Battling Stigma: Adult female identity and the use of affirmative feminist therapy with women who do not have children

by

Yulia Koba

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Dedication

I dedicate my dissertation work to my family. I am especially grateful to my loving, caring, and dedicated parents, who by their own example showed me how to be persistent, hardworking, and resilient.

I also dedicate my work to my husband, who has been my strength, greatest supporter, and motivator throughout this difficult process. Finally, I dedicate this work to my children, who I hope will be inspired by my example.

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TABLE OF CONTENTS

Abstract

This clinical dissertation focuses on psychological and identity issues experienced by women who do not have children. This topic is important because this clinical population has been overlooked. Although childless and childfree women are a growing population in the United States, a significant gap exists between research and practice. This clinical dissertation aims to address this gap by critically reviewing the research literature on childfree and childless women as well as on pronatalism and androcentric developmental theories that perpetuate biases against women who do not have children. The literature review discusses a feminist approach in working with these women. Findings from interviews with mental health professionals who work with childless and childfree women in their practices are discussed. The information from the literature review and professional interviews was integrated into the creation of a formal oral and visual presentation, which was delivered to a group of mental health professionals to enhance their knowledge, skills, and awareness of the issue of voluntary and involuntary childlessness. Materials created and used in the presentation included outlines, slides, and handouts. Participants' evaluation data and a summary of the feedback are discussed. Additional suggestions for reducing the gap between research and practice pertaining to voluntary and involuntary childlessness, as well as a discussion of the study's limitations and implications, are offered.

Keywords: childfree, childless, infertility, voluntary

CHAPTER I: Introduction to the Study

In most societies, including those in the West, parenthood is considered one of the major developmental milestones—a sign of ultimate adult maturity and of the completeness of adult identity formation. An expectation exists that a heterosexual adult will have a child at some point in life. Rowland (1992, p. 45) noted that pronatalism, the discourse and beliefs that promote human reproduction, is "endemic in western society." In fact, the social and psychological value of parenthood is deeply ingrained in the dominant Western value system. Pronatalism is a prevailing paradigm that defines socio-cultural attitudes, as well as political policies, concerning reproduction and childbearing. Veevers (1980) described pronatalism as an inherent value system that governs society and directs its laws, economy, public policies, and elected officials. Besharow (2012) asserted that many governmental public policies directly impact fertility, thereby promoting childbearing and reproduction.

Pronatalist attitudes are closely tied to women's identity formation. Within a patriarchal paradigm, a woman's identity has been defined in relation to others, and her roles as mother, daughter, sister, and wife have all been emphasized. A woman's ability to produce male offspring for her husband's line has traditionally been the crowning achievement of her development. In her landmark work *The Feminine Mystique*, Betty Friedan (1963) exposed pronatalist culture by pointing out that, "in our culture the development of women has been blocked at the physiological level with, in many cases, no higher need recognized that the need for love and sexual satisfaction" (as cited in Castaldo, 2008, p. 41).

In the 20th century, the pronatalist ethos continued to prevail in society, encouraging reproduction and "exalting the role of parenthood" (Jamison, Franzini, & Kaplan, 1979, p. 266). Still, within the context of contemporary pronatalist society, women who do not have children

can face social stigma and are labeled “barren” as well as “unfulfilled, selfish, irresponsible, and unhappy” (Letherby, 2002, p. 10). Dominant social narratives dictate that having children is the norm whereas childlessness—regardless of the reason—is perceived as a deviation from that norm. Letherby and Williams (1999) argued that “women without children represent the ‘other’ in societies that value children and motherhood…. They are also treated as childlike rather than fully adult. Women who have no children are considered to have no responsibilities and thus to be like children themselves” (p. 723). In her recent book *Childless Marriage*, Sue Fagalde Lick (2012) pointed out that, when women reach their mid-30s, they are expected to settle down and start a family; if they do not “everyone wants to know what’s wrong with them” (p. 12).

All major developmental life cycle theories consider parenthood to be the major milestone that has to be reached in order for men and women to develop an identity of a mature, responsible adult. Theorists consider childbearing in women to be a very important achievement necessary for the development of adult identity. Within the pronatalist discourse, parenthood is seen as a right of passage into adulthood, with motherhood being the crowning achievement of a female body (Gold, 2002).

It is important to note that the majority of developmental theories taught in graduate schools for psychologists, social workers, and other mental health professionals are androcentric and therefore transmit androcentric (and pronatalist) biases to students and future clinicians, who in turn are likely to impose these biases upon the women with whom they work. Indeed, some literature specifically focuses on women’s psychology as well as on the nuances of which mental health practitioners need to be aware—when working with both women in general and childless and childfree women in particular. However, in training programs, students are only likely to be exposed to this literature if they are enrolled in highly specialized courses (e.g., a women’s

psychology course), but not in their general clinical training. Moreover, instructors and mental health professionals have been socialized within a pronatalist society and have been trained by and exposed to instructors, mentors, and theorists/researchers who also have been socialized within a pronatalist society, thereby making it more likely for them to espouse and pass on pronatalist viewpoints themselves. Thus, it is possible that these mental health professionals will have unprocessed biases against childless and childfree women and, if so, will fall short of being able to work effectively with childless and childfree women without asserting their biases, discriminating against, and (perhaps unwittingly) stigmatizing these women. This clinical dissertation aims to provide an alternative to the pronatalist perspective as well as offer information on the experiences of childless and childfree women—information that can fill in one gap in the educational experience of mental health professionals.

This clinical dissertation also offers a treatment approach in working with childless and childfree women—an approach that does not impose a pronatalist viewpoint on clients. In her book *Divorced Without Children: Solution Focused Therapy With Women at Midlife*, Castaldo (2008) proposed that affirmative feminist therapy can help childless and childfree women construct a new narrative of their identity. More specifically, these women can grow to conceptualize their childless status in positive terms, instead of as a failure, based on a pronatalist discourse.

Purpose

The purpose of this clinical dissertation is to compile relevant literature and, based on the literature findings, develop a presentation that will be provided to mental health professionals working with childless and childfree women. Given the previously discussed gaps in training, the purpose of this clinical dissertation is to increase professionals' awareness of specific issues

related to working with women who do not have children, including the experiences and effects of being childless and childfree in today's world.

Goals and Objectives

This dissertation reviews selective literature that describes the ways in which childfree and childless women are perceived in contemporary society, including the effects that their childless/childfree status has on their identity. Moreover, this clinical dissertation has three specific goals and objectives.

The first goal is to increase mental health professionals' understanding of the kinds of biases that childless and childfree women face due to living in a pronatalist society, including social isolation, stigmatization, and invasion of privacy. To address this goal, this clinical dissertation explores the ways in which androcentric developmental theories contribute to the perpetuation of biases toward women who do not have children. The various ways in which childless women handle their childless status and negotiate stigma also are explored.

The second goal of this clinical dissertation, as well as that of the presentation, is to help mental health professionals understand that they themselves have been raised and trained within a pronatalist society. By becoming more conscious of their specific attitudes and biases toward childless and childfree women, mental health professionals can be better equipped to not re-stigmatize childless and childfree women by imposing pronatalist views on them.

The third goal of this clinical dissertation is to describe feminist therapy as an intervention that can be used by mental health professionals when working with women who do not have children. Feminist therapy involves creating a new narrative that affirms women's identity and that can help involuntarily childless and voluntarily childfree women find a satisfying identity outside of motherhood.

CHAPTER II: Literature Review

Cultural Views on Womanhood and Female Identity Development

Background to Pronatalism

In most societies, including those in the West, parenthood is considered one of the major developmental milestones, a sign of ultimate adult maturity, and the completion of adult identity formation. Rowland (1992) noted that pronatalism, the belief in the importance of parenthood, is endemic in Western developed society.

Pronatalism is central to notions of gender and female identity. Castado (2008) pointed out the lack of a theoretical framework that can conceptualize female identity without parenthood: "Developmental life cycle theories have stopped short of inclusion of mature single adulthood without children as a normative developmental stage" (p. 41). Moreover, Gold (2013) pointed out that a child is deemed necessary in order to transform a couple into a family as "children are a necessary part of the family's legitimization" (p. 225). Ireland (1993) noted that "female reproductive capacity has become central and definitive for normative female development. Maternity has been the cornerstone of the mature adult identity for women" (p. 7).

In fact, the social and psychological value of parenthood is deeply engrained in the dominant Western value system. In particular, according to McQuillan et al. (2012), the United States remains one of the most pronatalist countries among wealthy, industrialized nations. Besharow (2012) asserted that many governmental policies encourage and directly impact fertility and promote childbearing and reproduction. In her influential book *Childless by Choice*, Veevers (1980) described pronatalism as an inherent value system that governs society and directs its laws, economy, public policies, and electoral politics. It is predicated upon the expectation that heterosexual adults will have a child at some point in their lives. Indeed, the

majority of young people report that they want to have children at some point in their lives and that they view having children as a natural, desired event and a logical step that follows getting married (Thornton & Young-Demarco, 2001).

Underpinning much of the pronatalist discourse is the notion of a woman's biological clock—the fact that a woman has a limited number of years, after which her reproductive capacity declines significantly. Although it is technically true that a woman has a time frame with which to work if she desires to become pregnant, Friese, Becker, and Nachtigall (2006) pointed out that the term *biological clock* became part of a discourse that signifies much more than a mere biological capacity for reproduction:

> Over the past generation, aging and female reproduction have been lodged within the gendered and gendering debates regarding women's involvement in the workforce and demographic shifts toward delayed parenting that culminate in discourses on the "biological clock." (p. 1055)

Erikson (1964, p. 27) suggested that, at some point in her life, a woman realizes that she possesses a productive "inner bodily space" that needs to be filled. The motherhood mandate is so deeply engrained into most people's psyches that parenthood is the norm in Western society whereas not having children is considered to be a failure (Ulrich & Weathrall, 2000). Gillespie (2003) asserted that the "urge to have a child is both a powerful and a complex force" (p. 122). Not only does pronatalist discourse place motherhood at the center of female identity, but it also defines women's gender roles within society (Russo, 1979). Within the pronatalist discourse, a woman's role as a mother is central to her actual existence (Russo, 1979). Thus, a woman can occupy multiple roles, but she is often made to feel guilty or ashamed by family, friends, and peers if these roles involve being away from her child (Russo, 1979), not to mention childless.

The competing demands that motherhood and having a career place on women can help explain why only a very small number of women occupy managerial positions (Hewlett, 2002). Although women who manage to be mothers while also holding a successful executive occupation certainly do exist (e.g., the CEO of Yahoo!, Marissa Mayer), they are the exception, rather than the rule. Women do hold more managerial positions now than in the past, but when compared to the proportion of men who hold comparable positions, the proportion of women in these positions is still quite low. For example, in the United States, only 4.8% of women held CEO positions in Fortune 500 companies in 2014—an increase since 1995 (0%) and 2005 (1.8%), but still very low when compared to the 95.2% of men who held comparable positions in 2014 (Catalyst.org, retrieved January 25, 2015, from http://www.catalyst.org/).

Pronatalism may be an important explanatory factor. In "Distorted Views Through the Glass Ceiling: The Construction of Women's Understanding of Promotion and Senior Management Positions," Liff and Ward (2001) found that women who held junior managerial positions and contemplated starting a family were concerned about their ability to combine the demands of a senior position—which would require longer hours and larger workloads—with motherhood; "their uncertainties were reinforced by the very small number of visible senior women with children who could act as role models (or even as evidence that it was feasible)" (p. 26).

Three Dominant Discourses Enabling Pronatalism

Morell (1994) identified three dominant discourses that enable pronatalist cultural hegemony and conceptualize female identity: (1) derogation*,* which depicts childless women as morally inferior; (2) compensation*,* which depicts childless women as desperate to compensate

for their lack of children; and (3) regret, which conceptualizes childless women as necessarily experiencing remorse and disappointment.

Derogation. According to Morell (1994), within the pronatalist discourse, motherhood is directly linked to female moral virtues, selflessness, and nurturance; when a woman acts in a caring way toward someone, she is described as motherly. Morell (1994) suggested that equating motherhood with moral virtue is highly problematic as many women who are not mothers are very caring and selfless, while many mothers are very far from being caring and selfless (as evidenced by multiple child abuse and neglect cases). Furthermore, Morell (1994) pointed out that, within the pronatalist discourse, not having children is equated with the rejection of family values, which has very negative political and social connotations in a society founded upon family values. Morell (1994) suggested that not having children is interpreted as a selfish act of self-indulgence and consumerism: "One way the moral meanings of motherhood are created and sustained is through stereotypical representations of intentionally childless women and couples as self-indulgent consumers" (p. 77). These depictions derogate women who do not have children, portraying them as selfish and lacking virtue.

Compensation. Morell (1994) asserted that pronatalist discourse defines motherhood as a far more superior source of joy and fulfillment than all other activities, which are seen as both inferior and compensatory. Childless women are often seen through a distorted lens that frames their lives in terms of deficiency, absence, emptiness, and the urge to compensate for their failings. Every non-mother's activity, achievement, and effort are viewed as a form of compensation for her missing child:

> *Whatever* a childless woman *does have* or *does* may be viewed as merely compensation for the missing real experience of motherhood. Motivations to

> achieve, active public commitments, avocations, relationships with pets, are commonly interpreted as evidence of the inevitable void left by a failure to mother. (Morell, 1994, p. 89)

Compensatory discourse negates a non-mother's achievements and efforts, in her career or other activities, by defining them in relation to the fact that she does not have children. For example, as indicated by Morell, popular culture depicts childless women as having compensatory and substitutional relationships with their pets, through figures such as the pathetic "cat lady" who dies alone with only her cats to keep her company.

Regret. The most damaging and, unfortunately, prevalent discourse to which childless women are subjected is the discourse of regret, which claims that women who reject motherhood ultimately regret their decision and will end up leading a lonely and pitiful life. Morell (1994) argued that the threat of impending regret remains a powerful means of scaring women into motherhood: "the threat of regret is one way that pronatalism is promoted" (p. 24).

Paetro (1989) suggested that many women decide in favor of having a child out of fear of remaining childless, but then regret their decision to have children for the rest of their lives. According to Morel (2000), although regret can be a very strong emotion linked to childlessness, women who do not have children do not necessarily experience regret. Some childless women experience moments of ambivalence, rambling, wavering, and musing about their choice, but would not describe themselves as regretful (Minden, 1996; Morell, 2000).

Indeed, research findings do not support this popular belief that childless women are unhappy, unfulfilled, or regretful (Bulcroft & Teachman, 2011). Moreover,

depression and feelings of loneliness among childless individuals in old age are reported at similar levels as those among individuals who do have children (Koropeckyj-Cox, 2007). More recently, Hansen, Slagsvold, and Moum (2009) conducted a study exploring the links between parental status and psychological wellbeing in mid-life and old age. The study distinguished between cognitive components, such as self-esteem and reported life satisfaction, and affective components, which included depression, loneliness, and so forth. The results were based on data gathered from 5,189 men and women who were interviewed by phone. Data showed that parental status has an effect on cognitive wellbeing, with childless women reporting significantly lower self-esteem and life satisfaction; however, parental status was not shown to have an effect on emotional wellbeing. More specifically, the study did not find any association between parenthood status and affect, such as depression and loneliness. These findings suggest that lower levels of cognitive wellbeing may be derived, in large part, from socially transmitted values and norms; in other words, childless women are socialized into believing that not having children should be reflected in their self-esteem.

Similarly, Umberson, Pudrovska, and Reczek (2010) conducted a meta-analysis of research conducted from 1999 to 2009 on the effects of parenthood on wellbeing. They pointed out that most studies conducted in the 2000s found that parenthood does not predict wellbeing, but can be a stressor under certain circumstances such as financial difficulties.

Historic Institutionalizing of Pronatalism

Pronatalism has been established as a hegemonic paradigm within Western society for a number of reasons. First, the relative lack of reliable and effective contraception until modern

history meant that sexual activity led to pregnancy in fertile adults; most adults who engaged in sexual activity would become parents at some point in time. Although contraception was widely practiced, in various forms, throughout history, modern technology and socio-legal developments have made contraception more available and effective than ever before. For example, in the United States, contraception was illegal in some states and available only to married couples in others. The law prohibiting the use of contraception by married couples was only repealed in Connecticut in 1965, after being ruled as unconstitutional. In 1972—not even 45 years ago—the United States Supreme Court case *Eisenstadt v. Baird* made contraception legally available to unmarried individuals throughout the country. Intra-uterine devices (IUDs) came into widespread use only in the 1960s, when plastic and metal devices became safely available to general consumers. Safe, highly effective, and widely available oral contraceptives—as well as the legalization of abortion—provided women with alternatives to motherhood (Gillespie, 2000; Quarini, 2005). However, although contraceptives are legal and available nowadays, societal norms and attitudes about motherhood remain deeply ingrained in society.

Second, although at least some forms of contraception and abortion were available in the past, economic and social realities meant that parents purposefully sought to have more children. For example, the historically agrarian way of life in many societies meant that having children was often necessary for survival. Moreover, high infant mortality rates and the absence of vaccination meant higher birth rates in families (Camiscioli, 2001).

Third, beyond economic necessity, religious values played a part in the establishment of pronatalism. The Judeo-Christian tradition, upon which Western culture is largely based, has historically encouraged procreation and prohibited contraception and abortion. These religions promote procreation and encourage childbearing as a duty and moral responsibility (Veevers,

1980). Although pronatalist ideals were already present, religion served to cement these ideals in our relatively religious society over the millennia. Given these factors, for centuries, the lives of Western communities have been organized around families, where marriage served as a religious, social, and political cornerstone on which society was built (Thornton & Young-Demarco, 2001).

Contemporary Shifts to Pronatalist Views

During the last five decades of the 20th century, many changes took place in the social and medical domains, which facilitated the expansion of life choices for women. Increased access to reliable contraception, alongside socio-economic changes (lessening the hold of the previously discussed hegemonizing forces, such as increased secularization and less economic dependence on offspring), made it possible to separate reproduction from sexual activity, enabling women to engage more freely in sexual relationships. Better medical care and growing urbanization reduced the need for couples to have multiple offspring. Moreover, the civil rights movement and especially the second wave of feminism changed the way that society conceived gender roles. Some women began rejecting the motherhood mandate assigned to them, in what Lisle (1996) described as a counteraction to the baby boom. Given the increased rates of childlessness, during the early 1980s, there was a rise in scholarly interest in the phenomenon of childlessness. Feminist scholars produced a large body of literature that challenged traditional family structures and pronatalist discourse (Veevers, 1980).

However, the social changes ushered in by better birth control and second-wave feminism did not go unchallenged. Thornton and Young-Demarco (2001) pointed out that, in the United States in the late 1990s, a revival of conservative values emerged in response to the shift in gender roles and more liberal morals. The conservative movement promoted pronatalism and

condemned abortion and other reproductive choices. Jamison et al. (1979) characterized this conservative response by its pro-procreation stance and support of traditional family values, which continue to exert considerable influence on American culture and society. For example, Thornton and Young-Demarco (2001) found that young women and men in the 1990s placed more importance and value on family and childbearing than their peers in the 1970s did. A resurgence of traditional family values, gender roles, and childbearing has been the general trend (Fitch & Ruggles, 2000).

Gender Role Attitudes and Pronatalism Today

In "The End of the Gender Revolution? Gender Role Attitudes from 1977 to 2008," Cotter, Hersen, and Vanneman (2011) examined gender role attitudes. Findings from a general social survey suggested rapid changes in gender roles and societal attitudes between the 1970s and 1990s, but indicated almost no changes from the 1990s to 2008. In other words, while society was reexamining its attitude toward gender roles and female identity during the first period (with the emphasis on pronatalism decreasing), this process reversed during the second period.

Cotter et al. (2011) explained that the period of rapid changes during the 1970s and 1980s occurred as the second wave of feminism became prominent and that the shift back to pronatalism found in the second period occurred in opposition to this second wave. The scholars explained that the second period can be characterized by an antifeminist backlash that became prominent in the mid-1990s, which was the crucial point at which attitudes toward gender roles regressed back to much earlier norms. More specifically, the scholars hypothesized that the reversal in gender attitudes can be explained by the increased prominence of a new cultural discourse, which they termed egalitarian essentialism. Egalitarian essentialism affirms the

principles of feminism and gender equality but at the same time affirms traditional motherhood roles and advocates for intensive mothering (Cotter et al., 2011). The discourse of egalitarian essentialism is a new, prominent sociocultural framework that reinforces the return to traditional gender roles while also upholding the egalitarian values of feminism, thereby denying any allegations of disadvantaged status or lack of power for women (Chrales & Grusky, 2004).

In *Backlash: The Undeclared War Against American Women*, Susan Fludi (2006) attempted to explain how egalitarian essentialism came to dominate. She described that, in the 1970s through the early 1990s, the focus was on equal social, political, and economic rights for women and, consequently, many women embraced feminist values; this new attitude manifested in many women pursuing careers and not having children. However, Fludi (2006) described that, in the later 1990s, the rhetoric of the media changed from feminist values (focusing on equal rights) to egalitarian values (focusing on the statement "you can have it all"). In other words, women were being taught that they could have a career but also go back to traditional family values at the same time. However, Fludi (2006) argued that, in reality, women cannot "have it all" and that this viewpoint is an illusion and a disservice to women. Women who believed and endorsed the feminist agenda were suffering burnout from attempting too much. Women who focused on their careers and who "postponed marriage now confronted a man shortage while their biological clocks made them desperate" (Fludi, 2006, p. 78). Furthermore, working mothers were being sidetracked onto a "mommy track," and daycare options were scarce (Fludi, 2006, p. 79). However, rather than citing disadvantage or disempowerment as reasons to denounce the disillusionment and problems that women faced, an anti-feminist backlash prevailed, perpetuating pronatalism and its values.

In her famous bestseller *Lean In: Women, Work, and Will to Lead,* Sheryl Sandberg (2013), the CEO of Facebook, discussed the myth of "having it all" and offered a very honest and disenchanting account of her personal experience of being a mother and a top manager of a major company. Sandberg (2013) suggested that the phrase so often used in the media ("she has it all") is the greatest trap for women and did tremendous damage to women who desperately sought to have it all as they inevitably failed and experienced burnout and disappointment: "Superwoman is the adversary of the women's movement" (Sandberg, 2013, p. 123).

Fludi (1991) argued that the antifeminist backlash adopted new antifeminist language of "ticking biological clock," "postfeminism," and "mommy track." Such rhetoric was strengthened by the rising concept of "intense motherhood," which implied that only a stay-at-home parent could raise a psychologically and physically healthy child who was adequately prepared to thrive in the super-competitive contemporary environment. In other words, parenting demands seemed to increase at the same time that demands external to motherhood increased for those who pursued alternative paths such as advancing their careers (Vinson, Mollen, & Smith, 2010). For example, mothers saw the emergence of new, so-called "developmental" toys and games, where children had to listen to Mozart in the womb. Meanwhile, the time commitment and dedication to work, at least among professional women, also increased dramatically, making the choice—career or family—for professional women who want children, if not obvious, then inevitable (Douglas & Michaels, 2004). A recent decision of Yahoo! CEO, Marissa Mayer, to ban flexible work arrangements is illustrative. Ending flexible work arrangements, which make it possible for mothers to both work and raise children, will likely lead many of Yahoo!'s female employees to leave the workforce and become stay-at-home mothers. In the vein of egalitarian essentialism, these changes reinforce the return to traditional gender roles given that, based on current social

discourse, women do not really have the choice to build their career and be a "good mother" at the same time. Instead, they are left with the choice to build their career and be a "neglectful mother" or abandon their career to be a "good mother" (Fludi, 1991).

In "Childlessness and Women Managers: 'Choice,' Context and Discourse," Wood and Newton (2006) examined women managers' choice to remain childless. They found that many women who occupy junior managerial positions have to work long hours and simply do not have the opportunity to start a family due to a corporate culture that does not allow maternity leave and/or flexible working hours. Moreover, the authors found that several of their participants described their choice to remain childless as a sacrifice for their career. Liff and Ward (2001) interviewed 52 female childless managers in a similar study. The women in their study believed that motherhood would "spell the end of their career" because "the organization was not willing in practice to support, or adapt to, parents and were likely to interpret any interest in, say, reduced hours as a lack of commitment to a career" (p. 26).

Furthermore, the United States does not provide public childcare, making it difficult for women who work to find care for their children. Private childcare providers are available to a only very small part of the population who can afford the expense. At the same time, subsidized childcare available to low-income families/mothers lacks quality and is characterized by a large number of children being placed in the same space as well as by a lack of personalized attention to the children.

In *The Truth Behind Mommy Wars: Who Decides What Makes a Good Mother?*, Miriam Peskowitz (2005) argued that multiple publications about child molestation cases in daycare centers and other childcare institutions were a part of a deliberate divide-and-conquer strategy implemented by the hegemonic pronatalist discourse, which replaced gender role struggles with

"mommy war" conflicts between stay-at-home and career mothers; this strategy shifted attention away from gender inequality and sexism (Cotter et al., 2011). Decisions to focus on motherhood and to be stay-at-home mothers are ultimately justified by the newly prominent discourse of pronatalism in a way that is difficult to denounce by feminist ideals, as the decisions are understood as women choosing to stay home — not for their husbands or because of sexist pressures, but as a result of an empowered, self-made choice to support their children's advancement, safety, and mental health.

Women Who Do Not Have Children

Being Infertile, Childless, and Childfree

Infertility is defined as a couple's inability to conceive following 12 months of unprotected intercourse and/or the repeated inability to carry a pregnancy to a live birth (Johnson & Fledderjohann, 2012). As a medical diagnosis, infertility is usually used with a woman who wants to conceive a child but is unable to do so due to medically established physiological reasons. Matthews and Matthews (1986) argued that a difference should be drawn between infertility as a biological functional condition with a medical diagnosis and the social condition of being involuntarily childless. While *infertility* is a medical term, *involuntary childlessness* is a social and moral condition.

Matthews and Matthews (1986) argued that the diagnosis of infertility has a multi-dimensional impact on individuals and couples, the psychological consequences of which cannot be underestimated. They described infertility as involving many complex social processes, during which the person who is diagnosed with infertility acquires the social status of being involuntarily childless and has to adapt to that status. Specifically, they pointed out that infertility affects an individual's identity and that the failure of a woman to live up to her own expectations

and those of others results in "identity shock" (p. 645). The degree of this shock depends on the level of strength of the expectations surrounding parenthood within herself and/or her environment (Matthews & Matthews, 1986).

The body of literature includes a variety of terms used to describe individuals and couples without children. Some authors use the term *childless* whereas others use *childfree*. *Childfree* refers to individuals and couples who do not want to have children. The word *childless* is ambiguous in its meaning, as it includes those childless by choice and those who wanted to have children but could not have them for some reason. Specifying whether one is *voluntarily* or *involuntarily* childless takes away the ambiguity and makes the distinction clearer.

Six professionals with expertise in working with issues related to involuntary and voluntary childlessness were consulted to ascertain how their clinical experience compared to the literature. Mary Hayden, Ph.D., a licensed clinical psychologist who works with and is actively involved in the LGBTQ community, pointed out that the term *childless* refers to a lack of something, missing out, loss, grief over that loss, a lack of choice, and a condition rather than a voluntary state. Meanwhile, the term *childfree* refers to a proactive choice. Jennifer Bessel, Ph.D., a licensed clinical psychologist who works with women who undergo fertility treatments, pointed out that her clients "can move towards the term childfree only when they have processed the trauma and emotions that they have gone through" (personal communication, August 3, 2015). However, Gretchen Kubacky, Psy.D., a licensed clinical psychologist specializing in treating women who have been diagnosed with infertility and are undergoing infertility treatment, noted that the term *childfree* elicits a strong reaction in women going through infertility treatment: "Childfree tends to elicit some panic in infertility clients, as they cannot imagine actually *choosing* not to have children" (personal communication, August 5, 2015).

Delineating Among Women on the Continuum of Childlessness

Ireland (1993) outlined three distinct categories that define childless women: (1) conventionally minded women, who desire children but cannot have them for some reason; (2) transitional women, who contemplate childbearing but ultimately do not have children; and (3) transformative women, who do not desire to have children. This categorization clearly distinguishes between women's intentions to have or not have children and emphasizes the specific choices that women make regarding their desire to have children. However, other theorists, like Monarch (1993), have argued that "intentions do shift and change and there is often not a clear boundary between 'voluntary' and 'involuntary' childlessness" (p. 27). McAllister and Clarke (1998) pointed out that only a few women actually make a definite, irreversible choice to become childless; for the majority of women, childlessness is a continuous process, rather than an absolute decision. Along these lines, Letherby (2002) proposed considering childlessness along a continuum, where some women occupy a more definitive place than others. Recent advances in reproductive technology and numerous cases of pregnancies that have resulted in women well beyond their reproductive age giving birth have further blurred the border between voluntary and involuntary childlessness. Options such as egg freezing and surrogacy have afforded women more time before making a decision about having children and have increased women's ability to change their minds and move around along the continuum.

In "The Truth About the Childless Life," Melanie Notkin (2013) coined the term *circumstantial infertility*, which she describes not as a biological inability to conceive and bear a child to term, but as being childless due to lacking a partner or financial resources or due to other life circumstances. Notkin (2013) argued against what she called a "childfree myth"—the discourse that claims that many successful men and women choose not to have children. In her

recently published book, *Otherhood,* Notkin (2014) pointed out the way in which childlessness is often misinterpreted as a choice:

> Often, a women's involuntary childlessness, such as mine, is misinterpreted as having come about by choice. In fact, I've always envisioned motherhood as part of the romantic wholeness of marriage and family—and in my mind, it still is inseparable from love. Without one, I haven't had a chance at the other. (p. xi)

Notkin (2014) suggested that the increased number of childless women in contemporary society is a social issue that deserves special attention. She argued that the distinction between childfree and childless women is hazy and that women often fall somewhere along a continuum; furthermore, she argued that women who are circumstantially infertile have to face the reality and accept that they will not have children.

Involuntary Childlessness

Letherby (2002), Notkin (2013), and Notkin (2014) argued that women's childlessness has to be interpreted as an ongoing series of choices, rather than as one single event. Women often delay childbearing in favor of education, career, and other life choices and find out either that they do not want to have children or that they cannot have children when they are ready to do so. Furthermore, the population of involuntarily childless women might include those who biologically cannot conceive a child as well as those who face other factors that prevent them from having a child, including not having a partner and/or the financial ability to have a child (Letherby, 2002). This section refers to a wide range of women who are childless but who, at some point in their lives, did get to the point of wanting to have a child; therefore, they are considered involuntarily childless. Women who are voluntarily childfree will be discussed in a later section.

It is important to note that not all involuntarily childless women struggle with infertility. Some never even find out if infertility is an issue for them because other reasons preclude their possibility of having a child (e.g., they do not have a partner and, therefore, never try to have a child, even though they want to have a child). Nevertheless, infertility is an issue with which many women who are involuntarily childless struggle; therefore, a discussion about infertility is included in this section.

As already discussed, infertility is a medical diagnosis that is accompanied by the social-emotional experience of being involuntarily childless. Gillespie (2000) emphasized that involuntary childlessness is perceived and constructed as a medical illness, a disease that afflicts women's bodies and renders them sick, failed, or abnormal. Often, a woman is reduced to her "faulty" body part, is treated as a patient, and is labeled with her diagnosis. Ulrich and Weatherall (2000) pointed out two major ways through which infertility is constructed: as a physical impairment and as a failure event—namely, an event was expected to happen, but failed to happen due to some biological barrier.

Motherhood as a Rite of Passage into Adulthood

Recognizing the impact of infertility is necessary in order to negotiate its personal and social meanings and to manage its consequences. Greil (1991) asserted that, in contemporary American society, parenthood is an expected desirable life event and "a social rite of passage into adulthood" (p. 15). In pronatalist cultures, including the United States, motherhood is often equated with adulthood; infertile women are viewed as incapable of transitioning into adulthood and achieving a full adult status (Griel, 1991). Furthermore, motherhood is seen as a milestone of adult development, as a source of fulfillment, and as an indicator of psychological and social completeness (Ulrich & Weatherall, 2000). In this context, parenthood constitutes an important

milestone and a defining event in a person's life; as follows, infertility represents a nonevent—something that did not happen. Greil (1991) described infertility as "status blockage" (p. 23) because it prevents the infertile/childless woman from achieving a new status by becoming a parent.

Emotional Impact of Infertility and Involuntary Childlessness

Infertility and involuntary childlessness often have quite an emotional impact on women. In their analysis of survey data from the National Survey of Families and Households, White and McQuillan (2006) concluded that, "whether barriers to fertility are circumstantial or biomedical, relinquishing the intention of having future children will lead to increase in distress" (p. 479). McCathy and Chiu (2011) added that many women with infertility who went through unsuccessful treatment experience their infertility as an existential crisis that threatens their sense of wholeness and psychological wellbeing.

Letherby (2002) noted that, "emotionally, infertility is crushing" for women who define themselves through motherhood because society takes reproduction for granted and, "in a sense, failure in this area becomes a failure in life," which causes "anger, shame, confusion—a feeling of helplessness. Infertility pervades every aspect of [these women's] life" (p. 281). Women who are involuntarily childless not only feel distress because they are missing out on the experience of being a mother, but they also must grieve because they are likely to miss out on the experience of being a grandparent (Letherby, 2002).

The majority of the literature on involuntary childlessness and its impact focuses on grief as a response to perceived loss and on ways to overcome feelings of sorrow and despair. Miall (1985) found that involuntarily childless women "labeled themselves as 'failures' even without

[external] rejection or disapproval" (p. 393). Gonzalez (2000) argued that infertility/involuntary childlessness is a transformational process, during which women mourn their loss.

Infertility as a Master Status of Self-Identity

Social constructions of female identity have historically been based on women's gender roles as mothers, both within individual households and in the community at large. Motherhood has traditionally been promoted as the ultimate and most "normal" aspect of female identity (Nakamo & Glenn, 1994). Gillispie (2000) observed that "the nurturance of children has historically been seen to be what women do, and mothers have been seen to be what women are" (p. 225). In addition, motherhood "constitut[es] the central core of normal, healthy feminine identity, women's social role and ultimately the meanings of the term woman" (p. 225).

Ireland (1993) pointed out that "it is practically impossible to think of the woman who is not a mother without thinking of something absent, lacking or missing, so prominently is motherhood woven into the social construction of the adult identity" (p. 123). Within the prevailing pronatalist discourse, childless women are thus defined by lack and absence. As concepts of womanhood are so closely interlaced with motherhood, women who do not have children are an oxymoron because they are defined by something they are not (Hird & Abshoff, 2000). This fact has major theoretical implications for examining how female identity is conceptualized in contemporary Western societies.

In contemporary pronatalist society, fertility is conceptualized through the lens of androcentric developmental theories and represents a major developmental milestone and the source of fulfillment for many women (Letherby, 2002). Given the high priority placed on having children and on the experience of motherhood, infertility and involuntary childlessness effectively serve as an assault on a woman's gender identity (Becker, 2000) and impact her sense

of self, damaging her whole self-perception—beyond the areas related to reproductive functions (Sandelowski, 1993). For example, Miall (1984) found that most of her research participants who had been diagnosed with infertility perceived their diagnosis as a disability that would impair their overall functioning. Furthermore, reduced self-esteem is a covariate of adjustment to infertility and a consequence of being diagnosed (Schneider & Forthofer, 2005). Infertility is a stigmatized condition that cancels out and overwhelms all other identity characteristics, thereby becoming the "master status" (Pfeffer & Woollett, 1993, p. 153) that defines a woman.

After the grief has been worked through, many women are left with a sense of deficiency (Ireland, 1993). For women who subscribe to the pronatalist discourse, who value motherhood in such a way that they constructed their identity around the expectation of having children, and who see parenthood as an intrinsic part of adulthood, the inability to have children can cause identity disruption, may lead to cognitive dissonance, and can be interpreted as a failure to achieve physiological, psychological, and social expectations (Ireland, 1993; McQuillan, 2012; Ulrich & Weatherall, 2000). The internalized self-concept of motherhood, as well as the importance ascribed to motherhood, may make such women feel inadequate and deficient. Moreover, Gonzales (2000) found that the inability to demonstrate the physical and symbolic changes of pregnancy was associated with feeling inadequate. Ireland (1993) put it more strongly: An involuntarily childless woman can feel deficient, like "she has a hole in her identity" (p. 7).

Ulrich and Weatherrall (2000) interviewed 19 women who were recruited at the local fertility clinic, with the aim of analyzing their data from a non-pronatalist perspective. The authors found that women perceived their diagnosis of infertility as a physical impairment and failure. One of the participants described her experience as follows:

> I was being picked on by his parents. His parents wouldn't leave me alone. They felt I wasn't trying. I was just feeling like a failure—failure as a woman because you know this is what you are here for and I actually felt as though I had failed my husband because I wasn't giving him an heir to the throne…it's an absolute feeling of failure and my mother felt as though she had failed me. (Ulrich & Weatherrall, 2000, p. 328)

Field consultants interviewed for this dissertation echoed Ulrich and Weatherrall's (2000) findings, reporting that the most common barriers childless/childfree women face when moving past their childbearing decision are the societal pressure, family expectations, and fear of regretting their decision to not have children and/or stop trying in the case of infertility. Dr. Walker described it as "pressure, pressure, pressure, overt and covert. It comes from peers, media, and family. We are misfits and it takes a lot of ego strength to say that you're going to go against the flow" (personal communication, August 5, 2015).

The loss of identity experienced by many women struggling with infertility and involuntarily childlessness stems from a loss of control that permeates beyond the reproductive area of their lives (Franklin, 1990). Infertility and involuntary childlessness take away a woman's ability to plan and control her future and, by doing so, damage her life plan and sense of self (Charmaz, 1991). Powerlessness, both real and perceived, has been found to be one of the major threats or assaults to an individual's identity, and such powerlessness can arise from infertility (Gonzales, 2000). Gonzales's (2000) research showed that women who are infertile/involuntarily childless experience loss of control in many areas of their lives, which compromises their "ability to plan for the future and…to exercise freedom of choice" (p. 367).

He emphasized the debilitating effects of experiencing a lack of control and feeling helpless, which many of his research participants reported.

According to Deveraux and Hammerman (1998), women may allow their infertility to become emblematic of their identity because being defined as "infertile" has caused them to lose touch with their true identity; thus, they are reduced to their diagnosis. In *Infertility and Identity*, Deveraux and Hammerman (1998) asserted that women who face medical infertility and/or involuntary childlessness must integrate this aspect of themselves into their identity through a process of acceptance and negotiation. For some women, the process is relatively unproblematic, and they are able to successfully integrate their new status into their identity without disruption. However, for women who perceive infertility as a major stressor, a significant disruption of their life course, and a threat to their sense of self (Culey et al., 2009; Greil, 2010; McQuillan et al., 2012; Wirtberg et al., 2007), the process of acceptance and negotiation is more complicated. Deveraux and Hammerman (1998) suggested that it is necessary for women to negotiate their self because they, along with many other women, perceive motherhood as a social expectation and as a normative aspect in the development of their romantic relationships. The field consultants reported that the most commonly reported presenting problems among women without children who seek therapy are major depressive disorder, general anxiety disorder, and marital problems.

It is important to note that infertility/involuntary childlessness is not a single event, but rather a process that women must go through in order to renegotiate and adjust their self-concept and identity (Matthews & Matthews, 1986). When faced with involuntary childlessness, individuals must go through an identity transition and must reconstruct their perspective on life

(Daniluk & Trench, 2007). They need to incorporate their involuntary childlessness into their identity and restore their sense of self.

Social Expectations and Negative Impact of Infertility

American pronatalist society holds a strong social expectation for adults to be fertile, and the norm is to have biological children (Greil, 1991). Many involuntarily childless women find themselves surrounded by co-workers, friends, and family members who talk about their pregnancies, their children, and their children's developmental milestones. As Loftus (2002) noted, "women with children are everywhere, at the supermarket, at the mall, on city streets, and even on television. Everywhere the infertile woman looks she is reminded that she is unable to become a mother herself" (p. 367).

The social stigma attached to being childless puts more pressure on an already destabilized identity. Social identity theory holds that a person's social identity is formed and maintained through a process of social comparisons (Tajifel, 1978). In the case of those who are infertile/involuntarily childless, women compare themselves with others who have children or who are pregnant and, in turn, define their identity in terms of their inability to have children. It is not surprising, then, that infertility often involves social experiences associated with blame, shame, guilt, and increased psychological distress (Greil, Slauson-Blevins, & McQuillan, 2010). Moreover, because infertility is not readily apparent, women who face infertility often feel the need to justify and explain themselves (Ulrich & Weatherrall, 2000).

Letherby (1999) interviewed 24 women who defined themselves as involuntarily childless and/or infertile in order to learn more about their psychological and social experiences of infertility. The majority of participants identified two common themes: feeling incomplete and experiencing social stigma due to their infertility. Some participants reported that they did not

feel deficient or that they were lacking anything within themselves, but rather, that others ascribed those qualities and feelings to them, assuming that they were pitiable and unfulfilled as women. The other important theme reported by participants is that others have many misconceptions about infertility, including its causes and treatment options. People often view infertility as easily treatable, with widely accessible treatments available to anyone who "really" wants to have a baby. Some participants reported that they managed the stigma of infertility by concealing their condition. At the same time, others felt the importance of "coming out," comparing their experience to the experience of those in the LGBTQ community.

Gonzalez (2000) interviewed 25 individuals diagnosed with infertility. In the article entitled "Infertility as a Transformational Process: A Framework for Psychotherapeutic Support of Infertile Women," Gonzalez pointed out that infertility is a socially constructed concept that should be understood as a complex, multidimensional process, rather than as a sequence of independent emotional events. Five distinct themes emerged from the data: (1) mourning the loss of one's ability to have children, (2) assault on personal identity, (3) failure to fulfill a prescribed societal norm, (4) transformation, and (5) restitution. Gonzalez (2000) noted that women who have struggled with infertility and the ensuing involuntary childlessness go through a process of learning how to deal with the stigma of childlessness. The assault on a person's identity and failure to fulfill societal norms were the most damaging and psychologically taxing themes reported by participants. All 25 participants reported feeling that they were treated with less respect following their diagnoses of infertility. They perceived themselves as less valuable to their spouse, family, and society. Participants also reported that their failure to conform to the societal norms led to an assault on their identity in terms of threats to their sense of self. They reported feeling powerless, stigmatized, and alienated. The final themes identified by Gonzalez,

transformation and restitution, related to women reframing their experience of infertility within an alternative, non-pronatalist framework and redefining their identity by separating their female identity from their reproductive capacity. This part of the process will be explored later in this document, during the discussion of feminist therapy.

Within a pronatalist social context, women who are infertile and involuntarily childless often experience alienation, stigma, social isolation, and invasion of privacy. These concepts will be discussed in more detail next.

Alienation. In *Reproducing Reproduction*, Franklin (1998) suggested that women who have been diagnosed with infertility not only experience the social aspects of their diagnosis, but also feel deviant themselves, as compared to the rest of the population. Griel (1991) asserted that, in pronatalist societies where parenthood is the established norm, non-parenthood and/or the inability to become a parent places the individual outside of the norm.

Exley and Letherby (2001) expanded on this idea, explaining that involuntary childlessness has an impact on a woman's social identity, resulting in her feeling outside of the mainstream. They argued that being involuntarily childless makes some women feel like strangers in a normative society; they are part of the group, but at the same time, they are outside of it. This perceived status of being an alienated stranger impacts their relationship not only with themselves, but also with others.

Stigma. Exley and Letherby (2001) found that "infertility and involuntary childlessness are potentially stigmatizing and damaging to an individual's identity" (p. 126). Women often delay treatment or do not seek treatment because they are concerned with being given a formal diagnosis of infertility; they fear both their emotional reactions to finding out that they are infertile as well as the social stigma that is likely to ensue (Bunting & Boivin, 2007). Many

individuals perceive themselves negatively and feel stigmatized due to being infertile (Miall, 1985). Even in developed countries, where a childfree lifestyle is seemingly accepted by society, women may still experience the stigma of infertility (Greil, McQuillan, & Slauson-Blevins, 2011).

In *With Child in Mind*, Sandelowski (1993) argued that contemporary Western societies view infertility and childlessness as both a disability and a form of deviance. She argued that childlessness is stigmatized precisely because it represents deviation from the norm in pronatalist societies. On the other hand, women who seek aggressive forms of treatment, such as in vitro fertilization (IVF), also are stigmatized and criticized, being labeled as "obsessed and neurotic" in their pursuit of pregnancy (Miall, 1994, p. 412).

Although both men and women are just as likely to be infertile, society typically focuses on the woman who does not have a child. The "blame" for infertility is usually attributed to the woman in heterosexual couples; psychological or sexual malfunctioning of the female—not the male—partner is typically assumed (Deveraux & Hammerman, 1998). It is not surprising, then, that women internalize infertility as part of their identity more than men do (Greil et al., 1988) and often experience *felt stigma*—a negative internal self-view (Greil, 1991). The felt stigma can then become the reason for these women's social isolation.

***Social isolation*.** Many, although not all, women who have been diagnosed with infertility or who are involuntarily childless experience poor psychosocial outcomes, including a loss of social connections, sexuality, financial resources, psychological stability, and privacy (Deveraux & Hammerman, 1998). Schneider and Forthofer (2005) conducted a secondary analysis of several studies that investigated psychological factors associated with perceived

stress and infertility. They found that social isolation is one of the most significant sources of distress among women who are infertile.

In an age of technology, when multiple support groups are available online, social isolation might seem unlikely. However, Malik and Coulson (2010) evaluated women who are participating members in online infertility support communities. Participants completed an online questionnaire regarding their perceptions about the quality of their online support. The results indicated that more than half of the sample perceived participation in online infertility support groups as disadvantageous and stopped or avoided participation. They did not like reading about negative experiences or about other women's pregnancies; they also did not like finding inaccurate information or experiencing the addictive nature of the online setup. The study confirmed that, despite the wide availability of resources, social isolation still is a problem that many women with involuntary childlessness face.

Violation of privacy. Finally, infertile and involuntarily childless individuals must face an invasion of their privacy. To begin with, the medical treatment for infertility is very invasive. Addressing infertility touches on deeply personal and intimate aspects of women's private lives, such as the frequency of intercourse, sexual history, birth control methods, history of sexually transmitted diseases (STDs), and the dates of their menstrual cycles. Furthermore, not only are fertility treatments invasive, but so are the well-meant but unsolicited advice and questions from friends, colleagues, and relatives (Deveraux & Hammerman, 1998; Miall, 1985). In addition, women often experience informal social sanctions, such as the dismissal of their condition (Miall, 1985).

Gonzales (2000) suggested that women are often ambivalent about revealing their diagnosis of infertility or the reason behind their involuntary childlessness. Yet they often find

themselves in a double bind: If they keep their infertility a secret, they end up struggling with the burden of that secret as well as having to endure social conversations regarding their reproductive decisions (Gonzales, 2000); on the other hand, in revealing their infertility, women may have to endure unwanted expressions of sympathy as well as unsolicited advice (Gonzales, 2000).

Voluntary Childlessness

More and more women in the United States are choosing to opt out of motherhood or delay childbearing. In 2014, 19% of women between the ages of 40 and 44 did not have any children (Gormly, 2013). Blackstone and Stewart (2012) found that childlessness is also increasing among younger women, as 28% of women aged 25 to 29 did not have children in 2010. Although these statistics do not differentiate between voluntary and involuntary childlessness and do not take into consideration adoption, there is a significant trend toward childlessness.

In "Choosing to be Childfree: Research on the Decision Not to Parent," Blackstone and Stewart (2012) suggested that, in order to gain an understanding of the social phenomenon of childlessness, the questions of how adults come to identify as childless/childfree and why they choose to opt out of parenthood need to be asked. Their extensive literature review demonstrated that the decision to not have children can be explained by macro-social forces (such as career choices) and micro-level social conditions (such as the motivation to maintain freedom and autonomy). Agrillo and Nelini (2008) found that childless women cite freedom from childcare responsibility, mobility, and aversion to lifestyle change among the most common reasons for their choice.

Although the obstacles faced by involuntarily childless and voluntarily childfree women overlap, voluntarily childfree women face additional challenges. Women who are voluntarily childfree routinely experience stigma. Likewise, they often experience their identity, choices, and human dignity being invalidated and devalued. These experiences will be discussed more in the following sections.

Stigma

Many women report being stigmatized because of their childless status, and the literature supports that voluntarily childfree women are perceived in negative terms (Gillespie, 2000; Letherby, 2000; McGuire, 2007; Mollen, 2006; Morell, 1994, 2000). More specifically, childfree women are typically seen as selfish, materialistic, less caring, less responsible, immature, neurotic, cold, unwomanly, socially undesirable, and maladjusted (Letherby, 2002; Park, 2005; Vinson et al., 2010).

In addition, women who reject parenthood are thought to suffer from pathological disturbances (Hird & Abshoff, 2000) and are regarded less favorably on all dimensions of personality, as measured on the Personal Attributes Questionnaire (Mueller & Yoder, 1997). In the media, women who choose not to become mothers in order to advance their careers are portrayed as dangerous, unhappy, regretful, unfulfilled, and even deranged (Morell, 1994). If infertility is a medical term for a type of disability, then the voluntary refusal to have children is viewed as a mental or moral defect and defined as deviance (Miall, 1986). The assumption is that there must be something wrong—if not physically, then mentally—with the woman who refuses to procreate.

Several field consultants interviewed for this dissertation reported that, in their clinical experience, women report experiencing a lot of stigma related to their childlessness. Some

women have to process their shame and guilt evoked by the attitude of their families, who think that by not having children these women are "getting off easy" or "taking the easy way out." Other clients reported being dismissed or treated as irrelevant by friends or siblings because they did not have children of their own. Some childless clients have experienced stigma in the form of sarcastic comments from their peers with children, such as "you are so lucky"; these peers interpret such choices as an indication of selfishness and irresponsibility.

Mollen (2006) identified five major themes of stigmatization that voluntarily childfree women experience: being excluded from discussions that focus on children, being expected to work longer hours, being considered abnormal, being pitied, and experiencing discrimination. According to Mollen (2006), the stigma faced by women who choose to remain childfree shows that their choices challenge the pronatalist ideology:

> On a fundamental level, women opting out of mothering challenge the ideology of the institution of parenting, calling into question the rigidity of gender roles, of what women are supposed to covet, and of the sociopolitical, religious, and familial idealism of creating the next generation. (p. 278)

Park (2002) described two techniques that 24 voluntarily childfree women and men in her study used to manage their stigmatized identities and to assert their right for self-fulfillment and adult identity without having children. First, individuals who used *passing* did not reveal their intent to remain childless in order to normalize their identity. Second, those who utilized *identity substitution* denied their choice in the matter; instead, they attributed their childlessness to biological or other circumstances (Park, 2002). Some voluntarily childfree women have even reported resorting to lying about being infertile, such as claiming that they unsuccessfully attempted IVF (Rich, Taket, Graham, & Shelly, 2011). However, other childless women have

adopted a more proactive position. They defend their choice by claiming that it is not selfish; rather, they argue, parenting is selfish as children often serve the unresolved needs of the parent. Furthermore, some women have justified their choice by rejecting the common myth of a biological drive to become mothers whereas others defend their choice by stating that they choose self-fulfillment and personal growth over having children (Park, 2002).

Invalidation and Devaluation of Identity, Choice, and Human Dignity

Voluntarily childfree women are often perceived to be a threat to family values and to be anti-family (Morell, 1994). A moral difference is assumed to exist between "normal" women and women who choose not to have children. Women who voluntarily choose not to have children are considered to be either deranged or morally suspect; therefore, their choice is invalidated. Pronatalist discourse has helped create a dichotomy between good, morally wholesome women who embrace maternity and bad women who choose to reject motherhood.

Gillespie (2000) studied 33 women who defined themselves as voluntarily childless (i.e., they actively chose not to have children). All of the participants reported that they had been treated with disbelief and faced strong negative reactions to their decision to remain childless. The women reported that their choice to remain childless was either interpreted as deviant or was regarded with incredulity. Participants described that certain people tried to legitimize their choice by coming up with a reason that they deemed more acceptable and legitimate, such as infertility. In essence, participants reported that their choice to remain childless was reframed as an involuntary misfortune, rather than as a deliberate choice. In addition to others conveying disbelief, participants reported that their choices were commonly disregarded or dismissed. Indeed, Gillespie emphasized that the participants reported being treated as "future" mothers who, as they matured into "normal" adults, would ultimately come to embrace their role as

mothers. Participants reported being told that they would change their mind regarding having children and that they would eventually become ready to embrace their "natural" role.

Gillespie (2000) concluded that, within the prevailing pronatalist culture, the choice to be voluntarily childfree is discounted, disregarded, and delegitimized as people assume that women will later regret this choice. This process of dismissing voluntarily childfree mothers and of normalizing that the only acceptable reason for childlessness is infertility reinforces the belief that motherhood is a necessary role that all psychologically healthy women embrace. Thus, women who voluntarily reject motherhood are considered to be outside the norm, and their choice is constructed as deviant or immature (Gillespie, 2000). Offering a general commentary on the study's findings, Gillespie (2000) asserted that rendering voluntarily childfree women's explanations of their choice as "unreasonable, irrational, juvenile, and regrettable" negates these women's choice and their very agency as independent human beings (p. 229). All six field consultants interviewed for this clinical dissertation reported that their clients do not report any regrets regarding their childbearing decision; however, Dr. Kubatsky reported that some of her clients exhibited "anticipatory regret." They expressed concerns about not having children to care for them during old age: "Who will take care of me when I am old? What will I do when everyone else is with their grandchildren?" (personal communication, August 5, 2015).

Rich et al. (2011) identified several major themes around which stigmatization occurs: society's equating femininity with motherhood, the promotion of dichotomous notions of natural/unnatural, and the viewpoint that childlessness is a discrediting attribute for undervaluing voluntarily childfree women. The voluntarily childfree women in their study reported being asked repeatedly by their friends, colleagues, and even therapists for the reasons behind their decision to not have children (incidentally, this is an example of therapists' biases leading to the

stigmatization of patients, which will be discussed later in the section that addresses treatment). Participants also reported being treated as if they were abnormal. One of them remarked that having children is "the default position. And if you don't have kids by a certain age, then there is something wrong with you" (Rich et al., 2011, p. 234). Other participants reported being treated as deficient and/or invisible, as not full adults, and as individuals who do not belong to the "real" world of mothers. Most women felt that, if it became known that they chose to not have children, they had to justify and explain their decision to remain childless. Moreover, the participants felt excluded because of their childless status. Finally, the study showed that women often felt that they were reduced to only one attribute of their identity: their childlessness.

These results are consistent with Morell's (1994) findings, which identified themes of feeling devalued and invisible in situations where stigmatization with regard to childlessness occurred. Park (2002) also found that the identities of childless women are reduced to their childless status; rather than being seen as whole people, voluntarily childless women are seen as defiance and are judged based on their childless/childfree status as opposed to being viewed as a whole multidimensional person. Most field consultants for this dissertation reported that they do not think they are biased toward women who do not have children and that they do not find working with them challenging. Most field consultants gave similar answers, reporting that they respect their clients' choices.

Developmental Theories

Life Cycle Psychological Theories

Traditionally, psychological theories of human development discuss, conceptualize, and explain human development from an androcentric perspective. For Freud, Erikson, Kohlberg, and many other male theoreticians, the developmental goals for females focused on "learning to

become an adaptive helpmate to foster male development"(McGoldrick, 1989, p. 202). Most Western developmental theories emphasize autonomy, independence, and assertiveness, rendering attachment, relatedness, and caring—the very characteristics expected of women—inferior and worthless (McGoldrick, 1989). In "Women Through the Family Life Cycle," McGoldrick (1989) pointed out that women naturally define themselves through relationships. However, within patriarchal discourse, women are always defined through men—as their daughters, wives, and mothers; "rarely has it been accepted that women have a right to a life for themselves" (p. 200). However, more recently, a larger number of women have chosen to pursue an education and career and to postpone childbearing, indicating a desperate need for a paradigm shift in the androcentric developmental theories that are still taught in universities around the country.

Freud's theory of development

Freud, the father of psychology and the first researcher of the human psyche, proposed that the male stood as the universal model of the human being. Central to the male's identity is the phallus, which Freud theorized is responsible for shaping a boy's identity and character. Because girls do not have a phallus, they must be terrified by what they lack; therefore, their development is defined by their striving to attain a phallus. Freud's developmental theory, therefore, depicts women as having a fundamental deficiency. Women's desire to have a male organ was thought to produce psychological consequences that resulted in an inherently unstable identity, whereby women were "born patients." According to Freud, women could not mature and develop to the same level of psychological development as men because they had to mourn the absence of the male organ and invest their energies in finding a man to whom they could attach as a way of obtaining the desired object (Freud, 1901).

Freud's subsequent model of psychological distress completely ignored social factors that might influence a person's development, presuming that individual reality is determined primarily by unconscious forces operating within a person's mind. According to Freud, pathology is the result of the ego's failure to mediate the animalistic desires of the id and the superimposed control over them through the agency of the superego. This model separates a person's emotional problems from her social, economic, and political context; in essence, a person is viewed as existing in a vacuum, and psychological problems are seen as internal, rather than as influenced by external forces. Models such as Freud's can be damaging to women because they conceptualize problems that are actually produced by gender inequality and oppression resulting from an individual's insufficiency and pathology.

Freud's model of intra-psychic conflict was grounded within the context of a patriarchal society and, thus, reinforced male supremacy and endorsed sex-segregation. His theory had an immense impact on psychological interventions, including the treatment models created to treat hysteria and what were deemed to be female neurotic traits. Freud conceived the psychoanalyst–patient relationship in terms of "a superior and a subordinate" dynamic, in which the therapist is the authoritative father figure and the patient is the helpless, powerless, naïve child (Rief, 1979, p. 138). The therapist had to be the expert who would assess the client, diagnose the pathology, and determine the appropriate treatment. Moreover, the therapist had to be a detached, neutral observer who did not show any emotional response to whatever the client presented; rather, he or she was to offer an interpretation based on his or her knowledge of psychopathology derived from the medical model.

One of the major premises of traditional therapy is the neutrality of the therapist, who is not invested in the relationship with the patient. Within the psychoanalytic tradition, the therapist

is the mirror, a white sheet upon which the patient projects his or her fears, feelings, and emotions; the therapist then is to provide unbiased interpretations, based on his or her academic knowledge and clinical experience. This model presumes that the therapist's absolute neutrality is not only possible, but also necessary for the therapeutic process to take place. Consequently, the role that therapists' personal values, norms, beliefs, and prejudices play in their interpretation of events and in their treatment of patients is disregarded.

Erickson's individual life cycle.

Pronatalist trends are entrenched in psychological theories, including Erik Erikson's theory of human development, which is among the most influential theories in 20th-century psychology (Miller, 2010). Although grounded in psychoanalysis, the Eriksonian model has been widely discussed and recognized in other fields as well, even today. However, many of the psychoanalytic notions advanced by Erikson have been criticized for being unscientific and failing to take into account conflicting data, especially when it comes to their application to women and people of other cultures (Hansson, 2014). Despite this, Erikson's stages remain a popular model for explaining human personality development.

Erikson's model proposes that an individual's personality development happens during eight stages, starting from infancy and lasting through old age. Each stage is characterized by a "crisis"—a psychological dilemma—and a set of existential tasks that the person must resolve in order to grow successfully. The theory posits that these stages and crises are universal and that everyone goes through them, despite some individual variability in timing (Miller, 2010).

Erikson's first five stages are an expanded version of the stages of psychosexual development, first identified by psychoanalysis. Unlike Freud, who primarily focused on sexuality throughout the developmental stages, Erikson focused on personality and identity.

Erikson's seventh stage, middle adulthood, presents a very interesting and complicated period (Sokol, 2009) and is of particular interest to the topic of this clinical dissertation as it reflects a pronatalist attitude. The conflict of this stage is between generativity and stagnation. *Generativity* refers to the "need to be needed" and most often takes the form of parenthood and raising children. According to Erikson (1950), generativity "is primarily the concern with establishing and guiding the next generation… the concept is meant to include… productivity and creativity" (p. 267). However, if one is not generative, she or he might become stagnant. People in *stagnation* do not contribute to society or refuse to do so. They are overtaken by dissatisfaction with life and their place in it. This can manifest in depression, anxiety, or other psychopathological conditions (Sokol, 2009). In "Generativity Versus Stagnation: An Elaboration of Erikson's Adult Stage of Human Development," Charles Slater (2003) suggested that people who desire to have children but cannot parent for some reason may find themselves in a state of stagnation and thus experience a crisis.

Erikson (1968) proposed that female anatomy impacts and predetermines female identity formation and "personality configuration" (p. 250). In "Womanhood and the Inner Space," Erikson (1968) attempted to apply his developmental theory to female development, pointing out that female identity development must differ from male identity development because of women's "somatic design that harbors an 'inner space' destined to bear the offspring of chosen men" (p. 266). When Erikson pointed out that the "inner space" can be a major source of psychological distress for women if it is not filled, he was obviously referring to women who did not have children. According to Erikson, childless women will experience emptiness and will mourn the loss of the possibility of having a child.

Critics of Erikson's theory have highlighted the pronatalist thought entrenched in his theory. Gergen (1990) pointed out that, grounded in a mid-20th-century worldview, "Erickson views a woman's capacity to reproduce and mother as the single most important determinant of her adult identity. Men, however, can achieve generativity through intellectual, occupational, and other public endeavors" (p. 278). What is most disconcerting is that this theory is used as the model for normative female (as well as male) development, even to this day, despite the radical social changes that have occurred since it was first conceptualized.

Feminist Critique of Androcentric Developmental Theories

Gergen (1990) noted that most developmental theories follow the same trajectory and pacing, viewing the developmental periods of childhood and adolescence as very active and dynamic and adulthood as relatively stable, with a steady regression into old age. However, within this broad trajectory, women's development is conceptualized differently than men's development, with all of the high points of her development concentrated in young adulthood, during which time women typically marry and have children. As wives and mothers, women's identity remains stable throughout their 30s and then follows a slow regression from their 40s onward. Gergen (1990) argued that,

> while this narrative form is a simplified schematic compiled from these various theoretical versions of women's lives, to the extent that it represents the status quo, it serves to exacerbate the plight of the mature woman who is faced with no clear alternatives. It operates as an invitation to anxiety and depression. (p. 477)

From the perspective of feminist critics, the problem with the prevailing developmental models is twofold. On the one hand, women are, as Gilligan (1993) asserted, "forcefully placed into men's life cycle," insofar as prevailing developmental theories emphasize the importance of

individuation, self-realization, self-actualization, and self-sufficiency, which can only be attained by men because of their status as non-dependent individuals. On the other hand, according to the same developmental scheme, women are excluded from ever possibly attaining this independent status because of the overwhelming importance placed on their status as wives and mothers. Therefore, women are in a double bind.

For example, in Erikson's model, men's development is characterized by the ability to achieve autonomy and individuation. Only after the process of individuation is completed can a man enter adulthood and proceed to the next stage of productivity and creativity, which involves "establishing and guiding the next generation" (Erikson, 1964, p. 28). Gilligan (1993) underscored that, in contrast, according to this accepted model of development, women's path to adulthood has to pass through attachment and care. Women can only achieve adulthood, not through individuating, but through their capacity to care for others. Accordingly, Erikson (1968) emphasized that women must be "trained to be wives and mothers" (p. 128). He suggested that a woman's identity development is different from a man's in the sense that "she prepares to attract the man by whose name she will be known, by whose status she will be defined, the man who will rescue her from emptiness and loneliness by filling 'the inner space'" (as cited in Gilligan, 1993, p. 12). Within this highly gendered model, women are presented as being naturally good at relating to others and at developing connections, but these skills are not considered valuable skills in the process of adult identity formation because individualization is prioritized.

Gilligan (1993) also pointed out the contradictions in Erikson's claim. On one the hand, his developmental theory is supposed to be universal, reflecting the development of both genders; on the other hand, he claims that women's development is different from men's, placing women in a situation in which developmental conflict is inevitable. Watsell (1996) similarly

argued that most developmental theories present male development as the norm of healthy functioning; women are reduced to being capable of achieving only a lesser standard of male functioning. That is, according to Erikson, women must achieve mature adulthood through separation, individuation, and self-realization, but they also must attract men who are able to rescue them from emptiness and loneliness by filling their "inner space" (Gilligan, 1993, p. 12). Moreover, Gilligan (1993) emphasized the conflict within women's identity at the heart of this model. A woman's identity is defined through relationships, attachments, and the quality of care that she provides to others, as she is expected to bear children and create a family. However, as Erikson claimed that his developmental theory is universal, women are also expected to strive for achievement and self-actualization, which, for Erikson, takes place in the public sphere. Yet the roles of wife and mother, which are so crucial to female development because they fulfill women's "biologically determined destiny," are largely limited to the private sphere (Erikson, 1964, p. 129).

Gergen (1990) underscored the fact that most psychological research and developmental psychology, at least up until the early 1990s, did not even question the notion that a woman's most important role is to be a caregiver to her children. In fact, research in the 1970s and 1980s emphasized the preeminent role of maternal care (Kagan, 1984). Writing from the female perspective, Daniels and Weingarten (1982) described parenthood as being a powerful generator of development: "It gives an opportunity to refine and express who we are, to learn what we can be, to become someone different" (p. 24).

Gergen (1990) highlighted the sociopolitical consequences of the valorization of maternity, when seen in relation to male-oriented developmental theory, by asking a very important question: "How is it that theories of the woman's lifecycle have contributed to the

perpetuation of male dominance within Western culture?" (p. 483). In answering this question, she concluded that, "in its debilitating view of women's life trajectory and its support for the status quo, existing developmental theory functions as an instrument of sociopolitical oppression" (p. 481).

To illustrate this critique, when judged by the standards of the male model of healthy development, many women may be succeeding. However, those who demonstrate independence, assertiveness, and characteristics of being goal-oriented and focused on their careers can face stigma and social disapprobation. As stated earlier, career-oriented women who have children must juggle the often-conflicting demands of work and motherhood placed on them while those who choose to remain childless and to focus other goals are often subjected to negative attitudes (Blackstone & Stewart, 2012).

Ultimately, Gilligan (1993) argued that it is very difficult for women to achieve social recognition as fully individuated and psychologically healthy adults because the standards used to judge women are those that were established for men:

> Life cycle descriptions, derived primarily from studies of men, have generated a perspective from which women, insofar as they differ, appear deficient in their development…. This construction reveals the limitation in an account which measures women's development against a male standard and ignores the possibility of a different truth. (p. 170)

Given this limitation, women can never win. If they choose to leave work to raise a family, they do not receive monetary compensation and face more difficulty in establishing themselves in a career once they return to work. If they prioritize their career, then they face the stigma of being considered selfish and uncaring. For Gilligan (1993), this type of inherent conflict is a result of

the female life cycle being forced to fit into the male model. Given the uneasy fit, female trajectories often appear as deviations from the norm, where the women themselves are perceived as deviant.

Thus, many women experience considerable conflict between desiring professional achievement and financial independence, on the one hand, and their personal relationships and socially prescribed roles as nurturers and caretakers on the other. This conflict results in many women feeling "either divided in judgment or betrayed" (Gilligan, 1993, p. 159). Ultimately, Gilligan (1993) emphasized the inadequacy of the existing models, noting that "there seems to be a line of development missing from current depictions of adult development…the silence of women in the narrative of adult development distorts the conceptions of its stages and sequences" (p. 156). She underscored the importance of conducting developmental psychological research in a way that focuses on female adult development and defines it in women's own terms.

Female adaptation to the social environment.

In her book *Women and Madness*, Phyllis Chesler (1972) compared marriage and therapy, drawing parallels about the oppressive nature of both. She claimed that both reproduced and reinforced female helplessness and passivity through the establishment of purportedly appropriate female behavior, thoughts, and desires for women. The very controversial book made an impact by arousing feminist consciousness and encouraging feminist therapists to examine their personal biases, the existing models of psychotherapy, and the ways in which both perpetuate oppression.

Chesler (1972) argued that the theories of normative development and of psychological pathology were inherently flawed, as they took the white, middle-class male as the model of

normality and, consequently, pathologized those who did not fit into this model, including women and ethnic/racial minorities. Chesler argued that the principle framework for mental health is masculine, under which psychologists accepted masculine development and behavior as the model of healthy functioning and rendered any deviations from that model as pathological. Chesler highlighted the double standards of the mental health profession and argued that both society and clinicians reinforce the model. A woman has to adjust in order to fit into the male "model of normality" (Chesler, 1972, p. 85); the failure to adapt and adjust to this normality results in a view that she suffers from psychopathology.

Working with Women Who Do Not Have Children

Women who do not have children socially and politically challenge the broader pronatalist ideology—and not necessarily by choice. Castaldo (2008) asserted that, "in order for a woman to embrace her development as an autonomous competent woman, a major paradigm shift in self-concept is necessary" (p. 31). From the perspective of psychology, a key question for both involuntarily childless women and voluntarily childfree women concerns the process of identity formation: How can a childless woman who wanted children, but for some reason cannot have them, redefine her self-conceptualization; detach her identity from the perceived failure of not achieving motherhood; and see herself, not in terms of her disability, but as a whole, fulfilled, and non-stigmatized adult? Conversely, how can a voluntarily childfree woman, who faces social reprimand for her decision, occupy the status of a competent, adult female?

Therapist Self-Awareness

The dominant culture of parenthood imposes its hegemonic power upon all of society; therefore, psychologists are not exempt from contemporary society's value system that shapes perceptions about what is normal, acceptable, and healthy. Russo (1979) asserted that the

pronatalist paradigm is so deeply ingrained in our society that psychology researchers and scholars struggle to fully appreciate the centrality of motherhood to female identity. Many people simply do not question the social order and view parenthood as a normal and natural part of development, which is needed to achieve mature adulthood. Ultimately, this view results in bias against childless individuals and couples.

Psychologists live within the current pronatalist society and practice within its cultural context, so they are inevitably exposed to its values and biases. For example, psychology students are taught developmental models that uphold parenthood as an inevitable step in an adult's development. Developmental life cycle theories, such as Erikson's, consider parenthood to be a major milestone that has to be reached in order to develop an identity as a mature and responsible adult. For women, these theories consider childbearing itself, not just parenthood, to be a very important milestone necessary for the development of adult identity. Mollen (2006) pointed out that a psychologist's male's and female's unchecked pronatalist biases might result in harmful assumptions, assigned values, and personality attributions concerning childless and childfree women. She warned that therapists should not assume that every childless or childfree woman is deviant, unfulfilled, and/or selfish. Instead, therapists should focus on empowering women, helping them battle stigma, normalizing their decision, and acknowledging the true consequences of being marginalized.

To counterbalance their potential for bias, psychologists and other mental health professionals have been encouraged to pay attention to and acknowledge the diverse experiences of the populations with whom they work. Psychologists are taught to be sensitive of the culture, religion, racial and ethnic composition, socioeconomic status, and sexual orientation of the populations with whom they work. They are also taught that, in order to be helpful to clients and

to establish a productive therapeutic relationship, psychologists must be aware of their own value systems and acknowledge and confront their biases, conditioning, and preferences. However, the issue of parenthood bias and the marginalization of childless and childfree individuals are seldom addressed; therefore, they remain largely unexplored within the literature and within the training and practice of mental health professionals. A paucity of research examining mental health professionals' attitudes toward childless and childfree individuals or how unexamined biases might negatively impact the women with whom these professionals work exists. In fact, counseling clients from a pronatalist standpoint would likely make childless and childfree women feel misunderstood and stigmatized, thereby decreasing the effectiveness of therapy and damaging the therapeutic relationship. In "Perceptions of Childfree Women: The Role of Perceivers' and Targets' Ethnicity," Vinson et al. (2010) strongly suggested to clinicians working with childfree women to examine and process their own beliefs and attitudes toward childfreedom.

Feminist Therapy

Overview of feminist therapy. The women's movement, which gained prominence at the end of the 1960s, challenged the prevailing models of Freudian psychoanalysis and behaviorism by encouraging women and men to be more conscious of social oppression and the importance of individual context. This new ethos was supported by the work of Carl Rogers, who introduced what, at the time, was the radical idea of seeing and treating a patient not as a mere subject of an experiment, but as an individual—a fellow human being.

Feminist psychotherapy took Rogers' notion further by looking not only at the individual psyche of a particular person, but also at the context in which the person lives, including the political, social, and economic forces that shape one's environment and subsequently contribute

to the development and maintenance of one's symptoms. Whereas the medical model treated the psychiatric disorder as a disease that can be cured like the flu, feminist psychotherapists look for the external triggers that may have precipitated a patient's symptoms (Greenspan, 1993). Feminist critics also challenge the role of the psychiatrist as an omniscient expert, which they claim constructs a dynamic based on the therapist's superiority and the patient's inferiority, thereby reproducing the patriarchal model of male–female relationships and causing women to feel anxious, doubtful, dependent, and ashamed of their problems (Greenspan, 1993).

Feminist therapy was originally formulated by women who were not satisfied with conventional approaches to therapy and wanted to challenge existing premises of traditional psychotherapy. Taking a historical view, feminist psychologists maintained that, for centuries, women had been socialized to be submissive, dependent, and accommodating to men and had been forced, often through violence and other forms of coercion, to accept the demands of patriarchal society, which thrived on women's powerlessness and denied them authority. Many feminist therapists formed consciousness-raising groups, in which they could discuss patriarchal oppression—often in formats that eschewed traditional authority structures.

Feminism and feminist therapy further evolved from the need to raise awareness about gender inequality and its effect on women's psychological wellbeing. As feminism progressed through several stages of development, it became increasingly sensitive to the experiences of different groups of women, such as working class women, women of color, women who do not identify as heterosexual, and to how multiple forms of oppression (sexism, racism, classicism, and homophobia) intersect in their lives. Today, feminist therapy has developed a multicultural and postmodern framework capable of recognizing how oppression operates; feminist therapy undertakes as its goal the empowerment of clients, as opposed to the "treatment of patients'"

(Brown, 2009, p. 35).

What distinguishes feminist therapy from other forms of therapy that identify as nonsexist and humanistic is that it focuses on empowering the client by inviting her to critically examine the ways in which society has contributed to her distress, the imprint this has had on her personality, and the ways in which she can gain power and make changes at an individual level, while supporting changes in her community and society at large.

Principles and goals of feminist therapy. Two fundamental beliefs provide the foundation for feminist therapy: (1) the personal is political and (2) symptoms are coping tools. With these beliefs in mind, the goal of the therapist is to help the client examine how external realities of women's lives impact their problems and contribute to the development and maintenance of their symptoms. The therapist then helps the client understand that her symptoms are a way of coping, adjusting, and surviving in patriarchal society, rather than signs of dysfunction. In contrast, traditional therapies based on the medical model conceptualize the case based on the presented symptoms and signs and then decide on a diagnosis that drives the treatment plan and the formulation of interventions. Feminist therapists believe that psychological symptoms have to be interpreted within the broader familial and social context in which they occur (Enns, 1997).

The feminist therapy approach promotes a better understanding of the client's problems and facilitates effective interventions aimed at empowerment and rehabilitation. As Greenspan (1983) argued, "when clients are encouraged to look exclusively inside themselves for the source of a problem, they are inclined to blame themselves for the entire problem, and 'adjust' to the circumstances around them" (p. 146). Feminist therapy believes that decontextualizing a person's symptoms endorses blame, shame, and guilt, thereby perpetuating the pathology.

From the perspective of feminist therapy, the medical model reinforces the client's powerlessness and helplessness by defining female psychology in terms of deficits and by denying women any possibility of normal adult functioning. In setting out a diagnosis, the medical model then creates a powerful social construct of normal and abnormal functioning, facilitating objectification of the client (Suyemoto, 2000). In contrast, feminist therapy avoids diagnostic labels; if one must absolutely be given, then the therapist arrives at it collaboratively with the client, making the client aware of the diagnosis and the reasons it has been given. In this way, power has been given back to the client, who is the expert of her own experiences.

Feminist therapists understand psychological symptoms as adaptive strategies and try to establish how these symptoms operate within the client's context. Mitchell (2014) underscored that the most important premise of feminist therapy is to see and understand the context in which clients live. Feminist therapists believe that, just as pain is a physical sign of a physiological dysfunction or disorder within the body, psychological symptoms are signs of psychological distress triggered by the client's environment. Within this context, some of the behaviors that may have previously been adaptive and functional, actually helping a client survive in her previous environment, might become maladaptive in the larger world that she enters as an adult (Mitchell, 2014). The field consultants interviewed for this clinical dissertation supported feminist theory's conceptualization and reported that they conceptualize cases as non-pathologically as possible.

Utilizing feminist therapy to work with clients is very different from the framework promoted by the conventional medical model:

> Rather than viewing symptoms such as depression, anxiety, or passivity as a problem to be eliminated, the feminist therapist views these patterns as indirect forms of expression

> that can be refocused in more direct and productive forms of communication as a client gains stronger sense of self. (Enns, 1997, p. 11)

The feminist therapist, therefore, points out the adaptive and functional nature of the symptoms that the woman is experiencing, helps her find more effective ways to adapt to her current circumstances, and empowers her to change these circumstances, if she wishes to do so. This may involve helping the client examine and explore power structures that dominate her life, such as the schemas of gender that may impact her perception of her reality and the reality of others.

A feminist therapist empowers the client by helping her identify her best resources for healing. Ballou and West (2004) suggested that the ultimate goal of the feminist therapist is to help the client identify her strengths in order to increase her self-worth as well as help her direct those strengths in order to improve her functioning. Bruns and Kachak (2011) pointed out that the feminist therapist should strive to help the client "develop the ability to map the ever morphing terrain of mattering, power, context, and experience as well as continually center the margins and question cultural trances" (p. 4).

Although feminist therapy offers a crucial perspective for understanding the experience of clients and a general approach to therapy, feminist therapists do not limit their interventions to those developed by feminist therapists (Brown, 2009). They are encouraged to use and adapt other modalities and interventions that might benefit their clients. For example, the cognitive-behavioral modality can be used in order to expose the client's core beliefs about herself and the world as well as to identify any distorted cognitions that contribute to the maintenance of her symptoms. Likewise, mindfulness can be practiced in order to reduce a client's tension and level of anxiety. Whatever the therapists' choice, they have to make sure that they practice within the premises of feminist therapy in order to respect the client as the agent of change and as an

egalitarian partner in the therapeutic relationship.

The client–therapist relationship in feminist therapy. Egalitarian relationships, in which the patient is the expert of her own feelings, emotions, and experiences, represent the cornerstone of feminist therapy. Feminist therapy is a collaboration of two equals, where both individuals have an equal amount of authority and where the power dynamic of the relationship needs to be examined and revised in order to create equality of power.

Enns (1997) emphasized that the neutrality of the therapist is a myth and cannot be achieved; in other words, bias is unavoidable. Within feminist therapy, the therapist is called upon to examine and acknowledge her or his biases and beliefs as well as to develop a thorough understanding of how they affect the therapeutic process.

As an empowering and egalitarian model of therapy, feminist therapy acknowledges and promotes clients' rights to make informed decisions about their treatment. By making an informed decision about whether to enter counseling and the areas of focus in the treatment, the client is viewed as an agent who takes responsibility for her actions. Informed consent is crucial in this regard and is, therefore, seen as a fundamental part of feminist therapy (Enns, 1997). Such therapy is a seen as a contract between two parties who entered into it voluntarily. It is the responsibility of therapists to provide the client with information regarding their theoretical orientation, the cost and estimated length of the treatment, and any other information that might facilitate the client's decision-making process; therapists also need to warn the client about any limits to confidentiality (Ballou & West, 2004; Enns, 1997). Although informed consent is usually obtained at the beginning of treatment, the therapist is encouraged to review it and revise the treatment goals with the client, thereby fostering a more egalitarian relationship by allowing the client to make informed decisions on how she chooses to employ the therapist's expertise. It

also closes the gap between the expert and the client by bringing them together into a collaborative process. Self-disclosure is another important tool employed in feminist therapy in order to build an egalitarian relationship between the therapist and the client (Ballou & West, 2004). An appropriate amount of self-disclosure can dispel the paternalistic myth of the all-knowing expert and can facilitate the formation of a therapeutic alliance based on the similarity of experiences; furthermore, self-disclosure can foster feelings of empathy and understanding. However, excessive and inappropriate self-disclosure by the therapist can harm the therapeutic relationship by creating undefined, blurred boundaries and by placing the experiences of the therapist at the center of therapy.

Feminist therapy for childless women. Given its critical view of patriarchal gender relations and resistance to stereotypes about women's behavior and psychology, feminist therapy offers a potentially valuable approach for counseling childless women. Pronatalist society imposes social expectations that force women to see and value themselves as caregivers because it views self-care as selfish and inappropriate for women. Such norms often force women to "lose touch with their own emotions, desires, identity, and goals" (Enns, 1997, p. 30). Women are socialized into caregiving roles; therefore, motherhood—the ultimate caregiving role—is thought to be "inevitable and desirable" for every "normal" woman while women who chose not to have children are viewed as selfish (Letherby, 2002, p. 12). Those who are unable to have children are regarded as incomplete and unfulfilled. Thus, feminist therapy can help childless and childfree women understand the enormous social pressures that may be bearing down on them. Feminist therapy can also help these women develop a plan for self-care and self-nurturance by helping them look beyond the role of the caregiver in order to affirm their individuality.

All six field consultants revealed that they do not use any interventions specific to the population comprised of women who do not have children. Four of the six field consultants reported that they use cognitive modalities in order to perform cost–benefit analyses and help their clients process the feelings associated with not having children; they also develop an acceptance and commitment therapy (ACT)/dialectical behavior therapy (DBT) lifestyle value assessment and teach grounding and anxiety-reduction exercises, such as mindfulness.

Alternative Life Cycle for Childless and Childfree Women

Given the increasing tendency in Western societies for people not to have children despite the overwhelming importance placed on the begetting of children in Erikson's highly influential model, psychologists have begun to question this model and propose modifications and alternatives. Pelton and Hertlein (2011), for example, offered an alternative life cycle model for voluntarily and involuntary childless women, which clinicians may find useful when conceptualizing cases and working with women who do not have children. They emphasized that their proposed life cycle model is focused on helping women without children to develop an identity and legacy that are not contingent upon having children. They proposed four stages/tasks that are necessary for childless women to complete in order to form a healthy identity and resolve the crisis posed by Erikson's generativity versus stagnation conflict.

The first step in this model involves making the decision to remain childless. This, as Pelton and Hertlein (2011) noted, is often an involved process. Letherby (2005) also emphasized that the process can be lengthy, occurring in stages. For example, a woman undergoing fertility treatment may gradually come to question the value of pursuing further treatment and decide to discontinue such treatment. Alternatively, a woman in her 20s might frequently mull over the idea of having a child but, as she reaches her mid-30s, may decide against it. Given the

complicated nature of this decision-making process, Pelton and Hertlein (2011) underscored that women should be supported in ensuring their individuation, differentiation, and creation of boundaries so that they are able to make autonomous decisions without outside pressure becoming too overwhelming or posing a threat to their identity.

Once a decision is made, managing stigma and pressure is the second very important step that childless women have to negotiate. Pelton and Hertlein (2011) noted that, during this stage, women have to learn how to deal with the enormous pressure put on them by family, friends, and societal norms. Successful management of this pressure will help childless women focus on themselves and move on to the next stage, which is the negotiation of their non-parent identity, rather than remain stuck in the managing stigma stage.

During the next stage, childless women define their identity as an adult without children. Women learn to appreciate their interests, hobbies, and other activities that can facilitate their fulfillment and adult development. This can be a very fulfilling stage, as "the childfree woman has the unique opportunity to carve out an adult identity that does not include parenthood" (Pelton & Hertlein, 2011, p. 46).

The final stage of the model focuses on building a support system and leaving a legacy. Pelton and Hertlein (2011) emphasized that social isolation and the lack of adequate support systems are among the several reasons for the increased anxiety and life dissatisfaction that childless women experience as they age. Therefore, childless women should be encouraged to strengthen their ties to their community and engage in activities outside of the home as well as intellectually and emotionally fulfilling activities. Engaging in some kind of activity that promotes generativity, such as tutoring or volunteering, would be helpful in creating a legacy.

CHAPTER III: Methodology

Design Concept and Objectives

This clinical dissertation (and the resulting presentation) had three goals. The first goal was to increase mental health professionals' understanding of biases faced by childless and childfree women living in a pronatalist society. Along these lines, this clinical dissertation examined the ways in which androcentric developmental theories are complicit in the perpetuation of biases toward women who do not have children. The second goal was to address biases that mental health professionals might have toward women who do not have children. The third goal was to discuss a useful treatment modality—namely, feminist therapy—for working with women who do not have children. It is hoped that, by increasing awareness of their biases, which have likely developed within a pronatalist society, mental health professionals can modify their behavior and improve the quality of services that they provide to women who do not have children.

Procedures

The selective literature review was conducted by gathering literature relevant to the following areas of study: women who are involuntarily childless, women who choose not to have children, developmental theories, and feminist therapy. PsyINFO, books, research articles, professional works, and other academic resources, as well as blogs, magazine articles, interviews, and faculty feedback, were employed to gather relevant data.

The selected literature review sections were completed; the purpose, goals, and objectives of the clinical dissertation were established, and methods were outlined. A clinical dissertation proposal meeting was held on October 27, 2014. The meeting participants included the clinical dissertation chair, Dr. Ronda Doonan, the academic consultant, Dr. Christina Magalhaes, and the

author of the dissertation. This meeting was aimed at providing the author with suggestions in order to improve the final product of the clinical dissertation. Moreover, during the meeting, a list of field consultants, proposed interview questions, and a proposed evaluation scale (for the audience of the presentation to fill out) was presented to the committee for consideration.

Potential field consultants were identified from Internet searches and personal referrals. Internet searches on specialists who work with voluntary childless women and women diagnosed with infertility were used in order to identify specialists who work with these particular populations. Several field consultants were selected, based on their experience and expertise. The information received from the interviews was used to supplement the literature review and help decrease gaps in the existing literature related to involuntary and voluntary childless women. The field consultants were emailed a Field Consultant Interview Consent Form and Field Consultant Interview Questions. The selected field consultants were offered different options for communication (e.g., phone, e-mail, and Skype).

The final product of this clinical dissertation was the development and delivery of a one-hour visual and oral presentation to mental health professionals. The oral and visual presentation discussed the findings reflected in the literature review as well as input obtained from the clinical dissertation chair, academic consultant, and selected field consultants. Presentation evaluation forms were developed and given the presentation audience in order to gather information about the presentation's strengths and weaknesses for use in making the necessary changes for future presentations.

Target Audience

The target audience for the presentation included mental health professionals who provide mental health services to women. Audience members at a community mental health

clinic were selected because these professionals work with women who might experience the types of issues described in this clinical dissertation. It is hoped that, by attending the presentation, these professionals were able to serve the targeted population with more sensitive and appropriate client-oriented therapeutic services. The presentation was open to all mental health professionals interested in expanding their knowledge and understanding this particular population.

Project Resources

The presenter utilized appropriate electronic devices, such as a computer, a projector, and a screen. Such technology aided the presenter in providing mental health professionals with a high-quality product.

CHAPTER IV: Results

Field Consultant Interviews

Six field consultants with theoretical knowledge and clinical experience working with women without children were selected for their clinical expertise and academic knowledge. These field consultants' contributions were used to supplement the literature review, expand the findings from the existing research, and add ideas/issues neglected in the literature. The Field Consultant Interview Questions are included in Appendix A. All of the field consultants chose to communicate their clinical perspectives via e-mail. A brief description of each field consultant is provided below.

Brief Consultant Profiles

Jane Beresford, Psy.D., is a licensed clinical psychologist with more than 25 years of private clinical and forensic experience in Encino, California. She has worked in multiple clinical settings, including community mental health, state hospitals, and Veterans Affairs (VAs). Her clinical interests include women's health and the effect of stress on fertility.

Jennifer Bessel, Ph.D., is a licensed clinical psychologist who has worked in private practice for more than 18 years in San Diego, California. Her primary area of specialization is working with women who undergo fertility treatments; she also specializes in fertility hypnosis.

Mary Hayden, Ph.D., is a licensed clinical psychologist who has worked in private practice for more than 35 years. She has extensive experience working with women who are voluntarily and/or involuntarily childless and women who are in the process of moving past their childbearing decisions. Dr. Hayden also works with and is actively involved in the LGBTQ community.

Kristina Rodriguez, Psy.D., is a licensed clinical psychologist who has worked in private practice for more than 15 years. The primary area of her specialization is working with women who have been diagnosed with infertility. She runs infertility support groups that offer women support and psychoeducation about their condition.

Gretchen Kubacky, Psy.D., is a licensed clinical psychologist with more than 25 years of experience as a social worker, including more than 10 years of private practice experience in Brentwood, California. She specializes in treating women who have been diagnosed with infertility and are undergoing infertility treatment.

Elen Walker, Ph.D., is a licensed clinical psychologist who has worked in private practice for more than 25 years in Bellingham, Washington. One of her primary areas of specialization is women's psychology. She is the author of *Complete Without Kids: An Insider's Guide to Childfree Living by Choice or by Chance* (2011).

Consultants' Responses to Questions

The following subsections provide a discussion of consultants' responses to the questions provided.

Question 1. When asked about their theoretical orientation, Dr. Walker said that she is an existentialist who also specializes in cognitive behavioral therapy. Dr. Hayden stated that she practices from a psychodynamic and feminist theoretical orientation. Dr. Rodriguez reported that her primary theoretical orientation is based on a cognitive behavioral foundation. Dr. Bessel stated that she practices from a psychodynamic perspective. Dr. Kubacky practices from a psychodynamic perspective. Dr. Beresford practices from cognitive behavioral and human existential perspectives.

Question 2. The field consultants were asked about their experience regarding whether the terms *childless* versus *childfree* make any difference to clients. They unanimously stated that the term *childless* refers to a lack of something, missing out, loss, grief over that loss, a lack of choice, and a condition rather than a voluntary state. Meanwhile, the term *childfree* refers to a proactive choice. Dr. Bessel pointed out that her clients "can move towards the term childfree only when they have processed the trauma and emotions that they have gone through" (personal communication, August 3, 2015). However, Dr. Kubacky noted that the term *childfree* elicits a strong reaction in women going through infertility treatment: "Childfree tends to elicit some panic in infertility clients, as they cannot imagine actually *choosing* not to have children" (personal communication, August 5, 2015).

Question 3. Three of the six field consultants said that the most commonly reported presenting problems among women without children who seek therapy are major depressive disorder, general anxiety disorder, and marital problems. Dr. Hayden reported that her lesbian clients have reported conflicts within the relationship when one partner wants to have children and the other does not and the family of origin pressures them to produce grandchildren.

Question 4. The majority of field consultants reported that they did not notice any specific psychopathology as being common in women without children. However, Dr. Bessel, who works with clients going through infertility treatment, reported that her clients often present with depression, anxiety, and relational issues. Dr. Hayden reported that she has one client who suffered from depression and grief because she was unable to conceive after having an abortion.

Question 5. Most field consultants reported that they do not use any interventions specific to the population comprised of women who do not have children. The majority of field consultants reported that they use cognitive modalities in order to perform cost–benefit analyses

and help their clients process the feelings associated with not having children. Dr. Kubacky reported that she uses an ACT/DBT lifestyle value assessment; she also uses grounding and anxiety-reduction exercises, such as mindfulness. Dr. Hayden reported that she works on helping women clarify "whether her desire to have children reflects her own genuine desire or whether she is responding to societal pressures to 'fulfill her destiny as woman' by having children" (personal communication, August 5, 2015). She added that "I always work to counteract such societal pressures and encourage each woman to pursue goals reflective of her own deepest sense of what she wants for herself" (personal communication, August 5, 2015).

Dr. Walker echoed Dr. Hayden's statement by suggesting that "for most being a mom is the central role they take on in life" (personal communication, August 5, 2015). According to Dr. Walker's and Dr. Rodriguez's clinical experiences, women who do not have children need to work on making sure their lives have purpose and meaning without children.

Dr. Bessel, who primarily works with women trying to conceive or dealing with grief and loss over not being able to have a family, reported that she found hypnosis to be very helpful for clients undergoing fertility treatment. In addition, mindfulness, validation, and education are important for all her clients.

Question 6. All six field consultants stated that their clients have not reported any regrets regarding their childbearing decision. According to Dr. Kubatsky, some of her clients exhibited "anticipatory regret." They expressed concerns about not having children to care for them during old age: "Who will take care of me when I am old? What will I do when everyone else is with their grandchildren?" (personal communication, August 5, 2015). Dr. Walker reported that she sees a lot of women who had children and regretted their decision due to family conflicts. "I see many mothers later in life who are unhappy with their relationships with adult children and also

distressed because they have limited career, let health and looks go, and don't feel connected with their husbands after children leave home" (personal communication, August 5, 2015). Dr. Beresford reported that approximately 30 percent of her clients experience some form of regret over their childbearing decision. Dr. Bessel noted that regret is typically reported by women who did not have children due to infertility (medical and/or circumstantial), but not by women who actively choose a childfree lifestyle.

Question 7. When asked whether women without children report experiencing stigma related to their childlessness, Dr. Kubacky reported that, in her clinical experience, she noticed that women experience a lot of stigma related to their childlessness. She mentioned that some women have had to process their shame and guilt evoked by the attitude of their families, who think that by not having children the women are "getting off easy" or "taking the easy way out." Her other clients have reported being dismissed or treated as irrelevant by friends or siblings because the women do not have children of their own. Dr. Kubacky reported that some of her clients indicated feeling that their childbearing decision and the fact that they do not have children define their identity in terms of lack and deficiency, which Dr. Kubacky described as follows: "Some of my clients feel ashamed for being broken, infertile, barren (or similar terms) because they don't have children." She further noted that some clients reported feeling pressured by friends and family to have children, which is not an overt stigma, but something they internalize as a stigma of being "less than" (personal communication, August 5, 2015).

In her clinical practice, Dr. Hayden has observed women who do not have children dealing with pressure from their families to have children. Some have reported that it is very difficult for them to maintain friendships with people who have children and very different lifestyles (personal communication, August 5, 2015). Dr. Walker also reported that her clients

often process their strained friendships and feelings of not fitting in with their friends who have children and grandchildren.

Dr. Rodriguez reported very similar findings. A lot of childless women in her practice have reported feeling societal pressure and shame associated with their childlessness. They have experienced stigma when responding to repeated questions about why they do not have children. Dr. Rodriguez also reported that some clients feel ostracized by women who have children because they feel that they do not have much in common with them. Her clients reported that they often feel that their friends and people in general focus on motherhood as the defining aspect of the female identity instead of focusing on getting to know a person individually.

Dr. Bessel, who works with women going through infertility treatments and dealing with medical diagnoses of infertility, reported that her clients are typically coping with infertility and at times may have to make the decision to live childfree. Her clients feel a stigma about their infertility and not being able to get pregnant as well as not adopting children. Dr. Bessel noticed that part of the stigma has to do with not understanding how all of the options work; someone might choose to try IVF and then not have any additional emotional or financial resources to pursue other options after that. It is a difficult choice for this population to decide when they will stop trying to have a child and make the choice to live childfree (personal communication, August 7, 2015). Dr. Beresford noted that some of her childless clients have experienced stigma in the form of sarcastic comments from their peers who have children, such as "you are so lucky"; they interpret such choices as an indication of selfishness and irresponsibility.

Question 8. When asked about how they address the stigma, how they conceptualize cases, and what interventions they use most, the field consultants responded that they conceptualize cases as non-pathologically as possible, consistent with their theoretical

orientation. Dr. Kubacky reported that she often sees a lot of shame and guilt associated with the choice or inability to have children. She said that she looks at overall patterns of avoidance, shame, and anger to lead her clients in exploring what exactly "happiness" and "fulfillment" mean, depending upon the total picture as far as their physical health, mental health, life circumstances, and stated goals.

Dr. Hayden reported that she works toward helping her clients label the stigma as a form of oppression and societal control over women. She encourages clients who are unsure about whether to have children or not to be aware of the fact that "there are good reasons not to have children in a world struggling with overpopulation and an endangered ecosystem. The socially responsible thing might be not to have children" (personal communication, August 5, 2015).

Dr. Rodriguez also conceptualizes cases as non-pathology. She encourages women without children to make friends in their communities who share similar hobbies and lifestyles. In therapy, she works on rebuilding clients' self-esteem and improving their boundaries. Dr. Walker also emphasizes the importance of social support within the community.

Question 9. Most field consultants reported that they do not think they are biased toward women who do not have children and that they do not find working with them challenging. Most field consultants gave similar answers, reporting that they respect their clients' choices. Dr. Hayden reported that she finds it challenging to "accept the deep longing many women feel about having a baby and raising that child" (personal communication, August 5, 2015). She reported that she tries to honor such longings and assist women in their search to become mothers. Dr. Hayden admitted that her empathy is challenged when she sees the extent to which some couples go to conceive a child, "sparing no expense and sometimes compromising the woman's health with fertility drugs" (personal communication, August 5, 2015). Dr. Walker also

admitted that she finds it difficult to encourage and affirm women who want to be a mother and also express their desire to have a full-time career.

Question 10. Most field consultants reported that the most common barriers childless/childfree women face when moving past their childbearing decisions are the societal pressure, family expectations, and fear of regretting their decision to not have children and/or stop trying in the case of infertility. Dr. Walker described it as "pressure, pressure, pressure, overt and covert. It comes from peers, media, and family. We are misfits and it takes a lot of ego strength to say that you're going to go against the flow" (personal communication, August 5, 2015).

Presentation and Evaluation Feedback

Presentation

The final product developed for dissemination was a one-hour PowerPoint presentation delivered on November 18, 2015, at Hollywood Mental Health Center. The 15-person audience included a licensed clinical psychologist, several licensed clinical social workers (LCSWs), two psychiatrists, and clinical psychology interns.

The presentation provided important and useful information about women who do not have children, including the experiences and effects of being childless and childfree in today's world. The PowerPoint presentation comprised 19 slides, along with presentation lecture notes (see Appendixes B and C). Slide topics covered (a) pronatalism, (b) infertility, (c) involuntary and voluntary childlessness, (d) stigma related to not having children, and (e) treatment considerations. The salient points were explained in more detail, with additional information included in the lecture notes. The PowerPoint presentation was delivered using the projector, and the presentation slides and evaluation forms were printed and passed out to the audience

members. The presentation took about one hour and concluded with ample time left for questions, comments, and the completion of the evaluation forms (see Appendix D).

Evaluation feedback

After the end of the presentation, those in attendance were given the Presentation Evaluation Form, which they were asked to fill out anonymously. The Presentation Evaluation Form included eight questions, seven of which utilized a five-point Likert scale (where 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree). In addition to the seven questions requiring a rating score, one question asked the audience to provide written comments.

The review and analysis of the data extracted from the Presentation Evaluation Form showed that a majority of the audience members found that the presentation fulfilled the stated presentation objectives. A majority of the audience members agreed or strongly agreed that the presentation (a) increased their understanding of biases that childless and childfree women face ($M = 4.87$, $SD = 0.35$); (b) increased their self-awareness of their own biases toward women without children ($M = 4$, $SD = 0.74$), and (c) effectively described feminist therapy as an intervention that can be used by mental health professionals when working with women who do not have children ($M = 4.2$, $SD = 0.78$). Regarding the other rating scale questions, most audience members agreed or strongly agreed that the presentation was well organized and the salient points were clearly explained and easy to understand ($M = 4.73$, $SD = 0.46$). Most audience members agreed that the presenter appeared knowledgeable about the presentation topic ($M = 4.8$, $SD = 0.41$). Moreover, the audience members agreed that the presenter was responsive to questions ($M = 4.87$, $SD = 0.35$). The feedback on the statement “I would recommend this presentation to other professionals” was mixed ($M = 4.4$, $SD = 0.82$).

Only three audience members provided written feedback on their Presentation Evaluation Form. All comments were positive, saying “very interesting topic,” “much needed research,” and “great job.” Moreover, it was noted that the presenter was “knowledgeable,” “engaged,” and “professional.”

The audience members also offered constructive criticism, such as that the presentation was “a bit overwhelming” and was “presented too fast.” A few audience members stayed after the presentation to ask questions that they came up with later and make comments that they wanted to make personally to the presenter.

Product Sample

Please refer to Appendixes B and C for a copy of the PowerPoint presentation slides and presentation lecture notes.

CHAPTER V: Discussion

Implications of Oral and Video Presentation

The primary goal of this dissertation was to increase mental health professionals' awareness of specific issues related to working with women who do not have children, including the experiences and effects of being childless and childfree in today's world. The dominant culture imposes its values and norms upon all of society; therefore, mental health professionals are not exempt from contemporary society's value system that shapes perceptions about what is normal, acceptable, and healthy. As mental health professionals live within the current pronatalist society and practice within its cultural context, they are inevitably exposed to its values and biases. Students are taught developmental models that uphold parenthood as an inevitable step in an adult's development. Developmental life cycle theories, such as Erikson's, consider parenthood to be a major milestone that has to be reached in order to develop an identity as a mature and responsible adult. For women, these theories consider childbearing itself, not just parenthood, to be a critical milestone necessary for the development of adult identity. Parenthood is viewed as a normal and natural part of development that is needed to achieve mature adulthood. Ultimately, this view results in bias against childless individuals and couples. Informed by the literature and field consultants' interviews, a presentation was developed for mental health professionals.

It is hoped that the oral and visual presentation developed achieved three goals. The first goal was to increase mental health professionals' understanding of the kinds of biases that childless and childfree women face when living in a pronatalist society, including social isolation, stigmatization, and invasion of privacy. To address this goal, the presentation described the ways in which androcentric developmental theories contribute to the perpetuation of biases

toward women who do not have children and the various ways in which childless women handle their childless status and negotiate stigma.

The second goal of the presentation was to help mental health professionals understand that they themselves have been raised and trained within a pronatalist society. By becoming more conscious of their specific attitudes and biases toward childless and childfree women, mental health professionals can be better equipped to not re-stigmatize childless and childfree women by imposing pronatalist views on them.

The third goal of the presentation was to describe feminist therapy as an intervention that can be used by mental health professionals when working with women who do not have children. Using feminist therapy, mental health professionals can help women create a new narrative that affirms their identity and can help involuntarily childless and voluntarily childfree women find a satisfying identity outside of motherhood.

Personal Account and Critique

Women's psychology has always been my clinical interest. I feel very strongly about women's health, including mental health and well-being. I have a history of advocating for women and feel very passionately about advocating against any kind of oppression. The topic of this clinical dissertation came quite easily. As I have personally experienced pressure from medical doctors and family members, I wanted to address the issue of societal pressure for women to have children and disseminate an intervention that would not perpetuate the bias against women who choose to postpone becoming a parent or not become a parent at all.

Although choosing my topic was quite easy, composing my literature review and finding field consultants proved to quite challenging for several reasons. I found a lot of literature, including books, articles, and other publications, published in the early 1990s, when there seems

to have been a rise of interest in the topic of childlessness and a challenge to pronatalism's status quo. However, I had a very hard time finding any recent literature or studies on voluntary childlessness; rather, most recent studies focus on infertility and postponed parenthood.

I also faced major difficulties finding field consultants who had relevant clinical experience and an interest in contributing to my studies. The majority of clinical psychologists I approached specialized in the treatment of psychological implications of infertility. Only after a long and challenging search did I manage to find clinical psychologists who work with women who need help going through the reproductive decision-making process. Ultimately, I was able to interview six clinical psychologists who agreed to serve as field consultants for my clinical dissertation. The interviews provided me with invaluable information about the clinical work these consultants do in the field.

My personal goal for this dissertation was to bring awareness to the stigma women who do not have children face in contemporary society and to the fact that, although about 18 percent of women ages 40 to 44 in the United States do not have children, the topic of childlessness is neither addressed nor discussed in the literature or media (Gormly, 2013). It is my hope that my clinical dissertation and presentation will help raise awareness of the stigma faced by women who do not have children. It has been an honor to work closely with my dissertation committee and field consultants, who helped me learn more about women who do not have children.

The feedback that I received on the presentation was very helpful for me personally and for the topic of my dissertation. I learned that my audience was very interested in the topic and the research findings. However, constructive criticism concerning insufficient information about feminist therapy made me realize that more research is needed in the area of interventions tailored to women who do not have children.

Limitations and Suggestions for Further Research

There are several limitations to this dissertation. One major limitation is that all the literature that I was able to find discussed heterosexual women and couples, but did not specifically address how the topic of childlessness is relevant to the LGBTQ community. Therefore, my literature review talked about women, but did not address specific needs and concerns of lesbian women and/or women in same sex marriages. I was curious as to why there is no literature on childless/childfree women who represent the lesbian community; a report by one of my field consultants, Dr. Hayden, shed some light on this issue. When I asked her why she felt biased toward women who do not have children, she answered "as a childless lesbian who has always been happy not to have children, is hard for me to accept the deep longing many women feel to have a baby and raise that child" (personal communication, August 5, 2015). During my interview with her, it became clear to me that many clinicians assume that lesbian women do not plan or desire to have children just because of their sexual orientation. However, I find this notion quite problematic, and I think more research is needed in this area.

Another limitation was the general shortage of literature on voluntary childlessness and circumstantial infertility. Interest in the topic of childlessness seems to be decreasing, which might be associated with the rise of traditional pronatalist values or recent advances of technology in the medical field, leading to more emphasis on infertility treatment for those women who want but cannot have children and less interest on those who choose not to have children. The literature on the psychological effects of voluntary childlessness and circumstantial infertility is extremely sparse.

A further limitation of this dissertation was that the literature used for this dissertation did not distinguish between such factors as living in cities and rural areas, socio-economic status,

culture, sexual orientation, and religion or the way these factors would mediate the impact of pronatalism.

Conclusion

This clinical dissertation, including its product (i.e., an oral and visual presentation), was completed in order to help mental health professionals gain insights into the issues that women who do not have children face in contemporary society, thereby helping them raise their own awareness of their values and attitudes as well as introducing the tenets of feminist therapy and its benefits as an intervention. Based on an extensive literature review and feedback received from clinical psychologists practicing in the field, an oral and visual presentation was developed as a means of disseminating the information to mental health professionals.

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APPENDIX A: Field Consultant Interview Questions

Questions for the field consultants:

1) What is your theoretical orientation?

2) Based on your experience, what differences (if any) do the terms childless versus childfree make?

3) In your practice with women who do not have children, what do they most commonly report their presenting problem to be?

4) Did you notice any specific psychopathology as being common in women who do not have children (more depression, anxiety, etc.)?

5) Are there any specific interventions that you find most effective when working with women who do not have children?

6) The literature related to stigma and childlessness says that the public believes that women who don't have children regret their decision later on in life. Is this something that your clients report?

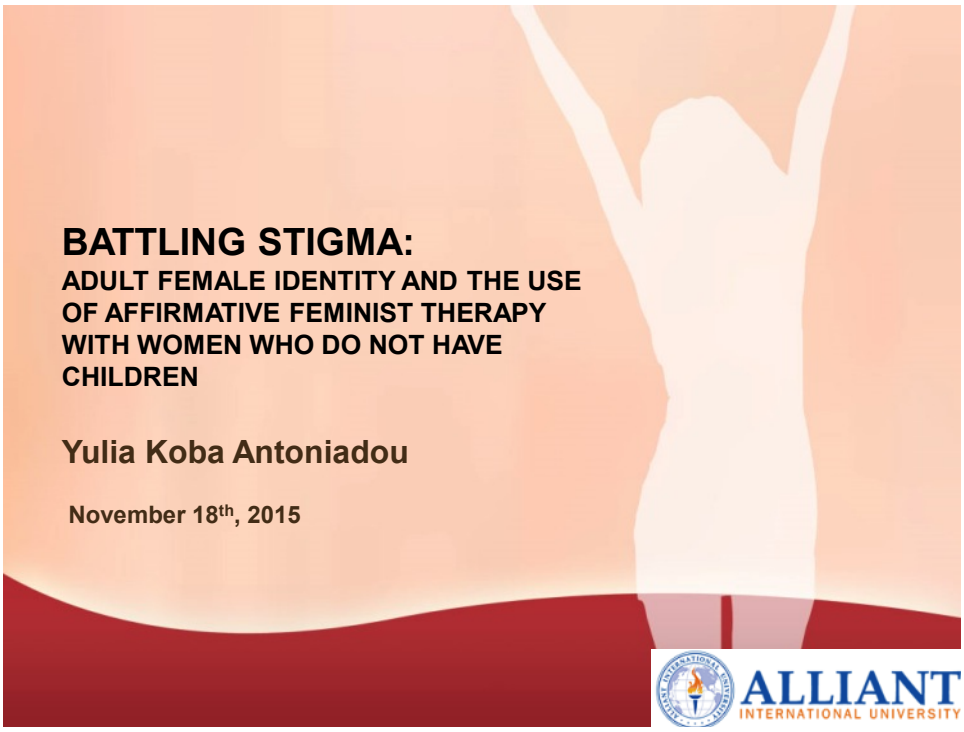
7) In your clinical practice, do childless/childfree women report experiencing stigma related to their childlessness?

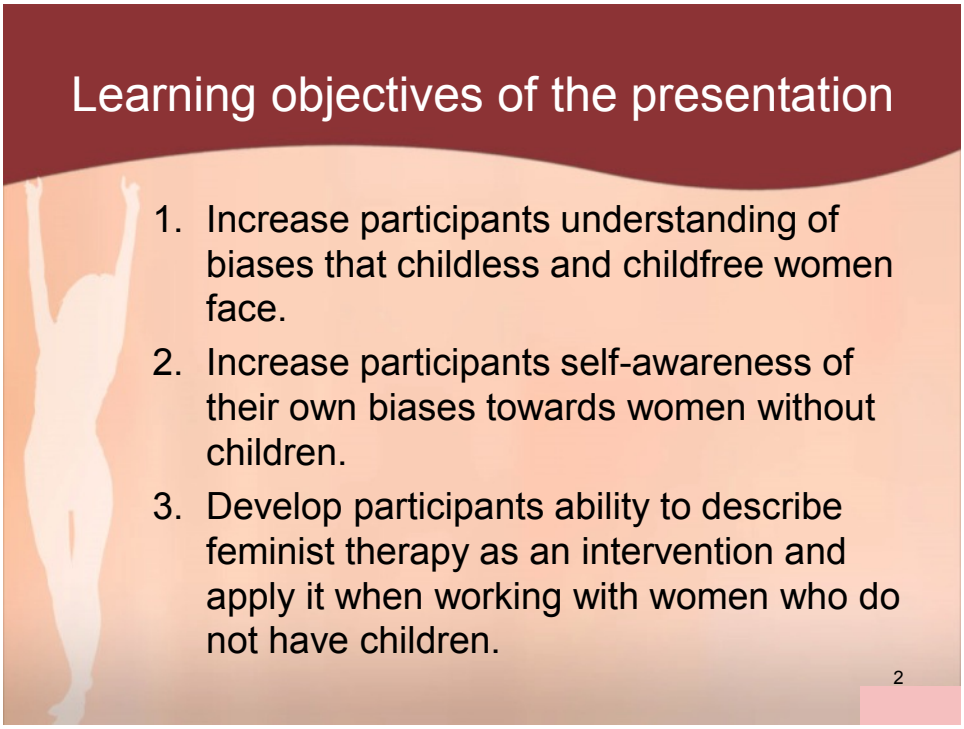
8) How do you address this stigma? How do you conceptualize these cases and what interventions do you most commonly use?

9) What do you personally find most challenging when working with childless/childfree women? In which situations do you become aware of your biases?

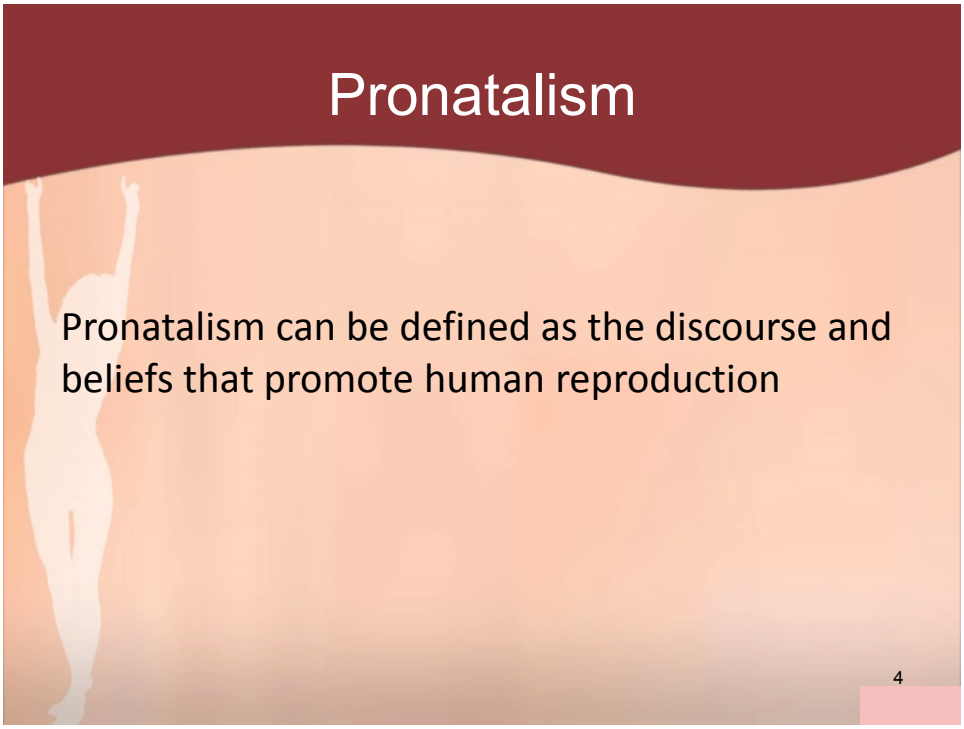
10) For women who choose not to have children, what seem to be the most common barriers to them moving past their childbearing decision?

APPENDIX B: PowerPoint Presentation Slides


BATTLING STIGMA:
ADULT FEMALE IDENTITY AND THE USE OF AFFIRMATIVE FEMINIST THERAPY WITH WOMEN WHO DO NOT HAVE CHILDREN
Yulia Koba Antoniadou
November 18th, 2015
ALLIANT
INTERNATIONAL UNIVERSITY


Learning objectives of the presentation
1. Increase participants understanding of biases that childless and childfree women face.
2. Increase participants self-awareness of their own biases towards women without children.
3. Develop participants ability to describe feminist therapy as an intervention and apply it when working with women who do not have children.
2


Why there is Taboo about
childless women in our society?
3


Pronatalism
Pronatalism can be defined as the discourse and beliefs that promote human reproduction
4

Pronatalism

- Pronatalism
- Three Dominant Discourses Enabling Pronatalism
  - Derogation
  - Compensation
  - Regret
- Gender Role Attitudes and Pronatalism Today

5

Women Who Do Not Have Children

- Infertility
- Involuntary (Circumstantial) Childlessness
- Voluntary Childlesssness
- Childfree

6

Women Who Do Not Have Children

- Delineating the Continuum of Childlessness
- Motherhood as a Right of Passage Into Adulthood
- Infertility as Master Status of Self Identity
- Emotional Impact of Infertility and Involuntary Childlessness
- Social Expectations and Negative Impact of Infertility

7

Voluntary Childlessness

- How adults come to identify as childless/childfree?
- Psychological Impact of the choice to remain childfree:
  - Stigma
  - How do childfree women negotiate the stigma
  - Invalidation and Devaluation of Identity, Choice, and Human Dignity

8

9

Developmental Theories

- Life Cycle Psychological Theories
- Freud's theory of development
- Erickson's individual life cycle
- Feminist critique of androcentric developmental theories

10

"You're either working at this intense high level or you're having kids. There's something in me that's focused and single-minded" She elaborated by saying "I'm kind of full of admiration for women who can mix it together--working and having kids--but I'm not sure I could have." (New York Times) 11

Working with Women Who Do Not Have Children

- Therapist Self-Awareness
- Feminist Therapy for childless women
  - Principles and goals of feminist therapy
  - The client-therapist relationship in feminist therapy
  - Case conceptualization
  - Interventions

12

"Did I ever want kids? No. I think maybe it's because I'm an only child. I like children, but especially when they're 18. I didn't start out not to get married and have children. I don't regret that I couldn't pass on some of my genes, which sounds so incredibly narcissistic, but that I couldn't pass on some of the opportunities" (Montgomery, 2007)

13

Questions

14

Evaluation and Feedback

Can you, please, fill the evaluation form

Thank you

15

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19

APPENDIX C: PowerPoint Presentation Lecture Notes

Slide 1: Title Slide

Slide 2: Learning objectives of the presentation

- Goal of the presentation: to increase mental health professionals' awareness of specific issues related to working with women who do not have children, including the experiences and effects of being childless and childfree in today's world.

Slide 3: Why there is Taboo about childless women in our society?

Slide 4: Pronatalism

- It is a prevailing paradigm that defines socio-cultural attitudes, as well as political policies concerning reproduction and childbearing. Veevers (1980) described pronatalism as an inherent value system that governs society and directs its laws and economy.
- Pronatalism is central to notions of gender and female identity.
- A child is deemed necessary in order to transform a couple into a family: "children are a necessary part of the family's legitimization" (p. 225). Ireland (1993) noted that "female reproductive capacity has become central and definitive for normative female development. Maternity has been the cornerstone of the mature adult identity for women" (p. 7).

Slide 5: Pronatalism (cont.)

- Morell (1994) pointed out three dominant discourses that enable pronatalist cultural hegemony and that conceptualize female identity.
- **Derogation:** motherhood is directly linked to female moral virtues, selflessness, and nurturance; when a woman acts in a caring way toward someone, she is described as motherly. This highly problematic because it implies that childless women is somewhat morally inferior.
- **Compensation:** motherhood is seen as a far more superior source of joy and fulfillment. Childless women are often seen in terms of deficiency, absence, emptiness, and the urge to compensate for their failings. (e.g. pets). (**draft page 10)**
- **Regret:** Morell (1994) considered it to be the most damaging and prevalent discourse, which claims that women who reject motherhood ultimately regret their decision and will end up leading a lonely and pitiful life.
- Umberson, Pudrovska, and Reczek (2010) conducted a meta-analysis of research conducted from 1999 to 2009 on the effects of parenthood on wellbeing. They pointed out that most studies conducted in the 2000s found that parenthood does not predict wellbeing but can be a stressor under certain circumstances such as financial difficulties.
- **Gender Roles in 21st century:** 70s-90s –a lot of changes, but 90s- 2008 almost no changes regarding gender attitudes. The period of rapid changes during the 1970s and 80s occurred as the second wave of feminism became prominent and that the shift back to pronatalism found in the second period occurred in opposition to this second wave. Feminism was replaced with egalitarian essentialism which affirms the principles of feminism and gender equality but at the same time affirms traditional motherhood roles and advocates for intensive mothering. It says "you can have it all" As a result a lot of women opt out of their careers and "choose" motherhood.

Slide 6: Women Who Do Not Have Children

- *Infertility* is defined as a couple's inability to conceive following 12 months of unprotected intercourse and/or the repeated inability to carry a pregnancy to a live birth (Johnson & Fledderjohann, 2012). As a medical diagnosis, infertility is usually given to a woman who wants to conceive a child but is unable to do so due to medically established physiological reasons. While *infertility* is a medical term, *involuntary childlessness* is a social and moral condition. The population of involuntarily childless women includes those who biologically cannot conceive a child, as well as those who face other factors (*circumstances*) that prevent them from having a child, including not having a partner and/or the financial ability to have a child, career demands, etc.
- The term *Childfree* refers to individuals and couples who do not want to have children. The word *childless* is ambiguous in its meaning, since it includes those childless by choice and those who wanted to have children but could not have them for some reason.
- Field consultants agreed that the term *childless* refers to a lack of something, missing out, loss, grief over that loss, a lack of choice, and a condition rather than a voluntary state. Meanwhile, the term *childfree* refers to a proactive choice.

Slide 7: Women Who Do Not Have Children (cont.)

- Monarch (1993), Letherby (2002), and Notkin (2013) suggested to consider childlessness on a continuum, where some women occupy a more definitive place than do others. Ireland (1993) suggested that there are 3 distinct categories of childless women *conventionally-minded* women, who desire children but cannot have them for some reason, (2) *transitional* women, who contemplate childbearing but ultimately do not have children, and (3) *transformative* women, who do not desire to have children.
- Social constructions of female identity historically have been based on women's gender roles as mothers, childless women are thus defined by lack and absence. Daniluk & Trench (2007) suggested that infertility/involuntary childlessness is not a single event, but rather a process that women must go through in order to renegotiate and adjust their self-concept and identity. They need to incorporate their involuntary childlessness into their identity and restore their sense of self.
- The majority of the literature on involuntary childlessness and its impact focuses on grief as a response to perceived loss and on ways to overcome feelings of sorrow and despair. After the grief has been worked through, many women are left with a sense of deficiency (Ireland, 1993). For women who subscribe to the pronatalist discourse, who value motherhood in such a way that they constructed their identity around the expectation of having children, and who see parenthood as an intrinsic part of adulthood, the inability to have children can cause identity disruption, may lead to cognitive dissonance, and can be interpreted as a failure to achieve physiological, psychological, and social expectations.
- Negative effects of infertility include social alienations (e.g ., stigmatization, social isolation, and violation of privacy.)
- Most field consultants reported that the most common barriers childless women face when moving past their childbearing decision are the societal pressure, family expectations, and fear of regretting their decision to not have children and/or stop trying in the case of infertility.

Slide 8: Voluntary Childlessness

- In 2014, 19% of women between the ages of 40 and 44 did not have any children (Gormly, 2013).
- In "Choosing to be Childfree: Research on the Decision Not to Parent," Blackstone and Stewart (2012) found that the decision to not have children can be explained by macro-social forces (such as career choices) and micro-level social conditions (such as the motivation to maintain freedom and autonomy). Agrillo and Nelini (2008) found that childless women cite freedom from childcare responsibility, mobility, and aversion to lifestyle change among the most common reasons for their choice.
- Women who are voluntarily childless routinely experience stigma. The literature supports that voluntarily childfree women are perceived in negative terms. childfree women are typically seen as selfish, materialistic, less caring, less responsible, immature, neurotic, cold, unwomanly, socially undesirable, and maladjusted (Letherby, 2002; Park, 2005; Vinson, Mollen, & Smith, 2010) In the media, women who choose not to become mothers in order to advance their careers are portrayed as dangerous, unhappy, regretful, unfulfilled, and even deranged. (Next slide)
- Mollen (2006) identified five major themes of stigmatization that voluntarily childfree women experience: being excluded from discussions that focus on children, being expected to work longer hours, being considered abnormal, being pitied, and experiencing discrimination.
- Negotiating Stigma: Park (2002) described two techniques that childfree use to manage their stigmatized identities and to assert their right for self-fulfillment and adult identity without having children: passing did not reveal their intent to remain childless in order to normalize their identity and identity substitution denied their choice in the matter; instead, they attributed their childlessness to biological or other circumstances (Park, 2002).
- Voluntarily childless often experience their identity, choices, and human dignity being invalidated and devalued. Voluntarily childfree women often are perceived to be a threat to family values and to be anti-family (Morell, 1994). A moral difference is assumed to exist between "normal" women and women who choose not to have children. The assumption is that there must be something wrong—if not physically, then mentally—with the person who refuses to procreate (Miall, 1986).
- Within the prevailing pronatalist culture, the choice to be voluntarily childfree is discounted, disregarded, and delegitimized; people assume that women will later regret this choice. This process of dismissing voluntarily childfree mothers and of normalizing that the only acceptable reason for childlessness is infertility reinforces the belief that motherhood is a necessary role that all psychologically healthy women embrace. Thus, women who voluntarily reject motherhood are considered to be outside the norm, and their choice is constructed as deviant or immature.

Slide 9: Image

Slide 10: Developmental Theories

- Traditionally, psychological theories of human development discuss, conceptualize, and explain human development from an androcentric perspective. For Freud, Erikson, Kohlberg, and many other male theoreticians, the developmental goals for females focused on "learning to become an adaptive helpmate to foster male development" (McGoldrick, 1989)
- Freud's developmental theory, therefore, depicts women as having a fundamental deficiency. Women's desire to have a male organ was thought to produce psychological consequences that resulted in an inherently unstable identity.
- The conflict of Erikson's seventh's stage of development Generativity refers the "need to be needed" and, most often, takes the form of parenthood and raising children. However, if one is not generative, she might become stagnant. Furthermore, Erikson (1968) proposed that female anatomy impacts and predetermines female identity formation and "personality configuration". Also, Erickson proposed that female identity development is defined by women's "somatic design that harbors an 'inner space' destined to bear the offspring of chosen men".
- From the perspective of feminist critics, the problem with the prevailing developmental models is twofold. On the one hand, women are placed into men's lifecycle, as prevailing developmental theories emphasize the importance of individuation, self-realization, self-actualization, and self-sufficiency, which can only be attained by men because of their status as non-dependent individuals. On the other hand, according to the same developmental scheme, women are excluded from ever possibly attaining this independent status because of the overwhelming importance placed on their status as wives and mothers (Next Slide.)
- (Gilligan (1993) - As a result of this limitation, women can never win. If they choose to leave work to raise a family, they do not receive monetary compensation and face more difficulty in establishing themselves in a career once they return to work. If they prioritize their career, then they face the stigma of being considered selfish and uncaring. Thus, many women experience considerable conflict between desiring professional achievement and financial independence, on the one hand, and their personal relationships and socially prescribed roles as nurturers and caretakers, on the other. This conflict results in many women feeling that they can never win.

Slide 11: Julia Gillard Image

- Julia Gillard, former Australian prime minister, has even been publicly attacked by other politicians for her decision not to have children.
- In 2010 liberal Sen. Bill Heffernan had to apologize for saying that Gillard was unfit to be deputy prime minister because she was "deliberately barren." She responded by saying:

Slide 12: Working with Women Who Do Not Have Children

- The dominant culture of parenthood imposes its hegemonic power upon all of society; therefore, psychologists are not exempt from contemporary society's value system that shapes perceptions about what is normal, acceptable, and healthy. Mollen (2006) pointed out that a psychologist's male's *and* female's unchecked pronatalist biases might result in harmful assumptions, assigned values, and personality attributions concerning childless

and childfree women counseling clients from a pronatalist standpoint would likely make childless and childfree women feel misunderstood and stigmatized, thus decreasing the effectiveness of therapy and damaging the therapeutic relationship.

- Feminist therapy is a form of therapy that is nonsexist and humanistic, it focuses on empowering the client by inviting her to critically examine the ways in which society has contributed to her distress. Feminist psychotherapists look for the external triggers that may have precipitated the patient's symptom, it examines the context as opposed to the internal conflict of the ct. and looks for the ways in which the ct can gain power and make change.
- Two fundamental belief of feminist therapy are: Personal is Political and symptoms are coping tools. The therapist helps the client understand that her symptoms as an adaptable way of coping, adjusting, and surviving in patriarchal society, rather than signs of dysfunction. The feminist therapy approach promotes a better understanding of the client's problems and facilitates effective interventions aimed at empowerment and rehabilitation.
- The relationship between the client and the therapist is based on egalitarian principals of equality, in which the client is the expert of her own feelings, emotions, and experiences. Feminist therapy is a collaboration of two equals, where both individuals have an equal amount of authority and where the power dynamic of the relationship needs to be examined and revised in order to create equality of power.
- The field consultants I interviewed for this dissertation agreed that it is very important to conceptualize these cases as non-pathologically as possible, consistent with your theoretical orientation. It is important to assess for shame and guilt associated with the choice or inability to have children and look at overall patterns of avoidance, shame, and anger to lead her clients in exploring what exactly "happiness" and "fulfillment" mean. It is also important to help clients label the stigma as a form of oppression and societal control over women, encourage them to stay connected to their community and seek social support
- Exploration of the client's values, helping her clarify whether her desire to have children reflects her own genuine desire or whether she is responding to societal pressures to 'fulfill her destiny as woman' by having children.

Slide 13: Condoleezza Rice Image

Slide 14: Questions

Slide 15: Evaluation and Feedback

Slide 16: References

Slide 17: References

Slide 18: References

Slide 19: References

APPENDIX D: Evaluation Form

BATTLING STIGMA:
ADULT FEMALE IDENTITY AND THE USE OF AFFIRMATIVE FEMINIST THERAPY WITH WOMEN WHO DO NOT HAVE CHILDREN

by Yulia Koba Antoniadou

Presented at Hollywood Mental Health Center on 11/18/2015.

Please provide your opinion regarding today's presentation by marking the box that corresponds with your level of agreement with each statement.

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The presenter fulfilled the objective of increasing participants understanding of biases that childless and childfree women face					
The presenter fulfilled the objective of increasing participants self-awareness of their own biases towards women without children.					
The presenter fulfilled the objective of describing feminist therapy as an intervention that can be used by mental health professionals when working with women who do not have children					
The presentation was well organized; the points were clear and easy to understand.					
The presenter appeared knowledgeable about the presentation topic.					
The presenter was responsive to questions					
I would recommend this presentation to other professionals					
Additional comments:					

Thank you for your attendance and completing this evaluation form!