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“No One’s Gonna Say *That* at Church:” Women’s Experiences with Infertility  
in Christian Faith Communities

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A thesis  
presented to  
the faculty of the Department of Communication & Performance  
East Tennessee State University

In partial fulfillment  
of the requirements for the degree  
Master of Arts in Communication & Storytelling Studies

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by  
Donna J. Paulsen  
May 2020

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Dr. Amber Kinser, Chair  
Dr. Christine Anzur  
Dr. Julia Dodd  
Dr. Jennifer Adler

Keywords: Christian, faith, identity, infertility, motherhood, miscarriage, muted group, women

## ABSTRACT

“No One’s Gonna Say *That* at Church:” Women’s Experiences with Infertility  
in Christian Faith Communities

by

Donna Paulsen

This study explores women’s experiences with infertility in Christian faith communities. Drawing from nine one-on-one interviews, the author argues that the presence of particular religious ideologies, social interactions, and rituals within faith communities contributed to the stigmatization and marginalization of study participants. Employing Muted Group Theory, the author uncovers the communicative strategies infertile women employ to resist these oppressive practices. A qualitative analysis of participants’ narratives presents two principal categories, containing a total of four findings relating to the harmful beliefs and practices of these women’s faith communities. The author argues that the veneration of motherhood and children suggests that infertile women inherently lack purpose and value and that the failure of Christian faith communities to provide safe environments for women without children exacerbates their isolation and grief. Action steps for Christian faith communities are recommended.

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## DEDICATION

To the nine women who shared their experiences with me  
and the countless others whose stories have yet to be told.

You are not alone.

## ACKNOWLEDGEMENTS

Thank you academic advisors. Dr. Amber Kinser for serving as my advisor and thesis committee chair. Your lived experiences, areas of academic expertise, and personal commitment to the success of this project and to my personal development as a researcher, writer, and individual were such a precious gift. Dr. Jennifer Adler, Dr. Christine Anzur, and Dr. Julia Dodd for serving as my thesis committee. I am grateful for your interest in my topic, investment of time, and insightful feedback.

Thank you ETSU faculty and friends. Molly Catron, Nancy Donoval, Dr. Kelly Dorgan, Dr. Andrew Herrmann, David Novak, and Dr. Delanna Reed for being the kind of faculty who keep your doors and hearts open. You have helped me grow as a thinker, researcher, and storyteller. Abby Lewis, Dallas Lay, Isaac Price, Paul Taylor, Sarah Trent, and Joshua Whitehead for your friendship and support throughout the entire grad school journey. My life has been forever changed by knowing you. I am so thankful my cohort was you. Kallie Gay for cheering for me from the other side of the finish line. Laughton and Erin Messmer and the ETSU Speech and Debate Team for letting me tag along with you for the past two years. It was quite a ride. Go Bucs.

Thank you mentors. Mr. Matthew Moore, for helping me find and cultivate my voice. From that first day in Fundamentals of Speech, until now, you have been a faithful friend. I aspire to be the kind of important person for others that you have been for me. Dr. Christopher Smith for climbing down to sit beside me in the cave. The time you dedicated to entertaining my questions and encouraging me to think prepared me for graduate school. I'm out here daring greatly and encouraging others to do the same. Dr. Robert Yale, for your life and legacy. The

picture we took together on the day we graduated from college was my daily reminder to embrace every opportunity to make the most of each new day.

Thank you family. Dad and Mom, for your love and prayers. I could hear you cheering me on through every obstacle. David and Emily for loving me so much and for providing me with an occasional escape from the craziness of graduate school. Daniel, Anna Lynn, Matthias, and Samuel, for your love and for never doubting that I could do this. Bethany, for your love and support and for being the very best sister a girl could have. You are my favorite human.

Thank you tribe. Chuck and Kristin Lawrence, for your long-distance love and support. When I'm with you, I'm home. Allison Nickerson, for your faithful friendship. You are one of the wisest women I know. When I think back to graduate school I will remember all of our late night, three-hour-long phone conversations, when I talked about my research until we both fell asleep. This project has your fingerprints all over it and for that, I am grateful. Mark Emmons for your willingness to talk about the hard stuff. Your honesty is so refreshing. This project is for Julie too. May we all love like she did.

Thank you friends. Tom and Ericka McClelland for welcoming me into your home. The delicious home cooked meals and exceptional conversations were a balm for my soul. Natalie Pickering for your friendship, wise counsel, and for being my safe person when the rest of the world didn't make sense. Julia Slemper for the hand-delivered soups, warm hugs, and encouragement. Abigail Blythe, for our weekly breakfasts and invigorating discussions. You are my best daughter. Michael Hardin, Shawn Dunn, Heather Miller, and Bob Hechemovich for telling me, "You got this!" every day I made it to the gym. Hayley Barbour, Laura Gentles, Lisa Holbrook, Kristin Stenger, and Shannon Thomson for the many cups of coffee and 'just keeping it real' conversations.

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## CHAPTER 1

### INTRODUCTION

On July 31, 2015, I became an infertile woman. I certainly had not planned to. I had been scheduled for a minor corrective procedure, but when a hospital staff person accidentally wrote “endometrial ablation” on my patient intake form, and the surgeon followed protocol, the deed was done. When I woke up from surgery and discovered the medical error, my entire world shifted. I was still in my fertile years. I had planned on having children. Then, with one surgical act, the lining of my uterus was cauterized. I would never be able to get pregnant.

Having been raised in a conservative Christian home, my immediate impulse was to interpret my experience through the lens of the religious ideology with which I had been raised. The image of what happy Christian womanhood looked like had been imprinted on me from an early age. Some of my earliest memories are of my mom playing with me, reading to me, and teaching me how to do things around our home. One day she confided to me that all she had ever wanted to be was a wife and mother. She smiled, contented. She told me that she hoped that I too would grow up, get married, have children, and experience some of the same joys of motherhood that she had. And so, for the majority of my girlhood and teenage years I had anticipated this future role and the satisfaction that would come with it.

Following my surgery, my immediate impulse was to believe that due to my sterility, I was no longer a viable candidate for marriage. I asked myself, “What good Christian man would ever consider me for a potential mate?” I thought that if I could not produce children, I was worth less. I felt like damaged goods.

When I asked myself why I felt this way—why I felt ashamed and guilty about something that had been done *to me*—the answer alluded me. But then, two days after my

surgery, when I walked through the front doors of my faith community, I understood. As I stood in the entrance way, surrounded by families with small children, I saw the world through new eyes. My entire framework had been shaped by the normalcy of women as wives and mothers. As I observed all of these women, with their husbands and children, I knew that this was a category into which I no longer fit. I could no longer become one of them. I would never achieve a viable pregnancy. I would never become a mother to biological children. I was no longer ‘normal.’ I had become ‘other.’

Prior to that Sunday morning, my pastor had visited me at home. During our conversation, he encouraged me to exercise caution when sharing about what had happened. He was worried that the members of our faith community might respond poorly and say hurtful things. He counselled me to tell no one. Looking back, I know that he was trying to protect me from the insensitive comments or misguided advice that people can be prone to offer in moments of discomfort. But unfortunately this act of silencing hurt me too. What I needed most, in the midst of my grief, was the comforting presence of others. I needed others to grieve with me. Instead, I was asked to bear my pain alone—to paint on a smile and pretend that nothing had changed.

But, as I continued to live and engage within my faith community, I was constantly reminded of my otherness. On the first Mother’s Day after my surgery, I arrived at church and sat towards the back of the room. I watched as several couples approached the front of the room with new babies in their arms. Baby dedication was always scheduled on Mother’s Day. For them it was a special ritual, a time to celebrate new life and give thanks. For me, it was another reminder of what my community valued, something I would never have and someone I could never be.

As the women around me celebrated positive pregnancy tests, gathered around growing bellies, and planned baby showers, I stood just outside their circle. When my friends talked about motherhood, remarked on their children's achievements, and shared about family life, I found it difficult to engage. I asked myself why I was still pretending to be one of them.

As the months passed, and I grew more familiar with my new identity, I wrestled with knowing who I could tell and from whom I should conceal the truth. Whenever I risked disclosure, I learned within the first few minutes of conversation if they were a safe person or not. Those who were safe would cry with me, or hold my hand, or wrap me in a warm hug, and they would say very little. Those who were unsafe would visibly shrink back, eyes darting nervously as they searched for the right thing to say. I learned to hold my secret identity close, being selective in my vulnerability, attempting to keep myself from being hurt by controlling my environment.

At the same time, I was making observations and had begun to notice populations within my faith community that had previously been invisible to me. I had been given new eyes to see others who were outside of 'normal' like me. There were other women who had no children. There were single mothers. There were even a few mothers who were 'different.' I became friends with some of these 'misfits' and we had long conversations about our otherness. I sensed the deep shame in these women. I grew indignant at the social and religious norms that had created obstacles to our experiencing authentic community and I began to question what it would take to move them.

I already knew I was good at asking questions and I was growing less afraid of making others uncomfortable while doing so. I decided to embark on a new adventure. I travelled across the country to enroll in graduate school. Even as I was unloading the boxes from the moving

truck, an inescapable idea was growing in my mind. I went to campus and sat down with my new academic advisor. I was nervous. I told her that I knew what topic I wanted to explore for my thesis but that I was worried she might tell me no. I told her my story. She listened and nodded. I asked her if it was permissible to research something that was so personal, and I questioned if she thought my bias would get in the way. She told me it could potentially be difficult but that it was important and then she said that because it was important, it was absolutely worth doing.

Over the next eighteen months, I devoted myself to researching women's experiences with infertility within Christian faith communities. I spent countless hours poring over articles and books. I sat down, one-on-one, with nine remarkable women and listened to their stories. I analyzed those narratives and made discoveries about how they had reconciled their experiences with their faith. I labored intensely through the writing process as I grappled with how to best honor, articulate, and represent their voices. In crafting this thesis, I hope I have created something that will help the women who have struggled, as I have, with feelings of shame and unacceptance. I look forward, with hope, to a future where every woman is seen, heard, and embraced by her community.

This thesis is divided into five chapters. In the next chapter, chapter two, I review the extant literature on women's experiences with infertility and identify a research direction for the study. In chapter three, I discuss the research methodology I employed as I gathered and analyzed study data. I reveal the findings of my research in the fourth chapter, and then close with my recommendations and research reflections in the final chapter.

## CHAPTER 2

### LITERATURE REVIEW

The view that a woman's function is primarily that of a mother is a long-established and deeply rooted ideology. Throughout history, motherhood has been traditionally perceived as both a normative and central role for women (Abbey, Andrews, & Halman, 1992; Allison, 1979; Jennings, 2010; Russo, 1976; Whitehead, 2016). While based in biology, the idea of a woman's primary role as mother is a norm that is established and enforced by social and cultural institutions. Within every culture there exists a complex web of a people's history, religious influence, and gender-prescribed behavioral norms (McQuillan, Greil, Shreffler, & Tichenor, 2008). These serve to build the foundation for the culture and influence the actions of those living within that society. While female bodies generally are equipped with the necessary biological parts to carry a pregnancy and give birth, much of the impetus for childbearing comes from the way a culture defines what it means to be a woman and how individuals adapt to what is perceived to be the societal norm. Greil (1991) argued that:

norms as expectations for behavior are embedded within the structure of social interaction. The normality of parenthood is not something learned once and for all but, rather, something continually relearned in the course of everyday life . . . the normality of parenthood is . . . reinforced by the mere fact that parenthood is statistically normal . . . individuals cannot help but observe that most people of a certain age seem to have children. (p. 52)

As individuals live and move within their community, they interact with others and develop their views about what is normal and what is expected from them in order to function within that society. Loftus and Androit (2012) submitted that women tend to articulate two

primary reasons for wanting to become mothers. First, “women feel that they have wanted to be mothers since they were children” and, second, “women feel that they want to become mothers later in life, either because others expected it of them, or because they want to be like the other mothers they already knew” (p. 230). This finding illustrates the power of both sex-role socialization and cultural reinforcement in establishing and reinforcing what many women experience as a motherhood mandate in society today.

Sex-role socialization has much to do with setting the expectations of children for their future lives (Russo 1976). Women, as well as men, are presented with gendered norms from the earliest stages of their infancy. From a young age, women are taught to connect womanhood with motherhood. Loftus and Androit (2012) stated that “through anticipatory socialization, little girls are taught to emulate mothers and prepare themselves for fulfilling this role when they become adults” (p. 230). The toys young girls are given to play with and the mothering role they are encouraged to mimic with their dolls teach them to anticipate having children of their own one day.

Although not all girls are socialized to anticipate that they will become mothers, through societal reinforcement, the desire to become a mother can manifest itself later in their lives. Whitehead (2016) contended that comparison is typical during gender identity development and stated that it is not uncommon for “individuals to compare themselves to the norm along most life-course stage markers” (p.114). The desire to fit in and to be like others is not unusual. Some women pursue motherhood largely because they perceive everyone else around them as doing it and feel pressure to conform to what is normal (Jennings, 2010). In addition to the societal expectations surrounding womanhood, pregnancy and childbirth are also bonding experiences for many women. Women build community through contributing to conversations and sharing



stories (Loftus & Androit, 2012; Whitehead, 2016). In the absence of children, they can find it more challenging to establish commonality with their peers.

### **Women without Children**

The general expectation that most women will have children presents some unique challenges for women who choose to remain childfree and for women who desire to become mothers but who find themselves biologically unable to do so. Greil, McQuillan, and Slauson-Blevins (2011) stated that “all societies are pronatalist,” and “some emphasize the centrality of motherhood to a women’s identity more than others” (p. 740). While the societal response to women without children varies from culture to culture, it often carries a negative connotation. Women without children, regardless of the reason, are often pitied (Akarsu & Beji, 2019), labeled ‘barren’ (Sewpaul, 1999), viewed as deviant for not fulfilling the ‘natural’ social function of a woman (Gillespie, 2000), or judged as selfish for placing a career or other goals in front of having a family (Chester, 2003).

It is important to note some of the differences between individualist and collectivist cultural attitudes towards women without children. Within collectivist cultures, a tremendous value is placed on the family and community, as well as on fostering interdependence and group cohesion (Buluc-Halper & Griffin, 2016, p. 2). Motherhood is closely connected to marriage (Greil, McQuillan, & Slauson-Blevins, 2011, McQuillan, Torres Stone, & Greil, 2007) and children represent the joining link between two families or clans, the assurance of a future lineage, and financial security (Sewpaul, 1999). Childlessness, therefore, “is not only experienced as a crisis for the couple; it is also regarded as a tragedy or a disaster by the community” (Sewpaul, 1999, p. 743). Akarsu and Beji (2019), found that in societies where pregnancy and childbirth are connected to familial status, infertile women are often held

responsible, can experience social exclusion, face the threat of divorce, and even see their husbands take another wife in order to have children.

Within individualist cultures there tends to be more acceptance for women without children as it is often assumed to be an individual's or couple's choice. Having children in these cultures is often "primarily viewed as an extension of a couple's desire to have their own ideal family, irrespective of societal expectation, social status, or wealth" (Buluc-Halper & Griffin, 2015, p. 3). Rather than a requirement, parenthood is understood as a life satisfaction goal or a personal joy (Hynie & Burns, 2006). Therefore, although women without children in individualist cultures can still find themselves subject to an expectation or the curious scrutiny of their immediate community, they are typically presented with additional identity-forming roles, besides the role of mother, that can shield them from some of the shame and censure that women in collectivist cultures encounter.

### **Women's Experiences with Infertility**

The Center for Disease Control (2019) defined infertility as "not being able to get pregnant (conceive) after one year (or longer) of unprotected sex." The separate, but related category of impaired fecundity includes women who are non-surgically sterile, women who are able to achieve pregnancy but have difficulty carrying a baby to term, and women who have been sexually active, without contraception, and have not become pregnant in thirty-six consecutive months or longer (Chandra, Copen, & Stephen, 2013, p. 3). Because these two clinical definitions present the potential for overlap, assigning an absolute diagnostic term to a woman experiencing "fertility problems" is complicated.

Due to differing definitions for infertility and impaired fecundity worldwide, a lack of uniformity in how the data is gathered, and a notable absence of studies regarding male

infertility, the global infertility rate is difficult to determine (Inhorn & Patrizo, 2015). According to a 2010 systematic analysis of 277 health surveys that examined the national, regional, and global trends in infertility prevalence since 1990, an estimated 48.5 million couples worldwide experience infertility. The study found that the levels in most world regions had changed very little between 1990 and 2010 and approximately 1.9% of women exposed to the risk of pregnancy were unable to attain a live birth (primary infertility) and 10.5% of women exposed to the risk of pregnancy who had had at least one live birth were unable to have another child (secondary infertility) (Mascarenhas, Flaxman, Bowerma, Vanderpoel, & Stevens, 2012). This means that approximately 12% of women around the world experience some form of reproductive impairment. The CDC (2019) reported that this figure is still true a decade later, in the US, noting that “6% of married women, aged 15-44, are unable to get pregnant after one year of trying” and “12% of women, aged 15-44, have difficulty getting pregnant or carrying a pregnancy to term, regardless of marital status.”

Given the fact that the majority of women do not report any biological difficulties while pursuing motherhood, infertility presents itself as an abnormal and undesirable trait. In his classic work, Goffman (1963) explained that any attribute that makes someone different from others, “in the category of persons available for her to be,” has the potential to reduce the individual “from a whole and usual person to a tainted, discounted one” (p.3). However, Goffman also stated that this discrediting or stigmatization of an individual is a direct result from a need to “reclassify an individual from one socially anticipated category to a different . . . one.” It is not the undesirable attribute that creates the stigma but rather the fact that the attribute is “incongruous” with the “stereotype of what a given type of individual *should* be” (p.3, emphasis

added). Therefore, it is the common role expectation that women will become mothers that places infertile women into the category of ‘other.’

### **Identity Dissonance**

The otherness of a women’s experience with infertility presents itself in two significant ways that require closer examination. First, infertility is experienced as a failure to perform gender in the manner that society expects (Loftus & Androit, 2012; Matthew & Matthews, 1986). Second, infertility is experienced as a “failed life course transition” (Loftus & Androit, 2012, p. 227). Both of these experiences are closely connected.

Given the normalizing of motherhood, the inability to conceive and bear a child or carry a child to term produces gender identity dissonance for many women. Loftus and Androit (2012) stated that women who were taught to “do gender by having children and discussing their offspring” can experience “gender destabilization” when they find themselves unable to get pregnant (p. 227). A woman’s normative and multiple identity roles as wife, daughter, or daughter-in-law, all come with a set of “behavioral expectations,” one of which is to become a mother. Women who are unable to meet the social role expectations embedded within these multiple identities experience “high levels of emotional distress” as they perceive failure to become a mother as a failure to fully perform those identities (Loftus & Namaste, 2011, p.41-42). Consistent with these authors, Jennings (2010) suggested that infertility is experienced as “a shared loss,” as women grieve the deprivation of the mother and grandmother roles along with the bonding that can take place between family members through the shared experiences of motherhood (p. 223). Even in cases where a woman is not pressured by her family or friends, she will often stigmatize herself (in view of her perceived failure), developing “negative self-perception and self-esteem” (Akarsu & Beji, 2019, p. 9). It should be noted, however, that social

expectations are not deterministic in their own right. Buluc-Halper and Griffin, (2015) argued that regardless of the established cultural norms within any given society, a woman's experience of infertility will be impacted by the degree to which she has internalized the social role expectations, perceived or real, of her community (p. 3). Even so, infertility can be perceived as such a failure to perform, that some women experience "identity shock" when faced with involuntary childlessness (Matthews & Matthews, 1986, p. 646).

Infertility as a failure to perform a gendered identity is closely connected to the experience of infertility as a "failed life course transition." Loftus and Androit (2012) explained that "identities are based on our roles and our interactions and are often tied into our stage in the life course" (p. 229). Because parenthood, in addition to being a behavioral expectation for women, is often viewed as an expected life transition to adulthood (Callan & Hennessey, 1988), women who do not achieve biological motherhood are often regarded as having failed to advance to the next life stage. In this way, motherhood can be understood as a rite of passage and infertility as a "denied access to normality" (Greil, 1991, p. 60). Because few medical diagnoses are final, and medical exploration and intervention offer the hope of a potential remedy, most women and couples facing infertility do not view biological parenthood as absolutely unattainable. Greil (1991) called infertility an experience of "status blockage" and argued that those facing reproductive obstacles may feel as though they are only being temporarily "deterred from fulfilling their own expectations of what it means to be an adult" (p.103). Women describe their experiences as "caught in the middle" (Sandelowski, 1987), "not yet pregnant" (Greil, 1991) and "Mother. Unmother" (Chester, 2003).

The experience, of not having arrived somewhere or not having accomplished something that is connected to one's identity was described by Turner (1987) as "liminal," or the position of

one who is “betwixt and between” two different states (p.3). Turner explained that a state is a “relatively fixed or stable condition” that includes “such social constancies as legal status, profession, office or calling, rank or degree” (p. 4). Any initiate that hopes to transition from one state to the next must undergo a certain rite of passage that will advance her to the next stage. Turner noted that during the transition or “liminal period” between states, “the state of the ritual subject is ambiguous” until he passes through to the other side (p.5). So, as long as a woman clings to the hope that she will become a mother, she remains in perpetual limbo, waiting to assume the “potential identity of biological mother” (Loftus & Namaste, 2011, p. 37). She cannot advance forward. Here the woman is stuck on an emotional threshold, not knowing if she should “rightfully mourn for what she cannot have or hope for what she might still obtain” (Matthews & Matthews, 1986, p. 644). This “liminal” state is highly unstable and, when prolonged, will affect the individual in some adverse ways. Loftus and Androit (2012) explained that “infertility constitutes a period of destabilizing the self” where the failure to transition impacts a woman’s concept of her identity and her ability to relate with others (p. 228).

### **Physical Toll**

As a woman begins to experience the social stigma attached to her impaired fertility, she will likely seek ways in which she can manage and rectify her impaired status. Greil (1991) suggested that, were the pressure surrounding motherhood absent or less intense, a woman may address her inability to procreate by either choosing to adopt or by deciding to remain childless (p. 48). Unfortunately, the established social and cultural norms combined with the fairly recent medicalization of reproduction have effectively redefined and shaped what it means to be infertile in society today.

The twentieth century brought about many advances in science and technology. As science began to explore and learn more about women's bodies, new technologies emerged. Whiteford & Gonzalez (1995) found that the development of medical technology in the 1960s and 1970s transformed the way infertility was perceived. As new drugs and treatments were introduced, infertility was reconceptualized as "a medical condition that could be fixed" (p. 29). Infertile women and couples were suddenly presented with a variety of options that, in addition to stimulating hope, provided the opportunity to strategize a game plan for confronting a diagnosis (Hammerli, Znoj, & Berger, 2010, p. 777). Greil (1991) suggested that the experience of infertility is characterized by a sudden "loss of control" (p. 73). Thus, exploring various medical treatment options helps women and couples regain that sense of control. Hammerli et al. (2010) observed that women who are given medical choices experience reduced emotional distress when facing their fears regarding infertility (p. 777). While the exact numbers are difficult to establish, approximately half of all infertile couples in developed or developing countries, pursue medical intervention (Bovin et al., 2007).

However, this enticing promise of a medical solution does not come without a cost. While women are promised more control over their bodies' biological processes, the medical industry strengthens its control over the ways in which infertility is socially interpreted and managed. Greil (1991) contended that as infertility became medicalized, medical institutions were given power to shape an infertile couple's experience. When infertility began to be defined in medical terms—as a medical problem—that could be treated in medical institutions, the infertile became patients, and were assigned a new identity as someone who is "sick" (p. 34-35). Labeling and treating infertility as an illness that has the potential to be cured cultivates a

growing dependence on the medical community to provide a solution and salvage the potentially “spoiled identity” of someone who cannot bear children (Goffman, 1963).

The current medical treatment plans for women or couples facing infertility range from the noninvasive to invasive, free to extremely costly, and of short duration to spanning many years. What often begins as a simple recommendation to chart basal body temperatures to track ovulation can lead to hormone injections, intrauterine insemination (IUI), or egg extractions for in vitro fertilization (IVF). Katz et al. (2011) reported the median per-person estimate, for treatment cost per successful outcome, to be \$5,894 for those taking medications only to \$61,377 for those using IVF (p. 920). When delivery cost was added to the expense of the treatment plan, the final amount per successful outcome increased to \$14,045 (medications only) to \$76,395 (IVF) (Katz et al. 2011, p. 920). While it is difficult to estimate the average length of time a woman may devote to pursuing motherhood via medical intervention, the nurturing of hope, and plethora of options, make it difficult to stop. Some women will only give up the pursuit when they have reached physical, emotional, and financial depletion (Daniluk, 2001, p. 442).

While continuing the search for a satisfactory solution until all options are exhausted is quite tempting for many women facing a potential future without children, there is a costly exchange involved. Greil (1991) suggested that women who decide to seek medical treatment place themselves in a “paradoxical situation” because in order “to regain a sense of control” they have placed themselves within a medical context in which they have little authority (p.78). The redefining of infertility as a medical condition forces the individual to accept and to play the “social role of the sick person” (Whiteford & Gonzalez, 1995, p. 29). By accepting this role and submitting to a recommended course of action the woman is in some ways conceding that she is



“defective,” “broken,” or a “failure” (Berger, Paul, & Henshaw, 2013; Loftus & Namaste, 2011; Whiteford & Gonzalez, 1995). Whiteford and Gonzalez (1995) argued that:

The very process of medical intervention further stigmatizes women and devalues them for any accomplishments outside of reproduction . . . once a woman enters into the medical intervention process to treat infertility there is great pressure placed on her to continue treatments until there is either a ‘successful’ outcome, or all the options have been exhausted (p. 36).

Unfortunately, many women do become lost inside the medical machine. They are continually presented with new directional choices and the tantalizing promise of yet another medical “solution” to their “problem.” However, their experience is that of a “pawn” in the game of medical experimentation or a “guinea pig” during the testing of new treatment options (Daniluk, 2001). Greil (1991) felt that infertility should be classified as a chronic illness because it is a long-term condition, understood as a physical disability, whose treatment plan is expensive, time-consuming, and invasive. He goes on to observe that “like the chronically ill, the infertile may come to feel that the quality of their lives has been adversely affected by their condition and that the treatment regime now occupies an imposing place in their lives” (p. 49).

In addition to the humiliation of submitting to clinical tests and procedures, the risks associated with certain treatments can be quite serious. Complications during the egg retrieval process for IVF can result in “bleeding, infection or damage to the bowel, bladder, or a blood vessel” (Mayo Clinic, 2020). And, even after successful egg retrieval, fertilization, and embryo transfer, the risks of miscarriage, premature delivery, and birth defects are still present. According to the Mayo Clinic (2020), between 2% and 5% of women who receive IVF will experience an ectopic pregnancy, some may increase their risk of developing ovarian cancer later

in life, while others may develop ovarian hyperstimulation syndrome (OHSS), a painful condition that manifests in bloating, nausea, vomiting, shortness of breath, faintness, and rapid weight gain. Although extremely rare, OHSS has been known to result in patient deaths (Bewley, Foo, & Braude, 2011).

Infertile couples also face a loss of privacy in their intimate lives. Bodies become subject to the “scrutiny of medical examination” (Daniluk, 2001, p. 445). Sex becomes a scheduled clinical procedure; something that just needs to be done, rather than enjoyed (Greil, 1991, p. 122), and can become associated with “failure” rather than “mutual pleasure and intimacy” (Daniluk, 2001, p. 445). In addition, the sense of urgency connected to time already lost and the financial burden of medical treatments do very little to decrease the stress placed on performance in the bedroom. Even years after choosing to end treatment, many couples struggle to recapture the “sexual spontaneity and intimacy” they once enjoyed (p. 445).

Finally, for women and couples belonging to faith communities or those who adhere to certain religious traditions, the process of making medical decisions is further complicated by the ethical dilemmas posed by various forms of reproductive science. For some, the high view of parenthood and children will justify using whatever means necessary to secure a pregnancy, while others will face strong objections from their clergy, family, and friends regarding the permissibility of various procedures (Klitzman, 2017, p. 229). For example, various Protestant denominations, while open to in vitro fertilization, as long as all embryos are used or made available for adoption, oppose the practice of surrogacy; the Vatican officially opposes artificial insemination when semen is collected through masturbation; Jewish rabbis differ widely on their view regarding the use of donor gametes; and within Islam, embryo donation is absolutely forbidden (Jennings, 2010, Klitzman, 2017, Roudsari, Allen, & Smith, 2007). Many women feel

that their spiritual leaders are ill-equipped to answer their questions and complain about a lack of sensitivity to their struggle. Some feel hurt when their pastor or priest's response does not seem to take their unique circumstances into account or feel guilty when they feel condemned for a decision they have already made (Feske, 2012). Klitzman (2017) found that it is not unusual for women to choose to disregard the admonition of their clergy, proceed with a treatment, and keep it a secret. Others go "rabbi shopping" until they locate someone who will give them their blessing (p. 233).

### **Emotional Distress**

While infertility exacts a heavy physical toll on the lives of those it touches, it provokes a substantial amount of emotional distress in women as well. Some have argued that "the single most important issue" facing infertile women are the "emotions surrounding the unfulfilled wish for a child" (Hammerli et al., 2010, p. 776). When the ultimate outcome is unknown, the path to achieving a successful pregnancy is unclear, and the cause for infertility is unspecified, women experience great "uncertainty" (Loftus & Namaste, 2011, p. 37) or "ambiguity" in their daily lives (Sandelowski & Pollock, 1986, p. 142). Women's emotions fluctuate, as contradictory feelings wrestle for control. They experience fear (Hammerli et al., 2010, p. 771), feelings of "helplessness" (Berger et al., 2013, p. 61), and grief (Forrest & Gilbert, 1992, p. 47). At the same time, for women who are actively pursuing medical treatment, there is the conflicting but positive presence of hope (Hammerli et al., 2010, p. 771). The internal struggle between negative and positive emotion can produce "high levels of emotional distress" (Loftus & Namaste, 2011, p. 42), anger (Parry, 2004, p. 914), stress and pain (Berger et al., 2013). Women also exhibit depressive symptoms (Domar, Broome, & Zuttermeister, 1992) presented as feelings of

loneliness, “futility,” “emptiness,” and “despair” (Callan & Hennessey, 1988; Daniluk, 2001, p. 442).

The cyclical nature of a woman’s menstrual cycle means that most women facing infertility will experience all of these emotions on a regular basis. In her autoethnographic account, Parry (2004) said “I felt like I was on an emotional roller coaster. I started out each month full of hope, then I would crash down and then start all over again. It was a cycle of peaks and valleys” (p. 913). With each infertile month, there is an acute sense that time is being wasted, consumed by rituals, and running out, that heightens every emotion (Daniluk, 2001; Sandelowski & Pollack, 1986). Every month there is a period of waiting and hoping, followed by deep feelings of loss and grief when a woman does not become pregnant (Berger et al., 2013; Chester, 2003). Some women compare their infertility experience to the “death of a loved one” (Berger et al., 2013, p. 60) or as a kind of “dying” (Ryan 2005) as they grieve both the loss of their identity as mother (Chester 2003) and the loss of the children they had dreamed about and hoped to create (Berger et al., 2013; Daniluk 2001).

The reoccurring loss of a deeply desired identity, the burden of making medical decisions, and the flood of conflicting emotions drives many women to seek out coping strategies. Unfortunately, many women find relief through employing methods that have the potential to create deeper psychological and emotional distress. Women suppress their feelings and practice “denial and avoidance” by keeping their circumstance a secret from friends and family (Berger et al., 2013, p. 63). This attempt to dismiss, ignore, or bury their natural human response to loss, grief, and disappointment often leads to prolonged periods of social and emotional isolation (Loftus & Namaste, 2011). Multiple studies recognize and advocate for the psychological and spiritual counseling of women facing infertility (Berger et al., 2013; Domar et

al., 2005; Forrest & Gilbert, 1992; Hammerli et al., 2010; Roudsari & Allen, 2011; Thorn, 2009). But Bovin, Scanlan, & Walker (1999) suggested that, in spite of reporting high levels of psychological distress, only 8.5% of the infertile women in their study were seeing a counselor. Tragically, many infertile women avoid seeking counseling services in fear of the stigmatization attached to seeking mental health services (Roudsari & Allen, 2011, p. 164; Thorn, 2009, p. 2).

### **Spiritual Questioning**

In addition to the physical toll and emotional distress produced by infertility, many women find themselves facing a spiritual crisis (Roudsari & Allen, 2011; Ryan, 2005; Sandelowski & Pollock, 1986). As the “ability to have children is typically taken for granted” (Smith & Smith, 2004, p. 51), a sudden confrontation with a circumstance beyond one’s control, combined with a dwindling confidence in the power of medical science, compels some women to search for resolution by turning to religion, exploring faith in God, or praying for a miracle (Klitzman, 2018, p. 227; Sandelowski, 1986, p. 72; Sewpaul, 1999, p.748). And, while some women obtain peace through personal prayer (Roudsari, Allen, & Smith, 2014, p. 120), the belief that their experience is “part of a divine plan” (Domar et al., 2005, p. 46), or that infertility presents them with an “opportunity for personal and spiritual growth” (Jennings, 2010, p. 229; Ryan, 2005, p. 66), they also report “estrangement” from God (Sandelowski & Pollock, 1986, p. 144), “enormous burdens of guilt and grief” (Sewpaul, 1999, p. 753), and anger that God does not answer their prayers (Roudsari, Allen, & Smith, 2014, p. 118).

Infertility calls into question many presuppositions women have regarding their bodies, personal choice, and fate. Those who believed they could choose how and when they became pregnant are confronted with their sudden lack of control. Chester (2003) said of her own experience with infertility:

I became an expert on reproductive technology, and after discovering how the tiniest of details must come together to get that egg and sperm to meet at just the right instant, I decided it was a miracle any of us are here at all. There is nothing natural about it. It's all divine intervention. (p. 777)

For women who believe that having a baby is supposed to be part of their life plan, questions regarding God's love and justice are common (Feske, 2012, p. 3). Many women debate the fairness of their circumstances and search for someone to blame (Klitzman, 2018, p. 227). This line of questioning inevitably leads many women to turn inward. They ask, "Why is God punishing me like this?" (Whiteford & Gonzalez, 1995, p. 33) and "What have I done to deserve this . . . what have I done that is evil?" (Sewpaul, 1999, p. 749). In the absence of concrete answers, some women connect their infertility with decisions they made in the past (Forrest & Gilbert, 1992, p. 45). This can elicit feelings of guilt and shame without any immediate resolve. For the woman who perceives herself as worthy of motherhood, the absence of a divine reward elicits feelings of anger towards God and a growing bitterness toward others, for whom motherhood appears to have come easily (Sandelowski & Pollock, 1986, p. 144). Women within the infertile community, who commit to the hard work and personal sacrifice required of them in pursuit of motherhood, often develop a sense of "deservedness" or entitlement that is only intensified as time goes on (Whitehead, 2016, p. 109). Sewpaul (1999) noted that, within some communities, the held belief that a greater faith in God will be rewarded with a miracle can also contribute to angry and bitter feelings toward God when a woman's efforts and prayers go unanswered (p. 750). This intense, complex grappling with difficult theological questions that lack concrete answers leads some women to lose faith in the power of prayer, leave their church, and seek the support of others like them in outside support groups (Feske, 2012).

## **Social Isolation**

For many women, impaired fertility generates a physical, emotional, and spiritual struggle that has the salient power to negatively impact their relationship with their partners, friends, and family. While most women acknowledge the vital importance of being surrounded by a loving and supportive community during their ordeal, they also report having a relatively limited support system and feeling great loneliness (Berger et al., 2013). One potential explanation could be the all-encompassing nature of pursuing infertility treatment. Parry (2004) observed that a woman's pursuit of motherhood can become so consuming that she can no longer enjoy a "normal life" (p. 919). Many women give up relationships that are meaningful to them and even abandon their career in pursuit of that single goal (Chester, 2003). However, when considering the compounding effect of having to navigate the physical and emotional stress while bearing the additional burden of the felt, or expressed, role expectations of others, it is not surprising that many women choose to practice selective sharing and withdraw from a larger society altogether. In addition to feeling exhausted, unhappy, and insufficient, they do not want to deal with the persistent questions and curiosity of others. These women do not want advice; they do not want to be cast as an object of pity; and they do not want others talking about their situation with others (Akarsu & Beji, 2019).

For some women, it is the general lack of understanding and the failure of others to acknowledge their loss that hurts the most. But many others express frustration at being subjected to "insensitive" comments, "probing" questions, and the "absence of validation" (Berger et al., 2013). Feske (2012) noted that suggestions like, "Just relax," "Take a vacation," or "Adopt and you'll get pregnant" are unhelpful and dismissive of the pain experienced by infertile individuals (p. 9-10). Loftus and Namaste (2011) observed that many women give up

relationships with friends and avoid certain social gatherings in order to prevent these kinds of uncomfortable conversations (p. 46).

For women of childbearing age who struggle to get pregnant, the presence of other mothers, children, and babies can prove to be quite difficult. Many women find it challenging to participate in social gatherings where pregnant women or babies are present (Berger et al., 2013). As mentioned above, women often make social comparisons between themselves and others, and desire to be like other women (Loftus & Andriot, 2012; Whitehead, 2016). So, within societies where motherhood is viewed as a signifier of womanhood, or as an important rite of passage, women who cannot conceive are made to feel like outsiders. According to Sandelowski and Pollack (1986) infertile women experience an “unbridgeable gap” between themselves and the fertile within their social circles as they are not part of the “club” of women who have experienced pregnancy, childbirth, and motherhood (p.144). This felt exclusion can often lead to feelings of jealousy that cause women to further distance themselves from their fertile friends and find reasons to avoid spending time with them (Whiteford & Gonzalez, 1995, p. 35). Regrettably, over time, every withdrawal from a potentially painful social encounter increases the felt separation and the actual isolation of women struggling with infertility.

### **Infertility within Christian Faith Communities**

As “families and communities help to define the experience of infertility” for women (Ridenour, Yorgason, & Peterson, 2009, p. 37), the way in which a woman’s faith community addresses her experience with infertility has the ability to make a profound impact (Feske, 2012). While one might assume that the presence of a faith community, and the spiritual guidance of a pastor, priest, or other spiritual leader would provide infertile women with a safe haven for spiritual questioning and emotional support, the opposite is often true. The current body of



research insists that while faith communities have the potential to be a resource, source of support, and context for healing, more often than not, they are a burden, source of strain, and just one more painful obstacle for those facing infertility (Domar et al., 2005, Nouman & Benyamini, 2018, Ridenour, Yorgason, & Peterson, 2009, Roudsari & Allen, 2011, Ryan, 2005). This challenging dialectic occurs due to a historically rooted and complex religious ideology regarding a woman's role, the importance of children, and infertility. Ryan (2005) explained:

The difficulties infertile believers encounter in drawing a useable or healing wisdom from faith traditions stem both from how we treat infertility within communities of faith and the way that we talk about infertility in theological terms. (p. 70)

As the beliefs and subsequent values of faith communities will inform the accepted and promoted social norms of its members (Buluc-Halper & Griffin, 2015), and the way in which the community functions to either help or hurt the infertile women within their membership, it is important to explore the origin of those beliefs.

Throughout the Bible, the fundamental text of the Christian faith, infertility is approached through a perplexing narrative web that links the curse of sin and death with the promise of redemption and new birth. According to Ryan (2005), the “interwoven symbolisms of judgment, blessing, and mystery yield a confusing answer to the suffering occasioned by infertility” in modern times (p. 69). For example, in the biblical book of Genesis, the creation narrative describes the first couple's decision to disobey God. Following the transgression, a series of curses are pronounced. To the woman, God says, “I will surely multiply your pain in childbearing; in pain you shall bring forth children” (Genesis 3:16, ESV). Interestingly, this is preceded with a promise that a future offspring of the woman would crush the head, and thus

defeat, the serpent, who represents sin and death (Genesis 3:15, ESV). This promise of future redemption, coupled with the curse, establishes narrative tension. From this point forward, each time a woman is described as having conceived a child, the unstated question becomes, “Will this be the offspring that was promised—the one who will break the curse?”

With the promise of human redemption at stake, the Old Testament paints a grim picture of every woman who struggles or fails to conceive. Childlessness is cast quite negatively, and the barren women is depicted as “an object of pity” (Smith & Smith, 2004; Ryan, 2005). Later in the book of Genesis, Rachel, the second wife of Jacob, is depicted crying and pleading with her husband to “Give me children, or I shall die!” (Genesis 30:1, ESV). In I Samuel, Hannah is found weeping and refusing to eat because the Lord had closed her womb (I Samuel 1:5b, 7b, ESV). When both of these women do finally become pregnant and give birth to sons, they view their children as an answer to prayer and a sign of God’s blessing (Genesis 30:23; I Samuel 1:27, ESV). These early stories serve to lay the foundation for an ideology that views fertility as a sign of God’s favor and infertility as a curse.

The dread of the barren womb persists throughout the Old Testament and is further exacerbated through warnings that mirror the language of the curse pronounced in the creation narrative. God later declares to the fledgling nation of Israel, “If you will not obey the voice of the Lord your God or be careful to do all His commandments . . . cursed shall be the fruit of your womb and the fruit of your ground” (Deuteronomy 28:15a, 18a, ESV). And while this is also preceded with a promise that, for those who obeyed, the fruit of their womb would abound (Deuteronomy 28:11, ESV), the negative connotations connected to fruitlessness are firmly established by the end of the historical narrative.

As the barren womb is depicted throughout the Old Testament as a sign of God's judgment for disobedience, some interpret infertility as a "punishment from a higher power for past sins and indiscretions" (Domar et al., 2005, p.46) and treat infertile women as "morally suspect" (Whiteford & Gonzalez, 1995). According to Feske (2012), in the struggle to make sense of their experience, "many infertile individuals will interrogate not only the divine, but also themselves and ask . . . has God turned away from me? Have I done something to cause this to happen? Is this a form of punishment?" (p.3).

While adhering to a strict ideology of infertility as divine judgment may not be as prevalent within many Christian faith communities today, an opposing but equally damaging ideology still persists in many conservative communities that emphasize the goodness of motherhood or parenting. The divine mandate given to the first couple to "be fruitful and multiply" (Genesis 1:28, ESV) is often used to extol the idea that the primary purpose of marriage is procreation and that women "should restrict themselves to the roles that God and nature prescribed to them, namely, wife and mother" (Sandelowski, 1990, p. 483). Ryan (2005) found that procreation is often "treated as one of the primary goods of marriage" within communities of faith (p.70). It is a common expectation that couples within faith communities will have children as "a normal function of their marriage" (Smith & Smith, 2004, p. 49) and infertility can undermine "the meaning and purpose of both their marriage and their very existence" (Matthews & Matthews, 1986, p. 643).

Childbirth and reproduction have typically been seen as "central to self-identity and to the fulfillment of gender roles and religious duties" for women (Oren-Magidor, 2015, p. 86). Nock (1987) stated that women who believe in the "inherent, God-given, differences between men and women," will most likely "pursue the traditional feminine role" of mother (p. 384).

Biblical passages like Proverbs 31 are used in some, perhaps many, faith communities to establish a model that every god-fearing woman should aspire to. And when she does, “Her children rise up and call her blessed; her husband also, and he praises her” (Proverbs 31:28 ESV). As “religious and gender ideologies are both vital cultural factors that are likely to influence the importance of motherhood,” for those religions that embrace a pronatalist ideal, the value of becoming a mother is only amplified for religious women (McQuillan et al., 2008, p. 481).

Placing an overt emphasis on the high and holy calling of motherhood will inevitably result in the marginalization of those who either choose not to or are unable to conceive and bear children. Domar et al. (2005) reported that infertile woman and couples who belong to spiritual communities that make parenthood a core identity experience a heightened sense of social isolation and stigmatization (p.46). For the infertile, community gatherings can be a source of additional “stress and tension” (Nouman & Baenyamini, 2018, p. 161) as many churches focus their ministries around family and children (Feske, 2012; Greil, 1991).

Participation in church activities can be just one more “painful reminder of a woman’s infertile status” (Jennings, 2010, p. 224) especially within faith communities that recognize holidays and sacred days that celebrate parenthood and family life. Mother’s Day, Father’s Day and Christmas can be difficult for those who have experienced a pregnancy loss or infertility (Feske, 2012; Smith & Smith, 2004, p.53). These holidays are particularly difficult, Ryan (2005) noted, because they do not recognize the “pain of longing for parenthood alongside the joy and struggles of its realization” (p. 69). Many faith-based programs, activities, and biblical texts can be presented with what feels like a lack of sensitivity or awareness to those who are struggling to conceive (Smith & Smith, 2004, p. 52).

Faith communities often run programs that require volunteers to achieve their aims. Many infertile women and couples experience discomfort when they are asked to participate in the planning and preparation for events that focus on children and family. Baby showers, vacation Bible school, and teaching Sunday school can be just one more painful reminder of what they do not have. While on one hand many women welcome the opportunity to become involved, they also confess “jealous” feelings, “discomfort,” and a “sense of loss” when surrounded by other couples with children (Smith & Smith, 2004, p.53). And, although some couples draw strength from the personal relationships they enjoy within their faith communities, Greil, (1991) found that “they were *far outnumbered* by those couples who viewed their religious affiliation as one more obstacle to overcome in their attempt to deal with their infertility” (p. 170, emphasis added).

### **Summary**

The long-established institution of motherhood continues to create tension for women who choose to remain childfree or find themselves involuntarily childless. Depending on a woman’s cultural and social context, she can feel pressured from actual or perceived expectations of her family, friends, and community. Because only 12% of women experience some form of reproductive impairment (CDC 2019), infertility is regarded as abnormal. The resulting stigma categorizes infertile as impaired, broken, or sick. Women who desire to become biological mothers, but encounter difficulties in doing so, may choose to pursue medical treatment. Depending on what course of action they choose to pursue, and how quickly they achieve the desired result, treatments can span a few months or many years. For those for whom it takes years, the physical toll can be devastating. Many of these women experience emotional

pain and stress as they wrestle with their unfulfilled desire for a child. The presence of negative emotions like anger, sadness, and depression can cause many women to withdraw from society.

The infertile Christian woman, in addition to experiencing the stigma and the physical and emotional struggle, may also be presented with an additional challenging layer as she interacts with those within her community of faith. Women who belong to Christian faith communities that hold a religious ideology that champions motherhood can experience a crisis of faith, as they question why they have not been able to physically fulfill what they had believed to be, and had been assured was, their calling. Many of these women suffer marginalization within their communities when they are simply unable to conform with the expected natural matter of course.

### **Grounds for Research**

The extant literature has examined the physical, emotional, psychological, and social toll of infertility on women. Multiple studies stress the need for increased counseling efforts (Berger et al., 2013), access to mental health professionals (Forrest & Gilbert, 1992), “active-confronting” and “meaning-based” coping strategies (Hammerli et al., 2010), and support groups that can address the needs of infertile women (Loftus, 2009). Other studies focus on the importance of understanding a woman’s cultural context (Burnett, 2009; Thorn, 2009), as well as considering her religious background (Buluc-Halper & Griffin, 2015) before infertility counseling. Several studies emphasize the power of religious convictions to aid women in the development of unique coping strategies, even when those beliefs forbid the exploration of some medical treatment options (Czarnecki, 2015, Jennings, 2010, Klitzman, 2017). Domar et al. (2005) found that women who possess a “high level of spiritual well-being experience less infertility distress and fewer depressive symptoms” (p.45). Additional research has confirmed

this finding. Religious and spiritual health is linked to the emotional well-being and “life satisfaction” of women facing infertility (Etemadifar et al., 2016; Mahajan et al., 2009; Nouman 2018; Ridenour, Yorgason, & Peterson, 2009). However, rather than concentrating their research around what a woman’s faith community might do to promote her spiritual well-being, scholars have historically focused on advising the medical community.

Roudsari, Allen, & Smith (2007) identified a “remarkable gap” in the available literature addressing infertility through the lens of religion and spirituality and called for further research focused on how health care professionals might incorporate religious and spiritual components into their daily practice in order to provide more holistic care for women (p.145-147). Answering their own call, Roudsari, Allen, & Smith (2011, 2013, 2014) drew from interviews with women connected to various denominations of Christianity and Islam, in an effort to identify the religious and spiritual coping strategies they employ and to inform the medical community about the potentially unmet spiritual needs of their patients. These scholars urged physicians to ask questions about a patient’s religious and spiritual background before making recommendations for counseling (2011); encouraged medical professionals to consider how religion can have a positive impact on the marital relationship of couples who face an infertile diagnosis together (2013); and argued that “multidisciplinary teams” that include counselors and chaplains, in addition to doctors and nurses –were needed to address the needs of infertile women (2014).

In spite of this call, the academic literature that seeks to specifically address pastors, ministry leaders, and lay people within Christian faith communities is sparse. Smith and Smith (2004) offered a preliminary qualitative investigation regarding the experiences of faith-based infertile couples but specifically direct their findings towards advising professional counselors on how to help infertile couples “cope with any negative influence and emotional distress their

experiences in these communities may cause” (p. 60). Feske (2012) provided thoughtful qualitative research that directly engages the theology, anthropology, and rituals that shape the experiences of infertile people within Christian faith communities and offers a list of tangible suggestions for pastors and church members who desire to honor the experiences and feelings of those struggling with infertility within their membership. This final study laid an excellent foundation for what this thesis will uniquely aim to accomplish.

A veritable chasm still exists between what is known about women’s experiences with infertility and impaired fecundity and how that knowledge is practically embodied within Christian faith communities. The barriers created by conventional social norms, the stigma attached to those physically unable to reproduce, and the deep-seated religious ideology that elevates motherhood all continue to work together to create stubborn obstacles for women and couples. Such obstacles impede honest and open dialogue about the beliefs and actions that must change in order for women to feel safe, represented, and spiritually cared for.

The goal of this project is to amplify the voices of women and translate their lived experiences into useable knowledge for other women, faith community members, and faith community leaders. By employing a qualitative approach, this project seeks to represent women’s experiences with infertility and pregnancy loss within their Christian faith communities. By employing the ideas of Muted Group Theory (Ardener, 1975, Houston & Kramarae, 1991, Kramarae, 2005, & Orbe, 1996, 1998, 2005), this study will identify the particular ideologies, social interactions, and practices that contribute to the marginalization of infertile women, as well as uncover the strategies of resistance they employ. Embedded within the stories of every muted group are seeds for fruitful change. It is my hope that this study will culminate in an accessible resource for researchers, pastors, ministry leaders, and lay members to



not only acknowledge the perceptions and practices that are harmful to women but also to offer helpful and healing ways to think and talk about infertility within faith communities.

## CHAPTER 3

### METHODOLOGY

This project was born out of a desire to inspire change regarding the way infertility is addressed within faith communities. Based on my personal experience with involuntary childlessness, and conversations with other women, I suspected that infertile women comprised a muted group (Ardener, 1975) within Christian faith community culture. While much had already been written about on the topic, my personal observations led me to believe that in spite of a large body of academic work, the experiences of infertile women had remained relatively unchanged. Even when pastors, or community leaders, became aware of infertile women within their communities and endeavored to acknowledge their presence in more affirming ways, a curious lack of connectivity between the pulpit and pew seemed to persist. The interpersonal experience for infertile women within many Christian faith communities was still one of marginalization, stigmatization, and isolation.

I sought to discover where the breakdown was occurring between what was already known about women's experiences with infertility and the failure of Christian faith communities to embody that knowledge experientially, in the way that they thought and communicated about infertility within their cultures. Viewing the problem through the lens of Muted Group Theory (Ardener, 1975), and the further developmental work on the theory from Houston and Kramarae (1991), Kramarae (2005), and Orbe (1996, 1998, 2005), helped me to identify infertile women as a marginalized group that had been silenced and "rendered inarticulate" by a dominant group (Ardener, 1975). As a minority population, these women's presence within their communities was virtually invisible; their voices were not being heard; and their experiences were not being

validated. Kramarae (2005), suggests that these experiences are constitutive of muted group members who:

may have a lot to say, but they tend to have relatively little power to say it without getting into a lot of trouble. Their speech is disrespected by those in dominant positions; their knowledge is not considered sufficient for public decision-making or policy making processes of that culture; their experiences are interpreted for them by others; and they are encouraged to see themselves as represented in the dominant discourse. (p. 55)

It was not my assumption that these women's muted status was intentionally imposed but rather that it was the innate result of a general lack of education and the persistent social norms and religious ideologies that have long contributed to the marginalization of 'others.'

I considered the potential of presenting these women's stories to faith community members and questioned if a thoughtful and productive dialogue might occur. My goal was to raise awareness and to increase the level of understanding and compassion towards infertile women within faith communities. I aspired to find a new way to communicate and advocate the need for social change. I thought that everyone should be encouraged to "consider and learn from the experiences of others" (Kramarae, 2005, p. 56) and that the act of sharing stories could restore the broken connection between the teller and her audience by eliciting empathy and introducing points of mutual identification. As Orbe (2005) writes of his own experience:

What began as [an] exploration of my own cultural status evolved as a multidimensional adventure in seeking insight into the various ways in which we are all similar and different, wise and ignorant, and oppressive and oppressed. At

the core of my healing is an increased understanding of self – and by extension  
how self is constantly informed through my interactions with others (p. 66)

I had personally witnessed the power of personal stories to forge connections between strangers and build bridges within fractured communities. My past experiences with storytelling led me to believe that if story could help faith community members see and empathize with the painful and grief-laden experiences of these often-invisible members and, if they were presented with some real implementable solutions for change, they might respond in more compassionate and life-giving ways than they had historically been known to do.

As I continued to ponder this population and the growing desire I had to say what its members had found it difficult to communicate, three concrete goals emerged; 1) to provide women, who self-identify as having experienced involuntary childlessness within the context of a faith community, with the opportunity to share their stories with a sympathetic and empathetic listener; 2) to discover new ways to think and talk about infertility that would create safer, more compassionate, and spiritually nurturing faith communities; and 3) to present a constructive body of research that was accessible to academic and religious communities.

Employing a qualitative approach, I gained access to the stories of individual women. I embraced a “co-cultural approach” (Orbe 1996, 1998, 2005) which seeks “to avoid the negative or inferior connotations of past descriptions” for muted groups (Orbe 1998, p. 2). I sought to amplify the voices of my participants by giving them freedom to “articulate their own experiences in whatever voice(s) they deemed as ‘appropriate’” (Orbe, 2005, p. 65-66). I wanted to hear each woman’s “authentic voice” (Houston & Kramarae, 1991, p. 389) and believed that, when given the opportunity to speak, these women would have a lot to say.

When it came to discovering new ways to think and talk about infertility, I turned to Houston and Kramarae (1991) who explain how women in non-dominant positions adopt various “strategies of resistance” to confront the muzzle imposed by the dominant group and their discourses. Orbe (1996) agrees that “muted groups do not necessarily remain muted, but instead create strategies to overcome their mutedness” (p. 159). Finding and naming the particular “strategies of resistance” employed by infertile women became my primary objective. Embedded within those strategies I could identify the views they found most problematic while learning the innovative and inspirational ways they communicated their resistance to the ideology that threatened them.

### **Participants**

The participants for this study were volunteers who self-identified as meeting the criteria of: 1) being a woman over the age of 18; 2) having experienced impaired fertility or infertility; and 3) having attended or been a member of a faith community while experiencing involuntary childlessness. Every woman who volunteered met these criteria and was invited to participate in the study.

This project unfolded in two phases. Phase one served as a pilot study consisting of three interviews. During phase one, I recruited participants for my study using a digital “flyer” (see Appendix A) and through personal referral. I posted the flyer on my personal Facebook page and asked my faith community pastor and administrative assistant to share the details of my study via word-of-mouth and through an e-mail announcement (see Appendix B) sent to faith community members.

One participant volunteered to be interviewed after being told about the study by the pastor of the church I attend. One participant was recruited by an acquaintance who believed

they had a friend who fit my criteria. The third participant contacted me via e-mail after learning about the study from the first participant.

During phase two of the study, I re-posted the digital flyer on Facebook and distributed paper flyers (see Appendix A) to attendees at a women's ministry leaders' brunch. Friends and colleagues reposted the digital flyer to their Facebook pages. Several of the women's ministry leaders volunteered to share the study details with members of their faith community.

Of the six participants who volunteered during phase two, two were recruited by women who had attended the brunch and one of those participants recruited a friend following her own interview. One participant contacted me after seeing the digital flyer on Facebook; one sent me an e-mail after she learned about my project and, following our interview together, she recruited a friend who contacted me by phone and became my ninth and final participant.

The nine women who participated in this project represented three Christian denominations, five local faith communities, and a broad demographic of infertility experience. The women reported experiencing periods of infertility lasting between six months to ten years. Five of them had experienced multiple miscarriages and three had never become pregnant. One participant reported male infertility as the primary factor for her inability to become pregnant. Eight of the women were married. Five participants had no living children and four had two living children. Two participants were in their early 50's, three in their 40's, two in their 30's, and two in their late 20's.

### **Data Collection**

To collect my data, I used private, one-on-one, semi-structured interviews. All interviews were captured on two audio-recording devices and lasted an average of forty-five minutes. While drafting my first interview schedule (see Appendix C), I drew from Berg (2009) and Madison

(2012). I intended to learn more about each women's experience within her faith community: the conversations, religious ideology, and relationships that shaped her experience. I sought to understand the difference between the communication she had found most and least helpful. I wanted to know if she had felt marginalized by her faith community due to her fertility struggles.

Each interview took place on a day and time that was convenient for the participant. Due to the personal, and potentially emotional, nature of women's experiences with infertility, it was important to ensure that each woman felt safe and comfortable while interviewing. With this in mind, I believed that my participants would feel most at ease in the privacy of a personal residence. I offered to meet with women in their home or, if they preferred, at my apartment. Five participants chose to come to my apartment; three invited me to their homes; and one requested that I meet with her in a private conference room at her place of work.

After a brief introduction to the study, in which I attempted to clearly communicate what I hoped to learn from my participants (Berg, 2009, p. 116), and a review and signing of the informed consent document, I began each interview by identifying myself as a single, infertile woman and briefly described my personal investment in the project. My objective in self-disclosure was to "establish some sense of common ground" and "rapport" with each woman (Berg, 2009, p.130). I wanted her to know that I was familiar with some of the emotions and experiences of infertility, having experienced the loss of fertility myself. Although the majority of my participants were married, which made their circumstance different from my own, I had experienced marginalization within my own faith community and was interested to learn how our experiences were similar and dissimilar. Identifying myself a fellow 'other' was strategic and effective. Several of my participants visibly let down their guard following my admission and articulated their experiences quite candidly with me throughout their interview.

During phase one, being relatively new to qualitative research, I felt anxious about making sure I covered all of my prepared questions. This resulted in a more structured interview than I had envisioned. After the first three interviews, I began to question this approach. I wondered if I had truly afforded my participants the enough opportunity to voice all that they may have desired to say. I recalled Madison's (2012) advice to be aware of the natural occurring power differentials between interviewer and interviewee (p. 40). I determined that my more formal posture might have created some unnecessary barriers and I resolved to adjust my approach during future interviews.

As my primary objective was to hear the authentic voice of these women, I revisited the interview schedule, reworded and rearranged several questions and condensed the original eleven questions into nine, with some alternations to the groupings of possible prompts beneath each primary question (see Appendix D). During phase one, I had also noted that all three participants had talked about their faith in God and how their experience with infertility and pregnancy loss had impacted their relationship with God. Recognizing this emerging trend, I added a final question to address that theme during phase two. After reviewing my revised interview schedule, I was then encouraged by my academic advisor to begin each interview by simply asking the women to "tell me their story." This approach, she argued, would not only give each participant the freedom to share what they wished to say, but they might also answer a number of my prepared questions in advance of me asking them.

As I continued to review the data from phase one, I was encouraged to discover that some of the most interesting and insightful moments had occurred when my participants had chosen to deviate from my schedule. My confidence in qualitative research increased. Berg (2009) encouraged me to relax and just, "*Let people talk!*" (p. 142). I now believed my participants



would tell me all that I needed to know. During phase two, I began every interview by asking each woman to tell me her story. As my advisor had predicted, I quickly discovered that she would address most of my questions during their opening monologue. Granting each participant the freedom to tell her story, in the order and manner in which she wished, created a safer environment where her authentic voice could be heard.

Although I had approached this project with what I believed to be a strictly intellectual curiosity, I was surprised to discover how often I was moved emotionally by my participant's stories of loss. At times I struggled to maintain the professionalism as a reasonably impartial researcher. I could feel the emotional weight of these women's grief. On more than one occasion, I considered pausing the interview, reaching out, and offering my sympathy. I experienced frustration when they talked about feeling alone and misunderstood. I felt angry and indignant when I listened to some of the hurtful things that had said and done by faith community members. I grew weary and discouraged. I began to question if my research would make any impact at all, in the face of what had begun to feel like impossible odds. Following several interviews, I found myself weeping as I recalled the painful stories that had been shared with me.

At the same time, I was humbled and inspired by the resilience, strength, and dignity of these women. In spite of some extremely difficult and distressing experiences, they did not identify themselves as victims. In the moments where I anticipated expressions of hopelessness, I was told stories of personal transformation instead. They spoke of intense suffering but also of the growth that had resulted from the struggle. Their stories revealed an increased compassion for others, a greater appreciation for human kindness, and a new discernment regarding the relationships that matter most. When describing their darkest moments, they chose to celebrate an increased faith and hope in the goodness of God.

At the conclusion of every interview, when I thanked each woman for speaking with me, naming myself a privileged recipient of the gift of their story, I was stunned by how often my participants expressed their gratitude for having been given the opportunity. I was repeatedly thanked for my willingness to listen, my compassion, and my investment in the work I was doing. Two women told me that our interview was the first time they had ever been asked to share their story of infertility and pregnancy loss.

As I concluded my interviews and began reviewing the data, my sense of personal responsibility grew. I had been entrusted with the vulnerable and intimate details of human suffering. The very nature of these women's experiences, the inescapable marginalization, the weighty grief resulting from their loss, and their endurance through pain, compounded my burden. I thought of Richardson (2011), who says, "when I move deeply into my writing, both my compassion for others and my actions on their behalf increase." Like Richardson, I had been profoundly moved by my participant's stories. A new longing, to represent each one to the best of my ability, was planted within me. I gratefully recognized that I was no longer standing alone in my desire to affect social change. These women had been willing to speak, and in so doing, to stand with me. Together we could shed a brighter light on women's experiences with infertility and pregnancy loss within communities of faith.

### **Data Analysis**

Following each interview, I transcribed the audio recordings verbatim, using Descript, a secure, downloadable, software program that turns audio files into text. After running each audio file through the software, I listened back to each interview and manually edited the text to ensure I had an accurate transcript. I assigned pseudonyms to each participant and changed other identifiers that could reveal their identities. In the spirit of the study, for my pseudonyms, I

selected the names of barren women in the Bible: Sarah, Rebekah, Rachel, Hannah, Ruth, and Elizabeth. In addition, I chose Hope and Joy, two Christian virtues I observed in my participants, and Grace, a core tenet of the Christian faith.

As I began to analyze and interpret my data, I was informed by Charmaz (2014) who advocates for a grounded theory approach. Charmaz (2014), encourages the qualitative researcher to ask, “analytical questions” of the data through at least two phases of “initial” and “focused” coding (p. 109). Initial coding, for example, involves assigning actions, using gerunds, throughout the entire interview. This line-by-line analysis provides the researcher with an opportunity to zoom out from the data and gain a broader perspective before identifying the major themes. Simply asking the question, “What is happening here?” eliminates any initial pressure, often felt by researchers, to immediately look for the topics or themes they may have already expected to find. Having completed one initial pass through the data, the researcher can then progress into focused coding, which allows her to identify the significant and repeating codes. These codes then serve to “advance the theoretical direction” of the research (Charmaz, 2014, p.138). Throughout this process, Charmaz also suggests noting “in-vivo” codes which are the “special terms” participants use to describe their experience (p. 134). Although these codes may not become primary themes, they can help the researcher understand participants’ meanings and motivations.

As I made my way through each interview, employing initial, focused, and in-vivo coding, patterns and themes began to emerge. I sat for many hours, with transcripts in hand, asking questions of the data, taking notes in the margins, and comparing the emerging codes across all nine interviews. During phase one, I had employed “writing as a method of inquiry” which allowed me to explore the themes I had observed in the first three interviews (Richardson,

2011, p. 959). Then, over a year later, with six more interviews in hand, I returned to those original memos and compared them with the newer data. In spite of the adjustments to the interview schedule, made between phase one and two, I was pleased to discover a compelling consistency in the themes addressed across all nine interviews.

All nine of my participants portrayed experiences consistent with the literature. They described the physical toll of infertility, the pressure of making medical decisions, and feeling 'broken.' They emphasized the presence of negative emotions including; anxiety, fear, and depression. They talked about being angry with God, feeling frustrated by their lack of control, and questioning the character of God in the midst of their suffering. They articulated an uncertainty regarding their value and purpose as women and expressed feelings of inadequacy and failure. They shared stories about not fitting in, social avoidance, and isolation.

Being satisfied that these women's experiences were consistent with what was already known about infertility and pregnancy loss, I narrowed my focus to uncover the religious ideology and faith community practices that my participants found most problematic. I reviewed the data again, specifically highlighting the places where these women expressed confusion, frustration, or stated a decidedly different belief or opinion than what they perceived to be the accepted ideology. In doing so, I was able to identify these women's 'strategies of resistance' (Houston & Kramarae, 1991) and then work backwards to pinpoint the specific ways in which their faith communities had made them feel misunderstood, invalid, or muted.

Four compelling themes emerged from the data and organized themselves into two distinct categories. The first category incorporated the influence of certain religious ideologies concerning women's roles and the value placed on children. The second category included two

observations regarding the definition and practical role of faith communities within the life of their members. And to a discussion of those findings, I now turn in chapter four.

## CHAPTER 4

### FINDINGS

The study of women's experiences with infertility and miscarriage within the context of Christian faith communities presented a complex and multi-faceted web of social, relational, and ideological interplay. The influential presence of certain social norms, inter-relational expectations, and religious thought that all work together to influence women's perception of identity and sense of belonging made it difficult to separate the data into clearly delineated findings. However, while rearranging and grouping the emerging themes together, it became clear that two inter-relating factors were at play: belief and action.

When the women I spoke with shared their experiences with me, they talked about faith community members saying and doing things that had a profoundly negative impact on their experiences with infertility. When examining these harmful behaviors, it became clear that certain beliefs were at the root of each one. On one hand, it appeared that the faith community members were to blame for adopting an exclusionary ideology, but at the same time, it became apparent that many faith community members were unaware that their beliefs and actions were causing anyone harm. In other words, they were practicing their beliefs without giving much thought to how those beliefs might be impacting others. This became the first major category of findings, which I called "embodied but unexamined beliefs." Beneath this categorical title, two findings emerged. The first finding was connected to the belief that a woman's primary purpose and worth lay in her ability to have children. The second, to the belief that children are 'everything,' that they are evidence of God's blessing and a symbol of worthiness for those who have them. For these two findings, it was a failure of faith community members to examine those particular beliefs that led to the inadvertent stigmatization and marginalization of infertile women.

During their interviews, these women also expressed disappointment regarding certain expectations they had for faith community life that had not been met. When examining the failure of their faith communities to live up to these expectations, it became apparent that certain claims had been made regarding core community values that, when put to the test, had proven false. In other words, these women's faith communities had promised one thing but delivered the opposite. This became the second major category of findings, which I called the "claimed but unembodied values." Beneath this categorical title, two additional findings emerged. The first was linked to the claim that faith communities are safe spaces. The second, to the claim that faith communities are pro-life. For these two findings, it was a failure of faith community members to embody their values that led to the isolation and exacerbated grief of infertile women. In summation, beneath two major categories pertaining to belief and action, four separate findings emerged which I will explore in further detail now.

### **The Embodied but Unexamined Beliefs**

A normative assumption in many Christian faith communities—that all women will become mothers—results in the stigmatization and marginalization of women who do not get pregnant or struggle to conceive a viable pregnancy. As one of my participants, Grace, noted, many faith communities only seem to "celebrate the stories" they are most comfortable with. "I don't think it's intentional," she said, "I think it's unexamined. I would like the church to examine, *why do we think what we think? Why are we comfortable with certain stories and uncomfortable with other stories?*" (emphasis added). It was Grace who brought the first major category to light. The embodied but unexamined beliefs are accepted social and religious norms, adopted by members of faith communities, who have not given thoughtful consideration to the potential impact of accepting those norms as universal.

When recalling some of the hurtful things that had been said by members of her faith community, Hannah said, “It’s not intentional . . . but I think there are assumptions behind those conversations.” Those assumptions, as several of the participants would go on to explain, included the belief that every woman’s life would and should follow a similar path to marriage and children. This assumption produced two frustrating norms that were impossible for infertile women and women who struggle with pregnancy loss to achieve. The first was that the ability to produce children determines a woman’s value, and the second was that raising children defines a woman’s worth. These norms were closely associated but manifested themselves in different ways.

### **Motherhood as “the only thing that gives a female value”**

Many Christian faith communities have historically venerated motherhood. The value assigned to becoming a mother is demonstrated through their enthusiastic embrace of women and couples with children. Many faith communities advertise themselves as ‘family-friendly,’ and cater to women who are mothers through a wide variety of program offerings including support groups and Bible studies. Motherhood, as an assumed role for all women, is reinforced through the practices and rituals of community life.

The overt celebration and veneration of mothers and progeny within faith communities can challenge, even if unintentionally, an infertile woman’s sense of identity and individual worth. When comparing herself to her peers, she may question her purpose in life and if, in the absence children, she has anything of value to offer her partner, her community, or the world. Questioning their value in the absence of children was a theme that echoed across several participants. Rebekah commented, “I kind of hate the idea that [motherhood] is the only thing that gives a female value.” When asked to explain, Rebekah explained that she had dated several



men throughout her high school and college years whose connections to certain faith systems led them to dismiss her as a viable candidate for marriage. Reflecting on expressly stated comments she heard, Rebekah said:

“She’s not wife material,” was actually said in my presence . . . . It was amazing to me, how many times there was that, “You are not worth a relationship with because [having children] is not ever going to be an option.” . . . It was kind of universal, and almost all of them—it was specifically kind of in a religious sense . . . their ideas were, “That’s not really acceptable as far as a woman goes.”

The belief that a woman’s true value lies in her ability to produce children is rooted in accepted social and religious norms regarding a woman’s biological design and her unique ability, and thus responsibility, to ensure the continuity of both the family and the faith. Ruth exemplified this expectation when she stated, “I feel less of a wife, less of a woman, because I can’t give [my husband] what we were designed to do.” For Ruth, the inability to carry a pregnancy to term was not only a failure to achieve her intended biological design but a failure to fulfill her marital duty to her husband as well. She went on to explain, “[My husband] is an only child so that will be the legacy that he will never have . . . he will never have that namesake.” Ruth felt personally responsible to give her husband a “namesake” and thus ensure his “legacy.” She felt that her failure to do so was a poor reflection on her womanhood and thus made her “less of a woman.”

Elizabeth discovered just how closely biological design and purpose were connected in the minds of her faith community members following her hysterectomy, a surgery she personally referred to as a “footnote” on the long saga of her infertility. She was surprised by the fact that her surgery was the point in time when “people were all sympathetic.” She said, “People asked

me, ‘I bet [having surgery] was *so hard* because you were grieving.’” She attributed their sympathy to “the expectation [that], you lose that part of your body, and then you will grieve forever.” From Elizabeth’s vantage point, it was frustrating that the finality of the hysterectomy, and the consequent impossibility of her future childbearing, prompted a far more compassionate response from her community than the decade-long grief accompanying her infertility had. The compassion of Elizabeth’s faith community members reflected the social role restriction placed on woman that was also demonstrated by Ruth’s story. The dysfunction, or loss of a woman’s reproductive organs is ideologically connected not only to design failure and the loss of potential, but a deficit to her womanhood as well.

**The cost of venerating motherhood.** The embodied belief that a woman’s design and duty are attached to her ability to produce children establishes motherhood as the chief paradigm for all women. Any identity outside that of mother will therefore, by comparison, be greatly diminished, as will the personal sense of self-worth for those unable to achieve motherhood. While likely unintentional, the veneration of motherhood within many communities of faith leaves infertile women with no place to go. These women, perhaps like most people, do question their purpose and value in the absence of social validation. The participants of this study experienced feelings of inadequacy, failure, shame and guilt when faced with their inability to perform what their faith community affirmed as their biological destiny and religious responsibility.

***Inadequacy and failure.*** In addition to the importance of belonging to and being accepted by their community, the women who participated in this study acknowledged the significance placed on their ability to contribute something valuable to their communities. When

the arrival of a baby is celebrated as a significant contribution, the individual offerings of a childless women can feel inadequate.

When Rebekah ruminated on the multiple rejections she had faced after potential partners were made aware of her inability to bear children, she said, “it was like, that’s all you would ever be considered in the culture, is this disposable, useless, female.” There were times, Rebekah said, that she even felt like “a waste of space.” To combat similar feelings, Hannah found herself compensating for the fact that she was not having children by devoting more and more energy into a career as a “missionary woman.” She explained, “there was this rationalization that my identity is as a worker for God . . . maybe that gets me points in the faith community. . . . If I can’t have children, at least I’m doing God’s work, right?” Ruth further stated that she felt compelled to “make up for” her inability to give her husband children. She said, “I keep the house extra clean; I cook more . . . you know, be there for him.” The fact that Rebekah, Hannah and Ruth felt “useless,” and experienced pressure to win “points” and “make up” for not having children demonstrates the amount of value they and their communities had attached to women’s procreative capacity.

Prolonged feelings of inadequacy eventually lead the infertile woman to feel like a failure. Every time Hope is asked by a new acquaintance if she has children, she is reminded of her inability to carry a pregnancy to term. When comparing herself to others in her community who have exhibited no signs of difficulty when it comes to pregnancy or delivery she said, “I haven’t been successful. . . . I have felt like a failure.”

***Shame and guilt.*** For the participants of this study, the pressure of social expectations and their failure to achieve them eventually evolves into introspection and feelings of shame and guilt. Rebekah felt as though she had been placed in a “tainted” or “whore” category by her

community, as though she was guilty of sin. Grace also wrestled with questions about who was to blame. She said, “I remember experiencing a lot of insecurity about my worth as a woman . . . feeling that it was my fault, that the problem was *in me*, so it was my fault” (emphasis added). From early childhood, Grace had believed that God rewards good people with good things and punishes bad people with bad things. When a community member jokingly suggested to Grace, “Well, so-and-so is able to have babies . . . why don’t your husband and her get together and have babies?” Grace felt deep shame. She said, “I knew I wasn’t good, and I knew I couldn’t be good.” She began to assume that her infertility was a punishment and felt “no hope, because I’m never going to be . . . good enough.” This kind of debilitating shame was also felt by Ruth, who eventually told her husband:

Maybe we should divorce and you go find another wife . . . because that’s what you deserve . . . I can’t do this for you, I feel terrible. I feel like I’m less than nothing. You need to go find another wife.

Both Ruth and Rebekah, as well as the member of Grace’s community, all came to similar conclusions—that the inability to produce children meant they were “disposable,” or at least replaceable. Their faith community’s veneration of motherhood led each of these participants on a long and painful journey and the emotional cost proved high.

**Strategies of redefining womanhood.** When confronted with the veneration of motherhood, the participants of this study felt compelled to define their identities and measure their worth by what had been set before them as the chief paradigm for women. As Kramarae (2005) explains, these women's experiences had been "interpreted for them by others" and they had been "encouraged to see themselves as represented in the dominant discourse" (p. 55). For as long as these women accepted the faith communities' dominant ideology regarding motherhood, the "power to shape and control [their] talk" was held by the majority (Houston & Kramarae, 2015, p. 389). However, when allowing the dominant group to define and measure them, these women experienced and expressed feelings of inadequacy, failure, shame and guilt that threatened their emotional, and spiritual well-being. In order to reclaim and redefine their own identity and sense of worth, the participants of this study developed several personal and interpersonal "strategies of resistance" (Houston & Kramarae, 1991). Combating the dominant ideology that left them feeling unworthy and ashamed, they established their identity as a child of God, found a new purpose through helping others, and formed new definitions for what it means to be a Christian woman.

***Reclaiming identity.*** Rejecting the assumption that a woman's identity is singularly defined by being a mother, participants of this study chose to view themselves, first and foremost, as children of God. Rachel found new confidence in claiming her identity as a woman in a relationship with God:

I know who I am. I am God's child, and nobody, no person on this earth, can change that. . . . It doesn't matter what other people do or say; I'm God's child. That's who I am, and that doesn't change.

Rachel's declaration that "what other people say" is of little consequence, helped her define her identity as independent and freed from the constraints of the dominant ideology. Similarly, Grace reflected a sense of freedom when she described a "glorious revelation" she experienced when she began to believe that her "infertility was not a punishment," and that her identity and worth should not be defined by what she could not do. "It's not about me and it's not about me doing anything," she said. "It's the finished work of Christ on my behalf. That's who I am . . . in Christ. . . . I am God's child by virtue of Christ's sacrifice." Through the biblical narrative of Christ's bodily sacrifice for the sin of humanity, Grace found a new way to interpret her experience with infertility. When she chose to accept the personal sacrifice of Christ as proof of both God's love and her value to Him, she no longer interpreted her infertility as a punishment for her sin. Instead, she found peace in believing that there was nothing she could do, or not do, that would alter God's love for her.

***Finding purpose.*** In addition to claiming the identity of "child of God" and defining individual worth as being a recipient of God's love, the participants of this study found new purpose through helping others. Hope believed that her multiple miscarriages were used by God to increase her awareness of and compassion for other women's suffering. She felt that God was calling her to "reach out more" to those in her community who are hurting. She said that her "path" had taught her "how to console others." She said, "when somebody else goes through it, you can help that person, in Christ . . . to survive, to look at Him, and not at [their] own pain." Because of her experience, Hope feels more competent to offer comfort and encouragement to women within her faith community who are hurting.

Sarah and Hannah echoed this sense of being called to find ways to reach out within their communities to care for other women. When reflecting on the women she has already had the

opportunity to encourage, Sarah said, “I really do think that . . . I was put in this path for a reason.” When Hannah identifies women who are struggling with infertility or pregnancy loss within her faith community she tells them, “I see you. I want to know your story. I want to sit with you in the weeds.”

After Elizabeth discovered that her identity was “not around my job . . . not around [children] . . . not whether I’m a mom or not,” she took to the internet to blog about her experiences. She wanted to “try to be the woman that was there for other people” who were facing infertility. Her willingness to be vulnerable increased her visibility as an infertile woman within her faith community and she became a point of contact for others who were struggling. Following purposeful interactions with these women, Elizabeth believed that she could “make a difference . . . because of how I was uniquely made, and the skills and giftings I have.” Through redefining her identity and finding purpose through helping others, Elizabeth began to view her infertility as an asset, rather than a liability. Claiming to be “uniquely made” rather than, as the dominant discourse might suggest, without purpose, has allowed Elizabeth to reclaim her sense of worth.

In addition to finding a renewed sense of purpose through helping others, some participants of this study began to focus on larger institutional reform. When Joy found it difficult to go to “the house of the Lord,” following her experience with multiple miscarriages, she became convinced that her faith community needed to be doing more to help women. She said she found it “untheological” not to talk about infertility issues. She believed that the church, as a community, should be equipped to care for members who are suffering. She expressed frustration at the awkwardness and shame surrounding infertility that silences women and lamented, “How the heck are you supposed to ‘bear each-others’ burdens’ when you don’t know

what's going on with people?" She wished more women could be "bold about their story," although she acknowledged that "not every woman is as bold" as she tries to be. Still, even she was "waiting for the courage" to e-mail her pastor and offer her suggestions for practical ways to care for women who have experienced a miscarriage within their faith community.

For a few participants, the desire for change was strong enough to motivate them to take direct action. Following a "dark time," Ruth and her husband decided to go public with their infertility struggle. "We were planning on going through it privately," Ruth said, "but then I felt like, if I could help someone . . . we can pull together and come through it together." Ruth shared her story during a community gathering and began to make connections with other women within her congregation who had experienced infertility and pregnancy loss. Ruth said that as a result of her action, her pastor discovered that there were more women in his congregation struggling with infertility issues than he knew and became motivated to study more on the topic. Ruth encouraged him to think about beginning a support group in the near future. Ruth said of her decision, "If it's handled properly, it can turn into a beautiful ministry; you can help so many people."

***Redefining Christian womanhood.*** After reclaiming their identities as children of God and proactively finding purpose in serving others, these women found new ways to define their womanhood. Rebekah provided a beautiful story to illustrate how an infertile woman can form a new definition for what it means to be a Christian woman. After experiencing several rejections by potential partners, Rebekah was offered a different perspective. One night, while eating dinner with some friends, she was told, "There's so many ways to be motherly in the world that has nothing to do with [biological motherhood]." One of Rebekah's friends pointed to Mother Teresa as an example and encouraged Rebekah to use her "mothering energy" in other ways. At



that moment, Rebekah discovered she was no longer “stuck in that story that so many faith practices have of . . . you’re supposed to get married, have kids, do the family thing” and she counted herself “lucky” to have been offered a new perspective on womanhood.

From that point on Rebekah said that “grace” would “shine a light” on the places she could use her energy for good in the world. She found her place of belonging and worth through serving her family and friends and participating in community service projects. When considering the traditional norms of motherhood espoused by many faith communities, Rebekah said she thought, “that’s kind of our human failing . . . thinking of [mother love] from a very small, human perspective instead of that divine perspective.” When speaking to other women who struggle with infertility, she told them “you still have great value and something precious to offer.”

Similar to Rebekah, when given the opportunity to state her perspective, Elizabeth tells the members of her faith community:

It is not the universal path of a woman to grow up, get married, have a bunch of kids, have an empty nest, go play with your grandkids. . . . Do not expect that.

Give everyone the freedom to have the unique, individual life that God may have for them.

The participants of this study confronted the belief of their faith community that viewed producing children as a woman’s primary purpose. The assumptions inherent to this belief were strongly refuted by the women who contributed their stories to this project. In spite of their faith communities’ dominant discourse, these women developed powerful strategies of resistance to reclaim their identity, purpose, and worth as women. They identified themselves as individuals loved by God and discounted the assumption that motherhood is the only path available to

women for making a meaningful contribution in the world. Their experiences challenged the dominant narrative of motherhood and forced an interrogation of the first embodied but unexamined belief that worked against them. Closely tied to the veneration of motherhood, however, is the veneration of children, the second finding to which I now turn.

### **Children as “Everything”**

Many Christian faith communities are built around family life. The community calendar and programming are often designed with families in mind and seek to provide parents and their children with safe, productive, and fun activities. Many faith communities employ full-time student program directors, children’s ministers, and youth pastors. Sunday school, Vacation Bible school, and youth groups are just a few of the offerings that communicate the willingness of the community to aid parents in the nurture and spiritual development of their children. Placing this kind of emphasis on family communicates that children are valuable.

The second unexamined belief that was challenged by the women who participated in this study was introduced by Rebekah when she questioned how early in a dating relationship an infertile woman should disclose her inability to produce children when perceiving that it was “everything” to a potential partner. The term ‘everything,’ while vague, indicated that, for many people, the ability to have children was one of the most important factors in selecting a mate. However, according to the participants of this study, the notion that children are ‘everything,’ deserved closer examination.

The veneration of children, like the veneration of motherhood, leaves women who struggled to conceive or carry a pregnancy to term bereft of any visible representation to validate their existence. In this case, women without children were not only made to feel ‘less’ than their peers but, in the absence of the ‘blessing’ of children, felt as though their worthiness as a woman

was being called into question. The proclamation of certain biblical texts, the embodied practices of faith community members who seem to view children as a symbol of spiritual maturity, and the observance of annual and weekly rituals that honor mothers and celebrate the presence of children, cast those without children as objects of pity or suspicion.

Within many Christian faith community discourses, children are espoused as gifts from God and the act of child rearing as a special assignment from God. These views are supported with biblical references like Psalm 127:3-5 that says, “Children are a heritage from the Lord, the fruit of the womb, a reward” (ESV). The biblical language of ‘reward’ might suggest that children are given to those who have earned a spiritual stamp of approval from God. In addition, some Christian couples view the arrival of children as a unique calling. One participant, Hannah, explained, “[Children] are also His, so our responsibility is to make disciples of the Lord.” This means that while children are a gift, they still belong to God, and the couple has been entrusted with the important work of raising that child in the Christian faith.

Given this ideology, it should not be surprising that the family can be interpreted as a symbol and outward sign of faithful obedience, sanction, and success. When embodied, this belief engenders assumptions regarding those for whom children are not possible. If children are a ‘reward,’ perhaps the absence of children is a punishment? If children are a ‘blessing’ then perhaps those who do not have children were not worthy of receiving such a blessing? If Christian couples are called to raise up the next generation, than perhaps the infertile Christian couple was not deemed spiritually mature enough to be entrusted with such a task?

That a direct connection between worthiness and having children is drawn by faith community members, however consciously or unconsciously, is evidenced by the things they do and say. Hannah remembered feeling as though her faith community was making the assumption

that her infertility was due to “sin in [her] life,” and even though she dismissed it as “bogus theology” she still “felt the stigma.” This stigma, attached to the absence of children, was also experienced by Hope who felt as though her community may not view her as a spiritually mature adult until she became a mother. “We have felt looked down upon,” Hope said, “like you’re not a complete human being . . . if you don’t have children.” Grace often felt excluded from conversations, as though members of her community believed “you’re not one of us because you don’t have kids,” and “you wouldn’t understand; you don’t have kids.” Elizabeth remembered overhearing comments from members of her faith community suggesting that those without children were at a spiritual disadvantage:

“You don’t really understand love until you have kids,” was said right in front of me. And, “You don’t really get God’s love until you have kids.” Um, hello . . . that’s not the way God works! He’s not withholding His love from people if they’re not parents!

When children are understood to be both a reward and a validation from God, faith community rituals are created to honor those whom God has blessed. The women who participated in this study identified two practices they felt exemplified the veneration of children: Mother’s Day and the Children’s Sermon. As Mother’s Day always falls on the second Sunday in May, it typically coincides with Christian community gatherings. Faith communities observe the holiday in different ways. Many have historically been known to recognize mothers by asking them to stand during the service, by presenting them with a small gift, such as a flower, or by offering a special prayer of blessing for them. Some, in an effort to recognize all women also include the ‘future mothers.’ Some faith communities will schedule baby baptisms or child

dedications to coincide with Mother's Day as a way to honor both parent and child simultaneously.

The 'Children's Sermon' is a weekly ritual that some faith communities' practice. All of the young children are invited to come to the front of the room during the service. A pastor or minister gathers the children around and presents an abbreviated lesson from the sermon text. At Hope's church, this time concludes with an invitation for community members to proclaim a special blessing over the children.

Such ritualized practices imbue the community with particular meanings. In fact, rituals are important to the establishment, maintenance, and cohesion of every community. Schechner (2013) explained that "in religion, rituals give form to the sacred, communicate doctrine, open pathways to the supernatural, and mold individuals into communities" (p. 52). Within Christian faith communities, many rituals, like baptism and the Lord's Supper, or Eucharist, are fundamental in providing members with both a visible and tangible representation of core beliefs. Other rituals, like Mother's Day, which began as a secular, state-sanctioned holiday, have been adopted and adapted by faith communities for their own use. Although rituals are often seen as being divided between sacred and secular, Schechner (2013) argues that "the distinction between the two is often difficult to make" (p. 53). Any ritual performed within a faith community will carry a sacred overtone, and thus will "communicate doctrine." The recognition of Mother's Day communicates both a secular and sacred value of children, even without saying so. Schechner explains, "rituals don't so much express ideas as embody them" (p. 57). The weekly ritual of the Children's Sermon provides an example of embodied representation, as the value of children is expressed by devoting a portion of the service to their recognition. Ritual is also important in maintaining community cohesion. "Normative

communitas,” Schechner (2013) argued, is what happens when a community experiences unity through sharing a common experience (p. 70). These shared experiences are important to shaping the identity of the community as a whole and creating symbols that unite them together. When a community member is prohibited from participating in “communitas” either by choice or by censure, they will be made to feel separate from their community. This experience of being made ‘other’ can be devastating, especially when one had previously experienced “communitas” with that community in other ways.

**The cost of venerating children.** When the veneration of children becomes a primary tenet of community life, the felt social pressure to produce a child can produce social, physical, spiritual, and emotional distress for women who struggle to conceive or carry a pregnancy to term. The expressed ideology that having and raising children should be an important priority for every Christian couple compelled the participants of this study to sacrifice time, relationships, and finances in medical pursuits of children. They wrestled with difficult spiritual questions and experienced dark and debilitating emotions surrounding their perceived deficiency. Following feelings of anger, unworthiness, and hopelessness, they struggled with bouts of depression and even thoughts of suicide.

***Shaming rituals.*** The social stigma attached to infertile woman within faith communities can be devastating, especially during holidays and rituals that recognize and honor parents and their children. Celebrating Mother’s Day, baby dedications, and the ‘Children’s Sermon’ are all moments during faith community gatherings where infertile women, and women without children, can experience exclusion, embarrassment, or reminders of painful memories. Sarah tried to speak out against the practice of rewarding only the mothers on Mother’s Day in her faith community:

They used to give gifts to all the mothers on Mother's Day . . . I'm like, "No. Please don't do that." And they were like, "Why?" And I said, "Well, you're basically giving a gift to all the mothers, what about the people that were never able to have children, or never got married . . . what do you do for them?" . . . they were like, "Oh! We never thought of that!"

This gross oversight of women currently struggling with infertility or miscarriage not only singles them out as 'childless' among their peers but, from Hannah's perspective, induces feelings of "associated shame" for not having children. When thinking about a past Mother's Day recognition, she remembered feeling "aghast" at the church's "lack of sensitivity."

Like Hannah and Sarah, Elizabeth was upset by her faith community's lack of compassion when they scheduled baby dedication on Mother's Day. She said, "I've tried to be a voice to say, 'You know when you do a parent-child dedication on Mother's Day it's extra hard.'" She said, "They didn't always get it but I said, 'Look it's hard to go to church on Mother's Day!'" Since voicing her concern, Elizabeth has "heard [more] affirming language from the pastors on Mother's Day, for the most part." Likewise, Hannah thought that some faith communities were trying to do "better from the pulpit in acknowledging that we have women in this desperate situation," but added, "we have a long way to go."

The annual recognition of mothers was not the only practice these women struggled with. In addition to Mother's Day, the 'Children's Sermon' was introduced by Hope as an example of a weekly ritual that inadvertently dishonored women. While she has now grown to accept the practice, there was a time when she struggled deeply with feelings of anger and jealousy as she watched all of the children walk up the center aisle during the service for their lesson. This weekly reminder of her inability to bear children made Hope feel "like a failure," when she felt

ashamed as though she was being compared to “all the people not having any trouble getting pregnant, or bearing children, and bringing kiddos around.”

**Medical intrusions.** The experience of social stigmatization compels many women to pursue medical intervention to help them achieve a viable pregnancy. The women who participated in this study took a variety of approaches when it came to medical treatments and they varied in their psychological and physical comfort levels while doing so. For Sarah and Hannah, the experience was fraught with difficulty. Both women lamented the financial strain, amount of time spent, and the loss of sexual intimacy with their husbands. Sarah said that she and her husband “spent a lot of money they didn’t have” and described a five-year period that involved, “money going down the drain, no baby, money going down the drain, no baby.” For Sarah, “every month was heartbreak.” She said that pursuing artificial insemination was “a horrible time because everything was ‘have to’ and . . . it wasn’t about ‘the natural’ anymore.” Like Sarah, Hannah associated her memories of medical intervention with personal loss. She remembers getting “caught up . . . in the desperation” for almost a decade. When she and her husband decided to try intrauterine insemination, she said, “the financial toll started contributing to those pressures . . . we’re still paying for that, actually.” During that time, Hannah redirected her focus toward what she could control—her “professional career aspirations”—and “pushed back” her role as a wife to her husband. “It was awful,” she said, “the toll on our marriage . . . and the performance expectations in the bedroom . . . and how that impacts the sexual intimacy. . . I’m not proud of those years.”

**Spiritual estrangement.** In addition to the financial, temporal, and relational costs associated with pursuing medical treatment, the Christian women who participated in this project, admitted to feeling angry at God and wrestling with difficult theological questions when



they were unable to conceive or carry a pregnancy to term. Sarah, Elizabeth, and Grace all felt as though they were being “punished” by God for something they did that was wrong. Sarah, for example, remembers praying, “Am I being punished? Why is this happening to me? God, show me why this is happening! Why me? Why does it seem like it’s only me and nobody else?” Like Sarah, Rachel felt “confused” and “very frustrated” after two miscarriages. She began to question “if God even existed.” In the absence of concrete answers, Joy confessed to feeling “so angry” that she avoided going to church for a month. She questioned why God would withhold a second child from her and wondered if she was simply “not good enough” to “have another child.” Similarly, Ruth experienced a “very long angry phase” during which she questioned God’s fairness as her inability to conceive again felt like “a cruel joke.”

***Hopelessness.*** For these women, feeling estranged from God, wrestling with feelings of unworthiness, and searching for illusive answers cultivated a spirit of hopelessness. “The future looked very bleak” Elizabeth said, and described her life without a child as a “flat line.” She found herself asking, “What do you look forward to? How do you mark your life? What do you plan for? What does life revolve around?” She also began to worry about who would take care of her when she grew old. She asked herself, “Is this really me? Is it really going to be me when I’m sixty-five or seventy-five, and probably a widow with no kids, and . . . all the unknowns that come with that?” Like Elizabeth, the absence of children made the future uninviting for Sarah and her husband. Even after they “closed the door” on and “moved on” from, attempting to conceive, Sarah described their life together as “stuck” and “spinning our wheels.” The unfulfilled dream of having a biological child had cast a pall over her outlook on the future. It was difficult for her to feel excited about making plans with her husband, of “just he and I.” Even though she and her husband frequently talked about places they would like to travel, and

the fact that without children they would have the finances to do so, they had not booked a trip. “You know how you go somewhere for the first time and it’s like the best ever,” Sarah asked in her interview, “and then you go back to that same place another time and you’re like, ‘meh’?” For her, even travelling to visit a new place following the grief of infertility would be uninteresting and just “meh.”

The compounding effects of social isolation, marital and financial strain, and spiritual doubt resulted in dark and depressive moods for some participants. “I understand why people go out, and do heroin, or do drugs, or, you know, drink a bottle every night,” Hope said. “Because you can’t, you can’t bear it—the disappointment, and the failure, and the loneliness.” The inability to bear such intense emotions can lead to a “very dark time,” according to Ruth, who said she believed “[the devil] can come in, and [pregnancy loss] can turn into anxiety, depression, suicide.” During her interview, Joy confided, “I had a lot of suicidal thoughts during that time . . . I ended up going on antidepressant medicines.” After two emotional losses, Rachel also asked, “What’s the point of even living this life, if it’s just going to end and it’s going to be over . . . and there’s nothing after that?”

Faith communities who embody an ideology that places children on a pedestal run the risk of shaming women without children, regardless of the communities’ intent. The participants of this study were driven to pursue costly medical intervention, experienced spiritual estrangement, and faced “dark” days when they were unable to produce children. However, in the midst of what began to feel like hopelessness, these women found ways to nurture a different perspective that helped them effectively resist the narrative that worked to exclude or erase them.

**Strategies of redirecting hope.** The ideology of children as ‘everything,’ can inadvertently contribute to a number of adverse side effects for women without children. The women who participated in this study found themselves wrestling with what they believed about God, what they could do to change their circumstances, and ultimately where they could go to find hope. In spite of the dominant narrative that left them feeling empty, these women identified several points of Christian theology they used to reframe their personal narrative. This strategy involved adopting a perspective that was “consistent with their self-image” and did not “disrupt the expectations of the dominant society” (Orbe, 1998, p. 159). Through claiming the theological view of God’s sovereignty, relinquishing control, and placing hope in God, these women took beliefs congruent with the expressed beliefs of their faith communities and used them to redirect their hope.

The Christian women in this study developed a strong personal theology through the experiences of infertility and miscarriage. They had their faith in God put to the test. “It was an experience of challenging, what do I really believe about who God is?” Grace said, “Who is He? What does that mean in the middle of *this*?” When many of their assumptions about how life was supposed to work were not fulfilled, they found themselves ‘going back to the drawing board’ to ask foundational, sometimes uncomfortable, questions about God sovereignty and human agency and control.

***Relinquishing control.*** For these women, the experience of infertility and miscarriage proved that the decision to have a child was ultimately not their choice. Where Hannah had once believed, “I can make this happen” and that getting pregnant was “something I can control,” she ruminated that “dreams do not always get realized.” She interpreted her infertility journey as “a surrendering of sorts” during which she believed God was “stripping [away her] perceived

control.” Eventually, Hannah came to understand that only God could give her a viable pregnancy. Similarly, Joy was convinced that, “God is in control” and laughingly suggested that during a pregnancy she was only the “incubator.” She said, “There’s nothing you can do that’s gonna bring healthy life. It’s really up to the Lord.” Grace echoed, “God is in control, totally in control. . . . We want to get from [infertility] to the place where we have children, yet we know that if that’s not God’s plan, we’re not gonna get there.”

Letting go of the perception that they had the power to control their circumstances brought these women a sense of relief and comfort. By turning the responsibility of creating life over to God and choosing to trust Him, they were released from the burden they felt for failing to produce a child. From that point forward they began to claim a different narrative. “I’m sure there’s a greater plan for it that we just don’t know,” Ruth said, “I trust that He knows what’s best.” Like Ruth, Sarah now believes, “God has a different plan for us . . . there’s a reason for this happening.” Also trusting that “He [God] has his reasons for doing certain things,” Hope said, “I don’t have a great vision, but I know He does, even though I don’t see it.” For Grace this meant, “I just have to get up every day, and do what I have to do, and trust that God wrote the story . . . He’s written a part that He knows is perfect for me.”

***Anchoring hope.*** Following the decision to relinquish control to God, these women began to perceive that placing their hope in anyone other than God was unwise. “God gave me a shift in my perspective,” Elizabeth said, “only [He] knows what’s actually going to happen and He does not promise us anything except for life in Him.” For these women, placing their hope in a future child, or anything else, had proved tenuous, driving them to seek a more permanent theological solution.

For the participants who had experienced miscarriage, attaching hope to a pregnancy had proved futile. Joy highlighted a recent trend on social media where women announce a viable pregnancy following a miscarriage as a “Rainbow Baby.” This relatively new terminology, drawn from the biblical story of Noah’s Ark, was coined as a way to acknowledge a previous loss while celebrating the end of a painful episode. Joy said she hated the term and felt the term was misguided. She argued that:

your expectations should never be in that child, that ‘Rainbow Baby’ . . . [to] fix everything . . . the Lord is the only one who can fix everything. . . I would have never imagined I would have two more miscarriages . . . but I did, so [the baby is] not the rainbow, the rainbow is looking at God.

The women who participated in this study came to believe that faith in God was the only secure source of hope available to them in a life filled with so much uncertainty. Because they chose to believe that life is created and sustained by God, that God is all-knowing and ultimately the one in control, their hope had to be placed in Him. This hope was born from the felt presence of God during their struggle. Rachel said she could not imagine going through miscarriage “without having faith” and “believing in God.” She understood her trust in God’s love to be what sustained her during two painful losses. “God is still God,” Grace said, “and He is with me, in my pain.” When recalling the difficult delivery of a stillborn infant, Hope said, “it was awful but at the same time, I know God was there.” She wrote a poem following her baby’s funeral in which she explored God’s presence, even in death. She wrote, “Hope in Him, not in your dreams. hope in Him, not in your children, or in your house, or in your expectations. Hope in Him, not in yourself. Let your hope be placed in Him.” She concluded her interview by saying, “[God] will always be there, the one thing that will never go.”

The participants of this study actively challenged practices of their faith communities that placed spiritual significance on children, centered programming around the concept of family, and participated in rituals that venerate children. The social stigmatization and the physical, spiritual, and emotional distress they experienced as a result of their inability to have children prompted a reexamination of the emphasis their faith communities had placed on children as ‘everything.’ As these women searched for a different way to interpret their experiences, they identified several points of Christian theology that helped them reframe their personal narrative. They adopted the theological view of God as sovereign, they relinquished control, and they redirected their hope to God. With this reframing strategy, they regained their confidence, experienced freedom from guilt, and found hope.

This concludes my examination of the two findings connected to the embodied but unexamined beliefs. As the stories of these women demonstrated, exclusionary ideology is often difficult for members of a dominant group to identify. The adoption of certain of social norms and religious ideologies, without a careful evaluation of what they reinforce or whom they silence and harm, leads to the stigmatization and marginalization of individuals who fail to live up to those standards. But just as belief in action has the power to harm others, so does inaction. I now turn to an examination of the participants’ experience of the values that faith communities claimed but did not embody, the review of two more findings.

### **The Claimed but Unembodied Values**

Although the Christian faith tradition has often claimed to champion the marginalized in society, when faith communities fail to recognize marginalized peoples within their own communities, that claim is proven false. That is, it becomes an empty claim. The claimed but

unembodied values are the social and religious ideological declarations that faith community members confess but fail to practice.

The values discussed below were not explicitly stated by the participants of this study but were uncovered through an examination of the many times they expressed confusion, frustration, or disappointment when their faith community members did not speak or act in the ways these women had anticipated they would, or had hoped they would, based on the values they espoused. These faith communities had claimed to value the importance of being a “safe space” for every member and they had claimed to be pro-life. Unfortunately, when confronted with the issues of infertility and miscarriage, they had failed at both, and this failure had led to the isolation and exacerbated grief of these women.

### **Faith Community as “Safe Space”**

Many faith communities market themselves as being open and inviting places, where everyone who wishes to join is welcome. Members are encouraged to bring a neighbor or friend. Those who are curious to learn more are encouraged to return. Visiting families are invited to consider making the community their new ‘church home.’ Visitors often receive informational pamphlets outlining the various programs and offerings the community can provide. Some communities ask visitors to fill out a small response card and check the appropriate categorical boxes so that someone can ‘follow up.’ Becoming an official member is promoted and new members are assisted with exploring options to find a place where they can use their skill set to serve the community.

Unfortunately, as previously established, faith communities are far more influenced by social norms than they may realize. Many Christian faith communities organize their members into life-stage categories such as ‘single,’ ‘young married,’ and ‘married with kids.’ Adopting

accepted social categories like these not only reifies the path of marriage and raising children, it also can have the adverse effect of relegating the infertile woman or woman without children into the unstated but equally clear category of ‘abnormal.’ The stigma attached to what Goffman (1963) would call her “spoiled identity” then results in her being marginalized within her own community. The women who participated in this study felt the stigma attached to their difference. When thinking back to the years she had struggled with infertility, Elizabeth said she had needed “safe places” but when thinking about who she could talk to within her faith community, she had a hard time identifying “what was safe space.”

The women who participated in this study acknowledged a strong preference for women becoming mothers within their faith communities. And, because marriage, pregnancy, and childbirth were the assumed traditional life-path, and as such functioned as rites-of-passage for women, infertile women are left with no place to go. In other words, there was no ‘normal’ group to which they could belong. Elizabeth cynically repeated a litany of invasive personal questions that ‘normal’ people asked those perceived to be outside the norm:

When you gonna meet somebody? When you gonna date somebody? When you gonna get married? When you gonna have a kid? When you gonna have another kid? You can’t have kids! Are you going to adopt? Have you thought about adopting?

These sorts of interrogations are common when the social norm dictates the necessity of putting people in categories, and then assigning few options among them. Goffman (1963) explains that when someone does not fit a “socially anticipated category” society seeks to put them in an “equally well-anticipated one” (p. 3). As Elizabeth’s example demonstrated, as long as someone is still anticipating getting



married or becoming pregnant, they can be placed in a ‘not yet’ category. Unfortunately, as Goffman (1963) demonstrates, when an acceptable category is not found for the person in question, they are usually viewed as possessing “a failing, a shortcoming, a handicap” (p. 3). For Elizabeth, this barrage of questions was “the worst” and she admitted such interrogations made her feel a “little prickly” because they seemed to emphasize all the ways she had failed to meet other people’s expectations. Similarly, Grace felt the stigma attached to her identity. She said, “If you’re not being a mother,” the implied questions seem to be, “What are you?” and “Why are you?” She came to believe that becoming a mother “was the only thing that was going to give me entry into the community of women.” She said of her felt isolation, “I was a strange animal . . . I think they just didn’t know where to put me.”

That the normativity of motherhood creates impenetrable social barriers for infertile women was evidenced by a compelling story that Rachel offered regarding her attempt to join a “mommy group” at her faith community. She said, “When I got pregnant, I contacted somebody . . . to say, ‘I’m pregnant! I’d like to come. . . . When I have the baby . . . I’d like to join the group!’ She was invited to start attending meetings right away, even though she was the only “mom there, [whose] child wasn’t born yet.” When Rachel lost her pregnancy, a group leader encouraged her to keep coming anyway, but Rachel was not comfortable doing so. She said:

They would probably allow me to come back, but I don’t feel right about going back. . . . I’m very bad about worrying what other people think. . . . They would never ever say to me that I wasn’t welcome . . . but in my head, I would be thinking, that they were thinking, that I didn’t belong there.

Not surprisingly, the experience of felt social stigma can spawn an intense desire to become a mother. Rebekah recounted an interaction she had with a personal friend who became “obsessed with adoption.” Rebekah was confused by her friend’s “deep seated” desire for children, given what Rebekah thought was a compelling display of life and job satisfaction. Rebekah asked her friend why having a baby was so important. Her friend replied, “This is what you do. You hit your thirties, start building the family.” As Rebekah continued to watch her friend struggle through the adoption process, Rebekah asked her friend, “Why?” once more. Her friend, then exasperated, exclaimed, “I’m trying to be normal!”

Unfortunately, even for women who eventually achieve a viable pregnancy, adopt, or choose to live childfree, the experience of grief and the memories of having been stigmatized by their communities may fundamentally change the way they view and experience life. The women who participated in this study described intrapersonal changes that resulted from their struggles. “This has changed who I am,” Rachel said, “how I look at the world, how I think about people.” Hope admitted, “I have changed. . . . I’m never going to be the same,” and Sarah said, “It will never be the same,” when considering her future after infertility. This changed identity meant a future of forever being ‘different’ and meant that finding and experiencing a true sense of ‘community’ would prove to be elusive.

**Faith community as threatening space.** Being placed in an ‘abnormal’ category, even unintentionally, by members of one’s own community automatically creates an unsafe environment for the stigmatized individual. For the women who participated in this study, faith community became a threatening space. Declaring certain things, like motherhood and children, ‘normal’ makes infertility or pregnancy loss risky topics to introduce into conversations. These women began to feel like pariahs, even before they disclosed their struggle to anyone. Goffman (1963) suggests that there are “great rewards” when a person can “pass” as normal because once the stigmatizing factor becomes known, a “discrediting” will occur (pp. 74-75). Given the high stakes, these women regularly wrestled with the fears associated with disclosure, relational awkwardness, and the pain of isolation.

***Fear of disclosure.*** The fear of what would happen post-disclosure prompted some of the women who participated in this study to stay silent for as long as possible. When Hope accidentally learned of a friend’s miscarriage, and expressed her sympathy, her friend was quick to tell her, “Nobody knows; don’t tell anybody.” In the midst of a painful loss, Hope’s friend perceived disclosure to her faith community as unsafe. Other women, like Hope’s friend, chose not to talk about her losses; Ruth shed a light on one reason why when she described her faith community’s practice of always seeking to embody, “strength . . . faith . . . trust.” Because she only heard messages about the victorious Christian life, Ruth felt as though she could not reveal any weakness, lack of faith, or doubt in the midst of her struggle. If she disclosed her pregnancy loss, she risked the double stigma of infertile woman and bad Christian. Elizabeth had a similar experience. It took her “some years” before she “got to the place” where she could tell her pastor about her struggle with infertility. She said:

It was so hard to verbalize without . . . a little fear, I was so afraid of . . . [losing] control . . . or breaking down, or not being able to really talk about it. . . . I was afraid to go there.

Because Elizabeth was not comfortable with the possibility of becoming emotional, and thus showing weakness, in front of her pastor, she lacked access to the spiritual counsel she longed for. Joy ironically noted that when someone asks you, “How are you doing?” to respond, “Terrible” is never appropriate. She said, “No one’s gonna say *that* at church!” Because Sarah, like the others, felt pressure to present a strong Christian persona, she berated herself, telling herself to “get it together” when she became emotional, because she “was a mess” and “wasn’t dealing with it well.” The emotional gag these women experienced made any truly authentic interactions within their faith communities challenging and resulted in significant intrapersonal and interpersonal tension.

***Relational awkwardness.*** The inability to disclose differences or display emotion creates a powerful barrier to maintaining authentic relationships. When conversations become laborious, stilted, or strewn with unseen landmines, relationships suffer. The women who participated in this study discovered that just as infertility and miscarriage shaped their identity, so pregnancy and childbirth shaped the identities of their fertile friends. These women lamented the loss of friends with whom they no longer shared commonality. “It becomes totally uncomfortable when . . . friendships are shifting to . . . all mommies and babies,” Rebekah said; “It’s really hard for somebody without a baby.” She noted her difficulty in relating to “conversations about what the baby is doing or what new techniques you’re using to do this, that, or the other.” Sarah said, “Guess who’s pregnant now?” became a running “joke” with her husband as they guessed which friend she would “lose to pregnancy.” She said, “I lost them as friends, because we didn’t have

that in common. . . . When you have kids, that becomes your life, which is understandable. If I had kids it would be the same way.” Sarah admitted that she put her friends “in a different category” too, once they had friends and knew it had made her friends uncomfortable. When some of Sarah’s friends became pregnant, they “walked around on eggshells” to avoid hurting her feelings. She said, “I look back on it and think, we could have handled that a lot better.” Noting her own difficult experience in maintaining friendships with mothers, Elizabeth said, “It’s been challenging, it takes a lot of effort.”

In addition to the fear of relational awkwardness with friends, the women who participated in this study often felt responsible when a disclosure about their fertility struggle caused another person’s discomfort. It is common for stigmatized individuals to assume they are to blame for other’s embarrassment and these women were no exception. They frequently internalized their own pain while negotiating their disclosures to minimize other’s uneasiness. Hope noticed that people “get really awkward” and usually “jump to another question” when she mentions her pregnancy losses. “They seem to regret asking.” Rachel said, of her interactions with faith community members. Not wanting to be “a burden on people,” Rachel felt responsible to always assure anyone who responds awkwardly to her losses that everything is “totally fine.” Sarah remembered that even her pastor “wasn’t really equipped with many comforting things to say” and was “pretty helpless” when she disclosed her struggle to him.

The social awkwardness that resulted from not knowing what to say or how to navigate conversations about infertility or miscarriage created a threatening environment for the women who participated in this study, as well as for their faith community members. In an effort to evade future interactions fraught with so much tension, many of these women, along with

members of their faith communities, resorted to social avoidance as a means to escape awkward conversations.

***Social avoidance.*** Employing the strategy of social avoidance went both ways. Women who have experienced infertility or miscarriage often sense their ‘otherness’ even before others do and choose to withdraw. Sarah felt “angry at anybody who had children, anybody who could conceive,” which resulted in her putting some distance between her and some of the women in her faith community. It can be easy for women without children to draw the natural conclusion that friendship with mothers will be too difficult. Joy admitted that it was easy for her to form “preconceived notions of, ‘Well, they’re not going to include me because I don’t have a kid,” which caused her to prematurely retreat from potential relationships. It can become even more difficult after faith community members know about a woman’s struggle to conceive. Following her second miscarriage, Rachel began attending a different service “to avoid some people.” She said, “I’ve drawn in more . . . the people I know [at church], I don’t really want to see ‘em.” Rachel knew that seeing people she knew would lead to questions about her pregnancy losses and she wanted to avoid those kinds of painful conversations.

Although some disclosures have the potential to lead to a supportive connection, many more taught the women who participated in this study that they should be exceptionally cautious when approaching the subject of their infertility or pregnancy loss. Ruminating on the repellant nature of pain and suffering, Rebekah compared the sudden desertion of friends to “watching roaches when somebody turned on the light.” The awkwardness of not knowing what to say, or how to help, engenders a hasty retreat. “Most people would just not talk to me about it; they would avoid it at all costs,” Sarah said, “and I knew that’s what they were doing. It was pretty obvious.” Like Sarah, Rebekah found herself, “farther and farther out of most social circles.” She

“fell by the wayside” and got the feeling she was being “peripheralized.” In the end, she equated her experience to being “on the outside looking in.” While faith community members may feel that avoidance is the best strategy, Hannah disagreed. When reflecting on her own experience, she said, “The silence is really dishonoring.” From her vantage point, when no one asks, the silence reflects disinterest, lack of genuine concern for the individual and, at worst, erasure.

**Strategies of fostering ‘other’ communities.** Fear of disclosure, the awkwardness of community members, and the pain of social avoidance contributed to an absence of community for the women who participated in this study. The claim that faith communities are a safe space had been proven false, as was evidenced through community members’ words and actions. These women struggled to fit in and when they could not achieve a socially acceptable category, felt marginalized and isolated. In the absence of community, however, these women discovered new ways to create safe places for themselves. In his research on co-cultural communication practices, Orbe (1998) identifies one strategy that stigmatized individuals can use to negotiate their marginalized positions within dominant culture. This strategy, called “intragroup networking,” happens when minority persons identify “other co-cultural group members who share common philosophies, convictions, and goals” and begin to work with them (p. 9). The participants of this study employed this strategy in three ways; they formed friendships with older women within their faith communities, sought to become safe people for ‘others’ within their faith communities, and went in search of other ‘outsiders’ outside their faith communities.

***Forming friendships with older women.*** Within many faith communities, women without children are not the only population who experience stigmatization. Any individual who does not satisfy the dominant group’s definition of ‘normal’ can be marginalized. Single women, the divorced parent, or the widower are a few examples of individuals who may not fit within the

dominant group's accepted categories. Several women who participated in this study identified the 'empty-nester' as an ideal candidate for friendship. Hannah said, "Over the course of my life, I have gravitated toward older women, Hannah said, "they either had adult children or . . . they did not have babies or young children at home." The absence of children meant that these women were less consumed with conversations revolving around motherhood and child rearing. Sarah admitted that she is already looking forward to the day when her friend's children leave home. She said expectantly, "They'll be empty nesters soon . . . I'll get them back!"

This draw toward and connection with older women was also associated with the fact that women who are in the midst of struggling with infertility or pregnancy loss may look for a mentor who can teach them how to cope. Elizabeth said she didn't know "anybody who experienced infertility" and lamented not having "anybody to look up to in it" during her struggle. The participants of this study discovered that even when an older woman has not experienced infertility, they had lived long enough to have experienced the pain of loss. For an 'empty-nester' that loss was their child's maturation and departure from home, which provided enough commonality for a relationship to form. Hannah said of one older friend, "She . . . entered my experience . . . she was able to give me, a hopeful . . . vantage point." The perspective of someone older instills a level of trust as these women valued the wisdom that comes from lived experience. The only people Hope felt "the confidence to talk to" besides her husband, are "the older ladies in church." Similarly, Rachel said of an older woman, who had experienced pregnancy loss, "it meant so much more when she would check on me . . . she seemed to do it even more than the rest of them and I think it was because she, she really knew. She had been there." Sometimes these women just needed a caring, older figure that was willing to offer them genuine sympathy. Ruth recounted an experience when a teacher was "holding me,



almost cradling me, and I just broke down crying. . . . She was just like, ‘I’ve got you. I’ve got you.’” For Ruth, the presence of this older woman, “holding [me] through the pain, instead of just, ‘I’m praying for you,’ or just, a tap on the back,” was “very healing.”

***Becoming safe people.*** In addition to forming friendships with older women, the participants of this study sought out and befriended other women within their faith communities who were also experiencing infertility and pregnancy loss. When asked what they wanted other women who are silently struggling with infertility issues to know, “You are not alone,” was a consistent reply across all nine interviews. In the absence of *safe space*, these women become *safe people* for one another. Sarah, for example, seeks to be, “a person to talk to” and “a shoulder to put your head on.” And, although both Grace and Hannah have children now, both women have actively sought to remember the pain of their own experiences. A few years ago, on Mother’s Day, Hannah recalled becoming “emotional on behalf of her sisters” who had not been able to conceive. She remembered women in her social circle who used to joke about being “fertile myrtles” as if achieving a pregnancy was easy. She said, “I don’t ever want to lose my sensitivity.” Just as Hannah tries not to forget the painful parts of her experience, Grace reflected, “There are so many things people said [to me] that were not intended to be hurtful, or unkind, or shaming. . . . I’m thankful for that awareness because . . . I don’t want to be that person who says those things.” In addition to becoming a safe person, some women were compelled to create safe places for others. Elizabeth wanted to “do something for women like me,” so she wrote lesson plans and hosted a study group for women struggling with infertility grief and pregnancy loss. She also authored several blog posts that explained, “how to talk to somebody who is [experiencing infertility],” and “things not to say.” Feeling like “there’s not enough people willing to speak out publicly,” Elizabeth was resolute: “I’ve got to do what I can.”

*Making connections outside the faith.* Finally, in addition to befriending older women and becoming safe people for other women within their faith communities, the participants of this study left their faith communities in search of ‘outsiders’ with whom they could connect. Several of these women said they found a greater sense of belonging when spending time with a group that had no faith affiliation. They expressed gratitude and affection for the supportive friends they had discovered through their involvement in non-religious online and local groups. When Elizabeth “didn’t know who to talk to,” she went online. “Even though it’s not Christian based,” she said the online community she found provided a refuge where she could talk “about stuff that nobody else got.” After seeking out connection with local women, Rachel began attending a grief support group for “any mother who has lost a child.” The meetings were “a very safe place” where she “met other girls who are going through similar circumstances.” She attributed her survival through the “stale time,” “doubts,” and “struggles” to their “encouragement.” When Grace’s faith community marginalized her, she “found a place” for herself and “made friends in the community” outside of church. She said she “met lots of other women, and other people . . . who could recognize me for something other than [motherhood].” Also seeking connection but feeling that working with people who were actively focused on helping others would give her a place to belong, Rebekah put energy into community service projects. She said of the experience, “Habitat for Humanity, or the food pantry service has really been the only time where it [didn’t] feel like being on the outskirts.”

The women who shared their stories for this project challenged, and sometimes outright rejected the notion that their faith community was a safe space. These women’s observations and interactions with faith community members demonstrated that while it was a safe environment for those who could pass as normal, it was a threatening space for those who could not. When

only normalized people fit in and belong, the stigma attached to women deemed not normal engenders fear, social awkwardness and, eventually, isolation. In spite of the many obstacles to finding a sense of belonging within their faith communities, these women did strategically identify individuals within and outside of their faith communities with whom they could experience community.

Just as these women's faith communities had failed to embody the value of 'safe space,' the participants of this study also revealed another disconcerting inconsistency: faith community members' failure to fully embody the value of pro-life. To explore this claimed but unembodied value, I now turn to my fourth and final finding.

### **Faith Community as Pro-Life?**

It is well-established that Christian faith communities celebrate life. The belief that "life begins at conception" is a tenet of Christian ideology, rooted in the Biblical narrative of God's creation, and expressed through the values and practices of the faith. The Psalmist declares to God, "For you formed my inward parts; you knitted me together in my mother's womb. I praise you, for I am fearfully and wonderfully made" (Psalm 139:13-14a, ESV). This passage is often quoted to justify the strong pro-life sentiment of the church. The women who participated in this study affirmed this belief. Joy, for example stated, "life begins at conception" and added:

When I saw [the] heartbeat at six weeks . . . I realized, 'that's a life!' . . . I need to celebrate that life . . . and praise God for that life because it takes a miracle to have a child . . . for a little heart to start beating.

Because Christian faith communities view life as a miracle of God, many of them devote special attention to honoring the arrival of every new child. The announcement of a pregnancy is a cause for celebration. Women gather to host baby showers and bring gifts for the expectant

mother. Just after the birth, visitation hours are set, and meal-trains are arranged. New babies are admired and the parents congratulated. The public ritual of baby dedication or baptism often serves as a community covenant, whereby members also pledge their willingness to assume the responsibility of assisting the parents to raise the child in the faith.

The traditional, pro-life view, held by many devoted to the Christian faith, has historically engendered hostile encounters with those who identify as pro-choice when it comes to the subject of abortion. Faith communities have sponsored marches, petitioned Congress, and gone to great lengths to advocate for the lives of the ‘unborn.’ When it came to this study, however, a rather bizarre inconsistency emerged. That is, the intense devotion to recognizing and cherishing the lives of the unborn did not translate to the loss of these women’s non-viable pregnancies. During her interview, for instance, Hope expressed confusion over the lack of acknowledgement women receive from faith community members after a pregnancy loss. In an effort to understand the discrepancy she commented, “I don’t know if it’s a matter of how people see life, or when life becomes life to people—when life becomes important enough to be grieved?” This was a peculiar statement given the fact that Hope indicated her faith community was pro-life. Hope was not alone. Several of the study participants felt as though their grief had been dismissed by members of their faith communities. The paradoxical question quickly became, if those considering an abortion are viewed as carrying a life worth fighting to preserve, why would the loss of a pregnancy to miscarriage not count as a life “important enough to be grieved?”

**Pro-life and infertility: making the connection.** The participants of this study identified both infertility and miscarriage as a loss of life and they expressed grief over those losses in a variety of ways. They grieved their empty wombs, they grieved the loss of time, and they grieved the loss of children. Those who were able to become pregnant and then miscarried viewed every pregnancy loss as the death of a child. Those who experienced primary infertility and never conceived, also grieved the loss of children. Ruth explained:

Miscarriage is one type of child loss . . . not being able to [get pregnant] is a child loss, because that's a child that I can't have, that will never be, that will never exist. To me, that is child loss as well.

For those whose believed they should be able to conceive, but whose wombs remained empty, month after month, the grief grew. "Infertility is grief," Hannah explained, "It's grief process, over and over again . . . every month of your life, for how many years? . . . it's layer upon layer, upon compounding effect." Affirming the recurring, cyclical nature of the grief, Ruth felt that, "Every time you have a menstrual cycle, it's a reminder that your womb is empty, that there's nothing there this month."

The monthly reminders added up and the loss of time became something to be grieved as well. Joy commented that her husband "mourned the life of the months that we weren't pregnant, that we could have been pregnant." Like Joy, Ruth talked about her husband's struggle with grief. She was quite candid regarding her perception of her husband's experience:

I can see the joy in his face, [but] the minute that he even sees the box of tampons up there or . . . I'm lying on the couch . . . I can see that hurt just go right across his face because it's another month that's lost.

The emptiness they felt in their bodies, compounded by the loss of time, culminated in a profound grief connected to the loss of children. Elizabeth compared her primary infertility to “the grief of losing [her] Dad.” Although her father died many years previous, she tearfully commented, “sometimes I still think about him.” Even though Elizabeth never experienced a pregnancy loss, the loss of never having conceived a child was as tangible a loss as the death of her father, whom she had known many years. Sarah, who also had primary infertility, was thankful that she never experienced a miscarriage but lamented:

I will be seventy years old and . . . it will always be painful. . . . You will always remember what you went through, and the pain that it caused, that you always longed for that child, especially having a child of your own.

When considering the number of times she had miscarried, Joy said, “I will never be able to truly verbally communicate the true depth of my grief.” She said, “People try to love you through it” but she felt they “never saw the grief and the true depth of heartache” she experienced.

**Infertility and loss: a total disconnect.** Given that many Christian faith communities go to great lengths to advocate for the life of the unborn, it is ironic that when it comes to in-house experiences of infertility and pregnancy loss, a strange and disconcerting disconnect exists.

While the women who participated in this study viewed infertility as the loss of potential children and miscarriage as the legitimate loss of life, many within their faith communities did not. Despite these women’s attempts to communicate grief, the strong pattern of resistance to their expressions of mourning were painfully obvious to them. When confronted with infertility and pregnancy loss, faith community members were routinely dismissive, silent, or insensitive.

**Dismissal.** When women and their husbands are grieving the loss of a child to either infertility or miscarriage, the prevailing compulsion of many faith community members is to

side-step their own awkwardness through dismissal. “I don’t know why the church doesn’t talk about infertility more,” Hope wondered, “maybe because it’s uncomfortable and sad?” She believed that her faith community member’s inability to “tackle” the topic stemmed from their lack of knowledge of “how to help people going through infertility” or perhaps “apathy.” She said she definitely experienced a “brushing off” during her attempts to talk about her experiences. Joy’s experience was consistent with Hope’s. “It’s hard. It’s awkward,” she said, “it’s just swept under the rug and it’s not talked about.” The lack of acknowledgement toward their profound sense of loss was hurtful. As Rachel shared:

Probably the most hurtful thing is when people say things that make it sound like my losses are no big deal. They’ll say, ‘Oh well, you’ll get pregnant again.’ Or ‘Maybe it’s not meant to be.’ . . . They are really trying to be helpful. . . . They’re not saying mean things; they’re saying things to try to be encouraging. But they’re actually not because it makes me feel like it’s not a big deal, and it is a big deal to me. It’s a very big deal.

Rachel went on to say, “I feel like they don’t understand that I’m grieving.” And she noted that, for those who did know about her losses, there was an attitude of, “‘But you already grieved . . . you’ve already gotten over this, haven’t you?’” In both cases, Rachel felt that members of her faith community were encouraging her to move past her losses quickly. A member of Joy’s immediate family took a similar approach when they dismissed her grief because “they’re not really your children,” and “you never held the baby; you didn’t know the baby.” For people, like Joy’s family member, who claimed to believe that life begins at conception, this logic was profoundly flawed.

*Silence.* In addition to dismissal, silence is often employed by faith community members as a way to avoid uncomfortable conversations. “I would say that is a very normal and unfortunate thing,” Hope said, when talking about “not being able to express, or even knowing how . . . with the people in my church.” A refusal to acknowledge, or to make room for others to talk about their painful experiences is very “dishonoring,” according to Hannah, who described “the most hurtful” thing as “the silence” that was present in all of her faith community interactions. She lamented that “not speaking into it, not seeing, wondering, taking the risk to ask a question from just a genuine space is the most hurtful.” Joy noted the use of silence when she avoided going to church for six weeks following a miscarriage. She said, “people knew how much I was struggling but . . . no one called to check up on [me].”

The women were not the only ones hurt by silence. Elizabeth became emotional while telling a story about her husband who had attempted to connect with other men on the issue. She said:

My husband goes to church on Father’s Day, and it’s kind of sad when the guy at the door says, ‘Happy Father’s Day!’ to everyone who comes in. It’s not real good . . . guys experience infertility too. . . . Men never talk about it, nor ever do they even ask about it. . . . on Father’s Day, he posted a big post on Facebook . . . shared his heart, and not a single man, friend of his, commented or liked his post. It was only women that reacted to his post. . . . He felt that.

Although the women who participated in this study acknowledged the uneasiness that can accompany a conversation with someone who is hurting, it in no way alleviated the pain they felt when no one was willing to talk to them.



*Insensitive solutions.* Dismissal and silence were not the only two tactics faith community members used to avoid discussing the difficult topic of loss. Some members attempted to console these women and offer them some encouragement by attempting to problem-solve their pain. Unfortunately, the quick-fix ‘solutions’ they provided still reflected an unwillingness to acknowledge the grief these women were feeling. Joy summarized three common suggestions women receive when she said, “It’s the mindset of, ‘It’s fine, you’ll have another;’ ‘It’s fine, you can adopt;’ ‘It’s fine, you can love other people’s kids.’”

Faith community members made the mistake of moving past a loss too quickly by encouraging couples to just “try again.” “People should be careful with their words,” Ruth said, “because what they see as encouraging . . . can really hurt.” When someone tells her, “‘Well, you guys can try again’ . . . ‘God can still do it, He can give you another one,’” Ruth interprets that as the person “looking so forward to the [baby] that could come that [they’re] forgetting about the one that we lost.” Ruth explained:

It’s almost as if they are bypassing the event. ‘Forgetting those things of the past!’ is what I’ve heard a lot, quoting out of the Bible, ‘Forgetting those things that are past!’ But to me, that is saying, forget my child, as if they never existed, and to me, my child existed.

For Ruth, the child she had lost could not simply be replaced by a different child. When she was encouraged by her community to move on from the event and “forget” the past, it conveyed, even if unintentionally, that the life of that child and the grief she felt was unimportant.

Another quick-fix solution offered by faith community members is that the infertile woman or couple should adopt. The adoption solution is certainly not new, as it feels like both a viable and charitable remedy, but the participants of this study argued that it should never be

used to ‘fix’ infertility. Elizabeth explained, “My perspective has always been: adoption is not a cure for infertility. It’s something that any family could consider whether [they] have kids or not.” And, the experience of adoption is certainly nothing like biological parenthood, as Sarah found out. She recounted her first, and only visit to an adoption agency, where they talked about “how much it costs.” She walked away from that meeting thinking, “anybody can have a child, but all the scrutiny that you have to go through for adoption . . . there’s something not fair about this.” For Sarah, the fact that adoption required months of paperwork and a stressful vetting process disqualified it as an automatic replacement for biological parenthood. When Grace thought about the potential of her and her husband never getting pregnant, she found herself thinking, “worst case scenario, there are still children” we could adopt. During the interview she was quick to add, “I don’t think that, but that’s where my head was.” For Grace, Sarah, and Elizabeth, adoption was not a ‘cure’ that could fix their painful loss of biological children.

In addition to biological replacement and adoption, the final quick fix solution offered by faith community members was the suggestion that these women could still find joy in being mother-*like*, or in becoming a ‘spiritual mother’ to other people’s children. Elizabeth found such notions irritating. She said:

You get all the people that say things like, ‘Oh, you can be a mother in other ways.’ Well no, I’m not a mother. I never will be a mother. I’m not going to go turn around and go volunteer in the kid’s ministry so I can be a surrogate mom.

When Elizabeth’s friend told her that she was, “mothering people . . . spiritually” she argued, “It’s not mothering. It’s not the same thing. Don’t put me in that category . . . don’t try to put ‘fake mom’ on me because I’m not a mom.” Elizabeth’s frustration stemmed from the fact that her faith community was more interested in categorizing her, and forcing her into a motherhood

mold, than they were in accepting her for who she was. In an attempt to make her fit in, it was suggested that she try to play the part of ‘spiritual mother,’ but attached to this easy solution, was a disregard for her unique identity as well as her grief.

**Strategies of embodying grief.** Although the women who participated in this study specifically equated their experiences with infertility and miscarriage as loss of human life, many within their faith communities did not. The failure of these faith communities to embody their pro-life claim when it came to the felt loss of these women left them isolated in their grief. When dominant groups dismiss women’s experiences as “trivial” they often creatively resist through “reclaiming, elevating, and celebrating” that discourse in other ways (Houston & Kramarae, 1991, p. 394). In spite of the dismissal, silence, and insensitive solutions offered by faith community members, these women developed several bold strategies to grieve, honor their dead, and acknowledge the life of every child they had known and loved.

***Acknowledging the loss.*** First, these women gave themselves, and other women like them, permission to grieve. Hope remembered struggling with what emotion she should be feeling following her first miscarriage. At first she tried to think positively and told herself, “Well, you had a miscarriage, but I guess you can get pregnant!” As she continued to wrestle with her feelings, her husband helped her to make an important connection. She said, “For the first baby, [my husband] had to prod me to cry, and to acknowledge, ‘that was a life!’ She continued, “then, for our second miscarriage, that one was an easy one to cry [for].” After experiencing multiple miscarriages, Joy was adamant, “Life begins at conception,” she said, “it doesn’t matter how old that child is, you still get to mourn it.” Within her community, she directly acknowledges a loss of life when she tells women who have miscarried, “Your baby was so loved, it’s an honor that that baby [had] you as a Mom. Take time to mourn your child. Mourn

this life.” When visiting with women who are grieving, Grace said, “I want the grief, and the crying, and the pain, and the anger, or shame, and fear to just be okay to talk about, cause it’s real, it’s okay, and it’s normal.” Rachel tells women like her who are grieving, “Give yourself time; [do] not feel rushed to heal.”

*Honoring the life.* In addition to allowing themselves to grieve, it was important to these participants to find ways to honor their dead. Following a pregnancy loss, the bereaved should be provided with “healing interventions” that facilitate the expression of grief, validate the death, help make sense of the loss, and provide a supportive environment for grief processing. These “interventions” for parents who experience miscarriage, stillbirth, or infant death, can include a support group, holding a memorial or funeral, and even burial service when possible (Capitulo, 2005, pp. 393-395). When the right to grieve is denied, the ability to make sense, process, and find closure is prevented. Social denial of grief is a “disenfranchised grief” that occurs when a person experiences “a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported” (Doka 1989, pp. 3-4). Although “the loss is not socially defined as significant,” the denial of that person’s grief will “exacerbate the problem of bereavement” and “intensify emotional reactions” connected to that grief (Doka 1989, p.7). Without any opportunity to emotionally process their losses with the support of the community, the women who participated in this study found it difficult to find closure. At first Ruth and her husband didn’t understand that they needed closure. Ruth said:

We were trying to just fight through it . . .to push through it with faith and prayer.

But we weren’t actually doing anything and haven’t done anything to actually show that the baby was here, that the baby mattered.

After going through some grief counseling, Ruth and her husband came to understand that they needed to “search for that way, an appropriate way, to close [two miscarriages].” Joy and her husband held a small burial service for one of their losses. Although too early to determine the sex, Joy said, “I saw it come out . . . I was able to hold the baby . . . we actually buried it, and prayed over that child, and prayed over that life.” This ceremonial act of memorializing provided Joy and her husband with the ability to move forward. One faith community did openly acknowledge a couple’s loss. After the death of her stillborn infant, Hope’s faith community held a memorial service. Hope said, “I know that the funeral was for me and my husband . . . there were so many people . . . so much support.” The community brought her and her husband meals, took care of household chores, and kept Hope and her husband “basically breathing and walking” in the midst of their grief. For Hope, this tangible “respect for life and death” demonstrated what a faith community is “supposed to be” and “what it could be.” She said, “in the midst of the horribleness of everything, it was a very good thing.”

***Claiming the child.*** Finally, after grieving and honoring their dead, these women strategically acknowledged their losses through naming the deceased, claiming the identity of mother, and declaring their children’s existence to others. Rachel named both of the children she lost and frequently mentions their names in conversation. Hope refers to herself as a mother and her husband as a father even though they don’t have any “living children.” When meeting someone for the first time who asks her if she has children, Hope says, “I do have children, but they are with Christ.” This redirection towards positioning miscarried children in heaven with God, or with Christ, appeared in several interviews. Joy is quick to correct anyone who says, “You just have one.” She tells them, “No, we have one and then we have three in heaven that we’ll meet someday.” Joy explained her “bold” approach: “I’m not going to hide from my

losses,” she said, “those are my children . . . I would rather be bold and my children’s lives be acknowledged than not.” Although it can be a “difficult question” to answer, Rachel tells people, “I have two babies in heaven.” She acknowledged there have been times when she says, “No” to avoid an awkward conversation, but afterwards she always feels guilty for “being mean to her kids by saying they didn’t exist.” Lastly, Grace highlighted a “fascinating” cultural practice she had learned about while living overseas. She explained that in this particular country, “when you ask a woman, ‘How many children do you have?’ she will say, ‘Seven, three living.’ Because, if, if she has a miscarriage, or loses a child in infancy, that’s her child.” Grace thought this was “a wonderful, beautiful thing” and lamented the absence of such a practice in her own faith community.

This final finding, the failure of faith community members to connect their strong pro-life claim with recognizing the lives lost to infertility and miscarriage within their membership, was quite troubling for the women who participated in this study. The inability or unwillingness of family and friends to acknowledge their loss, and to empathize with them, exacerbated their grief. Yet, in spite of the frequent attempts of faith community members to dismiss, silence, or provide insensitive solutions, these women found ways to boldly resist by developing strategies that allowed them to express their grief and remember their dead.

It was the failure of faith communities to embody the values they claimed to hold that hurt women within their membership. But, in spite of their disappointment, these women found agency through reaching out to connect with others like them and giving themselves permission to grieve their losses. I now turn to a final summary of the study’s four primary findings.

## Conclusion

The two categorical conceptions of the ‘embodied but unexamined beliefs’ and the ‘claimed but unembodied values’ produced the four major findings discussed in this chapter. All four findings demonstrated the inter-relational aspects of belief and action. The first and second findings demonstrated the failure of some faith community members to examine their beliefs and practices from the perspective of those who might be hurt by the exclusionary ideology. While often unintentional, the belief that a woman’s primary purpose and worth lie in her ability to have children and the belief that children are ‘everything’ does result in the stigmatization and marginalization of women without children.

The third and fourth findings revealed a troubling inconsistency between the expression of core community values and the ways those values were lived out. While the faith communities generally presented themselves as safe spaces that celebrated “life,” the acceptance of certain normative social categories and the refusal of some community members to validate loss of life, resulted in the isolation and exacerbated grief of members who struggled with infertility and pregnancy loss.

The women who participated in this study experienced feelings of inadequacy, failure, shame, and guilt when they were unable to produce children. Some chose to pursue costly medical intervention. They were driven to ask difficult spiritual questions and received very little help from their communities in answering them. Some wrestled with depression and thoughts of suicide. Within their faith communities, these women were made to feel abnormal and regularly experienced fear, awkwardness, and even guilt when interacting with other community members. When they chose to disclose their losses, they were routinely dismissed, silenced, or given insensitive solutions that only intensified their grief.

In the midst of a dominant discourse that continually threatened to marginalize or erase them, these women developed powerful strategies of resistance. When their identity and worth as women was called into question, they claimed their identities as children of God and found purpose through helping others. When they were presented with the notion that children are the most valuable contribution they could make to society, they pushed back, claiming God's sovereignty and redirected their hope to God. In faith communities that marginalized these women for their perceived differences, they proactively formed friendships with other women like them, and some went in search of new friends outside their communities. After faith community members dismissed their losses, these women stood firm, giving themselves permission to grieve, and honoring their dead by claiming their lost children to others. Through each of these strategies, these women exemplified a growing faith in God, an independent dignity in the midst of their suffering, a growing awareness and compassion for isolated individuals, and an unrelenting commitment to the children they had known and loved.

The findings of this study contribute to the literature and knowledge about women's experience with infertility and pregnancy loss in important ways and, despite some study limitations, illuminates the potential for future research. In the next chapter, I discuss each of these factors before closing with some of my personal reflections regarding the project.



## CHAPTER 4

### DISCUSSION

Because infertility has the power to profoundly impact a woman's identity and relationships, as well as her physical, emotional, psychological, and spiritual well-being, there are many implications for future research directions. For the academic community, this study provides a unique application of Muted Group Theory to the specific population of Christian infertile women. It also adds to the body of research on identity, stigma, and social constructs and makes contributions to grief studies as well.

For the medical community, it supports the work of previous researchers who identified the need for increased counseling efforts (Berger et al., 2013), recognition of religious background (Buluc-Halper & Griffin, 2015), and the greater awareness of medical health care providers regarding the unmet spiritual needs of their patients (Roudsari, Allen, & Smith, 2007). While many researchers found that religious and spiritual health is linked to the emotional well-being and "life satisfaction" of women facing infertility (Domar et al., 2005, Etemadifar et al., 2016; Mahajan et al., 2009; Nouman 2018; Ridenour, Yorgason, & Peterson, 2009), they focused their research toward advising physical and mental health care providers rather than faith community leaders.

This study, once again, affirmed the need for spiritual counseling for Christian infertile women and went a step further by focusing on identifying the beliefs and actions of faith community members that contribute to and exacerbate an infertile woman's distress. By collecting these women's stories and employing Muted Group Theory as a lens through which to examine their 'strategies of resistance,' this study is uniquely positioned to provide

recommendations for change, as articulated by study participants, for faith communities, their leaders, and members.

### **Recommendations**

This study illuminates one particular population within Christian faith communities—the infertile woman, and reveals the social, emotional, physical, and spiritual stressors present in her experience. It challenges some of the accepted ideology of Christian faith communities and demands a reexamination of the beliefs and practices that have inadvertently hurt these women. The following recommendations for change, as articulated by study participants, are offered here.

#### **Infertility Education**

The words and actions of the members within these women’s faith communities revealed an obvious lack of education regarding infertility and pregnancy loss. For any change to occur, faith community leaders and members must become more educated on these topics. Education could help to reduce the stigma and shame connected to infertility and provide opportunities for women’s experiences to be recognized and honored. Ruth articulated her desire when she said, “I would really love to see more support groups, books, book clubs, seminars, just education [in] the church, because . . . if you’re ignorant [on] the issue, how much help are you really giving me?” It is important to note that while several of the participants of this study advocated for community education, not every woman in similar circumstances should be expected to bear the burden of educating her community. Even so, these women are well-positioned to be the most knowledgeable sources on these topics. Faith community leaders and members should receive their stories, as these women are able to tell them, and work closely with these women to ensure that their experiences are informing any education initiatives.

## **Category Expansion**

The women who participated in this study were stigmatized and marginalized for their failure to achieve the anticipated norm of motherhood. The acceptance of certain social norms and religious ideologies placed women without children outside the ‘normal’ categories. Rather than accepting each individual as their own unique person, these women were encouraged by faith community members to “try again,” adopt, or become mother-*like* so they could achieve the social expectation of motherhood. The women who participated in this study suggested the need for category expansion within their faith communities. During her interview, Grace asked, “What are we going to do to get comfortable with these other stories and celebrate them and see the beauty in them, and begin to use language, and events, and worship that acknowledges all of the stories?” These women confronted the notion that all women become mothers and challenged their faith communities to reconsider the social norms that are emphasized and celebrated within community life. They advocated nurturing attitudes of inclusivity and acceptance for all members.

## **Spiritual Counseling**

The women who participated in this study demonstrated remarkable courage as they wrestled with some very difficult theological questions. Unfortunately, they were often left to their own devices while doing so. For some, the isolation produced feelings of guilt, failure, shame, anger, depression, and even thoughts of suicide. When Sarah remarked that her pastor “was pretty helpless” and didn’t “have many encouraging words” to address her situation, she highlighted her leader’s lack of preparedness to provide her with spiritual counsel. It is important for pastors and ministry leaders to be equipped and available to address the spiritual crises that many women facing infertility and pregnancy loss experience. Fortuitously, the women who

participated in this study demonstrated the application of several theological views that helped them navigate their ordeal and begin to heal. It is likely that other women who have experienced infertility and pregnancy loss could name other spiritual applications as well. The implementation and provision of counseling services within Christian faith communities could go a long way in helping these women.

### **Bereavement Ritual**

The lack of a death or mourning ritual following the loss of children—whether through miscarriage or inability to conceive—left the women who participated in this study without closure. When confronted with the knowledge of these women’s losses, faith community members routinely dismissed their grief, were silent, or offered insensitive solutions. In so doing, these women’s losses were not acknowledged, nor their feelings honored. In the absence of a traditional funeral service, faith communities must now search for a new and innovative way to provide infertile women and couples with a safe space to process their grief, receive the empathy of friends and family, and begin the healing process. As Hope said of the funeral her faith community held, “it was very important and [showed] respect for life and death . . . and *how community is supposed to be . . . in the midst of everything, it was a very good thing*” (emphasis added).

In summary, the women who participated in this study recommended the development of educational opportunities, the reduced emphasis on social categories, provision of spiritual counseling, and implementation of bereavement rituals to address the needs of infertile women within Christian communities of faith. Through creating a greater awareness, extending a warm welcome to every individual, providing spiritual counseling for those in need, and recognizing the loss of every life, faith communities can begin to be safer spaces for women experiencing

infertility or pregnancy loss. Such changes can help faith communities become places of healing and hope.

### **Limitations**

One of the challenges that I faced during the study was the fact that ‘infertility’ can be interpreted in a number of ways. The participants who self-identified as having experienced ‘impaired fertility’ were not familiar with clinical definitions and therefore represented a broad spectrum of fertility related experiences. One participant was not sure if she qualified because she was unmarried. Another participant had experienced multiple miscarriages but did not technically meet the medical definition of having attempted pregnancy for twelve months or longer without success. And one participant revealed, mid-interview, that she and her husband had not conceived due to “male factor infertility.” While the women who participated in this study presented an exceptional cross section of experiences relating to primary infertility, secondary infertility, and miscarriage, it also created a dichotomy when it came to motherhood. Four participants reported that they now have two living children. Five had no living children and, of those five, three had received primary infertility diagnoses, while the other two had achieved pregnancy but had not been able to carry the pregnancies to term. Future research in this field may find it necessary to describe the participant criteria in very specific terms to more effectively focus their study.

A second limitation was the diversity of the participants’ ages. While the variety of life experiences and unique perspectives of each participant made important contributions to the study, I informally observed a disparity between how the younger women (20s and 30s) had articulated and interpreted their experiences relative to how the older women (40s and 50s) articulated theirs. While the older women remembered the presence of an oppressive stigma that

had isolated and silenced them, the younger women appeared to possess more communicative power within their communities. In other words, their ‘mutedness’ took noticeably different forms. One potential influence—the growth and expansion of the internet—may have provided younger women with greater access to medical research, opportunities to learn from other’s disclosures, and places to voice their stories. Further, feminist contributions continue to influence cultural understandings regarding the value of women authoring their own experiences and serving as experts in interpreting their own lives. These two factors may explain some of the differences I observed between the age groups of my participants. Future research could explore whether such differences occur in other faith community contexts and the ways in which online information and communities, feminist gains, and other variables might account for them.

In addition, while I was quite pleased with the number of participants, as well as the variety of life experiences they brought to this study, the women represented in this research were all physically located in the Southern Appalachia region of the United States. This region, colloquially referred to as the ‘Bible Belt’ is often recognized for being conservative and for holding to ‘traditional’ gendered roles. It was therefore impossible to determine if the values and practices described by these women could be applied to Christian faith communities broadly, or if the conservative values of the region were a contributing factor to their reported experiences. While at least three participants mentioned living outside the region at one time, including two who lived abroad, future research should expand beyond this region.

Due to the conservative nature of the region, and the use of snowball sampling as a recruitment method, the nine women who participated in this study all identified as Christian women and were connected to three denominations and represented five local faith communities. The Christian faith, while widely practiced throughout the United States, is not representative of

other faith systems and practices. The five faith communities represented in this study are only a small sample of a much larger evangelical American church. Future research should be expanded to include other faith systems and practices including a broader sampling of Christian denominations.

### **Future Directions**

While much research has been done on women's experiences with infertility, the field is still ripe with potential. This particular study focused on obtaining and interpreting the stories of Christian women. As implicated by this work, future research needs to be directed towards addressing the needs of infertile members within communities of faith. During the course of this project, several emerging themes identified problem areas for infertile women in Christian faith communities. These women lamented a lack of mentorship, the inability to have a publicly recognized way to contribute something of worth to their community, and the absence of death or mourning rituals to assist them through the grieving process. In the absence of such offerings, the women were left to navigate their experiences on their own. Although they developed many creative coping strategies, future research could help illuminate the potential for faith community outreach programs and ministries that could strategically address these women's needs. In what follows, I suggest some approaches that may be useful for researchers.

The women who participated in this study demonstrated a desire for spiritual mentorship. While they struggled to disclose to their male pastors, they did find and establish meaningful relationships with older women who had more life experience or who had also experienced some form of loss. Future research should be conducted into this fascinating pattern of infertile women being drawn towards the older women within their communities and the relationships they form with them.

For these women, the ability to make a meaningful contribution was very important. When the women who participated in this study were unable to produce children, they were made to feel as though they could not contribute anything of value to community life. Future research might identify specific ways that modern Christian women without children define what Christian womanhood means to them.

Following the loss of their children, the participants of this study were prohibited from finding closure. They had no outlet through which to process their emotions and were made to feel guilty when they disclosed pain. The absence of loss recognition, grief validation, and a place to honor their dead exacerbated an already painful experience for these women. Future research might explore the potential healing that a death or mourning ritual could introduce into the lives of infertile Christian women. Faith communities need to understand how to provide their infertile members with an opportunity to process their loss.

In addition to research directed towards meeting these needs, the male partners of infertile women could prove to be an important new field for researchers. Because this study was particularly focused on identifying and interpreting the experiences of women, no husbands or male partners were interviewed. While the male experience of infertility was beyond the scope of this study, several participants identified it as a significant gap in the research. Six participants specifically talked about their husband's experiences. Two participants inquired about research pertaining to the male partner experience and asked me to consider the potential of interviewing their husbands in the future. They specifically lamented faith community silence on this topic. Future research is needed on male-factor infertility, the male partner experience, and the impact of infertility on Christian husbands.



During the course of this project, I also became particularly interested in making sense of the inability of Christian faith communities to address infertility and pregnancy loss in more healing and affirming ways. Because Christian belief is rooted in the narrative of the suffering and consequent resurrection of Jesus, the Christian faith system is already equipped with ideology that acknowledges human pain and suffering while providing hope. The fact that infertility was still being interpreted as God's punishment for unconfessed sin, motherhood as a chief paradigm for all women, and women's experiences with loss as inconsequential was baffling. Future research might continue to address the lack of connectivity between Christian belief and practice. There is more work that needs to be done in both educating and equipping Christian faith communities to care for the hurting in their midst.

### **Research Reflections**

A significant portion of my time in graduate school was dedicated to researching women's experiences with infertility. Looking back, I cannot think of another time in my life when I have been so fully devoted to one project. I thought about my subject matter all the time: in class, at the gym, over cups of coffee with my friends, and every weekend when I spent time with my own faith community. At times it felt all-consuming. A strong desire for social change within faith communities was what drove me. In the earliest stages of the project my advisor asked me to sit down and identify my motive for pursuing this topic. Later that day, I journaled:

I want to change the way Christian women experience infertility. I want to challenge the ways we think and talk about infertility within communities of faith.

I want faith communities to be places for healing and hope, not places that add to the felt stigma, pain, and isolation of these women.

Throughout the project my resolve never really waivered. It would be one of the longest and most difficult projects I have ever worked on, but I did it because it mattered to me.

This was not just the story of my participants alone; it was my story as well.

I will always remember meeting my first participant. She and her husband were introduced to me by a mutual friend who thought she might be interested in sharing her story. The introduction was made and I just stood there, paralyzed for a moment. It was my turn to speak. I felt I had to justify my reason for researching such a difficult and personal topic. When I opened my mouth and heard the words, “I can’t have children,” I surprised myself. I had never said that out loud to anyone before. Without a word, the woman who later became my first participant, stepped forward and wrapped me in a hug. “I’m so sorry,” she whispered in my ear. In that moment, I began to understand that this project was going to be about more than the affirmation and healing of others, it would also be about my own.

This project taught me that I was not alone. Following my surgery, I had lived in relative isolation for almost three years. I was very selective with my disclosures and felt the stigma and shame attached to my single, childless status when I did. As I began to meet my participants and listen to their stories, I was stunned by their resiliency. Each one of their stories was wildly different, but each one contained brilliant moments of raw honesty that left me breathless. I was moved to tears. Sometimes I felt angry. I was inspired to keep working. Even towards the end, when I was running on fumes to finish writing, the memory of their earnest faces, their stories, and their bravery in the face of such tremendous loss were the motivating factors that kept me moving forward. I had been entrusted with their sacred stories and I felt the weight of my responsibility to represent these women and their experiences well.

Meeting these women, and hearing their stories emboldened and empowered me to embrace my own story. I suddenly found that I was speaking more freely. I was telling more and more people about the research I was doing, and in the process, the details of my own story. I began to realize the potential of storytelling; an increased empathy for others, human connection, and perhaps even the social change I had longed for. My surgery was not the end of my story, it had been the beginning. Although I hadn't chosen it, it had chosen me; and now I had the opportunity to do something that mattered with it.

My academic career as a graduate student provided me with many opportunities to become educated on my topic. During my first semester, I piloted my study in Qualitative Research Methods in Communication and learned what would be required of me to prepare and write a thesis. In Communication Ethics, I wrote an autoethnography in which I revisit the painful memories of my surgery, the doctor who hurt me, and the power of forgiveness to heal. Although difficult to write, this paper helped to prepare me for the self-disclosure that would be necessary during the interview process. In my second semester, I was asked to craft and perform a "Who I Am" story in Applied Storytelling. This assignment provided me with a safe environment to confront my fear of stigmatization and share parts of my story in front of a live audience for the first time. In Communication Theory, I was introduced to Muted Group Theory and recognized its potential for my research. I also wrote a personal narrative that explores my identity as a woman who, in the absence of biological children, invests her time, energy, and love into the lives of others' children. During my third semester I enrolled in Women, Gender, & Religion in America and conducted an exploration of the autobiographical Christian self-help infertility literature published between 1980-2019. This course was instrumental in developing my research and writing skills, along with providing me with yet another lens through which to

examine Christian women's experiences with infertility. Finally, in my last semester, in *Issues in Communication and Culture*, I wrote a personal narrative that explores my personal journey towards redefining my identity following involuntary sterilization.

Following the completion of my thesis, my first inclination is to take a break. My choice to research women's experiences with infertility has cost me emotionally, physically, and spiritually. For almost two years, this project has been my focal point of my life and it has profoundly and powerfully changed me. Early in my academic career, when I began to fear I might be defined by the topic, I pushed back. I told my faculty and cohort that I didn't want to become 'the infertility girl.' But now, at the end of this particular leg of my journey, I understand that, in some capacity, it will always be a part of me. I have become more knowledgeable and am willing to speak about this subject with anyone who may have interest.

I am now prepared and further compelled to bring my knowledge to faith community members. As a result of a recent conversation with one of my faith community leaders, a special gathering has been planned, and the community has been invited to come together and "mourn with those who mourn," to acknowledge loss of many kinds, and to offer helpful and healing spiritual counsel for those in need.

In addition, I have written and will be performing an original ethnodrama exploring women's experiences with infertility and pregnancy loss. After obtaining permission from each of my participants to retell some of their stories, I created a script using selected excerpts taken directly from their interview transcripts. The show is currently in pre-production and later this year I will perform these women's stories before live audiences.

Meeting my participants, hearing their stories, and putting in the intellectual work to make sense of their experiences has taught me to believe in the power of one voice, one life to

make a profound difference. These women inspired me to believe that the work that I was doing was important. I am thankful to have been given the opportunity.

During this process I matured as a reader, writer, and critical thinker. Now, in the spirit of friendship to future graduate students and thesis writers, I offer some recommendations. When possible, choose your topic early and take advantage of the many opportunities you will be given to explore your area of research. As noted above, with a little creativity, many class assignments can become a place to explore your area of interest. Commit to becoming a functioning expert in your field and take careful note on anything that could aid you in the development and writing of your thesis. From your first day, until your last, the many books and journal articles you will be assigned will each contain something that can inform or illuminate your topic. Choose a unique color pen or special highlighter and take notes in the margins of all your readings when you think something might apply. Keep everything from every class and review your notes often. Allow yourself to think, to feel, and to wrestle. Anything worth doing is going to be difficult. There will be tears of frustration but also glorious moments of sheer brilliance. In the end, you will have grown as an individual, made a difference in the lives of others, and produced something important. It will not be easy but it will be worth it.

## REFERENCES

- Abbey, A., Andrews, F. M., & Halman, L. J. (1992). Infertility and subjective well-being: The mediating roles of self-esteem, internal control, and interpersonal conflict. *Journal of Marriage and the Family* 54(2), 408-417.
- Akarsu, R. H., & Beji, N. K. (2019). Spiritual and religious issues of stigmatization women with infertility: A qualitative study. *Journal of Religion and Health*, 1-12.  
<http://doi.org/10.1007/s10943-019-00884-w>
- Allison, J. R. (1979). Roles and role conflict of women in infertile couples. *Psychology of Women Quarterly*, 4(1), 97-113.
- Ardener, E. (1975). The problem [of women] revisited. In S. Ardener (Ed.), *Perceiving women* (pp. 19-27). London: Malaby Press.
- Ardener, S. (2005). Ardener's "muted groups": The genesis of an idea and its praxis. *Women and Language*, 28(2), 50-54.
- Berg, B. L. (2009). A dramaturgical look at interviewing. *Qualitative research methods for the social sciences* (7<sup>th</sup> ed., pp. 101-157). Boston: Allyn & Bacon.
- Berger, R., Paul, M.S. & Henshaw, L. A. (2013). Women's experience of infertility: A multi-systematic perspective. *Journal of International Women's Studies*, 14(1), 54-68.
- Bewley, S., Foo, L., & Braude, P. (2011). Adverse outcomes from IVF. *BMJ: British Medical Journal (Online)*, 342. <http://dx.doi.org.iris.etsu.edu:2048/10.1136/bmj.d436>
- Boivin, J., Scanlan, L. C., & Walker, S. M. (1999). Why are infertile patients not using psychosocial counselling?. *Human Reproduction*, 14(5), 1384-1391.
- Buluc-Halper, E., & Griffin, P. W. (2015) Multicultural considerations in infertility counseling. Article 18. ACA Annual Conference. Orlando FL.

- Burnett, J. A. (2009). Cultural considerations in counseling couples who experience infertility. *Journal of Multicultural Counseling and Development, 37*(3), 166-177.
- Callan, V. J., & Hennessey, J. F. (1988). The psychological adjustment of women experiencing infertility. *British Journal of Medical Psychology, 61*(2), 137-140.
- Capitulo, K. L. (2005). Evidence for healing interventions with perinatal bereavement. *The American Journal of Maternal/Child Nursing, 30*(6), 389-396.
- Centers for Disease Control and Prevention. (2016, July 15). *Faststats infertility*. Retrieved from <https://www.cdc.gov/nchs/fastats/infertility.htm>
- Centers for Disease Control and Prevention. (2019, September 2). *Infertility*. Retrieved from <https://www.cdc.gov/reproductivehealth/infertility/index.htm>
- Chandra, A., Copen, C. E., & Stephen, E. H. (2013). Infertility and impaired fecundity in the united states, 1982-2010: Data from the national survey of family growth. *National Health Statistics Report, 67*, 1-18.
- Charmaz, K. (2014) *Constructing grounded theory*. (2<sup>nd</sup> ed.) Thousand Oaks: Sage
- Chester, D. H. (2003). Mother. Unmother: A storied look at infertility, identity, and transformation. *Qualitative Inquiry, 9*(5). 774-784.  
<http://doi.org/10.1007/1077800403254887>
- Czarnecki, D. (2015). Moral women, immoral technologies: How devout women negotiate gender, religion, and assisted reproductive technologies. *Gender & Society, 29*(5). 716-742. <http://doi.org/10.1177/0891243215591504>
- Daniluk, J. C. (2001). Reconstructing their lives: A longitudinal, qualitative analysis of the transition to biological childlessness for infertile couples. *Journal of Counseling & Development, 79*(4), 439-449.

- Doka, K. J. (1989). Disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 3-11). Lexington Books.
- Domar, A. D., Broome, A., Zuttermeister, P. C., Seibel, M., & Friedman, R. (1992). The prevalence and predictability of depression in infertile women. *Fertility and Sterility*, 58(6), 1158-1163.
- Domar, A. D., Penzias, A., Dusek, J. A., Magna, A., Merari, D., Nielsen, B., & Paul, D. (2005). The stress and distress of infertility: Does religion help women cope? *Sexuality, Reproduction & Menopause*, 3, 45-51.
- Etemadifar, S., Hosseiny, R., Ziraki, A., Omrani, A., & Alijanpoor, M. (2016). The relationship between spiritual well-being and life satisfaction in females with infertility. *Women's Health Bulletin*, 3(4).
- Feske, M. C. (2012). Rachel's lament: The impact of infertility and pregnancy loss upon the religious faith of ordinary Christians. *Journal of Pastoral Theology*, 22(1), 3-1.
- Forrest, L., & Gilbert, M. S. (1992). Infertility: An unanticipated and prolonged life crisis. *Journal of Mental Health Counseling*, 14(1), 42-58.
- Gillespie, R. (2003). Childfree and feminine: Understanding the gender identity of voluntarily childless women. *Gender & Society*, 17(1), 122-136.  
<http://doi.org/10.1177/0891243202238982>
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New Jersey: Spectrum Inc.
- Greil, A. L. (1997). Infertility and psychological distress: a critical review of the literature. *Social science & medicine*, 45(11), 1679-1704.



- Greil, A. L. (1991). *Not yet pregnant: Infertile couples in contemporary America*. New Brunswick: Rutgers University Press.
- Greil, A., McQuillan, J., & Slauson-Blevins, K. (2011). The social construction of infertility. *Sociology Compass*, 5(8), 736-746. <http://doi.org/10.1111/j.1751-9020.2011.00397.x>
- Hammerli, K., Znoj, H., & Berger, T. (2010). What are the issues confronting infertile women? A qualitative and quantitative approach. *The Qualitative Report*, 15(4), 766-782. <https://nsuworks.nova.edu/tqr/vol15/iss4/1>
- Hodin, S. (2017, January 18). *The burden of infertility: Global prevalence and women's voices from around the world*. Retrieved from <https://www.mhtf.org/2017/01/18/the-burden-of-infertility-global-prevalence-and-womens-voices-from-around-the-world/>
- Houston, M., & Kramarae, C. (1991). Speaking from silence: Methods of silencing and of resistance. *Discourse & society*, 2(4), 387-399.
- Hynie, M., & Burns, L. H. (2006). Cross-cultural issues in infertility counseling. In S. N. Covington & L. Burns, L. (Eds.) *Infertility counseling: A comprehensive handbook for clinicians*, (2<sup>nd</sup> ed., pp. 61-82). New York, NY: Cambridge University Press.
- Inhorn, M.C., & Patrizio, P. (2015). Infertility around the globe: New thinking on gender, reproductive technologies, and global movement in the 21<sup>st</sup> century. *Human Reproduction Update*, 21(4) 411-426. <http://doi.org/10.1093/humupd/dmv016>
- Jennings, P. K. (2010). "God had something else in mind": Family, religion, and infertility. *Journal of Contemporary Ethnography*, 39(2), 215-237. <http://doi.org/10.1177/0891241609342432>

- Katz, P., Showstack, J., Smith, J. F., Nachtigall, R. D., Millstein, S. G., Wing, H., Eisenberg, M.L, Pasch, L.A., Croughan, M.S., & Adler, N. (2011). Costs of infertility treatment: results from an 18-month prospective cohort study. *Fertility and Sterility*, 95(3)
- Klitzman, R. (2018). How infertility patients and providers view and confront religious and spiritual issues. *Journal of Religion and Health*, 57(1), 223-239.  
<http://doi.org/10.1007/s10943-017-0528-4>
- Kramarae, C. (2005). Muted group theory and communication: Asking dangerous questions. *Women and language*, 28(2), 55-61.
- Loftus, J., & Andriot, A. L. (2012). “That's what makes a woman”: Infertility and coping with a failed life course transition. *Sociological Spectrum*, 32(3), 226-243.  
<http://doi.org/10.1080/02732173.2012.663711>
- Loftus, J. & Namaste, P. (2011). Expectant mothers: Women’s infertility and the potential identity of biological motherhood. *Qualitative Sociology Review*, 7(1). 36-54.
- Loftus, J. (2009). “Oh, no, I'm not infertile”: Culture, support groups, and the infertile identity. *Sociological Focus*, 42(4), 394-416.
- Madison, D. S. (2012) Methods. *Critical ethnography: Methods, ethics, and performance*. (2<sup>nd</sup> ed., pp. 19-50). Los Angeles: Sage.
- Mahajan, N. N., Turnbull, D. A., Davies, M. J., Jindal, U. N., Briggs, N. E., & Taplin, J. E. (2008). Adjustment to infertility: the role of intrapersonal and interpersonal resources/vulnerabilities. *Human reproduction*, 24(4), 906-912.  
<http://doi.org/10.1093/humrep/den462>

- Mascarenhas, M.N., Flaxman S.R., Boerma, T., Vanderpoel S., & Stevens, G.A. (2012). National, regional, and global trends in infertility prevalence since 1990: A systematic analysis of 277 health surveys. *PLoS Med* 9(12).
- Matthews, R., & Matthews, A. M. (1986). Infertility and involuntary childlessness: The transition to nonparenthood. *Journal of Marriage and the Family*, 48(3), 641-649.
- Mayo Clinic. (2020, March 27). *In vitro fertilization (IVF)*. Retrieved from <https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384716>
- McQuillan, J., Greil, A. L., Shreffler, K. M., & Tichenor, V. (2008). The importance of motherhood among women in the contemporary United States. *Gender & Society*, 22(4), 477-496. <http://doi.org/10.1177/0891243208319359>
- McQuillan, J., Torres Stone, R. A., & Greil, A. L. (2007). Infertility and life satisfaction among women. *Journal of Family Issues*, 28(7), 955-981. <http://doi.org/10.1177/0192513X07300710>
- Nock, S. L. (1987). The symbolic meaning of childbearing. *Journal of Family Issues*, 8(4), 373-393.
- Nouman, H., & Benyamini, Y. (2019). Religious women's coping with infertility: Do culturally adapted religious coping strategies contribute to well-being and health?. *International Journal of Behavioral Medicine*, 26(2), 154-164. <http://doi.org/10.1007/s12529-018-9757-5>
- Orbe, M. P. (1996). Laying the foundation for co-cultural communication theory: An inductive approach to studying "non-dominant" communication strategies and the factors that influence them. *Communication Studies*, 47(3), 157-176.

- Orbe, M. P. (1998). From the standpoint(s) of traditionally muted groups: Explicating a co-cultural communication theoretical model. *Communication Theory*, 8(1), 1-26.
- Orbe, M. P. (2005). Continuing the legacy of theorizing from the margins: Conceptualizations of co-cultural theory. *Women and Language*, 28(2), 65.
- Oren-Magidor, D., (2015). From anne to hannah: Religious views of infertility in post-reformation England. *Journal of Women's History*, 27(3). 86-108.
- Parry, D.C. (2004). Understanding women's lived experiences with infertility: Five short stories. *Qualitative Inquiry*, 10(6). 909-922. <http://doi.org/10.1177/1077800403261852>
- Richardson, L. & St. Pierre, E.A. (2011). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative inquiry* (pp. 959-978). Thousand Oaks: Sage.
- Ridenour, A. F., Yorgason, J. B., & Peterson, B. (2009). The infertility resilience model: Assessing individual, couple, and external predictive factors. *Contemporary Family Therapy*, 31(1), 34-51. <http://doi.org/10.1007/s10591-008-9077-z>
- Roudsari, R. L., Allan, H., & Smith, P. (2013). A qualitative inquiry into the mediating role of religion and spirituality in adjusting marital relationships of infertile women. *Journal of Midwifery and Reproductive Health*, 1(1), 33-41.
- Roudsari, R. L., Allan, H. T., & Smith, P. A. (2014). Iranian and English women's use of religion and spirituality as resources for coping with infertility. *Human Fertility*, 17(2), 114-123. <http://doi.org/10.3109/14647273.2014.909610>
- Roudsari, R. L., Allan, H. T., & Smith, P. A. (2007). Looking at infertility through the lens of religion and spirituality: A review of the literature. *Human Fertility*, 10(3), 141-149. <http://doi.org/10.1080/14647270601182677>

- Roudsari, R. L., Allan, H. T. (2011). Women's experiences and preferences in relation to infertility counselling: A multifaith dialogue. *International Journal of Fertility and Sterility*, 5(3), 158-167.
- Russo, N. F. (1976). The motherhood mandate. *Journal of Social Issues*, 32(3), 143-153.
- Ryan, M. A. (2005). Faith and infertility. *The Center for Christian Ethics*, 65-74.
- Sandelowski, M. J. (1990). Failures of volition: Female agency and infertility in historical perspective. *Signs: Journal of Women in Culture and Society*, 15(3), 475-499.
- Sandelowski, M. J. (1987). The color gray: Ambiguity and infertility. *Image: The Journal of Nursing Scholarship*, 19(2), 70-74.
- Sandelowski, M., & Pollock, C. (1986). Women's experiences of infertility. *Journal of Nursing Scholarship*, 18, 140-144.
- Schechner, R. (2013). *Performance studies: An introduction*. Third Edition. New York: Routledge.
- Sewpaul, V., (1999). Culture religion and infertility: A South African perspective. *The British Journal of Social Work*, 29. 741-754.
- Smith, J. A., & Smith, A. H. (2004). Treating faith-based infertile couples using cognitive-behavioral counseling strategies: A preliminary investigation. *Counseling and Values*, 49(1), 48-63.
- Thorn, P. (2009). Infertility counselling: Alleviating the emotional burden of infertility and infertility treatment. *International Journal of Fertility and Sterility*, 3(1). 1-4.
- Turner, V. (1987). *Betwixt and between: Patterns of masculine and feminine initiation*. Illinois: Open Court.

Whiteford, L. M., & Gonzalez, L. (1995). Stigma: the hidden burden of infertility. *Social Science & Medicine*, 40. 27-36.

Whitehead, K. (2016). Motherhood as a gendered entitlement: Intentionality, “othering,” and homosociality in the online infertility community. *Canadian Review of Sociology*, 53(1), 94-122.

## APPENDICES

### Appendix A: Flyer

# Participants Needed

for a new graduate research study:

## Women's Experiences with Infertility within Faith Communities

### Private Interview

This study is seeking women who are 18 years or older, who have impaired fertility or who have received an infertile diagnosis who would be willing to talk to a researcher about how their experience was influenced by the presence of their faith community.

If you have any questions or would like more information about this study, please contact Donna Paulsen, Graduate Student in the Department of Communication & Performance at East Tennessee State University, at [paulsend@etsu.edu](mailto:paulsend@etsu.edu)



## **Appendix B: E-Mail Announcement**

Donna Paulsen is a graduate student at ETSU and is conducting a research project entitled *Women's Experiences with Infertility within Faith Communities*. She is looking for participants in her research. She would like to set up a private interview with anyone who would be willing to sit down and share their story with her. For more information you can e-mail her at [paulsend@etsu.edu](mailto:paulsend@etsu.edu) or call her at (phone number omitted).



## Appendix C: Interview Schedule

### Women's Experiences with Infertility within Faith Communities

#### Interview Schedule

##### **Aims or Goals:**

1. To provide women, who self-identify as infertile, with an opportunity to share their lived experiences with a sympathetic listener.
2. To collect the stories of women who have experienced infertility within the context of a faith community.
3. To contribute to a gap in the research regarding the stigma of infertility.

##### **Guidelines:**

1. **Infertility.** We are focusing today on the question, *'How is a women's experience with infertility influenced by the presence of her faith community?'* I'll be asking you to share some of your personal experiences, perspectives, and stories with me.
2. **Passing.** If you want to pass on a question, simply say, *'Pass'*.
3. **Breaking.** If you want to take a break at any time, just let me know.
4. **Stopping.** If you want to stop the interview at any time, just let me know.
5. **Freedom to share.** The purpose of this interview is for you to share *your* experiences with a sympathetic listener. I will not be giving you advice or making any judgement calls on anything that you choose to share with me.
6. **Time.** I have allotted a total of 1½ hours for our time together today.
7. **Bathroom.** If you need to use the bathroom during our time, please let me know and we will take a break.
8. **Cell phones.** Let's both silence our cell phones for the duration of our interview.
9. **Follow-up interviews.** At the conclusion of this interview, I may ask you if you would be willing to participate in future research.

##### **When We Write about Your Experiences:**

1. I will be making a recording of our interview. I will be using two recording devices so that if the battery were to fail in one, I would still have a reliable copy.
2. I will be the only person who has access to the recordings.
3. I will be using the recordings to create a complete transcript of our conversation. I will do this so that I can review and conduct research using your stories.
4. I do plan to use direct quotations from this conversation. I will use pseudonyms to protect your identity. I will also change indirect identifiers. (e.g. name of faith community, town, or landmarks) There is always a possibility that either you or someone you know will be able to identify you, but my goal is to do my absolute best to protect your privacy and confidentiality.
5. I plan to write up my findings in a report that I hope to publish. This report will seek to add to a gap in the research about women's experiences with infertility and provide a new resource for researchers, faith community members and faith community leaders.

## Interview Questions

- 1. Can you begin by describing a meeting/service/gathering with your faith community? [Aim 1]**

Possible Prompts:

- a. What day of the week do you meet?
- b. What takes place during your meeting/service/gathering?
- c. What are things that you usually do, see or hear?
- d. Are there any liturgy/rituals/order of service that are repeated each week?

- 2. What beliefs/values does your faith community hold regarding children? [Aim 1]**

Possible Prompts:

- a. Can you help me understand the foundation for these beliefs/values?
- b. Do you agree or disagree with these beliefs/values?

- 3. When you are meeting someone for the first time and they ask you if you have any children, how do you answer that question? [Aim 2]**

Possible Prompts:

- a. What words/terms do you use/prefer to use when talking about infertility?
- b. How does answering that question make you feel?
- c. How do people usually respond to you?

- 4. Is the subject of infertility something that is talked about openly within your faith community? [Aim 2]**

Possible Prompts:

- a. If Yes, what is generally communicated about the topic?
- b. If No, why do you think that it is a topic that is not discussed?

- 5. It has been my observation that people within faith communities tend to form groups with others who are like them or who have had similar life experiences. Has this been true in your experience? [Aim 3]**

Possible Prompts:

- a. Do you feel as though you have a place of belonging, a place that you fit in within your faith community?
- b. Are there other couples or women who have had similar experiences to yours that you have connected with?

- 6. In thinking about your infertility journey within the context of your faith community, who do you feel most comfortable talking to about your experiences? [Aim 2]**

Possible Prompts:

- a. Who do you feel least comfortable talking to?
- 7. In thinking about your infertility within the context of your faith community, what is the most helpful thing that someone has said or done for you? [Aim 2]**
- Possible Prompts:
- a. What is the most unhelpful thing that someone has said or done for you?
- 8. Sometimes women who are working through challenges with infertility feel/experience what has been described as a 'disenfranchised grief' (*a grief that is unacknowledged or invisible to others*). They are working through personal feelings of disappointment and loss but do not have a way to communicate that to others within their community. Have you ever experienced something like that? [Aim 3]**
- 9. Do the beliefs/values of your faith community ever influence the way that you feel about yourself? [Aim 2]**
- Possible Prompts:
- a. How would you compare these feelings to when you are at home or at other social gatherings?
- 10. If you were asked to speak publicly to your faith community about this topic, what would you say? [Aim 3]**
- Possible Prompts:
- a. What would you want your minister/pastor/priest to know about your experience?
  - b. What would you want people who have children to know?
  - c. Would you have any words of advice for women experiencing infertility?
- 11. Any other thoughts about infertility that you want to say? Something we've talked about or something we haven't? [Aim 1]**

## Appendix D: Revised Interview Schedule

### Women's Experiences with Infertility within Faith Communities

#### Interview Schedule

##### **Aims or Goals:**

1. To provide women, who self-identify as having experienced impaired fertility or infertility, with an opportunity to share their lived experiences with a sympathetic listener.
2. To collect the stories of women who have experienced impaired fertility or infertility within the context of a faith community.
3. To contribute to a gap in the research regarding the stigma of infertility.

##### **Guidelines:**

1. **Infertility.** We are focusing today on the question, *'How is a women's experience with infertility influenced by the presence of her faith community?'* I'll be asking you to share some of your personal experiences, perspectives, and stories with me.
2. **Passing.** If you want to pass on a question, simply say, *'Pass'*.
3. **Breaking.** If you want to take a break at any time, just let me know.
4. **Stopping.** If you want to stop the interview at any time, just let me know.
5. **Freedom to share.** The purpose of this interview is for you to share *your* experiences with a sympathetic listener. I will not be giving you advice or making any judgement calls on anything that you choose to share with me.
6. **Time.** I have allotted a total of one hour for our time together today.
7. **Bathroom.** If you need to use the bathroom during our time, please let me know and we will take a break.
8. **Cell phones.** Let's both silence our cell phones for the duration of our interview.
9. **Follow-up interviews.** At the conclusion of this interview, I may ask you if you would be willing to participate in future research.

##### **When We Write about Your Experiences:**

1. I will be making a recording of our interview. I will be using two recording devices so that if the battery were to fail in one, I would still have a reliable copy.
2. I will be the only person who has access to the recordings.
3. I will be using the recordings to create a complete transcript of our conversation. I will do this so that I can review and conduct research using your stories.
4. I do plan to use direct quotations from this conversation. I will use pseudonyms to protect your identity. I will also change indirect identifiers. (e.g. name of faith community, town, or landmarks) There is always a possibility that either you or someone you know will be able to identify you, but my goal is to do my absolute best to protect your privacy and confidentiality.
5. I plan to write up my findings in a report that I hope to publish. This report will seek to add to a gap in the research about women's experiences with infertility and provide a new resource for researchers, faith community members and faith community leaders.

6. I also plan to use excerpts from your stories in a script for a one-act play that I plan to perform before a live audience. This play will seek to inform and educate the audience about women's experiences with infertility within faith communities.

### **Interview Questions**

- 1. Could you begin by telling me about your faith community? [Aim 1]**

Possible Prompts:

- a. What day of the week do you meet together?
  - b. What takes place during your service or gathering?
- 2. What does your faith community believe about having and mothering children? [Aim 1]**

Possible Prompts:

    - a. Are there any verses or sayings that you frequently hear about children?
    - b. Are there any special events or rituals that demonstrate what your faith community believes about children?
  - 3. Do these beliefs and values, regarding mothering and children, ever influence the way that you feel about yourself? [Aim 2]**

Possible Prompts:

    - a. When someone in your faith community asks you, 'Do you have children?' how do you answer that question?
    - b. How does answering the question, 'Do you have children' make you feel?
    - c. When you choose to share about your experience with impaired fertility or infertility with others, how do they usually respond to you?
  - 4. Is infertility something that is talked about within your faith community? [Aim 2 & 3]**

Possible Prompts:

    - a. If Yes; in what context (sermon, small group) is it talked about? What has been communicated about this topic?
    - b. If No; why do you think infertility is something that is not talked about?
  - 5. It is often easy for people to form friendships with others who are like them or who have had similar life experiences. Has this been true of your experience within your faith community? [Aim 3]**

Possible Prompts:

    - a. Do you feel like you (fit in / belong) within your faith community? Why or why not?
    - b. Can you tell me about a time when you felt (most included / excluded) within your faith community?

- c. Who are (most comfortable / least comfortable) talking with about your experiences?
  - d. Are there any other women who have had similar experiences to yours that you have been able to connect with? Tell me about that relationship.
- 6. Sometimes women who have been diagnosed with impaired fertility or infertility experience invisible grief (*feelings of disappointment and loss that others can't see and don't acknowledge*). Have you experienced this? [Aim 2 & 3]**
- Possible Prompts:
- a. If Yes; has it been possible for you to be honest about your (feelings / emotions) with members of your faith community? Why or why not?
  - b. If Yes; can you tell me about a time when you shared these kinds of feelings with someone in your faith community?
- 7. In thinking about your experience with impaired fertility or infertility within the context of your faith community, what is the (most helpful / most unhelpful) thing that someone has (said / done) for you? [Aim 2]**
- 8. What do you wish you could say to members of your faith community? What do you wish members of your faith community understood about your experience? [Aim 3]**
- Possible Prompts:
- a. What do you wish your priest or pastor knew about your experience?
  - b. What do you wish your faith community knew about your experience?
- 9. Women facing the challenges that accompany impaired fertility or infertility have reported that they have found themselves questioning God's plan. Have you? [Aim 2]**
- Possible Prompts:
- a. How has your experience (impacted / influenced) your relationship with God?
  - b. What role has your faith played in the midst of this experience?
  - c. Do you have any words of advice for other women of faith who are experiencing impaired fertility or infertility?

## VITA

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