“IT’S NOT THAT EASY”:

BLACK WOMEN, FAMILY, SOCIETY AND INFERTILITY

by

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ABSTRACT

Managing infertility can be an isolating and arduous experience physically and emotionally. In the United States, an estimated 12% of women experience infertility. Black women in the United States experience infertility at high rates and are less likely than their white counterparts to seek treatment for the condition (Wellons et al., 2008). At the same time, Black American culture puts a high value on motherhood and family.

The goal of this study is to highlight the infertility experiences of Black women by centering the perspectives of middle-income, Black women. To gain understanding of this phenomena, an intersectional approach was employed using life course theory framework alongside Black feminist theory, engaging 11 participants located throughout the United States, ages 29-42 across two focus groups.

This study found that Black women facing infertility were able to redirect their focus from primarily family building to other goals, participate in other forms of mothering, and engage in various forms of coping, including setting firm boundaries, creating and maintaining a strong persona, and sharing their stories with others. Black women also encountered racism in medical settings and were subject to misinformation regarding fertility. Findings suggest the need for better education on reproductive health for Black women and the larger community, culturally relevant training for medical professionals specializing in infertility, and more mental and emotional health support, as useful tools in helping Black women navigate infertility.

Chapter 1

INTRODUCTION

Throughout childhood and adolescence, family members, media, and social norms generally emphasize the importance of parenthood and parenting; this is especially true for women (Miall, 1994). Even with recent shifts regarding who and what constitutes a “family,” many women and men identify traditional notions of parenting as part of their life goals and plans. It can be devastating and jarring for an individual or couple to receive a diagnosis of infertility. Exploring the experiences of women and men who encounter fertility challenges serves to contribute to, and expand the field of family science, adding to the understanding of layered familial dynamics such as, family composition, stressors, and family-life satisfaction. This research will examine the infertility experiences of a particular segment of the population challenged by fertility, namely, Black women in the United States. Even with many notable celebrities and public figures such as Gabrielle Union, Tyra Banks, and former First Lady Michelle Obama coming forward with their struggles to conceive, the experiences of Black women are often missing from the literature examining family building and infertility.

Definition of Key Terms

Though this project will not focus on the medical aspects of reproductive health specifically, it is important to establish the medical definitions and distinctions related to infertility, treatment, and the number of people affected by this diagnosis. Laying this foundation is critical to creating a more complete understanding of the experiences and challenges individuals face related to infertility.

Infertility: Medically, infertility is a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination (Definitions of Infertility and Recurrent Pregnancy Loss, 2013). In women 35 and older, the period is shortened to six months. For the purposes of this research, the word infertility will be used as a term to include cis gender women who experience difficulties getting pregnant and/or maintaining a pregnancy, regardless of their marital status—this framing is not meant to exclude or minimize various family types—instead it is meant to add to the existing literature on infertility for a specific segment of the population, Black cis gender women. Recognizing that transgender and same sex couples and individuals may encounter challenges, concerns, and experiences that are beyond the bounds of this particular study. The National Survey on Family Growth (NSFG) (2019) further classifies infertility by qualifying that neither the respondent nor her current husband or cohabiting partner is surgically sterile. The NSFG also uses the term *impaired fecundity*, which is defined as the physical ability of a woman to have a child and not

simply to conceive a pregnancy (NSFG – Listing I – Key Statistics from the National Survey of Family Growth, 2019). Additionally, infertility is presented only for married couples and refers only to problems getting pregnant. In the United States, 13.1% of women aged 15-49 live with impaired fecundity, and 8.8% of married women are classified as infertile. Worldwide, it is estimated that up to 48 million couples and 186 million individuals live with infertility (World Health Organization, n.d.).

Assisted Reproductive Technology (ART): ART refers to the medical interventions and procedures that aid reproduction in those facing difficulty and includes all fertility treatments in which either eggs or embryos are handled (CDC, 2019). This includes in vitro fertilization (IVF), a process in which eggs are removed from a female's ovaries, fertilized with sperm in a petri dish, grown inside a lab for several days, then transferred into the uterus (CNY Fertility, n.d.). ART does not include any treatments where only sperm are handled, i.e., intrauterine insemination (IUI), where specially prepared sperm are inserted into the woman's uterus (Centers for Disease Control, 2019). There are other less invasive treatment options, including various hormone courses, most of which involve a woman enduring various injections and procedures; and other assistive options such as Intracytoplasmic Sperm Injection (ICSI), where a small needle, is used to inject a single sperm into the center of the egg (American Society for Reproductive Medicine, n.d.). Importantly, any ART protocols or other medical interventions are not cures to infertility, only means to assist with fertility challenges, and improve the chances of conception (CDC, 2019). Most

insurance plans do not cover, or do not fully cover the costs associated with fertility treatments; however, insurance can reduce out-of-pocket costs. The cost of fertility treatments in the United States can range from $4,900 to over $30,000 plus the cost of medications, of which the average cost is around $4,000 (CNY Fertility, n.d.). The costs associated with infertility treatments can limit one's ability to fully utilize ART interventions.

Infertility in the United States

Infertility affects an estimated 12% of women in the United States, and though it is often framed as such, infertility is not solely a woman's issue (CDC 2019). Globally, 40–50% of fertility issues are linked to male factor infertility (Kumar & Singh, 2015), and in the United States, for approximately 35% of couples with infertility, a male factor is identified along with a female factor. In about 8% of couples with infertility, a male factor is the only identifiable cause (CDC, 2019). Not only does infertility affect both men and women physically, but both can experience feelings of distress. Women often feel inadequate and deficient for failing to fulfill personal and societal roles, while men often feel inferior, ashamed, and angry (Covington & Burns, 2006).

Black women in the United States experience infertility at high rates. Black women make up 14% (9,040,160) of all women in the United States ages 15-44, third in number to White women (35,022,798) and Latinas at 21% (13,740,485) (March of Dimes, 2022). A 2008 study found that 48% of the Black women participants

self-reported as infertile, versus 31% of White women participants (Wellons et al., 2008). This same study concluded that Black women had significantly higher odds of ever having experienced infertility, even after adjustment for socioeconomic position, marital status, and other risk factors for infertility (Wellons et al., 2008). Not only do Black women experience infertility at higher rates, but they also wait longer to seek treatment (Jain, 2006). Black women also suffer higher rates of many gynecological and hormonal conditions that affect reproductive health such as polycystic ovarian syndrome (PCOS) and uterine fibroids, with earlier onset, and more severe symptoms (Baird et al., 2003). While there is evidence that many of the adverse health outcomes for Black women remain across socioeconomic status and irrespective of access to treatment, there is no clear association between infertility and education or poverty-level income (Chandra & Stephen, 2013).

Within much of Black culture, many families hold “traditional” values and views on family. Being a parent is a central aspect of African American[1] family life, and many Black families tend to highly value children (Hill, 2001). Traditionally, a family’s esteem and worth are often related to the presence of children (Logan 2001). Because having children/being a mother is valued, women without children may feel left out and de-valued because they are not considered mothers by society’s standards. When faced with fertility challenges, while one study (Wellons et al., 2008) found that 48% of Black women self- identified as infertile, the CDC (2014) reports that only

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[1] Black or Black American is the author's preferred term to refer to those of African descent in the United States and globally, however, African American is used interchangeably in this writing when referencing or quoting the works of others.

eight percent (8%) of Black women seek infertility treatment. One of the few studies examining the experiences of Black women found that when African American women cannot conceive a child, it harms their sense of self, in relation to both their gender and racial identities (Ceballo et al., 2015).

There are many significant, interrelated aspects of fertility and reproductive health related to this research inquiry that will not be explored in depth in this study. These issues include lack of access to infertility treatment for women of lower socioeconomic status, insurance coverage of infertility for the insured, reproduction and family building for sexual and gender diverse individuals and couples, and stratified reproduction. Stratified reproduction is the hierarchical organization of reproductive health, fecundity, birth experiences, and child-rearing that supports and rewards the maternity of some women, while despising or outlawing the mother-work of others (Riley & Brunson, 2018). Though stratified reproduction is closely connected to race, class and medical access, a deep dive into this concept and other topics are beyond the scope of this research. For the purposes of this research inquiry, the focus will be on the lived experiences of middle/upper-income Black women facing fertility challenges in order to keep the work concise and focused. Centering the experiences of middle- and upper-income Black women highlights a marginalized population (Black women), who are also in a privileged socioeconomic class, a group of women whose experiences are not often explored.

Considering the above, this work seeks to highlight the gender, racial/ethnic, cultural, and emotional experiences of Black women as they negotiate familial aspirations and challenges. This research aims to contribute to the family science literature by expanding our understanding of fertility challenges for middle/upper-income Black women and families. As such the following research question will be explored: *How do middle/ upper-income Black women navigate familial and cultural positions when faced with fertility challenges?*

Chapter 2

LITERATURE REVIEW

Until recently, much of the research regarding infertility has been medical in scope, with some psychological and psychosocial works. Within the last 15-20 years, there has been an increase in research concerning the psychological and psychosocial aspects of infertility. Previous research focused on psychosocial *responses* to assisted reproductive technologies (ART) and less on the experience of involuntary childlessness or 'disrupted reproduction,' and its effect on the lives of individuals and couples (Covington & Burns, 2006). Examining the experience of infertility is important in understanding how this diagnosis impacts families, including one's individual development and familial relationships. However, there is a gap in the literature, particularly in the United States, when examining the infertility experiences of racially and ethnically marginalized women. Available research in the United States often uses samples that are majority, if not completely White women, and White women who are middle income and above; specifically, leaving out those who are White with lower socioeconomic standing. Several studies conducted in the United States acknowledge this limitation, noting their study participants were "all Caucasian" (Parry, 2005, p. 279), that "participants were predominantly of white background" (Slade et al., 2007 p. 2311), or that "the sample was composed primarily of White college-educated women in their late 30s or 40s" (Myers, 2017, p.783). These studies also acknowledge the lack of diversity among study participants may

ultimately affect their findings. Further, Myers (2017) acknowledges that "while the homogeneity of the sample allows within-group variation to emerge more clearly, it also limits conclusions that can be drawn" (p.786). This lack of diversity further warrants the need to expand our understanding of fertility beyond primarily White women, to include the challenges, experiences and familial dynamics of Black women facing infertility.

Globally, infertility research (Galhardo, 2015; Koropeckyj-Cox & Copur, 2015; Matsubayashi et al, 2001; Remennick 2000) is conducted in countries with a homogenous cultural and racial population, also primarily sampling women who are middle income and above. Though the existing works focus on a narrow sample, it is likely that some past findings regarding women and infertility, such as anxiety, depression, grief, guilt, and lower self-esteem, would be present in the experiences of Black women diagnosed with infertility, as the desire to parent is not exclusive to women of any particular race or culture. However, given the individuals' varied experiences in the U.S. based on racial and economic stratification, this is an area worth investigation. There are very few peer-reviewed research articles specifically focused on Black women and infertility. Among the first was Ceballo and colleagues' (2015) examination of the infertility experiences of Black women in the United States. Some more recent works by Dana-Ain Davis (2014, 2019, 2020), Tina Sacks (2018), and others examine Black women's experiences in the medical system generally, and obstetric and maternal healthcare experiences of Black women more specifically,

which Davis has expanded to include ART. There are other related works done by Camisha Russell (2015, 2018, 2022), which examine race in reproductive biomedicine. Several key findings of the Ceballo et al. (2015) study include the greatly impaired sense of self, and gender identity associated with infertility for women in the study. In line with the recommendations outlined by Ceballo, et. al (2015), I also undertake this research to normalize conversations around and awareness of Black women's infertility experiences.

The Black Family in the Literature

Research and concepts of Black families are often framed in one of three perspectives: a cultural deviant perspective in which Black families are viewed as pathological; a cultural equivalent perspective, in which Black families are viewed as legitimate to the extent that their lifestyle is consistent with that of White families; and a cultural variant perspective, in which Black families are considered as functional and as uniquely different from White families (Hollingsworth, 2013; Willie and Reddick 2010).

From a cultural deviant lens, Black families were cast as non-existent, fragmented, or deficient (Moynihan, 1965). The prevailing thought was that the experience of slavery destroyed family structure and accounted for the "failure" of Black families (Willie & Reddick, 2010). A commonly cited report, *The Negro Family: The Case For National Action*, often referred to as the Moynihan Report, noted "the fundamental problem... is that of family structure" (Moynihan, 1965 p.i).

This report claimed that Black fathers were not present, which contributed to the creation of a matriarchal structure within many Black households and communities. This negative framing significantly informed the narrative regarding the "deterioration" of Black society (Moynihan, 1965). These ideas continue to linger, often shaping research surrounding Black families. Several studies in the immediate years following the Moynihan Report, including Warren Tenhouten's 1970 study of Black and White families which concluded that "the data from the empirical study do not show lower-class black husbands to be powerless in either their conjugal or their parental roles" (Tenhouten, 1970, pp.70). Black scholars specifically in the decades following the Moynihan Report criticized the "inordinate focus on poor, single-mother families as perpetuating a distorted, stereotypical image of the 'typical' black family" (Hill, 2005, p.64). These researchers began to take an asset-framing, cultural variant approach, with the aim of challenging negative stereotypes of Black families by noting their strength and diversity (Logan 2001), and by highlighting characteristics such as gender role flexibility, resiliency and adaptivity. In fact, Willie and Reddick (2010) determined that Black middle-class, working-class and low-income families operate as egalitarian families, where the husband and wife make decisions for the family as a unit. Further, some researchers recognized that many enslaved families living on plantations were composed of two parents (Hill, 2005).

However, the idea of enslaved nuclear families has been challenged, not due to its inaccuracy or the rarity of the occurrence, but because it reinforces dominant cultural norms, and inadvertently sanitizes the slavery experience. Hill (2005) noted,

“the notion that Black people managed to maintain a reasonable semblance of the two-parent family during slavery produced a monolithic picture of the Black family” (p.68). However, the concept of a nuclear family did not, and does not mirror the reality for many families (Vereen, 2007), and holds Black families to a standard many other racial/ethnic families do not uphold.

Past examinations of Black families identified various living arrangements, including having multiple generations in a home, strengthening the belief that family structure is not as critical to psychosocial outcomes as quality time, and support (Vereen, 2007). A recent study confirms this concept, with the finding that African Americans routinely interacted with members of their family, displayed a high degree of family closeness, and exchanged support fairly frequently (Taylor et al., 2021).

Much of the research regarding Black families and individuals focuses on those in lower socioeconomic tiers (Burton 1999, 2010; Jarrett, 1994, 1997, 2012, etc.), which does not give a full perspective of Black existence. This has been true for decades, as Dill (1979) proclaims, “Too often, social science researchers have sought to describe black women and their families as if they were a monolithic whole, without regard for differences in social class. In other words, social science has generally supported the notion that Afro-American culture is synonymous with lower class culture and that it disappears as black Americans gain middle class” (p.551). Given that much of the literature on Black families and women tends to focus on single, low-income, female headed households, this research aims to challenge and

expand said narratives, focusing on the experiences of middle and upper-income Black families.

Black family and social science theorists and scholars such as Logan (2001) believe that several of the structures and values of West African familial traditions, such as strong kinship bonds, collective parenting, pride, and high value on children survived through enslavement. Current examinations have found that Black Americans rely on collective community efforts and kin networks to support the educational and social advancement of their children (Carey, 2016, 2018), manage life problems, and maneuver stressors related to competing work and family demands (Council, 2021). Black American family systems can be thought of as African in nature and American in nurture (Nobles, 1974), and these African-derived ideas also laid the foundation for the rules of a distinctive Black American civil society (Collins, 2000).

Examining the perspectives and experiences of family building within Black families that have adopted or internalized familial norms that value children or see children as "necessary" to the family building process, will add yet another facet of understanding to the nuances and intricacies of Black family and culture. In the context of a family-centered culture, having difficulty conceiving or living as involuntarily childfree may have a major impact on Black women's self-esteem, relationships, and levels of stress.

Psychosocial Impacts of Infertility and Stress

The literature that is available regarding psychological/emotional aspects of fertility such as self-concept, depression, stress, and feelings of a loss of control are varied, with some findings indicating a direct link between the experience of infertility and negative feelings about self, and how one is perceived by others (Galhardo et al., 2013). Past inquiries have established that the inability to reproduce naturally can spur on shame, guilt, and low self-esteem. These negative feelings may lead to varying degrees of depression, anxiety, distress, and a poor quality of life (Rooney & Domar, 2018). A 2011 study of Portuguese women noted that overall, infertile individuals showed higher correlations between depressive symptoms, and see themselves as existing in the minds of others as someone with negative characteristics, such as being unattractive, worthless, defective, or inferior (Galhardo et al., 2013). These individuals also perceived themselves negatively as inadequate, different, unlovable, and unworthy (Galhardo et al., 2011).

Individuals facing infertility also cope with grief and loss. Research shows that when a couple experiences infertility, it is common for them to pass through all the known stages of grief and mourning (e.g., state of shock, denial, anger, isolation, and finally acceptance; Patel et al., 2016). The feelings of grief and loss can include a sense of loss for physical and mental health, life goals and status, changes in relationships, and the loss of control. Infertility involves grief and loss whether it is a

profound distinct loss at the onset of treatment or a gradual accumulation of losses over time (Covington & Burns, 2006).

There are also multiple levels of stress that accompany an infertility diagnosis, including managing treatment, and relationships. Galhardo, Pinto-Gouveia, Cunha, and Matos (2011), found that infertility and its treatment are stress-inducing conditions. Another study found that because infertility is “unanticipated, may be unexplained, and lasts for an indeterminate length of time, infertility creates overwhelming stress and tests normal coping mechanisms” (Whiteford & Gonzalez, 1995 p.28). A 2016 study found that infertility specific stress in women is related to the age at diagnosis, duration of infertility, cause of infertility, repeated pregnancy tests, treatment failures, psychiatric morbidity, coping abilities, social support, stigma, and psychological interventions received (Patel et al., 2016). Patel and colleagues also found that infertility-specific stress in women was less when a diagnosis of male factor infertility was made. Further, women with an infertile husband may perceive the need to protect their partner from the even greater stigma associated with male sexual dysfunction, with women less concerned about their own personal "inadequacy" (Miall, 1986). Findings from a 2011 study by Galhardo et al., indicate that age, length of time with an infertility diagnosis, number of treatments (successful or unsuccessful), and financial position have little to no influence on the feelings experienced by these women.

Stigma and Infertility

The existing literature addresses stigma as it relates to infertility and how infertility can affect an individual's navigation through relationships, as well as how individuals might relate to themselves. The inability to fulfill the expectations of normative gender roles is often seen as not "normal," creating stigmatization (Panggabean, 2016). Social stigma is a social process supported by power that distinguishes people based on social statuses and results in social devaluation (Major, 2018). It is noted as well that expectations and experiences of stigmatization can be stressful, and stigma-related stressors can undermine mental and physical health (Chaudoir et al., 2013). Infertility counseling literature has referred to infertility as "a universally stigmatizing condition" (Hynie and Burns 2001 p.61). Whiteford and Gonzalez (1995) refer to infertility as "a secret stigma, distinguished from more obvious examples of stigmatization because it is invisible" (p.28). Individuals who struggle with fertility would be classified as discreditable, as people whose stigma is concealable (Goffman, 1963). Those dealing with infertility may anticipate stigma from others, which may lead them to isolate from others. Because infertility is not obvious, those affected must decide to disclose their status and potentially face stigmatization. Unlike an obvious physical disability, infertility does not have external manifestations and can be uncovered only through disclosure (Remennick, 2001).

A study of Turkish (Ergin et al., 2018) men and women who had difficulty conceiving found that 44% of participants hid their status from those in their

community due in part for fear of social stigma. Additionally, 38% of participants feared social exclusion; in female participants, the rate was 43%. Another study found that women reported higher levels of fertility-related stigma than men and were more at risk of being stigmatized for fertility difficulties, however, women reported greater disclosure than men (Slade et al., 2007). This same study also posited that stigma would be associated with reduced disclosure rates. Existing literature has found that feeling supported influenced women's comfort in disclosing their status and the disclosure of infertility most therapeutic when done with other infertile couples (Miall, 1986). Similar patterns were found with Black women, with the possibility of cultural factors contributing to their silence. Ceballo, et. al. (2015) found some Black women viewed their silence about reproductive difficulties as supporting racial solidarity by hiding their own personal vulnerabilities from public view (Ceballo et al., 2015). Culturally, these women learned expectations about privacy, and keeping private matters "private" provides a means of protection from authority figures and people outside the community who may be unlikely to understand how African American families negotiate survival. Other work regarding stigma concluded that having a concealable stigma can trade off better social interactions, at the expense of greater cognitive detriments (Chaudoir et al., 2013).

Stigma associated with infertility that has been cited in some literature regarding Black American and African cultures is that of a childfree or infertile woman not being fully recognized by her community as a woman. Findings from a

study of Black South Africans found a primary stigmatizing theme to be that infertile women could not achieve adulthood status (Mabasa, n.d.). This is fitting with the cultural finding that African American communities often assign adult status to women who become biological mothers (Collins 2002). Both findings center around the ways in which womanhood is attached to or synonymous with motherhood in both Black American and many African cultures.

Stigma is noted as being a vehicle for maintaining social norms and power. As Remennick (2001) noted in her study of infertile Israeli women, internalized stigma as a psychological state is only possible when its carriers adopt mainstream social definitions of the norm; this is especially true about hidden conditions (Remennick, 2001). In this view, childlessness can be seen as an act of resistance, particularly for women, where one can regain control of their place in society and family and decrease or eliminate self-stigma. In this way women, specifically Black women in this instance, can take control of their own narrative regarding reproduction and mothering. As expressed by Patricia Hill Collins (2000), Black women's agency becomes important in determining what a Black women's standpoint on motherhood will be.

Pronatalism

One key concept or ideology to understanding the heartbreak that comes with an infertility diagnosis is the concept of pronatalism. Pronatalist ideology embodies the belief that a person's social value is linked to procreation (Parry, 2005). While

pronatalist ideology is believed to impact all adults, women in particular, are the most affected by its assertions (Parry, 2005). The United States is a pronatalist society in ideology, even if not fully in policy. The negative perceptions of involuntary childlessness are undoubtedly related to the pronatalist views of marriage that pervade Western society's endorsement of the fertility norms of having and wanting children, and transcends sex, age, race, religion, ethnic, and social class divisions in North America (Miall, 1986). In a country with pronatalist ideals or policies, a person's social value is linked to reproduction and parenting. The commitment to parenthood in western society has been attributed, in part, to the Judeo-Christian tradition, which sees children as blessings from heaven and barrenness as a curse or punishment (Miall, 1994). Simply put, infertility goes against the mainstream pronatalist definition of what it means to be a woman (Bell, 2019). Even as Western society evolves, under a pronatalist ideology, a woman's social worth is inextricably linked to her ability to achieve biological motherhood (Parry, 2005).

Motherhood and Back Fertility Mandates

As previously discussed, in a pronatalist society, a woman's (and to a lesser extent, a man's) value and place in society is based on childbearing. This societal view creates a space for what is characterized as the Motherhood Mandate (Parry, 2005). The Motherhood Mandate, a term created by Nancy Russo, is characterized in the form of a mandate which requires having at least two children and raising them well (Russo, 1976). Essentially, motherhood is a central part of womanhood, and all

women should be mothers, and it is expected for women to conform to this expectation to be legitimized in society. The Motherhood Mandate is a common theme found in infertility literature when examining the role of gender and a woman's standing in society. Those who subscribe to the Motherhood Mandate can view having no children as a deficient condition (Russo, 1976). The literature on infertility that utilizes the motherhood mandate, notes often that the expectations tied to fertility are based in biology and enforced through sociocultural norms and institutions. A 2019 investigation of infertility experiences of diverse women found that the Motherhood Mandate leaves women who struggle with fertility, as well as those who choose not to mother outside of the accepted norms. For these women, it is not just motherhood but the ability to become mothers, through reproductive capacity and procreation, that is tied into their identities as women. When they are unable to achieve this, they feel like they are "failing" at womanhood (Bell, 2019).

The Black Fertility Mandate is a theme and term that emerged from the 2015 research by Ceballo, Graham, and Hart in their examination of Black women and infertility. The Black fertility mandate is the belief in ubiquitous Black fertility (Ceballo et al., 2015). While this belief runs parallel to the motherhood mandate, it is also anchored in deep-rooted stereotypes around Black (hyper) fertility myths and stereotypes, as well as cultural messages around mothering and what constitutes a "good" woman or mother. Dating back to slavery, there has been a notion that Black women are naturally fertile and sexual. This notion is rooted in the Jezebel image as applied to Black women, a character in the Bible seen as a violent and whorish woman

in the book of Kings (Collins 2004). It commonly manifests as the belief that infertility is a condition experienced by White women and not a concern for Black women. The Ceballo, et. al. (2015) study found that the concept of the Black fertility myth was discussed by Black women across all social class groups. The same study also found that for many participants, motherhood was equated with being a ‘‘good’’ Black woman as well as a “good” Black wife, and for some women, biological reproduction was a social imperative mandated by norms consistent with their gender, race, and religious identities (Ceballo et al., 2015). As a one Black woman participant of another study noted “That’s what we do…to have kids was just the norm” (Bell, 2019, p.58).

Motherhood/Mothering in Black Culture

Aligned with past characterizations of the Black family, the image of Black women has been shaped by past negative portrayals in early popular culture, such as minstrel shows, and reinforced in past academic work rooted in deficit ideologies (Hill, 2001). Black women have not been able to exist with nuance. Instead, they have been relegated to roles inclusive of the selfless, faithful, obedient, sassy mammy; the domineering, aggressive, and emasculating sapphire (Collins 2000); and Jezebel, an image that constructs Black women as having voracious sexual desires (Windsor et al., 2011). All of these images are in line with the narrative that “Negro women were already accustomed to playing the dominant role in family and marriage relations” (Moynihan 1965, p.17). Other characterizations include that of a welfare queen, a

woman that is a lazy, unwed, negligent mother, who games the welfare system; and the crack whore—women who will do anything to get their drugs especially trading sex (Windsor et al., 2011). The common use of these images in media and popular culture contributes to the biases that influence policy, opportunities, and perceptions affecting Black women. Throughout the research literature, in media and everyday discourse, Black women have been conceptualized as either bad mothers, unfit, uncaring, immoral, or inadequate (Ceballo et al., 2015), or as self-sacrificing "mammies" (Collins 2000).

However, Black women experience motherhood and womanhood very differently than what is typically portrayed in dominant culture. The existing literature establishes that in Black culture, considerable significance and honor is given to mothers by peers, elders, and her children (Logan, 2001). Hill (2005) calls this the Black cultural ethos of motherhood and observes that it "tends to valorize African American mothers as tough, competent, who excel at the work of raising children" (p.135).

Often, becoming a mother is one of the most significant personal and social identities for many Black women (Chaney & Brown, 2015). This reverence for motherhood can be seen culturally, in popular music, where Black male artists use positive terms such as "Queen," "Good Woman," and "Strong Sista" to describe their mothers (Chaney & Brown, 2015). In addition, the many hip hop and R&B songs dedicated to the love and strength of mothers, such as "I'll Always Love My Mama" by The Intruders, "Dear Mama" by Tupac, and "Mama" by Boyz II Men; and to

motherhood by women, including “To Zion” by Ms. Lauryn Hill and “Thanks for My Child” by Cheryl “Pepsii”-Riley. Cultural narratives that highlight fertility, giving birth, and mothering are also very prominent in Black culture, reflecting motherhood as a symbol of power, evident in song lyrics such as “We birth Kings. We birth tribes” (Knowles-Carter, Dixie, King, 2020).

Motherhood is seen as a significant marker of womanhood (Hill, 2009) within Black culture. In Cassandra Chaney’s 2011 study of African American women’s perceptions of womanhood, themes related to mothering emerged often, with responses such as “being able to raise her family in an orderly fashion” as part of the definition of womanhood and noting a part of showing womanhood is when “women takes care of the children” (Chaney, 2011 p.524). There is some growing pushback among certain Black scholars on motherhood and the “strong Black woman/mother” trope as cultural identities of Black women, noting that this cultural construction of Black womanhood merely inverts and remixes derogatory stereotypes (Hill, 2009). In the case of Black cultural ethos of motherhood, the implication that Black women have an innate ability to mother can also be problematic (Hill, 2005).

Past characterizations in research and public discourse of Black women have consistently shown that there is a prevailing stereotype externally that African American women, as a group, are overly assertive, independent, and difficult to get along with, essentially overbearing, and attitudinal (Chaney, 2011). However, within Black culture, women’s innovative and practical approaches to mothering fosters admiration, and can create a sense of empowerment (Hill Collins, 2000). Black

women and mothers have been negatively framed within the dominant culture, creating a narrative that further marginalizes and limits these women. However, Black motherhood is a position that is highly respected in the Black family and has historically been an important demonstration of Black womanhood. Given the significance of the Black cultural ethos of motherhood, the goal of this inquiry is to investigate where a woman who struggles with her fertility, or even one who chooses not to mother fits into the community and culture. How can she fully participate in and be respected when what is seen as a key aspect of womanhood is elusive?

Chapter 3

THEORETICAL FRAMEWORKS

To anchor this research, life course theory (life course perspective) (Bengtson & Allen, 1993) alongside Black feminist theory (Combahee River Collective, 1977; Collins 2000; hooks, 1981) as an intersectional approach to understanding the infertility experiences of Black women were utilized. Intersectionality, a term first used by Kimberlee Crenshaw in 1989, describes how multiple oppressions are experienced, and as a way to analyze interlocking systems of privilege and oppression (Aguayo-Romero, 2021). Intersectionality can be defined as multiple, interconnected layers of existence and identity, and seen as a framework for contemplating being in the world and being with others (Gines 2011 p.275). Family studies scholar April Few Demo advocates for the integration of critical theories and an intersectional approach in family studies research. She encourages the use of critical and multiethnic theories to broaden the explanatory power of traditional family theories (Few, 2007), further encouraging the use of intersectionality and intersectional analysis as the future of mainstream family science (Few-Demo, 2014). Few-Demo (2014) conceptualizes intersectionality as a theoretical framework that guides methodological considerations and data interpretation. Use of these methodologies will provide a more comprehensive and complex understanding of the infertility experiences and perspectives of Black women.

Life Course Theory

The aim of life course theory is to understand the multiple factors that shape people's lives from birth to death, placing individual and family development within a cultural and historical context (Levesque, 2011). The utilization of life course theory allows for the exploration of the individual experiences as well as within a family group. Life Course Theory emphasizes the social creation of meanings attached to family roles (Umberson et al., 2010). Family roles are a key component of understanding an experience navigating family relationships. The family consists of interacting personalities, dynamics, and develops over time; the behaviors, needs, and various career trajectories are contingent upon-and sometimes in conflict with-others in their family (Bengtson & Allen, 1993). Life course theory consists of five broad concepts: cohorts, transition, trajectory, life events, and turning points**.**

A **Cohort** is defined as a group of people who were born during the same historical time period and who experience particular social changes within a given culture in the same sequence and at the same age. Cohorts can be different sizes, and vary across societies (Levesque, 2011). The concept of **Transition** proposes that each person experiences several transitions, or changes in roles and statuses that represent a marked departure from prior roles and statuses. Many transitions are related to family life (marriages, births, divorces, deaths, etc.), and each transition is accompanied by family member exits and entrances (Hutchison, n.d.). **Trajectory** involves long-term

patterns of stability and change in a person's life, which often involve multiple transitions (Levesque, 2011). A **Life Event** is a significant occurrence involving a relatively abrupt change that may produce serious and/or long-lasting effects (Levesque, 2011). The final concept, **Turning Point,** can be defined as a major life event or transition that produces a lasting shift in the life course trajectory. This event serves as a lasting change. In this view there are three types of life events that can serve as turning points: (a) life events that either close or open opportunities; (b) life events that make a lasting change on the person's environment; and (c) life events that change a person's self-concept, beliefs, or expectations (Hutchison, n.d.).

Additionally, there are four interrelated themes: interplay of human lives and historical time, timing of lives, linked or interdependent lives, and human agency in making choices, along with two emerging themes, diversity in life course trajectories and developmental risk and protection (Hutchison, n.d.). **Interplay of Human Lives** and historical time notes that people born at different times face different historical worlds, with different options and constraints. This is particularly true for societies with rapid change. This theme is related to the cohort effect concept (Hutchison, n.d.). The **Timing of Lives** refers to the age at which specific life events and transitions occur, and the focus on particular roles and behaviors are associated with particular age groups, based on biology (Levesque, 2011). In most Western societies, the life course is at least partially age-differentiated, with social roles on the basis of age or life period (Mortimer, 2004). In this theme, age is categorized in three ways:

biological, psychological, and social. *Biological age* is used to indicate a person's level of biological development and physical health. *Psychological age* relates to the capacities one has, and the skills they use to adapt to changing biological and environmental demands. This includes concepts such as learning, intelligence, and motivation. Lastly, *social age* refers to the age-graded roles and behaviors expected by society, the socially constructed meaning of various ages (Hutchison, n.d.).

Linked or interdependent lives highlights how human lives are interdependent and describes the ways in which people are reciprocally connected on various levels. The family is the primary arena for experiencing and interpreting wider historical, cultural, and social phenomena. The final theme, **Human agency in making choices** refers to individuals constructing their own life course through the choices they make (Mortimer, 2004). In recent years, two additional themes have been added to life course; *diversity in life course trajectories*, which examines variability within cohort groups, *and developmental risk and protection*, which emphasizes the links between the life events and transitions of childhood, adolescence, and adulthood (Levesque, 2011)

In examining the infertility experience of women in this study, the concepts of transition, turning point and human agency will be applied. A diagnosis of infertility as a turning point in the life course; an event that changes a person's self-concept, beliefs, or expectations (Levesque, 2011). There is ample evidence in the existing infertility literature that infertility affects a woman's self-concept among other things.

Infertility is an event that could close the door of parenting, or could be experienced as an open door to explore new ways of experiencing family–reflecting a transition or adjustment to one's family development. The concept of agency considers individuals as active agents in interaction with social contexts and structures (Umberson et al., 2010) and speaks to decision-making when deciding on treatment protocol, in attempts to take control over her life trajectory. An infertility diagnosis may limit a woman's sense of agency over her life, leaving her to feel out of control and helpless. This research is most interested in how women cope with, make meaning of, or reconcile their infertility diagnosis, including their turning points, transitions and human agency.

Black Feminist Theory

As a critical social theory, Black feminist thought or consciousness, is the recognition that Black women are status deprived because they face discrimination based on both their race and gender (Simien, 2004; Hill-Collins, 2019). Black Feminist Theory is also the shared belief that Black women are inherently valuable (Combahee River Collective, 1977) and aims to speak to the experiences of Black women collectively across the African diaspora (Few, 2007). Through the paradigm of Black feminist thought, Black women, have the ability to create their own ideas about the meaning of Black womanhood through their collective lived experiences (Collins, 2000). Incorporating Black feminist theory allows for the explanation of behavioral

motivations rooted in unique cultural factors while examining the "collective voice" of Black women (Few, 2007).

A key concept in Black feminist thought is that of "other mothers" (othermothers), women who assist bloodmothers (biological mothers) by sharing mothering responsibilities (Collins, 2000). Othermothers can be conceptualized as women-centered extended kin and fictive kin networks, which can include, grandmothers, aunts, sisters, cousins, godmothers, and "aunties" (Collins, 2000). Othermothers also exist as a community concept, as those who advocate and care for those in the community, seeing all Black children as their children. This has spurred some Black women to become social activists and is associated with the "mothering the mind" relationships that may develop between Black women teachers and their Black students (Collins, 2000).

The voices and images of Black women have been silenced or controlled by both White and Black men as well as White feminists, often by exclusion through the "pattern of suppression by omission" (Collins 2000, p.7). It is important to highlight and explore how Black women define their own experiences and relationships within their own cultural framework. Few-Demo (2007) notes in her advocacy for intersectional and critical work in family studies, that "conducting research on Black women that does not acknowledge our intersecting subjectivities results in the essential erasure of our diverse within-group experiences" (p.463). Because clarifying Black women's experiences and ideas is a fundamental aspect of Black feminist

consciousness (Collins, 2000), intersectional work through a Black feminist perspective should be tailored to collect culturally relevant information when Black women are the subjects, because the personal, historical, and familial experiences of Black women are different (Chaney, 2011). In Evelyn Simien's exploration of Black feminist thought, she argues that "using survey items designed for White women results in a measurement of support for White feminism among black women–not black feminist consciousness" (Simien, 2004, p.86). General questionnaires do not take into account any cultural differences or nuance of experience, and therefore may miss key experiences and feelings when applied to non-White populations. This has been the case in the past as it relates to infertility-focused research, where Black women and other women of color have been excluded or nominally included in samples, and researchers are left to make inferences based on little to no data, or not include the experience at all. A prime example of this is the 2012 Loftus and Andriot study with a sample of midwestern, White women. The team asserted that "It might reasonably be argued that this is a largely White, Midwestern and heterosexual phenomenon", and "It is quite possible then that experiences presented here are unique to White women" (Loftus & Andriot, 2012, p.241), while also acknowledging that there is a need for more diverse research on the infertility experiences of women of color. When Black women, and other women of color have been included in past infertility research, the questions are not relevant or specific to the unique experiences of the women who sit at the intersection of three marginalized statuses: woman, Black,

and infertile. Centering the voices of Black women can serve to inform approaches and practices that best support their concerns and needs.

This study aims to center the perspectives of Black women's experiences and meaning making related to infertility, from a Black woman, to add to the discourse on family building, infertility, and familial relationships within Black families and communities. This work also seeks to create space for a more nuanced discourse within Black feminist thought as it relates to the field of family sciences.

Chapter 4

METHODOLOGY

This study explores the lived experiences of Black, middle-income women who struggle with their fertility; uncovering how they make meaning of family, womanhood, and their navigation of familial relationships. Because the aim of this inquiry is to better understand the experiences of this group, a qualitative research design was most fitting, taking a phenomenological approach (Merriam &Tisdell, 2016). Qualitative research is the process of inquiring into, documenting, and interpreting the meaning-making process (Patton 2015), with the aim of understanding an experience. The goal of phenomenology as a qualitative method and methodology is to gain understanding of the essence of the lived experience (Byrne, 2001). This qualitative inquiry is an attempt to draw meaning from and conceptualize the experiences of infertility expressed by participants in this sample and begin to make inferences and connections to the broader experience of Black women facing infertility.

Qualitative research methods include case studies, interviews, field observations, content analysis, ethnographies, action research, and focus groups as ways to collect data (Patton 2015). Each approach has value and can best be determined depending on the research question and goals of the study. Ethnographies aim to understand and examine a culture and how the culture influences behavior. Content analysis, an examination of texts and other communications, can be applied to

many forms of communication, including written documents, websites and blogs, video, and photographs. Action research is conducted with the goal of creating social changes, and focus groups, which are defined as an interview with a small group of people on a specific, targeted topic or topics (Patton, 2015).

Qualitative inquiries can be valuable tools in gaining an understanding into how people interpret their experiences, and what meaning they attribute to said experiences (Merriam &Tisdell, 2016), which is why it is the best fitting design frame for this study. Specifically, a focus group was conducted to capture the perspectives, experiences and meaning making of Black women who are currently or have in the recent past experienced infertility. The focus group was led by the PI of this research, serving as a moderator to facilitate the group by posing open ended questions, facilitating discussion, and encouraging participants to reflect on, and unpack their experiences, thoughts, and opinions on the topic of infertility among Black, middle-income women.

Participants

Women participating in this study met the following criteria:

1. *Identify as a heterosexual, cis-gendered, Black woman and reside within the United States.*

   Because same-sex and transgender couples and individuals likely face additional or separate challenges and stigma in navigating family and culture, the focus was on those who are cis gendered women who are single or in a

heterosexual partnership. Additionally, Black is meant to encompass women of the African diaspora residing in the US, including participants whose culture is not exclusively American, which includes mixed-race Black identifying women, Afro-Latina women, and women who have emigrated from Africa, the Caribbean, or any other region with a Black/African population. A recent study compiled by the Pew Research Center states that the Black population in the United States is diverse with varied ethnic and racial identities reflective of intermarriage and international migration (Tamir, 2021).

2. *Between the ages of 25-45*

Agencies of the Federal Government use the age range of 15-44 when looking at fertility and measures for women. For the purposes of this study, the focus was women 25-45 years old, an age range where women are likely to be establishing themselves or are established in their career and are likely to be considering expanding their family. In many of the referenced studies, the average noted mean age of participants was 36. While women over 45 do become pregnant naturally or through the use of ARTs, this group may have additional considerations and stigma due to age, which are not factors being explored in this inquiry.

3. *Participant or partner has been medically diagnosed with infertility (dealing with either male and female or female factor), not medically sterile, AND dealing with primary infertility.*

It has been established that infertility affects both men and women, and it has also been established that women are questioned more often about not having children, and

it is often assumed that if there is any difficulty becoming pregnant, it is due to female factors. For the purposes of this study, cases where the male was the sole factor were not considered because this scenario may create other experiences and feelings.

Couples or individuals experiencing primary infertility, when a pregnancy has never been achieved, are desired because they have not attained parenthood and the stigma could be experienced more acutely. Those who experience secondary infertility, having at least one prior pregnancy or live birth, likely have experiences that differ from those who have never experienced pregnancy or are not currently parents. This is not to diminish the emotional toll this may take on women, however for the purpose of this research, the focus will be on those experiencing primary infertility.

4. *Annual income of $42,00-$70,000 single, and $60,000-$100,000 (+) partnered*

The focus on middle-income Black women is not intended to be elitist, classist, or reinforce any notions that Black middle and upper-income families are separate or of more value or moral standing. It is meant to contribute to the discourse on the diversity of lived experiences of Black people in the United States. While Black people certainly exist in lower socioeconomic spaces, and disproportionately so, and it is crucial to examine the effects of systemic injustices and systems impacting the physical, social, and mental well-being of those most affected, it is also important to expand the lens of research of Black experiences and Black middle-income families because it counters the narrative that all Black people are low income and broadens

the lens of the Black experience in America. Additionally, women who exist in a lower SES space are often not in a financial position to make any attempts to remedy their infertility via ART. Bell (2014) notes, "women of low SES can literally not afford to focus on something they are unable to resolve" (p.119). This could be an additional stressor and create another experience for these women. The income range was determined by available data on what is considered middle class by household income. The median income in the United States for 2019 was $62,843. For a Black family in 2019, it was $43,862 (*Census - Table Results*, n.d.)

5. *Medical insurance that covers at least a portion of fertility treatment costs*

Women with at least partial insurance coverage for infertility services are more likely to utilize the options available. A 2006 study found that complete insurance coverage for IVF in the United States was associated with a rate of utilization that was 277% of the rate in the absence of coverage (Jain, 2006).

6. *Has undergone a treatment protocol in the last 5 years.*

Actively pursuing pregnancy is a sign that parenting is desired. Someone who is diagnosed but does not have the desire to become a mother would not make the investment in pursuing pregnancy with medical interventions, and therefore would not be ideal for the sample of this inquiry. Treatment included but was not limited to, IVF, IUI, timed intercourse, diet changes, and hormonal supplements.

Participants were recruited through a flyer (Appendix B) posted in various online spaces for Black women and women of color generally, such as Black Greek Letter Organizations or Black sorority (Divine Nine) spaces, and support spaces for women of color in graduate school, as well as private, online spaces for Black women and women of color specifically focused on infertility, and an African-American Adoption group on Facebook. The flyer was also shared to Instagram anonymously and was reshared by several accounts. The flyer was also shared with the peer-leaders of a national infertility support group for Black women to share with their respective groups across the country. Women who responded to the flyer completed a brief survey to determine their eligibility for participation in the study. A total of 37 women completed the initial survey for participation. Of that 37, 25 women met the criteria to participate in the study and were emailed an invitation to participate in the study and were also provided an informed consent form (Appendix C). Ultimately, 12 women completed the informed consent form, and demographic survey required to participate. While 12 women completed the required paperwork to participate, only 11 women participated in the focus group, as one potential participant did not attend the focus group. The "no-show" participant's responses were removed from the aggregate demographic data to accurately reflect the sample.

The sample for this study consisted of eleven women in various locations across the United States, all of whom identified as cis-gendered, heterosexual

Black/African-American women, with two participants noting additional cultural heritage; one Caribbean and one African; their specific countries of origin were not specified. The average age of the participants was 37 years, with the oldest participant being 43 years old, and the youngest 29. None of the women in the sample had biological, or stepchildren, though one participant was a mother of two through adoption. Further participant information is listed in Table 1.

Table 1

Participant Demographics

Pseudonym	Age	Relationship Status	Number of Protocols	Fertility Challenges Diagnosed As	Annual Household Income
			Focus Group 1		
Jill	40	Married	1-3	Male & Female	$100,000- $129,999
Toni	39	Long Term Relationship	Haven't started	Male & Female	$100,000- $129,999
Keisha	38	Single	4-6	Female	$40,000- $69,999
Nia	41	Married	1-3	Female	$200,000+
Andrea	34	Married	4-6	Male &Female	$70,000- $99,999
			Focus Group 2		
Michelle	36	Married	1-3	Female	$200,000+
Erica	42	Married	1-3	Female	$40,000- $69,999
Jada	43	Married	4-6	Female	$160,000-$189,999
Faith	29	Married	4-6	Female	$100,000- $129,999
Shauna	33	Married	1-3	Female	$70,000- $99,999
Kim	32	Married	1-3	Female	$130,000- $159,999

Human Subjects/IRB

Prior to recruitment and data collection, this study was reviewed and approved by The University of Delaware Institutional Review Board (IRB) for human subjects research and given exempt status. An informed consent form informing participants of the purpose of the study, their ability to withdraw from the study at any time, and resources regarding infertility and coping was supplied to all participants.

Study Design

To investigate the question *How do Black women navigate familial and cultural positions when faced with fertility challenges?* Two focus groups were conducted to best explore the feelings and experiences of this population of women. The intent of using focus groups for this inquiry was to create a secure and open environment to generate meaningful and fruitful conversation around the participants' experiences with infertility. Focus groups are known to be an effective method to measure meaning, and to gauge experiences, impressions, and emotional concerns, and are noted to be a useful and effective tool and opportunity for deeper examination of difficult topics, such as infertility (Lume & Berg 2015). A unique feature of focus groups is that the group interaction is part of the data collection. Through conversation, participants are encouraged to talk to one another. Because the information gained from a focus group is socially constructed within the interaction of the group, this method is conducive for inquiries from a constructivist perspective

(Miriam & Tisdale 2016), exploring how participants make meaning of their experiences.

The two focus groups were conducted using the ZOOM video conference platform in January and February of 2022. Focus group one consisted of five participants and focus group two consisted of six participants. Additionally, the use of cameras was not mandatory for participation, though most participants chose to keep their cameras on and remain visible to the group. All participants were reminded that the session would be recorded and that they were free to leave the group at any time if they became uncomfortable. Questions for the focus groups came from an interview guide (moderator guide) (See Appendix D). The questions were developed with the research question as a guide, using information from existing literature, and a review of the posts and discussions on the pages of three key Black infertility groups on Facebook; *Fertility for Colored Girls* and *The Broken Brown Egg*, and *Black Women and Infertility*. These public Facebook pages are often a place for information sharing and discussion related to infertility, and included questions such as "In what ways do you manage intrusive questions related to reproductivity/children?", "Do you ever feel your womanhood or adultness is minimized by others because you do not have children?", and "Does not having children/experiencing infertility ever make you feel you have failed or not reached a goal?" allowing for group interaction and conversation. Each focus group lasted approximately 90 minutes. Both sessions were recorded and transcribed using Zoom recording and transcript tools. The facilitator

also took notes during the focus group sessions. These notes allowed for the return to topics/questions of high interest to participants and were also used to further inform the coding and analysis of the data.

Analysis

The transcripts of each focus group were cleaned for grammar and software error and were each pre-coded and notated as part of the coding process (Saldana 2015). Pre-coding in this context consisted of highlighting phrases of interest on a first pass of the data. Next, the transcripts of each group were coded in first cycle open coding (Merriam & Tisdell 2016). During open coding the transcripts were reviewed more critically and thoroughly, in an effort to find patterns and connections, creating initial categories which allowed for the emergence and discovery of themes across the focus groups. Open coding consists of creating broad categories based on the data (transcripts). Some of the first categories include themes such as disappointment, anger, and relationships. Using an inductive approach (Merriam & Tisdell 2016) allowed for the data to lead in the creation of codes and themes. Inductive approaches consist of the discovery of patterns, themes and relationships through engagement with the data (Patterson 2015). As the themes emerged, a second cycle of coding was performed using Dedoose software to assist in tracking codes and important phrases and narrowing down themes.

Continued review of the transcripts allowed for the emergence of 12 initial themes including dyadic relationship, religion/spirituality, and strong Black woman.

After review and discussion between the primary researcher and her advisor, themes were merged/collapsed to reduce redundancy. A final review of notes taken during focus groups and a third round of coding related several codes and themes, producing a total of five major themes: Black Mothering Mandate; Other Mothers; Doing it the Right Way: Societal Expectations; Culturally Relevant Reproductive Health Education; and Complex Coping, which these will be further described and discussed further in the following sections.

Chapter 5

FINDINGS

I analyzed the data with the intent of identifying common themes and concepts from the conversations across both focus groups. Analysis of the transcripts uncovered many common experiences and thoughts across the two focus groups, including frustrating experiences with medical professionals, the expectations of being a childfree auntie, and feelings of guilt and obligation. Further coding and analysis of transcripts led to the creation of five main themes with several subthemes, to best capture the experiences of the participants, consisting of the following: Black Mothering Mandate; Other Mothers; Doing it the Right Way: Societal Expectations; Culturally Relevant Reproductive Health Education; and Complex Coping.

Black Mothering Mandate

This theme represents experiences and ideas that encompass both the Black Fertility Mandate and the Motherhood Mandate. The Black Mothering Mandate represents the social expectations of motherhood for Black women in that they are perceived to be inherently fertile, and that they should become mothers because that is their obligation as a woman. This theme includes the subthemes of guilt and responsibility, and not feeling like a woman, either from external sources or as an internal assessment.

The Black Mothering Mandate often showed up as others wanting or expecting motherhood from the women, usually asserting they would be good mothers and should become a mother as soon as possible. Older family members expressed concerns about women becoming "an old maid" as expressed by one participant, Toni (39) in the first focus group: "And then you get that 'old maid' question and statement like 'Oh, you know you gotta do it before this time' we got to do it before that time." Another participant, Jill (40) remarked that even peers will note age when expressing their concern, "…you know, 'have a baby by 34. We getting older.'" Shauna (33) another participant, mentioned often receiving pressure from her family and her in-laws:

> That part is like, really hard my family and my husband's family. I think it's kind of like, they just want to see me be a mom because they're like you're so great, with your nieces and nephews.

The Black Mothering Mandate also showed up in how the women felt about their difficulty conceiving in relation to the expectations of their family, specifically their spouses. Many of the women expressed feeling as if they are letting their husbands down. Faith (29) a participant in the second focus group shared her thoughts on disappointing those around her:

> For me, I don't really care about letting my family down. It's definitely letting my husband down. We were the first out of like our group of friends to get married, but yet, like, everybody else had children or been pregnant or is pregnant now, and here I am with just two dogs. So I know he's like, they're looking at him like, 'hey you have to have kids so they can play sports

> together, or do this together', like so they're in like the same age range and it's like, yeah not gonna happen, but thanks for playing. So I just, I feel bad for him, because I know he has to have like those like awkward conversations.

Michelle (36) was very transparent in sharing her guilt and regrets around her infertility and her marriage:

> Guilt has weighed heavily on me, up until about six months ago. I felt like I was letting my husband down. Our ideal of what we wanted our family to be, how many children, we want to have, and so on. There was some resentment from him at one point. We ended up having [to] see a therapist and talk through some things.

The Black Fertility Mandate is the other key feature of this theme. Toni articulated the concept well when discussing what women don't say about the experience of infertility:

> I don't think we've talked about the infertility part. I think it's the assumption that Black women should just have kids because history says, you know our grandparents and ancestors had 9,10…20 kids so it shouldn't be a problem.

Toni also explained, "It's just assume[d] that, you know, you should be able to pop out a baby, because everyone else pops out a baby."

A final feature of the Black Mothering Mandate is that of not feeling like a woman. Erica (42) a participant that has experienced at least 2 protocols of treatment raised very poignant and moving points when the group was asked about their womanhood or adulthood and mothering.

> I think it is it's not necessarily like other people making me feel that way it's really self-imposed. At one point I used to just refer to myself as a broken woman, like I'm a broken woman, or I didn't feel like a fully blossom[ed] woman, because there was an aspect of womanhood that I was not achieving.

Affirming Erica's point, several other focus group participants admitted to sometimes feeling "like an outsider" (Jill), and the difficulty of seeing themselves as being a "whole woman" (Shauana). Another participant, Nia (41) shared an experience of having her womanhood minimized from others:

> Yeah, you just made me think. There was one guy, we were in college together, friends and we reconnected a few years back, and he has a family. He's very religious and he was asking me how [I] was doing, and he told me that I was immature, that was the word he used or something very similar, because I was married, but my husband and I were just traveling, not having any kids.

Through the Black Mothering Mandate, the women expressed their experiences navigating womanhood, self-perception, challenging long held beliefs about Black women's fertility and ability to and the expectation to mother.

Other Mothers

Another prevalent theme, one that has been discussed in previous research around Black mothers is the notion of "Other Mothers." Other Mothers is rooted in the work of Patricia Hill-Collins (2000), where Black women support and assist other Black women by taking on mother-type roles in their families, friendship networks, and their community. All of the women had nieces and nephews and/or godchildren or other children in their lives that they were connected to. In response to being asked

about family expectations of them as childfree women, the subtheme of “Rich/Fun Auntie” emerged. Rich Auntie is one type of “Other Mothering” that occurs. Based on the respondents’ description, a Rich/Fun Auntie represents a woman, either single or partnered with no children of her own, who has the perceived disposable income and free time to assist with mothering duties; a woman who often steps in to help with childcare, attends special occasions such as graduations and recitals, and offers mentorship to children. Further, they often have the time and means to take the child places and/or finance experiences or buy items for the child. In some instances, these are items or experiences the parents are not willing to or cannot afford to provide.

As expressed by Michelle:

> I don't think I was ever expected to do more, but I do more because I, I have that time I have those resources. I don't have children, on my own I go over and beyond, for my nieces and nephews. I have two that spend the summer and Christmas with my husband and I every year, and we go to bat for them.

Shauna noted that she and her husband enjoy creating enjoyable experiences for the children in their lives, and relish being seen as “fun”

> I love going to fun like kids stuff! So I get to be like be ‘Hey! Can you bring so-and-so over this weekend, so we can have fun?’ So I think me and my husband are seen as like the real fun aunt and uncle that like, we just love to spoil the kids

Nia shared that while she doesn't mind helping her nieces and nephews, the expectation can sometimes become entitlement:

> … my brother was living in New York close to where I live, So yes, in some cases, and not only that, but also sometimes foot the bill because you don't have any kids so you can afford to help out so that has happened quite a bit. Well, they had a very expensive gift, I thought, they basically asked me to pay for it. And so that's the first time I said no because I feel like before, I would do it.

Some women found that the bloodmothers/parents put boundaries on their Other Mother capacities because they are not traditional or biological mothers. Shauna related her experience of being asked to participate with her nieces and nephews, but being restricted by their biological parents on how she could interact:

> …it's like 'hey you need to come over and see your nieces and nephews'. OK, cool. Then when I get there, and they're doing something, you know, that I personally think that they shouldn't be doing, my brother kind of scolds me like 'don't tell my children what they can and can't do because you don't have any kids'. And it's like OK, but…if your kid knock[s] something over, then you know you don't want me to say anything?

Kim, 32, shared a similar experience of wanting to help a family member, but being met with some resistance because she herself is not a mother:

> So nobody's ever really expected me to do anything, in particular with regard to the children in our family. But I do have one younger cousin who I'm pretty close to and I just saw a gap and needed to be filled. But when I tried to do that, I think his parent was not extremely receptive to it, so it's something that I always have to balance, like letting him fall between the cracks and then what

> their expectations are of me, especially because I don't have children of my own.

The concept of Other Mothers was reinforced and nuanced, as the women revealed that being an Auntie meant more than just occasional visits and birthday gifts. The women's perspectives and insights demonstrate that they take their OtherMothering connection and roles seriously, though there are instances when they receive some push back, or resistance from family members.

Societal Expectations: Doing it the Right Way

The third theme, Societal Expectations: Doing it the Right Way, encompasses values and ways of being that were taught to women in their youth and adolescence. Societal Expectations: Doing it the Right Way goes beyond the expectation to have children, it involves the idea that there is a "proper" order in which to do things related to family development (e.g. marriage, then pregnancy) and subscribing to that philosophy has not yet produced the promised life outcome (of children). This theme reflects culturally specific interpretations and application of societal expectations of Black girls and women. This theme includes the subthemes of anger and frustration with women who did not "follow the rules", yet and still managed to have children. While the women expressed frustration that despite their adherence and belief in messages received regarding success, virtue, and sex, they did not express regrets about their choice to "follow the rules" that their families had provided to them.

Several women shared that they were given very specific guidelines for living and the order in which they should live their lives as women. Faith articulated the essence of the societal expectations theme with her statement:

> …and like you're supposed to wait until you're married and like you're financially stable [to have kids]. It's like I waited till all of that happened and I have nothing to show for it.

Toni also spoke about the explicit order of things as she was raised to understand them.

> my parents were like ‘yes, focus on education and then you can get to the rest of that stuff [marriage, children, family, etc].

Many of the women voiced their frustrations at the perceived family successes of those who did not subscribe to the blueprint provided by society and their families. For example, Michelle said she felt discouraged at the supposed ease that those who didn’t follow the rules had with starting a family:

> My frustration was with others who did not follow the rules, who did not get married, start their careers and they were able to have children, it was easy for them, and here I was struggling for years and still am, and they are on their third or fourth child, and I haven't had the first.

Embedded in this prescribed correct way to do things were also messages about sex and sexuality, respectability, and success. Erica described how the messages given in her youth stayed with her, affecting her relationships into adulthood:

> I can hear my parents voices, mainly my dad you know ‘don't open your legs’ and ‘be a lady’, and all these things, you know that just kind of paralyzed me really, because it, you know when I did get in a, you know-- when I was dating

> my husband and we started getting intimate, it made it difficult, you know it made it difficult for us to be intimate or to, you know, just show each other love in that manner because I'm paralyzed that I'm I don't want to do anything wrong and I don't want to get pregnant. and I'm--I'm like 30 you know at the time.

Faith also expressed the anxiety around dealing with relationships and sex

> You're not, like, supposed to have sex when you're like a teenager you're not supposed to look at a boy is like, if you look at a guy you'll get pregnant like so it's just like this, like stigma in your head that like something's happening you're going to get pregnant you're going to get kicked out of the House and like you're supposed to wait until you're married and like you're financially stable it's like I waited till all of that happened and I have nothing to show for it.

There was an overall feeling of being misled by buying into the "right way" to do things, specifically because it did not yield the promised result or outcomes the women desired. While there were feelings of disappointment concerning doing things the right way and not having children, there was also a sense of gratitude for what their lives looked like now despite infertility, as Toni encapsulated with her statement:

> I've been able to do so much, and I know that I'm in a better position…. I'm in a position where I'm at a terminal degree, I've done everything I'm supposed to do you know; you got the house, you got the car, you know you're eating healthy, you're making the somewhat right decisions. What else do I need to do?

Kim poignantly observed that she would not have been in a position to treat her infertility issues had her life taken a different path:

> Yeah, I personally haven't had any regrets yet. Umm…I think back to being 19 years old, and I had some signs of PCOS [Polycystic ovary syndrome] then. I didn't think anything about it, but if I had, you know figured out that I was infertile at that point, like where the hell was I going to get $25,000 to pay for IVF anyway? So, I can, you know, get the treatment that I need now, because of the steps I took then. So I'm just like, grateful that I didn't have to deal with this when I was younger and I was just more free.

The messages regarding success, womanhood and sex received in adolescence had a lasting effect on both groups of women. The focus on abstinence until marriage, and academic, financial and professional success as a pathway to womanhood was not a pathway that produced outcomes the women were promised or desired. While this was frustrating to many, participants largely were satisfied with their life outcome, even with fertility challenges.

Culturally Relevant Reproductive Health Education

Education, advocacy, and access to resources was also a prevalent theme across both focus groups, reflected in the theme Culturally Relevant Reproductive Health Education (Ladson-Billings, 2014). This theme addresses both community and healthcare professional education and misinformation about reproductive health and Black women, the need for more patient information, and the importance of self-advocacy. There was a consensus across groups that there is a lot of

misinformation about reproductive health in the Black community, which makes it difficult for women to connect or explain what they are going through with infertility, among other things. Erica articulated the need for education and awareness about reproductive health saying:

> I think there needs to be a level of education in the Black Community before we even get to this point. I just think that there should be a point where we are more educated and accept the fact that not everybody can have a child, and there are resources out there and things that are available to help.

How the women experienced medical professionals and navigated their experiences within doctor's offices and clinics was very significant and at times a very emotional topic for the women. Some women suffered setbacks in treatment due to what they felt was lack of concern or effort on the part of the physician. Andrea (34) shared her and her husband's experience of seeing three doctors before being properly diagnosed and receiving effective care:

> And it wasn't until I went to get a second opinion that I found out that I had low ovarian reserve. This started when I was 29. I've been your patient since the age of 27, and turning 28. Why they had me to go to a second doctor, to find out, I had low ovarian reserve? And it wasn't until I went to the *third* doctor that from the very beginning put my husband on clomid, sent me to an Ob gyn to discuss my endometriosis before we even discuss fertility treatment. So, I had to go through two doctors to finally get to the third one to treat both myself and my husband at the exact same time for all the presenting factors.

Nia, who works in healthcare, relayed an antidote related to the difference in care and information sharing for Black patients versus White patients:

> Going back to the race issue, I have a friend who's African American she's 35 or 36, and there's this White, I have a White colleague whom I'm close to about the same age. The White lady, her doctor told her a year ago you're turning 35 and need to think about freezing your eggs and she was shocked. And, actually, I sat down with her, and I said, 'you know what, that's a good idea to go through it'. The other lady [Black], we all work in the same medical environment, no one has ever told her that, and so, as I was telling her what I was going through. She found that she had fibroids so she had all the symptoms as we're discussing. So my question, my issue was, they are the same age, they have the same, everything on same on paper except the race thing.

One participant shared that her experience was not just in misdiagnosis or bad bedside manner, but also encompassed perceived racial bias or assumptions, Jada (43) explained:

> It was very--I was hurt almost every time I went in there, because every time I went it was oh, how are you paying for this, because they just couldn't grasp that a Black couple was coming in they're saying that our IVF is going to be paid for 100%.

Here, Jada's anecdote provides a glimpse into the assumptions being made about a couple's financial ability to afford fertility treatment based on their racial standing in society.

A major concern and point of lamentation amongst focus group participants was the lack of knowledge the women themselves initially had regarding their reproductive health, and their inability to properly advocate for themselves in medical settings. Several women expressed their concern that they missed opportunities to be treated sooner, to ask the right questions, and make better health choices. Erica spoke about learning on the fly about what was happening to her body and the need to educate Black women and girls early about reproductive health:

> I feel like once a Black woman, Black girl, gets her period, we should be having these conversations, because you know, when I was dealing with fibroids my mother didn't know what fibroids were. And I had to do my own research and to understand the surgery, you know I have so I have my doctor take a picture of the fibroids and when I saw the size of them, I immediately knew that I've had these for a long, long time.

Jada spoke very passionately about the need for self-advocacy with physicians as Black women:

> I think it's really important for us to start talking about self-advocacy in the doctor's office. We shouldn't have to do that, but we really do so. I see myself as "Jada from the block" but I've had to go to my doctor's office and say: 'Look I'm—I also have a doctorate, this is what I know, this is what I understand, before I can even get the treatment that I need, and that shouldn't have to happen and everybody doesn't necessarily have access to that kind of information.

Further, Andrea articulated the importance of not only advocating for self, but for partners when male factor is part of the diagnosis:

> And I think that is [the] issue with learning to advocate for yourself, especially as women of color and when you have a husband, learning to advocate for either for him or pushing him to advocate for himself.

The importance of education and advocacy was one that all participants in both focus groups felt very strongly about. All the women believed there was work to be done in educating those around them as well as those in the medical community about their needs, and the unique and nuanced experiences of Black women managing infertility.

Complex Coping

The final theme, Complex Coping, relates to the ways the women in the study manage their relationships, feelings, and experiences related to infertility. Their coping strategies are nuanced in that the women utilized various strategies in different ways depending on the dynamic and context of various situations regarding their fertility challenges. There were several common coping strategies, not all of them intentional, including: acting as a "strong black woman" while managing infertility, sharing their stories of infertility with others, responses to unsolicited advice and critiques, a strengthened relationship with their spouse, rejoicing in the "successes" of others, and the use of religion and spirituality.

In discussing their infertility journey, many women spoke about their relationships, especially with their husbands. While everyone acknowledged the stress and difficulty of managing infertility, they also observed that their bond with their spouses seemed to strengthen while traversing their fertility experiences. Several of

the women attributed this to having better communication in order to navigate their experiences, as Shauna shared regarding her husband, “I'm lucky enough to have a husband that's like ‘it's OK, just let it out. It's okay just, just cry it out’”. Michelle opened up to the group about the difficulties she and her husband faced when beginning treatment, but after therapy, describes their relationship by saying “we're in a happy, healthy space now”.

A unique feature of the infertility experience of Black women is the perceived need to show up as the “strong Black women” while managing infertility. When a question was posed around the need to be strong, a resounding “yes” from women in both focus groups was the answer. Erica expressed the emotional work and the perceived need to put on an unbothered façade:

> Ummm I’ve had nights where I cry in the dark, when my husband's not around, because I can’t show that this is getting the best of me and…yeah. I just can't I can't show emotion. I can't cry about it, I can-- it's just like you have to get over it quickly.

Shauna felt that because she was enduring all of the treatments, she was already identified as strong and needed to continue to promote or live up to this narrative:

> …so somebody has to stay strong in this, and since I’m the one that's getting prod[ed], poked, and all these other appointments I might as well be the strongest one out of the two of us.

Conversely, Jada pushed back on the narrative of Black woman strength when dealing with infertility, and suggested it may be rooted in other feelings:

> I think most people would just describe it as strong, but I think it's more like just like unattached from the process.

The responses of the women highlight the complex coping employed as they processed their emotions related to the infertility process.

Focus group participants also discussed encounters with well-meaning friends and family giving advice, sharing antidotes, and offering solutions or theories on their fertility challenges. A number of women expressed having little patience for these types of interactions and shut them down by being honest about their situations or challenging the opinions and narratives. Shauna remarked that "they'll most likely get a very smart remark" when commenting on her fertility. Jada shared a similar sentiment:

> At this point I just go ahead and get an attitude, because I think people know, like what our journey has been. And then for work, I'm a scientist, so I think people understand that I understand the process and I just feel like if they disregard that then they're just being rude, so I just say what I need to say, or let them know why what they're saying is either hurtful, or just inaccurate. It is hard to hear sometimes what people believe.

Erica shared that she deals with elders differently, as she felt that for older generations "it's like ingrained in them to ask married couples about kids". For her peers, she had a different approach:

> When it's my peers, who have like smart statements to say, or question it, I'll just, you know if they're going to come at me with this like you know playful "it's easy" type of thing, I gave it to them raw. I was like well I've been pregnant, and I've miscarried. So that's--that's my journey. It's not that easy.

Though women identified negative interactions with family and friends, they also found that sharing their infertility stories was a common way of managing the infertility experience. Sharing was seen as a way to educate and normalize infertility among Black women, but also as a therapeutic outlet. Keisha commented that she's also made connections and built friendships through sharing:

> Pretty much I will talk to anybody about it, but that actually being able to be open about it, it actually helps me out a lot. Since I've opened up, I've met so many different women from all over.

Shauna's thoughts were that sharing was a part of her acceptance and processing of her diagnosis as well as being valuable for others:

> I feel like sharing my story is kind of helpful to others. Now that I've gotten more comfortable with what my situation is, I've been more vocal with sharing it because it is very important.

Being self-aware and managing potentially upsetting situations was a shared experience for many women. Two participants mentioned keeping a distance from infants and birthing related events. Keisha stated "I stay away from baby showers and [gender] reveals…and new babies", while Toni's boundary was infants themselves: "I try not to hold babies that are less than three months old".

Seeking the help of a therapist or counselor also came up in both focus groups. Many participants noted it was crucial to their survival and navigating infertility.

> Yeah I actually have a therapist. I've been in therapy since March of last year… But you know once you build a bond with your therapist, its-- I love

> her! I love her to death, I really do. But it's I think, I think everybody should seek therapy.

Jill expressed feeling a bit discouraged because finding a Black woman therapist with openings had been difficult during the COVID-19 pandemic, but she was determined to connect with a professional.

> I've been looking for therapists…it was vital that in this season my life that I need someone to be able to just talk and process it through.

A portion of the women in this study identified their reliance on God, church and spirituality as key in navigating their infertility experience. These women drew strength and clarity from their spiritual support, as Jill shared:

> God knows I'm a woman of faith, so I wholeheartedly went there first myself, but the answer was more or less pray about it, you know. It was those realms, but you know faith without work is dead, there's other actions that we need to take as well.

Conversely, Shauna felt that dealing with infertility tested her faith in God, but this ultimately led her to a more free and open spiritual position:

> I can say my faith has been tested. Really, really tested, and I feel like, you know that's when I kind of, I guess, opened [me] up to, I guess more of like a holistic side of things. And now I feel like it's OK. It's OK for me to believe what I believe and to go through this journey.

While several women relied on their spiritual foundation, some found faith and spirituality alienating and weaponized in Black infertility spaces:

> In the Black spaces, is just kind of, I'll just say like thrown in your face. And then, so, like navigating your faith, if your personal faith--navigating your faith and this struggle, especially if you've experienced loss, grief and faith that I think is a common topic, but how do you reconcile the two? …I'm finding also that the Black fertility pages on social media at least, are very like faith based and that's not really my jam either so.

An almost universal feeling among the women in both focus groups was a sense of joy and hope when another woman managing infertility had a successful pregnancy. Andrea spoke about the excitement of a pregnancy announcement from someone known to have challenges, "when it's somebody that's gone through the trenches with you; overly excited tears of joy" remarked Andrea. The women also expressed a sense of community, calling the baby "our" baby. The new pregnancy is seen as a victory for all Black women dealing with infertility and a sign of hope as Erica notes:

> I know, three women who are expecting and it hits differently, because I know their struggle. So for me if they're, if I'm really close to them, and I know that I've been walking this journey with them, like they're having my baby too. Like I tell them: Look, you, you're doing this for me too.

Keisha also voiced her feelings of excitement and community over a new baby:

> …I actually get more excited when one of us gets pregnant. What?! You know I'm just too excited because we're on the same journey. So we're gonna have us a baby that's, that's what…when I talk to her, I say "how's *our* baby doing?"

Infertility can be a frustrating experience for anyone who receives this diagnosis. The women in this study navigate their relationships and their own feelings through a variety of actions and processes that allow them to make sense of and cope with a diagnosis that is life changing. The salient themes of Black Mothering Mandate; Other Mothers; Doing it the Right Way: Societal Expectations; Culturally Relevant Reproductive Health Education; and Complex Coping exemplify the ways Black women facing infertility make meaning of cope with and build community around this family challenge.

Chapter 6

DISCUSSION

Many of the findings in this study are consistent with previous findings regarding infertility experiences generally and what is known about the experiences of Black women specifically. Black women are experiencing infertility in a way that is influenced by race and culture, as well as gender, and have an intersectional experience that is likely distinguishable from women in other cultural or racial groups.

Life Course

Examining the themes found through life course perspective can see how managing infertility affects the lives of women and how they may navigate their available choices, view themselves, and manage their relationships.

Not being able to achieve traditional motherhood and meet an expected cultural marker of womanhood is experienced as a perceived failed, or delayed, life course transition for the women in this study. Infertility prevents or hinders those who desire motherhood from achieving an anticipated and socially appropriate goal and represents a major disruption in their projected life course (McQuillan et al., 2007).

In life course theory, each life transition generally equates to a change in family statuses and roles (Hutchison, n.d.). By not becoming a mother and going to the elevated woman status, these women are not able to make the full conversion into the next life stage, leaving them in a sort of limbo, affecting the women's sense of self. As illustrated through their insights, the women see themselves as "less" of a woman, this was most evident in the Black Mothering Mandate theme. Past work examining infertility and life course found that when life course is disrupted, an individual's sense of identity will likely be affected (Exley & Letherby, 2001). The women noted that they feel isolated, left out, and as if they are still waiting to achieve womanhood in some ways. The Black Mothering Mandate is reinforced within the sample, as the women testify to being questioned and encouraged to mother, despite their other accomplishments, reflecting long-held beliefs about womanhood and motherhood; and these mandates seem to be particularly high within the Black community. The perceived failure or delay is expressed by the expectations of children from the women. Children, especially after marriage or by a certain age is a societal expectation of women aligned with life course cues (McQuillan et al., 2007) and an association of motherhood to womanhood.

An experience with infertility causes some disruption to not only life course expectations, but to everyday life and relationships with others as well (Exley & Letherby, 2001), which is present in the limitations placed on their "Auntie" duties. Being an Auntie is not a guarantee of overcoming the non-mother status. There are

sometimes boundaries and limits placed on the mothering abilities of the women in this context because they are not biological mothers. The dismissal of advice and correction has been noted in past infertility literature. Because they do not have children of their own, the belief is they cannot understand what it is like to have a child and to parent (Loftus & Andriot, 2012). Experiencing limitations based on their motherhood status left the women feeling confused, frustrated, and excluded. For some, it shaped their willingness to participate in the lives of the children in their networks that they valued, creating hesitancy to participate and/or feeling further marginalized.

Navigating the transition disruption (delay) may require women dealing with infertility to reframe and shift their life course expectations and self-narrative (Cunningham, 2014; Exley & Letherby, 2001). The decision to reframe concepts of family, womanhood, and mothering can be a turning point for these women, as this will steer the life course trajectory based on the reimagining of their life and relationships. Part of reframing and reimagining the life course of these women shows up in their decision-making processes, and embracing other ways to imagine family, such as adoption, which one participant, Jill had, or seeking out donor material (eggs, sperm, or embryos), as Keisha planned to do, or the choice made by some women to live child free and no longer pursue medical interventions.

Moreover, a few women expressed their interest in exploring adoption at a later date, but planned to continue medical intervention at the present time. Some, like

Keisha and Toni conceptualized a path forward to parenting that did not include a husband. While parenting with a husband was the anticipated life course, both women made the choice to pursue motherhood either as a single mother, or with a committed, non-live-in partner. The agency women participants demonstrated reflects the myriad of ways they have or are managing this challenge in their life course/transitions to attain some degree or modicum of motherhood.

This set of women managed the stress of their status in various mostly healthy ways, as evident in the Complex Coping theme. A 2014 examination of women's infertility experiences found that women's responses to infertility can be complex and frequently involve anger, frustration, guilt and resentment, a sense of failure and of life 'on hold' (Cunningham, 2014, pp.156). Participants engaged in emotion work–the management of one's feelings and the expression of those feelings (Exley & Letherby, 2001) when deciding how to interact with family and friends and what to share regarding their infertility and treatment plans as appropriate.

The women of this focus group protocol created and enforced strong boundaries around what they would discuss with others, their responses to critiques, and the events they were willing to attend. This emotion work helped the women to maintain relationships by managing their responses to others, as well as to preserve and manage their own emotional reactions. The emotion work and management of relationships exemplified by the women is consistent with other research regarding infertility and terminal illness. It is important for the women to be perceived well,

even when conversations may be tense or uncomfortable, as some women expressed. They valued the relationships of family and friends and recognized they may need familial support in the future and did not want to alienate them. However, they had the desire to remain true to themselves and honest within their boundaries with others.

Findings from this research are consistent with past results that while engaging in emotion work, there is sometimes a struggle between one's own needs and those of significant others, which may lead to the denial of one's own feelings and needs (Exley & Letherby, 2001). This is aligned with work in stigma and infertility, noting that women will often engage in passive strategies such as information management, and "strategic avoidance" (Remennick, 2001). In regard to the stigma associated with infertility, women engaged the concept of covering, the notion that when individuals who are both aware of their stigma and prepared to accept it still make an effort to prevent the stigma from taking over, by reducing any tension therefore enabling normal interaction to continue (Exley &Letherby, 2001)

In receiving an infertility diagnosis and handling all that is associated with it, the women experience a loss or limitation of their agency. Human agency, the concept of being able to construct a life course by choices made, is stripped at diagnosis. While there are various treatment options and solutions available, none have a guaranteed outcome. In this way, reproductive technology creates the illusion of control and brings hope, but can also create uncertainty as hopeful, potential mothers wait for an outcome (Cunningham, 2014). The women in this study, however, did not appear to be

bound by this lack of control over this aspect of their lives. Women used the diagnosis as a turning point, eventually charting a new, even if temporary, life course. Further, these women demonstrated some degree of acceptance as they enjoyed other goals as single and/or child free women, such as travel and pursuing advanced degrees, focusing human agency or control in other facets of their lives. Previous work concluded that for some women, the "biological inability to have children is the main issue and lack of control in this area is related to lack of control in everything" (Letherby, 2002 pp.281). This ability to shift control may be attributed to the fact that these women, as educated, and middle-income, have the resources to focus their life course goals elsewhere. McQuellen et al. (2007) found that resources can mitigate negative consequences of blocked goals, and those with more resources are less reactive to negative life events because they have alternatives.

Losing human agency is present within the theme *Societal Expectations: Doing it the Right Way*, specifically as it relates to messages the women received in their youth about sex, relationships, and success. At a young age, these women regularly received messages from parents and others in authority (pastors, teachers) to focus on achieving academic and professional goals, and importantly, to delay sex. As adolescents and even as young adults, these women felt they were unable to deviate from this prescribed life course to the point that even when they were "of age" and status, they had difficulties creating emotional and physically intimate bonds with their partner. This impeding of agency frustrated the women, knowing in hindsight

they did have the ability to make different choices for their life in these areas, and the negative effect this messaging had on them as it relates to relationships, reproduction and family building.

Life course provides a framework with which to understand the women's trajectory as they work towards motherhood, or for some choosing to live child free. Experiencing a failed or delayed life transition such as infertility can have lasting affects and force major changes in trajectory and agency. Infertility pushed these participants to reframe their life course and definitions of family, though ultimately, the women had few regrets related to their life course to date. Through life course concepts, we can begin to understand decision making, relationships, and even social interaction in the context of infertility.

Black Feminist Theory

Dana-Ain Davis (2020) notes that "racism is not external to the process of ART. Rather, women encounter racism as part of the exhaustive experience of being Black" (p.58). By giving voice and legitimacy to the experiences of Black women and infertility, principles of Black feminist theory were employed in the effort to center Black women's voices and experiences.

The Black Mothering Mandate theme, which encompasses the Motherhood Mandate, and the Black Fertility Mandate were present and affirmed in this inquiry. The women in the study enforced the mandates by buying in to the belief that pregnancy would come easily because their mothers, grandmothers, and other women

around them became pregnant, often more than once, seemingly without any issue, reinforcing the idea that all Black women are “invariably fertile” (Ceballo et al., 2015). The expectation for Black women has been to marry and reproduce to fulfill their roles as Black wives and Mothers (Ceballo et al., 2015), which is represented in the Black Mothering Mandate. However, through a Black feminist lens, infertility presents an opportunity for women to challenge and evolve what motherhood and family mean in Black culture, as it is in the hands of Black women to define and value their experiences with motherhood (Collins 2000).

The findings of a 2011 study found one of the significant beliefs of Black women is that womanhood is achieved when one successfully and effectively rears their family (Chaney, 2011). Culturally, not only is motherhood seen as a significant marker of womanhood, but motherhood also provides a respectable social identity (Hill 2005). The cultural significance of motherhood leaves Black women who suffer through infertility on the cusp of Black womanhood, unable to achieve full “womanhood” status. This was evident when women discussed feeling like less of a woman, feeling left out of birthing stories, and constant questioning surrounding their child-free status.

Not achieving full Black womanhood is stigmatizing, as the women want to be seen and respected as fully women, yet their infertility leaves them as outsiders. The cohort of women in this study did not allow the stigmatizing status to isolate them, which is inconsistent with other findings, but aligned with the idea of pushing the

culture forward by normalizing an evolving stance on motherhood and family as Black women. Ceballo et. al (2015) found silence and isolation to be a key component of Black women's infertility experience, where a 2007 study concluded that women were more likely to disclose their infertility status, despite being more stigmatized than men (Slade et al., 2007). The 2015 Ceballo et al study would be the most generalizable and applicable to this group, as both samples are Black women. Time may be a variable, as attitudes and infertility support spaces have expanded, and may account for the difference (Wane, 2000).

The reluctance and hesitation of this group to share their status was rooted in the lack of knowledge and awareness regarding infertility and reproductive health more than any feelings of shame related to experiencing infertility. These women may also feel less internalized stigma because they have chosen to not buy in at all, or do not fully subscribe to the external social definitions of what womanhood and Black womanhood are (Remennick, 2001). This again reflects a buy in to Black feminist ideals, even if not intentional, and follows the suggestion of Collins (2000) that African American women need a revitalized Black feminist analysis of motherhood.

Black women must then find other ways to participate in womanhood, and one way that can be done is by acting as a mothering figure, as highlighted by the theme Rich/Fun Auntie, as othermother. Collins (2000) conceptualizes othermothers as assisting bloodmothers by sharing mothering responsibilities. Othermothers are accepted as an important part of family and fictive kin networks in Black culture.

Othermothering is a practice brought over from African cultures and maintained in Black American culture over time. African philosophy submits that children do not belong solely to their biological parents, but to the community, and this philosophy and tradition inform what is conceptualized as other mothers in Black American (and throughout the diaspora) family culture (Wane, 2000). The women in this study embodied the role of Othermother as the Rich/Fun Auntie, stepping in, most times without prompting, to support blood and fictive kin with children. Women across both groups noted that they enjoyed spending time with and being a mother-figure to these children. While this concept is not grouped here as a form of coping (Complex Coping theme), actively spending time and nurturing relationships with the children in their lives served as a form of mothering, and by extension a form of coping for the women in the study.

Coping was revealed as a complex dynamic, at times contributing to women's healing and other times described as, harmful. One such nuanced coping was being constantly strong and participating in the strong Black woman narrative, while not allowing oneself to be visibly vulnerable. Most women who admitted to engaging in this behavior verbalized that they often cried when they were alone, and felt they were not able to show sadness, exhaustion, or fear, even when there was a supportive partner or other family member. Overall, this coping strategy appeared to be damaging to the women's mental and physical health, as they are unwittingly upholding

stereotypes of Black women as un-feminine and being an overly strong matriarch (Collins 2000), an image that has plagued Black women for centuries.

Culturally Relevant Reproductive Health Education

This study uncovered an issue that was of concern to all the participants and affected every aspect of their journey, and that was education regarding infertility as it relates to Black women, and harsh treatment within medical systems. There was a predominant sentiment that within the Black community, the lack of knowledge regarding reproductive health generally was detrimental and problematic. Previous studies have recognized the limited information regarding infertility among Black women. A 2019 study found Black women scored low on infertility knowledge generally and were unaware of the risk factors affecting fertility such as age and obesity (Wiltshire et al., 2019). It is clear that relevant, contextual and

More disturbing to the participants of this study was the lack of knowledge, care, and bedside manner experienced in medical settings. This finding is consistent with other examinations of Black women's infertility experiences, as well as the testimonies of Black women's general experiences with the medical establishment (Davis, 2020). Even with increased access to quality care, Black people, including middle-income Blacks, do not receive the same level of care as Whites (Sacks 2018). Studies have also shown that medical students believe biological falsehoods such as Black people's skin is thicker than White people's, and most relevant to this inquiry, Black couples are significantly more fertile than White couples (Hoffman et al., 2016).

A 2017 literature review of 35 studies found an implicit preference favoring White people was common across providers, regardless of specialty (Dehon et al., 2017). Black women reported being rushed and not listened to in medical settings, even when the provider was Black (Sacks 2018). This is in line with previous work focused on the Black infertility experience that found 26% of the women in the study described encounters with medical professionals that may have been influenced by gender, race, and/or class discrimination, and experienced doctors who made assumptions about their sexual promiscuity, their inability to pay for services, and their ability or support a child (Ceballo et al., 2015).

Unfortunately, the experiences outlined by the women are nothing new. Medical racism, the recognition that when the patient's race influences medical professionals' perceptions, treatments and/or diagnostic decisions, places the patient at risk (Davis, 2019). Obstetric racism is unique to women of color, Black women specifically, and can be described as "an extension of racial stratification and registered both from the historically constituted stigmatization of Black women and from their recollections of interactions with physicians, nurses, and other medical professionals during and after pregnancy" (Davis, 2019, p.581). Obstetric racism can include, but is not limited to, critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent (Davis, 2019). This is evident in the antidotes shared by study participants in being misdiagnosed,

minimized, and spoken down to. For centuries Black women have experienced medical racism, obstetric racism, and obstetric violence, a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated because they are obstetric patients (Davis, 2019). Most notably the mid-1800s surgical experimentation of James Marion Sims on enslaved women without consent or anesthesia, to Henrietta Lacks, whose harvested cervical cells (done without her consent) which came to be known as “HeLa” cells, were instrumental in the discovery of several medical and pharmaceutical advances, including the polio vaccine, and research that laid the foundation for IVF (T Demo et al, 2015; K.A. Ducre, 2015). Black women are experiencing racism and discrimination in using a biomedical technology a Black woman helped make possible.

Black Feminist Theory provides the lens in which to understand and uncover the complex and nuances experiences of fertility of Black women. Being a Black woman navigating infertility comes with some additional challenges both culturally and personally that color this experience. The women who participated in this study navigated not only cultural expectations and medical racism but are in their own way reshaping what Black womanhood and motherhood look like in the 21st century.

Limitations and Future Research

There are several limitations to this study. While the focus groups yielded rich data from engaging conversations, the sample size was small (N=11). A larger sample, and perhaps a mixed method designed study may get even more nuanced feedback regarding this experience. Replicating this study including Black women from all socioeconomic groups, Black queer women, Black trans women, women who are diagnosed as infertile but do not want to have children, as well as those who do not have insurance coverage may add additional depth to the conversation and findings. A study that included any one of or combination of these additional categories of women may provide additional insight on life course and life satisfaction, navigating relationships, and coping. Additionally, while the sample contained women from various parts of the country, many came from the same general pool of women: Black infertility support spaces. Casting a wider net to recruit participants could result in different responses. This could also be a contributing factor as to why this group of women were more open to discussing their challenges than previous studies have found. Being a part of support spaces likely increases women's openness to dialogues and sharing. Exley & Letherby (2001) found that support from other women with the same experience made women more comfortable sharing their experiences, and this seemed to be the case for women that participated in this study.

The potential for future research related to this topic is vast, because of the overlapping identities and sociopolitical issues (e.g., class, race, gender, medicalization of infertility, obstetric racism, stratified reproduction, treatment access, etc.), there are numerous ways to approach the topic. Within the findings of this paper, any one of the five themes generated from this research could be studied more in depth. Within the Black Mothering Mandate, examining the relationship between biological parents and the aunties, and exploring perception versus reality of the involvement of a child-free woman could reveal other concerns or ways of engaging Black womanhood. Societal Expectations theme and sub themes have potential regarding familial and cultural messages about womanhood and sexuality. There is also opportunity to further explore what mediating affects support groups may have on managing infertility stress. There is a growing interest focused on medical and obstetric racism, ART treatment and outcome disparities, yet there is room and a need to conduct further research related to reproductive health information within Black families and communities.

Recent studies examined Black women and infertility from various disciplines and viewpoints (Davis, 2020; Wiltshire et al, 2022), indicating the growing recognition of the importance and relevance of including the experiences of Black women in infertility discourse. It is important, to not only examine the infertility experiences of Black women, but for other cultural and racial groups, as well as men, and to make infertility inquiries in all disciplines more inclusive of various income

levels, race and ethnicities to better reflect the many ways that infertility affects women in a more nuanced and holistic way.

Family Science Implications and Practice

Within the field of family science, this study gives further insight into how the construction of family continues to evolve and into the complexities of creating a family and working amongst Black families and individuals. These findings can provide insight into the perspective of Black clients managing infertility and give clinicians more background, and a better cultural context and awareness to better inform medical, psychological and support practices. Understanding how Black women manage and navigate their relationships can better prepare practitioners to create treatment plans, and to suggest tools and exercises that may assist women to better navigate and engage in healthy coping techniques to manage the emotional and medical needs of women and couples experiencing infertility. Marriage and family counselors may find the understanding gained from this study useful to contextualize conflicts and aid in creating effective communication and processing feelings, and insights on helping families have difficult but honest conversations about reproductive health, family health history, and family expectations. For those who work as adoption professionals, understanding the experiences of infertility before coming to adoption to parent, can better aid them in navigating the emotional processes of adoption in context. Lastly, those who work in ministry may be interested in the perception of

religion and faith as it relates to infertility. Being mindful of alienating women by weaponizing faith and religion or minimizing their pain with only faith-based solutions.

Findings also offer interdisciplinary implications, in the realm of public health and healthcare practice. The low information state regarding reproductive health among Black individuals and communities is an opportunity to create programming and campaigns about reproductive health for men and women, to facilitate better health outcomes for Black women, and to empower them to advocate for themselves in healthcare settings. Regarding trainings for healthcare professionals, these finding can be applied to create trainings and promote cultural awareness and competency when dealing with patients who are Black women, awareness of bias in healthcare and their own personal biases, and improved patient interactions.

Chapter 7

CONCLUSION

It has been well established that an infertility diagnosis can be a life changing event for those who desire to mother. This inquiry explored the specific infertility experiences of Black, middle and upper-income women. While several of their experiences confirm existing findings, such as feelings of inadequacy, grief, and feeling isolated, these women experienced this from a nuanced, cultural, and racial perspective.

The cultural value placed on motherhood as an integral part of Black womanhood plays a role in these women experiencing specific forms of in group marginalization; having their womanhood and maturity questioned, isolation caused by the need to present as a "strong Black woman", and feeling inadequate because due to the cultural, and sometimes personal belief that Black women are naturally fertile. Yet these women know their other accomplishments are noteworthy and substantial, and they often choose to focus on other goals while they navigate through infertility.

Managing infertility often meant managing the emotions and reactions of others, including the expectations of mothering from those around them, and managing the amount and type of information shared to avoid potentially stressful or tense conversations. These women participated in other forms of mothering

(Othermothers), by spending time with and supporting children in their lives as an Auntie, something that had a great deal of significance, even when there may be resistance to discipline or child-rearing advice because they are not mothers in the traditional sense. Despite all the stress inherent in infertility, the “success” stories of other women who have been trying to conceive while managing infertility brought joy, hope, and a collective sense of accomplishment to the women of this study.

Medical and obstetric racism in treatment is a distinguishing factor in Black women’s experiences in infertility. Women shared that they often had to seek second and sometimes third opinions to receive a proper diagnosis and treatment, and were questioned about their ability to afford fertility treatments. Facing bias and racism in a clinical setting adds to the stress and anxiety of infertility, something their White counterparts do not have to face.

Through the findings of small studies such as this one, and larger scale, peer reviewed research that focuses on the Black infertility experience, there is hope that women can feel less isolated. Further, culturally relevant care and support can be provided in family, individual, and community work, as well as in medical settings to address and shrink the gaps in Black mental and physical health care

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Appendix A
IRB APPROVAL

Institutional Review Board
210H Hullihen Hall
Newark, DE 19716
Phone: 302-831-2137
Fax: 302-831-2828

DATE:	November 24, 2021
TO:	Jamel Hicks
FROM:	University of Delaware IRB
STUDY TITLE:	[1836060-1] Black Women, Family, and Fertility
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
EFFECTIVE DATE:	November 24, 2021
REVIEW CATEGORY:	Exemption category # *(2)*

Thank you for your New Project submission to the University of Delaware Institutional Review Board (UD IRB). According to the pertinent regulations, the UD IRB has determined this project is EXEMPT from most federal policy requirements for the protection of human subjects. The privacy of subjects and the confidentiality of participants must be safeguarded as prescribed in the reviewed protocol form.

This exempt determination is valid for the research study as described by the documents in this submission. Proposed revisions to previously approved procedures and documents that may affect this exempt determination must be reviewed and approved by this office prior to initiation. The UD amendment form must be used to request the review of changes that may substantially change the study design or data collected.

Unanticipated problems and serious adverse events involving risk to participants must be reported to this office in a timely fashion according with the UD requirements for reportable events.

A copy of this correspondence will be kept on file by our office. If you have any questions, please contact the UD IRB Office at (302) 831-2137 or via email at hsrb-research@udel.edu. Please include the study title and reference number in all correspondence with this office.

INSTITUTIONAL REVIEW BOARD

www.udel.edu

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Appendix B

RECRUITMENT FLYER

Black Women, Family, and Fertility Challenges

Seeking study participants.

Graduate student looking for Black women who are willing to share their stories and participate in a focus group conversation around how they manage relationships and their feelings while experiencing fertility challenges as part of a master's thesis study. *All focus groups will be conducted virtually and are confidential.*

You may be eligible* if you are:

Black/African-American	Woman 25-45 Years Old	Experiencing or have experienced fertility challenges

**additional criteria may apply*

Click the link below for additional information

https://forms.gle/6BsRdLXpwZVvmFsM7

jmhicks@udel.edu

Jamel Hicks, Master's of Science Student

Human Development & Family Science

University of Delaware

Appendix C
INFORMED CONSENT

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Study: Black Women, Family, and Fertility

Principal Investigator(s): Jamel M. Hicks

KEY INFORMATION

Important aspects of the study you should know about first:

- **Purpose:** The purpose of the study is to explore Black women's experiences with family and how they feel about themselves as they face fertility challenges.
- **Procedures**: If you choose to participate, you will be asked to take part in a focus group with 3-4 other women also experiencing fertility challenges to discuss your experiences and perspectives.
- **Duration:** The focus group will last approximately one hour.
- **Risks**: The main risk or discomfort from this research is that you may feel uncomfortable discussing your feelings or experiences. You may choose to withdraw from the project at any time without any consequences.
- **Benefits:** There are no direct benefits to you for participating
- **Alternatives:** There are no known alternatives available to you other than not taking part in this study.
- **Costs and Compensation:** If you decide to participate there will be no cost to you. There is no compensation for your participation.
- **Participation:** Taking part or not in this research study is your decision. You can decide to participate and then change your mind at any point.

Please carefully read the entire document. You can ask any questions you may have before deciding If you want to participate.

You are being invited to participate in a research study. This consent form tells you about the study including its purpose, what you will be asked to do if you decide to take part, and the risks and benefits of being in the study. Please read the information below and ask us any

questions you may have before you decide whether or not you want to participate.

PURPOSE OF THE STUDY

The purpose of this study is to learn more about Black women's experiences with family and how they feel about themselves as they face fertility challenges, and the role race and culture might play in the experience. We want to learn about how you manage your relationships with family and friends, and how you feel about yourself while having difficulty conceiving.

WHO IS BEING ASKED TO PARTICIPATE?

You will be one of approximately 15 participants in this study. You are being asked to participate because you are a woman between the ages of 25 and 45 who identifies as Black/African American, is considered middle class or above, and have faced fertility challenges. To participate in this study, you must:

1. Identify as a heterosexual, CIS, Black/African American woman
2. Reside in the United States
3. Be between the ages of 25-45
4. You or your partner has been medically diagnosed with infertility (female factor **or** male *and* female factor)
5. Primary infertility (no living biological children)
6. Minimum Annual income of $42,000 single, and $70,000 partnered
7. Medical insurance that covers at least a portion of fertility treatment costs
8. Actively using ARTs to conceive or have used ART in the last 3 years

Not meeting these criteria will be reason to be excluded from this study.

PROCEDURES: WHAT WILL YOU BE ASKED TO DO?

As part of this study, you will be asked to participate in a focus group of 3-5 women where you will be asked questions and have conversation about your experiences, feelings, and thoughts around your fertility challenges. This session should last one hour and will take place virtually using Zoom. The focus group will be recorded, however the recording will not be shared. It will only be used by the researcher to understand and examine themes that arise from the conversation.

You will be asked to complete a brief demographic survey to document your age, income, etc., to determine if you are within the participation criteria and are invited to participate in the study based on your responses. This form is to help you decide if you would like to take part in this study. If you decide to participate, you will be asked to complete a demographic form, and participate in a virtual focus group using a secure Zoom meeting link. We will work with your schedule to identify a time and day that works best for you and the other research

participants. Session participants as well as the researcher are expected to be in a quiet, private space, and all are requested to wear earphones to keep the conversation confidential.

WHAT ARE POSSIBLE RISKS AND DISCOMFORTS?

Possible risks of participating in this research study are that you may feel uncomfortable while answering questions. Talking about your family relationships and your reproductive health may make you feel uncomfortable, sad, or angry. If at any time during the session you feel overwhelmed or uncomfortable, you may choose to not answer the question, or leave the focus group. By participating in a focus group, there is a small chance that you may see or be seen by someone you know. You may choose to have a one-on-one interview with the researcher if you are not comfortable sharing within a group. During the focus group, you may send a message to the researcher to state your discomfort or desire to leave. If you would like to seek additional information or support after your participation, or experience any increased levels of sadness or stress, the below resources may be helpful:

RESOLVE (The National Infertility Association) resolve.org

Therapy for Black Girls (Black therapist search tool and mental health resources) therapyforblackgirls.com

Fertility for Colored Girls (Support groups, resources) fertilityforcoloredgirls.org

The research team does not expect your participation in this study will expose you to any risks different from those you would normally encounter in daily life.

WHAT ARE POTENTIAL BENEFITS FROM THE STUDY?

You will not benefit directly from taking part in this research. However, the knowledge gained from this study may contribute to our understanding of the infertility experiences of Black women in the United States and may contribute to how clinicians (medical and counseling) approach Black women dealing with infertility.

CONFIDENTIALITY: WHO MAY KNOW THAT YOU PARTICIPATED IN THIS RESEARCH?

The responses you provide during the focus group will be confidential. If results of this study are published or presented, individual names and other personally identifiable information will not be used. To minimize the risks to confidentiality, the names and identities of all participants will be protected by assigning pseudonyms, or using initials when discussing responses. The findings of this research will be reported using pseudonyms for your privacy and research confidentiality. The PI and her advisor will be the only persons with access to

the focus group video and transcripts. We cannot promise that information shared with other study participants during the focus groups will be kept confidential. However measures will be taken to ensure all participants keep all information shared during the focus group confidential.

The findings of this research may be presented or published in academic journals or other scholarly/artistic formats. If this happens, no information that gives your name or other details will be shared.

Focus group sessions will be recorded for the purposes of analysis and note taking/transcription. Real names will not be displayed in Zoom. No one outside of the research team will have access to the recordings of the focus group. Notes and transcripts, as well as video will be kept indefinitely in a secure, encrypted, online storage platform.

We will keep your study data confidential and only those with permission on the research team will have access to information that identifies you.

COSTS AND COMPENSATION

There are no costs associated with participating in the study, and there is no compensation for your participation.

DO YOU HAVE TO TAKE PART IN THIS STUDY?

Taking part in this research study is your decision. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide later not to participate, or if you decide to stop taking part in the research, there will be no penalty or loss of benefits to which you are otherwise entitled.
Your decision to stop participation, or not to participate, will not influence current or future relationships with the University of Delaware.

The investigators reserve the right to remove you from the study without your consent at such time that he/she feels it is in your best interest. This may include instances where a participant is disruptive, uncooperative, or dismissive of the feelings or experiences of other participants. If, at any time, you decide to end your participation in this research study please inform our research team by telling the investigator. If you, or the investigators, stop your participation in the study we will keep any data collected of you until that point.

INSTITUTIONAL REVIEW BOARD

This research study has been reviewed and approved by the University of Delaware Institutional Review Board (UD IRB), which is a committee formally designated to approve,

monitor, and review biomedical and behavioral research involving humans. If you have any questions or concerns about your rights as a research participant, you may contact the UD IRB at hsrb-research@udel.edu or (302) 831-2137.

CONTACT INFORMATION

If you have any questions about the purpose, procedures, or any other issues related to this research study you may contact the Principal Investigator, Jamel Hicks at (302) 746-2218 or jmhicks@udel.edu or Dr. Ann Aviles 302-831-4724, or amaviles@udel.edu

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CONSENT TO PARTICIPATE IN THE RESEARCH STUDY:

I have read and understood the information in this form and I agree to participate in the study. I am 18 years of age or older. I have been given the opportunity to ask any questions I had and those questions have been answered to my satisfaction. I understand that I will be given a copy of this form for my records.

________________________________ ________________________ __________

Printed Name of Participant | Signature of Participant | Date

(PRINTED NAME) | (SIGNATURE)

________________________________ ________________________ __________

Person Obtaining Consent | Person Obtaining Consent | Date

(PRINTED NAME) | (SIGNATURE)

If participant agrees only contact information can be kept. Permission to be contacted about future studies does not mean that identifiable private information about the subject can be kept

<u>OPTIONAL</u> CONSENT TO BE CONTACTED FOR FUTURE STUDIES:

Do we have your permission to contact you regarding participation in future studies? If you agree to being contacted in the future, we will keep your contact information. Please write your initials next to your preferred choice.

_________YES _________NO

<u>OPTIONAL</u> CONSENT FOR ADDITIONAL USES OF IDENTIFIABLE VIDEO RECORDINGS/PHOTOGRAPHS

I voluntarily give my permission to the researchers in this study to use videos and photographs of me (and/or my child) collected as part of this research study for publications, presentations, and/or educational purposes. I understand that no identifying information beyond that contained in the video recording will be provided to educational/scientific audiences; however my facial features (and/or those of my child) may be seen.

______________________________ ______________________________ _________

(Printed Name of Participant OR Parent/Guardian) (Signature) (Date)

Appendix D

MODERATOR GUIDE

The following questions are to be used as a guide for information gathering and conversation concerning participants experiences with infertility, social and family relationships, self-concept and stigma among other topics.

Family/Socialization

What is your family like (parents, siblings, grandparents, aunts/uncles, nieces/nephews, etc)?

What is your sister circle (close friends network) like?

How are holidays special occasions celebrated with your family?

Are you an aunt, “auntie”, godmother?

What has your experience been in role(s)?

Are you the only person in your family or circle that does not have children?

Are you ever expected on to baby sit or take on more family responsibilities?

Do you find it challenging to maintain friendships with those who are mothers?

In what ways do you manage intrusive questions?

Do you feel supported?

Do you ever feel you are disappointing your family because of infertility?

Do you ever feel your marriage is incomplete or invalid without children?

What does motherhood mean to you?

Stigma/Mandates

What do you think about the belief that all women should be mothers?

Have you shared your status with anyone close to you outside of your home (partner)?

(If No) How do you think others would feel about you if they knew about your fertility challenges?

(If yes) What reactions did you receive when you shared your story?

What does being a woman/womanhood mean to you?

Do you ever feel your womanhood or adultness is minimized by others because you are child free?

Self Concept

Are there ever times you felt angry for “doing things the right way” and now not being a parent?

Do you feel your accomplishments are minimized because you are not a mother?

Do you feel motherhood is expected of you as a Black woman?

Are there experiences where you have felt left out because you are not a mother?

How much do you think motherhood is part of becoming a woman?

General

Do you have any spiritual/religious beliefs?

How have your beliefs shaped your experience with infertility?

How do you feel when women share their “success stories”?