruption.

For another couple, the concern about confidentiality was a barrier to participation. In talking to one couple on the phone, the concern about confidentiality was again expressed. Even after long explanations (15 minutes) of how anonymity was protected, there prevailed a concern that participation would jeopardize their chances at adoption. They decided not to participate.

Difficulties in recruiting participants from the adoption agencies may also be attributed to the amount of time that people had been in the process and the general emotional fatigue that they felt as a result. In talking to people who did participate from these groups, one gets the sense that many of the issues have been talked about and analyzed by the couple over and over. As a result, the prospect of going over it all again with a researcher may have seemed simply too tiring for some couples to participate. For example, in contacting one couple for an interview, the husband answered the phone and had this to say:

My wife sent in that form without really consulting me. I am not the kind of person who really wants to talk about that kind of thing. Besides, we've been all through Children's Aid with this thing and frankly I'd like to put it to rest. My wife doesn't like to live through this stuff every time we talk about it. And we've talked about it again and again and again.

There was the sense that these people were reluctant to devote more time to a process that had already been very expensive in terms time, privacy and emotional energy.

In addition to some of the unique recruiting problems in each of the groups, there were some other observable tendencies that may explain non-participation across all of the groups. No doubt one of the key difficulties in recruiting participants for this research is the sensitive and private nature of the topic. Infertility

touches on issues such as ways of coping with crisis, sexuality and family values which are all areas typically considered to be private by most couples. Therefore, the thought of discussing these with a stranger was too much to bear for some couples.

Men seemed to be more reluctant than women to participate in the study. One of the main reasons given for not participating in the study was the husband's unwillingness to talk about his feelings about infertility. On numerous occasions the wife said something like:

No, my husband is just not ready to talk about it. Its just not something he talks about anyway. Usually he is OK talking about things like this but in this case he just feels that it is too private.

In some cases, the husband participated even after showing some initial reluctance. For example, one woman said this:

I was ready to agree to the interview right off the bat. But he didn't want to initially. I think that he is shy and feels this is personal.

The way that couples were recruited also seems to have some bearing on the number who agreed to participate. As the above discussion has pointed out, the two methods that were used to recruit couples into the study were a mail-out invitation letter and a personal introduction and explanation of the study to couples at the clinic. One woman, who had been recruited personally through the clinic, asked about how many other people were in the study and how they had been persuaded to participate. I explained that

some had also been recruited through letters to which she replied:

I would have never participated if someone had just sent me a letter. This is too private to just talk to anyone about it. I think because I saw you at the clinic that day and you explained it to me that it seemed OK.

With the sensitive nature of infertility, it seems apparent that a letter was more likely to lead to non-participation than a personal contact. This is certainly reflected in the different rates of participation for the study (see Table 1), with personal contact being dramatically more successful than letters in recruiting participants.

For other couples, the timing of the request to participate seemed crucial in their decision to participate or not. For these couples, significant events in the infertility process that were happening at the same time as they were being asked to participate influenced their decision. For example, one woman had this to say:

I almost threw this damn thing in the garbage when I received it. We got it just after I miscarried. I just let it sit there for a couple of weeks and finally got the nerve to send it in.

For another woman, recent attendance at an infertility support group meeting was instrumental in deciding to participate:

I immediately wanted to send it in because I wanted to help. But I was only in that frame of mind because I had been to a couple of support group meetings where I discovered that it does help to talk about it with others who are in the same boat. Therefore I felt that since it helped me, I could help in the study. Now if

it had come three months ago, before I had gone to any of the meetings, I would have thrown it right in the garbage - I was so angry then.

Other timing considerations may also be relevant in explaining non-participation. One could speculate that if the couples were approached at particularly difficult times in the infertility process (such as failure of a particular treatment or more generally at times of depression or diminished hope), one would expect greater reluctance at entering into the study.

#### Putting the Sample in Context: Limitations on Generalizability

The generalizability of the results of this study depends in large degree on the representativeness of the sample. In order to generalize accurately to the larger population from which the sample is drawn, it is necessary to identify the ways in which the sample is, or may be, different from the population. In Chapter 5, there is a comparison of sample characteristics and population characteristics. However, the extent to which the sample reflects the population is determined by a number of factors including sources of bias in the recruitment procedure and rates of non-participation.

There are several sources of sampling bias arising from the way that participants were recruited for the study.

First, in choosing a Fertility Clinic as a sampling source, it is possible that there is an under-representation of people who are in the beginning stages of the fertility investigation. These couples would likely be still seeing their family doctor for preliminary tests and treatments. Also, couples who are attending the clinic may be couples with fertility problems that are more difficult to identify. Family doctors or local specialists may run basic fertility tests on their patients which identify some of the more obvious fertility problems (e.g. low sperm count or blocked tubes). This may give rise to an over-representation of couples who are "normal infertile" (i.e. idiopathic infertility where there is no identifiable cause) or who have more subtle or difficult to diagnose fertility problems requiring the services of a speciality clinic. As a result, the sample from the Fertility Clinic may have more couples who are later on in the fertility process and who have more difficult fertility problems than one would expect in the population as a whole.

Second, in choosing public adoption agencies as a source of a sample, there is a possibility that couples who choose alternate adoption strategies would be under-represented. There is a greater chance that those who seek to adopt privately by putting their names in with physicians and lawyers, or who apply to private adoption agencies or who seek an international adoption would be under-

represented. Because some public agencies no longer accept couples on their waiting lists, due to the length of these lists, it is impossible to determine whether couples pursue these alternatives out of choice or necessity. If one could say with certainty that it was out of choice, then there would be the possibility that these couples would be more highly committed to parenthood because of the amount of work that is involved in following this route. However, because many of the couples who choose these alternatives cannot get on the list with a public agency, it is impossible to say if they would be in any way different from couples seeking to adopt through a public agency. Furthermore, some couples no doubt pursue private and public adoption concurrently. Hence, it is difficult to say with any certainty the extent or direction that this bias might take.

Finally, because not all couples who were contacted agreed to participate, the representativeness of the sample can be questioned on the grounds of non-response. Are those who choose to participate in the study significantly different from the population of couples who attend the Fertility Clinic or the adoption agency? As is the case with most non-response, one can conjecture that those who do participate may be more highly motivated and more open in talking about sensitive topics. The implication of this, of course, is that the sample may under-represent couples who

see infertility and adoption as very private issues or who do not see the merits of doing research on the topic. Other possible reasons for non-response could include separation or divorce, changed addresses or loss of the questionnaire. One could also speculate that those people who did not meet the basic eligibility criteria (see Appendix C) would not be highly motivated to return the form to the researcher.

In summary, there are limitations on the generalizability of the sample. These limitations, however, are only problematic if their significance is overlooked when interpreting the data. Keeping them up front and in the open is the only way of accurately placing the data in context.

## ANALYZING THE DATA

In analyzing the data, a number of statistical procedures were used. In order to examine the bivariate relationships between the independent variables and the dependent variable, crosstabulations were obtained. Pearson's Product Moment Correlation Coefficients were used to determine the strength of association between the independent and dependent variables. This coefficient varies between -1.00 (perfect negative association) and +1.00 (perfect positive association) with 0.00 signifying no relationship. The .05 level of significance was chosen as



the minimum acceptable level. However, in reporting the correlation coefficients, actual levels of significance are reported.

The use of Pearson's  $r$  assumes that both independent and dependent variables are intervally measured. In this analysis, the assumption was made that all variables used in calculating associations were continuous, and therefore, interval. In this regard, the data fit the assumptions of the general linear model thereby allowing for correlation analysis (Hunter, 1985:653).

In order to determine whether the associations were in fact linear, as opposed to curvilinear, the statistic eta was used. As Loether and McTavish (1974:251) point out:

Since Pearson's  $r$  and eta have essentially the same form, and differ only in the source of the refined prediction, they can be compared directly ... If eta is larger than Pearson's  $r$ , then one can infer that category means do not fall along a simple straight line, and thus to some degree, the nature of the association is curved or different from a straight line.

In instances where eta was significantly larger than Pearson's  $r$  ( $>.10$ ), thereby indicating a curvilinear relationship, these are identified and discussed.

Multivariate analysis was also conducted using the multiple regression technique. Multiple regression is a general statistical technique that allows the researcher to analyze the relationship between the dependent variable and a set of independent variables. While taking into account

the relationships among the independent variables, it is used to analyze their predictive power on the dependent variable. When the best linear equation is found, the researcher can conclude that the independent variables included in the equation best explain the variance in the dependent variable.

The selection of independent variables for the multivariate analysis was guided by theoretical considerations. Only those variables that might logically explain transition to adoptive parenthood were put forth. The independent variables that were selected were first examined for multicollinearity in order to ensure that none of the independent variables were highly intercorrelated. Intercorrelations in the .8 to 1.0 range are considered problematic.

The backward elimination technique was used as a way of determining which independent variables would be left in the regression equation. With this technique, all independent variables that are to be regressed are tested for tolerance prior to entry into the equation. The tolerance of a variable is the proportion of its variance not accounted for by the other independent variables in the equation. All independent variables passing the tolerance criterion are entered into the equation. At each step of regression, the independent variables are examined for

removal and the variable with the largest F-value is then removed (SPSSX Inc., 1983). The independent variables are thereby removed, one at a time.

In order for the regression to be based on the same universe of data, listwise deletion of missing data was used. With this approach, all cases with missing values were automatically eliminated from all calculations.

In carrying out both the bivariate and multivariate analysis, the SPSSX (1983) computer package was used.

#### INFERTILITY AND ADOPTION AS SENSITIVE TOPICS: METHODOLOGICAL CONSIDERATIONS

In carrying out this research, several unique methodological considerations warranted attention. These included: using the couple as the unit of analysis; catching the dynamic aspects of the process; the problem of accessing a private sphere of family life; ethical considerations in the interview, the role implications for the researcher as an "insider", and finally, the validity of "insider" data.

#### The Couple as the Unit of Analysis

Throughout this study, the couple was the unit of analysis. Although the interview was structured in such a

way so as to elicit some of the individual views of both husbands and wives, it was deemed important to interview them together, so as to come to an understanding of their shared meanings. Mudd (1980:28) has pointed out that it is of "paramount importance" to look at the experience of both man and woman in their relationship. Likewise, Marshall (1967) concludes that infertility is a conjugal problem and should be studied as an interacting unity of husband and wife.

Although the couple is the unit of analysis insofar as the couple was interviewed together, no assumption is made that the spouses hold identical views on the various issues addressed in the interview. That assumption has led researchers in the past to make generalizations about family reality on the basis of one respondent in the family. This tendency to assume that the views of one family member accurately represents the responses of other family members, has been called one form of the "ecological fallacy" (Larson, 1974).

The most obvious form of this methodological weakness has been demonstrated in the tendency to make generalizations about the family on the basis of wives' responses. This has led Saffilios-Rothschild (1969) to comment that much of family sociology would be more appropriately entitled "wife's family sociology." As her empirical review clearly indicates, there are varying levels

of congruence between husbands and wives' perceptions of family decision-making. The discrepancy between the responses of husbands and wives is a function of husbands and wives having separate subjective "realities" that do not always coincide. Each spouse defines situations differently according to his own needs, values, attitudes and beliefs (Saffilius-Rothschild, 1969:291). These separate realities of husbands and wives warrant attention in the study of infertility. Humphrey (1977), for example, points out that men and women have divergent attitudes towards childlessness and parenthood.

In recognition of the importance of obtaining various family members' perceptions of family phenomena, Thomas and Calónico (1972) have pointed out the importance of understanding family through "multiple member measures." Berardo, Hill, Fox, Wiseman and Aldous (1981) concur with this, suggesting that by conducting in-depth interviews with more than one family member that it is more likely that the researcher will get a picture of the family "in situ."

In light of these considerations, this research sought to examine both the shared reality between husband and wife as well as that part of their reality which is not shared. Interviewing the couple proved a most effective and efficient manner for understanding the shared reality of husband and wife, whereas an independently filled out

questionnaire was used as a way of understanding each spouse's independent reality. Interviewing spouses together has the following advantages: with two accounts, a more reliable picture may emerge as the bias in one version may be balanced by that in the other; spouses can corroborate the statements of the other; they can jog one another's memory; and spouses tend to keep each other honest (Allan, 1980). Furthermore, as Hill and Scanzoni (1982:931) point out, the conjoint technique has the net effect of reducing social desirability effects and improving reliability and validity because spouses are constantly checking back and forth with each other to make sure they are reporting accurately. Conversely, the presence of one's spouse may inhibit certain responses, and for this reason, there is an advantage to questioning spouses separately. By interviewing the couple and by also giving a questionnaire to each spouse, this research attempted to understand both shared and independent realities.

The interview schedule was designed in such a way as to tap into these shared perceptions of biological and adoptive parenthood. Both the husband and wife were asked to respond to the same question. In practical terms, this often involved prompting spouses to agree or disagree with what the other had said. This was particularly important for questions that dealt with such critical areas as feelings about infertility or feelings about readiness for adoption.

In this way, areas of convergence and divergence in their meanings of parenthood could be identified. Of course, there were limitations with this approach. Most notable was the tendency on the part of some spouses to simply agree with the other spouse because nothing else came to mind. For others, this tendency to agree may have been indicative of a social desirability response insofar as spouses may have wanted to present a unified front to the researcher.

Interviewing the couple also permitted the researcher to observe their dynamics as they negotiated and discussed various issues. In a sense, this allowed the researcher to "catch the process."

### Catching the Process

As Straus (1964:341) has convincingly argued, a discipline concerned with a group like the family "cannot depend on the characteristics of individuals, or, in most cases, on the summation of the properties of the individuals making up the group ... instead, it is necessary to develop ways of measuring group properties." Likewise, Wiseman (1981) has called for an increased emphasis on naturalistic approaches which allow family dynamics to be studied as they actually occur. Olson and Cromwell (1975), in a study of family power, suggested that this understanding comes, not

from looking at outcomes of the process, but at the process itself.

Although it may be necessary to look at the separate realities of husbands and wives, it is by no means sufficient. What is overlooked in this approach are the shared meanings, the "dynamics", or as Straus (1964) would call them, the "group properties" that tell us something about interaction and the social construction of reality. Of particular interest in this research is the manner and the extent to which couples come to some agreed upon or shared definition of what it means to be a parent. By interviewing the spouses together, the researcher can "witness how the couple perform together, how they attempt to support and influence one another and how they cope with disagreement" (Allan, 1980:208). In this respect, the joint interview is the vehicle for gaining insight into aspects of their marriage relationship. This is especially pertinent in exploring how infertile couples come to some consensus in the various decisions that they may must make throughout the infertility process. Examples of this include how couples decide to seek treatment, how they decide to continue or discontinue tests or treatments, or how they decide to enter into the adoption process. Also important are the ways in which couples share their thoughts and feelings about the loss of biological parenthood and the possibility of adoptive parenthood.



### Accessing the Private Sphere

The structures and processes of the family are unlike any other small group. Walters (1982), for example, has pointed out that families are different from other small groups because of biological ties, commitment and attachment, and the prospect of future interaction. Accordingly, there is a unique set of methodological problems that are encountered when studying this unusual group. Some of these unique methodological difficulties warrant attention when looking at the meanings that infertile couples attach to parenthood.

Perhaps the most fundamental methodological difficulty was the collection of data from a group that so highly values its autonomy and privacy. For the researcher seeking to gain access to family life, this ideology of privacy can manifest itself as a conspiracy of silence.

Goffman's (1959) distinction between behavior which occurs in "back regions" and "front regions" is illustrative of the difficulties that are encountered by family sociologists seeking to understand the private lives of families. Certain activities within the family, especially those that deal with sex or reproduction, are highly private activities that occur in the "back regions." By contrast, families also have a public side that they present in the "front regions." This is an effort at collective "impression

management" whereby they attempt to present the image that "everything is fine." The researcher frequently has access to their "public" presentation but not to their private "back region" behavior.

Infertility, especially in light of its "stigmatizing character" (Veevers, 1980:6), is a highly privatized aspect of family life. A researcher might expect difficulty in gaining access to this "back region behaviour." However, in carrying out this research, this researcher generally declared his own personal involvement with adoption and infertility, and this may have led to a greater than normal access to this privatized sphere. Humphrey (1969b) reported a similar experience in his research when he pointed out that a woman interviewer who was infertile seemed to have established greater rapport with the interviewees because of her infertility.

For most couples who agreed to participate, it seemed that they valued the opportunity to talk. This was evidenced by statements made at the end of the interview which reflected the importance of the discussion for the couple. It was not uncommon for couples to say things like "I've never heard you say things like that before, even though I knew you were thinking them (said to the spouse)" or "We've talked about some things here tonight that I've wanted to say but never have" or simply "it has been very

good for us to talk about this tonight - we will no doubt be talking about some of these things all week." Another indication of the value that was placed on the interview was the amount of time that couples devoted to it. The average length of time for the interview was about two and a half hours and some couples spent up to four hours talking about their experiences. In many cases, couples would spend up to an hour after the formal interview was finished describing other experiences they had had. In some instances, these last minute revelations constituted some of the most interesting and intimate data. Gelles (1976) has offered a plausible explanation for the value that participants place on such interviews. He suggests that interviews on sensitive family issues are often seen as an opportunity for an "emotional catharsis" which is rewarding.

#### Ethical Considerations in the Interview

Because of the private and sensitive nature of infertility and adoption, it was necessary to protect the anonymity of the subjects. This was accomplished by omitting any identifying information such as names, addresses or phone numbers from the interview schedules. Second, in this analysis, unusual or peculiar information or circumstances that could lead to the identification of one of the research subjects was deleted or altered in order to ensure the

anonymity of the participants.

However, ethical considerations also guided the way in which the interview was conducted. The researcher was mindful that limits had to be placed on the extent of probing done to elicit information. The potential negative consequences of couples saying more than they normally would about a particular issue when being prompted by a researcher can be disruptive to family relations once the researcher has departed (LaRossa, Bennett & Gelles, 1981). In fact, in some instances, the exposure of "family subjects to themselves through case analysis" can be detrimental to the self-esteem of individual members (LaRossa et al., 1981:310). In addition, research on sensitive family topics, such as infertility and adoption, unless guided by clear objectives, can be likened to nothing short of "voyeurism" (Gelles, 1978). Furthermore, as Cicourel (1967:64) reminds us, even where there is apparent readiness by respondents to submit to the interview, this is not a guarantee that the subjects have no objections to the interview, or that objections will not emerge over the course of the interview.

#### Role Implications for the Researcher as Insider

Because of the researcher's experience with infertility and adoption, he can in this case be considered

an "insider." Some implications of this were clearly advantageous, while others were disadvantageous.

One of the chief benefits of being an insider was that rapport was more readily established with couples. The researcher was perceived as sharing the same reality. As Berk and Adams (1970:103) argue, when there is greater social distance between the participant observer and the subjects, there tends to be greater difficulty in establishing and maintaining rapport. This greater difficulty can be attributed to a sense of mistrust or suspicion when the researcher is an outsider who is unfamiliar with the nuances of how to behave or with the argot of the group. The insider is clearly in an advantageous position in this regard, for by using and emphasizing the fact of their shared experience, he is more quickly accepted and trusted. Hence, as is the case with any newcomer to a group, the often awkward process of "fitting in" is facilitated by the common ground of experience from which the new relationship is forged.

To facilitate this, this researcher made a point of stressing his own experience with infertility. After the initial cordial exchanges, I would begin talking about how I came to be interested in the topic of infertility by focussing on my own experience of it - how I took for granted that I could have children, how disbelieving I was when I discovered that I might not be able to and the

disappointments I had along the way in coming to terms with infertility. Rapport may have been more quickly established because I was seen as someone who had a "sympathetic ear" and who could understand their condition. As an indication of this, one woman pointed out in the middle of the interview "I don't think you would have been able to do this research if you hadn't gone through having the problem." By presenting myself in this way, there was a solid grounding upon which we could reciprocally gear into each other's social world.

One of the implications of this closer familiarity for the insider is that there may be greater tension between "role demands" and "self demands." This tension is present because

... every field work role is at once a social interaction device for securing information for scientific purposes and a set of behaviors in which an observer's self is involved (Gold, 1957:218).

In light of the scientific emphasis on "objectivity," the demands of the self or the subjective perceptions of the researcher are often overlooked or consciously denied in favour of a detached or "objective" approach. For the insider, however, these demands of self are a more salient force. His personal involvement predisposes the researcher to a specific perspective or world view that is shaped by a highly idiosyncratic set of thoughts, feelings and experiences. To be sure, all researchers enter the field

with a set of predetermined assumptions and expectations. However, the insider is unique in the degree to which his taken-for-granted reality shapes these expectations. Few researchers have explored the effect that these subjective demands have on the outcome of the research process. In reflecting on the subjective origins of his own research on urban crime, Friedrichs (1981:217) makes the disturbing conclusion that most academic papers, including his own, are presented as "products of a disembodied intellect." It would seem that, for the insider, past-related experiences become an essential part of the research process that demand conscious and deliberate application, not just acknowledgement. Practically speaking, this means that the presentation of self in the research process includes statements and disclosures about one's experience with the phenomenon in question.

In this particular research, such disclosures as "I know from my experience of going through infertility for five years that it can be a very frustrating experience," or "I felt the same way when that happened to me" were simple ways of indicating personal awareness of what they were talking about. In this regard, I would argue that the "role demands" as an inside researcher are best met by being adequate to the "self demands" as a person who has experienced, thought about and felt infertility.

The deliberate use of one's experience in research on sensitive topics such as this is important in unravelling the experience of the other. Berk and Adams (1970:115) point out that the revelation of some intimate facts promotes acceptance and trust in the field work relationship which can pay dividends in terms of the depth and quality of the data collected. In that sense, a relationship within the research context is not unlike any other relationship that is forming, where the reciprocity of disclosure is crucial for understanding. Wax (1971:20) has also emphasized the importance of establishing the "reciprocal social response" by showing respect and interest and by giving assistance to respondents. The insider is in a good position to do this because of the broad base of experiences and resources that can be drawn on in order to enhance the reciprocity of the interview interaction. In this research, it seemed appropriate to provide information as a way of "giving back" to the respondents. For example, couples would often ask for information about how they compared with other people I interviewed. This was usually an appeal to see how "normal" they were in their experience of infertility. Whenever possible, an attempt was made to tell them how they were similar, yet unique in comparison to other couples interviewed. Some couples asked for practical information with respect to infertility support groups, doctors and adoption procedures. This was provided whenever possible.



An implication of the researcher giving assistance is the potential for role confusion in the mind of the participant. Because of the close familiarity of the researcher with the subject matter and the casual style with which this information was shared, there may have been a greater likelihood that the researcher's role was confused in the mind of the subject. For example, Bott (1957:20) has described being identified in "largely incompatible and partly inappropriate roles; those of friend, research worker and therapist."

This confusion is especially probable when the topic is a personal or private problem that is in need of solution. When the researcher is viewed as highly educated and with knowledge of the problem, he or she can be perceived as an expert who not only asks questions but who can also provide answers. Lopata (1980:78) describes the difficulty that she and her staff encountered in doing research with widows:

Over and over, we found the respondents expecting some sort of direct help as a result of the interview, a solution of problems and even a complete change in life. They assumed that the interviewer ... has the power to bring societal resources to them ... It is difficult to be faced by a respondent who is so obviously in pain or need and whom we are not trained to help.

In doing interviews with infertile couples, similar expectations emerged which made it difficult to stay in the researcher role. As infertility is such an emotionally-

laden topic, couples might easily confuse the role of the researcher with that of a counselor or a supportive friend. For example, one husband and wife were having widely different experiences in the way that they were coping with infertility and were having difficulty understanding each other's experience. As a result they turned to the interviewer to help them understand one another:

SHE: He doesn't know exactly how I feel and I find that hard to understand, because he is my husband and this is his problem too. He wants a child too. He just seems to be able to accept it so much easier without asking questions.

HE: Well you just have to accept it, no?

SHE: Well I agree with him, you have to accept it because I have no choice. Like what am I going to do? I can't go on crying all my life. But what I can't understand is 'How can it be so much easier for him to accept than me?' How? (turning to me inquisitively)

In this instance, a simple therapeutic technique was used to simply reflect the same question back at her. In other words, the person was asked why she thought it was easier for him to accept it to which she responded with a long explanation about his family background. This technique was effective insofar it served both the respondent's therapeutic need as well as the researcher's need for data. By not offering advice or possible explanation, it allowed the role of researcher to take precedence.

Miller (1969) has warned against the problems associated with "over-rapport" and recommends that a balance be struck between rapport and objectivity. This advice is

particularly relevant for the insider doing research because the danger of over-rapport is greater. In recognition of this, an effort was made maintain some social distance between myself and the couples under study.

Ironically, when it comes to highly personal issues, some people are more comfortable talking to a stranger with whom there is little possibility of future interaction than with close friends and relatives. This became particularly evident when the tape recorder had been shut off at the end of the interview. Many of the respondents indicated that they had never talked about some of these things either between themselves or with close friends or family members. One man explained it this way at the outset of the interview:

Husband: You know, I felt a little bit uncomfortable about you coming here to talk about this tonight.

Interviewer: Well it is a topic that is very private. I know that in my own experience I didn't find it easy to talk to people about it - even close family and friends.

Husband: Well that's the funny thing about it. Its probably easier to talk to you because you are a complete stranger than, lets say, my mother. For instance, she lives with us and she asked us at the supper table who was coming tonight. I just said you were some researcher coming to talk to us about some things. I was uncomfortable even telling her what you were coming for. I was very evasive.

Perhaps Simmel's (1950:404) explanation of the "stranger" comes closest to accounting for these intimate disclosures. For Simmel, the perceived "objectivity" of the stranger may give rise to "the most surprising openness -

confidences which sometimes have the character of a confessional and which would be carefully withheld from a more closely related person." Furthermore, playing the role of the objective stranger incorporates a structured balance between "distance and nearness, indifference and involvement" (Simmel, 1950:404). The implications of this for the insider are clear: use the nearness and involvement that is afforded by the shared experience to gain access and establish trust, but maintain whenever possible the distance and mystery of the stranger in order to encourage the intimate disclosure of information.

Being "in the know" can also work against the investigator. When the researcher and the subject operate from a shared reality, there may be a tendency to take too much for granted. This can serve to inhibit the flow of data in two ways. First, the researcher may overlook certain aspects of the subject's reality because of his or her presumed familiarity with that reality. In this sense, initial familiarity with the phenomenon under study results in a blindness to certain details that might be important. Second, persons may withhold information because it is seen as too obvious in light of the shared reality with the researcher. One instance of this in this research occurred when a woman began to talk about her experience of going to the gynecologist for infertility investigation and having to sit in a waiting room of pregnant women. She said: "Its not

fun going to these things ... but well, you know." In this situation it was necessary to establish a "pretense awareness context" (Glaser and Strauss, 1967) that conveyed a message of my own ignorance. Therefore, regardless of whether or not I could anticipate what they were going to say, I encouraged them to continue by saying something like, "No, I'm not really sure what you mean, could you explain?" or "No, I've not had that kind of experience, please go on." At least in these situations, there was an opportunity to tease out what it was that was taken-for-granted.

Considerably more disconcerting, however, is the possibility that subjects would not even say certain things because they felt they were insignificant or too obvious because of the shared, taken-for-granted reality with the researcher. In this regard there may be an indeterminant amount of data that is lost on account of the shared reality base.

Another potential disadvantage of being an "insider" is that there may be a greater likelihood of introducing bias into the research because of the way that personal experience colours one's "way of seeing." Although this personal involvement may be considered to be problematic by some by the fact that it may introduce bias, it should be remembered that it is impossible to avoid some level of subjectivism when recording and interpreting data (Bogdan, 1972:45).

### The Validity of Insider Data

The danger of subjective distorting of the data by an 'insider' is worthy of attention because close familiarity and pre-acquaintanceship with the subject matter is perhaps more likely to colour the way that one sees a phenomenon. In such circumstances, the way that the researcher reports on his findings may be more a reflection of his experience, than that of the subject. However, in doing research such as this, that seeks to understand the meaning that certain phenomenon hold for people in their lives, there is some suggestion that objectivity is most successfully achieved as the researcher gets closer to the phenomenon under study. Wolff (1964:248), for example, suggests that the best method for achieving objectivity is not for the researcher to distance himself, but to "surrender" himself to the phenomena that he wishes to understand. This involves "total involvement, suspension of received notions, pertinence of everything, identification and the risk of being hurt" (Wolff, 1964:236). Only when the researcher gets close enough so that the phenomena can reveal itself to him, is he "being adequate to the object." Likewise, Blumer (1969:86) emphasizes the importance of the researcher "taking the role of the acting unit whose behavior he is studying" in order to get accurate data. To try to collect data from a distance is to risk "the worst

kind of subjectivism" (Blumer, 1969:86) or the "fallacy of objectivism" (Denzin, 1978b:10).

The insider has a head start on this proximity because of his pre-acquaintanceship with the phenomenon. As a result, taking the role of the other is facilitated. Working from a base of shared reality, the insider can get closer to the "other's" domain of experience. In so doing, the insider is afforded an intimate glimpse of "other's" reality.

There is no doubt that, in this research, the gap between the researcher and participants was narrowed by my personal experience with infertility. This personal experience allowed me to get close to the other's experience and, in so doing, it promoted a sense of being "adequate to the object" [ie. the issue of infertility] that would otherwise not have been achieved. It is likely that, only because of my personal experience were couples willing to discuss their grief over being unable to have children, their feelings of isolation resulting from the inability of their reference group to understand their predicament, their feelings of violated privacy and their feelings of persistent depression or aimlessness. If so, the cost of subjective bias is offset by the greater closeness to the phenomenon that is achieved by the insider.

In the chapters which follow the results of the main

study are presented.



## CHAPTER 5

### THE TRANSITION TO ADOPTIVE PARENTHOOD: SAMPLE CHARACTERISTICS AND GROUPS USED IN THE ANALYSIS

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### THE TRANSITION TO ADOPTIVE PARENTHOOD: SAMPLE CHARACTERISTICS AND GROUPS USED IN THE ANALYSIS

In the chapters that follow, the data of the main study are presented. This chapter examines first the characteristics of the sample group used to understand people who go through the transition to adoptive parenthood. This is followed by a discussion of how the sample was divided into three categories, each representing a particular stage in the process of transition. These three categories represent the dependent variable and are used in most further analysis to trace the progression from biological parenthood to adoptive parenthood. To give shape to the ensuing analysis, the chapter concludes with an overview of the relationship between the infertility process and the adoption process.

#### SAMPLE CHARACTERISTICS

Couples who go through the transition to adoptive parenthood can be examined along two dimensions: demographic characteristics and fertility-related characteristics. Data

were collected separately from husbands (N=76) and wives (N=76) and are usually presented separately for each. The exceptions are length of marriage and the fertility-related characteristics which are 'couple' phenomena. As there were no significant differences among the groups on any of the demographic variables, these data are presented for the sample as a whole rather than individually for each of the three sample groups. On some of the fertility related characteristics there were some differences, but these are discussed later.

#### Demographic Characteristics

Age. The mean age of the sample was 31 for husbands and 30 for wives. As Table 2 shows, approximately one half of the sample were between the ages of 28 and 33, while about one quarter were 34 or older.

Table 2. Age distribution

Age	Husbands (N=76) %	Wives (N=75) %
< 28	20.0	30.3
28-33	53.3	48.7
> 33	26.7	21.0
Total	<u>100.0</u>	<u>100.0</u>

Length of marriage. About one-half of the sample had been married for between five and ten years. One third had been married for less than five years while 14% had been married for more than ten years. The mean length of marriage was 6 years.

Table 3. Length of marriage

Number of years married	(N=74) %
1	4.1
2	2.7
3	10.8
4	17.6
5	8.1
6	13.5
7	13.5
8	9.5
9	4.1
10	2.7
11	6.8
12	1.4
13	2.7
14	1.4
15	1.4
Total	100.0

Number of times married. Nine out of ten couples were in their first marriage. Only one couple was not married. Seven percent of husbands and nine percent of wives had been married more than once.

Table 4. Number of times married

Number of times married	Husbands (N=75) %	Wives (N=76) %
0	1.3	1.3
1	92.0	89.5
> 2	6.7	9.2
Total	<u>100.0</u>	<u>100.0</u>

Education. The sample was highly educated. One-third of men and one-fifth of women, in comparison to only 8% in the general population, held university degrees. By contrast, only 4% of husbands and 1% of wives compared to 21% in the general population had grade school or less.

Occupation. Corresponding to the high levels of education, the sample also consisted of a high concentration of respondents in professional or managerial positions. As shown in Table 6, approximately one-third of husbands and one-quarter of wives held positions at a professional or management level. By contrast, only 17% in the general population had occupations at this level. Van Keep and Schmidt-Elmendorff (1975) also report a high proportion of upper-middle class respondents in their sample.

Table 5. Education

Level of Education	Husbands (N=75) %	Wives (N=75) %	Census, 1981 (N=17,811,490) %
Grade School	4.0	1.3	20.9
High School	32.0	33.3	46.3
Community College	24.0	22.6	20.6
Some University	8.0	21.4	3.8
Bachelor's Degree	20.0	14.7	8.4
Master's Degree	6.6	5.4	
Doctorate	2.7	0.0	
Professional Degree	2.7	1.3	
	32.1	21.3	
Total	100.0	100.0	100.0

1. Based on a population 15 years and over showing highest level of education.

Religious affiliation. Consistent with the general population (see Table 7), approximately two-fifths of the sample were Protestant. Catholics were slightly under-represented in the sample. While almost one-half of the general population are Catholic, only one-third of the sample were Catholic. More of the sample (14% of husbands and 10% of wives) indicated no religious affiliation in comparison to the general population (7%).

Table 6. Occupation

			<sup>1</sup>
	Husbands (N=74)	Wives (N=75)	Census, 1971 (N=7,889,545)
Occupation level	%	%	%
<sup>2</sup>			
Professional	17.6	0.0	8.3
<sup>3</sup>			
Management	9.5	6.6	4.2
Semi-professional	6.8	20.0	4.1
Technicians	9.5	5.3	1.6
Supervisors	0.0	0.0	5.8
Foremen	0.0	0.0	3.6
Skilled Clerical	6.8	14.7	8.3
Skilled Trades	16.2	6.7	11.9
Semi-skilled Clerical	5.4	25.3	14.8
Semi-skilled Manual	16.2	0.0	10.9
Unskilled Clerical	1.4	5.3	5.1
Unskilled Manual	8.1	16.0	15.1
Farmers	2.7	0.0	3.0
Farm labourers	0.0	0.0	3.2
Total	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>

1. Source: Pineo, Porter and McRoberts (1977)

2. The categories "self-employed professionals" and "employed professionals" used by Pineo et al. (1977) were collapsed into a single category called "professionals."

3. The categories "high management" and "middle management" used by Pineo et al (1977) were collapsed into the single category "management."

Table 7. Religious Affiliation

Religion	Husbands (N=74) %	Wives (N=74) %	Census, 1981 (N=24,083,500) %
Catholic	31.1	32.4	47.4
Protestant	41.9	40.5	41.2
Jewish	0.0	0.0	1.2
Other	13.5	17.6	2.8
None	13.5	9.5	7.4
Total	100.0	100.0	100.0

Country where born. Similar to the general population, the majority (84%) of the sample were born in Canada. Only 20% of husbands and 16% of wives were born in a country other than Canada.

Table 8. Country of birth

Country	Husbands (N=75) %	Wives (N=76) %	Census, 1981 (N=24,083,500) %
Canada	80.0	84.2	83.9
Other	20.0	15.8	17.1
Total	100.0	100.0	100.0



Ethnic background. Approximately one quarter of the sample indicated that their ethnic background was Canadian. The largest proportion of both husbands (36%) and wives (47%) were of British, Scottish or Irish background and this was consistent with the general population. There was a slightly higher proportion of Germans and Italians in the sample when compared to the general population. However, this reflects the fact that the sample was drawn largely from Kitchener and Hamilton which have strong representations of German and Italian (respectively) ethnic groups.

Table 9. Ethnic Background

Ethnic background	Husbands (N=72) %	Wives (N=72) %	Census, 1981 (N=24,083,495) %
Canadian	26.4	22.2	—
British, Scottish, Irish	36.1	47.2	40.2
Italian	11.1	2.8	3.1
German	9.7	6.9	4.7
United States	1.4	0.0	—
Other	15.3	20.9	48.0
Total	100.0	100.0	100.0

Size of family of origin Only 5% of husbands and 3% of wives were only children. Approximately half of the sample came from families of 2 or 3 children. This is consistent with Lenton, Weston and Cooke (1977) who reported that the majority of infertile women come from small families. By contrast, one-quarter of the husbands and one-third of the wives came from families of five or more children.

Table 10. Size of family of origin

Family size	Husbands (N=75) %	Wives (N=76) %
1	5.3	2.6
2	24.0	21.1
3	22.7	27.6
4	22.7	15.8
5 or more	25.3	32.9
Total	100.0	100.0

Adoption in family of origin. Only one husband (1%) and none of the wives were themselves adopted. Six percent of the husbands and one percent of the wives had a sibling who was adopted.

### Fertility-Related Characteristics

Expected family size. Couples were asked to indicate whether they had come to some agreement on the number of children they would like to have. Forty-three percent of the couples had come to some agreement. As Table 11 shows, two-thirds of those who agreed desired to have two children, with the remainder wanting three or four. None expressed a desire to have only one child. In fact several expressed concerns about the prospect of having an only child. One quarter of the husbands and 16% of the wives rationalized their desired family size by saying that they would have any number but one. By far the most common reason given by husbands (21%) and wives (38%) for their desired family size was that they came from a family of that size.

Table 11. Expected family size when spouses agree

Number of children	(N=33) %
2	66.7
3	27.3
4	6.0
Total	<u>100.0</u>

In 29% (N=22) of the cases, spouses did not agree on the size of the family they would like to have. Wives tended to express a desire for more children than husbands. The mean expected number of children for husbands was 2.9 while for wives, the expected number was 3.5. As Table 12 shows, one-half of husbands expected to have two children, while only 27% of wives expected to have two children. One half of the wives compared to only 23% of the husbands wanted 4 or more children.

Table 12. Expected family size when spouses disagree (N=22)

Expected number of children	Husbands (N=22) %	Wives (N=22) %
0	0.0	4.5
1	9.1	0.0
2	50.0	27.3
3	18.1	18.2
4	9.1	27.3
5	4.5	4.5
6	4.5	18.2
>6	4.5	0.0
Total	100.0	100.0

Nature of the fertility problem. As Table 13 indicates, the fertility problem was believed to be with the wife in almost three-fifths of the cases. In only 18% of the cases was the fertility problem exclusively male-related, while in 15% of the cases there was a combined problem between husband and wife. This is consistent with reports in the literature which suggest that, in the majority of cases, infertility is female-related. For example, Sherris and Fox (1983:L-113) suggest that female infertility accounts for 50 to 70% of all infertility; Kraft et al., (1980) indicate that the problem is female-related in 50% of the cases, male-related in 30% of the cases and a combined problem in 20% of the cases; and Zimmerman (1982) points out that infertility is exclusively male-related in only 10-15% of the cases. Other reports (Contemporary Obstetrics and Gynecology, 1980; Menning, 1977) suggest an equal distribution of fertility problems between men and women but it is unclear what these estimates are based on. In 9% of the cases, there was no diagnosis. This is referred to as idiopathic infertility or "normal infertility" (Wallach, 1980) and is estimated to occur in 5 to 10% of all cases (Behrman and Kistner, 1968; Bernstein and Mattox, 1982; Menning, 1977).

Table 13. Etiology of fertility problem by gender

Fertility problem with:	(N=74) %
Husband	17.6
Wife	58.1
Both	14.9
Uncertain (no diagnosis)	9.4
Total	<u>100.0</u>

Etiology of the fertility problem by diagnosis. A similar distribution of identified fertility problems was found between this sample and other samples. Most notably, the data presented for Collins (1986) represent the distribution for the McMaster University Fertility Clinic, from which part of the present sample was drawn. Although basically similar, there was a higher proportion of endometriosis in this sample (22% compared to 6% in Collins (1986)) and a lower proportion of unexplained infertility (6% compared to 21% in Collins, (1986)). However, these rates, although different from Collins, (1986), are within the normal range reported elsewhere in the literature (Bernstein and Mattox, 1982; Cooke et al., 1981).

Table 14. Etiology of fertility problem by diagnosis, compared to other studies.

Diagnosis	(N=97) % of responses <sup>1</sup>	Collins (1986) (N=407) % of cases	Cooke et al, (1981) (N=388) % of cases	Bernstein & Mattox (1982) (estim) % of cases
Sperm	24.7	22.2	21.1	40
Tubal disorder	23.1	31.9	14.2	20
Endometriosis	21.7	6.2	31.7	5
Ovulation	17.5	16.7	15.7	25
Unexplained	7.2	21.5	--	5
Other	5.2	1.5	17.3	5
Total	100.0	100.0	100.0	100

1. The percentages in column 1 represent the percentage of responses. Given that some couples had more than one diagnosed physiological problem, they could give more than one answer. As a result, the total number of responses was 97 and the percentages given for this sample represent the proportion of diagnosed problems in relation to all other problems. Percentages presented for the comparative studies are based on an assessment of the primary diagnosis in the couple and are therefore, based on the total number of cases. This table is intended to give some cursory indication of how the distribution in this sample is similar or different from others. Caution, therefore, should be exercised in making direct statistical comparisons between the distribution in this sample and others.

Future tests or treatments. Three -quarters of the sample (N=74) were still active in some type of fertility testing and treatment. The other one-quarter of the sample had definitely finished with testing and treatment. Of those who were still active in the testing and treatment process (N=56), over one-third were involved in an in-vitro fertilization program<sup>1</sup> (see Table 15). One-third were expecting other tests in the future while one-quarter were expecting some kind of treatment (other than IVF) in the future.

1. Whereas one might expect that such a high proportion of IVF patients would affect the generalizability of the results because they are usually considered to be at the end of the infertility process and therefore more likely to exhibit higher levels of adoption readiness, this tended not to be the case in this study. Two methods were used to check out whether the IVF patients would affect the study in this way. First, the distribution of IVF patients in the groups used for the analysis (see pg. 204) was examined. Forty percent (N=8) were not active in the adoption process (i.e. Group I), while 60% (N=12) were active (i.e. Group II). Given that a high proportion (40%) were not active in the adoption process, this in itself would suggest that they may be no closer to adoption readiness than couples undergoing other treatments. Second, a bivariate analysis was conducted to examine associations among the variables used in the analysis with this group of IVF patients excluded. The results of this analysis varied only slightly with the results of the main analysis.



Table 15. Future tests and/or treatments

Type of test/treatment:	(N=56) %
New tests to be done	19.6
Tests to be repeated	14.3
Additional treatments	23.2
In-vitro fertilization	35.7
Artificial insemination, donor	7.1
Total	<u>100.0</u>

Number of years since first suspecting a fertility problem.

The mean length of time for having suspected a fertility problem was 5 years. One-quarter of the sample had been aware of a fertility problem for two years or less. Three quarters of the sample had been aware of a fertility problem for five years or less.

Table 16. Number of years since first suspecting a fertility problem

Number of years	(N=74) %	Cumulative %
1	10.8	10.8
2	12.2	23.0
3	16.2	39.2
4	17.6	56.8
5	20.3	77.1
6	4.1	81.2
7	6.8	88.0
8 or more	12.0	100.0
Total	<u>100.0</u>	

Number of years married before first aware of a fertility problem. Couples were asked to indicate how long they were married before they first thought that they actually might have a fertility problem. In this regard, couples were asked to indicate when they first subjectively defined their inability to conceive as a fertility problem. One-quarter of the sample (N=19) had received some kind of fertility-related diagnosis before they were married. Of the remaining cases (N=55), 56% identified their fertility problem within the first three years of marriage, suggesting that these are the crucial years during which childbearing decisions are made. By five years of marriage 85% had identified themselves as having a fertility problem. For those who did not know at marriage of their fertility problem, the mean

length of time for becoming aware of a fertility problem was 3.5 years after marriage.

Table 17. Years married before aware of a fertility problem

Number of years	(N=74) %	Cumulative %
0 (knew at marriage)	25.7	25.7
1	14.8	40.5
2	14.8	55.3
3	12.2	67.5
4	8.1	75.6
5	13.5	89.1
6	4.1	93.2
7	2.7	95.9
8	1.4	97.3
9	2.7	100.0
Total	100.0	

Time before seeking medical attention. Once a fertility problem was suspected, the mean length of time before medical attention was sought was 10 months. About one-third of the sample went to a doctor immediately. By one year after suspecting a problem, three-quarters of the sample had sought medical assistance. Only five percent of the sample waited for more than two years to get help.

Table 18. Time before seeking medical attention

Time in months	(N=58) %
Immediately	32.8
1-12 months	41.4
13-24 months	20.7
more than 24 months	5.1
Total	<u>100.0</u>

#### THE DEPENDENT VARIABLE: THE THREE GROUPS USED IN THE ANALYSIS OF TRANSITION

The primary objective of this research is to look at the transformation of identity from biological parenthood to adoptive parenthood. As a result, the dependent variable is the transition to adoptive parenthood. That is, the study hopes to be able to explain some of the factors associated with the acceptance of adoptive parenthood by couples who have a fertility problem. In this respect, then, the axis along which the analysis is constructed is the way that people shift their commitments from biological parenthood to adoptive parenthood. To this end, the sample was divided into three categories or groups, with each representing a different stage in the process.

### Group Definitions

The three groups that were constructed for the purpose of the analysis each represent different gradients in the commitment to biological and/or adoptive parenthood. Group I consisted of those couples who were active only in the infertility process (not the adoption process) and had, therefore, a primary commitment to biological parenthood. Group II consisted of those couples who were active in both the infertility and the adoption processes. In this group, there was a divided commitment to biological and adoptive parenthood. Group III consisted of couples who were no longer active in the infertility process but who were active in the adoption process. This group had a primary commitment to adoptive parenthood.

Several questions were used to operationalize the dependent variable. In order to determine whether couples were active in the infertility process, they were asked "Are there other tests or treatments that you expect to have in the future?" (question 8). In order to determine if couples were active in the adoption process, they were asked "Did you ever consider putting your name on an adoption waiting list?" (question 28). The following criteria were used in evaluating couples in order to place them in one of the three sample groups:

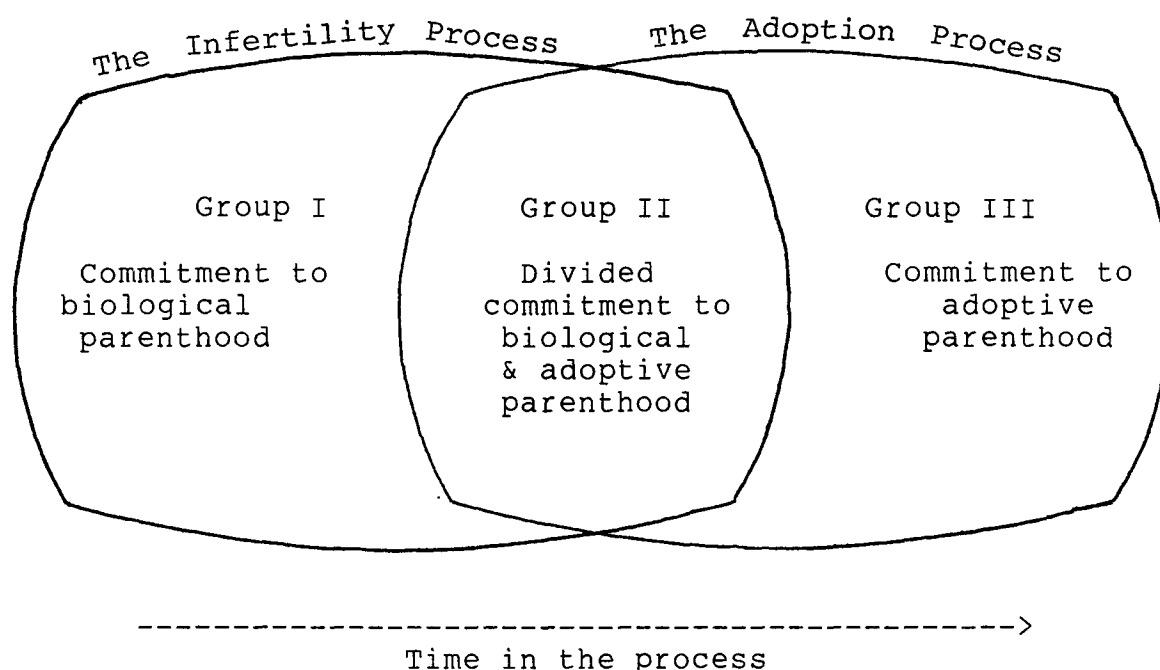
Group I: Participants responded to question 8 that they expected other tests or treatments in the future. In addition to those couples expecting the usual infertility tests and treatments, this group included couples who were involved in in-vitro fertilization (N=8) and artificial insemination by donor (N=3). They responded to question 28a that they had not yet put their name on the adoption waiting list or were not pursuing private adoption.

Group II: Participants responded to question 8 that they expected other tests or treatments in the future. This group also included couples who were active in in-vitro fertilization (N=12) or artificial insemination by donor (N=1). They responded to question 28a that they had put their name on the adoption waiting list or were pursuing private adoption.

Group III: Participants responded to question 8 that they did not expect any other tests or treatments in the future. They responded to question 28a that they had put their name on the adoption waiting list or were pursuing private adoption.

As Figure 1 indicates, these three groups can be conceptualized as representing the transition between the infertility process on the one hand and the adoption process on the other. Whereas exclusive participation in the infertility process represents a primary commitment to biological parenthood, exclusive participation in the adoption process represents a primary commitment to adoptive parenthood. In the area of intersection between the infertility and adoption processes, couples had a commitment to both biological and adoptive parenthood.

Figure 1. The relationship between the infertility process and the adoption process.



As Figure 1 also indicates, there is a time dimension that is involved in the shift in commitment from biological parenthood to adoptive parenthood. A significant correlation of  $.24^1$  ( $p < .05$ ) was found between the number of years since first suspecting a fertility problem and commitment to biological parenthood or adoptive parenthood.

1. An eta value of .53 on this variable suggests that the relationship between the number of years since first suspecting a fertility problem and stage in the process is somewhat curvilinear. This is the result of Groups I and II being similar in the proportion of people who had experienced infertility for a short period of time (1-3 years). For those who had experienced infertility for a longer period of time (7 years or more), the relationship was linear with 10% in Group I, 19% in Group II and 33% in Group III having experienced infertility for that period of time.

As indicated in Table 19, those in Group I had suspected a fertility problem for a shorter period of time than those in Group III. Similarly, those in Group II had been active in adoption for a shorter period of time than those in Group III. This suggests that those who knew of their infertility for a shorter time were most likely to be committed to biological parenthood, while those who had known for a longer period of time were most likely to be committed to adoptive parenthood. In this sense, each of the groups can be interpreted to represent a stage in the process of transition from biological parenthood to adoptive parenthood.

Table 19. Comparison, by group, of mean length of marriage, mean number of years since first suspecting a fertility problem, mean length of time on the adoption waiting list and percentage of couples who had a completed homestudy.

	I	Group I	I	Group II	I	Group III	I
	I	(N=30)	I	(N=26)	I	(N=18)	I
Mean no. of	I		I		I		I
yrs. married	I	5.8	I	6.6	I	6.8	I
Mean no. of	I		I		I		I
yrs. infert.	I	4.1	I	4.7	I	6.5	I
Mean no. of	I		I		I		I
yrs. ado.lst.	I	---	I	1.3	I	1.5	I
% with home-	I		I		I		I
study compl.	I	---	I	15.4	I	38.9	I



Caution, however, must be exercised in interpreting these findings to mean that all couples go through a neat, linear transformation from biological parenthood to adoptive parenthood. Given that the strength of the association is moderate, it should be interpreted as indicating a trend in shifting commitments from biological parenthood to adoptive parenthood over time. The exceptions to this linear transformation might include couples whose experience of the infertility process is truncated by a diagnosis of sterility before they even tried to have children (N=3); couples who at some point may have been active in adoption but who have shifted back to a primary commitment to biological parenthood because of new reproductive alternatives like in-vitro fertilization (N=1); or couples who received an abrupt and absolute diagnosis of sterility in the course of their infertility investigation who then shifted more quickly than a couple without such a diagnosis to a sole commitment to adoptive parenthood (N=2). To summarize then, Figure 1 represents the relative commitment to biological and adoptive parenthood of the three sample groups as expressed at the time of the study with an indication of the way that these commitments shift over time.

The distribution of the sample groups is summarized in Table 20. Although 76 couples responded to the study, two were not interviewed and as a result, no data were collected to determine which group they were in.

Table 20. Group distribution

Group	(N=74)	
	f	%
Group I (active infertility; inactive adoption)	30	40.6
Group II (active infertility; active adoption)	26	35.1
Group III (inactive infertility; active adoption)	18	24.3
Total	<u>74</u>	<u>100.0</u>

#### THE RELATION BETWEEN THE INFERTILITY PROCESS AND THE ADOPTION PROCESS: AN OVERVIEW

The chapters which follow have been constructed to represent different substantive aspects of the transition to adoptive parenthood. Following the theme of examining the relationship between the infertility process and the adoption process, Chapter 6 focusses on the infertility process. When couples encounter a fertility problem, biological parenthood can no longer be taken-for-granted. It becomes problematic. As such, it brings into question some fundamental assumptions about the meaning and importance of parenthood. For such couples, it brings into focus other people's expectations for them as parents and their own

feeling regarding the importance of children and the parenthood role in their lives. It challenges the couple to consider the relative merits of a biological tie to a child and the importance of pregnancy, and often creates in the couple a sense of ambiguity and lost control over their desire to become parents. Although the focus of Chapter 6 is on the implications of the infertility process for the identification with biological parenthood, it will include a discussion of how the meaning of biological parenthood changes over time among the three groups.

In Chapter 7, the adoption process is the focus of attention. Of particular interest in this chapter is the way that couples either do, or do not, come to some 'resolution' of the infertility process. In order to understand adoption readiness, it is necessary to look at how people come to terms with the loss of biological parenthood. Here lies the critical link between the infertility process and the adoption process. By way of elaborating this link, this chapter will attempt to discover whether there are any critical incidents that precipitate the shift from biological parenthood to adoptive parenthood. The adoption process will be considered in terms of growing awareness, beginning first with a set of thought processes geared towards the possibility of becoming adoptive parents, to the increased consideration of adoption as a more serious option as time goes by. The central focus

of this chapter will be the examination of possible indicators of adoption readiness. How does a couple increasingly come to identify themselves as adoptive parents? Conversely, what are the obstacles to identification with adoptive parenthood?

For those for whom adoptive parenthood becomes a real option, they must prepare or be prepared by others to become adoptive parents. In Chapter 8, the process of resocialization to adoptive parenthood is to be examined as it occurs on two basic levels: the informal and the formal. An attempt will be made to determine how, on the informal level, various significant others, including spouses to each other, family, friends and work associates act as a socializing force in shaping an identification with adoptive parenthood. On the formal level, the adoption agency no doubt plays the most powerful role in preparing couples for the possibility of adoptive parenthood. The manner in which the official adoption agents resocialize couples to adoptive parenthood is another key focus of this chapter.

## CHAPTER 6

### THE INFERTILITY PROCESS: BIOLOGICAL PARENTHOOD AS PROBLEMATIC

## Chapter 6

### THE INFERTILITY PROCESS: BIOLOGICAL PARENTHOOD AS PROBLEMATIC

Regardless of the stage that couples were in with respect to the transition to adoptive parenthood, there was one experience that all couples in this study held in common, and that was the experience of dealing with a fertility problem. While there was considerable variation in the extent to which they subjectively defined their situation as problematic, at some fundamental level, the natural, expected or taken-for-granted transition to biological parenthood was in some way disrupted in all cases. From an objective standpoint, then, all couples had experienced biological parenthood as a problematic, regardless of their subjective perception of it as problematical.

The amount of time that they had known about their fertility problem ranged dramatically from those who had known for less than a year to those who had known for more than 22 years. Although all couples had experienced the infertility process, not all couples in the sample were actively involved in the testing and treatment process at

the time of their interview (see Table 20). Nonetheless, the taken-for-granted meaning of parenthood was, at some point, called into question.

This chapter focusses on biological parenthood as problematic. It examines how biological parenthood came to be problematic within the context of normative expectations and the relative importance of motherhood and fatherhood. Within this context, it examines changes in the meaning and importance of parenthood, how couples explained biological parenthood as a problematic, and how couples began to relinquish identification with biological parenthood in favour of adoptive parenthood.

Since all couples in the sample experienced parenthood as a problematic, much of the discussion in this chapter focusses on the sample as a whole. Where the three groups differ on any of these dimensions, these too are discussed. However, when the impact on the sample as a whole is discussed, the assumption can be made that the three groups did not differ significantly on that dimension.

### Normative Pressure for Parenthood

Although some analysts (Griffith, 1973; Scanzoni, 1975; van Keep & Schmidt-Elmendorff, 1975) have suggested that the normative pressure for parenthood is decreasing, others (Poston & Gotard, 1977; Veevers, 1980) have indicated that, even in light of increasing rates of voluntary childlessness, there is still a strong cultural pressure for married couples to become parents. Furthermore, as Freshnack and Cutright (1978) have suggested, interpretations of decreasing normative pressure may merely reflect an increasing acceptance of the postponement of childbearing to later years. In any case, although the childless couple may be more socially acceptable in today's society, [infertile couples continue to acutely feel the social pressures to become parents (Seibel and Taymor, 1982).]

Consistent with this, the couples of this study clearly expected that they should have children. Eighty-four percent of couples expressed in some way that they felt a pressure from others to become parents. For the other 16%, their own intrinsic desire to have a child seemed to override these external pressures. For many couples (N=18), this expectation for parenthood evoked a generalized feeling of being set apart or left behind by their peers. One couple discussed their feelings of being outsiders to the "normal" course of development:



W: You don't feel like you are part of the mainstream. Even watching T.V. the emphasis is on having kids. It is even difficult to make friends because they expect you to have children.

H: It makes you very sensitive that the whole world is geared towards the nuclear family.

W: It's like a membership. You aren't part of the group when you have a fertility problem. Our friends who have children seem to apologize for them. (3450:11,21)<sup>3</sup>

Interactions with friends and family members played an important role in conveying the expectation that they become parents. Friends of the same age who were beginning to have children created a peer pressure by focussing attention on children and the parenting experience. As Stebbins (1970:36) has suggested, falling behind one's reference group in this way heightens one's subjective awareness of the identity in question. For one man, a reunion with friends highlighted the sense of "falling behind" and intensified the importance of parenthood:

We went to a college homecoming and many of our friends had children and that was difficult - people expect that you will have children. (2311:11-M)

Watching family members have children also focussed attention on the absence of the parenthood role. For involuntary childless couples, relationships with family and

1. The numbers used to code responses have the following referents: the first digit refers to the group number (dependent variable); the next 3 digits refer to the couple identification number; any numbers after the colon refer to the number of the question from which the response was taken; and finally, the letter after the hyphen refers to male (M) or female (F).

friends often became strained as a result of the ease with which these others could get pregnant and have children. For example, Christmas, as a child-oriented event, was occasionally (N=4) mentioned as a time when the expectation for parenthood seemed to intensify. As one woman explained:

Now our families are growing - like at Christmas, we go and there are 4 new babies - you get to the point where you don't want to go to the family parties anymore because people look at you as if to say "Where are yours?" (2311:12-F)

This finding was similar to Bierkens (1975:180) who concluded that the problem of infertility was made more difficult for childless couples because they were "constantly witnessing pregnancies and births among their relatives and acquaintances."

The potential grandparents were a particularly salient force in conveying the normative expectation that their children have children. Eighteen couples expressed that their parents exert pressure on them to have grandchildren. For one woman, this expectation was very clearly announced when her mother asked "Do you think that I will have a grandchild before I die?" (3315:20-F) For others, the expectation was less overt but clearly present:

I think my parents are expecting that we will have our own biological children. They haven't really said anything out loud but deep down, I think they would like to see us have our own biological children because then it's the continuation of their family - I guess I feel guilty that we can't give them biological grandchildren and that I would be letting them down - although I'm sure if I ever said that they would be mad at me for saying it. (2316:17-M)

As the above passage suggests, considerable attention is focussed on the importance of the biological aspect of parenthood, rather than parenthood of any kind. Although this expectation for biological parenthood was not directly conveyed, it was nevertheless interpreted by some couples as the way parenthood should be.

These normative expectations for parenthood had been so internalized by couples that to have children was part of their taken-for-granted world. This desire to have children had been persistent and unfading, for as one woman stated, "I have always wanted to have children - since I was younger the desire has always been there." (3315:14-F) Similarly, for one husband these expectations for parenthood were so internalized that the desire to become a parent was something fundamentally human:

I've never thought of not having children. If you are married, its the natural thing to do. It's like a natural instinct or an uncontrollable urge to have children. (2504:14-M)

For another woman, this strong expectation to have children simply reflected the way things are supposed to be:

Something in your life would be missing without children. It would be a void. A friend of mine went through it and said "Its part of the plan - you get married, have a family, ITS the PLAN! Kids bring so many experiences into your life. (2312:14-F)

The way that this "plan" was to be carried out was often characterized by a romanticized, stereotyped imagery:

If someone asked what I wanted right now, it would be to have the country home with the two kids and the dog. Its a fantasy right now because I can't make it happen. We can buy the house but we can't get the kids. (1214:13-F)

The parenthood role was also patterned by age expectations. Parenthood was usually expected to occur within marriage after an initial 'settling down' period of several years. One woman described her difficulty in hiding her childlessness because of the time norms that influence the transition to parenthood:

It's [i.e.. childlessness] a hard thing to hide. You are no sooner married than people start asking. For 2 or 3 years you can put them off. But after awhile, what are you going to say? Now I find it easier just to tell them straight out. Why beat around the bush? (2504:22c-W)

Another man described his feelings of being set apart from his peers as a result of falling behind in the transition to parenthood:

People ask whether I have kids and how long have I been married. Then they look at me funny when I say I don't after having been married for 13 years. After that, I feel like I'm not like everyone else and I feel less of myself. (2505:24-M)

Most couples intended to comply with the expectation that they have children soon after marriage. When couples were asked when they had planned to start their families, 35% of wives and 24% of husbands planned to start having children right away without any effort to delay. The remainder indicated that they planned to start having their children after a period of 2 or 3 years during which they

could get settled in marriage, have time to travel or get financially settled in both work and housing arrangements. These family plans suggest that couples had internalized the expectation that they have children after a short period of settling down into marriage. This is consistent with Veevers (1980) who reported that after two years of marriage, people begin to expect that a couple will have children.

A composite index was developed to get a more quantified measure of the extent to which couples felt the normative pressure to have children. The Parenthood as Objective Reality Scale consisted of four items after four other items had been deleted because they did not meet with minimum acceptable reliability criteria.<sup>1</sup> The Cronbach

1. Two tests were used to empirically evaluate the reliability of the scales used in this study: Cronbach's Alpha test and the minimum acceptable item-total correlations (Warren, Klonglan and Sabri, 1969). Cronbach's Alpha test measures the internal consistency of a scale by measuring the extent to which items share a common core. A high reliability co-efficient signifies that a scale is measuring a unitary construct. The minimum item-total correlation serves as a quasi-significance test of linearity which defines the amount of independent variance of the total score contributed by each item if there were no experimental relationship. This procedure involves comparing each item-total correlation with the minimum acceptable item-total correlation. The minimum item-total correlation is defined as:

$$r = \frac{1}{\sqrt{n}}$$

where  $n$  is the number of items in the composite index. Only those items with calculated item-total correlations greater than the minimum acceptable item-total correlation coefficient are retained in the index.

Alpha reliability coefficient for the scale was .70. The scale was also assessed as to its face validity and was judged to be a valid measure of the importance of parenthood in marriage. The scale examined the relevant dimensions of (i) whether a childless couple was as much a family as a couple with children; (ii) whether their life could be completely fulfilled without children; (iii) whether there were a lot of pressures brought to bear on them to have children; and finally, (iv) whether they could be completely adult-like without being a parent. There were no significant differences among the three groups for this scale suggesting that the sample as a whole shared a similar perception of parenthood as objective reality. The sample as a whole tended to score in the middle range on this scale. With a possible range of scores from 4 (low pressure for parenthood) to 20 (high pressure for parenthood), the mean score for husbands was 9.6 and 10.9 for wives.

This suggests an equivocating kind of attitude regarding the pressure for and importance of parenthood. This was somewhat discrepant with their qualitative responses which suggested a clear and strong normative expectation for parenthood. This may be partially attributable to the fact that, although they may have felt a pressure to have children, they may have felt that their life could still be fulfilled without children or that they

could still feel like an adult or family without children.

In addition, the results of the scale may be an indication that the pressure for parenthood, as perceived by men, may not be as radically different from women as one might have expected. Although women indicated a higher perceived pressure for parenthood than men, suggesting that they may carry a greater proportion of the expectation for parenthood, the difference in scores was not large. This might be interpreted as an indication that the social meaning of parenthood, as a role and a status, is important to men too. However, as discussed in the next section (see Salience of Motherhood Versus Fatherhood), both men and women indicated on a variety of measures that parenthood was more important to women than men. One might partially explain this discrepancy as a function of social desirability. Insofar as both men and women are socialized to believe that motherhood is a stronger role identity for women than fatherhood is for men, they would be expected to reflect this difference in an interview setting, whereas they might not when privately filling out a questionnaire. Therefore, the results of this scale would indicate that, although parenthood may be a more important identity for women, the difference from men may not be as great as what emerges in interactive situations.

As the above discussion would suggest, parenthood is still considered to be a necessary adjunct to marriage. Not

only are couples exposed to a considerable amount of normative pressure to have children, but they themselves view parenthood as an expected stage of development in their taken-for-granted world.

### Salience of Motherhood versus Fatherhood

Although both men and women were exposed to the pronatalist prescription that they become parents, women were more often the direct target of these expectations. With few exceptions, the desire for parenthood and the frustration of infertility was more intensely felt by women. For example, only 7% of husbands and 5% of wives said that parenthood was more important for the man while 54% of husbands and 60% of wives said it was more important for the woman. Approximately one-third of husbands and wives felt it was of equal importance to both spouses. These findings are consistent with other research (see Table 21) which also report that parenthood is more important for women than men. For example, Bierkens (1975:179) reported that 66% of couples believed that childlessness is easier for men to bear than women. Likewise, van Keep and Schmidt-Elmendorff (1975:44) found that 72% of men and 45% of women said that childlessness was harder for the wife. Others (Brennan, 1975; Humphrey, 1977; Mulford and Salisbury, 1964; Veevers,



1980) concur with the greater salience of the parenthood role in the structure of female identity.

Table 21. Importance of parenthood for men and women compared with other studies

Parenthood more important or childless- ness more difficult for:	This sample			van Keep et al (1975)			Bierkens (1975)		
	N=148			N=150			N=310		
	%			%			%		
	M	I	F	M	I	F	M	I	F
Husband	7	5		1	1		6	6	
Wife	54	60		72	45		66	66	
Equal	39	35		24	50		--	--	
Unknown	0	0		3	4		28	28	
Column total	100	100		100	100		100	100	

In explaining the greater importance of parenthood to women, husbands and wives tended to offer different explanations. For wives, 37% explained the greater importance of motherhood by the fact that they envisioned parenthood as "their career or work in life." One quarter of the women indicated that it was "naturally" more important for the woman, while another one-quarter indicated that women are "socialized" to want to be mothers. For one woman,

the discovery of a fertility problem brought into sharp focus the difference in the meaning of parenthood for herself and her husband:

He wasn't as concerned as I was. I was pretty hysterical. I wanted kids so much that I thought "Why was I put on this earth?" I am not very religious but I asking "Why? What am I supposed to do if I can't have kids?" (3401:4c-F)

Another woman explained the social origins of the importance of parenthood to women:

I was going to say that it is more important to me because I'm a girl. But I guess there are some men who have that desire. But as a girl, you're brought up to want babies and that's how it got into my head. (2316:16-F)

Another woman described how her career plans and activities were focussed around the motherhood role:

All I've ever wanted was kids or else I would have gone farther in school for a career. All I can see in the future is to have children. (1231:11-F)

The most common explanation offered by husbands (30%) for the greater importance of parenthood to their wives was that it was in some way "naturally" or "instinctually" more important to women. Twenty-two percent of husbands said that it was more important to wives because they themselves had more outside activities such as work or recreation. For some of these men, these outside activities took on added importance as a way of compensating for the loss of parenthood. One man described how work functioned to compensate for this loss:

It is a setback timing-wise. If things had worked out we would have had a 4 or 5 year old child. Now I over-compensate at work. I work harder now than I would if I had a family. (2312:11-M)

Similarly:

I am more obsessed with career now than I would otherwise be. I don't have to be at home at a certain hour to see the kids (3450:11-M)

Twenty-two percent of husbands indicated that parenthood was more important to their wives because it was their wives who went through so many more disappointments in the testing and treatment process. For some of these men, being unable to have children didn't really bother them directly, but only indirectly because their wives would get upset about it. In this respect, the loss of the parenthood role tended to be experienced vicariously by some men through their wives. As one man explained it:

The most difficult thing for me is seeing her in the condition she is in. I can live without having kids but seeing her upset, upsets me. (2502:12-M)

Some men attributed this sense of vicarious loss to the fact that they had more outside interests and the parenthood role was not as primary as for their wives. As one man expressed it:

I am more frustrated for her than I am for myself. If we don't ever have children my life isn't going to stop. There are many other interesting things in life that I can do. But if she doesn't have a child, she will be more frustrated because she has her whole life wrapped up in it. (2309:12-M)

The greater importance of the motherhood role for women also emerged when husbands and wives were asked to indicate the relative importance of parenthood and work or career interests. Whereas only three-fifths of the husbands indicated that having a family was more important than work to them, almost all wives (93%) indicated that family was more important to them. The relative importance of family and work did not change over the three groups. Again, occupational activities tended to play a more central role in men's lives. One couple expounded on this difference:

H: I haven't been as affected as her [by infertility]. Being at work, I lead a more natural life. We are leading a normal life even without kids. It would be nice to have kids on evenings and weekends.

W: I think its easier for the man to cope with because he doesn't get the needles and the surgery and he is at work. I think about it more and women talk about these things more. So its on my mind a lot more. (2504:11)

Another woman explains how parenthood took primacy over work in her life:

Having a fertility problem has had a tremendous impact on me. It has affected my self image and my identity as a woman. I quit work to have children, and when I didn't get pregnant, I lost my career (2402:11-F).

Another indication that motherhood was a more salient role than fatherhood was that women tended to talk with other people about matters related to having children more frequently than men. Whereas nineteen couples pointed out that the woman talks more frequently about infertility or having children, none suggested that the man talks about it more frequently. For one woman, motherhood was often the

preferred topic of discussion in various social settings and this focus contributed to a sense of isolation:

I feel like a real outsider because anytime we go to parties, the ladies get together and talk about the children. I feel left out. (3313:11-F)

This supports the finding by van Keep and Schmidt-Elmendorff (1975:45) that childless couples reported feeling "excluded when people talk about children," and that this was more intensely experienced by women than men.

Men were much less likely than women to talk about having children and were much more selective in discussing infertility. As one man pointed out:

I've only told one person at work and he also had a problem (fertility). But we just didn't go in to it. With other male friends its just not something you bring up (2314:22d-M).

As another man indicated, most people assume that infertility is a "woman's problem" when you mention it and they just aren't interested in going into it with you:

When I tell the guys about it, they just aren't that interested. They don't usually follow it with questions. Some say, "Oh, is it 'women's problems'?" and then don't talk about it. She gets a lot more questions about it. (1251:22d-M)

This is consistent with the findings of Miall (1985:394) which suggest that infertility tends to be socially perceived as a "woman's problem."

There was clearly a difference between men and women with regard to the salience of the parenthood identity. For many women, parenthood continues to be a central, if not the

central role identity in their lives. Although family-related identities were considered important by men, they tended to be secondary in importance to their occupational-related identities.

#### When Biological Parenthood Becomes Problematic

On the basis of their taken-for-granted view of parenthood, couples usually assumed that they would simply become parents when they chose to do so. This is consistent with Kirk (1981:31) who has pointed out that biological parenthood is characterized by the presumption of fertility. In this regard, fertility tended to be seen as something that they could simply "turn on" at the appropriate moment after a period of having "turned it off" with the aid of contraceptives. As one man put it, "You use birth control all the time and you just think its going to happen when you want it to" (2353:4c-M). Another man expressed a similar frustration when he said: "You grow up trying not to get girls pregnant, and then when you want to, you can't!" (2211:4c-M). When couples were faced with the prospect of being unable to turn on their fertility as they had expected they could, they had to reconsider or "take stock" (Schutz and Luckmann, 1973) of their taken-for-granted identity of parenthood. In the place of biological parenthood, was the unexpected identity of a person who has a fertility problem.

Replacing the "parent" identity with an "infertile" identity was often so shocking to one's taken-for-granted world that the change occurred with reluctance, anger and disbelief. Of course, as Martin-Matthews and Matthews (1986), Mazor (1979), Menning (1977) and Renne (1977) have identified, the acceptance of an infertile identity is a process characterized by different combinations of surprise, denial, anger, isolation, guilt, grief or resolution. One man explained his feelings of surprise, denial and anger after hearing that he was sterile:

I had the feeling of "what did I do to deserve this?" I don't drink, I didn't run around with women. We build our lives together and its an ideal situation to bring up kids. What the hell is this [i.e. infertility]? Other people run around impregnating women. Why the hell does this happen to me? I felt it was an injustice to me - but I'm not bitter. It's like someone called the wrong number. Why me? (1250:12-M)

For many couples, infertility is the kind of life event that happens to other people. As a result, shock and surprise was the usual response. As one man succinctly described the news of infertility: "I was surprised. I always thought that these things happen to other people!" (1246:4c-M) A woman described the way that a diagnosis shook her taken-for-granted world:

When the doctor phoned to tell me, I just don't remember coming off the phone. It was something I had never thought about. I thought I was as normal as everyone else. It was a shock. (2217:4c-F)

In much the same way that one's reference group

conveyed the importance of parenthood as a role identity, it also contributed to the construction of biological parenthood as a problematic. This occurred when changes in the taken-for-granted world of biological parenthood were reinforced as a result of the responses of others to the problematic situation. For one woman this occurred as a result of others pitying her:

It has made me feel like you can't take anything for granted. You see people struggling or in pain and you thought that would never be me. Now I see them and I feel like them. I work with handicapped and they say "Don't pity me." I understood that intellectually but now I understand it emotionally. Many of my friends are pregnant and they say "Poor you!" They are pitying me! (1214:11-F)

Although most couples assumed they would become parents when they wanted to, a considerable number had entertained the possibility that they might have a fertility problem before they started trying to conceive. Excluding those who definitely knew of a fertility problem previous to trying (N=18), about one-fifth of the couples (N=15) considered infertility as a possibility. For these couples, the main reason why they did consider infertility was that they knew of someone who had a fertility problem (40% of husbands and 31% of wives) and, on this basis, considered it in relation to themselves. Other reasons included having previous medical problems that might in some way be related to having a fertility problem or hearing about infertility in the news media.



There was considerable variation in the way that couples came to define their situations as problematical. The type and timing of a medical diagnosis played a key role in how situations came to be defined as problematical or non-problematical. At one extreme were those couples who had received a definite diagnosis of absolute or near-absolute sterility. These couples clearly identified themselves as being "infertile" or having a "fertility problem" and realized that biological parenthood was problematic. For example, approximately 12% of couples entered into marriage knowing that there was a definite fertility problem and that their chances of becoming biological parents were limited.

At the other extreme were those couples who had been through a lengthy period of tests and treatments but who were still without a diagnosis. Known as "idiopathic infertility" 9.4% of the sample fell into this category and this is consistent with other reports (Bernstein & Mattox, 1982; Menning (1977)). For many of these couples, coming to an acceptance that biological parenthood was problematical was particularly difficult. One woman, who had gone through four years of testing without a diagnosis, explained:

We don't have a problem. It's just taking longer. So it depends what you call a problem. Even now we aren't sure that there's a problem. I don't allow myself to think that there is a problem so I believe that I will get pregnant. (1240:4c-F)

Even though couples felt a definite helplessness and lack of control over changing their situation when there was no

diagnosis, they were still reluctant to identify themselves as someone who had a fertility problem. One man explained this helplessness:

Without them finding anything definite, we don't really feel like we have a problem. If they could say it was definite, then we could make plans to do something definite about it. (1216:11-M)

For these couples, the medical process played the key role in defining their situation as problematical. In the absence of a medical diagnosis, they were unable to define their situation as a problem.

For some couples, there was a reluctance to accept the fact that biological parenthood was problematic even after some medical problems had been identified. These, however, were not diagnoses of absolute sterility, but rather, had been identified as problems that might impede the normal process of reproduction. Even the identification of a medical fertility problem did not always result in the couple defining the situation as problematical. By way of illustration, several couples expressed resentment that the interviewer would refer to them as having a fertility problem. In one case in particular, a woman had known about scarring, adhesions and partially blocked fallopian tubes for about 10 years but was extremely reluctant to identify herself as someone with a fertility problem or to define her situation as problematical. Before the interview began, she had this to say:

I tried to call you all day to tell you not to come. You see, I went to the doctor again this week and he said there really wasn't a problem - the tubes are still open and there is no good reason why I shouldn't get pregnant. Since you want to talk to people who have a fertility problem - right? - I didn't think you would want to talk to us. (1249:F)

Ironically, for some who had no definite diagnosis of sterility, there was a desire to have the "problem" identified so that they would no longer have to live with the uncertainty of not knowing. As much as they resisted identifying themselves as having a problem, they in a sense welcomed a definite diagnosis in order to cast an air of certainty on their situation. One couple was seriously considering a hysterectomy in order to end this ambiguity:

Four years of not knowing. I think it would be a lot easier to handle if they just said "You can't." But it's this 'maybe' - this back and forth that is hard to live with. It will be easier to live with a hysterectomy because I will know. (1209:10b-F)

For others, the diagnosis of a physiological problem served to concretize what they had come to expect after a period of trying unsuccessfully to get pregnant. For these couples, the diagnosis offered some explanation for their failed efforts, and allowed them to more definitely define their situation as problematical. In this regard, a diagnosis of sterility was more clearly identifiable as a "critical incident" (Strauss, 1958). As one man explained:

I never really thought about not being able to have kids. Maybe subconsciously but I didn't want to believe it. Then I more or less forced her to go to the doctor.

She didn't want to find out there was a problem. It never sunk in there was a problem until they told me we definitely couldn't. (1230:4c-M)

When the long sought-after diagnosis finally arrived, there was sometimes a sense of relief at no longer having to live with the ambiguity of not knowing whether or not there was a problem. At last the previously dispersed feelings could be focussed on a specific problem. For one man, this offered a tremendous sense of release:

When she told me [i.e. about the diagnosis], she just fell apart and I walked away - I was so angry at her, at the doctor - I was angry at everyone and anyone - but then there was relief - a load came off because of all the pressure that had been building up (3313:4c-M)

Bierkens (1975) similarly observed the couples in his study found it less difficult to cope with the definite finding of infertility than with the years of vacillation between hope and fear.

For most couples, however, the simple passage of time and the non-event of pregnancy were more crucial than the medical diagnosis for defining the situation as problematical. For example, 53% of women indicated that they came to believe there was a problem simply by the fact that they were not using birth control and not getting pregnant. The non-event of pregnancy, described by one woman as "month after month of 'nothing' happening" (2314:4-F) was the key for recognizing biological parenthood as problematical. For another couple, the absence of change that would come with parenthood and the loss of control over achieving it created

the problem:

When you have a child, your life changes. Now, for us, it doesn't change. When you plan to have kids you see that that is the way it should be. Our life has been incredibly easy for us. We got the jobs we wanted. We got the house we wanted. This [i.e. parenthood] we couldn't have. (2454:11-M)

Similarly, the situation was problematic for another couple after unsuccessfully trying to get pregnant for four years:

There is no reason why we couldn't get pregnant because there was never a diagnosis. On the other hand, time has passed by and nothing has happened (2402:10b-M)

There was considerable variation in the way that couples reacted to biological parenthood as problematic. When couples first suspected that they might have a fertility problem, the most common reaction was that it wasn't really a problem (14% of husbands; 19% of wives), that the doctor would be able to straighten it out (18% of husbands; 15% of wives), or that it was just a matter of time before they would get pregnant (15% of husbands; 12% of wives). These non-emotional responses at the outset of the fertility process are consistent with the findings of Wiehe's (1976b) research which indicate that subjects' initial reactions to infertility were neutral with a slight leaning in a positive direction.

Husbands and wives, however, expressed different emotional reactions to the prospect of a fertility problem. Whereas 35% of wives indicated that they were initially "worried, upset or confused," only 15% of husbands reacted

this way. From another perspective, 24% of husbands indicated that "it really didn't bother them" whereas only 4% of wives indicated this. This, however, may reflect the different experience of husbands and wives as a function of time. As van Keep and Schmidt-Elmendorff (1975) have indicated, childless women expressed lowest marital happiness immediately before the fertility problem is brought to the attention of the doctor, while in men it occurred while waiting for the medical diagnosis to be made.

When couples were asked to indicate the overall impact of infertility on their lives, the most common answer given by wives was that it became very difficult to see friends and family members having children. Whereas 31% of wives responded in this way, only 13% of husbands did so, suggesting that the peer pressure for having children is a much more salient influence for wives. For husbands, the most common answer was that infertility had "no effect" on them (19%) or that it is was "harder for her" (19%). Only 3% of women said it had "no effect" and none said that it was harder for the husband. Clearly, the lesser impact of infertility on men again lends support to the greater salience of the motherhood role for women than the fatherhood role for men.

Anger was also a common response when biological parenthood became problematic. Given the lack of control

that couples experienced in being able to do anything about their fertility problem, this anger was often focussed on the doctors in charge of their treatment who they felt should be able to do something about their problem. Consistent with Berk and Shapiro (1984) and Martin-Matthews and Matthews (1986), couples expressed anger and criticized doctors for the way that they managed their medical treatment. As one woman pointed out:

The frustrating thing about it is the slowness in the process - the delays and the miscommunication between the medical staff and us. The demands that they have shortchange the attention that we get. One doctor was really incompetent. He told me it was all in my head. (2219:12-F)

Likewise,

It's frustrating when you go to the doctor and these clinics and no one seems to have the answers. My experience with my previous doctor was that he was uncaring. It is such an emotional let down that you haven't learned anything from them. (2302:12-M)

In addition, people who either abused children or had abortions were frequently the targets of this anger. Eleven couples expressed their anger in this way. For example:

My views on abortion have changed. At first, I wasn't sure, now I get mad about people having abortions when there are so many people waiting [i.e. to adopt]. (2521:44-F)

Similarly,

When I see a young girl who is pregnant I get very angry. We went through a private adoption that failed and she was that age. I don't think they are very considerate. They neglect the kids and here we are with so much to offer, yet no one will give you the chance

to do it. (3350:11-F)

Coming to the realization that biological parenthood was problematic served to focus attention on the importance of parenthood as an identity. In light of insufficient typifications or explications that would enable them to fully understand the problematic (Schutz and Luckmann, 1973:14) couples experienced an increased awareness of their passage through this life career stage. Changes occurred in the commitment to and the salience of parenthood when biological parenthood became problematic, and it is to these changes that the analysis now shifts.

Commitment to Parenthood when Biological Parenthood is Problematic

When couples were faced with the prospect of being unable to meet the conventional demand that they become biological parents, they were thrown into the midst of a new decision-making process. Whereas biological parenthood was once considered automatic or taken-for-granted, infertility was problematic and precipitated a re-evaluation of identity. As one woman explained:

Before, I thought I knew that I could have a child -  
Now, I'm pushed to have to make a decision to adopt  
whereas before there was no decision to be made  
(2314:17c-F)

As part of this re-evaluation process, couples became more inwardly analytical of their reasons for wanting



to have children and how it would change their lives. For some (4% of husbands and 3% of wives) this created ambivalence:

H: There is indecision now. Do we really want one now for what it will bring or because we can't have one?

W: For 7 years of trying you ask the question so many times - you get so unsure - "Do we really want one?" and "Why?" It is now so confusing - you ask the question so many times that I'm not sure that we really even want children anymore. (3313:15)

For other couples, the absence of children precipitated a re-evaluation not only of whether or not to have children, but of the purpose and the viability of the marriage itself. For example, two couples were, at the time of the interview, seriously considering separation as a result of infertility. Two other women indicated that a previous marriage had split up on account of infertility. A man with a sperm problem explained:

We have had a lot of discussions about whether or not the marriage is viable. I feel that if it is important for her to have children and we can't then maybe the marriage should dissolve. Being married for 11 years and finding out that something you assumed was automatic threatens your marriage. To have to divorce because of it is traumatic to think about. (2505:11,12-M)

However, for most couples, dyadic adjustment did not seem to be adversely affected by the experience of infertility. Out of a maximum score of 151, the mean score for this sample was 118 for both husbands and wives. This compares favourably with other levels of dyadic adjustment that are reported in the literature. For example, Spanier

(1976) himself reported a mean score of 115 for the 218 married persons used to test the scale. Similarly, Fleming, McGowan and Costos (1985) report a mean score of 111 among a married control group used in the study of dyadic adjustment in transexual unions. Ladewig and White (1984) report significantly lower levels of dyadic adjustment (mean = 70) in their study of dual-earner marriages.

The favourable scores for dyadic adjustment in this sample of infertiles is consistent with other reports of marital satisfaction among other infertile groups. For example, van Keep and Schmidt-Elmendorff (1975:47) report that marriages of involuntary childless couples were no less happy than the marriages of a matched sample of couples who had succeeded in having children. Furthermore, Renne (1976) suggests that marital satisfaction may be stronger among the childless. In some instances, these higher levels of satisfaction were reflected in higher levels of communication between spouses (Bierkens, 1975; Humphrey, 1975; van Keep and Schmidt-Elmendorff, 1975).

When parenthood became problematic, there was a tendency for couples to discuss in some detail the meaning and value of children whereas before they had simply taken-for-granted that they wanted children without spending much energy discussing why. In response to the question "What do you see as the reasons why you want children?", 39% of husbands compared to 29% of wives said that they wanted to

be able to "help a child grow, develop and have values." Thirty-seven percent of wives and 24% of husbands indicated they wanted children in order to "share their love" with a child. Twenty-six percent of husbands said that they wanted kids because "they are fun to be with." One-quarter of the wives said that they "had always been around kids and had always loved kids." Very few couples gave exclusively biological reasons for wanting children. Only 4% of husbands and 6% of wives said they wanted children in order to "see their own characteristics and qualities in a child." Thirteen percent of husbands and 7% of wives said they wanted a child in order to "carry on the blood-line or the family name." This finding is consistent with van Keep and Schmidt-Elmendorff (1975:43) who reported that "continuing lineage did not emerge as a significant reason for wanting children."

For most couples, the desire and commitment to become parents became much more intense when biological parenthood became problematic. Slightly more than half of husbands (51%) and wives (56%) indicated that parenthood had become more important to them since discovering a fertility problem. Two-fifths of both husbands and wives indicated that the importance of parenthood remained unchanged while only 8% of husbands and 4% of wives indicated that it had become less important. The main reason

given for this increase in the importance of parenthood was that it was something they had to think about and talk about much more - it was no longer something they could take-for-granted. One man expressed it this way:

People keep telling you to stop worrying about infertility. But its like telling a kid to stop thinking about his presents on Christmas morning.  
(2303:12-M)

Other couples attributed the increased commitment to parenthood directly to the loss of control that they felt in making decisions about parenthood. Nineteen percent of wives and 15% of husbands indicated that the salience of the parenthood identity increased for this reason. For these couples, removing the choice of whether or not to have children was instrumental in heightening their desire for parenthood. With the choice removed, couples became powerless in the process, and as a result, parenthood simply became something they wanted more because they couldn't have it. As one woman put it:

Because the decision of whether or not we have children has been removed from us, then I think that there is a stronger urge to have kids. (2314:19-F)

Allison (1979:110) reports a similar finding for infertile women suggesting that the more she is unable to meet the role expectations for parenthood, the more likely she is to focus even more on the desire to have children.

Even for those couples for whom parenthood decreased in importance, the desire to become a parent still prevailed

but it took a place of lesser prominence in their lives. A woman who had experienced infertility for six years described the change:

Parenthood has become less important to me as of late - for a while it was really urgent but it is no longer the focus. You don't have to be a parent to go through life - but it would still be nice. (3313:19b-F)

Women were much more likely than men to cite age as the reason for the increased importance of parenthood. Only five percent of husbands compared to one-quarter of wives emphasized age as the most important factor. This may in large part be attributable to the fact that women, unlike their husbands, were faced with a limited reproductive life, and as a result, more often expressed the sense that their biological clock was ticking and time was running out.

In sum, to be confronted with a fertility problem was to have parenthood, as a taken-for-granted identity, called into question. For most, this process of re-evaluation resulted in a greater commitment to the parenthood identity. One implication of this abnormal pattern of parenthood was that it now had to be explained to significant others.

Accounting to Others When Biological Parenthood is Problematic

Because couples were unable to make the expected transition to parenthood, they were in a position of having to explain or to "account" for this normative violation. The need to account for the behavior usually arose innocently enough in the course of day-to-day interaction when significant others would ask about the presence of children. For those experiencing parenthood as a problematic, the question called out for an account of their childlessness. One woman described her feeling at having to explain:

I wish there was a simple explanation of yes or no with this but when people ask whether or not we have kids, there is no simple explanation. I wish there was. What really bothers me with all this is that you have to explain anyway. (1210:22c-F)

Another man described the pressure to explain and how he did offer explanations. At the same time, however, he denied that there was a pressure to account for infertility suggesting that although he may have resented having to explain, the taken-for-granted transition to parenthood was in fact disrupted:

People ask all the time "Is your wife pregnant?" or "Any kids?" and you have to explain to them. Well, not that you have to explain, but I tell them about the operation. (1232:12-M)

Consistent with the greater importance of parenthood for women and the greater likelihood for women to talk about

issues related to children and infertility, there was a tendency for women to have to account for their childlessness more often than men. One-quarter of the couples indicated that the wife had to account for infertility more often than men whereas no couples indicated the converse. As one woman simply explained:

With women, the issue comes up a lot more. "When is it going to be your turn?" (3313:22-F)

In keeping with this, van Keep and Schmidt-Elmendorff (1975:44) reported that women were much more likely than men to discuss their fertility problem with non-medical people.

Even in instances where the question of children was not overtly posed, couples tended to subjectively perceive that an explanation was called for. In instances such as this, the strength of the implicit normative expectation was clearly reflected. The need to account for their childlessness was described by one man:

With my parents we felt obligated to tell them because they seemed to be waiting. They never really asked us but it was like we go over there and we get this look (he makes a face suggesting inquisitiveness) - so we eventually told them. (2316:22-M)

There was a definite tendency for couples offer accounts in the form of "excuses" (Scott & Lyman, 1981) because of their lack of control over becoming parents. One method for doing this was to externalize the problem to the medical profession. By placing responsibility for fixing the problem with their doctor, couples did not have to take

responsibility themselves. For example:

Usually we don't tell people except when the question is asked of us "Do you have any children?" Then I answer by saying "we go to a specialist - we're having problems and are trying to get an answer. (2316:22-F)

For others, there was a tendency to try to trivialize the issue in order to deflect further interrogation:

We've never really told people that we can't have kids - we just tell them that we are having some trouble if they ask. (3315:22b-F)

Couples repeatedly emphasized the difficulties they encountered in trying to help others in coming to a shared definition of the situation. For most, there was a clear division between those who could understand their situation and those who could not. Eleven couples expressed the view that people who did not share the problem were unable to understand their situation. As one woman put it:

People who don't have the problem just can't understand. Like it's just natural to have kids and people put so much energy into not getting pregnant. To take fertility pills, people think you are crazy! (1238:44-F)

Sharing in the situation by having a fertility problem was perceived by most couples as a precondition of coming to a shared definition of the situation. As one woman explained:

I feel like you can talk to these people [the ones who have had a fertility problem]. I don't think that anyone who doesn't have the problem can really understand. How can someone with 2 kids really understand what I am going through? (2314:21b-F)

This finding supports that of Bierkens (1975) who similarly found that 50% of childless couples indicated they found



little understanding in other couples who do have children.

From those who did share the problem and could therefore share in the definition of the situation, there emerged a sense of comfort from feeling less isolated:

Because I know others I don't feel so isolated. Its nice to see that others are going through it as well. I feel more comfortable knowing I'm not the only one going through it. Seeing others and their experiences and seeing that their feelings are the same is comforting. (2312:21-F)

Others who did not share the problem were frequently perceived as being unable to understand their situation, and thus as unable to "place" them in their new identity (Stone, 1981) as an involuntarily childless couple. For many, this non-shared definition of the situation stemmed from a fundamental misunderstanding about the meaning and importance of parenthood in their lives. Whereas the childless couples of this study placed a high importance on becoming parents, those who were already parents tended to focus on the negative aspects of the experience. As one woman lamented:

People say "Oh they are great when they are small but look what happens when they grow up." In other words they are saying "you really don't want kids - so sometimes I don't go into it because they try to show how miserable their lives are. (2314:22d-F)

Similarly, one man described how others tried unsuccessfully to give comfort by discouraging them from parenthood:

Its nice that our friends have children - but when they hear that we don't have children they say "Oh you really don't want to have children anyway - look at how

much trouble they are!" or "Here if you want kids, you can have ours!" (3315:11-M)

In keeping with this, people who were single were perceived to be unable to share in their definition of the importance of parenthood:

Some of the girls I work with don't really care or go through the effort to try to understand. They can't relate to it at all. No understanding of how important it is to you. Especially those who are single - they really don't care. (2312:23-F)

For some couples, the definition of the situation was not shared because they were falsely attributed with the motives of the voluntary childless:

My mother was embarrassed because she thought of all the times they pressured us. They thought we were holding off for money. (2312:22-M)

For others, the definition of the situation is non-shared because others are perceived to be unable to understand the significance of the fertility problem. One man described the limited understanding that his own parents had of the situation:

Every time we talk to my parents, they just can't grasp what is happening. They just don't understand. If our infertility problem was a rope and they were drowning, they would probably drown. (1209:23-M)

The difficulty that others had in understanding the problem was partially attributed to non-obvious nature of the problem:

It's really something that people don't see or understand. Like you aren't missing an arm or anything like that. But you still have that physical handicap. You can't do what you want to do. (2504:44-F)

One couple explained the kind of reactions they get, again suggesting the difficulty that others have in "placing" the new identity of the childless couple:

H: The guys I have told most of them respond with sympathy like "its too bad". Some guys mean it but for others its like you stubbed your toe. When I first mentioned it at work I felt shunned - they say "what the hell is that?" "Are you shooting blanks?"

W: Some girls say when I tell them that I have endometriosis "Well is it cancerous?" Others say "Well I had a friend who had that and she got pregnant or they read this article and she got pregnant doing this. They make it sound so simple but I know its not that easy. I get so angry because they give you false hope. I wish people wouldn't give me advice. I don't think that people can understand unless they have gone through it. (3313:22,23)

In many cases, disclosing infertility created an awkward silence in the interaction. Ironically, one man likened the response to the loss of biological parenthood with the response that people usually reserve for death:

When I tell them [i.e. about infertility] its as if someone died. They don't know what to say. (2502:22d-M)

The way that couples accounted for their infertility changed over time. Perhaps the most striking change was the trend toward becoming more open in discussing infertility as time progressed. In this regard, couples created a more "open awareness context" (Glaser & Strauss, 1981) over time, thereby allowing their reference group to identify them as having a fertility problem. This tendency toward more openness was reflected in significant correlations between measures of infertility disclosure and the stage in the process. On one measure, couples were asked to indicate the

total number of people that they both had told about their<sup>1</sup> fertility problem. A significant correlation of .32 ( $p < .01$ ) was found between this number of people disclosed to and the stage in the process. As Table 22 shows, three-fifths of Group I had told 15 or less people, while only 12 % of Group III had told 15 or less people. By contrast, one-half of Group III had told more than 30 people while only 28% of Group I had told more than 30.

Table 22. Total number told of infertility, by group (N=71)  
 $r = .32$  ( $p < .01$ )

Number disclosed to	Stage in the Process					
	I	Group I (N=29)	I	Group II (N=26)	I	Group III (N=16)
15 or less	I	58.6	I	26.9	I	12.5
16-30 told	I	13.8	I	38.5	I	37.5
31 or more	I	27.6	I	34.6	I	50.0
Column total		100.0%		100.0%		100.0%

1. The Pearson correlation was calculated using the recoded categories for "Number Disclosed To" as identified in Table 22.

Other measures of infertility disclosure lend support to the tendency toward greater openness the longer one is involved in the process. Couples were asked to indicate who they had told about their fertility problem. The people they had told were classified into reference groups according to different levels of intimacy. The number who had disclosed to parents, siblings, close friends, work associates, acquaintances, neighbours, helping professionals and strangers is summarized in Tables 23 and 24. Although the three groups are similar in the extent to which they disclosed to parents, siblings, close friends and work associates, they begin to diverge when disclosing to more remote reference groups (acquaintances, neighbours, professionals and strangers). With these reference groups, there was a tendency for couples to become more open as they moved from Group I to Group III. This would suggest that, over time, couples became more comfortable in telling more distant people.

Table 23. Reference groups disclosed to, by group, for husbands (N=68).

Reference groups dis- closed to	Stage in the Process					
	I	Group I (N=25) %	I	Group II (N=25) %	I	Group III (N=18) %
Parents	I	88.0	I	96.0	I	94.4
Siblings	I	80.0	I	92.0	I	83.3
Friends	I	88.0	I	96.0	I	94.4
Work assoc.	I	72.0	I	64.0	I	77.8
Acquaintance	I	12.0	I	32.0	I	33.3
Neighbours	I	28.0	I	16.0	I	38.9
Professional	I	4.0	I	20.0	I	22.2
Stranger	I	0.0	I	4.0	I	5.6

Table 24. Reference groups disclosed to, by group, for wives (N=74).

Reference groups dis- closed to	Stage in the Process					
	I	Group I	I	Group II	I	Group III
	I	(N=30)	I	(N=26)	I	(N=18)
	I	%	I	%	I	%
Parents	I	83.3	I	96.2	I	94.4
Siblings	I	83.3	I	88.5	I	83.3
Friends	I	93.3	I	100.0	I	94.4
Work assoc.	I	50.0	I	76.9	I	61.1
Acquaintance	I	10.0	I	23.1	I	33.3
Neighbours	I	23.3	I	38.5	I	55.6
Professional	I	3.3	I	23.1	I	33.3
Stranger	I	6.7	I	7.7	I	16.7

When the number of reference groups to whom they had disclosed was tabulated, and correlated with stage in the process, significant relationships were found for both men and women. For husbands, there was a correlation of .32 ( $p < .01$ ) between number of reference groups disclosed to and stage in the process. For wives, the correlation was .38 ( $p < .001$ ). As indicated in Table 25, less than one-quarter of

husbands in Group I compared with 56% in Group III had disclosed to 5 or more reference groups. For wives, the difference was even more pronounced with only 14% in Group I compared to almost two-thirds in Group III who had disclosed to 5 or more reference groups (see Table 26).

Table 25. Number of reference groups disclosed to, by group, for husbands (N=73).  $r=.32$  ( $p<.01$ )

No. of Reference groups dis- closed to	Stage in the Process					
	I	Group I (N=30)	I	Group II (N=25)	I	Group III (N=18)
3 or less	I	53.4	I	32.0	I	22.2
4	I	23.3	I	24.0	I	22.2
5 or more	I	23.3	I	44.0	I	55.6
Column total		100.0%		100.0%		100.0%



Table 26. Number of reference groups disclosed to, by group, for wives (N=71).  $r=.38$  ( $p<.001$ )

No. of Reference groups dis- closed to	Stage in the Process					
	I	Group I (N=29)	I	Group II (N=25)	I	Group III (N=17)
3 or less	I	51.7	I	24.0	I	17.6
4	I	34.5	I	12.0	I	17.6
5 or more	I	13.8	I	64.0	I	64.7
Column total		100.0%		100.0%		100.0%

This trend toward more openness was also supported by the finding that couples in Group I were more likely than those in Group III to have purposely concealed their infertility from significant others. For both husbands and wives, there was a significant correlation of  $-.28$  ( $p<.01$ ) between the number of people that one had concealed infertility from, and the stage in the process.

Somewhat surprisingly, however, there was no increase on the measure of the extent to which couples perceived that others could understand their situation as they progressed from one group to another. Since couples disclosed more about their infertility the longer they were in the process, one might expect that couples would perceive

the level of understanding to increase as well. However, for both husbands and wives, the mean average level of understanding by others of their situation was "poor understanding" and this did not change significantly across the three groups. This rated fourth on a five point scale ranging from "understand completely" (1) to "no understanding at all" (5). Individuals rated their spouse, parents, friends and close relatives on the scale. This persistent perception that others did not understand their situation can be interpreted as another indication of the concern expressed by many that "no one can understand our situation unless they have gone through it." It may, however, also be explained by the fact that although they became more open over time, they became more open with increasingly distant reference groups. The very distance of such people would make it unlikely that they would express any more empathy with them than those close to them.

As the above findings suggest, couples became less evasive and more open in disclosing their fertility problem as time progressed. By way of explaining this increased openness, one man pointed out that people begin to suspect that there is a problem which then requires explanation:

With most of my friends it was not until about 2 or 3 years after we found out that we had a problem that I could tell them. Initially I just said, "well we're sure having fun trying!" but people are not stupid and you soon have to face up to it - So I told them that we have a problem (3313:22-M)

Others explained that it got easier to talk about it as time went on because of getting over the feelings of "shame" and "inadequacy" that were present at the beginning (3352:22c-M), and that over time, "it made me feel better to talk about it." (1228:22c-F)

For some, the greater ease with which they could account for their childlessness emerged as a result of developing a vocabulary for talking about it. The responses that they learned to use in situations ranged from simple statements like "We have a problem" or "We can't" to more elaborate statements designed to make others think about the situation. For one woman this meant becoming an "educator" in order to help others understand the situation:

I just tell them straight out - "We can't have kids" - boom! thats it. I don't need the social pressure. I take it on myself to educate people. (3308:22c-F)

For another woman, the intent was somewhat more malicious:

I get people asking "Do you have kids?" Then they'll say "No! Don't you like kids?" These people I blast. I go into why I can't have kids. I like to see these people get embarrassed. (3401:22c-F)

The consideration of adoption was also used as a way of accounting for childlessness. This method was used by the couples in Groups II and III as an indirect, but simple way of explaining the absence of biological children. For these couples, there was a tendency to avoid discussions of infertility, and instead, focus on adoption. As one man explained:

I haven't told any of them that we can't have kids, but I have told them that we are adopting. So they can put it together. We don't dwell on the infertility - its only a problem if you make it a problem. (3506:22c-M)

This supports Miall's (1986:273) finding that disclosure of intention to adopt often accounted to an admission of infertility.

Accounting for the absence of biological children was a pervasive pressure faced by all infertile couples as a result of their failure to live up to the normative expectation that they have children. As the above discussion suggests, two trends were evident. On the one hand, couples were increasingly open over time in disclosing their infertility. On the other hand, couples tended to perceive an inability on the part of their significant others to adequately understand their situation, regardless of what or how much they told them, unless they were themselves faced with a fertility problem.

#### Relinquishing Identification with Biological Parenthood

When biological parenthood was discovered to be problematic, not only were couples faced with the possibility that it might just take a little longer to get pregnant, but they were faced with the possibility that they might "never" get pregnant. With this realization as a starting point, couples underwent a process of re-evaluating

the importance of the biological aspects of parenthood. As part of this re-evaluation, some couples began to "let go" of their sole identification with biological parenthood and began to entertain the possibility of becoming a parent through adoption.

The focus of this section is on the manner in which couples began to relinquish identification with biological parenthood. Of particular importance in this process was, (i) the gradual loss of control that couples experienced in their efforts to become biological parents; (ii) the equivocating that couples experienced in making decisions to continue or discontinue the fertility testing and treatment process; and (iii) a shift in the meaning and importance of the biological aspects of the parenting experience. Although this process of "letting go" of biological parenthood is of fundamental importance for understanding the transition to adoptive parenthood, it's significance for the transition to adoptive parenthood shall be explored more fully in the next chapter. For now, the primary concern is to explore how couples begin to relinquish an identification with biological parenthood as an issue in and of itself. Of course, not all couples, especially those in Group I who had not even discussed adoption (N=2), had begun to "let go" of biological parenthood. However, these couples, rather than being excluded from this conceptualization, act

as the baseline from which the transition to adoptive parenthood can be seen to commence.

No doubt one of the key aspects for initiating the process of relinquishing identification with biological parenthood was the loss of control that couples experienced in becoming biological parents. Most couples felt that having a fertility problem had changed their sense of control over their lives. Women, however, were more likely than men to say that having a fertility problem had an effect on the extent to which they felt like they had control over their life. Whereas over three-quarters of the wives indicated that having a fertility problem changed their sense of control over their life, only one-half of husbands indicated that it changed for them. This may be a reflection of the greater salience of the parenthood role for women than for men. Whereas women had more invested in the motherhood role, men tended to have more invested in work-related activities. As a result, the loss of control associated with infertility had a greater impact on women. As one woman described the experience:

For me there has been a loss of control. It is no longer my choice as to whether or not I can get pregnant. People I know come off the pill and they get pregnant - that makes me mad. I just don't have control over my body. (3313:13-F)

Although one-half of the men did feel that infertility took away some of the control that they had over their lives, the other half indicated that it didn't really change their

lives. As one man pointed out: "I've carried on setting up my business. Because I can't have kids hasn't changed what I want to do with my life." (3522:13-M) For another man, infertility created some new freedoms:

It [i.e. infertility] gives you more freedom. We can take off when we want to. I can go fishing for a week if I want to. (1231:13-M)

Losing control over becoming a biological parent was frequently attributed to the power that physicians were perceived to have. In this regard, doctors were perceived to have the control over whether or not they became parents. As one woman described the physician's role, "the doctor is the main player, he is everything!" (1235:44-F) Another man described the feelings of dependency that this engendered:

We feel a lot more helpless now than when we first started. There is a lot of giving up to and depending on the doctors. Although we still feel like we can choose options, we are dependent on them. (2312:13-M)

This sense of powerlessness is consistent with the finding by Platt et al. (1973:976) that both infertile men and women tended to externalize the locus of control over events in their lives.

For others, there comes the eventual and dreaded realization that maybe not even doctors have the control over whether or not they will become adoptive parents. This in turn created an even greater sense of helplessness. As one couple eloquently stated it:

H: After month in and month out we began to feel it was beyond our control. The more things didn't work out, the more we began to feel that it was more out of control.

W: Having infertility is like being an alcoholic, only worse. Being an alcoholic, at least if you are going to do something, you have control over it. If you are going to change it, it has to come from you. With infertility though, you don't have control over it. That's what is so frustrating! There isn't anything you can do about it. Its up to the doctors. Even then, our doctor did all the tests and in the end, told us it was bad luck! At first I looked at my husband and said "Can you believe he said that?" But after awhile, I started to admire him for saying that. There's nothing they can find so its just bad luck. Not even he can control it. (1238:13)

With the transition to biological parenthood perceived to be out of human control, some couples (N=3) turned over control to fate or God:

We are becoming more stoic or fatalistic about it. If it happens it does. In the meantime we carry on our lives. (3501:10b-M)

Perhaps the most profound effect of the loss of control over the transition to biological parenthood was the sense that life was "on hold." Thirteen percent of husbands and 39% of wives indicated that waiting for parenthood pre-empted other life activities. This was described as a "moratorium in life" (2219:11-F) "a limbo" (2402:12-F) or "waiting for a bus - a holding pattern" (2219:11-M). Especially for women, this loss of control was perceived to interfere with other life commitments:

You are always waiting to see if it happens. It's very hard to make plans to go back to work, going back to school. If you do and get pregnant, you leave. Yes it does control you. I just can't commit myself to anything right now. (1215:13-F)



Similarly,

I don't feel that I have control. Where I am working, I would have liked to have left there by now and moved to a better job but I don't feel that it is fair to take a new job with the uncertainty of infertility and adoption when you might have to leave. I'm a planner and I just can't plan anymore. (2403:13-F)

And as Allison (1979) has pointed out, this reluctance to be fully committed to occupational activities when experiencing infertility is potentially a source of role conflict.

The loss of control that accompanied infertility created a sense of ambiguity about the future. For many couples, and especially women, the future was constructed around the desired transition to parenthood. As a result, there was a reluctance to make other kinds of plans in case these plans would in some way interfere with parenting if and when it happened. However, as time went by and couples were confronted by their own powerlessness to make parenthood happen, there was an escalating sense of "letting go" of biological parenthood. This is similar to Bierkens' (1975) finding that as time passes, the uncertainty and the fear of forever remaining childless increases.

Relinquishing identification with biological parenthood tended not, however, to be a neat, linear transformation whereby interest simply waned, but rather it tended to be a process consisting of a series of emotional peaks and valleys that over time diminished in intensity. The medical process of tests and treatments shaped this

pattern by creating, on the one hand, the optimistic expectation that something could be done, and on the other hand, by delivering the disappointing news that a particular test or treatment was unsuccessful. In this regard, the medical process structured their definitions of the situation. There was a general pattern of reverberation as couples got their hopes up following a treatment, only to have them dashed with the onset of yet another menstrual period. Through this process of tests and treatments, couples increasingly defined their situation as problematical, and as a result, their role investment in biological parenthood became less and less. Correspondingly, through this repeated process of emotional ups and downs, couples gradually relinquished their identification with biological parenthood.

Almost three-quarters of the couples pictured the fertility testing and treatment process coming to some distinct end point. Perhaps what is most interesting about this finding is that the other one-quarter could picture no end to the testing and treatment process. The majority (67% of husbands and 77% of wives) of those who could picture no end to the tests and treatments were in Group I, with the remainder in Group II. As indicated in Tables 27 and 28, almost one-half of both husbands and wives in Group I could see no end to the treatment. This strong commitment to the

treatment process and their obvious reluctance to end it suggests a strong identification with biological parenthood for these couples. As expected, there was a correlation of  $-.40$  ( $p < .000$ ) for husbands and  $-.44$  ( $p < .000$ ) for wives.

Table 27. End of tests and treatments, by group, for husbands (N=72).  $r = -.40$  ( $p < .000$ )

End of tests and treat- ments?	Stage in the Process					
	I	Group I (N=30)	I	Group II (N=25)	I	Group III (N=17)
Yes	I	53.3	I	72.0	I	100.0
No	I	46.7	I	28.0	I	0.0
Column total		100.0%		100.0%		100.0%

Table 28. End of tests and treatments, by group, for wives (N=73).  $r = -.44$  ( $p < .000$ )

End of tests and treat- ments?	Stage in the Process					
	I	Group I (N=30)	I	Group II (N=26)	I	Group III (N=17)
Yes	I	53.3	I	84.6	I	100.0
No	I	46.7	I	15.4	I	0.0
Column total		100.0%		100.0%		100.0%

For many of these people who saw no end to the tests and treatments, they would continue until someone told them to stop. One woman who had been trying for five years described her feelings:

Each time I go for a test, I think it is going to make it better, and then nothing happens. I say "Why am I doing this?" But I will keep going until the doctor says that there is no chance. (1233:9-F)

For another woman, the reluctance to give up on biological parenthood is reflected in a persistent drive to continue the medical process until she too is told she can no longer do so:

If I don't get pregnant, I will go through IVF until they say that I can't anymore. And that could be another 10 years because I'm eligible until I'm 38. (2212:9-F)

Other couples felt they had to do everything possible before they could call an end to biological parenthood. In some cases, this end was elusive in that technology was perceived as continuing to generate new possible solutions to the problem. A woman who had been through 8 years of testing and treatment continued to hope for a solution to the problem in order to have a biological child:

I grasped at straws - surgery after surgery to see if they could fix it. I'll still do it if the doctor says that there is a new procedure. I'll try it. Like last year I went in again. I'll go again being the guinea pig that I am. (3350:4c-F)

For some couples who could picture an end to the testing and treatment process, that end had a way of losing

its finite quality once it was reached. Upon reaching a pre-determined end point, some couples (9% of husbands and 16% of wives) decided that they weren't really ready for the end and as a result, they decided to go further. These ends can be seen as a kind of tolerance threshold, whereby people reach a saturation point and can go no further, but then decide to start again by exploring other avenues. It is this series of stops and starts that give the process of relinquishing biological parenthood it's reverberating quality. One couple related their experience of it:

H: It seems that it goes in cycles. You get so down and want to leave it. I am tired of all the problems and going ahead with it.

W: I think he reached that point [i.e. the end] a long time ago. I've reached that point a number of times. I have said "enough" and need a break away from it. For me the end will come in a few months when I have to go on with Danazol [i.e. a medication for endometriosis]. I don't want to take it so that may be the end. Although each time I reach those points I change and end up continuing on. (3308:9)

For others, "the" end had also been reached on a number of occasions and they came to expect that it had only a temporal quality to it:

After the next one - we are going to try Pergonal [a trademarked fertility inducing drug] - I think that we will call it quits. But you never know, we may get through that one and want to carry on. It's hard to say. (1210:9-F)

Likewise,

We're in for IVF. But I've said it so many times to R. and my doctor "Enough is enough! The testing is over!" After IVF being unsuccessful, I would say "enough!" But I have said it in the past that I just can't go through

this anymore and then R. and my doctor would encourage me to go further. (2312:9-F)

In this regard, and as Kraft et al (1980:622) and Menning (1977) have pointed out, a complete or final "resolution" of infertility is rarely absolute because the issue often continues to reverberate even when couples expect that the process has come to an end.

For some couples there was a reluctance to close the door on biological parenthood even after there was nothing else to try. One couple, who had been through the testing and treatment for six years at considerable emotional and physical cost could not say that they were finished with it:

I think that we are almost there. Not just physically, but it is emotionally draining. It's what it does to her. Not only does she look like she has all these zippers when she takes her top off, but it has been emotionally costly. (3313:9-M)

In some cases, the end came when couples no longer wished to tolerate the disappointment that accompanied the failed attempts at getting pregnant:

I reached that point after she came out of the hospital for a laparoscopy. I was hyped up that it was going to happen. Her period was late. Then her period came and we both came crashing down. I know how much she wants one. She's gone further than I would have. Seeing how it's devastated her, I gave up a little earlier. (2309:9-M)

For others, the day-to-day impact of the infertility process became too great to bear. For one woman, the cost of the strains that accompanied the testing became too great for the desired outcome of a biological child:

The strain of the tests and the temperature taking was getting to be too much. It got to the point where they wanted to cut me open and it was starting to strain our relationship and our sex life. We were at a crossroads. The specialist said that he couldn't do any more and that he could send us to the infertility clinic but he wasn't sure that that would do any good. So at that point we said enough. (3401:9-F)

Of course, in some instances (N=2), the end of the testing and treatment process occurred very abruptly when one of the partners was found to be sterile. In these cases, the identification with biological parenthood was also more abruptly severed. One woman conveyed her feelings when this happened:

The specialist told me that I wouldn't be able to have children. It was one of the hardest things in my life to accept. I think I'm more used to it now but it still makes me depressed and moody.(3522:4c-F)

The extent to which couples had relinquished identification with biological parenthood over time was further evidenced by changes in the importance of a biological tie to a child. Several measures were used to examine the degree of change in the importance of biological parenthood across the three groups. These measures included the importance of the pregnancy experience in the total picture of trying to have children; optimism for a biological child; and finally, the importance of a biological tie to a child.

Couples were asked to indicate on a five-point scale ranging from "much less important" to "much more important" how important the experience of pregnancy and the birth

process was in comparison to adoption. This question was designed to measure the importance of one aspect of the biological parenthood experience that would be missed in the adoptive parenthood experience. When the importance of pregnancy was correlated with stage in the process, a significant relationship was found for wives but not for husbands. For wives, there was a correlation of .31 ( $p < .01$ )<sup>1</sup> between the importance of pregnancy and stage in the process. Whereas 70% of women in Group I indicated that pregnancy was important or much more important, 54% in Group II and 39% in Group III indicated this. This would suggest that for women, the importance of the pregnancy experience diminishes over time as the prospects of becoming a biological parent become more remote. One woman explained these feelings:

I'm sad that I won't experience pregnancy and birth. But because we've lived with it [i.e. infertility], I've let go of it a bit. (2305:18b-F)

By contrast, most (55%) husbands indicated that pregnancy was important or much more important and this did not change significantly across the three groups. This would suggest that husbands were more earnest in holding on to the importance of pregnancy than their wives, and by extension,

1. An eta value of .42 indicates a slight curvilinear relationship.



exhibited more reluctance at relinquishing this aspect of the biological parenthood experience.

The explanations given by husbands and wives of why pregnancy was important offer some insight into the differences between men and women on this measure. Fifty-seven percent of wives compared to 34% of husbands indicated that pregnancy was simply something that they had always wanted to experience. It was seen as a time to feel a "glow for nine months" (2212:18b-F), to "feel the movements" (1204:18b-F) and as one woman described it:

That experience of pregnancy is supposed to be fantastic. It must be more difficult to establish a bond with a baby who is adopted. When you are pregnant, that bond develops before the baby even arrives. I wake up some mornings feeling sick and I say to myself "Wouldn't it be great if this was morning sickness?" (1223:18b-F)

By contrast, one of the most common reasons given by men for the importance of pregnancy was that it gave them time to prepare for parenting. Whereas 21% of husbands said pregnancy was important for this reason, only 12% of wives did so. One possible explanation, then, for the greater reluctance of husbands to "let go" of the importance of pregnancy was that they saw it's importance lying not so much in the experience itself, but as time during which they could physically and psychologically prepare themselves for the parenting experience. This preparation period was important because one could "grow into it with pregnancy rather than leaping into it with adoption." (2219:18b-M) Or

as another man put it:

If she gets pregnant, we know that nine months down the road there will be a little bambino. You have more of a build up. When we get a call [i.e. for adoption] it will be such a shock. (2453:18a-M)

The process of letting go of biological parenthood was also reflected in measures regarding couples optimism for and the importance of a biological child. Couples were asked how optimistic they were about their chances of having a biological child. Both husbands and wives became increasingly pessimistic about their chances of having a biological child as they moved from Group I to Group III. Optimism for a biological child and stage in the process were correlated at the  $-.39$  ( $p < .000$ ) level for wives and  $-.26$  ( $p < .05$ ) level for husbands. For wives, 62% in Group I were optimistic while 28% in Group III were optimistic. For husbands, 66% in Group I compared to 33% in Group III were optimistic about a biological child.

Clues for how optimistic they could let themselves be often came from the physician in charge of their treatment. Twenty-six percent of men and 18% of women indicated that they felt optimistic or pessimistic if their doctor felt that way. One man elaborated on the doctor's influence:

I am optimistic that we can have a biological child because the doctors seem to have the same optimism and hope and they seem to believe that there is a solution (2311:10b-M)

Even when there is no immediate solution to their problem, some couples vigorously held on to the promise of medicine to discover a solution in the future. For one man, whose wife had partially blocked fallopian tubes, there was still a strong sense of optimism:

Our doctor said that we have a good chance. You talk to the doctors and there are new breakthroughs all the time (2502:10b-M)

For other couples, the physician set the tenor for being pessimistic. One woman became very pessimistic when she discovered what her physician had written on her CAS application:

The doctor said on the CAS form that "NO!" we couldn't have children. That surprised me because he still wished me good luck. Initially he said "Don't adopt." Now he says "Go ahead with adoption." It's like he mislead us. (3307:10b-F)

The passage of time with no results was one of the main reasons for being pessimistic. Fifteen percent of both husbands and wives attributed their pessimistic attitude to simply "losing hope" over time. For one woman, the loss of hope corresponded with "biologically getting to the limit" (2403:10b-F) while for another it was simply the unexplained non-event of pregnancy:

I am very pessimistic because of the length of time. With no serious medical problems and no precautions, I figured I would have been pregnant. (3452:10b-F)

Optimism also faded as a result of "running into so many dead ends" (3350:10b-F) in the testing and treatment process. One woman elaborates on how pessimism took over as

a 'safer' way of approaching the prospect of becoming a biological parent:

I've been optimistic in the past. Then I go to the doctor and I get let down. There are only so many times that I can be up and then let down. I've become more guarded in the last year about letting myself get up. (2305:10b-F)

For many of those who were optimistic, the focus was on maintaining a sense of hope in the face of adversity. The reasons for their optimistic attitude were that "we must continue to hope and have a positive attitude" (13% of husbands, 17% of wives); "there is no good reason that we are not getting pregnant" (15% of husbands, 11% of wives); or that "it will work the next time and we will get pregnant" (12% of husbands, 5% of wives). For one couple, maintaining an optimistic attitude was the easiest way of coping with infertility:

If you think that it's not going to happen, you get depressed. The other extreme is being defiant and giving up. Staying optimistic makes it easier. If you tread water, it's easier to stay above than going down and up again. (1240:10b-F)

For another couple, attitude was directly related to outcome:

I struggle to stay optimistic. I don't know whether it's mystic or what, but if you are uptight, it's a well known fact that you might have more trouble conceiving. So I try to stay up. You hear about people adopting and then getting pregnant. (1214:10b-F)

For others, there was ambivalence over their chances of having a biological child of their own:

I'm not pessimistic because no one has told me I can't get pregnant, but on the other hand, I have been trying for 13 years. (3501:10b-F)

Couples were also asked to indicate the importance of a biological tie to them. One of the main reasons given for wanting a biological child was that it "allowed parents to see some of themselves in their child." Forty-six percent of husbands and 32% of wives said that biological parenthood was important for this reason. Other reasons included "you know what you are getting as far as the health and ancestral history of the child" (20% of husbands, 23% of wives); "you get to experience pregnancy" (8% of husbands, 18% of wives); or "you don't have to deal with adoption as an issue as the child is growing up" (13% of both husbands and wives).

Related to this, couples were asked to indicate whether having a biological child was more important to one spouse. Although one might expect that having a biological child would be more important to the husband because of our patriarchal tradition that has emphasized the importance of male bloodline inheritance, this was not borne out in the data. Rather, the importance of a biological child was equally distributed for husbands and wives with wives indicating that it was slightly more important for themselves. For husbands, 27% said it was more important for themselves, 28% said it was more important for their wives, and 45% said it was equally important. For wives, 37% said it was more important for themselves, 30% said it was more

important for their husbands, and 34% said it was equally important. This might be explained by the fact that more women than men were experiencing the medical fertility problem, and as a result, may have more intensely desired a biological child out of a sense of guilt or responsibility.

When the relationship between importance of biological tie to a child and stage in the process was examined, a similar trend to optimism for a biological child was discovered. Again, there was a significant correlation between importance of biological tie and stage in the process for both husbands and wives, but it was slightly stronger for wives. Relatively strong correlations of .40 ( $p < .000$ ) for husbands and .45 ( $p < .000$ ) for wives suggest that the importance of a biological tie to a child diminishes as one moves from Group I to Group III. Whereas almost two-thirds of husbands in Group I indicated that a biological tie to a child was important to them, 27% in Group II and only 11% in Group III indicated that it was important to them. For women, there was a similar pattern with 57% in Group I, 35% in Group II and 17% in Group III who considered biological parenthood important. Again, the lessening importance of a biological tie to a child supports the notion of a "letting go" process in their identification with biological parenthood.

## SUMMARY

Several patterns were clearly evident in the examination of biological parenthood as problematic and the subsequent process of relinquishing identification with biological parenthood. First, the meaning and importance of biological parenthood occurs against the backdrop of a set of strong normative pressures that suggest that couples should be biological parents. Women, more so than men, were the direct targets of these pressures because of the greater importance that they expressed for the parenthood role in their lives. When couples discovered that biological parenthood was problematic, their taken-for-granted assumptions about parenthood were called into question. As a result, there was a re-evaluation of the parenthood identity which resulted, for most couples, in an increase in their commitment to become parents.

As part of the discovery that biological parenthood was problematic, couples were put in the position of having to explain or account for their childlessness to their significant others because they were falling behind in their expected transition to parenthood. Although couples tended at the outset to be evasive and secretive about disclosing the details of their fertility problem, they became more open over time as they felt a greater need to explain and as they learned a vocabulary for accounting for their

childlessness.

As couples increasingly defined their situations as problematic, they began to relinquish their identification with biological parenthood. This process of "letting go" was often precipitated by the loss of control over becoming parents that couples experienced. For many couples, the pattern of relinquishing identification with biological parenthood was characterized by a pattern of reverberation whereby couples encountered a series of "tolerance thresholds." These thresholds suggest that there is an ironic mixture of both desire and reluctance to end the infertility process and to let go of biological parenthood.

Several indicators supported the notion that couples did in fact relinquish various aspects of biological parenthood in the face of a fertility problem. These included a decrease in the importance of pregnancy for wives, a fading of optimism for having a biological child, and finally a lessening in the importance of a biological tie to a child as one moved from Group I to Group III.

It was on the rocky ground of reconciling biological parenthood as a problematic with an intensifying need to become parents that the seeds of adoptive parenthood began to take hold. In the face of diminishing prospects for biological parenthood, couples began to consider adoption as one option for meeting both their intrinsic desire to become



parents and the normative expectation that they do so. Relinquishing identification with biological parenthood played a key role, if not the key role in assuming an identification with adoptive parenthood. In this sense, dealing with infertility as a problematic and the letting go of biological parenthood were significant for understanding the process of adoption readiness.

The next chapter focusses on the issue adoption readiness and the way that couples gradually assumed an identification with adoptive parenthood. It is in that chapter that the significance of relinquishing biological parenthood is discussed as it relates to readiness for adoptive parenthood. In addition, other indicators of adoption readiness are examined.

## CHAPTER 7

### THE ADOPTION PROCESS: ASSUMING IDENTIFICATION WITH ADOPTIVE PARENTHOOD

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### THE ADOPTION PROCESS: ASSUMING IDENTIFICATION WITH ADOPTIVE PARENTHOOD

For those couples who faced biological parenthood as problematic, adoptive parenthood became one alternative for bringing their actions in line with the normative expectation that they be parents. However, the transformation of identity that was involved in shifting from biological parenthood to adoptive parenthood was typically a long process that lasted for several years. Rather than a radical alternation of identity, the redefinition of parenthood to accommodate adoption was a process that was usually shaped by a series of critical events.

The focus of this chapter is on the significant events that were involved in the process of assuming an identification with adoptive parenthood. In the first half of this chapter, the critical incidents or turning points that initiated this process are examined. No doubt the key event in turning attention to adoptive parenthood was the reconciliation of biological parenthood as a problematic with their desire to become a parent. Two patterns of

transformation became apparent with respect to this reconciliation process. For some couples, there was a sequential pattern whereby they had to let go of their identification with biological parenthood before assuming an identification with adoptive parenthood. Others experienced a concurrent identification with both. In addition, there is a discussion of other critical events like age and the influence of significant others including physicians, family, friends and those who had adopted. In the second half of this chapter, the focus shifts from how the process of identification with adoptive parenthood begins, to how couples reach a state of social-psychological readiness to take on the role of adoptive parenthood. Here there is a discussion of both objective indicators and subjective perceptions of adoption readiness. Finally, there is a discussion of some of the obstacles that get in the way of an identification with adoptive parenthood.

#### INITIATING THE ADOPTION PROCESS: TURNING POINTS IN THE TRANSFORMATION TO ADOPTIVE PARENTHOOD

The first consideration of adoption marks the beginning of a new identity process. These often-times reluctant first thoughts set in to play a process whereby couples attempt to reconcile their intensifying need for parenthood with a set of new unknowns that come with

adoptive parenthood. The focus of this section is on the rudimentary aspects of the identity transformation from biological parenthood to adoptive parenthood.

### Infertility as a Critical Event

The way that couples came to seriously consider adoptive parenthood was shaped in large part by the way that they came to terms with their infertility. Although one would think that the kind of diagnosis that couples received would be of central importance for the consideration of adoptive parenthood, this did not emerge as a significant variable. As Table 29 shows, there were no significant differences (using Chi-square analysis) across the three groups on the nature of the fertility problem. This would suggest that the process of adoption readiness is not determined in a significant way by the kind of diagnosis that couples received. Furthermore, there was no significant correlation between whether or not they had received a diagnosis and stage in the process. Only 9% of the sample (N=7) had not received some kind of diagnosis and these couples were evenly distributed among the three groups. Again, this would suggest that the medical diagnosis was not an important factor for initiating the adoption process.

Table 29. Infertility diagnosis, by group (N=97).<sup>1</sup>

Type of Diagnosis:	Stage in the process					
	I	Group I	I	Group II	I	Group III
Sperm	I	8	I	9	I	7
Tubal	I	10	I	9	I	4
Endometriosis	I	7	I	8	I	6
Ovarian	I	8	I	5	I	4
Unexplained	I	2	I	3	I	2
Other	I	0	I	2	I	3
Column total		35		36		26

$$\chi^2 = 6.484 \quad p < .75 \quad (DF=10)$$

1. The figures in this table represent responses rather than cases because couples were allowed to indicate more than one diagnosis.

What did appear to be of greater importance for understanding adoption readiness was not the kind of diagnosis, but the degree of commitment to biological parenthood. In light of the fact that most couples (82%) received a diagnosis of a fertility problem that did not absolutely exclude the possibility of getting pregnant but

only lessened their chance, there was, with all diagnoses (except those who were definitely sterile N=6), a sense of uncertainty about whether or not they would become biological parents. As a result, couples' experience of the infertility process was typically characterized by an ongoing sense of ambiguity. One woman described this feeling:

It's the not knowing that if you had tried it again it might have worked. The possibility is always there for me because there is no really serious block. It's always hanging over you. And if you don't try, you feel like it might have worked. You are always waiting to see if it happens. (1215:12,13-F)

In light of this ambiguity, letting go of a commitment to biological parenthood was typically a slow and gradual process. For the many couples who experienced this uncertainty, there were two different responses regarding their consideration of adoptive parenthood. For some couples, the processes of relinquishing biological parenthood on the one hand, and taking on adoptive parenthood on the other hand, occurred in a sequential manner. For these couples, there had to be some sense of certainty that they would not become biological parents before moving on to a consideration of adoptive parenthood. For others, however, identification with biological parenthood and adoptive parenthood were experienced concurrently. For these couples, there was a continual reverberation between biological parenthood and adoptive

parenthood, insofar as they continued to hope for a biological child of their own while at the same time they increasingly identified themselves as potential adoptive<sup>1</sup> parents.

### Sequential Pattern of Transformation

For those couples who experienced the transformation of identity from biological parenthood to adoptive parenthood in a sequential manner (N=44), there was a linear, step by step progression whereby biological parenthood had to be left behind before moving on to adoptive parenthood. This meant for some couples that

1. In tracing these patterns, couples were fit into the sequential or concurrent pattern on the basis of their expressed commitment to the two identities. In this regard, the sequential versus concurrent pattern of transformation was an attitudinal variable. By contrast, couples were placed into the three main analytical groups on the basis of the behavioral criteria of whether or not they were active in the testing and treatment process and/or the adoption process. In order to determine which pattern couples followed, questions were asked regarding how they had come to a decision to put their name on an adoption waiting list, how they had come to consider adoption as a serious option, or whether there were any signs that a person could look for to tell them that they were ready to adopt. On the basis of their responses to these questions, couples were fit into one pattern or the other. For the sake of this analysis, those couples (N=6) who had an absolute diagnosis of sterility were excluded because they fit by default into the sequential pattern.



adoption would only be an option "after all avenues of having our own would be exhausted" (2238:33-M) or "when we are certain that we can't have our own" (1202:33-M) or "once you've played all your cards with infertility" (1235:33-M) or "when the biological door is closed" (1253:28a-M). For many couples, this need to reach an endpoint with infertility was thwarted by the uncertainty of their diagnosis, which in turn blocked any movement towards adoptive parenthood:

If they could say that it was something definite, then we could make plans and do something definite about it. Or we could make plans to adopt. (1216:11-M)

Without the diagnosis of a specific fertility problem, infertility was perceived by some not as a critical incident that occurred at a point in time, but rather, as an incremental process took place over time. In this regard infertility was perceived as the

gradual realization that there is something wrong. Even to this day, I'm not really sure that it is a problem but that it isn't just a matter of time. (1223:4c-M)

However, even this ongoing ambiguity could culminate to a point where the process of infertility did become a critical incident in the transformation from biological parenthood to adoptive parenthood. In some instances, this occurred when couples finally defined their infertility as a problem. This identification of themselves as having a fertility problem was instrumental in reshaping their sense of parenthood identity:

At first I was against adoption, but now I have changed completely around. I don't know why but I was totally against it then. I think now I have finally begun to accept that we have a problem, that there is something wrong. I think I always just held out for my own child. It is still important to have my own child but not important enough that I wouldn't want to adopt. (2203:27b-M)

For one woman, the turning point was "when optimism fades when it looks like chances are bad" (1210:33-F). For another, the turning point in the transition to adoptive parenthood occurred when he realized that biological parenthood could no longer be reasonably expected:

Once we had explored all the alternatives [i.e. for having a biological child], rationally we had to give up having our own. We had to wake up to the fact that we had to do something else. That's when we got very active in pursuing adoption. (3501:33-M)

For another woman, the turning point to adoption was a feeling of resignation that biological parenthood might never happen:

I would have to be resigned to the fact that I couldn't have my own children. I don't think I would know for sure about infertility, but I would have to be resigned to it. You see, for me, there will always be the chance of getting pregnant so being ready for adoption would be when I am resigned to it not happening. (1215:33-F)

For some, the move towards adoption is a result of losing hope over time as a result of repeated disappointments:

I'm not optimistic about AID [i.e. artificial insemination by donor] anymore. I did get hyped up about it but not anymore without any results. Seeing what it did to her - well I just don't need that anymore. I just don't let myself get hyped up about it anymore. So adoption is the way to go. (2309:27b-M)

For another man, this means feeling that they had done everything possible to become biological parents before feeling ready to take on adoption:

We have to have some closure on infertility. We wanted to know that we could have children. But there is a point where you give up all the drugs and surgery. We need to have the feeling that we have done everything that we can. (1207:33-M)

Coming to terms with infertility and being ready for adoption is sometimes marked, not just by the end of the tangible aspects of the infertility process such as the tests and treatments, but by working through the feelings that are engendered by infertility:

I think you are ready for adoption when you aren't crying every day. You've worked through your anger and your self pity. You need to work through your feelings of infertility and to give it a good shot before you are ready. (2402:33-F)

In light of this emphasis on having to first resolve the infertility process, to consider adoption before finding a definite answer to infertility would mean "admitting defeat." (1240:26-M) Or, as another woman said:

I would adopt but I need to find out more about the fertility problem. I don't want to think about adoption too much because that's giving up hope of having our own. (1232:35-M)

In addition, prematurely resigning oneself to the loss of biological parenthood would in itself be problematic:

I have to give myself the chance of getting pregnant. I have to do everything possible to have my own children. If I adopted before I did that then I think I would feel guilty that I never gave it a proper chance. (1241:33-F)

Not only would this engender feelings about having not given biological parenthood a proper chance, it was perceived to interfere with a proper identification with adoptive parenthood:

We are not ready to adopt yet because we have to get over the grief period where we have come to accept what we are up against. Until we get past that we would be in a real muddle with adoption. It would make things worse. (1237:31-M)

In some cases, however, the formal initiation of the adoption process was a critical incident because it was instrumental in shifting commitment from biological parenthood to adoptive parenthood. One man explained how the call to the agency precipitated a sequential transformation of identity:

I felt that when she called it was failure time. Like we're giving up. It was like the disappointment of not scoring a goal. It was a shock then... I was still grasping for straws and it put an end to that...I had to confront the problem. Now I don't have the feeling of failure anymore. Adoption has helped me. I like the idea of adoption now. (3352:27b-M)

For other couples, there is an anticipated re-evaluation of the meaning of parenthood that could only occur when biological parenthood could no longer be reasonably expected:

I think that you have to be completely convinced that you couldn't have your own baby. Then, is it your own baby or a baby that you want? You have to come to a point where if your own baby is not possible, or so dim that you then ask the question - Do we just want a baby? Or was it to have our own baby? That is a different question and one that we can't answer until we get to that point. (1214:33-F)

The sequential pattern of transformation is marked by a definite end to the process of seeking the identity of biological parenthood. For those who adopt a sequential pattern of transformation, this end to the infertility process is then a critical incident. Only when this end is reached does the transformation to adoptive parenthood begin. By contrast, some couples experienced the transformation of identity from biological parenthood to adoptive parenthood by being active in the pursuit of both identities.

#### Concurrent Pattern of Transformation

For those couples who experienced the transformation of identity from biological parenthood to adoptive parenthood in a concurrent manner (N=19), there was an ongoing commitment on the one hand to biological parenthood, and on the other hand, a new commitment to adoptive parenthood as an alternate way of becoming parents. For these couples, there was a realization that infertility may not have a distinct end, and as a result, the pursuit of adoptive parenthood becomes the way of optimizing the chance of having children:

We haven't exhausted all of the possibilities of having our own but we are willing to go ahead with adoption and still try for our own. I used to think that we would hit a dead end and then go ahead but its not like that. (1240:33-M)

The decision to commit oneself to adoptive parenthood in addition to biological parenthood may be the result of fewer options for successful infertility treatment and as a result, diminished hope for biological parenthood:

We thought of adoption more seriously when we started to get worn down with fewer options. We decided to go for adoption but will still try to get pregnant even with adoption. (2243:27b-M)

Although the chances for becoming biological parents may lessen over time, as one woman points out, it is not necessary to accept infertility before moving on to adoption:

Being ready for adoption is a combination of knowing that you want to be a parent and realizing that you may not have your own. I don't think that you have to accept infertility because we are, and will still try to have our own but realizing that we may not have our own. (2403:33-F)

Likewise, one man commented:

I don't think that you have to go so far that there is no hope before you adopt. Why wait until you are a basket case in going through all the pain and agony of infertility when having kids is all you think about and dream about? (2311:33-M)

In the face of a limited time span within which to have children, some couples were open to the prospect of being both biological parents and adoptive parents. In this respect, getting pregnant was still important but adoption was the back-up means to parenthood as a result of "not wanting to pass up having children at all." (2312:27b-F) For others, the possibility of having "one of each" is

entertained as the way of achieving their desired family size:

I've always been open to adoption. We've talked about both - what if we were to adopt and then get pregnant. I think that we could adopt and still keep trying to have our own. I wouldn't mind having one of each. (2219:33-F)

For those who experienced the transformation in a concurrent fashion, there was often a good deal of confusion and ambivalence about the degree of commitment to either biological or adoptive parenthood. In this regard, there was not always a shared commitment to both identities at the same time as much as a reverberating or equivocating dynamic of identification between the two identities. As one woman apologetically lamented at the end of the interview:

Sometimes in this interview, I felt like I was contradicting myself which makes me think that I haven't really accepted infertility or am ready for adoption. Like you go back and forth. Yes, I'm ready for adoption but I still want to try for my own. Then, maybe I'm not ready for adoption. I don't know. (2314:11-F)

Couples who experienced the transformation of identity from biological parenthood to adoptive parenthood in a concurrent manner maintained a commitment to both identities. The prospect of either identity or both identities being realized suggests that the transformation of identity cannot always be viewed as a neat, linear, temporal progression. Rather, as the above examples demonstrate, the transformation of identity from biological to adoptive parenthood can also be conceptualized as a

process of shared or reverberating commitment.

This finding is contrary to much of the literature on infertility and adoption which emphasizes a sequential shift in commitment from biological parenthood to adoptive parenthood. For example, most research stresses the importance of infertility "resolution" before successful adoptive parenting can occur (Castle, 1982; Kraft et al, 1980:619; Krugman, 1967:269; McNamara, 1975:15-17; Sorosky et al, 1978:71-86). However, as the concurrent pattern of transformation would suggest, not all couples fit the linear mould. As a result, it would seem prudent to consider in future research the possibility of different patterns of transformation.

#### Changes in Sequential versus Concurrent Patterns over Time

As Table 30 indicates, an interesting pattern emerged with respect to the kind of couples who experienced the transformation in a sequential pattern versus those who experienced it in a concurrent pattern. In Group I, couples were not actively pursuing adoption, and there was a very clear and obvious trend regarding the nature of the transformation to adoptive parenthood. Eighty-seven percent of these couples indicated that the transformation of identity from biological parenthood to adoptive parenthood



would occur in a sequential pattern. By contrast, those couples who were actively pursuing both a biological child and an adopted child (Group II) showed more of a mixed attitude toward this transformation of identity. In this middle group, 42% indicated that they would experience the transformation in a sequential pattern while 50% indicated that it would occur in a concurrent fashion. In Group III, there was a return to a sequential pattern, with 58% indicating that it was a sequential transformation. Only one-quarter in Group III perceived it as occurring in a concurrent pattern of transformation.

Table 30. Sequential versus concurrent patterns of transformation, by group (N=68).

Type of transformation:	Stage in the process					
	I	Group I (N=30)	I	Group II (N=26)	I	Group III (N=12)
Sequential (N=44)	I		I		I	
	I	86.7	I	42.3	I	58.3
	I		I		I	
Concurrent (N=19)	I		I		I	
	I	10.0	I	50.0	I	25.0
	I		I		I	
Unclear or spouses differ (N=5)	I		I		I	
	I	3.3	I	7.7	I	16.7
	I		I		I	
Column total		100.0		100.0		100.0

The trends in each of these groups are significant for coming to a better understanding of how perceptions of the transformation of identity to adoptive parenthood change over time. The fact that almost all couples in Group I perceived the transformation in a sequential fashion suggests that they had a strong and primary identification with biological parenthood. These couples, who tended to be in the early stages of the infertility treatment process, were more active in the medical investigation of their fertility problem, and as a result, were much more optimistic about the possibility of achieving biological parenthood. Since these couples perceived that the possibility of achieving biological parenthood was greater for them, they were much more reluctant to give up on biological parenthood in favour of adoptive parenthood until they had received some definite medical answers. They believed that only when such a point was reached would adoptive parenthood be a realistic option for them. And for the couples of Group I, the prospect of ending the infertility process and starting adoption was still somewhat remote.

For those few (10%) in Group I who viewed the transformation in a concurrent fashion, there was a discrepancy between their sense of identification with adoptive parenthood and their actions to become adoptive parents. These couples had taken no concrete steps to become

adoptive parents, yet, they had thought and talked about adoption and felt some readiness to take it on. In thinking about putting their names on the adoption list, these couples had simply "procrastinated" (1223:28b-M) or "simply didn't know how to go about it" (1222:28b-F) but had, nevertheless, indicated a readiness for adoption:

Adoption is a serious option for us because of the fact that there is a possibility that we can't have our own. At least with adoption, we will have a child (1223:27b-M)

In Group II, the fact that the majority fit the concurrent pattern suggests that adoption has become a more realistic option. Given that those in this group tended to be further along in the infertility process than those in Group I, one would expect that optimism for and identification with biological parenthood would begin to wane and that there would be an increased awareness of adoptive parenthood as an option. With one-half of this group fitting the concurrent pattern, one can surmise that the once exclusive identification with biological parenthood shifted to a split identification between biological parenthood and adoptive parenthood.

For those in Group II who fit the sequential pattern, there is an apparent anomaly between their attitudes and behavior. Although they have taken steps to initiate the adoption process (and are therefore classified as Group II), they have expressed the attitude that adoption

is not really a serious option for them until they get definite answers for their infertility. For many of these couples, the active pursuit of adoption occurred not as a result of giving up on biological parenthood, but rather in recognition of the long wait that is typically expected in order to become adoptive parents. In this regard, it would seem that couples were "hedging their bets" for adoption in recognition of this long wait, while at the same time continuing to invest themselves primarily in biological parenthood. By way of illustration, one couple was already well into their adoption homestudy but they did not think that adoption was a serious option for themselves. This suggested that their primary identification was still with biological parenthood even though they were actively pursuing adoption:

Interviewer: Do you consider adoption to be a serious option for yourselves at this point in time?

Husband: There aren't many options left but I don't think that we will have to go that way [i.e. adoption].

Wife: Until you finish the testing and treatment, you never really accept your infertility. So you still have to hope and not give up. I don't think that we will have to go the adoption route. (2314:27a)

Likewise, another couple explained that their active pursuit of adoption did not so much reflect an identification with adoptive parenthood, but rather suggested that they were rationally calculating their odds in order to maximize their chances of getting a child. When asked whether they considered adoption to be a serious option for themselves,

they responded:

Husband: No, because of the possibility of her getting pregnant.

Interviewer: How did you come to a decision to put your name on the adoption list then?

Husband: It was a hasty decision. We realized that it was going to take a long time. So we were playing it safe.

Wife: We wanted to cover ourselves. A nurse told us to put our name on the list. It didn't seem like a reasonable thing to do early on so we didn't do it because we would not believe that we wouldn't get pregnant. (2302:26,27a,29)

Similar to Group I, the majority of those in Group III fit into a sequential pattern. However, for this group, the explanation is quite different. These people are no longer active in the testing and treatment process, and as a result, their perception of the transformation of identity to adoptive parenthood was a retrospective account of what had already happened. For the majority of this group, then, identification with biological parenthood had essentially ended and their investment in the adoptive parenthood identity was absolute. For the 25% in Group III who fit the concurrent pattern, one can surmise there was a lingering hope for a biological child while investing in the adoptive parent identity.

Therefore, to put the transformation in stage-related terms, it would appear that those couples who are early on in the infertility investigation invested themselves exclusively to the pursuit of biological parenthood. These couples anticipated that adoption would

become an alternative only when there was a definite conclusion to infertility. However, as time progressed, and couples did not receive definite "answers" to their infertility, there was an increasing awareness that there might never be a definite answer or conclusion to infertility. In the face of this prospect, couples began to commit themselves to adoption, realizing that they might never have their own biological children. However, this did not mark a complete relinquishment of biological parenthood, but rather, it marked a shift from total investment in biological parenthood to a shared investment in biological parenthood and adoptive parenthood. Finally, for couples who had completed their tests and treatment, there was a primary identification with adoptive parenthood that was made possible by letting go of biological parenthood. For these couples, there tended to be a definite end to biological parenthood which allowed them to move on to adoptive parenthood. These couples thereby represented a final stage in the process of transformation of identity because of their exclusive commitment to adoptive parenthood.

Although the events associated with infertility were critical in tracing the transformation of identity from biological parenthood to adoptive parenthood, other events were important in moving couples towards the identity of adoptive parenthood. It is to these other incidents that attention now turns.

### Age as a Critical Incident

Age emerged as a significant turning point in the transition from biological parenthood to adoptive parenthood. For many couples, the desire to pursue adoption arose as a consequence of a vague sense that 'time was getting on' or that the 'biological clock was ticking away'. The awareness of age as a factor in the adoption process was more significant for women than for men. For example, whereas 15% of women indicated that age was the main reason for putting their name on an adoption waiting list, none of the men indicated that age was a critical factor. Similarly, 15% of women indicated that age was one of the main reasons for considering adoption as a serious option, while only 6% of men indicated this. One possible explanation for the greater importance of age as a critical incident for women would have to do with the finiteness of female reproductive capacity in comparison with male reproductive capacity. Since women face a limited number of years before menopause, there is no doubt a greater sense that time is running out. As one woman explained:

The biological clock was ticking. I had sort of given up getting pregnant. The doctor said we are on our own and gave us a 50-50 chance of conceiving. That's when we talked about adoption. (2403:26a-F)

Related to this, age was anticipated as a crucial event because it marked the point when biological parenthood

would be impossible or too dangerous to pursue:

Age is an important factor because there will be a time when it will be dangerous to get pregnant. Then we will consider adoption. (1250:33-M)

For many couples, age and the passage of time was interpreted for it's social meaning. It was not age per se that was important, but it was the representation by age of reaching a certain level of maturity and stability. In this regard, age was the marker that signified that they were in fact ready to take on adoptive parenthood:

Age is the most important factor that tells you that you are ready to adopt. I am getting on. We are more experienced than a younger couple. We are sure that we want a kid. (2316:33-M)

Another woman expressed a similar feeling:

I'm ready to be a parent. The older I get, the more exposure I have to children and the more I think about being a parent. Also we have lived together for 6 years and I know how you tick and that we have a good marriage. I wouldn't consider adoption if I thought we were going to split up. (2305:31-F)

Conversely, the passage of time was significant for another woman insofar as it gave rise to the possibility of becoming too complacent in life to take on parenthood:

You get more settled in life and you want to have a child before you get even more settled.(2225:33-F)

As the above discussion would suggest, age was significant for adoption readiness in two different ways. For some, it marked the end of the quest for biological parenthood because they would be too old, while for others it signified a point when they would be ready to start the adoption



process.

Although the sense of running out of time was important for couples because it moved them to initiate the adoption process, age as a critical event or turning point was often anticipated rather than actually experienced. In this regard, couples in Group I who still strongly identified with biological parenthood anticipated that age would be a critical incident in their consideration of adoptive parenthood. For these couples (N=26), more men than women expected that age would be an important factor in moving toward adoption. This would suggest that men too may experience a social clock in their consideration of parenthood. For one man, this meant not wanting "to adopt at an age when I couldn't enjoy the child" (1204:33-M) or for another woman, it meant thinking ahead to how it would affect their role as grandparents:

Our age is the main indicator of being ready. I would like to have my children so that I can enjoy my children's children. (1231:33-F)

Other couples had a tendency to set arbitrary age limits for themselves based on an assessment of the structural constraints of the agency to be able to provide a child when they wanted one. For these couples, age was an important factor in calculating when to put their name in for adoption. In this respect, couples "hedged their bets" for adoption by putting their name in and expecting they would be ready by the time it was their turn to adopt a

child. As one man explained:

We will let the four years be the time to decide [i.e. whether we are ready]. It was knowing that it was a long wait that made us put our name in [i.e. for adoption]. (2305:29-M)

Similarly, adoption became a serious option for one woman in light of:

Knowing how long the lists were and knowing we were getting older. I couldn't see putting it off any longer (2504:27b-F)

There was considerable variation in the actual age that became an impetus to do something about adoption. As one woman suggested:

Age is an important consideration. He is 25 and I am 22. If it takes three or four years, he is going to be 30. I want to get going before we are too old. (3315:27b-F)

Turning 30 was significant for another couple:

Age was the biggest factor in getting our name in because of the waiting. I'll be thirty next year and I figure I better get my name in because my time is running out (3304:26-F)

Or, for another couple, turning 40 was the turning point for getting the adoption process started:

Some people told us that if you turn 40 you don't have a chance to adopt and we knew it was probably going to take 5 or 6 years so we thought we better get our name in (3307:29-F)

For another man, 50 or 55 was the upper limit for adoption. When asked by the interviewer whether there were signs that could tell him he was ready to adopt, he replied:

Age. I'm running out of time. When you become 50 or 55 you can't adopt a 3 or 4 year old. (2225:33-M)

As the above would suggest, there was little consensus among couples regarding the age at which it would be too old to adopt. This suggests that age is highly subjective as a critical incident in the transformation of identity to adoptive parenthood. Unlike other couples who go through the transition to parenthood according to objective, normative expectations that they have children "on schedule", infertile couples must define for themselves a different time schedule in light of the different contingencies that adoption creates for them. These include a loss of control over the timing of the adoption process, the potential to delay the transition to parenthood to a time when biological parenthood would be impossible, and yet, a consideration of the acceptability of having a child at a later age in light of both medical and normative considerations.

Age and the resolution of infertility were both important events in the transformation of identity to adoptive parenthood. However, interactions with significant others played a key role in the way that this new identity was shaped.

### Significant Others in the Transformation of Identity

The establishment of an identity is contingent upon the responses of others in the situation (McCall and Simmons, 1978). Therefore, the shift to the identity of adoptive parenthood was, to a large degree, shaped by the responses, comments and suggestions that were offered by significant others. The significant others who played a particularly important role in initiating the transition to adoptive parenthood included the physician in charge of their fertility investigation, close friends and family members, and individuals who had some experience with adoption.

The physicians who were in charge of the fertility investigation played a significant role in initiating the transformation of identity from biological parenthood to adoptive parenthood. For 27% of wives and 17% of husbands, the doctor played a key role in initiating the adoption process. This is no doubt accountable to the tremendous power that the physician was perceived to hold by infertile couples who were seeking parenthood. As one woman commented, adoptive parenthood would become a viable option only "when the doctor tells us to consider adoption." (1230:33-M) As a result, when the doctor suggested that a couple look into adoption, this was often a critical turning point in letting go of biological parenthood and moving toward adoptive

parenthood:

We got to the point in the fertility investigation where there was nothing more that the doctor could do. I was getting frustrated and it was time to start accepting the fact that we couldn't have kids. So the doctor suggested that we start looking at other options - namely adoption. That's when we began to seriously consider adoption for ourselves. (3401:27b-F)

In addition to reaching an end with tests and treatments, some doctors played an important role in explaining the prospects for adoption. As one woman explained it:

My doctor found out that it wasn't me, so I asked my doctor what the options were and he said to put in for adoption because the waiting is so long. (2521:26-F)

Even when the testing and treatment process continued, some doctors encouraged couples to maximize their chances of getting a child by exploring the option of adoption. In this respect, doctors encouraged couples to "hedge their bets":

The doctor mentioned it to me right after my second laparoscopy and before tubal reconstruction. He encouraged us to explore our options. He said we should get our name in because we had to wait for three to five years and if you get pregnant in the meantime, then great. (2502:26-F).

The suggestion by the doctor that a couple look into adoption was not always welcomed. In some instances, the doctor's suggestion that they consider adoption was interpreted as putting pre-mature closure on their desire to become biological parents. Rather than being a turning point in considering adoptive parenthood, these ill-timed suggestions seemed to reinforce commitment to biological parenthood. As one couple explained:

Husband: When we first went to the doctor, it was a negative experience. It was if he couldn't help us. We didn't want to hear about adoption right off the bat.  
 Wife: The doctor asked us if we had considered it [i.e. adoption]. It was as if he was trying to tell me something (1235:26).

As shown in Table 31, friends, family members and those who had some experience with adoption also played an important role in suggesting to couples they consider adoptive parenthood. Whereas parents and siblings were most important for wives (63%), those who had some experience with adoption were most important for husbands (57%). The suggestion to adopt was frequently offered when they first explained their infertility. After hearing that there was a

Table 31. Significant others who play a role in the consideration of adoption. (Column totals sum to more than 100% because respondents could give more than one answer)

Significant others:	Husbands (N=18) %	Wives (N=24) %
Parents/sibs	38.9	62.5
Other with adoption experience	55.6	25.0
Agency officials	11.1	12.5
Friend	5.6	12.5
Column total	111.1	112.5

problem, well-wishing friends and family members automatically pointed out that "Well, there's always adoption!" (2305:23-F). Although this was not always taken seriously at the time of revealing infertility, it did serve to convey the expectation that adoption, and not childlessness was the expected course of action. For one woman, a discussion with her mother was critical for moving ahead with adoption:

Before I went to the hospital [i.e. for surgery], I was talking to my mom and she asked me whether we had considered adoption. I brought it up with T. [husband] then. (1232:26-F)

Friends and family members who had some experience with adoption also encouraged them to get started:

When we found out there was a problem and had surgery for it, we decided to do something. Friends [who were on the waiting list] encouraged us because of the long wait for adoption (2314:26-M).

For another couple, seeing a friend's adopted child was an important turning point for starting the adoption process:

Our friends who adopted encouraged us to put our name in on the adoption waiting list. So we went to visit their little guy and we really liked what we saw. So we decided to put our name in. (2505:29-M)

Doctors, friends, family and others who had experience with adoption played an important role in the transition to adoptive parenthood. From the perspective of the infertile couple, these people were significant others insofar as the adoption discussions with them were instrumental in moving couples toward a greater

identification with adoptive parenthood.

The First Step in the Formal Adoption Process: Calling the Agency

Putting one's name on an adoption waiting list was the event that marked the beginning of the formal adoption process. For many couples (N=15), the call was a way of "hedging bets" in recognition of the long wait that was involved in adopting a child. For some of these couples (N=5), the call to the agency did not so much reflect a serious commitment to adoptive parenthood, but was rather like a rationally calculated insurance policy designed to ensure that they would become parents if they failed to become biological parents. For these couples, then, the decision to call the agency was based primarily on anticipated criteria. For example, as one man pointed out in reflecting back on his decision to call the agency:

We decided that because the list was 6 years long, we would put our name in. But we didn't believe that we would ever have to do it. (3501:26-M)

Although the other 10 couples did "hedge their bets" in recognition of the long wait, their decision to contact the agency was also influenced by an assessment of their fertility problem. In this way, not only was their decision based on anticipated criteria, but on experienced criteria. For these couples, the experience of a diagnosis or the



absence of success in a treatment, combined with the anticipated long wait was crucial in deciding to call. As one man described it:

People tell you it takes so long, it takes so long [to adopt]. So we had a few tests. Quite a few people were pushing us to get on the waiting list saying that you can always cancel out. So once we had a few tests and they still couldn't find anything wrong - that's when we went ahead with it [adoption]. (2203:26-M)

For other couples, however, this step was significant because it represented the culmination of much discussion and soul-searching. As one woman put it:

You think about it for a long time. You deny that you even need to do it because you are given so much false hope [i.e. that you will get pregnant]. Finally, I called ... I was fed up with being a guinea pig. (3350:29-F)

Another couple described the enormity of the decision to start this process:

Interviewer: How did you come to a decision to put your name on the adoption waiting list?

Husband: We went at it from every different angle before we called. We talked to each other and everyone else. We discussed all the options.

Wife: We had an all night discussion for about seven nights. It was a very intense time. We talked about expectations, pros and cons. We brainstormed. What if? We would get up in the middle of the night and talk and go for walks. At the end we felt that adoption was the best for us. (3404:29)

Although most couples had intensive discussions about putting their name in for adoption, sometimes it was an unexpected event that prompted them to call the agency. For example, some couples (N=2) mentioned that a news report about infertility or adoption was instrumental in starting

the process:

We heard on the news about this couple who were too old to adopt. They were 37 or 38. So we figured we better get our name in before we are too old. (3306:29-F)

Attendance at a child-oriented event or celebration was often the catalyst to take action to initiate the adoption process. For example, two couples mentioned that Christmas, with its focus on children, was a critical event in moving toward adoption. As one woman explained:

I called in November. I had a whole day of kids. I had been Christmas shopping. I just felt so desperate. Christmas is such a hard time. (3352:29-F)

Similarly,

We were putting up the Christmas tree last year and he was really depressed. he said "I wish I was doing this for a child." That put the clincher on it - I called. (2312:29-F)

For another woman, the celebration of a pregnancy or the birth of a child was enough to get the adoption process moving:

My sister-in-law had a baby. She complained all the way through the pregnancy. Then she had the first granddaughter and thats what everyone wanted after four grandsons. That was the last straw. Within the week we got the forms from CAS and sent them in (2311:29-F).

Taking the step of putting one's name in with the agency was a significant event because it signified the beginning of a process which had a concrete end. Getting formally involved in the adoption process offered some relief from the ambiguity of infertility and the indecisiveness of whether or not to commit oneself to

adoption. As one woman expressed it:

It was a big relief when I signed up with CAS because then I knew we would have a child. Then I could plan for something in the future. (2454:44-F)

Women were most likely to be the ones to initiate the formal adoption process by putting in a call to the agency. In 85% of all cases (N=40), wives made the first call to the adoption agency. This is consistent with the greater salience of the parenthood role for women. Given that parenthood is a more central role identity in their lives, it is consistent that they would be the ones to take the initiative to start the adoption process.

#### ADOPTION READINESS

As the above discussion suggests, there were many turning points that initiated the process of identification with adoptive parenthood. However, these turning points or critical incidents did not typically represent a readiness to take on adoption, but rather signified a shift in commitment to more seriously consider it as an option. In this section, there is an exploration of the stage in the process when couples felt actually ready to become adoptive parents. To this end, there is a discussion of the objective measures used to identify this stage and the subjective perceptions, as expressed by couples themselves, of what it means to be ready to take on adoption.

### Objective Indicators of Adoption Readiness

Several measures were used to get an objective measure of adoption readiness. These included questions about whether they considered adoption to be a serious option; whether they were ready to adopt an infant if it were available; the frequency of their talks about adoption; whether they sought information on adoption; and whether they saw advantages to adoption. In addition, two composite indices were constructed to measure adoption attitudes and adoption readiness.

Perhaps the most direct measures of adoption readiness were the questions, "Do you consider adoption to be a serious option for yourselves at this point in time?" and "If a normal infant were available right now, do you think that you would be ready to adopt?". Whereas the first question elicited an attitudinal response with respect to the importance of adoption, the second question elicited a response regarding a projected course of action. Although similar trends were found on both of these dimensions, a much stronger association was found on the seriousness of adoption as an option. On this variable, there was a significant correlation of  $-.54$  ( $p < .000$ ) for husbands and  $-.62$  ( $p < .000$ ) for wives. As Tables 32 and 33 show, just over one-quarter of couples in Group I, three-quarters in Group

II and almost all couples in Group III felt adoption was a serious option. This suggests that as one becomes less active in the infertility process and more active in the adoption process, adoption is likely to be expressed as a more serious option.

Table 32. Seriousness of adoption, as an option, by group, for husbands (N=74).  $r = -.54$  ( $p < .000$ )

Stage in the process						
Adoption as a serious option?	I	Group I (N=30)	I	Group II (N=26)	I	Group III (N=18)
	I		I		I	
	I		I		I	
Yes	I	30.0	I	73.1	I	94.4
	I		I		I	
No	I	70.0	I	26.9	I	5.6
	I		I		I	
Column total		100.0%		100.0%		100.0%

Table 33. Seriousness of adoption, as an option, by group, for wives (N=73).  $r = -.62$  ( $p < .000$ )

Stage in the process						
Adoption as a serious option?	I	Group I (N=29)	I	Group II (N=26)	I	Group III (N=18)
	I		I		I	
	I		I		I	
Yes	I	27.6	I	80.8	I	100.0
	I		I		I	
No	I	72.4	I	19.2	I	0.0
	I		I		I	
Column total		100.0%		100.0%		100.0%

Similarly, a significant correlation of  $-.30$  ( $p < .01$ ) for husbands and  $-.33$  ( $p < .01$ ) for wives was found between readiness to actually adopt a normal infant immediately, and stage in the process. However, as Tables 34 and 35 indicate, on this measure the majority of all three groups indicated a willingness to adopt. Still there is some variance across the three groups. Whereas approximately three-fifths of Group I indicated a readiness to adopt a normal infant right away, approximately nine out of ten couples in Groups II and III indicated a readiness to adopt. This significant association may suggest that being active in the formal adoption process is a strong indication of readiness to adopt a normal infant.

Table 34. Readiness to adopt a normal infant immediately, by group, for husbands (N=71).  $r = -.30$  ( $p < .01$ )

Ready to adopt?	Stage in the process					
	I	Group I (N=28)	I	Group II (N=25)	I	Group III (N=18)
Yes	I	60.7	I	92.0	I	88.9
	I		I		I	
No	I	39.3	I	8.0	I	11.1
	I		I		I	
Column total		100.0%		100.0%		100.0%

Table 35. Readiness to adopt a normal infant immediately, by group, for wives (N=72).  $r = -.33$  ( $p < .01$ ).

Ready to adopt?	Stage in the process					
	I	Group I (N=28)	I	Group II (N=26)	I	Group III (N=18)
Yes	I	57.1	I	92.3	I	88.9
	I		I		I	
No	I	42.9	I	7.7	I	11.1
	I		I		I	
Column total		100.0%		100.0%		100.0%

Although the two measures of adoption readiness that are discussed above measure much the same phenomenon from different perspectives, there is a noteworthy discrepancy between the strengths of the associations. One might have expected the pattern of association to be essentially the same in both measures. However, an obvious difference in response on the two measures occurs for those people in Group I. Specifically, only about one-quarter of Group I would consider adoption a serious option, but three-fifths indicated that they would adopt a normal infant right away if it were available. The question that begs to be answered is why so many people would readily adopt a normal infant, even when they had neither considered it as a serious option nor had they taken any concrete steps to bring it about. Perhaps the most plausible explanation for this discrepancy is again the tendency for couples to "hedge their bets"

based on their awareness of the shortage of adoptable babies. In this regard, these couples expressed a readiness to adopt a child even though they didn't consider it a serious option because "we wouldn't want to pass up the opportunity" (1230:31-F) to get a child. As another woman explained:

It would be scary and exciting but I would go for it now, knowing that I may not have the chance when I am ready. So I am not emotionally ready now but I would make myself ready in order to take advantage of the situation. (1207:31-F).

For other couples, being ready to take on an adopted child simply emerged out of being ready to become a parent. For example, although couples in Group I were still investing themselves most heavily in becoming a biological parent, the desire to be a parent seemed to supersede whether it was biological parenthood or adoptive parenthood. What mattered most was becoming a family and enjoying the experience of parenting. In this regard, adoption was seen as an acceptable way of achieving this goal. One couple expressed this readiness, even though they had not taken any concrete steps towards becoming adoptive parents:

Husband: We are ready to adopt because we just want to share in the joy of children's lives.

Wife: We are just ready for it. We'd like to have a family so much. We have been ready for a couple of years. I want to be able to share things with a child. (1222:31)

Similarly for another man, it was having a child that was important, not whether the child was adopted or biological:



Adoption is a serious option for us because of the possibility that we can't have our own. At least with adoption, we will have a child (1223:27b-M).

Two composite indices were used to get a measure of adoption readiness. In the Adoption Attitudes Scale general attitudes toward adoption were measured. In the Adoption Readiness Scale an effort was made to get a more specific measure of couples' current readiness to take on adoption.

The Adoption Attitudes Scale consisted of five items after one item was deleted because it did not meet the reliability criterion.<sup>1</sup> Couples were asked to indicate on a five-point scale ranging from strongly agree to strongly disagree their level of agreement on the following items: "I could get as close to an adopted child as I could to a child of my own biological making"; "I feel comfortable when I think about the idea of bringing up a child that some one else gave birth to"; "I would never be as happy with an adopted child as I would with my own biological child"; "When one adopts, there is a much greater likelihood of not liking the child than if one gives birth to a child"; and "I really don't think there is any difference between parenting an adopted child and parenting a child of my own biological

1. The Cronbach Alpha reliability coefficient for the Adoption Attitudes Scale was .86. The following item was deleted because it did not meet the minimum acceptable item-total correlation: "When it comes to personality, children are born a certain way and there really isn't much you can do to change that."

making." In addition to being judged on face validity, the scale also demonstrated criterion validity insofar as it successfully delineated those who were active in the adoption process and those who were not. There was a significant correlation between the Adoption Attitudes Scale and stage in the process. The association was .39 ( $p<.001$ ) for husbands and .31 ( $p<.01$ ) for wives. As Tables 36 and 37 indicate, adoption attitudes became less negative as one became more actively involved in adoption. For husbands, 57%

Table 36. Adoption Attitudes, by group, for husbands (N=72).  
r=.39 ( $p<.001$ )

Adoption Attitudes	Stage in the process					
	I	Group I	I	Group II	I	Group III
	I	(N=28)	I	(N=26)	I	(N=18)
	I		I		I	
Negative <sup>1</sup>	I		I		I	
(10 - 19)	I	57.2	I	30.8	I	16.7
	I		I		I	
Neutral	I		I		I	
(20-22)	I	32.1	I	50.0	I	50.0
	I		I		I	
Positive	I		I		I	
(23 - hi)	I	10.7	I	19.2	I	33.3
	I		I		I	
Column total		100.0%		100.0%		100.0%

1. These categories for the Adoption Attitudes Scale were established by trichotomizing the frequencies for the sample as a whole, followed then by a crosstabulation.

in Group I, 31% in Group II and only 17% in Group III had negative attitudes toward adoption. For wives, 50% in Group I, 32% in Group II and 22% in Group III had negative attitudes toward adoption.

Table 37. Adoption Attitudes, by group, for wives (N=73).  
 $r=.31$  ( $p<.01$ ).

Adoption Attitudes	Stage in the process					
	I	Group I (N=30)	I	Group II (N=25)	I	Group III (N=18)
Negative (10 - 19)	I	50.0	I	32.0	I	22.2
Neutral (20-22)	I	26.7	I	28.0	I	33.3
Positive (23 - hi)	I	23.3	I	40.0	I	44.5
Column total		100.0%		100.0%		100.0%

Whereas the Adoption Attitudes Scale was designed to measure changes in general attitudes to adoption, the Adoption Readiness Scale was designed to reflect couples' willingness to take on adoption as an immediate course of action. This composite index again consisted of five items after one item was deleted because it did not meet

reliability criteria.<sup>1</sup> On a five point scale, couples indicated their level of agreement to the following items: "Adoption really seems like a last resort at this point in my life"; "I feel I am now ready to adopt a child"; "When I think about having to adopt, I get worried"; "We have discussed adoption and I know how my spouse feels about it"; and "I am looking forward to adopting a child." This scale also demonstrated criterion validity as evidenced in strong correlations between positive adoption attitudes and adoptive behaviour. Significant correlations were found between the Adoption Readiness Scale and stage in the process. For husbands, there was a correlation of .59 (p<.000),<sup>2</sup> and for wives, a correlation of .57 (p<.000). As indicated in Tables 38 and 39, approximately two-thirds of both husbands and wives in Group I had low adoption readiness scores while about 10% in Groups II and III had low adoption readiness scores. This suggests that one is unlikely to take active measures in the adoption process when there are feelings of reluctance or apprehensiveness toward adoption.

1. The Cronbach Alpha reliability coefficient for the Adoption Readiness Scale was .82. The following item was deleted because it did not meet the minimum acceptable item-total correlation: "Adoption isn't something that one can prepare for."
2. For husbands only, an eta value of .72 indicated a slightly curvilinear relationship.

Table 38. Adoption Readiness Scale, by group, for husbands (N=65).  $r=.59$  ( $p<.000$ )

Adoption Readiness	Stage in the process					
	I	Group I	I	Group II	I	Group III
	I	(N=22)	I	(N=26)	I	(N=17)
	I		I		I	
Low readiness	I	68.2	I	11.5	I	11.8
(10 - 16)	I		I		I	
Equivocating	I	27.3	I	30.8	I	29.4
(17 - 19)	I		I		I	
Hi readiness	I	4.5	I	57.7	I	58.8
(23 - hi)	I		I		I	
Column total		100.0%		100.0%		100.0%

1. The categories for the Adoption Readiness Scale were established by trichotomizing the frequencies for the sample as a whole, followed then by a crosstabulation.

Table 39. Adoption Readiness Scale, by group, for wives (N=71).  $r=.57$  ( $p<.000$ )

Adoption Readiness	Stage in the process					
	I	Group I	I	Group II	I	Group III
	I	(N=30)	I	(N=24)	I	(N=17)
	I		I		I	
Low readiness	I	66.7	I	8.3	I	5.9
(10 - 16)	I		I		I	
Equivocating	I	20.0	I	37.5	I	29.4
(17 - 19)	I		I		I	
Hi readiness	I	13.3	I	54.2	I	64.7
(20 - hi)	I		I		I	
Column total		100.0%		100.0%		100.0%

Although one would expect Group I to be different from Groups II and III on this measure, one would also expect that there would be more of a difference between Groups II and III. However, Groups II and III indicated roughly equivalent levels of adoption readiness. One would expect Group III to score higher levels of adoption readiness because of their sole commitment to adoptive parenthood. Group II, on the other hand, was still actively involved in the infertility process, and as a result, one would expect more moderate levels of adoption readiness given that they still had a lot invested in biological parenthood.

However, the pattern that emerged would suggest that, once an individual comes to a state of readiness to take on adoption, they will become actively involved in the adoption process and that it then matters little whether or not they are active in the infertility process. In this regard, one could interpret that coming to terms with adoption is not solely dependent on coming to terms with infertility. Although coming to terms with infertility is no doubt an important factor in feeling ready for adoption (as indicated above in the discussion of "sequential transformations of identity"), once this state of readiness is reached, it does not seem to be further influenced by whether or not a couple chooses to continue with infertility

tests and treatments. Stemming from this, it would seem that a significant turning point for adoption readiness is not the completion or ending of the infertility process, but the active initiation of the adoption process. One couple provides some insight into why the call to the agency is such an important part of adoption readiness:

Husband: It was a long time just psyching up to fill in the application forms. It took us 10 months, and in that time you go through so much emotional stuff to actually make the call.

Wife: It was an admission to myself that I was out of control. We had testing done and the choice was either a laparoscopy or Danazol [i.e. a drug for endometriosis] and we didn't want either of those so we talked about adoption. It took 10 months from then to actually call the agency. (3308:26)

Of course not all couples in Groups II and III indicated high levels of adoption readiness, and for these couples, adoption readiness was doubtless a more gradual process.

Another indicator of adoption readiness was the frequency of discussions about adoption. In using this measure, the assumption was made that the more important adoptive parenthood became as an identity, the more frequent would be the discussions that couples had about that identity. This stemmed from Stryker's (1980:84) theory that "the higher an identity in a salience hierarchy, the greater the probability that a person will perceive a given situation as an opportunity to perform in terms of that identity." There was a significant correlation of  $-.63$  ( $p < .000$ ) between the frequency of adoption talks and stage

in the process. When asked how often they had talked about adoption in the last six months, only 4% of couples in Group I compared with over one-half in Group II and two-thirds in Group III had talked about adoption once a week or more (see Table 40). This suggests that the more often one talks about adoption, the more likely one is to be active in the adoption process and disengaging from the infertility process.

Table 40. Frequency of adoption talks, by group (N=72).  
 $r = -.63$  ( $p < .000$ )

		Stage in the process					
Frequency in last 6 mos.	I	Group I (N=28)	I	Group II (N=26)	I	Group III (N=18)	I
	I		I		I		I
1X/wk or more	I	3.6	I	53.8	I	66.7	I
	I		I		I		I
1X/wk-1X/mon	I	35.7	I	38.5	I	33.3	I
	I		I		I		I
< 1X/month	I	60.7	I	7.7	I	0.0	I
	I		I		I		I
Column total		100.0%		100.0%		100.0%	

Consistent with the greater importance of parenthood to women, wives were more likely than men to bring up discussions of adoption. In 56% of the cases, wives usually initiated discussions of adoption, while in only 11% of the



cases were men the first to bring it up. In about one-third of the cases, there was an equal likelihood that either husband or wife would initiate the discussion.

Related to the measure of how often couples talked about adoption, a measure of how often they sought out information on adoptive parenthood also showed a significant correlation with stage in the process. Couples were asked whether they "actively seek out information on adoption." There was a significant correlation of  $-.45$  ( $p < .000$ ) for husbands and  $-.33$  ( $p < .01$ ) for wives. As shown on Tables 41 and 42, as couples more actively sought out information about adoption, they were more likely to be active in the adoption process and inactive in the infertility process. For example, among husbands, only 17% in Group I, 46% in Group II and 72% in Group III were actively seeking information on adoption. For wives, 37% in Group I, compared with 81% in Group II and 72% in Group III were actively seeking information on adoption. One woman provides some insight into the importance of information for coming to a state of readiness to take on adoption:

To be ready for adoption, you really have to research it. You go and get as much information as possible. With infertility, that's what I did. That was maybe a sign that I was accepting it. So with adoption, I will go and find out. It is a way of accepting it. (2507:33-F)

There were some differences between husbands and wives regarding the sources of adoption information. For

husbands, the main source of information was friends (43%) followed by professionals (33%) and books (23%). Among wives however, 38% got information from magazines, 38% got information from professionals and 36% got information from friends.

Table 41. Sought adoption information, by group, for husbands (N=74).  $r = -.45$  ( $p < .000$ )

Sought information?	Stage in the process					
	Group I (N=30)	Group II (N=26)	Group III (N=18)			
Yes	16.7	46.2	72.2			
No	83.3	53.8	27.8			
Column total	100.0%	100.0%	100.0%			

Table 42. Sought adoption information, by group, for wives (N=74).  $r = -.33$  ( $p < .01$ )

Sought information?	Stage in the process					
	Group I (N=30)	Group II (N=26)	Group III (N=18)			
Yes	36.7	80.8	72.2			
No	63.3	19.2	27.8			
Column total	100.0%	100.0%	100.0%			

Another indication of adoption readiness was the extent to which couples perceived that there were advantages to adoptive parenthood. Couples were asked the question: "Are there advantages to becoming an adoptive parent?" Again, there was a significant correlation between perceived advantages of adoptive parenthood and stage in the process. This association was somewhat higher for husbands ( $-.36$ ,  $p<.001$ ) than for wives ( $-.20$   $p<.05$ ). As Tables 43 and 44 show, as couples increasingly see the advantages of adoptive parenthood, they are likely to be active in adoption and inactive in infertility. This change was most pronounced among husbands, for only one-third in Group I compared to two-thirds in Group II and over four-fifths in Group III saw that there were advantages to adoptive parenthood.

Table 43. Advantages of adoptive parenthood, by group, for husbands (N=72).  $r=-.36$  ( $p<.001$ )

Any advantages?	Stage in the process					
	I	Group I (N=30)	I	Group II (N=26)	I	Group III (N=16)
Yes	I		I		I	
	I	36.7	I	65.4	I	81.2
	I		I		I	
No	I		I		I	
	I	63.3	I	34.6	I	18.8
	I		I		I	
Column total		100.0%		100.0%		100.0%

Table 44. Advantages of adoptive parenthood, by group, for wives (N=72).  $r=-.20$  ( $p<.05$ )

Any advantages?	Stage in the process					
	I	Group I (N=30)	I	Group II (N=24)	I	Group III (N=18)
Yes	I	60.0	I	70.8	I	83.3
	I		I		I	
No	I	40.0	I	29.2	I	16.7
	I		I		I	
Column total		100.0%		100.0%		100.0%

The advantage of adoptive parenthood most frequently cited by both husbands and wives was that they could avoid having to go through pregnancy. Almost two-fifths of wives and 30% of husbands stated that it would be advantageous to adopt because they would not have to go through the pain of labour. Almost one-quarter of both husbands and wives indicated that an advantage of adoption was that you chose the child, and as a result, the child was more special. Other advantages cited were that you had more time to prepare as parents because of the long waiting period (20% of husbands and 8% of wives) or that through adoption, you would give a child a good home (7% of husbands and 20% of wives).

One finding that is noteworthy by the absence of a significant change is the perception of adoptive parenthood

as being different from biological parenthood. Given that as couples moved from Group I to Group III they discussed adoptive parenthood more often and developed more positive attitudes toward adoption, one would expect that couples would become more aware of the difference of adoptive parenthood. Kirk (1964) has found that "acknowledgement-of-difference" is a key variable in post-adoption adjustment and is related to successful adoption outcomes. However, it would seem that this recognition of difference does not change dramatically in the pre-adoption transition to adoptive parenthood. Rather, approximately three-fifths of both husbands and wives in all groups indicated that adoptive parenthood would be different from biological parenthood. For many of these couples, accepting this difference was perceived to be an important part of getting ready for adoption:

The signs that tell you that you are ready are that you can accept that you have a problem, accept taking help, and accept the child of someone else's making. It's an acceptance of what it would be like if the child were to search and how I would feel. I had to think about whether I was ready to accept all the things that an adopted child could throw at you. (3308:33-F)

### Predicting Adoption Readiness Using Multivariate Analysis

In order to piece together the objective indicators of adoption readiness, multiple regression was used in order to analyze the predictive power of several independent

variables on the dependent variable. The dependent variable used was the transition from biological parenthood to adoptive parenthood (Group I to Group III). Nine independent variables were chosen for the regression analysis. Two criteria were used for deciding which independent variables to enter into the analysis. First, only those independent variables that had a significant ( $p < .05$ ) bivariate relationship with the dependent variable were considered. Second, from these significant independent variables, only those which had theoretical relevance for predicting adoption readiness were chosen.<sup>1</sup> On these grounds, the nine independent variables entered into the analysis were:

1. Disclosure of adoption plans to others
  2. Number of years since first suspecting infertility
  3. Know others who are adopted
  4. Importance of a biological tie
  5. Seek information on adoption
  6. see advantages to adoptive parenthood
  7. Others understand adoption feelings
  8. Frequency of adoption discussion in marriage
  9. Disclosure of infertility to others
1. Other independent variables were excluded because they measured similar phenomena. For example, optimism for a biological child, the importance of a biological child and the importance of pregnancy were similar and as a result, only the importance of a biological tie was used. Also those variables that directly measured adoption attitudes or the seriousness of adoption as an option were excluded because they could not be rationalized in terms of causality for adoption readiness.

Separate regression analyses were done for husbands and wives. For both husbands and wives, the best regression model included three independent variables. As indicated in Tables 45 and 46, the models were slightly different for husbands and wives. Beta values given in these tables represent the standardized regression coefficients and provide a basis for comparing the relative effect on the dependent variable of each independent variable. For husbands, advantages of adoptive parenthood, disclosure of adoption to others and frequency of adoption discussion in the marriage accounted for 44% (adjusted  $R^2$ ) of the variance in the dependent variable. For wives, knowing others who are adopted, disclosure of adoption to others and frequency of adoption discussion in the marriage accounted for 44% (adjusted  $R^2$ ) of the variance.

Table 45. Regression model of the independent variables in the regression equation, for husbands.

Independent variables:	Beta
Disclosed adoption	.39
See adoption advantages	-.21
Frequency of adoption talks	-.29

$R^2$   
 $R = .47$   
 $\text{Adjusted } R^2 = .44$

Table 46. Regression model of the independent variables in the regression equation, for wives.

Independent variables:	Beta
Disclosed adoption	.45
Know others who are adopted	.19
Frequency of adoption talks	-.24
<hr/>	
$R^2 = .47$	
Adjusted $R^2 = .44$	

The results of the regression analysis would suggest that for both husbands and wives, variables related to the discussion and disclosure of adoption are of central importance in explaining the transition from biological to adoptive parenthood. Consistent with the social psychological importance of interaction in the formation of identity, these variables focus attention on the importance interaction in the construction of the adoptive parenthood identity. As Berger and Kellner (1970) have pointed out, the construction of shared identities within marriage requires both an internal conversion whereby spouses can make sense out of their own reality, and validations by significant others of these identities. In the case of adoptive parenthood, these findings suggest that talking about



adoption both within the marital dyad and with significant others is central to the process of assuming identification with adoptive parenthood.

In addition to the discussion and disclosure of adoption, knowing persons who were adopted was of central importance for wives. This might suggest that interactions with others who had experienced adoption was an important source of validation for wives in the construction of the adoptive parenthood identity. For husbands, however, being aware of the advantages of adoptive parenthood was a key factor in the transition. This would suggest that, for husbands, their source of validation may be more of a generalized other, than a significant other. Whereas significant others who had experience with adoption played a key role for women, the nature of adoptive relationships in general seemed to have the greatest influence on men's transition to adoptive parenthood.

#### Subjective Indicators of Adoption Readiness

Further insight into the process of adoption readiness can be attained by examining couples' subjective perceptions of what it means to be ready to take on adoptive parenthood. The questions used to elicit these response were, "Are there any signs that a person can look for to

tell them that they are ready to adopt?" and "What has led you to consider adoption as a serious option for yourselves?".

Perhaps one of the most fundamental features of coming to terms with adoptive parenthood was to "fantasize" themselves in the role of adoptive parents. Schutz (1971) has emphasized the importance of "fantasizing" as the foundation for any projects of action. For one man, fantasizing was an important part of adoption readiness because it took adoption from the abstract and made it more real when he placed himself in the role of adoptive parent:

You are ready when you stop saying it [i.e. adoption] as a word and start thinking about yourself as a parent. My response to being blocked from being a biological parent was to put it out of my head. With adoption, I've had to come back to that. We talked about adoption as an idea and really didn't visualize ourselves doing it. Once she sent away for the [adoption] forms and information, I really began to think about it more (3450:27b,33-M).

As this would suggest, getting ready for adoption involved a process of anticipatory socialization whereby couples tried to place themselves in the role of adoptive parents. For one woman, adoption became a serious option through the process of trying "to think in my mind about how my life would change as a result of it [i.e. adoption]" (3307:27b-F). Similarly, one woman described how she was preparing for adoption by fantasizing some of the difficulties she might encounter as an adoptive parent:

Adoption is something that I have started thinking more seriously about. There are times when I think, "Am I the right person for this child?" or "Will I love this baby?" Usually it comes up when I see a family going through with a baby at the cash at work. (2521:33-F)

The physical preparations that were required to take on an adopted child often played an important role in mentally preparing couples for the experience of adoptive parenthood. In this respect, getting a room ready and buying clothes, diapers and baby furniture generated fantasies or mental rehearsals of what it would be like as an adoptive parent. One woman described this process:

With any child, there are a lot of things to prepare for the baby to come. When you get physically ready, you begin to get prepared mentally. (1232:33-F)

Perhaps one of the most common indicators of adoption readiness was one that was not easily articulated or measured. In this regard, adoption readiness was not a specific event but rather, was conveyed in a more generalized way as a feeling of being ready. One man likened this feeling of being ready for adoption with the feeling of infatuation that one has for another person:

Being ready for adoption - it's like a person being in love. It's something that takes up most of your time thinking about it. The same with adoption - I think that the desire must be so strong that you are always thinking about it. Then you are ready. (1206:33-M)

Another woman described gradual emergence of a feeling of "enthusiasm" that signified adoption readiness:

I felt ready for adoption when I started to feel some enthusiasm for adoption. Initially I wasn't enthusiastic. You build up walls to protect yourself.

But then I started to feel some of that enthusiasm. I don't jump into things quickly (2351:33-F).

For some couples, there was a definite turning point when you feel ready for adoptive parenthood. For one man, being ready is marked by "a feeling that comes a long - a confidence" (1232:33-M) while for another woman, it was simply a matter of "one day you wake up and you know you are ready" (1215:33-F). Similarly, for another man:

This morning at work I questioned whether I was ready - and I do feel inside that I am ready to take it on. It "clicks" to say you are ready. It feels right - financially, emotionally, having a good job and a stable marriage (2309:33-M).

While these "feelings" were of paramount importance for other couples in getting ready for adoption, it was sometimes the case that they did not culminate into a turning point where they absolutely felt ready to adopt. Although the majority of couples did feel there signs that would indicate a readiness for adoption, 13% of husbands and 17% of wives indicated that there was no specific turning point. Rather, these feelings of preparation and getting ready for adoption were ongoing and often without a distinct endpoint:

There isn't a point when you are totally ready to take on things like this. But it's feeling ready to have a family and that comes from being more aware of children. Suddenly you see children more directly and are more aware of them. Before you didn't notice kids as much. It's hindsight that shows you the change. (3506:33-M)

Another woman described how "desire and frame of mind" were important guidelines in gauging one's readiness for adoption. Here again, however was the suggestion that it wasn't entirely possible to be completely ready or prepared for events such as adoption:

I don't think that you can ever prepare yourself totally for the experience of adopting a child. I think your desire and frame of mind are what are crucial. Its the same as not parenting. You can't prepare yourself for that!" (2505:33-F).

The "feeling" of being ready or prepared for adoption usually emerged over time. Coming to terms with infertility and going through the adoption agency application procedure were often cited as important factors in this process. One couple explained how the feeling of readiness emerged as a result of these influences:

Interviewer: Are there certain signs a person can look for to tell them that they are ready to adopt?

Husband: I wonder if people are ready to adopt when they call the agency. I don't think so. People say "We have got to do something!" So you call and you go through all of the rigamorole. It isn't until you go to the agency and the sessions that they put on that you start to get ready. I would be afraid of the time when there is baby shopping where you could just go and get a baby. I don't think people would be psychologically ready. I think you have to go through all this for a few years before you are ready.

Wife: We put our name in and we sailed through all the interviews. We ended up putting a hold on our name on the list. We said "Wow! we're not ready!" You need time to work through your feelings of infertility to give it a good shot before you are ready. (2402:33)

Another couple described how a feeling of readiness came about as a result of going through the home study and disclosing adoption to their significant others:

Getting accepted through the home study made it seem very serious. We didn't tell people about adoption before the home study unless something happened that we didn't get approved. But now they know and that makes it more serious. (3452:27b-F)

In contrast to the objective indicators of adoption readiness, the subjective perceptions that couples had of what it meant to be ready to adopt were considerably more abstract. For many, these were hard to articulate feelings which nevertheless represented, for them, turning points in their assessment of their own readiness to adopt. In this regard, adoption readiness could not be attributed to any one circumstance or event, but rather, involved the emergence of a "sense" that they were ready to take it on. And as the above discussion suggests, these feelings of "enthusiasm" or "confidence", in combination with fantasizing themselves in the role of adoptive parents, were clear and obvious signs for these couples that they were ready to become adoptive parents.

#### OBSTACLES TO ADOPTION READINESS

Understanding the way that couples came to a state of adoption readiness can be further understood by examining some of the obstacles that prevented couples from identifying with adoptive parenthood. These included disagreement between spouses about adoption as an

alternative, consideration of childlessness as an alternative, concerns about the adoption process and perceived disadvantages of adoptive parenthood.

### Spousal Differences in Adoption Readiness

Perhaps the most critical hurdle that was encountered by couples in their effort to come an identification with adoptive parenthood was the disagreement between spouses regarding their readiness for adoption. When couples were asked whether they had the same feelings about adoption, approximately one-third of the sample indicated that they did not have the same feelings about adoption. The primary reason given for these different feelings was that spouses were at different stages of readiness. In this sense, when there was disagreement between spouses regarding adoption readiness, there was a sense of couples "holding back" from adoption. Disagreement, then, interfered with full identification with adoptive parenthood.

When there was disagreement, the willing spouse was usually reluctant to go ahead with adoptive parenthood for fear of repercussions from the unready spouse. One woman explained why they did not put their name on the adoption waiting list or consider it as a serious option even though she herself felt ready to be an adoptive parent:

We have not put our name on the list because he is just not for it and it's not something I am going to try to convince him about (1206:28b-F).

In many cases, the reluctant partner could not identify with adoptive parenthood because their primary identification was with biological parenthood:

Adoption isn't a serious option for me because of the possibility of her getting pregnant... After all the options for getting a biological child have been played out, then we'll be ready for adoption (2302:27a,33-M).

Another man explained how their non-shared definition of readiness served as an obstacle to full commitment to adoptive parenthood:

We're still at the discussion stage. I haven't fully investigated it [i.e. adoption] yet. If we are going to do it then we are going to do it together and she isn't ready yet. I don't want to pressure her. She has to come to it when she is ready. And there is no point in me pushing because then she might enter into it unwillingly. (1204:27b-M)

This hesitancy of one spouse to go ahead with adoption on his or her own when there is disagreement points to the importance of adoptive parenthood as a jointly constructed identity.

Surprisingly, however, spousal agreement on adoption readiness did not change across the three groups. Although one would expect that spouses in Group I would be at different stages of readiness because adoption was still somewhat remote, one would expect that spouses in Group III would be more closely aligned with each other. Given the importance of adoptive parenthood as a jointly constructed



identity, one would expect that more of those in Group III, who were solely active in the adoption process, would have come to some shared meaning regarding the importance of adoptive parenthood. However, this was not the case and several explanations can be offered as to why this was so.

For those in Group I, agreement between spouses may have stemmed from their lack of readiness, rather than a consensus on being ready. As one man put it "We are equal in our ambivalence." (1207:35-M) For another couple, "we both have the same feelings about adoption - we're just not interested right now!" (1215:35-F). For those couples in Group I who did disagree, lack of discussion about adoption readiness, because it was still a remote option, may partially account for their difference of opinion:

I'm more negative than he is. He can talk about adoption easier than me. He says he can always adopt. But I don't want to even discuss it. It's as if I talk about it, it will put a curse on our chances [i.e. of conceiving]. (1230:35-F)

By contrast, those in Group III were more likely to have discussed adoption frequently, and as a result, be more aware of their differences regarding adoption than those in Group I. As a result, the spousal difference on adoption in Group III may be a function of talking about it a great deal, and therefore being more aware of the subtle differences, whereas for those in Group I, the differences between spouses may reflect the absence of such discussions and a level of uncertainty regarding their spouse's

feelings. For one couple in Group III, the awareness of their differences emerged out of the process of negotiation that is involved in coming to some consensus on adoption readiness:

We are getting closer. We are merging. We've not got there yet. It is more urgent for me. We do have different feelings but we are getting closer all the time. (3308:35-F)

The awareness of very subtle differences between spouses is reflected in the experience of another couple who both felt ready to take on adoption, but where one spouse was more fearful of the unknowns in the process:

Husband: She is a little more apprehensive about the whole process.

Wife: It's fear of the unknown. (3452:35)

For some couples, reservations about adoption also had a tendency to fluctuate between spouses. In this regard, it was not always the case that just one spouse would be holding back from adoption, but rather, there would be a reverberation between spouses, where they would trade off being ready or not ready. As one woman explained:

Originally, he had more reservations about adoption. Now I am a little nervous about it - that they will reject me or that they will take the baby away. So we have reversed - I was initially keen and am now anxious. He was initially reserved and is now keen. (3401:35-F)

As the above examples of spousal differences would suggest, adoption readiness is not simply a point in time where spouses can say that they are mutually ready to take it on.

Rather, it would seem that for some couples, adoption readiness is an ongoing negotiated process that may not have a distinct endpoint.

### Choosing Childlessness over Adoption

Another obstacle that interfered with couples coming to a full identification with adoptive parenthood was the consideration of childlessness as an alternative. For these couples, waiting so long for children led them to question their commitment to parenting in light of some of the advantages of childlessness of which they were now aware. In making the situational adjustment to biological parenthood as a problematic, there is a bifurcative tendency among these couples insofar as they seemed to adjust not only along the dimension from biological parenthood to adoptive parenthood, but from biological parenthood to non-parenthood as well. As one woman described it:

We have been waiting long enough that we are having doubts about whether we still want a child. For seven years of trying, you ask the question so many times of why we want children, that you get unsure. "Do we really want one?" and "Why?" I'm not sure that we even want children anymore. (3313:15,31-F)

For another woman, years of involuntary childlessness allowed her career to flourish, and as a result, choosing to continue with career became an increasingly tempting alternative to adoption:

You get to the point where you feel that you could easily be selfish. With my job, I'm quite happy. These are priorities that take over. (3350:33-F)

Perceived Disadvantages of Adoption as a Barrier to Adoption Readiness

Concerns about various aspects of adoptive parenthood or the adoption process also created obstacles to full identification with adoptive parenthood. As couples fantasized themselves in the role of adoptive parents, some of the potentially negative aspects of the adoption experience emerged which created some reservations about their readiness to adopt. In order to explore these barriers, couples were asked the questions: "If you were to put your finger on one concern that you have about adoption, what would that be?" and "Are there any disadvantages to adoptive parenthood?"

The most commonly expressed concern about the adoption process was the uncertainty of the child's background. About one-third of wives and one-quarter of husbands indicated that not knowing the child's medical background, the care of the fetus during pregnancy, ancestry (i.e. is the child from bad blood?) or genetic characteristics were of concern to them in adopting a child. One couple expressed their concerns in this way:

Husband: You worry about the kind of person who gives up a baby.

Wife: My biggest concern is the heredity or the personality traits that are passed on. I believe a lot in heredity. The kids come with characteristics already established (1202:38).

The absence of background information would create for one woman an ongoing sense of "wonder about whose child you have" (1233:38-F). For others the child comes with it's "own set of baggage" (3506:39d-F) or a "set of characteristics that are in the genes" (1224:39d-F). These unknown biological characteristics created concerns about the kind of child they would get. As one couple put it:

I am afraid that the kid would be stupid or have birth defects. You are buying an unknown product. You are more familiar with the parameters when it's your own (1253:38-M).

For others, this concern resulted in the feeling that the child would turn "criminal" (1224:39d-F) or "turn out rotten and you'd be stuck with it for the rest of your life" (3308:38-M). Other couples expressed concern about whether the child would share their same interests:

When the child gets older and develops it's own personality, I wonder whether that personality is going to be in keeping with our beliefs and feelings. For example, we are very practical and went to university to get a job - what if the child wants to be a painter or something like that? (2454:38-F).

The significance of this unknown background and the uncertainty of the child's future was that couples anticipated they might not be able to commit themselves as fully to adoptive parenthood as they otherwise would to

biological parenthood. One woman described this in terms of bonding:

With adopted kids, there is more of a chance that they will turn out bad. My friend adopted and they turned out bad. I don't think there would be the same closeness. I don't think I would go all the way with bonding (1216:38-F).

The uncertainty of whether the biological mother would change her mind about adoption also emerged as a significant concern. Sixteen percent of husbands and 13% of wives expressed this as a barrier to their full commitment with adoptive parenthood. One woman explained her concern as "the insecurity of not knowing whether or not the parents show up on your doorstep" (1215:39d-F), while another explained it this way:

If the real parent tries to find the child, that would hurt me more than having your heart cut out. It would be like them taking your own flesh and blood. (3306:39d-F)

Couples frequently used the language that the "real" parents would come to take the child back suggesting that they, as adoptive parents, would be once removed from "real" parenthood. In this regard, adoption was often considered as "second best" (2402:35-M).

Reservations about adoptive parenthood and the corresponding restraint in identifying with it was also the result of having to tell the child about adoption, and related to this, the possibility of being rejected by the child when he or she found out they were adopted. Twenty-six

percent of husbands and 16% of wives worried about having to tell the child about adoption. Thirty-five percent of wives and 17% of husbands were afraid that the child would search and they would be rejected by the child. One woman described her concern about telling the child about adoption:

I'm apprehensive about telling my child that they are adopted. How do you deal with that possible hurt? (1209:38-F)

Couples also described the potential of being "hurt and betrayed" (1238:39d-F) if the child decided to search after being told about adoption. As one woman described the feeling:

I worry about being rejected by the child. Like them saying "You aren't my real parent" and then going and searching out their parents (2504:39d-F).

Telling the child about adoption carried with it the potential to damage the parent-child relationship:

I'm concerned how the child would react when he found out that he was adopted. Would he change his attitude about us as he grows up? Would he love us less when he knows? Would these other parents come into the picture? (1250:38-M)

Likewise,

I worry about the child constantly throwing it back in your face and seeking out the biological parents. When something goes wrong, its like "Why don't you take me back?" (3301:38-F)

Another perceived disadvantage of adoptive parenthood was dealing with the reactions of others to the adoption. Thirteen percent of husbands and 12% of wives expressed concern about how others would react to the

adoption aspects of the parenting experience. As one man simply put it, "people might look at you differently because of adoption" (1202:39d-M). For another couple:

The biggest disadvantage is outside interaction. How does society accept the adopted child? Children especially can be mean to each other (1204:39d-M).

In keeping with this, couples anticipated that the child would be "harassed" (1232:39d-F), "maybe called a bastard a few times" (3501:39d-M) or "teased and experience emotional trauma" (1206:39d-M). Other couples described how the reactions of others emphasize the difference of adoption in more subtle ways. For example:

I'm afraid that the child would be labelled ... For example, when I was in the hospital I talked to a woman about her family. She said that she had fifteen grandchildren and one adopted. The adopted child is set apart (2507:38-F).

In another instance:

I am concerned about the way that other people respond to the child. They might not think it is the same. The child is different. My niece is adopted and we all try to overcome the difference by saying how much they look alike (1235:39d-F).

For another couple, adoption gave rise to concerns that the child might not be accepted by extended family:

I'm afraid the baby wouldn't be accepted by close family and the child would always feel inferior. You would be alienated from the family (2453:38-F).

Another significant concern about adoption stemmed from having to go through the agency process. Twenty percent of wives and 17% of husbands expressed concerns about agency policies and procedures such as the length of time that was



involved in adopting a child, having to go through a process of evaluation and having to abide by certain restrictions set out by the agency. The length of the wait to adopt through the agency was a key factor for not moving ahead with adoption. As one man simply explained it: "It takes 5-7 years and I'm just not going to wait that long" (1241:28b-M). Similarly for another man:

Adoption isn't a serious option because of age and the long wait. I just didn't want to go through it all. There are too many restrictions. (1235:27a-M)

For those who did move ahead with the adoption process, there was often a precautionary "holding back" in their commitment to adoption in light of the long wait and the prospect that they might never get one of the few adoptable babies that were available. One person stated this as "wondering whether it would ever come to be" (2504:38-M), while for another, the concern was expressed as:

not ever being able to adopt because of the time it takes to adopt and whether there would be the right baby for us. Will it take even longer than the five years? (2521:38-F).

For another couple, it was the wait on top of all the other hurdles that are a part of the adoption process that held them back from fully identifying with adoptive parenthood:

We went in saying that we didn't like the idea. There are all kinds of hoops to jump through - like asking me all kinds of questions about my life. We had to ask whether it was all worthwhile. Plus waiting for the first six months until they even contact you is frustrating and long (3452:27b-M).

For another couple, adoption was not seriously pursued because of the agency's policy that one spouse stay home with the child for at least six months after placement:

Husband: We disagree with the ruling of her having to stay home for six months from work.

Wife: If I didn't have to leave my job, I would adopt right now (1228:28b,35)

For others, the evaluation procedure that was required by the agency impeded acceptance of adoption. For one woman, the agency process was a bunch of "rigamorole that I wouldn't have to go through if I was pregnant" (1253:38-F) while for another man, the prospect of being turned down was significant:

I haven't really had my mind set on adoption. I'm afraid of being turned down. I hate to be judged. And they don't educate you about what to expect (1231:38-M).

## SUMMARY

Identification with adoptive parenthood occurred at several different levels. These included how this process of identifying with a new identity began, how couples became more committed to this identity and finally, how couples encountered various obstacles that impeded this identification with adoptive parenthood.

In summarizing the turning points in the transformation of identity from biological parenthood to

adoptive parenthood, several considerations are of central importance. First, the way that couples resolved their infertility played a major role in shaping the transformation experience. For some couples, this meant finding a definite answer or end to their infertility before they could move on to adoptive parenthood. For others, the resolution of infertility meant accepting that they might, or might not become biological parents, thereby opening the way for a concurrent commitment to both biological parenthood and adoptive parenthood. Age was a critical turning point in initiating the move toward adoptive parenthood as couples considered the prospects of being too old to have children if they didn't take action. Significant others played an important role in helping couples to dismantle an image of themselves as biological parents and to reconstruct a new image of themselves as adoptive parents. Physicians, friends, and family, and people who had experience with adoption all played an important role in this regard. Women were most likely to initiate the formal adoption process by making the first call to the agency.

A number of indicators emerged to mark adoption readiness. Couples who indicated positive adoption attitudes, a readiness to take on adoption, frequent adoption discussions and that they had sought adoption information were most likely to be active in the adoption process and inactive in the infertility process. Regression

analysis suggested that disclosure of adoption information to others and frequency of adoption discussions were two of the key factors for explaining adoption readiness for both husbands and wives. In addition, the perceived advantages of adoptive parenthood was a key factor for husbands, while knowing others who had experience with adoption was crucial for wives. Furthermore, couples talked about adoption readiness as a "feeling" that one gets where you simply know that you are ready to go ahead with it. Going through the agency process was also seen to contribute to adoption readiness.

Adoption readiness can also be understood by looking at the impediments to assuming an identification with adoptive parenthood. These included disagreement between spouses about readiness, the consideration of childlessness as an alternative and perceived disadvantages of the adoptive parenthood role.

## CHAPTER 8

### RESOCIALIZATION TO ADOPTIVE PARENTHOOD

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### RESOCIALIZATION TO ADOPTIVE PARENTHOOD

Preparing for adoptive parenthood involved a unique process of socialization. Unlike couples who decide to have their own biological children and then simply proceed to do so, potential adoptive parents must go through a process that involves a very different set of preparatory experiences. These experiences involved not only coming to an emotional readiness to take on a different kind of parenthood, but involved interactions with family members, friends and the agents of the formal adoption process who all imposed a set of expectations of what it meant to become an adoptive parent.

Socialization into various role identities is essentially an interactive process (Bush & Simmons, 1981). In this regard, socialization to adoptive parenthood involved the active construction of a new role identity through interaction with others. Socialization to adoptive parenthood, however, can perhaps be more accurately examined as a process of resocialization. Given that most socialization experiences for parenthood are geared towards

preparation for the taken-for-granted role of biological parenthood, adoption introduces a new set of contingencies that require that these preparations for parenthood be reshaped. Specifically, this involved a set of preparatory experiences that are geared toward coming to terms with the "difference" of adoption.

In this chapter, this process of resocialization to adoptive parenthood is examined. As McCall and Simmons (1978) have pointed out, the process of taking on a new role identity through resocialization is characterized by an ongoing search for support and legitimation. In keeping with this, resocialization to adoptive parenthood will be examined as couples seek to obtain both informal support and formal legitimation. By way of understanding how couples obtain informal support, there is an examination of how couples are socialized for adoptive parenthood by interacting with significant others such as friends, family members and people who have adopted. Media presentations of adoption are also examined as an informal socializing influence. The resocialization process is also examined as it occurs within the context of the formal, legal adoption process. Here the focus is on interactions with the agents of the adoption process as couples seek formal legitimation for their anticipated role identity as adoptive parents. Specifically, there is an examination of the way that adoption workers, working within the context of

agency policies and structures, shape and direct the transition to adoptive parenthood.

#### INFORMAL AGENTS IN THE RESOCIALIZATION TO ADOPTIVE PARENTHOOD

As an informal process, resocialization to adoptive parenthood was shaped by interactions at various levels of intimacy and abstraction. At the most fundamental level, spouses socialized each other, through an ongoing process of negotiation and reality construction, to redefine the meaning of parenthood in light of adoption. Much of the discussion in the previous chapters has elaborated on this process within the marital dyad. Given that this has already received considerable attention, it will not be examined again in this section. Suffice it to say that spouses had a mutual socializing influence on each other in their shared construction of the adoptive parenthood identity. However, what has received considerably less attention is the way that forces outside of the marital dyad had an effect on the shaping of the adoptive parenthood identity. In this section, two of these external forces will be examined. First, interactions with significant others acted as a socializing influence in the transformation to adoptive parenthood. The way that couples "accounted" to others for the possibility of adoption, and the way that these others



reacted to adoption, was important for "placing" couples in this new role identity. Second, media treatments of adoption were an important socialization mechanism in reshaping couples' perceptions of adoptive parenthood. Popularized images of adoptive parenthood in various media are examined in terms of their influence on the preparation for adoptive parenthood.

#### Significant Others as a Socializing Influence

Interactions with friends, family members and people who had experience with adoption played an important role in the resocialization process to adoptive parenthood. Through the process of disclosing their consideration of adoption to these others, couples were able to take the role of these others in getting a perspective on themselves as they would fit into this new role identity. By monitoring others' reactions to them as prospective adoptive parents, couples could then re-align their actions so as to best fit with the expectations for the transition to the new role.

Approximately three-quarters of the sample had disclosed to others about adoption. Of these, about four-fifths had told parents, brothers and sisters and a close friend about adoption. By contrast, only about one-half of

husbands and wives had told a work associate while less than one quarter had told an acquaintance, a neighbour or someone else about adoption.

Couples became more open in disclosing adoption as they became more active in the adoption process. When the number of reference groups that one had disclosed to was correlated with stage in the process, there was a strong correlation of .61 ( $p < .000$ ) for husbands and .62 ( $p < .000$ ) for wives. Whereas only about one-quarter of husbands and wives in Group I had disclosed adoption plans to more than two reference groups almost all husbands and wives in Group III had disclosed to more than two reference groups (see Tables 47 and 48)<sup>1</sup>. This increase in disclosure about adoption would suggest that, as adoption becomes a more realistic option, interaction with others on the topic of adoption is also likely to increase.

1. In this analysis, couples who had not considered adoption as an option for themselves were excluded. These couples (N=11) were all in Group I. None of these couples had disclosed to others. To include them would falsely inflate the correlation, given that adoption had not seriously been considered.

Table 47. Adoption disclosure, by group, for husbands (N=63).  $r=.61$  ( $p<.000$ )

No. of reference groups disclosed to.	Stage in the process					
	I	Group I (N=19)	I	Group II (N=26)	I	Group III (N=18)
	I		I		I	
2 or less	I	78.9	I	30.8	I	5.6
	I		I		I	
more than 2	I	21.1	I	69.2	I	94.5
	I		I		I	
Column total		100.0%		100.0%		100.0%

Table 48. Adoption disclosure by group for wives (N=63).  $r=.62$  ( $p<.000$ )

No. of reference groups disclosed to.	Stage in the process					
	I	Group I (N=19)	I	Group II (N=26)	I	Group III (N=18)
	I		I		I	
2 or less	I	73.7	I	19.2	I	0.0
	I		I		I	
more than 2	I	26.4	I	80.8	I	100.0
	I		I		I	
Column total		100.0%		100.0%		100.0%

The most common way of disclosing adoption to these others was to talk about it in conjunction with infertility. In this regard, the "accounts" of adoption were often concurrent with the accounts of infertility. Fifty-two

percent of wives and 43% of husbands mentioned adoption as one option when explaining infertility. About one-third of husbands and wives deliberately set out to tell someone that they were going to adopt, while 20% of husbands and 16% of wives disclosed by saying that "we're waiting to adopt" when they were asked whether they had any children.

Related to this, as couples became more open about adoption, they were more likely to indicate that significant others understood their feelings about adoption. In this regard, it seemed that couples perceived that others could more definitely place them in the role of adoptive parents the longer they were in the adoption process and as they disclosed more about it. For example, there was a significant correlation of .27 ( $p < .05$ ) for husbands and .25<sup>1</sup> ( $p < .05$ ) for wives between ratings of how well others understood their feelings about adoption and their stage in the process. As Table 49 shows, only one-third of husbands in Group I compared with almost one-half of Group II and three-quarters of Group III indicated that others had a good understanding of their feelings about adoption. There was a similar trend for wives with 39% in Group I compared to 44% in Group II and 67% in Group III who felt that others had a good understanding of their feelings about adoption.

1. Eta values of .47 for husbands and .46 for wives indicate that the relationship was, to some extent, curvilinear.

Table 49. Others understand feelings about adoption, by group, for husbands (N=61).  $r=.27$  ( $p<.05$ )

Level of understanding	Stage in the process					
	I	Group I (N=20)	I	Group II (N=23)	I	Group III (N=18)
Poor	I	55.0	I	43.5	I	22.2
Moderate	I	10.0	I	8.7	I	5.6
Good	I	35.0	I	47.8	I	72.2
Column total		100.0%		100.0%		100.0%

Table 50. Others understand feelings about adoption, by group, for wives (N=66).  $r=.25$  ( $p<.05$ )

Level of understanding	Stage in the process					
	I	Group I (N=23)	I	Group II (N=25)	I	Group III (N=18)
Poor	I	47.9	I	24.0	I	16.7
Moderate	I	13.0	I	32.0	I	16.7
Good	I	39.1	I	44.0	I	66.6
Column total		100.0%		100.0%		100.0%

Most couples found that people were supportive of their adopting if they were unable to have biological children. When couples were asked how others reacted when they told them about adoption, over three-quarters of husbands and wives said that people were positive and supportive. Less than 10% stated that they received negative or discouraging comments. For some, the decision to adopt was cause for real excitement:

My friends were ecstatic. They knew what I had to go through. My mom thought it was great. She has been bugging me for a grandchild for a long time (3307:42b-F).

Others offered a more tempered support for adoption:

My parents reacted positively. They said "There's no harm in applying." "May as well." They are both aware of the time that we have to wait. (3308:42c-F)

Given the strong positive response to the prospect of adoption, it would again seem that there is support for the notion that adoption, and not childlessness, was the appropriate means for bringing their problematic behavior into line with normative expectations. As one woman explained:

They expect us to adopt because we have been married for so long. Like we have our house and car. But people then expect you to have kids. So people are happy when we say we have adoption as an alternative (3451:41c-F).

Another man explained that people reacted positively to adoption because:

Most people think we should have our children one way or the other, so whatever way we can - (2212:41c-M).

Although there is evidence that childlessness and actual adoptive parenthood elicit stigmatic responses (Miall, 1986), it would seem that anticipated adoptive parenthood does not suffer this same stigma. As one woman explained:

People have accepted it [i.e. the possibility of adoption] just fine. It's not been a horrible thing or a stigma. It's like I hope you get a child. I think they would all accept it (2521:42c-F).

When couples told others about the possibility that they might adopt, this frequently gave rise to a discussion about adoption. In many cases this stemmed from a curiosity that was aroused about what was involved in the adoption process. For example:

They were curious about what we had to go through and how we came to that decision (3522:41c-F).

Others were considerably more naive:

Most were shocked when we started talking about adoption. "You mean its that hard?" "It takes that long?" They have these turn of the century ideas that you can go and pick them out at the local orphanage. (3506:22d-M)

These interactions served as a socializing mechanism for couples insofar as the act of talking about adoption placed couples within the boundaries of this new role identity. In so doing, not only did couples begin to see themselves in this new role, but others would increasingly identify them as prospective adoptive parents. In keeping with this, one woman described how she would tell others about adoption as a way of preparing both herself and them for the new role:

Sometimes I tell people about adoption to see what their reaction is. I want to see how they respond. I knew that there were some negative ideas. It's part of the preparation. If they have something crummy to say [i.e. about adoption], I want to hear it now before I have a child (2351:41c-F).

Other people would offer stories about adoption experiences that also gave shape to the anticipated identity of adoptive parenthood:

When I tell people about adoption, some say "Well I could adopt a baby right away!" But they haven't had a chance to really think about it. They think it is great. My sisters relay stories to me about friends who adopted and how well it has worked out. (2507:41c-F).

In attempting to get support for their anticipated role as adoptive parents, the experiences of significant others who had some experience with adoption were a particularly salient influence. Most couples knew someone who was adopted (59% of husbands and 74% of wives) or who had adopted (67% of husbands and 78% of wives). In addition, there was a tendency that couples were more likely to know someone who was adopted as they became more active in adoption and less active in infertility. There was a significant correlation of .21 ( $p < .05$ )<sup>1</sup> for husbands and .20 ( $p < .05$ ) for wives between the number of people that one knows are adopted, and stage in the process. This would suggest that, as one becomes more active in the adoption process, one is either in a position to meet more people who

1. An eta value of .41 for husbands suggests that the relationship was slightly curvilinear.



are adopted or one simply becomes more aware of adoption identities in everyday interaction. Whatever the correct explanation, it would seem that knowing others who have experience with adoption becomes a more salient socializing influence as one becomes more active in the pursuit of adoptive parenthood.

Because couples anticipated themselves in the role of adoptive parents, those who had experience with adoption were cause for "watching them a little closer" (2403:40c-M). In this sense, people who had adopted served as "role models" (3450:41-M) or a "sounding board" (1238:42b-F) in the process of anticipatory socialization to adoptive parenthood. As a socializing influence, these people who had experienced adoption conveyed both positive and negative messages concerning the nature of the experience.

On the positive side, couples observed family or friends who had good adoptive experiences. Seventy percent of husbands and 55% of wives (N=46) indicated that the adoption relationships they observed were positive and a source of reassurance as they entertained the prospect of being in an adoptive relationship themselves. Their observations of these relationships resulted in positive images of adoption such as "they seem well adjusted" (2507:40c-F), "they're just normal" (3450:40c-M), "they don't seem different" (1230:40c-F), "you'd swear it was her

own" 2309:40c-F) or the adopted child "looks like them and fits in OK" (2521:40c-M). Another man was reassured by a cousin who "interacted well with her family and was loved and accepted" (2312:40c-M). The dominant focus in each of these examples was the absence of difference between adoptive parenthood and biological parenthood. As one woman described it:

I know all these [adopted] people and they all seem to be OK. So I feel comfortable with it. I don't see anything different between these people and their parents. They all have good relationships (1214:40c-F).

In fact, for some people, not only was the adoptive relationship not different, but better:

I have a friend who is adopted and he is great. His brother is a biological child and he is a slimeball (2217:40c-M).

This apparent "rejection-of-difference" (Kirk, 1964) when observing other adoptive relationships is discrepant with the earlier finding that three-fifths of couples acknowledged a difference between biological and adoptive parenthood. One possible explanation for this discrepancy is that although they project that their own adoptive relationships will be different, they may be attempting to "normalize" the relationship by focussing on the positive aspects that they observe in other relationships. In this regard, observing their own reactions to other adoptive relationships is a socializing influence insofar as they may gain some insight into how others may perceive them once in

an adoptive relationship. By observing other adoptive relationships, they can take the role of the other, and in so doing, develop a picture of adoptive relationships, seen from the outside, as being essentially no different from biologically-based parenting situations. This might then suggest that when they project themselves in the role of adoptive parents, they would hope that others would see the adoptive relationship as no different from any other. In this way, there is an apparent attempt to normalize their anticipated role identity of adoptive parenthood.

Significant others who had positive experiences with adoption also played an important role in allaying fears that couples may have had about some distinctive aspects of the adoption experience. One such concern was the way that the adopted child would react to being told about adoption. One couple was comforted by how this worked out with friends who had adopted:

It is reassuring to hear how they have told the kids and how they reacted. To see that they haven't lost anything or that the child hasn't run away is good (3401:40c-F).

For others, positive experiences with the searching issue cast adoptive parenthood in a more positive light. As one woman explained:

A friend who searched and found his biological parent ended up loving his adoptive parents more. That's reassuring to me (2453:40c-F).

On quite a different level, others who had experience with adoption were a positive socializing influence insofar as they cast the process of getting an adopted child in a more hopeful light:

We were encouraged by this couple who went through what we went through. They got a baby in a year. It worked out well for them (2217:40c-M).

Likewise,

They got children quicker than Children's Aid said they would. So I feel a little relieved that it will happen faster (2314:40c-M).

However, not all adoption experiences were positive. Although most couples had positive perceptions of other's adoption experiences, about one-quarter (24% of husbands and 25% of wives) were aware of stressful, unhappy adoptive relationships and this was cause for some worry in anticipating themselves as adoptive parents. In these instances, adoptees were "in and out of jail" (1216:40c-F), "they were runaways and into drugs" (2219:40c-F), or "troublemakers" (2302:40c-M). These images led one woman to conclude that "with adopted kids there is more of a chance that they will turn out bad" (1216:38-F). Another man described the negative socializing influence that these stories had on his preparation for adoption:

These adoptions make me more apprehensive because they are not all nice stories. For example, two of the adoptees we know have grown up great and two have ended up in prison. Her mother works in a prison and she tells us that a lot of them are adopted (3506:40c-M).

For some couples, the search by an adoptee for biological parents was a negative influence:

Of the two adopted people I know, one went looking for biological parents and the other didn't. It tears my heart out to think what if an adopted child of ours went looking for biological parents and mistreated us like D. did to his adoptive parents saying things like "You're not my real parents anyway" (3306:40c-F).

For others, the fragility of the adoption process itself gave rise to apprehensive feelings about adoptive parenthood:

A friend of my mother had adopted children and had the children taken away. I worry about that. She got them back but it worries me that they can be taken away (2211:40c-F).

### The Media as a Socializing Influence

The popular media was also a powerful socialization influence on couples who were considering adoptive parenthood. Newspaper portrayals of the long waiting lists and shortage of adoptable babies was a strong negative influence for one couple in proceeding with adoption (3308:30-M). Television, however, was mentioned as having the most powerful socializing influence. In particular, popular dramatizations that portrayed adoptive relationships as basically unstable were mentioned as a negative influence. Typically, adopted children were portrayed as being unhappy with their adoptive parents and as a result,

they left for a happy reunion and life with their biological parents. As one woman described it, "on TV, adoptees are always stepped on and they always seek their birth parents" (1209:40c-F). These programs, although not usually grounded in fact, made couples more apprehensive about adoption for fear that the child would be snatched away by the biological mother. One man explained his experience:

I am most concerned about the [birth] mother changing her mind. I saw this TV show last week where the birth mother gets her baby back by going to court (2316:38-M).

Another man described a similar experience:

I am afraid of the original mother and father trying to get the baby back. You see so much of that happening on 60 Minutes. The kid is 13 or 14 and then here comes the mother (1249:39d-M).

For others, TV cast the search for biological parents in a negative light. As one man explained it:

There is a whole new rack of problems when you tell the child he is adopted. You see these TV programs where the kid says "You aren't my real parents" and goes looking (1240:39d-M).

Both significant others and the media acted as salient socializing influences on couples who were considering adoptive parenthood. Although this informal support network was important in shaping the adoptive parenthood identity, the formal agency procedures for adopting a child structured the course of the socialization process to adoptive parenthood.

## FORMAL AGENTS IN THE RESOCIALIZATION TO ADOPTIVE PARENTHOOD

Representatives of the adoption agency were crucial players in the socialization process to adoptive parenthood. As state officials, their mandate was to act on behalf of the child. As a result, in relation to couples, their role was essentially that of gatekeepers. In this regard, they were there to protect the interests of the child and to make decisions about who would parent the child on the basis of who could best serve that child's needs. In order to do this, the agency had an elaborate screening process that was designed to determine which couples could best serve the needs of the children who they wished to place.

Couples were generally aware of this priority, for as one man stated "they [i.e. social workers] are there to provide a home for the child, not a service for us" (3452:30-M). From this perspective, the primary mandate of the adoption agency was not to prepare couples for adoption or to socialize them to adoptive parenthood. Nevertheless, the structure that was in place had the effect, from the perspective of the infertile couple who went through the process, of precipitating a re-evaluation of the parenthood identity. In this sense, the socializing effect that the agency had on couples was a by-product of their primary goal of protecting the child. Focussing on couples' subjective perceptions of the agency process, the discussion now turns

to the socialization experience within the formal adoption process.

### Resocialization Through the Formal Adoption Process

The loss of control over the timing of parenthood was perhaps one of the most demanding adjustments facing couples who were pursuing adoption. Already having confronted the loss of control over having their own biological children, couples were now faced with the additional task of having to wait for, and depend on others, in order to become adoptive parents.

The dependence of couples on the adoption agency lay at the root of these feelings of loss of control. In the minds of couples, the agency was very powerful, not only because they controlled the adoption process, but by their position of being able to determine whether or not they would become parents. One woman described how her experience with the adoption agency had so far affected her feelings about the adoption process:

It has opened my eyes to the frustration of going through the process. You are at their beck and call when they decide that the match is made. You have no control. You have to submit yourself to the process (3522:30-F).

As indicated in Table 51, this powerlessness was reflected in the way that the agency had thus far affected their feelings about adoption. The loss of control that



couples felt over becoming an adoptive parent was established very early on in the adoption process. In their first contacts with the agency, 43% of husbands and 36% of wives indicated that they encountered a barrage of discouraging comments about the bleak prospects of adopting a newborn in the near future. Even though most couples anticipated a wait for adoption, this initial contact was typically a sobering influence. It was socialization by discouragement. As one woman put it:

They haven't responded or even acknowledged our application. We don't hear anything from them. It is so discouraging. You feel like it's never going to happen. Then you hear about the number of babies going down because of abortions and you think do we even have a chance? (2309:30-F).

Table 51. How involvement with the agency had affected feelings about adoption for husbands (N=35) and wives (N=39). (Values in the table indicate responses, not cases).

How agency has so far affected feelings about adoption:	H (N=35)		W (N=39)	
	N	%	N	%
Discouraged (long wait; few babies)	15	42.9	14	35.9
Resentful at being judged	9	25.7	10	25.6
Alienated	1	2.9	4	10.3
Don't know what to expect	4	11.4	4	10.3

This treatment at the hands of the agency resulted for some (N=4) in feelings of alienation. One woman described how their involvement with the agency made adoption seem more remote:

Our involvement with the agency has distanced adoption from us. We sent in the application and there was no response or acknowledgement. Each month you feel more distance from them. As a result they feel very remote (3308:30-F).

One man rationalized the agency's approach as the way that "the agency weeds out those people on the borderline who are not very committed." (2504:30-M)

Couples were especially discouraged by the bleak prospect of getting a baby because of the shortage of infants:

They [i.e. the agency] don't sugar-coat anything. They say that if you want an infant, the odds are stacked against you. Especially at an age when you can still have them. They give you these pitiful statistics of how many kids are placed (2217:30-M).

Related to this was the length of time that couples had to wait to get an infant:

When I called the agency the first time the woman was very discouraging. She told me that it would be four years down the line. The last time I called they told me the list was closed. They were very discouraging (2312:30-M).

When the long wait was placed within the context of the couple's age and family goals, the outlook was very negative:

Husband: When we contacted the agency they were very pessimistic. We feel that if we get a homestudy by the time we are forty (they were both 34) that we will be lucky.

Wife: And they just told us that our chances were very, very poor because there were so few babies placed (2505:27a).

Another couple suggested that this discouragement is such a significant force that it calls into question the value of the parenting experience if they were ever to be so lucky as to get a child:

Even the pamphlets we got from the agency are very discouraging. I guess they try not to build your hopes. You end up waiting and waiting and waiting and getting even more discouraged and finally you get a child placed with you and you probably end up unhappy because you have been so discouraged all along. (2203:30-M)

As the above examples would suggest, the agency may have been more instrumental in preparing couples for the prospect that they might not become parents than in actually socializing them to take on the role of adoptive parenthood. This seemed especially true at the outset of the process when couples were given the dismal "odds" of getting a child.

One-quarter of couples (see Table 51) expressed resentment and powerlessness in going through the adoption process. This powerlessness was reflected in the words they used to describe the formal adoption procedure. As one man put it, "its like having a drill instructor walk into your environment" (3313:34a-M) or for another "this stranger walks in and has power over you" (2309:34a-M). People felt

they were being "judged" (2305:34a-F), "interrogated" (3522:12-F), "on trial" (2403:30-F), "fine combed" (1232:34a-M) or that someone was "going to play God with us" (2351:30-M). As one woman described it:

With adoption there is that uncertainty. There is always the sense that they are watching you. Do you measure up to the standard? (3401:12-F).

For others, there was the possibility of rejection to contend with:

I feel that you have to prove to someone else that you can be a parent. Its in the back of your mind - Will I be rejected? No one else has to go through this! (2312:30-M)

For another man, being rejected as an adoptive parent would mean double "failure":

I would hate to be a failure twice. Not getting a biological child and then not getting an adopted child would be very hard (2351:30-M).

These responses to the homestudy are consistent with Joe's (1979:20) observations that many infertiles respond to the homestudy with fear or rage at having to prove their fitness for parenthood.

For some couples, the adoption process was shrouded in a cloud of ambiguity. As indicated in Table 51, 11% of husbands and 10% of wives reported a strong sense of uncertainty about what to expect from the agency and what was expected of them in going through the adoption process. As a result, there was a characteristic aimlessness in the resocialization process to adoptive parenthood. One man

expressed his disappointment at having no direction in preparing for adoptive parenthood:

I really wish that there was something that could help you to prepare for adoption. We went into it all just not knowing what to expect (3452:44-M).

This uncertainty reinforced feelings of loss of control. As one man explained, the only certainty in an otherwise ambiguous process was that it would be a long wait:

I am really very vague about the whole process and what you have to go through - like I've never been through it before, eh? I don't know what to expect - what you have to do - what is involved in the homestudy and what you have to do - legally and things like that. They (the agency) just don't tell you what to expect except that it is a long wait. (2316:44-M)

In addition, couples were unclear about what to expect from the homestudy:

They don't tell you much about what to expect in the homestudy and what is coming up. They keep you on a tight rope - waiting and hoping and thinking about it but not knowing what's involved. (2521:30-F)

In light of this uncertainty about the homestudy, couples often focussed on facets of the evaluation procedure that were of lesser priority to the agency. Whereas the agency tended to focus on issues like infertility resolution and motivations for adoption, couples tended to focus on the physical aspects of the environment such as financial stability and a clean home for passing the home study. This concern by couples about physical appearances may reflect an awareness of middle-class standards that are typically associated with social workers (Joe, 1979:71-2). For

example, when couples were asked what they thought was expected in the homestudy, the most frequent response given by men was "financial stability" (41%), followed by a "clean and orderly home environment" (39%) and "a good marriage relationship" (38%). For women, the most frequent response was "a good marriage relationship" (51%) followed by a "clean and orderly home environment" (43%) and "financial stability" (34%). In keeping with this, one woman commented on the dreaded "white glove test":

On the day that she (the social worker) was coming to see us here, I cleaned the house from top to bottom. I was expecting the white glove test for any dirt or dust. When she came, she didn't even go beyond the living room. When I offered to show her around she wasn't interested and we just sat and talked.  
(3522:34a-F)

Other criteria that were often the focus of the agency homestudy tended to be largely unanticipated by couples. For example, only one percent of both husbands and wives indicated that the agency would be looking to see how well they had accepted their infertility. Only 15% of wives and 8% of husbands thought that the agency would ask them about adoption and how to handle adoption as a parent. As these findings would suggest, not only were couples poorly prepared as far as knowing what to expect in the adoption process, but they were at odds with the agency as far as what they felt was important in the evaluation process. No doubt the greatest disparity was on the issue of infertility resolution. Whereas the agency placed a good

deal of importance on this condition for adoption, couples themselves almost completely ignored this issue.

The aura of uncertainty that was prevalent in the early stages of the process usually continued throughout. However as people progressed through the evaluation process, the uncertainty often shifted from what was involved in the process itself to whether or not the process would pay the appropriate dividends. One woman, who already had a completed homestudy, felt that adoptive parenthood might still be as far off as when they started:

There is no commitment from CAS as to whether they will ever make a match. There is not a definite yes or no that it will ever happen. When she left after the homestudy she encouraged us to pursue private adoption if it came up. (3522:38-F)

For others, however, the homestudy was an important experience because it put an end to the uncertainty that they had felt. As one couple who had just completed their homestudy explained:

Husband: Before, adoption was something that was vague. Now it's more definite. They said to start getting ready.

Wife: Before they could refuse you. Now its more like pregnancy because we can look forward to the time when the baby will come (2353:30-F).

Most couples did not view the formal agency process as helping them to prepare for adoption. As another indication of this, 18% of husbands and 13% of wives indicated that their primary concern about adoption was the lack of preparation time. Unlike having a biological child

where there is a nine month period to get ready for parenthood, the preparation for adoptive parenthood was perceived as occurring between the call from the agency that there was a child and the actual arrival of the baby. This was usually a period of only 2 or 3 days and it was seen as the time when all the preparations were to take place. As one man stated it "you don't have nine months to prepare, you have 48 hours" (2403:39a-M). In this respect, going through the long process of interviews and homestudies with the agency tended not to be seen as preparation experience. As a result, the transition to adoptive parenthood would be very different from the transition to biological parenthood:

Husband: You are thrust into a new situation where you have to adapt. You don't have the nine months adjustment period - the actual adjustment occurs when the baby arrives.

Wife: You're thrown into it cold turkey. You don't have time to prepare yourself at all. (2505:39a)

Others perceived pregnancy as an important preparation time. With adoption, this time of preparation was absent. As one woman explained:

With pregnancy, you have a chance to bond with the baby, whereas with adoption, it's so abrupt. It's the emotional involvement with the fetus that is so important in pregnancy (2312:18b-F).

Biological parenthood was clearly advantageous in this way for another woman:

With a biological child, you're closer in the beginning. You already know the child for nine months. So you don't have to get to know the child. You have the emotional preparation of nine months. With CAS, you get it tomorrow (2311:17b-F).



The abruptness of adoption was perceived to create difficulties in taking on the role identity of parent to the child when it did arrive. One woman explained how the experience would probably be more like babysitting than parenting:

What would it be like to take the baby home? They call on a Friday and you bring it home the next day. What happens? All of a sudden you don't go out. It would be like babysitting. You just have no time to prepare for adoption (2502:38-F).

For others, the abruptness of adoption created some very pragmatic problems of preparation. Specifically, the short notice of adoption would make it difficult to change a busy, independent lifestyle. As one woman explained:

Having been independent and on my own for so long, I just don't know how much time you have for preparing for and adjusting to this child. What would happen to my job if all of a sudden you have a child dependent on you? There are restrictions in the teaching profession as to when you can quit (3308:38-F).

One implication of the abruptness with which adoptive parenthood is taken on is that it requires explanation to significant others who cannot easily "place" the identity of the new adoptive parent. In this regard, couples felt that not only were they ill-prepared to take on adoptive parenthood, but their network of friends, family and neighbours would also be ill-prepared for their transition to a new role identity. This lack of preparation among their significant others required that the adopting couple "account" for this new identity to others:

There is really no preparation for when the child is going to arrive. Then all of a sudden you have this kid who you take places where people didn't know you were pregnant or adopting. Then you have to explain. (2402:39a-M)

One man suggested that in addition to the abruptness of the adoption that makes it difficult to prepare, there is the "difference" of the adopted child in comparison to a biological child that one must also contend with:

It happens so fast. It would take some time to accept the child himself even though you have accepted going through the whole matter (2504:39a-M).

Although most couples did not see the formal agency process as an important socializing experience that would help them prepare for adoptive parenthood, there were some who did. As couples got further along in the adoption process, there was a tendency to see some merit in the formal procedures. Among men, 14% in Group II compared to 29% in Group III indicated that the agency helped them to know what to expect in the adoption process. Similarly, for women, 14% in Group II compared to 29% in Group III said that the agency helped them in this way. As a result of going through interviews, attending information meetings and going through the homestudy, couples were more likely to see that there was some socialization value in the formal adoption process. For one couple, the formal adoption process was a positive socializing influence because it answered some of their questions and helped them to confront

some of their fears about adoption:

Husband: They talk about all your worries. The things you don't know about adoption until you get into it. For me it's been a process of understanding whats involved. You only understand what it means once you are in it.

Wife: Its made me feel good about adoption. They have been open about answering questions and they are doing good things for the birth mother and adoptees (2454:30).

Others expressed similar sentiments when they stated that by "going to the agency we felt ready" (3450:30-F) or "they have helped out by showing that it is a big experience and what we have to do" (3310:30-F). For some couples, then, the agency was a positive socialization influence in preparing for adoptive parenthood.

### Responses to the Formal Agency Process

In light of the prevailing attitude that the adoption agency was there to judge them and not to help them, couples responded to the formal adoption process in two distinct ways. Corresponding to Goffman's (1959) distinction between front stage and back stage behavior, couples staged a public impression to the agency that they would make excellent parents, while in their private disclosures to each other, they expressed their anger and resentment at having to prove themselves worthy to the agency.

### Impression Management

In order to gain formal legitimation as adoptive parents, couples engaged in deliberate "impression management" (Goffman, 1959). In this regard, they attempted to portray to the agency representatives that they would be the best possible parents. This was usually a deliberate strategy. One man explained how the importance of impression management was weighed against honesty at their first adoption meeting:

At the first meeting, it was "Should we be honest? What should we say?" You want to show that you are the 100% best human being there is to be a parent (3352:30-M).

Similarly, another couple describes their tendency to "stretch the truth":

When you fill out the application forms, you really have to second guess them. On paper we looked pretty boring. So we had to stretch the truth a little bit to make ourselves look good to the birth mother (3401:30-F).

For another man, impression management was guided by the agency's expectations for them as a couple. In this regard, "you tell them what they want to hear" (3522:34a-M), are "accommodating for them" (3352:30-F), or at very least are very careful not to say anything incriminating:

It's nerve-racking. You feel like you are on trial. The one negative side is that you don't want them to get mad at you. I got a negative reaction from them (2403:30-F).

Usually the goal of this impression was showing that they were the "perfect parents" (3451:34a-M). As part of this,

one couple had the feeling that "we should hold hands and show that we had this great relationship" (2402:34a-F).

This effort to "impress them" (3401:12-M) also reflected their powerlessness in the process:

Husband: You are like a dog trying to please all the time.

Wife: I feel like a kid when I call them. You want to be the best and you want to project this image of being perfect. You are under the microscope. You want to say something but you don't feel like you can. It's the "we're close, so lets not rock the boat game." You can't express concerns because you don't want to have what you say misinterpreted. (3404:30)

Underneath this public performance to the agency were quite a different set of feelings. Dominant among these was the feeling of anger.

### Anger in the Adoption Experience

Although the surface presentation of self was controlled and calculated in order to create the right impression, the underlying feelings about the adoption process were quite different. Couples expressed anger, "reluctance" and "resentment" about being evaluated through the adoption process, especially in light of the uncertain outcome. Homans (1961:75) has suggested that anger occurs when distributive justice fails and people do not receive rewards in proportion to their investments. In the case of adoption, powerlessness and a scarce reward base provide a

perfect breeding ground for angry feelings. One man explained his feelings of resentment stemming from the unfairness of the process:

I resent being tested and prodded and being asked my feelings. People who have to adopt, and I understand the reason for it, people who suffer infertility have to lay bare their soul whereas those who have biological children don't have to do anything to show they are good parents. The system is unfair. (2505:30-M)

For another couple, the prospect of being turned down by the agency after all they had been through gave rise to angry feelings:

The thought of getting turned down is most upsetting. Who are they to say that we aren't good parents? What if they say no? I would be so angry. Especially when you are told since you are little that you would be the best mom there is (1231:34a-F)

The scarcity of adoptable babies as the due reward also gave rise to these angry feelings:

Husband: You hear that it takes so long to adopt. Eight years sometimes. It makes me angry.

Wife: I get angry when nothing happens. It makes me angry that they don't encourage the mothers to give the child up. Then they support her with welfare (2225:30).

For one man, the anger was masked behind a sense of bravado:

The social workers at the agency have made me feel more determined to have a child than ever. I don't have to prove that we are capable. They have to prove to me that I'm not capable (3306:30-M).

In addition to the anger that was fostered by the agency process and the shortage of infants, there was also a subtle, covert sense of competition that emerged among

couples. This came across as a feeling of *schadenfreude*, or joy at the misfortune of others. For one man, this occurred at an agency meeting where other couples were in attendance:

It helped to go to the meeting ... We talked to one couple who were too old and at least we weren't as badly off as them (2502:30-M).

In light of the adoption agency's primary concern with the child, couples experienced an underlying sense of alienation with the agency upon whom they were so dependent. Without direction, without power and without any promise of a pay-off at the end, couples persisted through the adoption process with their goal of parenthood still clearly and passionately before them. The intensity of their anger and the strategies that they devised to become parents were evidence of the strength of this ongoing conviction.

#### SUMMARY

The process of resocialization to adoptive parenthood was characterized by a number of unique socialization experiences. This involved a set of interactive experiences whereby couples sought support from significant others around them in order that they come to be identified as adopting parents. Family members, friends and people who had experience with adoption played a strong role in providing this support. Although there was generally a

supportive atmosphere for couples to take on adoptive parenthood, there were numerous socialization influences that highlighted problems with the role. These included stories of bad adoption relationships and failed adoption outcomes that were relayed by both significant others and popular dramatizations on television.

A crucial aspect of preparing for the role identity of adoptive parenthood was the process of gaining formal support from the adoption agency. Couples expressed feelings of anger, dependency, resentment and powerlessness in seeking legitimation from the agency. Couples tended not to view this process as a way of preparing for adoptive parenthood, but rather as an obstacle to be overcome. In this sense, couples did not perceive the agency as a source of support in helping them to prepare for adoptive parenthood, but rather, they saw them as the gatekeepers who would judge their worthiness to take on the role of adoptive parents. A strategy of impression management whereby they presented themselves as the "perfect parents" was one way of overcoming this obstacle in order to get a child.

Nevertheless, the agency was perceived as a powerful socializing agent. Unable to meet the demand for adoptable babies, couples perceived that the agency was focussing more on preparing them for the prospect of not becoming adoptive parents than the prospect of becoming adoptive parents. In



this sense, couples were socialized through discouragement to expect either a very long wait or the possibility that adoption might never happen for them. In light of the strong normative pressures that couples become parents, this was an intensely frustrating experience.

In addition, couples were given few guidelines for what to expect in the formal adoption process. This cast a shadow of uncertainty over the adoption process and couples expressed difficulty in taking concrete steps towards preparing for the anticipated role identity of adoptive parenthood. Most couples perceived the preparation for adoptive parenthood as occurring in the forty-eight hour period between the agency calling and the child being placed. In this regard, they tended not to see the homestudy as a preparation experience.

In conclusion, going through the formal process with the adoption agency was perceived primarily as a way of gaining formal and legal sanction. Although some couples reported that the agency was a constructive socializing influence in the preparation for adoptive parenthood, it would appear that this preparation occurs primarily on an informal plane as couples seek support from significant others.

## CHAPTER 9

## CONCLUSION

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Becoming adoptive parents, as an infertile couple, has been conceptualized in this analysis as a bidimensional process. It involves, on one level, a redefinition of the taken-for-granted meaning of parenthood as a result of the disruptive effect of infertility on the expected transition to biological parenthood. On another level, it involves the construction of a new and unanticipated identity, based on the contingencies presented by infertility and adoption. As part of the construction of this new identity, couples experience a process of resocialization whereby they slowly dismantle their image of themselves as biological parents and replace it with a new picture of themselves, both in their own eyes, and in the eyes of others, as prospective adoptive parents.

The focus of this chapter is to provide an overall summary of the findings that support this bidimensional process and to examine the implications of these findings. At the outset of this research, a number of propositions were constructed. A consideration of these propositions, in

light of the data collected, will be used to guide the summary. In addition, the implications of these findings are discussed as they relate to future research. In this regard, there is a discussion of how various anomalies discovered in this research, might be addressed in future studies. As part of this discussion, the limitations of this research are discussed. Finally, there is a discussion of the implications of this research for medical and social work practice.

#### THE PROPOSITIONS IN THE CONTEXT OF THE DATA

The eleven propositions that were constructed to guide the analysis are outlined on pages 131-133. The extent to which the data do or do not support these propositions is the focus of this section.

In Proposition 1, it was projected that couples would encounter a strong normative pressure for parenthood. This was, in fact, the case for the couples of this study. With few exceptions, couples expressed the feeling, at some point in the interview, that others expected that they should have children. For the few that did not indicate that they felt any external pressure to become parents, they did, nevertheless, report a strong intrinsic desire to become parents. Although this was not imposed externally, it might, for some, reflect the extent to which they had internalized

the expectation to become parents. In this regard, it is possible and even likely, that those few who did not report a pressure for parenthood, did at some level experience the expectation for parenthood.

The expectation for parenthood was also shaped by a set of time norms. Couples usually anticipated for themselves that they would have children within the first three years of marriage. This corresponded with the externally imposed expectation that they become parents during this time as evidenced by the mounting pressure that they encountered when this time passed and there were still no children.

The strength of this normative expectation had several implications. A feeling of social isolation from an otherwise fertile world was no doubt one the most significant. Couples expressed a feeling of being "left behind" as friends and family had children. In addition, couples reported feelings of disappointment at being unable to provide their parents with grandchildren. Not only were they saddened by the prospect that they might not have children for themselves, but they carried the extra burden of being unable to provide grandchildren.

Related to the normative expectation for parenthood was the proposition that motherhood would be more salient to the female identity than fatherhood to the male identity (see

Proposition 7). This proposition was supported by the finding that both husbands and wives indicated that parenthood was more important to the woman. Women were also more likely to talk about matters related to infertility or having children, and although men may simply not have been as expressive in talking about these issues, it would seem to indicate that parenthood is a more salient identity for women. As further evidence of this, women were most often the ones to initiate the adoption process by calling the agency. Although most findings did suggest that parenthood was more important for women than men, there was some indication that this might reflect social desirability in response. When asked directly about the importance of parenthood, one might expect that men and women would respond that parenthood is more important for women because they are socialized to do so. However, when asked indirectly as they were in the Parenthood as Objective Reality Scale, there was less of a dramatic difference between husbands and wives, suggesting that the differences may not be as great as they appear on the surface.

The gender difference in the importance of the parenthood identity was explained by respondents in a variety of ways. For some, motherhood was just "naturally" more important for women, while for others, socialization to become a parent was more focussed on women. Whereas many women indicated that their lives were constructed around the

parenthood identity, men were more likely to emphasize identities related to work as being the most central. For men, work and outside activities continued to hold a pivotal place in their lives, and as several mentioned, their lives were not going to stop for infertility. In fact, some men reported investing more energy into work as a way of compensating for the hole that was left in their lives by childlessness. Women, on the other hand, were more likely to set parenthood as a priority over work activities. For example, some women reported "putting their lives on hold" by not working outside the home, turning down promotions or not getting involved in other social or recreational activities because of the possibility of getting pregnant.

It was projected in Proposition 6 that, as a result of infertility, the parenthood identity would take on added importance in the salience hierarchy. A majority of couples indicated that their commitment to becoming parents intensified and became stronger as a result of having a fertility problem. The increased importance of parenthood was attributed to a number of factors: the loss of control over when and whether they would become parents; an increase in the amount of reflection and discussion about the importance of parenthood; and for women especially, age and the sense of running out of time.

Related to this, Proposition 5 proposed that, if

commitment to parenthood was low, couples would continue "trying" or opt for a childfree lifestyle, whereas if commitment to parenthood was high, couples would make the adjustment and pursue adoption. Few couples reported that commitment to parenthood had lessened in the face of infertility. Those couples who did, however, expressed ambivalence about adoption and began to question for themselves the importance of parenthood. Although these couples continued to try to get pregnant, they expressed the view that they had come to enjoy their lifestyle without children. For most, however, commitment to parenthood was high throughout the process. Although this did not always mean that they were currently pursuing adoption, they were at least considering adoption as an option at some point in the future if their efforts to become biological parents failed.

The way that couples managed infertility as a problematic in interactive situations was outlined in Propositions 2 and 4. In Proposition 2, it was projected that couples must "account for", or explain their infertility because it is incongruous with the normative expectation for parenthood. It was expected that these explanations would be in the form of excuses because the responsibility for the infertility would be externalized. Couples did indicate feeling pressure to explain the absence of children, which again reflects the strength of the



normative expectation that they become parents. Excuses were a commonly used form of explanation and these usually involved externalizing the problem to the medical profession. In these instances, it was doctors who were responsible for their childlessness insofar as they were slow in identifying or correcting the problem. Women had to account for infertility more often than men, again suggesting that women talk more often about matters related to children, and that parenthood may be of more importance in their lives.

Perhaps one of the most striking changes in the way that couples accounted for their infertility was that they became more open over time. Couples disclosed to a greater number of people, and to less intimate reference groups, as they moved closer to adoption. This is a function of an increase in pressure at having to explain childlessness as time goes on and also that couples got over their initial feelings of shame and inadequacy at having to disclose. Corresponding with this, they also indicated that they learned a vocabulary for how to tell others. In addition, disclosure of adoption plans was one way that couples indirectly disclosed their infertility.

Proposition 4 posited that, when others were unable to share in the definition of the situation as it relates to infertility or adoption, they would be unable to "place" the

infertile couple in their identities as involuntarily childless or as prospective adoptive parents. There emerged a clear division between those who could "place" them in these identities and those who could not. Sharing the experience of infertility and/or adoption was perceived by most couples as a precondition of coming to a shared definition of the situation. Those who did not share the experience of infertility or adoption were perceived as being unable to fully understand the importance of parenthood to them. Ironically, it was often significant others who had children who tended to trivialize the importance of parenthood by complaining about their own role as parents. Other barriers to a shared definition of the situation were identified as the non-obvious nature of the fertility problem and being falsely attributed as having the motives of the voluntary childless. In these instances, the non-shared definition of the situation, and the inability of others to place them in their new identities, left infertile couples feeling misunderstood and isolated.

Although couples became more open over time in disclosing their infertility, there was little change in the extent to which they felt others could understand their situation. This seemed to reinforce the feeling expressed by couples that only those who shared in the problem could truly share in their definition of the situation.

It was proposed in Propositions 8 and 9 that there

would be a shift in identification from biological parenthood to adoptive parenthood that would be marked by a series of critical incidents. The transition from biological parenthood to adoptive parenthood was examined in terms of how couples began to relinquish identification with biological parenthood and whether there were any significant turning points that marked a more serious consideration of adoptive parenthood.

The process of lessening their identification with biological parenthood was characterized by a gradual loss of control over becoming biological parents, a lessening of the importance of a biological tie to a child and an increasing reluctance to continue on with further tests and treatments. Although both men and women reported that infertility had undermined their sense of control over their lives, women tended to more acutely feel this sense of powerlessness. Doctors were often perceived as having the control that they no longer had. The implications of this loss of control were that couples felt a dependency on doctors, a sense that their lives were "on hold", and corresponding with this, an anxious sense of uncertainty about the future.

As optimism for having a biological child waned, the importance of a biological tie to a child also diminished. Whereas one might have expected men to hold on to the importance of a biological tie for a longer period of time

because of our lingering patriarchal attitudes that emphasize biological lineage, this was not supported by the data. Rather, women indicated that it was slightly more important for them. This might be explained by the fact that women felt a greater sense of responsibility or guilt for providing a biological child because they were more often the ones to be experiencing the medical fertility problem. The importance of the pregnancy experience also weakened over time for women, but not for men. Whereas pregnancy maintained a constant level of importance for men because it provided a time to psychologically prepare for a child, for women, its importance diminished over time as the prospects for becoming a biological parent diminished.

Perhaps the strongest indication of relinquishing identification with biological parenthood was the decision to end fertility tests and treatments. Couples reported that the final decision to end tests and treatments was often preceded by a series of "tolerance thresholds" whereby they projected a limit to the tests and treatments only to go beyond these limits once reached. In this regard, their tolerance for tests and treatments was extended by their reluctance to completely relinquish identification with biological parenthood.

Consistent with this, there were a number of "critical incidents" or "turning points" that emerged which marked a shift towards adoptive parenthood. Although for

some couples there was no specific turning point or event, but only a slow and gradual realization that they would adopt at some point, for most couples, there were specific incidents that could be identified as significant in moving toward adoption. These incidents included the way that couples came to terms with their infertility, age, and the influence of significant others.

Coming to terms with infertility, as a critical event, tended not to be tied to the nature of the fertility problem or the kind of diagnosis that was received. Rather, what was considerably more important for moving towards adoption, was the way that couples perceived the end to the infertility process. For some, adoptive parenthood would become, or did become an option only after the infertility process had definitely ended. In this regard, a definite answer or end to the testing and treatment was the critical incident that would move, or did move, couples toward adoptive parenthood. For these couples, the transition from biological parenthood to adoptive parenthood was experienced sequentially. For other couples, however, the end of the infertility process was not a necessary criterion for moving ahead with adoption. These couples tended to view infertility as an ongoing process that might not come to a distinct end. In addition, there was a tendency to recognize the long period of time that was involved in the adoption

process, and in this sense, they were "hedging their bets" for adoption by initiating the process as early as possible. For these couples, then, once the adoption process was initiated, it was experienced concurrently with the infertility process. As a result, their decision to initiate the adoption was often influenced by other considerations.

Age was one such consideration that emerged as an important factor in moving couples toward adoptive parenthood. For some couples, age was a critical event insofar as it marked the time of being "too old" for biological parenthood because it would be impossible or too dangerous to pursue. For other couples, however, age was tied not to biological parenthood, but to adoptive parenthood. This was expressed as a feeling of wanting to be "old enough", in terms of maturity, responsibility and stability, to take on the uncertainties associated with adoption. There was little consensus regarding the actual age that was critical for initiating the adoption process, suggesting that this incident is highly subjective and is affected by other considerations.

Significant others played an important role in moving couples to initiate the adoption process. Physicians were particularly important in this regard. In keeping with their own sense of powerlessness, many couples waited for their physician to tell them to move ahead with adoption.

This was usually interpreted by couples as an indication of a gloomy outlook for becoming biological parents. Friends, family members and those who had experience with adoption were also an important influence in moving couples toward adoption. Whereas family members were most important for wives, those who had some experience with adoption were most important for husbands.

Calling the adoption agency was a significant event for most couples because it offered some relief to the indecisiveness of whether or not to go ahead with adoption. In almost all cases, wives initiated the adoption process.

In addition to the "turning points" that marked the beginning of the adoption process, there were other indicators that showed that couples were more strongly identifying with adoptive parenthood and ready to take it on as a role identity. These were the indicators of "adoption readiness" and were assessed by both objective and subjective means. The objective indicators of adoption readiness included a willingness to immediately adopt a normal infant if available; positive attitudes toward adoption as measured by the Adoption Attitudes Scale; openness and readiness to adopt a child as measured by the Adoption Readiness Scale; frequent discussions of adoption within the marriage; seeking information about adoption; and recognition of the advantages of adoption. Multiple

regression analysis revealed that frequency of adoption discussions within the marriage and disclosure of adoption plans to others were critical factors in predicting adoption readiness. In addition, seeing the advantages of adoption was an important predictor of adoption readiness for husbands, while knowing someone who was adopted was important for wives.

An assessment of the subjective indicators of adoption readiness provided a more qualitative insight into what it meant to be ready for adoption. These indicators included fantasizing themselves in the role of adoptive parents, making physical preparations for the abrupt arrival of an adopted child, and feelings of "enthusiasm" or "confidence" in their consideration of the new role identity.

Those who were reluctant to commit themselves to adoptive parenthood identified various obstacles to adoption readiness. Perhaps the most significant obstacle that was encountered was disagreement between spouses. As projected in Proposition 10, in order for a couple to proceed with adoption, there would have to be a considerable level of agreement between spouses. When spouses indicated different levels of adoption readiness, there was generally a reluctance to move ahead with adoption. Usually the spouse who was ready to adopt was hesitant to move ahead for fear of later resentment by the partner who was not ready. Other



obstacles to adoption readiness included the consideration of a childfree lifestyle and perceived disadvantages of adoptive parenthood. These disadvantages included an uncertainty about the child's medical background and family heritage, a concern that the birth mother would at some point change her mind and show up at their doorstep, worries that the child would reject them in favour of the birth parent when he/she found out about adoption, a concern that the child would be ridiculed, and finally, the length and emphasis on evaluation of the agency process itself.

As outlined in Proposition 11, the transition to adoptive parenthood was expected to involve a process of resocialization that had few guidelines about how it was to occur. Although there were a number of formal requirements that had to be met in order to become an adoptive parent, these conditions did not seem to have as much of an effect on the shaping of adoptive parenthood identity as the informal interactions with friends, family members and people who had adopted. In this regard, the way that couples accounted for the possibility of adoption and the way that these others reacted to adoption, was an important socializing experience.

Adoption accounts were projected in Proposition 3 to play an important role in explaining the prospect of adoptive parenthood. As the data suggest, couples explained

their adoption plans, not only to get a reaction from significant others, but as a way of preparing these others to "place" them in the role identity of adoptive parent. In this respect, the resocialization experience was essentially interactive insofar as couples prepared for the adoptive parenthood role by seeing themselves in the eyes of their significant others. Couples became more open over time in accounting for their adoption plans and indicated that others became more understanding of their feelings about adoption. Consistent with this, couples reported that others reacted positively to the prospect of them adopting, suggesting that adoption, and not childlessness was the appropriate means for bringing their problematic behavior into line with normative expectations.

Those who had some experience with adoption were also a salient socializing influence. Couples reported being more aware of these adoptive situations as a way of anticipating the role for themselves. Most of their observations of other adoptive relationships were considered to be a positive influence in that most of these seemed to "turn out right." This served to normalize the adoptive relationship and to reduce some of their anxieties about unstable adoptive relationships. However, some adoptive relationships were a negative socializing influence because the adoptee had "turned out bad" or had rejected the adoptive parents. Media portrayals of adoptive relationships

contributed to this negative image by emphasizing unstable adoptive relationships and glorifying reunions between adoptees and their birth parents.

Although the formal adoption process was generally not viewed as a constructive socializing influence, it did, nevertheless, have a significant impact on the way that couples defined adoptive parenthood. In light of a shortage of adoptable babies, and a perception that the agency was not "on their side", couples expressed feelings of discouragement, powerlessness, resentment and aimlessness when discussing the formal adoption process. In fact, for some, the agency created such an abysmal picture of the prospect of them becoming adoptive parents that it appeared that they were being socialized to non-parenthood, rather than adoptive parenthood.

Going through the evaluation procedures associated with the homestudy tended to reinforce feelings of loss of control over parenthood that had been initially set into place by infertility. For some, this created feelings of anger and resentment towards the social workers involved in the formal adoption process. And although this anger was buried under a facade of being the "model parents" when talking to social workers, it was certainly allowed to flourish in the research interviews. Couples tended to perceive the homestudy as an assessment of their physical

environment and financial status as opposed to issues related to infertility or adoption.

The formal adoption process tended not to be seen as a preparation experience for adoption. Although some couples reported that it made them less fearful of adoption because they knew what to expect, most indicated that it did not prepare them for the adoption experience. This emerged from reports by couples that the preparation for adoption occurred in the short two day period between the time that the agency called and the time they were to pick up the child. The perceived abruptness of the process left many couples feeling inadequately equipped to make the transition in such a short period of time. In keeping with this, some couples anticipated the need to account for such a sudden change to those who were unaware that they were considering adoption.

#### IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

While many of the findings of this research supported data collected in other studies, several anomalies did emerge. When compared to other studies, some of the findings were puzzling, while others were incongruous with what has been reported elsewhere. The emergence of such puzzles, although providing fresh insight into

previously taken-for-granted findings, suggest new points of departure for future research.

One finding to emerge in this study that was not consistent with previously reported research, was the different patterns of relationship between the resolution of infertility and adoption readiness. Most of the literature that links these processes together places them in temporal sequence, whereby infertility must be resolved before adoption can be appropriately taken on. Although some couples in this research fit this pattern, many did not. A significant proportion of couples experienced a concurrent commitment to both biological and adoptive parenthood. What this would seem to suggest is that not all couples experience the transition from biological parenthood to adoptive parenthood in a purely linear fashion, as previously assumed. Rather, it would appear that some experience a series of reverberations between the two identities. For these couples, it was not the experience of having a biological child that was of greatest importance, but rather, the experience of becoming a parent.

This would suggest that the importance of "resolving infertility" as a precondition to adoption may be overstated in the literature and over emphasized in practice. Granted, for many couples, this is an important step for becoming adoptive parents. For others, however, it does not appear to be a significant or necessary part of the

adoption experience. In fact, for some couples, the significant turning point for adoption readiness, was not the end of tests and treatments, but the initiation of the formal adoption process. For these couples, the call to the agency reflected a new commitment to adoptive parenthood that did not require the abandonment of their commitment to biological parenthood. This would suggest that coming to terms with adoption is not solely dependent on coming to terms with infertility. In light of this, future research might fruitfully explore the ramifications of this kind of reverberating commitment for the adoption experience.

Given that couples must to some extent respond to the prognostications of their physician(s) in going through the infertility process, and the expectations of their adoption social workers in going through the adoption process, it is clear that these "formal" agents play an important role in shaping the transition to adoptive parenthood. However, it would appear that these roles have not been adequately addressed in the literature. Although the findings of this research provide some insight into how these significant players are perceived by the couple going through the transition, it would be valuable to assess the perspectives that these professionals have on their own role in shaping adoptive parenthood identity. For example, to what extent do doctors consciously and deliberately push

couples toward a consideration of adoption? How do they assess the appropriate timing for this kind of intervention? What are adoption workers' perceptions of adoption readiness? What are the rules and subjective expectations that guide their assessments of adoptive couples? By addressing these questions, one might better understand the structural constraints that are encountered by infertile couples and gain some insight into problematic areas of divergence in expectations between couples and the professionals with whom they are in contact.

Also emerging from this study was the finding that couples reported that adoption plans were not subject to stigmatic responses from others. In fact, the prospective adoptive couples of this study reported predominantly positive reactions from significant others. Although not in direct conflict, research by Miall (1984) reports that couples who have adopted are subject to stigmatizing responses from others. Kirk (1964) reported that childless couples entering into adoption, however, experience a "role handicap" which is reinforced by the reactions of others. Contrary to these findings, it appeared that in this study, adoption was the approved way of meeting the normative expectation that they become parents. Several explanations of this discrepancy are possible. First, as public attitudes move further away from hiding adoption (when children were secretly picked up at orphanages and never told) to more

openness and acceptance, it would seem that the experience of role handicap associated with adoptive parenthood would also be reduced. Hence, the difference between the results reported here and those of Kirk (1964) may simply reflect a historical change in adoption attitudes. The extent of this change, however, does require further research. In light of Miall's (1984) findings, it is possible that adoptive parenthood becomes stigmatic only in practice, and not as an anticipated identity. If this is the case, this shift in response of others must doubtless create some problems of adjustment for the adopting couple. Further study is required in order to understand if, when, and how this change occurs.

In the adoption literature, considerable emphasis is placed on the "acknowledgement-of-difference" (Kirk (1964) as a key variable in predicting successful adoption outcomes. However, there is little, if any, evidence in the literature of how prospective adoptive couples approach this issue. Three-fifths of the couples in this study indicated that adoptive parenthood would be different from biological parenthood. However, even more significant was that there was no change in this attitude as couples became more involved in adoption. Whereas one would expect that couples would be more aware of the difference as they discussed adoption more often, gathered information about it and went



through the agency process, this was not the case. Several explanations are possible for why there was no change. First, one could hypothesize that the critical time of change for the acknowledgement-of-difference may come only when the actual adoption occurs. In this regard, only when the situation is experientially real, rather than projected or fantasized, do these differences concretely emerge. Second, and from quite a different perspective, it seems quite possible that the unchanging nature of these attitudes is an indication that they are set into place before the adoption process begins and are relatively unaffected by subsequent socialization experiences within the adoption process. It is unclear whether the adoption itself would affect these attitudes. Given the importance of this variable in the adoption literature, future research might address the issue of whether there is a significant change in acknowledgement-of-difference between the pre-adoption and post-adoption experiences.

On a more general level, future research that examines the transition from biological parenthood to adoptive parenthood might benefit from a conceptual and analytical extension of the process at both ends. The parameters of the process that were chosen for this study were represented, at one end, by couples who had just become aware of infertility, and at the other end, to those couples who had been through the adoption process and were awaiting

placement. Pushing the process back beyond first awareness of infertility would amount to setting up a control group of couples (or for that matter, individuals) who planned to become biological parents, but who had not yet started trying and were not anticipating any fertility problems. This group would provide an analytical baseline for issues related to the taken-for-granted nature of biological parenthood and the related expectations regarding the shape of the "normal" transition to parenthood.

At the other end, the process of transformation to adoptive parenthood could be extended indefinitely into the adoptive parenting experience. The transformation of identity accompanying adoptive parenthood does certainly not end with placement. Rather, placement may be more appropriately conceptualized as the end of a first step in becoming an adoptive parent. Pre-placement identification with adoptive parenthood is, in a sense, the groundwork for constructing the adoptive parenthood identity. Through the actual experience of being an adoptive parent, this identity is further moulded and developed. In light of this, it would be revealing to extend the analysis of transition to adoptive parenthood by looking at the changes in identity at least in the first year or two after placement.

Ideally, one might also consider examining the transition to adoptive parenthood using a longitudinal

research design. This study focussed on a cross-section of couples who were at various stages in the transition to adoptive parenthood. With this approach, the assumption was made that couples would independently go through these representative stages. In order to more accurately monitor the transition, it would be beneficial to trace changes in individual couples over time.

#### IMPLICATIONS FOR MEDICAL AND SOCIAL WORK PRACTICE

This section focusses on the implications of some of the findings of this study for professional practice. The previous discussion addressed issues that have practical implications, but it is in this section that these implications are fully explored.

##### The Medical Process

Physicians in charge of the infertility investigation emerged as extremely important players in the transition to adoptive parenthood. The times when their influence seemed to be most critical were in defining biological parenthood as problematic and in suggesting to couples that they consider adoptive parenthood. In terms of defining biological parenthood as problematic, perhaps the

most difficult cases were those where no diagnosis could be made. For some of these couples, the absence of a diagnosis made it difficult to accept that they had a problem. It would seem that physicians might play a facilitating role in helping couples to define their situation as problematic by stressing the current limitations of medical science for diagnosing reproductive problems. By helping couples to identify their non-diagnosis as problematic in itself, they may assist couples to better deal with it as a concrete problem, thereby allowing them to move ahead with other options.

In instances where physicians did give a diagnosis, the reactions ranged from shock and disbelief to a sense of relief. For some, getting the news of a problem was extremely difficult to digest at the time because of the shock of the news. This would suggest that detailed explanations of the problem and future options might be better left, or repeated, during a follow-up appointment when couples would be able to more rationally consider the ramifications of their problem. By contrast, others who had gone for a long period of time with no explanation for their non-pregnancy, often received the news of a diagnosis with a sense of relief. For these couples, the news might not be so shocking because of their longing to have a problem identified, and as a result, it would seem more expedient to immediately move ahead with possible solutions to the

problem.

There was a tendency for couples to hand over control of their reproductive lives to their physician. Most couples went into the infertility investigation with a sense of optimism that "the doctor would fix it." When doctors were unable to live up to this high expectation, couples expressed anger, disillusionment and disappointment. This would suggest that there would be an advantage to carefully negotiating these expectations, in light of medical limitations, at the beginning of the medical process. As part of this, it would seem important that the issue of control might also be addressed directly and that efforts be made to emphasize the couple's autonomy in making informed decisions throughout the process.

Perhaps the strongest testimony to the transference of power from patients to physicians arose in the course of deciding when to voluntarily end the testing and treatment process, and when to start the adoption process. Many couples waited for their doctor to tell them to stop medical treatment or to start with adoption. Again, it would seem important that couples be encouraged throughout the medical process to make these kinds of decisions for themselves. Furthermore, couples might be encouraged to base their decision not only on medical criteria, but on other considerations in their lives, such as age or the emotional

impact of infertility on their marriage, their work or social life.

However, recognition must also be given to the fact that some couples will be reluctant to take full responsibility for these decisions because it is easier to have the physician tell them what to do. In these instances, there seems to be no way around giving couples a direct and deliberate push to either end the medical process or start the adoption process.

Couples who were more autonomous sometimes expressed the view that the medical process seemed to have a series of "tolerance thresholds" whereby they would set a limit on how far they would go, only to re-evaluate and go further once the limit was reached. The rather erratic nature of this process is perhaps a reflection of the need to exploit all medical options in order to come to some final acceptance of their infertility. In light of this, allowing couples to go to the end of all possible tests and treatments (including IVF and AID) may play an important role in coming to some resolution of their infertility. Others, however, who overly exploit medical resources in doing this, may need a firmer hand.

### The Adoption Process

No doubt one of the most striking findings to emerge in this study was the perception that the formal agency process was not a constructive socializing influence for taking on adoptive parenthood. What makes this even more significant is that couples usually expected that the agency process would help them in this way. This is in contrast with the adoption situation of 20 or 30 years ago when there was a surplus of babies to be adopted. Prospective adoptive couples, at that time, did not expect preparation from the agency, as much as they expected choice in the kind of baby they would get. Today, with a shortage of adoptable babies coupled with an ethos that professionalizes previously private family transitions (e.g. pre-natal classes, pre-marriage programs), couples expect some level of professional guidance in taking on a new identity like adoptive parenthood. Although some couples reported that the agency process was useful in this regard, it would appear that not all agencies provide the same programs of preparation. Whereas some provide fairly elaborate educational programs that do help couples to prepare, it seems that other agencies focus more directly on evaluating the couple for parenthood. Hence, it would appear that couples might benefit from more adoption education programs that were disassociated from the evaluation procedure.

Additionally, in light of the feelings of alienation from the agency that were often engendered during first contacts, it would seem reasonable that couples might be given information or programs that would initiate the preparation experience at an earlier time. Rather than feeling frustrated and rebuked during the often long waiting period, couples might use this time more constructively if they were challenged to consider various aspects of the adoption experience.

Related to this, couples reported increased sensitivity to adoption experiences as they got more involved in the process. Unfortunately one of the most powerful influences in this regard was media portrayals of adoption. Given that these portrayals often cast adoption in a negative light and in some cases reinforced myths about adoption, it would seem that there would be a strong justification again for providing a counter-balance of accurate information about the adoption process and its long term implications. This might take the form of an information package given to couples who apply for adoption that could include factual information about adoption rights and laws as well as "normalizing" information about the experiences of other couples who have gone through the process. In addition, the preparation classes that are already in place in a number of adoption agencies would seem to play a valuable role in achieving this end.



With respect to the evaluation procedure involved in the adoption process, it would appear that the expectation that a couple have "resolved" infertility before adopting should be considered less important than now seems to be the case. Although some couples need to have some closure to infertility before adopting, not all couples do. While some of these couples may be simply "hedging their bets" in recognition of the long wait for adoption, others seemed to manage a genuine commitment to both biological and adoptive parenthood.

#### SUMMARY

Becoming an adoptive parent is a social, interactive process. Although feelings of isolation often creep into this process, it is interactions with, and responses from a variety of others that ultimately shape the transition to adoptive parenthood. Unable to move with independent ease into parenthood as others do, couples with a fertility problem must consciously and deliberately plod their way to adoptive parenthood. While holding on to a persistent desire for parenthood, couples must reshape and recast this identity in their own eyes, and in the eyes of others, in order to accomodate the unexpected contingencies of lost

control, dependency on others and a changed normative schedule. And in light of this, interactions with doctors, assessments by social workers, and explanations to family and friends along the way, make the arrival at adoptive parenthood cause for a mixture of trepidation and celebration.

## APPENDICES

## APPENDIX A



McMASTER UNIVERSITY  
Department of Sociology  
1280 Main Street West, Hamilton, Ontario, L8S 4M4  
Telephone: 525-9140 Ext. 4481

TO: Potential participants of the "Infertility Resolution and Adoption Readiness Study."

FROM: Kerry Daly

This study is about the experiences of couples who are faced with a fertility problem. Of particular interest is the way that a fertility problem affects people's desire to become parents. I am interested in knowing how a fertility problem has affected you and how you are feeling about adoption as one alternative for becoming parents.

I am interested in this research for a couple of reasons. First, there has been little research that examines what parenthood means to people who must go to some length to achieve it. Second, having personally experienced both infertility and adoption, I am interested in systematically exploring how others deal with these important life events. In both instances, my primary aim is to gather information about your experiences so that others who go through the same experiences will be better prepared.

There are two parts to this study. One is a questionnaire that I would like each of you to fill in on your own. The other part is an interview with you as a couple. Both of these components can be done in one visit to your home.

All information that is collected by me will be kept confidential. Although McMaster University Medical Center is participating in this study, it is only for the purpose of recruiting participants. At no time will the medical staff have access to the raw data. The data will only be made available to the agency when they have been analyzed and only then in a summary, non-identifying form.

Approximately one to two hours of your time is involved for a brief questionnaire and an interview with you as a couple. If you would like to participate, then please read the enclosed "Who is Eligible?" sheet. If you meet all the criteria for participating in the study, then fill out the bottom of the page and return it to me in the stamped envelope that is provided. Upon receipt of this form, I will contact you to set up an exact time for the interview.

Thank you for your consideration.

Yours sincerely,

A handwritten signature in cursive script that reads "Kerry Daly".

Kerry Daly

## APPENDIX B



McMASTER UNIVERSITY

Department of Sociology

1280 Main Street West, Hamilton, Ontario, L8S 4M4

Telephone: 525-9140 Ext 4481

Dear Participant:

This letter is to certify that Mr. Kerry Daly is conducting the research described in the accompanying letter under my supervision and as part of the requirements for his Doctorate in Sociology. He is interested in talking with you about your attitudes and responses toward parenting as a result of your experience with infertility and/or because of your interest in adopting a child. In order to do this research he has received cooperation from both the Fertility Treatment Clinic at McMaster University and the Children's Aid Society of Kitchener-Waterloo.

As Kerry's supervisor, I will make every effort to ensure that this research will abide by the strictest ethical principles. The information that you provide Kerry will remain totally confidential. Moreover, I will ensure that the doctoral thesis that Kerry writes will contain no information that would make it possible to identify any particular person or couple that he has interviewed.

I hope that you will be willing to participate in Kerry's research and spend an hour or two discussing your attitudes and thoughts with him. Your cooperation will help him complete the requirements for his degree. In addition his research may help those who deal with infertile couples and couples who wish to adopt. It might also benefit other couples like yourself who may learn from this research that others have also experienced some of the same frustrations and hopes.

If you have any questions about this research before being willing to talk with Kerry, please feel free to call me (collect if necessary) at my McMaster University office (416) 525-9140 Extension 3603. If I am not in, simply leave your telephone number with my secretary and I will return the call. I will do my best to answer your questions and your call will be kept completely confidential.

Sincerely yours,

A handwritten signature in dark ink, appearing to read 'Ralph Matthews', written over a horizontal line.

Ralph Matthews, Ph.D.  
Professor

## APPENDIX C

WHO IS ELIGIBLE?

In order to participate in this study, it is important that you meet the conditions listed below. If you do not meet these conditions please return the form anyway indicating that you are not eligible for the study. To be eligible, we must:

- have no children (adopted or biological)
- not be pregnant
- have a fertility problem

## PLEASE INDICATE ONE:

- \_\_\_ We meet all of these conditions and are interested in participating in the study.
- \_\_\_ We meet all of these conditions but are not interested in participating in the study.
- \_\_\_ We do not meet all the conditions and therefore will not be participating in the study. (Please indicate which one(s).)

HUSBAND'S NAME:

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WIFE'S NAME:

---

ADDRESS:

---

---

---

PHONE:

---

We would be available for an interview in our home during the following times: (Please indicate 1st, 2nd and 3rd choice as well as times when you would be unavailable).

\_\_\_ Weekday

\_\_\_ Evenings during the week

\_\_\_ Weekends

## APPENDIX D



McMASTER UNIVERSITY

Department of Sociology

1280 Main Street West, Hamilton, Ontario, L8S 4M4

Telephone: 525-9140 Ext. 4481

Dear participant,

This study is about the experiences of couples who are faced with a fertility problem and who are considering adoption as one alternative for becoming parents.

I am interested in this research for a couple of reasons. First, there has been little research that examines what parenthood means to people who encounter difficulties in becoming parents. Second, having personally experienced both infertility and adoption, I am interested in exploring how others deal with these important life events. In both instances, my primary aim is to gather information about your experiences so that others who go through the same experiences might be better prepared.

There are two parts to this study. One is a questionnaire that I would like each of you to fill in on your own. The other part is an interview with you as a couple. Both of these can be done in one visit to your home.

All information that is collected by me will be kept confidential. Although Family and Children's Services of Guelph and Wellington County is participating in this study, it is only for the purpose of recruiting participants. At no time will the agency staff have access to the raw data. Furthermore, your decision to participate in the study will have no bearing whatsoever on your eligibility for adoption with the agency. The data will only be made available to the agency when they have been analyzed and only then in a summary, non-identifying form.

Approximately one to two hours of your time is involved for a brief questionnaire and an interview with you as a couple. If you would like to participate, then please read the enclosed "Who is Eligible?" sheet. If you meet all the criteria for participating in the study, then fill out the bottom of the page and return it to me in the stamped envelope that is provided. Upon receipt of this form, I will contact you to set up an exact time for the interview.

Thank you for your consideration.

Yours sincerely,

A handwritten signature in cursive script that reads "Kerry Daly".  
Kerry Daly

## APPENDIX E

## INFORMATION FOR CONSENT

You are being asked to consent to fill out a questionnaire and to be interviewed. The total time for filling out the questionnaire and being interviewed is approximately one to two hours.

There are a number of provisions which have been set in place to protect the confidentiality of your responses. First, the only identifying mark on the questionnaires or the interview schedule is an identification number. This number is used to link together, for the purpose of analyzing the data, your responses on the questionnaire with the interview data and the responses from your spouse's questionnaire. You are requested to not put your name on the questionnaire and the interviewer will not do so. Second, the data that are obtained will be treated with utmost confidentiality. Neither your doctor or the infertility clinic staff will not have access to the data. Third, the results of this study will likely be reported in academic journals and at professional conferences. In these reports, no individual will be identified. In other words, the data will be presented in a non-identifying and summary form.

Therefore, in consenting to participate in this study, I understand that:

- I am entering into the study voluntarily.
- the study is being conducted independently from the Infertility Clinic except for their request to you for participation.
- The data are not available to either your doctor or the infertility clinic staff.
- I am free to refuse to answer any questions which are put to me in either the questionnaire or the interview.
- I am free to withdraw from the study at any point.

---

CONSENT FORM

I have read the information sheet regarding the infertility and adoption readiness study and I consent to participate in this study.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## APPENDIX F

## INFORMATION FOR CONSENT

You are being asked to consent to fill out a questionnaire and to be interviewed. The total time for filling out the questionnaire and being interviewed is approximately one to two hours.

There are a number of provisions which have been set in place to protect the confidentiality of your responses. First, the only identifying mark on the questionnaires or the interview schedule is an identification number. This number is used to link together, for the purpose of analyzing the data, your responses on the questionnaire with the interview data and the responses from your spouse's questionnaire. You are requested to not put your name on the questionnaire and the interviewer will not do so. Second, the data that are obtained will be treated with utmost confidentiality. The staff at Family and Children's Services will not have access to the data. Third, the results of this study will likely be reported in academic journals and at professional conferences. In these reports, no individual will be identified. In other words, the data will be presented in a non-identifying and summary form.

Therefore, in consenting to participate in this study, I understand that:

- I am entering into the study voluntarily.
- The study is being conducted independently from Family and Children's Services except for their request to you for participation.
- The data are not available to the Family and Children's Services staff.
- I am free to refuse to answer any questions which are put to me in either the questionnaire or the interview.
- I am free to withdraw from the study at any point.

---

CONSENT FORM

I have read the information sheet regarding the infertility and adoption readiness study and I consent to participate in this study.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX G



## family and children's services of the waterloo region

Incorporated as the Children's Aid Society of the Regional Municipality of Waterloo

date

Dear

The purpose of this letter is to request your participation in a study of married couples who are experiencing a fertility problem and who are considering adoption as the means to parenthood. You have been randomly selected from our files as a couple who could make a contribution to this research.

The research is being carried out by Mr. Kerry Daly who is a doctoral student in the Department of Sociology at McMaster University in Hamilton. The research is being supervised by Dr. Ralph Matthews, also of the Department of Sociology at McMaster. Enclosed you will find letters outlining the nature of the study from Mr. Daly and Dr. Matthews. The study is being conducted with the co-operation of the Infertility Clinic at the McMaster University Medical Center and the Waterloo Region Family and Children's Services.

Your participation in this study is completely voluntary. Your decision to participate will not be made known to us at Family and Children's Services nor will your participation or non-participation reflect in any way on your eligibility to adopt. Nevertheless, I would encourage you to participate in order to further our knowledge in this area.

Sincerely,

Peter G. Ringrose

Peter G. Ringrose, Executive Director

355 CHARLES STREET EAST  
KITCHENER, ONTARIO N2G 2P8  
PHONE (519) 576-0540

BRANCH OFFICE: 168 HESPELER ROAD  
CAMBRIDGE, ONTARIO N1R 6V7  
PHONE (519) 623-6970



Family & Children's Services  
of Guelph and Wellington County

## APPENDIX H

I. A. Macrae - Executive Director

4th February 1986.

Dear

We have been approached by Kerry Daly, a doctoral student in the Department of Sociology at McMaster University, to participate in a study regarding fertility problems.

Having met with Mr. Daly, and reviewed his proposal, we think his study could be helpful to us in working with families considering adoption when infertility is a factor.

We have agreed to send the enclosed information to all childless families who have enquired about adoption through our agency. We have not given the researcher your name.

If you choose to participate in this study it will involve your interaction with Kerry Daley directly. We will not be told which families choose to participate and in no way will your decision affect your application to adopt with us. Nevertheless, we would encourage you to participate in order to further our knowledge in this area.

We look forward to working with you in the future regarding your application to adopt.

Yours sincerely,

(Ms.) Pat Giles, M.S.W.,  
for Children's Services Adoption  
Team.

PG/mdf

Head Office,  
F.C. Promoli Bldg  
55 Delhi Street,  
Box 1088  
Guelph, Ontario  
N1H 6N3

Box 645  
Arthur, Ontario  
N0G 1A0  
Phone (519) 848 2421

Palmerston & District Hospital  
Box 140  
Palmerston, Ontario  
N0G 2P0  
Phone (519) 343 2038

Groves Memorial Hospital  
235 Union Street East  
Fergus, Ontario  
N1M 1W3  
Phone (519) 843 2019

Louise Marshall Hospital  
630 Dublin Street,  
Mount Forest, Ontario  
N0G 2L0  
Phone (519) 323 2210

## APPENDIX I

INTRODUCTION

This study is about the experiences of couples who are faced with a fertility problem. Of particular interest is the way that a fertility problem affects people's desire to become parents. I am interested in knowing how your fertility problem has affected you and how you are feeling about adoption as one alternative for becoming parents. I am asking you to share your experiences about these things so that others who go through the same experiences will be better prepared.

There are two parts to this study. One is a questionnaire that I would like each of you to fill in on your own. The other part is an interview with you as a couple. The reason for this is to help understand how infertility affects you as an individual and as a couple.

I would like to start by having each of you fill out a questionnaire. The purpose of the questionnaire is to try to understand your individual thoughts about infertility, adoption and your relationship. Take as long as you would like to answer the questions.

(GIVE THEM THE QUESTIONNAIRES)

INSTRUCTIONS FOR THE QUESTIONNAIRE:

The first part of the study is the individual questionnaire which follows. In the questions where you must select from fixed categories, please indicate the option that best describes your experience by putting a check or an "x" beside the correct number. For example, 1 x Yes 2      No. When asked to "specify" please print your answer on the line provided. If for any reason you decide not to answer a question, then please put a line through that question.

1. How old were you at your last birthday?

     years old

2. How many times have you been married?

     times

3. What is the highest level of schooling that you have completed?

- 1      no formal education
- 2      some grade school
- 3      completed grade school
- 4      some academic high school
- 5      completed academic high school
- 6      some vocational high school
- 7      completed vocational high school
- 8      some community college
- 9      completed community college
- 10      some university
- 11      completed Bachelor's degree(s)
- 12      completed Master's degree(s)
- 13      completed Doctorate degree(s)
- 14      completed Professional degree(s)

4. What is your occupation? (For example, high school teacher, housewife or home-maker, salesperson, student at community college, part-time stenographer)

\_\_\_\_\_

5. What is your religion?

- 1      Catholic
- 2      Anglican
- 3      Presbyterian
- 4      United
- 5      Jewish
- 6      Moslem
- 7      None
- 8      Other

6. How often do you attend a church or synagogue?

- 1\_\_ more than once a week
- 2\_\_ once a week
- 3\_\_ 1-3 times a month
- 4\_\_ less than once a month
- 5\_\_ rarely
- 6\_\_ never

7. In what country were you born?

- 1\_\_ Canada
- 2\_\_ another country. Please specify \_\_\_\_\_.

8. What is your ethnic background?

\_\_\_\_\_

9. Are you adopted?

- 1\_\_ Yes
- 2\_\_ No

10. How many brothers and sisters do you have?

\_\_\_\_\_ brothers and sisters

11. Are any of your brothers or sisters adopted?

- 1\_\_ Yes
- 2\_\_ No

12. Which of the following is more important to you now?

- 1\_\_ having a family
- 2\_\_ both having a family and my work but having a family is more important
- 3\_\_ having a family and my work are equally important
- 4\_\_ both having a family and my work but my work is more important
- 5\_\_ my work

Opinion Questions

In the following questions, we are interested in your opinions about parenthood, having a fertility problem and adoption.

Beside each of the following statements presented below, please indicate by circling whether you:

SA - Strongly Agree  
 A - Agree  
 U - Undecided  
 D - Disagree  
 SD - Strongly Disagree

	<u>Strongly Agree</u>	<u>Agree</u>	<u>Undecided</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
13. I always wanted to have children.	SA	A	U	D	SD
14. Whatever children cost, they are worth it.	SA	A	U	D	SD
15. I could get as close to an adopted child as I could to a child of my own biological making.	SA	A	U	D	SD
16. A couple without children is just as much a family as a couple with children.	SA	A	U	D	SD
17. Adoption really seems like a last resort at this point in my life.	SA	A	U	D	SD
18. Children are not worth sacrificing work or career interests.	SA	A	U	D	SD
19. My friends expect that we will have children.	SA	A	U	D	SD
20. When it comes to personality, children are born in a certain way and there really isn't much you can do to change that.	SA	A	U	D	SD

Strongly Agree  
Agree  
Undecided  
Disagree  
Strongly Disagree

- |   |    |   |   |   |    |
|---|----|---|---|---|----|
| 21. I feel I am now ready to adopt a child.   | SA | A | U | D | SD |
| 22. My family expects that we will have children.   | SA | A | U | D | SD |
| 23. Children may tie you down, but they are worth it.   | SA | A | U | D | SD |
| 24. I feel comfortable when I think about the idea of bringing up a child that someone else gave birth to.        | SA | A | U | D | SD |
| 25. My life can be completely fulfilled without children.   | SA | A | U | D | SD |
| 26. When I think about having to adopt, I get worried.  | SA | A | U | D | SD |
| 27. Children make a lot of noise and tear up the house and these are major concerns in deciding to have children. | SA | A | U | D | SD |
| 28. There are a lot of pressures brought to bear on me to have children.  | SA | A | U | D | SD |
| 29. I would never be as happy with an adopted child as I would with my own biological child.                      | SA | A | U | D | SD |
| 30. We have discussed adoption and I know how my spouse feels about it.   | SA | A | U | D | SD |
| 31. I can feel fully like an adult without becoming a parent.   | SA | A | U | D | SD |



Strongly Agree  
 Agree  
 Undecided  
 Disagree  
 Strongly Disagree

---

- |  |    |   |   |   |    |
|--|----|---|---|---|----|
| 32. Spending time with my spouse and children would be less enjoyable than spending time alone with my spouse.                               | SA | A | U | D | SD |
| 33. When one adopts, there is a much greater likelihood of not liking the child than if one gives birth to a child.                          | SA | A | U | D | SD |
| 34. Being unable to parent because of infertility does not make me feel any less as a man or woman.  | SA | A | U | D | SD |
| 35. Adoption isn't something that one can prepare for.   | SA | A | U | D | SD |
| 36. I wouldn't mind doing the work taking care of a baby requires-feeding, changing diapers, giving them a bath, reading stories at bedtime. | SA | A | U | D | SD |
| 37. I am looking forward to adopting a child.  | SA | A | U | D | SD |
| 38. I really don't think that there is any difference between parenting an adopted child and parenting a child of my own biological making.  | SA | A | U | D | SD |

39. To what extent do you think that the following people understand your feelings about infertility?

	Understand completely	Reason- able under standing	Unsure	Poor under- standing	No under- standing
a) spouse	1__	2__	3__	4__	5__
b) parents	1__	2__	3__	4__	5__
c) friend(s)	1__	2__	3__	4__	5__
d) close relatives	1__	2__	3__	4__	5__
e) other (specify)					
_____	1__	2__	3__	4__	5__

40. To what extent do you think that the following people understand your feelings about adoption?

	Understand completely	Reason- able under standing	Unsure	Poor under- standing	No under- standing
a) spouse	1__	2__	3__	4__	5__
b) parents	1__	2__	3__	4__	5__
c) friend(s)	1__	2__	3__	4__	5__
d) close relatives	1__	2__	3__	4__	5__
e) other (specify)					
_____	1__	2__	3__	4__	5__

Marriage Questionnaire

The following questions are about your relationship with your spouse.

Most people have disagreements in their relationships. Please indicate below how much you agree or disagree with your partner for each item in the following list. Please put an "x" or a check on the category that best represents the extent of agreement.

	Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	_____	_____	_____	_____	_____	_____
2. Matters of recreation	_____	_____	_____	_____	_____	_____
3. Religious matters	_____	_____	_____	_____	_____	_____
4. Demonstration of affection	_____	_____	_____	_____	_____	_____
5. Friends	_____	_____	_____	_____	_____	_____
6. Sex relations	_____	_____	_____	_____	_____	_____
7. Conventionality (correct or proper behaviour)	_____	_____	_____	_____	_____	_____
8. Philosophy of life	_____	_____	_____	_____	_____	_____
9. Ways of dealing with parents or in-laws	_____	_____	_____	_____	_____	_____
10. Aims, goals and things believed important	_____	_____	_____	_____	_____	_____
11. Amount of time spent together	_____	_____	_____	_____	_____	_____
12. Making major decision	_____	_____	_____	_____	_____	_____
13. Household tasks	_____	_____	_____	_____	_____	_____
14. Leisure time, interests and activities	_____	_____	_____	_____	_____	_____
15. Career decisions	_____	_____	_____	_____	_____	_____

In the following questions, indicate with a check or an "x" how often you experience the following:

	All the time	Most of the time	More often than not	Occa- sionally	Rarely	Never
16. How often have you considered divorce, separation or terminating your relationship?	_____	_____	_____	_____	_____	_____
17. How often do you or your mate leave the house after a fight?	_____	_____	_____	_____	_____	_____
18. In general, how often do you think that things between you and your partner are going well?	_____	_____	_____	_____	_____	_____
19. Do you confide in your mate?	_____	_____	_____	_____	_____	_____
20. Do you ever regret that you married?	_____	_____	_____	_____	_____	_____
21. How often do you and your partner quarrel?	_____	_____	_____	_____	_____	_____
22. How often do you and your mate "get on each other's nerves?"	_____	_____	_____	_____	_____	_____

	Every Day	Almost Every Day	Occa- sionally	Rarely	Never
23. Do you kiss your mate?	_____	_____	_____	_____	_____

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	_____	_____	_____	_____	_____

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating ex- change of ideas	_____	_____	_____	_____	_____	_____
26. Laugh together	_____	_____	_____	_____	_____	_____
27. Calmly discuss something	_____	_____	_____	_____	_____	_____
28. Work together on a pro- ject	_____	_____	_____	_____	_____	_____

There are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no).

29.      Yes              No              Being too tired for sex.  
       \_\_\_\_\_        \_\_\_\_\_  
 30.      \_\_\_\_\_        \_\_\_\_\_        Not showing love

31. The dots on the following line represent different degrees of happiness in your relationship. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

*	*	*	*	*	*	*
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about your relationship?

\_\_\_\_\_ I want desperately for my relationship to succeed and would go to almost any length to see that it does.

\_\_\_\_\_ I want very much for my relationship to succeed, and will do all I can to see that it does.

\_\_\_\_\_ I want very much for my relationship to succeed, and will do my fair share to see that it does.

\_\_\_\_\_ It would be nice if my relationship succeeded, but I can't do much more than I am now doing to help it succeed.

\_\_\_\_\_ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

\_\_\_\_\_ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

WHEN YOU ARE FINISHED, PLEASE RETURN THE QUESTIONNAIRE AND WE WILL BEGIN THE INTERVIEW WHEN YOU ARE BOTH READY.

THANK YOU!

## APPENDIX J

## JOINT INTERVIEW

I hope that this interview can proceed much like a conversation with you. I am going to ask you questions and try to record as accurately as possible your answers. In a few instances, I will be able to check off an answer, as you did when you filled out the questionnaire, but most of the time I have to write your answers down. So if there is a pause in our discussion, it is because I am trying to write down something that you said.

The main purpose of the interview is to explore how you feel as a couple about fertility problems and adoption. Because the questions are directed to you as a couple, please feel free to discuss with each other your answers. Of course, it is not necessary for you to agree with each other in order to answer the question, but I am interested if you have different opinions on a question.

Some of the questions that I will ask you may be similar to questions asked in the questionnaire, but this will help me to have a more in-depth understanding of these issues.

You are free to refuse to answer any or all of the questions which will be put to you in this interview, if you feel that you may be uncomfortable or they intrude on your privacy. Also, you can stop the interview at any time for the same reasons.

All set?

Family Plans

First I would like to ask you some general questions about family plans.

1. How long have you been married?

\_\_\_\_\_ years

2 a) Before you were married, did you talk to each other about how many children you would like to have?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

W: \_\_\_\_\_

b) Did you agree on the size of the family that you would like?

1\_\_ Yes. Desired family size: \_\_\_\_\_  
 2\_\_ No.

Husband's desired size: \_\_\_\_\_

Wife's desired size: \_\_\_\_\_

c) Why did you think this was a desirable number?

H: \_\_\_\_\_

W: \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____



d) Back then, did you agree when you were going to start?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 W: \_\_\_\_\_  
 \_\_\_\_\_

#### Infertility Awareness

I would like to ask you now about when you first became aware that you might have a fertility problem.

3 a) Did either of you ever consider that you might not be able to have children before you actually started trying?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No (Go to Q. 4)	_____
_____	7. Refusal	_____
_____	8. Don't know/Can't remember	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 W: \_\_\_\_\_  
 \_\_\_\_\_

b) What made you consider that as a possibility?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

H

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Refusal  
8. Don't know  
9. Not applicable

W

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Back then, did you ever talk to each other about this possibility of not being able to conceive?

H

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Yes  
2. No  
7. Refusal  
8. Don't know  
9. Not applicable

W

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

4 a) How long were you married (ie in this marriage) before you first thought that you actually might have a fertility problem?

About \_\_\_\_\_ years after we were married.

b) What led you to think that you might not be able to conceive?

H: \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

c) What was your reaction when you first suspected that you might have a fertility problem?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

5. Once you suspected you had a fertility problem, how long did it take before either of you sought medical attention?

\_\_\_\_\_ months/years

6. In total then, how long has it been since you first suspected you had a fertility problem?

\_\_\_\_\_ months/years

7 a) Has a fertility problem been diagnosed?

<u>H</u>		<u>W</u>
___	1. Yes	___
___	2. No (Go to Q. 8)	___
___	3. Partial diagnosis	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

b) What is the problem that you have? (Check all that apply).

1\_\_\_ sperm problem

2\_\_\_ endometriosis

3\_\_\_ blocked tubes

4\_\_\_ hostile mucus

5\_\_\_ sperm antibodies

6\_\_\_ Other. Specify \_\_\_\_\_

7\_\_\_ Refusal

8\_\_\_ Don't know

9\_\_\_ Not applicable

c) Do you know who the problem is with?

<u>H</u>		<u>W</u>
___	1. Husband	___
___	2. Wife	___
___	3. Both	___
___	4. Uncertain	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

8. Are there other tests you expect to have in the future?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

9. Do you think of the fertility testing and treatment coming to an end?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

10a) At this time, how optimistic are you about your chances of having a biological child of your own? (Show card)

<u>H</u>		<u>W</u>
_____	1. Very pessimistic	_____
_____	2. Somewhat pessimistic	_____
_____	3. Neither optimistic or pessimistic	_____
_____	4. Somewhat optimistic	_____
_____	5. Very optimistic	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

b) Why do you feel that way?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

11. All things considered, what impact has having a fertility problem had on your lives up until this point?

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

12. At this point in your lives, what do you find is the most frustrating thing about having a fertility problem?

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

13. Has having a fertility problem had an effect on the extent to which you feel like you have control over your life?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

Attitudes towards Children

Now I would like to ask you some general questions about your attitudes towards children.

14. What do you see as the reasons why you want children?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

15. Have these reasons changed at all over time?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



16. Would you say that the desire to be a parent is stronger for one of you?

<u>H</u>		<u>W</u>
_____	1. Yes, for husband	_____
_____	2. Yes, for wife	_____
_____	3. No (equal desire)	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 17a) Some people say that having a biological tie to a child is important whereas others say that it is not very important to them. How important would you say this is to you? (Show card).

<u>H</u>		<u>W</u>
_____	1. extremely important	_____
_____	2. somewhat important	_____
_____	3. mixed feelings	_____
_____	4. of little importance	_____
_____	5. not important at all	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

b) Do you think that there are advantages to having a biological child in comparison to an adopted child?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c) Has having a fertility problem changed your views on having a biological child?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d) Would you say that having a biological child is more important to one or the other of you?

<u>H</u>		<u>W</u>
___	1. Yes	___
___	2. No	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

18a) In the total picture of trying to have children, how important is the experience of pregnancy and the birth process in comparison to adoption? (Show card).

<u>H</u>		<u>W</u>
___	1. much more important	___
___	2. somewhat more important	___
___	3. equally important	___
___	4. somewhat less important	___
___	5. much less important	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

b) Would you elaborate on why you think it is more, less or equally important?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

- 19a) Since discovering that you have a fertility problem, has parenthood become more or less important to you as a couple? (Show card)

<u>H</u>		<u>W</u>
_____	1. much more important	_____
_____	2. somewhat more important	_____
_____	3. feelings unchanged (Go to Q. 20)	_____
_____	4. somewhat less important	_____
_____	5. much less important	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

- b) Would you explain why parenthood has become more or less important to you as a couple?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

20. Are there certain people outside of your relationship who have an effect on your feelings about how important it is to be a parent?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_

Infertility - Reference Group

Now I would like to ask you a few questions about how your friends, family and others whom you know or with whom you associate relate to your fertility problem.

21a) Do either of you have a friend, acquaintance or family member who has a fertility problem?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

b) Has this had an effect on you?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

22a) Who have you told about your fertility problem? (Check all that apply).

<u>H</u>		<u>W</u>
___	01. Parents	___
___	02. Siblings	___
___	03. Close friend	___
___	04. Work associate	___
___	05. Acquaintance	___
___	06. Neighbours	___
___	07. Helping professional	___
___	08. Stranger	___
___	09. Other. Specify.	___
_____		
___	10. None of the above (If both none, go to Q. 23)	___
___	77. Refusal	___
___	88. Don't know	___
___	99. Not applicable	___

b) In total, approximately how many people have you both told about your fertility problem?

\_\_\_\_\_ people

c) How have you typically gone about telling these people?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

d) How have these people typically responded when you told them?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

23. Are there any situations that you can recall where you felt your feelings about your fertility problem were not understood by the people who were there?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

24. Are there some people from whom you purposely conceal your fertility problem?

<u>H</u>		<u>W</u>
_____	01. Parents	_____
_____	02. Siblings	_____
_____	03. Close friend	_____
_____	04. Work associate	_____
_____	05. Acquaintance	_____
_____	06. Neighbours	_____
_____	07. Helping professional	_____
_____	08. Stranger	_____
_____	09. Other. Specify.	_____
_____	10. None of the above	_____
_____	77. Refusal	_____
_____	88. Don't know	_____
_____	99. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

#### Attitudes towards Adoption

Now I would like to ask a few questions about your attitudes and feelings towards adoption. Some of these questions you may have considered and others you may not have but I would like to get your response to them anyway.

FOR GROUP I & II ONLY (GROUPS III AND IV SKIP TO Q. 26)

25. Have you ever talked about adoption with each other?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No (Go to Q. 27)	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_



26. At what point in the fertility investigation did adoption first come up?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

b) Over the past six months, about how often have you talked about adoption with each other? (Show card)

<u>H</u>		<u>W</u>
_____	1. Daily	_____
_____	2. Once a week	_____
_____	3. 2 or 3X/month	_____
_____	4. Once a month	_____
_____	5. Less than once a month	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

c) When you talk about adoption with each other, who usually brings it up?

<u>H</u>		<u>W</u>
_____	1. Husband	_____
_____	2. Wife	_____
_____	3. Both equally	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

27a) Do you consider adoption to be a serious option for yourselves at this point in time?

<u>H</u>		<u>W</u>
—	1. Yes	—
—	2. No (Go to Q.28)	—
—	7. Refusal	—
—	8. Don't know	—
—	9. Not applicable	—

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

b) What has led you to consider adoption as a serious option for yourselves?

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
—	7. Refusal	—
—	8. Don't know	—
—	9. Not applicable	—

FOR GROUP I & II ONLY (GROUPS III AND IV SKIP TO Q. 29)

28a) Did you ever consider putting your name on an adoption waiting list?

- 1\_\_ Yes considered and are on the list (Go to Q. 29)  
 2\_\_ Yes, have considered but not on list  
 3\_\_ No, have not considered it

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

b) Is there a reason why you have chosen not to put your name on the adoption waiting list?

<u>H</u>		<u>W</u>
___	1. Yes (Go to Q. 31)	___
___	2. No (Go to Q. 31)	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

Elaborate:

H: \_\_\_\_\_

W: \_\_\_\_\_

ONLY COUPLES WITH NAME ON ADOPTION WAITING LIST

29. How did you come to a decision to put your name on the adoption waiting list?

H: \_\_\_\_\_

W: \_\_\_\_\_

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

## ONLY COUPLES WITH NAME ON ADOPTION WAITING LIST

30. How has your involvement with the agency so far affected your feelings about adoption?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

31. If a healthy normal infant were available right now, do you think that you would be ready to adopt?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

32a) Have you ever been foster parents as a couple?

1 \_\_\_\_\_ Yes  
2 \_\_\_\_\_ No (Go to Q. 33)

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

b) Has this affected your feelings towards adoption?

<u>H</u>		<u>W</u>
—	1. Yes	—
—	2. No	—
—	7. Refusal	—
—	8. Don't know	—
—	9. Not applicable	—

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

33. Are there certain signs that a person can look for to tell them that they are ready to adopt?

<u>H</u>		<u>W</u>
—	1. Yes	—
—	2. No	—
—	7. Refusal	—
—	8. Don't know	—
—	9. Not applicable	—

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

34a) What do you think is expected in the home study in terms of demonstrating that a couple is eligible to be a parent?

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

b) Do you think that you meet these criteria?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

35. Would you say that you both have the same feelings about adoption?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

36. At this point in time, would you say that adoption is more important to one of you? (If yes, which one?)

<u>H</u>		<u>W</u>
_____	1. Yes, for husband	_____
_____	2. Yes, for wife	_____
_____	3. No (equally imp)	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

37. Do you actively seek out information on adoption?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
	(Check those which apply)	
	_____ Friends	
	_____ Family	
	_____ Books	
	_____ Magazines	
	_____ News media	
	_____ Professionals (doctor, social worker)	
	_____ Support group	
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

38. If you were to put your finger on one concern that you have about adoption, what would that be?

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____



39a) Do you think it would feel different being an adoptive parent in comparison to being a biological parent?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	3. Sometimes	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) Are there some satisfactions that biological parents have that adoptive parents don't have?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c) Are there advantages to being an adoptive parent?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

d) Are there disadvantages to being an adoptive parent?

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

Adoption and Reference Group

Now I would like to ask you a few questions about adoption with reference to the experiences of the people that you are usually in contact with.

40a) In the following groups of people, do you know any who are adopted? (Check those that apply)

<u>H</u>		<u>W</u>
<input type="checkbox"/>	01. Parents	<input type="checkbox"/>
<input type="checkbox"/>	02. Siblings	<input type="checkbox"/>
<input type="checkbox"/>	03. Close friend	<input type="checkbox"/>
<input type="checkbox"/>	04. Work associate	<input type="checkbox"/>
<input type="checkbox"/>	05. Acquaintance	<input type="checkbox"/>
<input type="checkbox"/>	06. Neighbours	<input type="checkbox"/>
<input type="checkbox"/>	07. Other. Specify.	<input type="checkbox"/>
-----		
<input type="checkbox"/>	08. None of the above	<input type="checkbox"/>
<input type="checkbox"/>	77. Refusal	<input type="checkbox"/>
<input type="checkbox"/>	88. Don't know	<input type="checkbox"/>
<input type="checkbox"/>	99. Not applicable	<input type="checkbox"/>

b) In the following groups of people, do you know any who have adopted children? (Check those that apply)

<u>H</u>		<u>W</u>
<input type="checkbox"/>	01. Parents	<input type="checkbox"/>
<input type="checkbox"/>	02. Siblings	<input type="checkbox"/>
<input type="checkbox"/>	03. Close friend	<input type="checkbox"/>
<input type="checkbox"/>	04. Work associate	<input type="checkbox"/>
<input type="checkbox"/>	05. Acquaintance	<input type="checkbox"/>
<input type="checkbox"/>	06. Neighbours	<input type="checkbox"/>
<input type="checkbox"/>	07. Other. Specify.	<input type="checkbox"/>
-----		
<input type="checkbox"/>	08. None of the above	<input type="checkbox"/>
<input type="checkbox"/>	77. Refusal	<input type="checkbox"/>
<input type="checkbox"/>	88. Don't know	<input type="checkbox"/>
<input type="checkbox"/>	99. Not applicable	<input type="checkbox"/>

ANSWER ONLY IF EITHER SPOUSE KNOWS ANYONE WHO IS OR HAS ADOPTED  
 c) Has knowledge of these adoptions affected your feelings  
 about the possibility of adopting a child for yourselves?

<u>H</u>		<u>W</u>
___	1. Yes	___
___	2. No	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 W: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ANSWER ONLY IF CONSIDERING ADOPTION (IE. IF YES TO Q.27)  
 41. Are there certain people who play an important role in  
 considering adoption for yourselves? (If yes, who?)

<u>H</u>		<u>W</u>
___	1. Yes	___
___	2. No	___
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

Elaborate:

H: \_\_\_\_\_  
 \_\_\_\_\_  
 W: \_\_\_\_\_  
 \_\_\_\_\_

ANSWER ONLY IF CONSIDERING ADOPTION (IE. IF YES TO Q.27)

42a) Have you told anyone about the possibility that you might adopt?

<u>H</u>		<u>W</u>
___	01. Parents	___
___	02. Siblings	___
___	03. Close friend	___
___	04. Work associate	___
___	05. Acquaintance	___
___	06. Neighbours	___
___	07. Professional	___
___	08. Other. Specify.	___
_____		
___	09. None of the above (Go to Q.43)	___
___	77. Refusal	___
___	88. Don't know	___
___	99. Not applicable	___

b) How did you go about telling them that you are considering adoption?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

c) How did they react when you told them that you were thinking of adopting?

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

<u>H</u>		<u>W</u>
___	7. Refusal	___
___	8. Don't know	___
___	9. Not applicable	___

43. Do you encounter situations where adoption is brought up as a topic of conversation? (If yes, please explain.)

<u>H</u>		<u>W</u>
_____	1. Yes	_____
_____	2. No	_____
_____	7. Refusal	_____
_____	8. Don't know	_____
_____	9. Not applicable	_____

Elaborate:

H: \_\_\_\_\_

\_\_\_\_\_

W: \_\_\_\_\_

\_\_\_\_\_

44. This study is about how infertile couples ready themselves for adoption because they can't have their own children. Is there anything else that you think is worth mentioning in this process that we haven't already talked about?

H: \_\_\_\_\_

\_\_\_\_\_


W: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REFERENCES

## REFERENCES

- Adler, J.D. 1982. Psychological Reactions to Infertility: Sex Roles and Coping Styles. Ph.D. Thesis, California School of Professional Psychology.
- Alexander, C.N. & Wiley, M.G. 1981. Situated activity and identity formation. In M. Rosenberg & R.H. Turner (Eds.) Social Psychology: Sociological Perspectives. New York: Basic Books, Inc.
- Allen, G. 1980. A note on interviewing spouses together. Journal of Marriage and the Family. 42:205-210.
- Allison, J.R. 1976. Infertility and Role Conflict: A Phenomenological Study of Women. Ph.D. thesis, California School of Professional Psychology.
- \_\_\_\_\_. 1979. Roles and role conflict of women in infertile groups. Psychology of Women Quarterly. 4:97-113.
- Andrews, R. G. 1970. Adoption and the resolution of infertility. Fertility and Sterility. 21:73-76.
- Aral, S.O. and Cates, W. 1983. The increasing concern with infertility. Why now? Journal of the American medical Association. 250:2327-2331.
- Arasteh, J.D. 1971. Parenthood: Some antecedents and consequences: A preliminary survey of the mental health literature. The Journal of Genetic Psychology. 118:179-202.
- Bachrach, C.A. 1983. Adoption as a means of family formation: Data from the national survey of family growth. Journal of Marriage and the Family. 45:859-865. 
- Ball, D.W. 1972. The 'family' as a sociological problem: Conceptualization of the taken-for-granted as prologue to social problems analysis. Social Problems. 19:295-307.



- Banks, A. 1962. Does adoption affect infertility? Fertility and Sterility. 7:23-28.
- Bankston, W.B., Forsyth, C.J. and Floyd Jr., H.H. 1981. Toward a general model of the process of radical conversion: An interactionist perspective on the transformation of self-identity. Qualitative Sociology. 44:279-297.
- Bardwick, J.M. 1974. Evolution and parenting. The Journal of Social Issues. 30:39-62.
- Barker, G.H. 1981. Your Search for Fertility: A Sympathetic Guide to Achieving Pregnancy for Childless Couples New York: William Morrow and Co.
- Becker, H.S. Sociological Work: Method and Substance. Chicago: Aldine Publishing Company, 1970.
- \_\_\_\_\_. 1981. Personal change in adult life. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons. 307-316.
- Becker, H.S. & Strauss, A.L. 1956. Careers, personality and adult socialization. American Journal of Sociology. 62:253-63.
- Behrman, S.J. and Kistner, R.W. (Eds.) 1968. Progress in Infertility. Boston: Little, Brown & Co.
- Bell, C. and Newby, H. 1976. Husbands and wives. In D.L. Barker and S. Allen (Eds.) Dependence and Exploitation in Work and Marriage. London: Longman.
- Bell, J.C. 1981. Psychological problems among patients attending an infertility clinic. Journal of Psychosomatic Research. 25:1-3.
- Benedek, T. 1970. The psychobiologic approach to parenthood. In E.J. Anthony and T. Benedek (Eds.) Parenthood: Its Psychology and Psychopathology. Boston: Little, Brown and Co., 109-208.
- Berardo, F. M., R. Hill, T.L. Fox, J.P. Wiseman and J. Aldous. 1981. A prescriptive analysis for the family field in the 1980's. Journal of Marriage and the Family. 43:249-270.

- Berger, D.M. 1977. The role of a psychiatrist in a reproductive biology clinic. Fertility and Sterility. 28:141-145.
- \_\_\_\_\_. 1980. Infertility: A psychiatrist's perspective. Canadian Journal of Psychiatry. 25:553-558.
- \_\_\_\_\_. 1980. Couples' reactions to male infertility and donor insemination. American journal of Psychiatry. 137:1047-1049.
- Berger, P.L. and Kellner, H. 1970. Marriage and the construction of reality. In H. P. Dreitzel (Ed.) Recent Sociology No.2 New York: The Macmillan Company.
- Berger, P.L. & Luckmann, T. 1966. The Social Construction of Reality. New York: Doubleday and Co., Inc.
- Berk, A. and Shapiro, J.L. 1984. Some implications of infertility on marital therapy. Family Therapy. 11:37-47.
- Berko, S. 1937. Childlessness: A Study of Sterility, Its Causes and Treatment. New York: Lee Furman.
- Bernard, J. 1982. The Future of Marriage. New Haven: Yale University Press.
- Bernstein, J. and Mattox, J.H. 1982. An overview of infertility. JOGN Nursing. Sept/Oct:309-314.
- Bierkens, B.P. 1975. Childlessness from a psychological point of view. Bulletin of the Menninger Clinic. 39:177-182.
- Blais, M. 1979. They Say You Can't Have a Baby: The Dilemma of Infertility. New York: W.W. Norton and Co.
- Blake, J. 1973. Is zero preferred? American attitudes towards childlessness in the 1970's. Journal of Marriage and the Family. 41:245-257.
- \_\_\_\_\_. 1974. Coercive pronatalism and American population policy. In R.L. Coser (Ed.) The Family: Its Structure and Functions. New York: St. Martins.
- Blum, A.F. & McHugh, P. 1971. The social ascription of motives. American Sociological Review. 26:98-109.

- Blumer, H. 1969. Symbolic Interactionism: Perspective and Method. Englewood Cliffs N.J.: Prentice-Hall Inc.
- Bogdan, R. 1972. Participant Observation in Organizational Settings. Syracuse: Syracuse University Press.
- Bohman, Michael. 1970. Adopted Children and Their Families. Stockholm: Proprius.
- Bonham, G.S. 1977. Who adopts: The relationship of adoption and social demographic characteristics of women. Journal of Marriage and the Family. 39:295-306.
- Bott, E. 1957. Family and Social Network. London: Tavistock.
- Braden, J.A. 1970. Adoption in a changing world. Social Casework. October:486-490.
- Bradley, Trudy. 1966. An exploration of caseworkers' perceptions of adoptive applicants. Child Welfare 45:433-443.
- \_\_\_\_\_. 1967. An Exploration of Caseworker's Perceptions of Adoptive Applicants. New York: Child Welfare League of America.
- Bram, S. 1978. Through the looking glass: Voluntary childlessness as a mirror of contemporary changes in the meaning of parenthood. In W.B. Miller and L.F. Newman (Eds.) The First Child and Family Formation. Chapel Hill, North Carolina: Caroline Population Center, 368-391.
- Brennan, W.C. 1977. An Investigation of Psychological Symptom Distress Levels of Childless Couples Choosing Adoption. Ph.D. The State University of New Jersey.
- Bresnick, E.R. 1981. A holistic approach to the treatment of the crisis of infertility. Journal of Marriage and Family Therapy. 7:181-188.
- Bresnick, E. and Taymor, M.L. 1979. The role of counselling in infertility. Fertility and Sterility. 32:154-156.
- Brieland, D. 1984. Selection of adoptive parents. In P. Sachdev (Ed.) Adoption: Current Issues and Trends. Toronto: Butterworths. 65-86.

- Brown, E.D. and Brieland, D. 1975. Adoptive screening: new data, new dilemmas. Social Work. 291-295.
- Burgess, L.C. 1976. The Art of Adoption. Washington: Acropolis Books.
- Burgwyn, D. 1981. Marriage Without Children. New York: Harper & Row.
- Bush, D.M. & Simmons, R.G. 1981. Socialization processes over the life course. In M. Rosenberg & R.H. Turner (Eds.), Social Psychology: Sociological Perspectives. New York: Basic Books Inc. 133-164.
- Calhoun, L.G. and Selby, J.W. 1980. Voluntary childlessness, involuntary childlessness and having children: A study of social perceptions. Family Relations. 29:181-183.
- Carr, G.D. 1963. A Psychosocial Study of Fertile and Infertile Marriages, Ph.D. Thesis, U. of Southern California.
- Carrol, J.F.X. 1968. The Acceptance or Rejection of Differences Between Adoptive and Biological Parenthood By Adoptive Applicants as Related to Various Indices of Adjustment/Maladjustment. Ph.D., Temple University.
- Castle, R.E. 1982. When adoption fails. Royal Society of Health Journal. 102:9-10.
- Chester, R. 1972. Is there a relationship between childlessness and marriage breakdown? Journal of Biosocial Science. 4:443-454.
- Child Welfare League of America. 1968. Standards for Adoption Practice. New York: Child Welfare League of America.
- Child Welfare League of America. 1978. Standards for Adoption Service. Revised Edition. New York: Child Welfare League of America.
- Cicourel, A.V. 1964. Method and Measurement in Sociology. London: Collier-MacMillan Limited.
- \_\_\_\_\_. 1967. Fertility, family planning and the social organization of family life: Some methodological issues. Journal of Social Issues. 23:57-81.

- Collins, J. 1986. Unpublished statistics. McMaster University Medical Center, McMaster University, Hamilton, Ontario.
- Contemporary Obstetrics/Gynecology. 1980. What you should know about infertility. 15:101-105.
- Cooke, I.D., Sulaiman, R.A., Lenton, E.A., and Parsons, R.J. 1981. Fertility and infertility statistics: Their importance and application. Clinics in Obstetrics and Gynecology. 8:531-548.
- Cooper, P.E., Cumber, B. and Hartner, R. 1978. Decision making patterns and postdecision adjustment of childfree husbands and wives. Alternative Lifestyles. 1:71-94.
- Cottrell, L.S., Jr. 1937. Research in causes of variations in fertility - social psychological aspects. American Sociological Review. 2:678-85.
- Davis, N.J. 1978. The Political Economy of Reproduction: An Analysis of Childlessness and Single-child Fertility Among U.S. Women. Ph.D. thesis, The University of Wisconsin-Madison.
- Davis, R.M. and Bouck, P. 1955. Crucial importance of the adoption home study. Child Welfare. 34:20-21.
- Decker, A. 1972. Psychogenic infertility: Fact or Fiction? Medical Aspects of Human Sexuality. 6:168-175.
- Dennison, Charles. 1940. Parenthood attitudes of college men. Eugenic News. 25:65-69.
- Denzin, N.K. 1978. The research act. In J.G. Manis & B.N. Meltzer (Eds.), Symbolic Interaction: A Reader in Social Psychology. Boston: Allyn and Bacon, Inc.
- Dukette, R. 1984. Value issues in present day adoption. Child Welfare. 63:233-243.
- Eisner, B.G. 1967. Some psychological differences between fertile and infertile women. Journal of Clinical Psychology. 19:391-395.
- Epenshade, T.J. 1977. The value and cost of children. Population Bulliten. 32:1-47.

- Farber, B. 1970. Studying family and kinship. In R.W. Habenstein (Ed.) Pathways to Data. Chicago: Aldine Publishing Company.
- Filstead, W.J. 1970. Qualitative Methodology: Firsthand Involvement with the Social World. Chicago: Rand McNally College Publishing Co..
- Fleming, M., McGowan, B. and Costos, D. 1985. The dyadic adjustment of female to male transexuals. Archives of Sexual Behavior. 14:47-55.
- Foote, N. 1981. Identification as the basis for a theory of motivation. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons.
- Freeman, E.W., Garcia, C.R. and Rickels, K. 1983. Behavioral and emotional factors: Comparisons of annovulatroy infertile women with fertile and other infertile women. Fertility and Sterility. 40:195-201.
- Freshnock, L. and Cutright, P. 1978. Structural determinants of childlessness: A nonrecursive analysis of 1970 U.S. rates. Social Biology. 25:169-178.
- Gallagher, U.M. 1975. Whats happening in adoption? Children Today. 4:11-13, 36.
- Gecas, V. 1981. Contexts of socialization. In M. Rosenberg and R.H. Turner (Eds.), Social Psychology: Sociological Perspectives. New York: Basic Books, Inc. 165-199.
- Gelles, R.J. 1978. Methods for studying sensitive family topics. American Journal of Orthopsychiatry. 48:408-424.
- Gibson, C. 1980. Childlessness and marital instability: A re-examination of the evidence. Journal of Biosocial Science. 12:121-132.
- Giele-Zwier, T. 1971. Onvruchtbaarheid en huwelijksatisfactie. NISSO Report. Zeist: Netherlands Institue for Socio-Sexological Research.
- Glaser, B. & Strauss, A.L. 1967. The Discovery of Grounded Theory: Strategies for Qualitative Research. New York: Aldine Publishing Company.

- Glaser, B. & Strauss, A.L. 1971. Status Passage. Chicago: Aldine.
- Glaser, B. & Strauss, A.L. 1981. Awareness contexts and social interaction. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons.
- Glick, P. C. 1977. Updating the life cycle of the family. Journal of Marriage and the Family. 39: 5-13.
- Gochros, H. 1967. Not parents yet: A study of the post-placement period in adoption. Child Welfare. 46:317-349.
- Goffman, E. 1952. On cooling the mark out: Some aspects of adaptation to failure. Psychiatry. 15:451-463.
- \_\_\_\_\_. 1959. The Presentation of Self in Everyday Life. New York: Doubleday & Company, Inc.
- \_\_\_\_\_. 1961. Encounters. Indianapolis: Bobbs-Merrill Educational Publishing.
- \_\_\_\_\_. 1963. Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, N.J.: Prentice-Hall.
- Goodacre, I. 1966. Adoption Policy and Practice. London: George Allen and Unwin Ltd.
- Goodman, K. and Rothman, B. 1984. Group work in infertility treatment. Social Work With Groups. 7:79-97.
- Greenbaum, H. 1973. Marriage, family and parenthood. American Journal of Psychiatry. 130:1262-1265.
- Griffith, J. 1973. Social pressure on family size intentions. Family Planning Perspectives. 5:237-242.
- Griffith, M.E. 1983. Resolving infertility: An emotional crisis. AORN Journal. 38:597-601.
- Grindstaff, C.F. 1975. The baby bust: Changes in Fertility Patterns in Canada. Canadian Studies in Population. 2:15-21.
- Grindstaff, C.F., Balarkrishnan, T.R. and Ebanks, G.E. 1981. Socio-demographic correlates of childlessness: An analysis of the 1971 Canadian census. Canadian Journal of Sociology. 6:337-351.

- Hastings, D.W. and Robinson, J.G. 1974. Incidence of childlessness for U.S. women, cohorts born 1891-1945. Social Biology. 21:178-184.
- Helperin, V.S. 1977. An Investigation of the Attitudes of Adoptive Parents Toward Childrearing Comparing Infertile Adoptive Parents with fertile Adoptive Parents. Ph.D. thesis, United States International University.
- Hepworth, H.P. 1980. Foster Care and Adoption in Canada. Ottawa: Canadian Council on Social Development.
- Hertz, D.G. 1982. Infertility and the physician-patient relationship: A biopsychosocial challenge. General Hospital Psychiatry. 4:95-101.
- Hill, R. and Aldous, J. 1969. Socialization for marriage and parenthood. In D.A. Goslin (Ed.) Handbook of Socialization Theory and Research. Chicago: Rand-McNally, 885-950.
- Hill, W. and J. Scanzoni. 1982. An approach for assessing marital decision-making processes. Journal of Marriage and the Family. 44:927-941.
- Hobbs, D.F., Jr. 1968. Transition to parenthood: A replication and an extension. Marriage and the Family. 30:413-417.
- Hoffman, L.W. and Manis, J.D. 1979. The value of children in the U.S.: A new approach to the study of fertility. Journal of Marriage and the Family. 41:583-596.
- Hollingworth, L.S. 1916. Social devices for impelling women to bear and rear children. American Journal of Sociology. 19-29.
- Homans, G.C. 1961. Social Behavior: Its Elementary Forms. New York: Harcourt, Brace & World, Inc.
- Houseknecht, S.K. 1977. Reference group support for voluntary childlessness: evidence for conformity. Journal of Marriage and the Family. 39:285-294.
- \_\_\_\_\_. 1978. Voluntary childlessness: A social psychological model. Alternative Lifestyles. 1:379-402.



- \_\_\_\_\_. 1979. Childlessness and marital adjustment. Journal of Marriage and the Family. 41:259.
- Hughes, E. 1937. Institutional office and the person. American Journal of Sociology. 43:404-413.
- Humphrey, M. 1969a. The Hostage Seekers: A Study of Childless and Adopting Couples. London: Longmans.
- \_\_\_\_\_. 1969b. The enigma of childlessness. New Society. 13:399-402.
- \_\_\_\_\_. 1975. The effect of children on the marriage relationship. British Journal of Medical Psychology. 48:273-279.
- \_\_\_\_\_. 1977. Sex differences in attitudes to parenthood. Human Relations. 30:737-750.
- Humphrey, M. and MacKenzie, K.M. 1967. Infertility and adoption: Follow-up of 216 couples attending a hospital clinic. British Journal of Preventive and Social Medicine. 21:90-96.
- Hunter, A. 1985. Doing it with numbers. The Canadian Review of Sociology and Anthropology. 22:645-672.
- Jacobs, L.J.W. 1975. Family Problems of Childless Adopting Couples Concerned with their Role as Parents. Ph.D. Thesis, United States International University.
- Jacoby, A.P. 1969. Transition to parenthood: A reassessment. Journal of Marriage and the Family. 31:720-727.
- James, W.H. 1981. Has fecundability been declining in recent years in developed countries? Journal of Biosocial Science. 13:419-424.
- Joe, Barbara. 1979. Public Policies Toward Adoption. Washington: The Urban Institute.
- Kadushin, A. and Seidl, F.W. 1971. Adoption failure: A social work postmortem. Social Work. 16:32-38
- Karrow, A.M. 1982. Infertility as a social problem. Fertility and Sterility. 38:392-393.

- Katz, S.N. 1964. Community decision makers and the propmotion of values in the adoption of children. Social Service Review. 38:26-41.
- Kaufman, S. 1970. New Hope for Childless Couples. New York: Simon and Schuster.
- Kaufman, S.A. 1969. The impact of infertility on the marital and sexual relationship. Fertility and Sterility. 20:380-383.
- Kellmer Pringle, M.L. 1967. Adoption - Facts and Fallacies. A Review of Research in the United States, Canada and Great Britain between 1948 and 1965. London: Longmans.
- Kent, K.G. and Richie, J.L. 1976. Adoption as an issue in casework with adoptive parents. Journal of the American Academy of Child Psychiatry. 15:510-522.
- Kirk, H. D. 1963. Nonfecund people as parents - some social and psychological considerations. Sterility and Fertility. 14:310-319.
- \_\_\_\_\_. 1964. Shared Fate. New York: The Free Press.
- \_\_\_\_\_. 1981. Adoptive Kinship. Toronto: Butterworths.
- \_\_\_\_\_. 1984. Shared Fate. Revised Edition. Port Angeles, Washington: Ben-Simon Publications.
- Kiser, C.V. 1939. Voluntary and involuntary aspects of childlessness. Millbank Memorial Fund Quarterly. 17:50-68.
- Kistner, R.W. 1973. The infertile woman. American Journal of Nursing. 11.
- Kraft, A.D., Palombo, J., Mitchell, D., Dean, C., Meyers, S., Schmidt, A.W. 1980. The psychological dimensions of infertility. The American Journal of Orthopsychiatry. 50:618-628.
- Krugman, D.C. 1967. Differences in the relation of parents and children to adoption. Cild Welfare. 46(5):267-271.
- Kuczynski, R.R. 1938. Childless marriages. Sociological Review. 30:120-144; 213-35; 346-64.

- Kuhn, M.H. 1964. The reference group reconsidered. Sociological Quarterly. 5:5-21.
- Kunz, P.R., Brinkerhoff, M. and Hundley, V. 1973. Relationship of income and childlessness. Social Biology. 20:139-142.
- Ladewig, B.H. and White, P.N. 1984. Dual earner marriages: The family social environment and dyadic adjustment. Journal of Family Issues. 5:343-362.
- Lamanna, M.A. 1977. The Value of Children to Natural and Adoptive Parents. Ph.D. thesis, University of Notre Dame.
- LaRossa, R., Bennet, L.A., Gelles, R.J. 1981. Ethical dilemmas in qualitative research. Journal of Marriage and the Family. 43:303-314.
- LaRossa, R. and M. LaRossa. 1981. The Transition to Parenthood. Beverly Hills: Sage Publications.
- Larson, L.E. 1974. System and subsystem perception of family roles. Journal of Marriage and the Family. 36.
- Laslett, B. & Rapoport, R. 1975. Collaborative interviewing and interactive research. Journal of Marriage and the Family. 37:968-977.
- Laucks, E.C. 1981. The Meaning of Children. Boulder, Col.: Westview Press.
- Laurence, J. 1982. The moral pressure to have children. New Society. 5:216-218.
- Lawder, E.A., Lower, K.D, Andrews, R.G., Sherman, E. A. & Hill, J.G. 1969. A Follow-up Study of Adoptions. Vol.1, New York: Child Welfare League of America.
- LeMasters, E.E. 1957. Parenthood as crisis. Marriage and Family Living. 19:352-355.
- Lenton, E.A., Weston, G.A. and Cooke, I. 1977. Long-term follow-up of the apparently normal couple with a complaint of infertility. Fertility and Sterility. 28:913-919.
- Lifton, B.J. 1982. Lost and Found: The Adoptive Experience. New York: Dial Press.

- Lindholm, B.W. and Touliatos, J. 1976. A factor analytic study of motivation and potential for adoptive parenthood. Psychological Reports. 39:751-755.
- Loether, H.J. and McTavish, D.G. 1974. Descriptive Statistics for Sociologists. Boston: Allyn and Bacon, Inc.
- Lopata, H.Z. 1980. Interviewing American widows. In W.B. Shaffir, R.A. Stebbins and A. Turowetz (Eds.) Fieldwork Experience: Qualitative Approaches to Social Research. New York: St. Martin's Press.
- Luckmann, T. 1978. Phenomenology and Sociology. Markham, Ont.: Penguin Books.
- Maas, H.S. 1960. The successful adoptive parent applicant. Social Work. 5:14-20.
- Magarick, R.H. 1976. Social and Emotional Aspects of Voluntary Childlessness in Vasectomized Childless Men. Ph.D. dissertation. The University of Maryland, Maryland.
- Mai, F. M., Munbday, R.N. and Rump, E.E. 1972. Psychiatric comparisons between infertile and fertile couples. Psychosomatic Medicine. 34:431-440.
- Marcianno, T.D. 1978. Male pressure in the decision to remain childfree. Alternative Lifestyles. 1:95-112.
- Marshal, Rose. 1967. Psychological Aspects of Infertility in Marital Pairs: A Comparative Study. Ph.D. thesis, Columbia University.
- Martin Matthews, A. and R. Matthews. 1986. Beyond the mechanics of infertility: Perspectives on the social psychology of infertility and involuntary childlessness. Family Relations 35:479-488.
- Matthews, R. and A. Martin Matthews. 1986. Infertility and involuntary childlessness: The transition to non-parenthood. Journal of Marriage and the Family 48:641-650.
- Mazor, M. 1979. Barren couples. Psychology Today. May:101-112.
- McCall, G.J. & Simmons, J.L. 1978. Identities and Interactions. New York: The Free Press.

- McCormick, T.M. 1980. Out of control: One aspect of infertility. JOGN Nursing. 9:205-206.
- McFalls, J.A. 1979a. Psychopathology and Subfecundity. New York: Academic Press.
- \_\_\_\_\_. 1979b. Frustrated fertility: A population paradox. Population Bulletin. 34:1-44.
- McHugh, P. 1968. Defining the Situation. Indianapolis: Bobbs-Merrill Company, Inc.
- McNamara, Joan. 1975. The Adoption Advisor. New York: Hawthorn.
- Mead, G.H. 1934. Mind, Self and Society. Chicago: The University of Chicago Press.
- \_\_\_\_\_. 1938. The Philosophy of the Act. Chicago: The University of Chicago Press.
- Menning, B.E. 1975. The infertile couple: A plea for advocacy. Child Welfare. 56:454-460.
- \_\_\_\_\_. 1977. Infertility: A Guide for the Childless Couple. Englewood Cliffs, N.J.: Prentice-Hall.
- \_\_\_\_\_. 1980. The emotional needs of infertile couples. Fertility and Sterility. 34:313-319.
- Miall, C. 1984. Women and Involuntary Childlessness: Perceptions of Stigma Associated with Infertility and Adoption. Unpublished Ph.D. Dissertation, York University, Toronto, Ontario.
- \_\_\_\_\_. 1985. Perceptions of informal sanctioning and the stigma of involuntary childlessness. Deviant Behavior. 6:383.
- \_\_\_\_\_. 1986. The stigma of involuntary childlessness. Social Problems. 33:268-282.
- Miller, B.C., Rollins, B.C. and Thomas, D.L. 1982. On methods of studying marriage and families. Journal of Marriage and the Family. 44:851-873.
- Mills, C.W. 1981. Situated actions and vocabularies of motive. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons. 325-332.

- Ministry of Community and Social Services (Ontario). 1979. The Person Other Than the Agency. Toronto.
- Ministry of Community and Social Services (Ontario). Unpublished adoption statistics. 1984.
- Moghissi, K.S. and Evans, T.S. 1977. Infertility. In D.N. Danforth (Ed.) Obstetrics and Gynaecology, New York: Harper and Row.
- Mondloh, R. 1969. Changing practice in the adoptive home study. Child Welfare. 48:148-156.
- Mosher, W.D. 1982. Infertility trends among U.S. couples, 1965-1976. Family Planning Perspectives. 14:22-27.
- Mudd, E.H. 1980. The couple as a unit: Sexual, social and behavioral considerations to reproductive barriers. Journal of Marital and Family Therapy. 6:23-28.
- Mulford, H.A. and Salisbury, W.W. 1964. Self-conceptions in a general population. Sociological Quarterly. 5:35-46.
- Neugarten, B.L., Moore, J.W. and Lowe, J.C. 1968. Age norms, age constraints and adult socialization. In B.L. Neugarten (Ed.) Middle Age and Aging. Chicago: University of Chicago Press.
- Olson, D.H. and Cromwell, R.E. 1975. Methodological issues in family power. In Cromwell, R.E. and Olson, D.H. Multidisciplinary perspectives of power. In R.E. Cromwell and D.H. Olson (Eds.) Power in Families. New York: John Wiley and Sons. 131-150.
- Ory, M.G. 1978. The decision to parent or not: Normative and structural components. Journal of Marriage and the Family. 40:531-539.
- Peck, E. and Senderwitz, J. 1974. Pronatalism: The Myth of Mom and Apple Pie. New York: Thomas Y. Cromwell.
- Pfeffer, N., and Woollett, A. 1983. The Experience of Infertility. London: Virago Press.
- Pineo, P.C., Porter, J. and McRoberts, H.A. 1977. The 1971 census and the socioeconomic classification of occupations. The Canadian Review of Sociology and Anthropology. 14:91-102.

- Platt, J.J., Ficher, I. and Silver, M.J. 1973. Infertile couples: Personality traits and self-ideal concept discrepancies. Fertility and Sterility. 24:972-976.
- Pohlman, E. Childlessness: Intentional and unintentional. 1970. The Journal of Nervous and Mental Disease. 151:2-12.
- Polit, D.F. 1978. Stereotypes relating to family size status. Journal of Marriage and the Family. 40:105-114.
- Poston, D.L., Jr. 1974. Income and childlessness in the U.S.: Is the relationship always inverse? Social Biology. 21:296-307.
- \_\_\_\_\_. 1976. Characteristics of voluntary and involuntary childless wives. Social Biology. 23:198-209.
- Poston, D.L. and Gotard, E. 1977. Trends in childlessness in the U.S.: 1910-1975, Social Biology. 24:212-224.
- Rao, S.L.N. 1974. A comparative study of childlessness and never-pregnant status. Journal of Marriage and the Family. 36:149-157.
- Reece, S.A. and Levin, B. 1968. Psychiatric disturbances in adopted children: A descriptive study. Social Work. 13:101-112.
- Renne, K.S. 1976. Childlessness, health and marital satisfaction. Social Biology. 23:183-197.
- \_\_\_\_\_. 1977. Theres always adoption: The infertility problem. Child Welfare. 56:465-470.
- Rindfuss, R.R. and Bumpass, L.L. 1976. How old is too old? Age and the sociology of fertility. Family Planning Perspectives. 8:226-230.
- Ritchey, P.N. and Stokes, C.S. 1974. Correlates of childlessness and expectations to remain childless. Social Forces. 52:349-356.
- Robinson, N.D. 1973. Adoptive Mothers' Perceptions of Stress in the Agency Home Study. D.S.W. thesis, Columbia University.

- Rogers, J.W. and Buffalo, M.D. 1974. Fighting back: Nine modes of adaptation to the deviant label. Social Problems. 22:101-118.
- Rosenberg, M. 1981. The self concept: Social product and social force. In M. Rosenberg and R.H. Turner (Eds.), Social Psychology: Sociological Perspectives. New York: Basic Books, Inc.
- Rosenblatt, P.C. and Hillabrant, W.J. 1972. Divorce for childlessness and the regulation of adultery. Journal of Sex Research. 8:117-127.
- Rosenblatt, P.C., Peterson, P., Portner, J., and Cleveland, M., Mykkanen, A., Foster, R., Holm, G., Joel, B., Keisch, H., Kreuscher, C. and Phillips, R. 1973. A cross-cultural study of responses to childlessness. Behavioral Science Notes. 8:221-231.
- Rosenfeld, D.L. and Mitchell, E. 1979. Treating the emotional aspects of infertility. American Journal of Obstetrics and Gynecology. 135:177-180.
- Rosenfeld, D.L., Bronson, R.A. and Vasquez, P. 1980. Current trends in adoption as seen in an infertility center. International Journal of Gynecology and Obstetrics. 18:204-207.
- Rossi, A.S. 1968. Transition to parenthood. Journal of Marriage and the Family. 30:26-39.
- . 1977. A biosocial perspective on parenting. Dedaelus. 106:1-31.
- Rothenberg, E.W., Goldey, H. and Sands, R.M. 1971. The vicissitudes of the adoption process. American Journal of Psychiatry. 128:82-87.
- Sachdev, Paul. 1984. Adoption: Current Issues and Trends. Toronto: Butterworths.
- Saffilios-Rothschild, C. 1969. Family sociology or wife's family sociology? A cross-cultural examination of decision making. Journal of Marriage and the Family. 31:290-301.
- Sawatsky, M. 1981. Tasks of infertile couples. JOGN Nursing. March:132-133.



- Scanzoni, J. 1975. Sex Roles, Life-styles and Childbearing: Changing Patterns in Marriage and the Family. New York: Free Press.
- Schatzman, L. & Strauss, A.L. Field Research: Strategies for a Natural Sociology. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1973.
- Schechter, M.D. 1970. About adoptive parents. In E.J. Anthony and T. Benedek (Eds.), Parenthood: Its Psychology and Psychopathology. Boston: Little, Brown and Co., 353-372.
- Scheff, T.J. 1970. On the concepts of identity and social relationship. In T. Shibutani (Ed.), Human Nature and Collective Behavior: Papers in Honor of Herbert Blumer. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
- Schutz, A. 1970. On Phenomenology and Social Relations. Edited by H.R. Wagner. Chicago: The University of Chicago Press.
- \_\_\_\_\_. 1971. Collected Papers I: The Problem of Social Reality. The Hague: Martinus Nijhoff.
- Scott, M.B. & Lyman, S.M. 1981. Accounts. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons.
- Seibel, M.M. and Taymor, M.C. 1982. Emotional aspects of infertility. Fertility and Sterility. 37:137-145.
- Shaffir, W.B., Stebbins, R.A. & Turowetz, A. 1980. Fieldwork Experience: Qualitative Approaches to Social Research. New York: St. Martin's Press.
- Shapiro, C.H. 1982. The impact of infertility on the marital relationship. Social Casework. Sept.:387-393.
- Shapiro, C.H. and Seeber, B.C. 1983. Sex education and the adoptive family. Social Work. 291-296.
- Sherris, J.D. and Fox, G. 1983. Infertility and sexually transmitted disease: A public health challenge. Population Reports. 11:114-152.

- Shibutani, T. 1962. Reference groups as social control. In A. Rose (Ed.) Human Behavior and Social Processes: An Interactionist Approach. Boston: Houghton Mifflin, 128-147.
- \_\_\_\_\_. 1978. Reference groups as perspectives. In J.G. Manis & B.N. Meltzer (Eds.), Symbolic Interaction: A Reader in Social Psychology. Boston: Allyn & Bacon, Inc., 108-116.
- Shyne, A.W. 1977. Adoption trends: 1976. Child Welfare. 56:479-480.
- Simpson, G. 1966. People in Families: Sociology, Psychoanalysis and the American Family. New York: Meridan.
- Smith, I.E. 1963. Readings in Adoption. New York: Philosophical Library.
- Smith, Jerome, and Miroff, F.I. 1981. You're Our Child: A Social/Psychological Approach to Adoption. Washington, D.C.: University Press of America, Inc.
- Sorosky, A.D., Baran, A. and Pannor, R. 1975. Identity conflicts in adoptees. American Journal of Orthopsychiatry. 45.
- Sorosky, A.D., Baran, A. and Pannor, R. 1978. The Adoption Triangle. New York: Anchor Press/Doubleday.
- Starr, P. Taylor, D.A. and Taft, R. 1970. Early life experiences and adoptive parenting. Social Casework. 491-500.
- Statistics Canada. 1983. Census of Canada, 1981: Selected Social and Economic Characteristics. Ottawa: Minister of Supply and Services.
- Stebbins, R.A. 1978. Studying the definition of the situation: Theory and field research strategies. In J.G. Manis & B.N. Meltzer (Eds.), Symbolic Interaction: A Reader in Social Psychology. Boston: Allyn & Bacon, Inc., 258-71.
- \_\_\_\_\_. 1970. Career: The subjective approach. Sociological Quarterly. 11:32-49.

- Stone, G.P. 1981. Appearance and the self: A slightly revised version. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology through Symbolic Interactionism. New York: John Wiley & Sons.
- Straus, M.A. Measuring families. 1964. In H.T. Christensen (Ed.) Handbook of Marriage and the Family. Chicago: Rand McNally.
- Straus, R.A. 1976. Changing oneself: Seekers and the creative transformation of life experience. In John Lofland (Ed.), Doing Social Life. pp. 252-272.
- Strauss, A.L. 1959. Mirrors and Masks: The Search for Identity. Illinois: The Free Press.
- Stryker, S. 1959. Symbolic interaction as an approach to family research. Marriage and Family Living. 21:111-119.
- \_\_\_\_\_. 1980. Symbolic Interactionism: A Social Structural Version. Menlo Park, Cal.: The Benjamin/Cummings Publishing Company.
- Taymor, M.L. 1978. Infertility. New York: Grune & Stratton.
- Thomas, D.L. and Calonico, J.M. 1972. Comparative family study through multiple member measures: A methodological note. Journal of Comparative Family Studies. 2:292-295.
- Thomas, W.I. 1978. The definition of the situation. In J.G. Manis & B.N. Meltzer (Eds.), Symbolic Interaction: A Reader in Social Psychology. Boston: Allyn & Bacon, Inc., 254-58.
- Tizard, B. 1977. Adoption: A Second Chance. New York: The Free Press.
- Thomas, D.L. and Calonico, J.M. 1972. Comparative family study through multiple member measures: A methodological note. Journal of Comparative Family Studies. 292-295.
- Thomas, Morlais. 1971. Foster/Adoptive Home Breakdown. Child Adoption. 66:29-33.
- Travisano, R. 1981. Alternation and conversion as qualitatively different transformations. In G.P. Stone & H.A. Farberman (Eds.), Social Psychology

- through Symbolic Interactionism. New York: John Wiley & Sons, 237-48.
- Turner, R.H. 1962. Role-taking: Process versus conformity. In A.M. Rose (Ed.), Human Behavior and Social Processes. Boston: Houghton-Mifflin.
- \_\_\_\_\_. 1972. Deviance avowal as neutralization of commitment. Social Problems. 19:307-321.
- Van Keep, P.A. and Schmidt-Elmendorff, H. 1975. Involuntary childlessness. Journal of Biosocial Science. 7:37-48.
- Veevers, J. E. 1973. The social meanings of parenthood. Psychiatry: Journal for the Study of Interpersonal Processes. 36:291-310.
- \_\_\_\_\_. 1980. Childless by Choice. Toronto: Butterworths.
- Wagner, H.R. (Ed.) 1970. Alfred Schutz: On Phenomenology and Social Relations. Chicago: The University of Chicago Press.
- Walker, H.E. 1978. Psychiatric aspects of infertility. Urologic Clinics of North America. 5:481-488.
- Wallach, E.E. 1980. The frustrations of being 'normal' yet 'infertile', Fertility and Sterility. 34:405-406.
- Waller, J.H., Rao, B.R. and Li, C.C. 1973. Heterogeneity of childless families. Social Biology. 20:133-138.
- Walters, L.H. 1982. Are families different from other groups? Journal of Marriage and the Family. 44:841-850.
- Warren, R.D., Klonglan, G.E. and Sabri, M.M. 1969. The certainty method: its application and usefulness in developing empirical measures in the social sciences. Rural Sociology Report No. 82. (Department of Sociology, Iowa State University)
- Weir, W.C. and Hendricks, C.H. 1969. The reproductive capacity of an infertile population. Fertility and Sterility. 20:289-298.
- Westoff, C.F. 1978. Some speculations on the future of marriage and fertility. Family Planning Perspectives. 10:79-83.

- Whelan, E. 1975. A Baby? Maybe. New York: Bobbs-Merrill.
- Wiehe, V.R. 1973. A Comparison of the Group and Individual Methods of the Adoptive Study in Relation to Attitudinal Change. Ph.D. thesis, Washington University.
- \_\_\_\_\_. 1976a. Attitudinal change as a function of the adoptive study. Smith College Studies in Social Work. 46:127-136.
- \_\_\_\_\_. 1976b. Psychological reactions to infertility. Psychological Reports. 38:863-66.
- Wiseman, J.P. 1981. The family and its researchers in the eighties: Retrenching, renewing, and revitalizing. Journal of Marriage and the Family. 43:263-266.
- Wolowyna, J.E. 1977. Income and childlessness in Canada: A further examination. Social Biology. 24:326-331.
- Wyatt, F. 1967. Clinical notes on the motives of reproduction. Journal of Social Issues. 23:29-56.
- Zaslove, H.K. 1978. Infertility as a life event. Journal of Human Stress. 4:2.
- Zimmerman, S.L. 1982. Alternatives in reproduction for involuntary childless couples. Family Relations. 31:233-241.
- Zober, E. 1967. The incidence of pregnancy among couples who contacted Iowa Children's Home Society about adoption. Child Welfare. 46:397-402.
- Zwimpfer, D.M. 1983. Indicators of adoption breakdown. Social Casework. 169-177.