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November 2004

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Arthur L. Greil

Alfred University, fgreil@alfred.edu

Julia McQuillan

University of Nebraska - Lincoln, jmcquillan2@Unl.edu

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Published in *Journal of Reproductive and Infant Psychology* 22:4 (November 2004), pp. 305–319; doi 10.1080/02646830412331298332 Copyright © 2004 Society for Reproductive and Infant Psychology; published by BrunnerRoutledge/Taylor & Francis. Used by permission. <http://www.informaworld.com/openurl?genre=journal&issn=0264-6838>

Submitted December 3, 2003; accepted July 4, 2004.

Help-Seeking Patterns among Subfecund Women

A. L. Greil

Division of Social Sciences, Alfred University, USA

J. McQuillan

University of Nebraska–Lincoln, USA

Corresponding author: A. L. Greil, Division of Social Sciences, Alfred University, 1 Saxon Drive, Alfred, NY 14802, USA. Tel. 607 871-2885; email fgreil@alfred.edu

Abstract

A random sample of women in the midwestern United States was studied in order to provide a fuller picture of the ways in which US women responded to subfecundity. Using a biomedical definition of infertility, we examined women who did not conceive within 12 months of unprotected intercourse whether they were trying to get pregnant or not. Of the 196 ever-subfecund women in our sample, 123 experienced subfecundity while trying to get pregnant; we called these “subfecund with intent.” Another 73 women experienced subfecundity while not actively trying to get pregnant; we called these “subfecund without intent.” Of the 196 subfecund women, 39% reported having sought treatment. Treatment-seekers had clearer intentions to get pregnant, were more likely to seek infertility information on their own, and were more likely to self-define as having fertility problems. Those with more income, more education and lower internal locus of control were more likely to seek medical help. Among the subfecund with intent who pursued medical help, about a fourth had received treatment. The few women who had sought spiritual counseling or non-conventional help often combined these actions with medical help-seeking. This study supported the conclusion that common-sense understandings among subfecund women play an important role in help-seeking behavior. From a practical point of view, there is a large unmet need for infertility services and infertility counseling in the United States.

Introduction

Most studies of women’s responses to subfecundity have had limited generalizability because they have focused primarily on treatment-seekers at infertility clinics connected with research hospitals (Greil, 1997). In the United States, where less than 50% of subfecund women have reported pursuing medical treatment (Chandra & Stephen, 1998), the experiences of half of these subfecund women have therefore remained virtually unstudied. Dependence on these clinic-based samples has made it difficult to sort

out the consequences of being infertile from the consequences of seeking treatment for infertility. Most importantly, the focus on patients at infertility clinics has made it difficult to study the choices that subfecund women have made about whether or not to seek medical treatment.

Conceptualizations of subfecundity vary across disciplines and studies. In this study, we used a measure of lifetime subfecundity. We use the term subfecundity interchangeably with infertility. We used a biomedical definition of infertility (inability to conceive after 12 months of unprotected intercourse) rather than a demographic conceptualization (no live births). As with the lay understanding of infertility as a problem with conception, this term does not imply childlessness. Most of the subfecund women in our sample who have ever had an episode of subfecundity reported that they now have biological children.

Most studies of treatment for impaired fecundity have focused on women from clinic samples who were actively involved in infertility treatment. These studies have highlighted the stressful nature of the infertility treatment experience (Becker & Nachtigall, 1991, 1994; Blenner, 1992; Whiteford & Gonzales, 1995). A common theme in this literature has been that infertility treatment holds a seductive promise that has compelled infertility patients to try any treatment that offers them the possibility of a baby (Busch, 2001; Greil, 1991; Sandelowski, 1993; Scritchfield, 1995; Williams, 1988). A parallel characterization of the infertile has been that they are "immersed in treatment" (Greil, 1991; Sandelowski, 1993; Sandelowski & Pollock, 1986). Only a few quantitative studies have focused on the treatment process. For example, Schmidt (1998) and Malin *et al.* (2001) studied the infertile patient's satisfaction with infertility treatment, while Beutel *et al.* (1999) explored treatment-related stress among patients being treated by means of advanced reproductive technologies (ARTs), and Glover *et al.* (1996) reported on differences between patients' and physicians' perspectives on treatment for impaired fecundity. None of these studies distinguished between treatment-seekers and non-treatment-seekers. Those that have made a distinction have usually taken a demographic approach and have concentrated on differences in treatment rates by age, race, and socio-economic status rather than details of help-seeking pathways (Chandra & Stephen, 1998; Hirsch & Mosher, 1987; Kalmuss, 1987), although Strauss *et al.* (1988) looked at psychological variables in an attempt to account for treatment persistence. Demographic analyses have revealed wide variation among societies in the proportion of subfecund women who have sought treatment (Schmidt & Munster, 1995). The United States, a nation which lacks a comprehensive national health care system, has lower utilization rates for infertility services than the United Kingdom or the Netherlands, for example, presumably for reasons related to access. Therefore, there is a need for research that looks at resources, demographic, and social psychological variables among all types of subfecund women.

The National Survey of Family Growth reports that, of the 10% of US women identified as fecundity-impaired in the 1995 NSFG, 43% had ever sought infertility services. We are thus confronted with a paradox. On the one hand, we have a group of women who seem prepared to do "whatever it takes" to become pregnant. On the other hand, there is a large group of women who do not seek treatment at all. We suggest that examining a broader spectrum of subfecund women will help address this paradox successfully.

To our knowledge, the only detailed examination of patterns of help-seeking based on a random population-based survey of infertile couples is the work of van Balen and

his colleagues. In a study of Dutch women, van Balen *et al.* (1997) examined the motivations of women who have considered and selected various options for dealing with infertility, including medical treatment, adoption, foster care, alternative medicine, and other life goals. Using the same data, van Balen and Verdurmen (1999) found that medical anxiety and duration of infertility were significantly associated with the choice of treatment pathway. Because only those who tried to get pregnant and those who considered themselves as having fertility problems were included in the sample, we know little about the excluded categories of infertile women who are technically subfecund but who do not self-identify as someone with fertility problems or who take no action. Because of the stigma of infertility, it is important also to understand the wider spectrum of women with fertility problems who do not self-identify (or who do not yet self-identify) as someone with fertility problems but who meet the medical criteria for subfecundity (see Daly, 1988; Greil, 1991).

Early approaches to medical help-seeking in the social sciences conceptualized individuals as rational deciders. Some scholars have called for an increased emphasis on help-seekers' perspectives in the study of help-seeking in an attempt to understand how individuals perceive their need for treatment. In a seminal work, Zola (1973) pointed out that symptoms are ubiquitous in social life and that the process of the social construction of illness is mediated by social triggers, such as perceived interference with personal and social relationships and sanctions from significant others. In a similar vein, Mechanic (1968) argued that help-seeking will be influenced by such factors as the perceptual salience of deviant signs and symptoms, the extent to which symptoms disrupt the activities of daily life, and competing possible responses to symptoms. Leventhal *et al.* (1980, 1984) emphasized the importance of "common-sense" understandings of symptoms and their meanings as a crucial part of the explanation of responses to health conditions. In a classic example, they pointed out that patients with hypertension—a condition that medical professionals consider to be asymptomatic—nonetheless typically believe they can sense when their condition is getting better or worse and take action in response to their "symptoms." Haug *et al.* (1998) demonstrated that bodily changes do not automatically result in self-diagnosis among older adults and interpreted this finding as supporting the common-sense approach.

The role of common-sense understandings may be more important to the explanation of help-seeking for some conditions rather than others. Common-sense interpretations should be more important for conditions that are not regarded as life-threatening (Alberts *et al.* 1998; Verbrugge, 1985). Common-sense interpretations may also be more important when it comes to such conditions as mental illness where there is not a general consensus that seeking professional help is necessarily the obvious choice. For both of these reasons, these factors may be particularly important in understanding help-seeking for subfecundity. Subfecundity is not generally life-threatening and, in fact, is often asymptomatic. Likewise, many people may not assume that medical treatment is the most appropriate response to subfecundity. While professionals may agree that a year of unprotected intercourse without conception is indicative of subfecundity, individual women employing common-sense perspectives may operate in the context of either a longer or a shorter time-frame. For example, women who are open to a pregnancy but not actively trying to get pregnant (subfecund without intent) are less likely to seek medical help unless the situation persists for a long time.

In this study, we examined the help-seeking patterns of a random sample of ever-infertile women (*i.e.* women who are currently experiencing infertility or who have done so in the past), paying special attention to their understandings of their situation. We focused on describing the characteristics of those who sought treatment and those who did not, making a studied comparison between the “subfecund with intent,” who have actively tried to get pregnant, and the “subfecund without intent,” who are technically subfecund but who do not appear to have been actively trying to get pregnant. For those seeking help, we have explored the many possible combinations of conventional, non-conventional, and spiritual help that existed among our sample.

Method

Sample

A random sample of US women ages 25–50 with an over sample of women in high minority (Black and Hispanic) census tracts was recruited. This sampling strategy was designed to guarantee that there would be adequate representation of minority women, an understudied group whose help-seeking patterns are believed to differ in significant ways from the US population as a whole. Women from 12 states in the upper Midwest participated in the study (Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, North Dakota, Nebraska, Ohio, South Dakota, and Wisconsin). Study participants were selected via random digit dialing. Interviews took place over the telephone using computer-assisted telephone interviews (CATI), a procedure that involves programming the survey and skip patterns into a software program. Answers to each question are entered into the computer as the interview takes place, and the type of answer determines the direction of skip patterns. The interviews were conducted in the spring of 2002 by the Bureau of Sociological Research of the University of Nebraska-Lincoln. The mean length of interviews overall was 36 minutes. The structured interview included measures of background characteristics, fertility status, pregnancy history, help-seeking behavior, and social psychological outcomes.

The overall response rate was 63%, but the rate of cooperation among contacted households was 78%. This response rate would be classified as “good” to “excellent” using Babbie’s (2004) rule of thumb. Comparison with census data for the 12 states showed that the average age (38 years) of the sample closely mirrored the general population. As intended, the sample over-represented African Americans: 15% of the sample is African American compared to 10% of women aged 25–50 in these states. As is usual with telephone surveys, the sample over-represented well-educated women: 36% of the sample compared to 27% in the census reported 4-year college degrees, limiting generalizability to areas beyond the Midwest and to less educated women.

Women were regarded as subfecund if they reported at least one of three situations: they ever tried unsuccessfully to get pregnant for 1 year or more, they ever tried for 12 months or more to conceive any of their pregnancies, or they ever had 1 year or more of unprotected intercourse without pregnancy. We used a lifetime prevalence measure of subfecundity; women were classified as subfecund if they had ever experienced a period in their lives when they fit the biomedical definition of infertility. Of the 580 women who were interviewed, 196 (34%) met the criteria for subfecundity at some point in their life and were asked questions about help-seeking. This paper describes only these 196 women.

Of these 196 women, 123 (63%) were classified as "subfecund with intent" because they reported that they had tried for longer than 12 months to conceive (with or without a pregnancy). We classified as "subfecund without intent" the remaining 73 (37%) women who reported having unprotected intercourse for more than a year without pregnancy but who did not respond affirmatively to the other qualifying questions. The subfecund without intent were not voluntarily childless; in fact, 90% of them were biological mothers. They were subfecund by the biomedical definition, but they were not necessarily actively trying to conceive. The subfecund without intent are unlikely to be represented in studies that employ clinic-based samples.

Materials

A structured interview including a wide range of items was used. Of particular relevance for this report were stages of help-seeking, spiritual help, information-seeking/self-education and such other variables as locus of control. Stages of help-seeking. We asked women several questions to assess levels of medical help-seeking. We combined responses to these questions into a single ordinal variable that measured the degree of involvement with help-seeking. Women were placed in the following categories:

1. Sought non-conventional help only.
2. Saw a doctor/clinic, got advice.
3. Had diagnostic tests.
4. Sought treatment.
5. Had treatment.
6. Is currently pursuing treatment.
7. Concluded medical treatment.

Women were placed in the highest category that they said "yes" to, with "no help" being the lowest and "concluded treatment" being the highest, regardless of the previous steps they took. Although we originally conceptualized the various treatment choices as comprising a series of stages, in which one stage (e.g. talking to a doctor/ clinic) was a necessary condition for taking successive stages (e.g. actually receiving treatment), not all women followed a conventional sequential path. For example, some said that they have had tests, but did not say "yes" to questions about talking to or getting advice from a physician or clinic staff. For the bivariate analyses, we collapsed categories 2 (saw a doctor or clinic) to 7 (concluded treatment) into a dummy variable with 1 indicating sought any medical help and 0 indicating no medical help-seeking.

Spiritual help. We also asked respondents if they had consulted a minister or other spiritual leader about fertility. Responses are coded as either "yes" or "no." Because it is possible and reasonable to consult a spiritual advisor at any stage in the treatment process, we treated this as a separate variable rather than combining it with the ordinal help-seeking variable.

Information-seeking/self-education. The women were asked if they engaged in any of a series of 10 information-seeking/self-education activities, such as reading a book or article about infertility or seeking information in the internet. See Table 4 for the detailed list of items.

Other variables. Respondents also answered questions about internal medical locus of control, identity as someone with fertility problems, and current desire for a baby (or another baby). We measured locus of control using five of the six items from the Internal Health Locus of Control scale (Wallston *et al.*, 1978), designed to measure the extent to which individuals believe that they can influence their own health outcomes (high score = more internally controlled). Internal medical locus of control is measured as the mean of five items, reversed, provided in a strongly agree (= 1) to strongly disagree (= 4) format: "If I get sick, it is my own behavior which determines how soon I get well again; I am in control of my own health; When I get sick, I am to blame; If I take care of myself, I can avoid illness; if I take the right actions, I can stay healthy" ($\alpha = 0.65$ among the subfecund). We measured identification as someone with an infertility problem with a single question: responses were coded as either "yes" or "no." Desire for a baby was also measured with a single question: "Looking to the future [if it were possible] would you, yourself, like to have [a/another] baby? Would you say definitely yes, probably yes, probably no, or definitely no?" Those who answered "yes" or "probably yes" were scored as a 1.

Finally, respondents answered questions about the timing of the infertility episode and background characteristics. The Expectation Maximization Imputation procedure in SPSS imputed values for 40 cases (7%) with missing data on income.

Analysis

Our primary intent was to provide a descriptive study of help-seeking by type of subfecundity (with or without intent). We were also interested in levels of help-seeking, whether or not respondents sought spiritual help, and types of information-seeking/self education. To determine if there are differences between the subfecund with and without intent, we used chi-square tests for the categorical variables and independent samples means tests for the continuous variables. To assess associations between categorical variables and help-seeking (yes/no) by fecundity status we used three way tables and chi-square statistics. To assess associations between continuous independent variables and help-seeking, we separately assessed each centered continuous variable in a logistic regression model with a dummy variable indicating subfecundity type and then added an interaction term of the continuous independent variable and subfecundity type.

Results

Description of the sample

Fewer than half of the women had their first subfecundity episode in the last 10 years (about 40%). Most were White; Whites had a greater representation among the subfecund with intent (77%) than among the subfecund without intent (67%). The majority of the women were currently mothers (over 85%), were married, and were employed. The average age was 39 for the subfecund with intent and 37 for the subfecund without intent. Most of the women had attended some college (about 14 years), and average income was about \$50,000. See Table 1 for details on all of the variables.

Table 1. Descriptive data by subfecundity type.

Independent variables	Subfecund without intent (<i>n</i> = 73)	Subfecund with intent (<i>n</i> = 123)	
<i>Background characteristics</i>			
Episode within 10 years (= 1)	39.84%	42.47%	
White, non-Hispanic	77.24%	67.12%	
Biological mother	85.37%	90.41%	
<i>Social roles</i>			
Social mother	5.69%	1.37%	
Married	81.30%	58.90%	**
Cohabiting	4.07%	6.85%	
Employee	78.05%	75.34%	
<i>Identity issues</i>			
Thinks has fertility problems	50.41%	9.59%	***
Would like [a/another] baby	42.28%	26.03%	*
<i>Self-education</i>			
Read articles on fertility in popular magazines?	60.55%	28.13%	
Read articles ... in technical/scientific journals?	50.00%	14.06%	***
Read a book about fertility?	42.20%	12.50%	***
Asked a healer/alternative medicine practitioner ...	16.36%	0.00%	
Consulted a minister or other spiritual leader ...	8.13%	4.11%	
Consulted a therapist or other mental health ...	8.18%	4.76%	
Discussed fertility with friends or family	66.36%	28.13%	***
Discussed ... others ... similar problems	58.18%	23.81%	***
Contacted a support group/health organization ...	15.45%	3.17%	*
Looked for information ... on the Internet	23.64%	10.94%	*
<i>Continuous variables</i>			
	<i>Mean (SD)</i>	<i>Mean (SD)</i>	
Age (25-50)	39.62 (6.71)	37.16 (6.84)	*
Education in years	14.28 (2.27)	13.64 (2.08)	
Family income (in \$10,000s)	5.89 (2.62)	5.17 (2.17)	*
Internal medical locus of control	2.79 (0.41)	2.81 (0.41)	

Note: Chi-square tests were performed for categorical dependent variables. Independent samples *t* tests were performed for continuous dependent variables.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Subfecundity: does intent matter?

Before separating all of the analyses by type of subfecundity, we compared these two groups of women on basic characteristics. Table 1 provides percentages for categorical variables and means and standard deviations for continuous variables by subfecund type. The subfecund without intent tended to be younger and have less family income than the subfecund with intent. Although parenthood status did not differ between the two groups, the subfecund without intent were less likely to be married, to want another child, and to think of themselves as having fertility problems. They were also less likely to report engaging in a wide range of information-seeking/self-education activities. The finding that these two groups had distinctive characteristics supports our decision to analyze treatment-seeking patterns separately by type of subfecundity.

Table 2. Treatment seeking by various independent variables and type of subfecundity.

Independent variables		Subfecund with intent % sought help (<i>n</i> = 123)	Subfecund without intent % sought help (<i>n</i> = 73)	<i>n</i> for row
Total sample		54.47	13.69	196
<i>Background characteristics</i>				
Episode timing	Beyond 10 years	43.24	14.29	116
	Within 10 years	65.31	12.90	80
	<i>chi-square p-value</i>	0.02	0.87	
Age in categories	Under 31 years old	27.27	9.09	22
	31–40 years old	59.70	14.91	80
	41–50 years old	52.92	14.29	94
	<i>chi-square p-value</i>	0.17	0.89	
Race/ethnicity	Majority	55.32	12.24	143
	Minority	41.38	16.66	53
	<i>chi-square p-value</i>	0.18	0.61	
<i>Social roles</i>				
Motherhood status	Not a mother	66.66	0.00	15
	Biological mother	49.52	15.25	171
	Social mother	66.66	0.00	10
	<i>chi-square p-value</i>	0.41	<i>n/a</i>	
Relationship status	No union	27.78	12.00	43
	Married	56.00	13.95	143
	Cohabiting	60.00	20.00	10
	<i>chi-square p-value</i>	0.08	0.89	
Employment status	Not employed	37.04	11.11	45
	Employed	56.25	14.55	151
	<i>chi-square p-value</i>	0.08	0.71	
<i>Identity issues</i>				
Self-identifies	Thinks no problems	26.23	9.09	127
	Thinks has problems	77.42	57.14	69
	<i>chi-square p-value</i>	0.00	0.00	
Want more children?	Does not want more	53.52	12.96	125
	Wants more children	50.00	15.79	71
	<i>chi-square p-value</i>	0.70	0.76	

Help-seeking and fecundity type

Of the 196 subfecund women, 77 (39%) said they sought some type of medical help for their fertility problem. As Table 2 shows, there were striking differences in help-seeking between the subfecund with intent and the subfecund without intent ($\chi^2 = 28.65$, $df = 1$; $p < 0.001$). Among the 123 subfecund with intent, 54% reported having sought medical help compared to only 14% of the subfecund without intent.

Table 2 presents the percentage of women who reported having sought help by various independent variables and type of subfecundity (subfecundity with intent *vs.* subfecundity without intent). We performed separate chi-square tests within each subfecundity type. For ease of presentation, we put the independent variables in the rows and treatment-seeking in the columns; therefore we presented row percentages and

Table 3. Medical help-seeking status by subfecundity type.

	Subfecund without intent % (n)	Subfecund with intent % (n)	Percentage of those seeking treatment % (n)	Total %
Did not seek medical help	46 (56)	86 (63)	61 (119)	
<i>Total seeking help</i>	54 (67)	14 (10)	39 (77)	
Non-conventional only	2 (3)		1 (3)	4
Saw a doctor/clinic, got advice	11 (14)	8 (6)	10 (20)	26
Had diagnostic tests	11 (13)	1 (1)	7 (14)	18
Sought treatment	4 (5)	1 (1)	3 (6)	8
Had treatment	4 (5)		3 (5)	6
Is currently pursuing treatment	4 (5)		3 (5)	6
Concluded medical treatment	18 (22)	3 (2)	12 (24)	31
	100 (123)	100 (73)	100 (196)	100 (77)

compared down. Among the categorical dependent variables, two variables were significantly associated with help-seeking. For both the subfecund with intent and the subfecund without intent, those who self-identified as having fertility problems were more likely to seek help. Among the subfecund with intent only, women with more recent first episodes of subfecundity were more likely to seek treatment for fertility problems. We assessed associations between three continuous variables and the likelihood of seeking treatment independently and by subfecundity type using logistic regression analyses. For all of these analyses, we first included a dummy variable to measure subfecundity type because of the strong association between subfecundity type and seeking medical help. Internal medical locus of control had a negative association; those with more control were less likely to seek treatment ($\exp(B) = 0.241, p = 0.005$) and education ($\exp(B) = 1.246, p = 0.012$) and income ($\exp(B) = 1.313, p = 0.001$) had positive associations, controlling for subfecundity type. None of the interaction terms reached statistical significance; the associations did not differ by type of subfecundity.

Patterns of help-seeking

Table 3 presents more detailed data on medical help-seeking by type of subfecundity. Among those who had sought help, there was considerable variation in help-seeking patterns. A small percentage (4%) of those who sought any help ($n = 77$) sought only non-conventional help. All in all, 43% of those who sought medical help for subfecundity reported receiving treatment. This figure includes those who got treatment but did not report their current status (6%), those who were still seeking treatment (6%), and those who have concluded treatment (31%). The remainder of the 77 women who sought medical treatment either saw a doctor to talk to or get advice from (26%), had diagnostic tests only (18%), or sought treatment but did not get any (8%). Not only were the subfecund with intent more likely than the subfecund without intent to have sought medical help, but more of the subfecund with intent had gone further in their pursuit of treatment; 48% of the subfecund with intent actually received treatment compared to 20% of the subfecund without intent.

Table 3 displays figures solely for those women who sought non-conventional help only, but it is, of course, possible to combine non-conventional help-seeking with other types of help-seeking. Only six women sought non-conventional help for infertility. Of those six, five were subfecund with intent and one was subfecund without intent. The question on non-conventional help-seeking gave participants considerable leeway to define "non-conventional" for themselves. Therefore not all observers would agree that these treatments are non-conventional. The one subfecund without intent woman bought an over the counter ovulation kit, as did one of the women in the subfecund with intent category. The remaining four said that they took "herbs, and went to a specialist in natural products," were "taking flaxseed oil," "used acupuncture and vitamin therapies, saw a naturopath" or did not specify the action they had taken.

Women varied in the combination of activities in which they engaged. Of the 20 women who saw and/or got advice from a doctor or clinic, 18 saw a doctor or clinic only, and two talked to a doctor or clinic only. Of the 14 women who got tests, three also saw a doctor or clinic, and 11 saw and talked to a doctor or clinic. Of the six women who sought treatment, two also saw and talked to a doctor or clinic, and four saw and talked to a doctor or clinic in addition to getting diagnostic tests. There were two general patterns among the five women who had treatment: two women combined seeking and talking to a doctor or clinic with seeking and having treatment; three women combined seeking a doctor or clinic, getting diagnostic tests and seeking treatment with having treatment. All of the five women who were still seeking treatment performed all of the previous actions except seeking non-conventional help. All of the 24 women who concluded treatment performed all of the previous actions and three had used non-conventional help as well.

We analyzed spiritual help-seeking separately from medical help. Of the 119 women who did not report to having sought medical help, three women (3%) consulted a minister or other spiritual leader about fertility. An additional 10 women sought religious or spiritual help in addition to medical help-seeking. The one subfecund without intent woman who consulted spiritual help also concluded treatment. The remaining nine women were all in the subfecund with intent category: four concluded treatment, one was currently pursuing treatment, one sought but did not get treatment, two had diagnostic tests and one saw and or talked to a medical doctor or clinic. There was no statistically significant relationship between seeking spiritual help and seeking medical help.

Information-seeking/self-education

As Table 4 shows, self-education was much more common among treatment-seekers than among non-treatment-seekers. Treatment-seekers were more likely to seek additional information about infertility than non-treatment-seekers through books, popular magazines, scientific journals, the Internet, support groups, talking to friends and family, contacting a minister or spiritual leader, or contacting a healer. For the subfecund with intent, all of the actions were significantly more likely among the treatment-seekers but, among the subfecund without intent, only reading magazines, discussing infertility with others, contacting a support group, and searching the internet were significantly different.

Only 33 subfecund women reported using the Internet as a source of information or support. Most women who used the Internet employed it primarily as a means of gathering knowledge about fertility problems in general or about a specific condition.

Table 4. Actions to seek information or self-educate about infertility by help-seeking and subfecundity type.

	Subfecund with intent		Subfecund without intent		
	No treatment	Treatment	No treatment	Treatment	
Read articles on fertility in popular magazines	41.07%	81.13% ***	23.73	80.00	**
Read articles on fertility in technical or scientific journals	35.09%	66.04% **	11.86	40.00	
Read a book about fertility	17.86%	67.92% ***	10.17	40.00	
Asked a healer or alternative medicine practitioner about fertility	8.77%	24.53% *	0.00	0.00	
Consulted a minister or other spiritual leader about fertility	1.69%	14.06% **	3.17	10.00	
Consulted a therapist or other mental health professional about fertility	1.75%	15.09% *	3.45	20.00	
Discussed fertility with friends or family	50.88%	83.02% ***	22.03	100.00	***
Discussed fertility with others who have experienced similar problems	36.84%	81.13% **	18.97	80.00	*
Contacted a support group or reproductive health organization for information about fertility	3.51%	28.30% ***	1.72	20.00	*
Looked for information about fertility on the Internet	7.02%	41.51% ***	6.78	60.00	***
Valid <i>n</i>	56	53	58	5	

Notes: Cells contain the percent who said "yes" to each question by subfecundity type and treatment seeking category. Separate chi-square tests were performed for the subfecund with intent and the subfecund without intent. Because of a programming error, 18 subfecund women were not asked these questions; some women also refused or said that they did not know the answers. Therefore, the sample sizes are smaller.

* $p < 0.05$; ** $p < .01$; *** $p < 0.001$.

About a third of the women (30%) who sought Internet information reported that they found it very useful ($n = 10$). About half (55%) of the women said that they talked to a medical professional about the information that they received online. Only a handful of women reported using the Internet interactively by contacting professionals for advice or by participating in chat rooms or list serves. For example, only two subfecund women joined an online support group.

Discussion

Studies of subfecund women drawn from infertility clinics or support groups have tended to characterize the subfecund as deeply committed to the pursuit of treatment (Busch, 2001; Greil, 1991; Sandelowski, 1993; Sandelowski & Pollock, 1986; Scritchfield, 1995; Williams, 1988). At the same time, demographic studies based on random samples (Chandra & Stephen, 1998; Hirsch & Mosher, 1987; Kalmuss, 1987) have found that less than half of subfecund women in the US have ever sought infertility services. How can we make sense of these contrasting findings? Why are some women who are trying to conceive willing to do anything to get pregnant while other subfecund women do nothing? We used a random sample of US women who meet the criteria for subfe-

cundity but who varied in help-seeking behavior and intention to get pregnant to shed some light on this paradox.

In this study we distinguished between the "subfecund with intent," who said that they have been actively trying to get pregnant, and the "subfecund without intent," who had a period of at least 12 months of unprotected intercourse but who did not say that they were trying to get pregnant. Distinguishing between the subfecund with intent and the subfecund without intent revealed important information about subfecund women. The subfecund with intent were much more likely to seek help, and among those who sought help, they were much more likely to receive treatment. Nevertheless, it is interesting that some women who did not see themselves trying to conceive still sought medical help for pregnancy.

We have limited information about the motivations and self-perceptions of the subfecund without intent. Our data cannot reveal why a large number of women who fit the biomedical definition of subfecundity did not describe themselves as having *tried* to get pregnant. A plausible explanation is that these women were open to the possibility of becoming pregnant but were not self-consciously trying to get pregnant. While we cannot enter the minds of these women and say with confidence that these women were "open to" rather than "trying for" a pregnancy, we can say that these women appear to have acted *as if* this were the case. It appears as if the subfecund without intent were less likely to pursue treatment because they did not conceptualize their situation as one requiring medical attention. Simply not conceiving after a year of unprotected sex was not sufficient to promote action among the majority of this group. We speculate that they have a more passive or fatalistic approach to parenthood than the subfecund with intent, with the exception of the 14% (10/73) of the subfecund without intent who did seek medical help. Clearly future research should explore women who are subfecund without intent to understand their responses to episodes of infertility.

One important limitation of this study is that it was based on cross-sectional rather than longitudinal data. We cannot determine if identity contributes to help-seeking or if help-seeking helps create identification with infertility. It is possible that women who see medical professionals learn that they meet the criteria for infertility, and that infertility is not necessarily the same as sterility. Women may be responding to being treated as a woman with fertility problems rather than deciding that first and then seeking treatment. Only longitudinal research will reveal if the subfecund without intent eventually go through a period of "trying" or not.

Over a third of our sample (37%) were subfecund without intent. Because our data over-represents minority groups and more highly educated Midwestern US women, we do not know if a similarly high percentage would emerge in nationally representative data. Of course, we cannot generalize beyond the US. These limitations also inhibit generalizing from the rates of help-seeking that we found. The absence of a national health care system, lower rates of access to health care and greater financial barriers to infertility treatment for US women make comparisons with European nations difficult. Future studies should include measures that will identify the subfecund without intent in other countries to provide comparisons with our findings and insights into the nature of this understudied group.

A number of scholars have stressed the importance of help-seekers' perspectives (Mechanic, 1968; Zola, 1973) and common-sense understandings of symptoms and their meanings (Haug *et al.*, 1998; Leventhal *et al.*, 1980, 1984) as a crucial part of the explana-

tion of responses to health conditions. Common-sense interpretations should be more important for non-life-threatening conditions where there is little consensus that seeking professional help is necessary. We found support for these theoretical assertions. Self-definition and common-sense understandings have strong associations with seeking medical help; however, it is possible for a woman to see herself as having tried unsuccessfully to conceive at some point in time without considering herself as someone with a fertility problem. Thinking of oneself as someone with fertility problems, actively "trying" to get pregnant and conceptualizing medical problems as something outside one's individual control were associated with more help-seeking.

Our study has demonstrated that quantitative research can contribute to our understanding of the role of self-definitions in shaping the behavior of subfecund women. Qualitative studies based on interviews with infertile couples (Daly, 1988; Greil, 1991; Sandelowski, 1993) describe a difficult identity transition in response to a non-event, the lack of conception. Previous studies have mostly focused on individuals and couples who have self-identified as having fertility problems to such a degree that they have sought help through a clinic or a support group. Thus, researchers have only been able to study the process of self-identification retrospectively. We need prospective studies of the process of coming to define oneself as someone who has a fertility problem that requires medical help.

For the subfecund with intent, women whose subfecundity episode occurred within the past 10 years were significantly more likely to report seeking help than those whose subfecundity episode took place further in the past. This is likely to be a result of advances in the medical treatment of infertility and of increased public awareness of infertility. It is likely that, in the last decade, more women have become aware of medical solutions to subfecundity and have greater faith in their efficacy. In addition to identity and availability issues, sufficient resources to enable access to treatment were also associated with treatment-seeking for all subfecund women. This supports previous help-seeking research (Shaw, 1989), which has shown that enabling factors such as higher family income and being employed increased the likelihood of medical help-seeking.

This study focused on women's attempts to overcome subfecundity by getting pregnant. There are, of course, other options for dealing with subfecundity that we will examine in future research (*e.g.* non-medical help, adoption, or remaining childless and focusing on other life goals). The numbers of women who engaged in non-professional medical help-seeking, such as seeking spiritual guidance or information/support on the Internet, were quite small. Therefore, these results need to be interpreted with caution. Among those few women, we found that those who pursued non-medical avenues (spiritual, self-education, non-conventional approaches) often engaged in conventional medical actions as well. Over half of the subfecund took at least one action to educate themselves about infertility. Informal actions (*e.g.* talking to friends or family) were more common than formal strategies (*e.g.* joining a support group or consulting a mental health professional). Only 33 of the subfecund said that they had used the Internet as a source of information, and even fewer women joined an online support group. Therefore researchers using Internet or support-group-based samples should use great caution in generalizing from these rare groups.

From a practical point of view, our research makes it clear that there is a potentially large unmet need for infertility services. Most of the subfecund women in our sample did not report availing themselves of medical treatment for infertility. Research needs

to be done to determine what steps are necessary to make infertile women aware of the services that are available and to insure that all those who desire infertility services have access to them. Our results suggest that many women do not realize that they meet the medical criteria for infertility and may therefore wait so long to get help that their chances of conception decrease. Few women reported pursuing help from mental health professionals; instead they relied on their own reading for information and on family and friends for support. In terms of practice, this suggests an unmet need for counseling services, while on a theoretical level it points to the importance of social networks in the help-seeking process.

In conclusion, contrary to perspectives which conceptualize help-seeking decisions as rational choices made by individuals, we found that common-sense understandings and self-definitions are central to medical help-seeking among subfecund women. We distinguish between women who are "trying" to get pregnant—the subfecund with intent—and women who "could have" gotten pregnant—the subfecund without intent. We argued that understanding how subfecund women conceptualize their situation is crucial to understanding their behavioral responses to subfecundity. This study supports those arguing for the importance of common-sense understandings of conditions to interpret the help-seeking process among subfecund women.

Acknowledgements

This is a much revised version of a paper presented at the International Conference on Social and Medical Perspectives on Infertility, November 2002, Goa, India. We would like to thank Lynn White for reading the manuscript carefully and making very helpful suggestions for improvement. We wish to thank David R. Johnson, Laurie Scheuble, Naomi Lacy, Danelle de Boer, and Mary Casey Jacob, members of the team that designed the larger study of which this is a part. The University of Nebraska provided essential funding.

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