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THE FAMILY

Infertility and Involuntary Childlessness: The Transition to Nonparenthood

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While the "transition to parenthood" has now received considerable attention from social scientists, the "transition to nonparenthood" experienced by infertile couples who are involuntarily childless has received little consideration. This article provides a theoretical framework for understanding the reality reconstructions, identity transformations, and role readjustments that must be made by involuntarily childless couples who are unable to make the transition to parenthood as they had anticipated.

Eighteen years ago, in her paper "Transition to Parenthood," Alice Rossi deplored the lack of attention that had been given to the social processes involved in such a transition. She posed two questions: "(1) What is involved in the transition to parenthood: what must be learned and what readjustments of other role commitments must take place in order to move smoothly through the transition from a childless married state to parenthood? (2) What is the effect of parenthood on the adult: in what ways do parents, and in particular mothers, change as a result of their parental experiences?" (1968: 26).

In contrast with Rossi's work, this article focuses on those couples who would like to be parents but who are unable to produce a biological child of their own. Such people suffer from the biologically and perhaps psychologically

caused condition of infertility and have the social status of being involuntarily childless. Unlike the voluntarily childless, most such persons have generally assumed that becoming parents was part of the process of adult family life. Because of this, the identities and social relationships of the involuntarily childless are likely to be very different from those of child-free couples who either do not want children or have not yet attempted to have them. To borrow Rossi's term, the involuntarily childless have undergone a "transition": from the anticipated status of potential parenthood to the unwanted status that will be referred to here as nonparenthood. With but minor amendment, the questions posed by Rossi are applicable to involuntarily childless couples. Thus, the following pages set forth a conceptual framework that can help explain (a) the transition to nonparenthood: the readjustments of identity and role commitments that must occur when the condition of involuntary childlessness occurs, and (b) the effect of infertility and involuntary childlessness on couples desirous of having children.

Both before and after the appearance of Rossi's article, the transition to parenthood has received considerable attention from family life specialists (e.g., Belsky and Rovine, 1984; Dyer, 1963; Gutmann, 1975; Hobbs, 1965, 1968; Hobbs and Cole, 1976; Jacoby, 1969; LeMasters, 1957; Russell, 1974). Likewise, the phenomenon of voluntary childlessness has been well studied (e.g., Veevers,

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1980). In contrast, the phenomenon of involuntary childlessness has been virtually ignored by family sociologists and psychologists. For example, in her 1983 Presidential Address to the American Sociological Association, Rossi totally overlooked the involuntary childless when she stated, "almost all adults take on parenting responsibilities at some point in their lives. There has been only a slight increase in voluntary childlessness" (1984: 3). References to infertility and involuntary childlessness simply are not to be found in most of the leading textbooks dealing with family life (e.g., Eshleman, 1981; Fullerton, 1977; Green, 1978; Hutter, 1981; Leslie, 1982; Melville, 1980; Nye and Berardo, 1973; Skolnick and Skolnick, 1974, 1980). The rare text that does mention the subject usually limits its discussion to a brief consideration of the possibility of adoption as an alternative to biological parenthood (Bell, 1979: 200-202) or to a discussion of alternative technologies of conception, such as artificial insemination (e.g., Bell, 1979: 203-204; Broderick, 1979: 296-298; Saxon, 1977: 406-408). No analysis of the social and psychological dimensions of involuntary childlessness is provided. Much the same can be said of the popular press. While recent advances in medical technology, such as *in vitro* fertilization and surrogate motherhood, have led to a plethora of articles about infertility and its treatment, the social and social-psychological dimensions of involuntary childlessness have generally been ignored. The only literature that deals with the social and social-psychological aspects of infertility and involuntary childlessness is based on the work of clinicians. Much of that work is impressionistic, is based on very small samples of persons seeking psychiatric help, and deals primarily with the psychological disorders that are supposed to *cause* infertility, rather than with the social and social-psychological *consequences* of infertility for the involuntary childless (see Martin Matthews and Matthews, 1986, for a review of that literature).

Such neglect by social scientists might be understandable if infertility and involuntary childlessness affected only a small proportion of females. Estimates of the prevalence of the problem range widely, from 1 in 12 to 1 in 5 couples (Burgwyn, 1981; Humphrey, 1969: 133; "Infertility," 1982: 102; Menning, 1980: 313; Speroff, Glass, and Kase, 1973: 172; Van Keep and Schmidt-Elmendorff, 1975); that it affects at least 10% to 15% of all married couples (Carr, 1963); and that at least 3½ million couples in the United States are infertile (Porter and Christopher, 1984: 309). Two reports by the U.S. National Center for Health Statistics (1982, 1985) provide estimates based on

interviews with national samples of women in the childbearing ages (15-44 years of age) in the non-institutionalized population. The center estimates that in both 1965 and 1976 about 1 in 10 married couples were infertile in that the women involved had never had a sterilizing operation and had unprotected intercourse during the preceding 12 months without becoming pregnant (1982: 1-3). Also significant was the finding that about 75% of all wives with impaired fecundity (which includes the surgically sterile and totals about 16% of all married women) wanted to have at least one child, and 57% of such women with one child wanted to have another (1982: 13). In a similar study done in 1982 with a national sample of 7,969 women in the childbearing ages and using the same criteria of infertility, the center reported that infertility had increased to the point where approximately 14% of married women were infertile (1985: 1-4).

Several studies have attributed such increases to side effects from the increased use of birth control, the later age at which couples now attempt to have their first child, and the considerable increase in prevalence of venereal diseases (Burgwyn, 1981: 93; James, 1981; Menning, 1977: 8; U.S. National Center for Health Statistics, 1982: 15-16). However, it is worth noting that even the high estimates of infertility provided by the National Center for Health Statistics do not reflect the full extent of the problem. Their estimates do not include those women who are not now married but who may have an infertility problem. Nor do they include those who may have previously been infertile but have overcome the problem through surgical or other means. They also do not adequately reflect the extent to which male infertility is a problem. Presumably a significant number of unmarried males are also infertile. Finally, there are undoubtedly many couples, particularly in their first years of marriage, who are using contraception simply because they are unaware that they are infertile. Such couples would not be included among the infertile on the basis of the center's criteria of measurement. Consequently, there can be no doubt that infertility and involuntary childlessness is widespread and that its neglect by family life specialists constitutes a major lacuna in our knowledge of the social psychology of the family.

Unlike the clinical work on the supposed causes of infertility, this article provides a framework of concepts to explain the *consequences* of involuntary childlessness. It focuses on the social construction of reality, identity, and role relationships of those who must undergo the often psychologically painful transition to nonparent-

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hood. It is, we believe, a significant conceptual advance over the existing theoretical work in this area. Like Rossi's work on parenthood, it is intended as a guide for further empirical investigation.

INVOLUNTARY CHILDLESSNESS AND REALITY RECONSTRUCTION

By its very nature involuntary childlessness must involve a major reconstruction of reality by both partners in an infertile couple and frequently also requires similar reconstructions by their family and friends. Berger and Kellner's (1970) application of the phenomenological concept of reality construction is of particular relevance to an understanding of involuntary childlessness. They contend that marriage is a process of redefinition in which "two strangers come together and redefine themselves" (1970: 53). They emphasize that this process is aided by others external to the relationship who "assist in codefining the new reality" (1970: 53). They further suggest that a primary function of marriage is to provide the couple with a distinctive private world over which they have some control and which they can shape to some extent as desired, in contrast with the broader social world that is largely beyond their control and which insists on shaping them (1970: 50-55).

Approximately 95% of newly married couples want and expect to have biological children of their own at some point in their life (Glick, 1977). This "subjective" redefinition of their goals is "objectified" by the statements and actions of others (most notably relatives) who give every indication that they are awaiting the arrival of children. Indeed, this is so much the expected or "taken for granted" reality in our society that we frequently divide the stages of family life into the dichotomy between family of orientation and family of procreation. However, for those couples for whom childbearing is problematic, sooner or later these sets of expectations begin to be questioned. Those who try to have children and are unsuccessful are in the unusual situation of having undergone the major reality reconstruction involved in getting married, only to discover that this is beginning to be undermined. They must now redefine themselves as a married couple for whom biological children might not necessarily be possible. Moreover, this must occur at the same time that the objective reality of their redefined status as a couple brings them into closer contact with other married couples (Berger and Kellner, 1970: 59-60), many of whom are publicly planning their pregnancies and having no difficulty in fulfilling their plans.

Infertility not only calls into question the biological function of marriage related to the procreation of children, but it also directly challenges the social function of marriage as providing some control over a private world. The inability to conceive is a situation over which the couple lack a full measure of control. Moreover, instead of marriage providing the infertile couple with "the sort of order in which they can experience their life as making sense" (Berger and Kellner, 1970: 59), they are slowly confronted with a situation of which they can make no sense. In an attempt to give sense to this new reality, many couples come to believe that it is a "curse" or punishment by God for their previous premarital sexual activities (Burgwyn, 1981: 2; Menning, 1977: 108-109; Pohlman, 1970: 8). To the extent that the couple regard having children as a fulfillment of both their marriage and even their purpose on earth, infertility calls into question the meaning and purposes of both their marriage and their very existence. As many infertile couples keep knowledge of their condition to themselves (Menning, 1977: 105-107 and 154), the subjective reality becomes distinctly different from the expectations of their objective reality.

It is under these social conditions that most couples embark on the quest for a medical solution to their problem. Because these fertility investigations normally take a long period of time, it is in this phase that the biological condition of infertility (usually defined as one year of unprotected normal intercourse that does not result in pregnancy) becomes transformed into the social condition of involuntary childlessness. Seeking treatment serves to objectify what had previously been only a personal and subjective reality. Whether or not they communicate to family and friends that they are seeking "outside" help will also influence how quickly, and the extent to which, they accept their infertility as objectively real.

In all infertility investigations, locus of control and responsibility become dominant issues. While, for other couples, family may be the one sphere over which they experience a sense of control, infertility treatment only intensifies the loss of control over the most private aspect of a couple's life together—their sexual relationship. This involves a loss of privacy as the most intimate details of their sexual life (such as monthly menstrual cycle and times of intercourse) are charted. Though these may never be communicated beyond the investigating physician, the fact that these details must be reported on every visit in itself constitutes an enormous loss of control over what for most other couples is very private behavior.

ior. Should the couple enter further into an investigation and treatment process, the loss of control increases. Every detail of their sexual activity is subject to external regulation. Not only must both partners submit to repeated examinations of their genitalia, but various tests require the production of sperm samples on a regular basis, medical investigation within one or two hours of intercourse, attempts at artificial insemination using the male partner's sperm shortly after it has been produced, and coitus interruptus. Control becomes even more an issue as the couple face the possibility of one or both of them proving to be sterile. Not only does this raise the possibility of "responsibility and blame" being assigned to one of the partners, but the designated person may feel guilt and experience doubts about the continuing affection of the other partner.

The way in which the couple deal with such pressures and the extent to which these pressures influence their marriage and lead to a reality reconstruction depend on three sets of factors: (a) the duration and outcome of their infertility investigation and the decisions they have had to make during it; (b) the extent to which the couple have developed shared constructs that enable them to deal with the situation they face, as well as the character of such constructs; and (c) the responses of significant other people, including other family members, to their situation. The implications of each of these are discussed below.

At all stages of an *infertility investigation* there are major decisions to be made that have an impact on the couple's social construction of reality. At one extreme are those couples who achieve a successful pregnancy spontaneously, with the aid of treatment provided by a clinic, or through a process of artificial insemination by donor (AID) or *in vitro* fertilization. At the other extreme are those who learn that their own sterility makes it impossible for them to produce a child by some or all of these methods. In addition, for approximately 10% (Menning, 1977: 66) of infertile couples, no discernible cause for their infertility is ever found. These are the so-called "normal infertiles."

For those who become pregnant in a very short time, either spontaneously or through a relatively straightforward treatment procedure, there is likely to be little long-term social or social-psychological impact and thus little need for an extensive reconstruction of reality. Few, if any, other persons will have known of their problem, and they will have had few decisions to make with regard to treatment. However, the impact on those who ultimately conceive a child after some extensive period of waiting and treatment is likely to be

more pronounced. Not only will the social pressure on them have intensified, but they will likely also have had to make important decisions about the type of treatment they are willing to receive. These decisions may include dealing with the moral implications of treatments such as AID and *in vitro* fertilization, and coming to terms with whether or not they can accept as "theirs" a child conceived in such a manner.

However, the strongest social and social-psychological impact is likely to be found among those who are proven sterile and among those who remain infertile without any reason being determined. Those who are sterile not only have to adjust to the threat that this reality may pose to their self-concept, but may also be required to deal with the difficult decisions related to AID and *in vitro* fertilization or to contemplate the possibility of a child-free lifestyle or adoption. Those for whom no physical cause is found also must make some of these same treatment decisions, while at the same time trying to decide whether and when to end the treatment and investigation process. Many such persons are faced with the dilemma of not knowing whether they can rightfully mourn for what they cannot have, or hope for what they might still obtain. For them, a permanent reconstruction of reality is often impossible, for only when they can bring themselves to end the search for an effective treatment can they reassume some measure of control over their private family world.

The idea that families have typical or *shared constructs* with which they deal with the world has been part of family theory for at least a quarter century. The idea was implicit in Bossard and Boll's (1950) analysis of family rituals, was made explicit in Hess and Handel's (1959) analysis of "family worlds," and has more recently become the focus of systematic theoretical elaboration and intensive empirical investigation in the work of Reiss (1981). Reiss contends that families differ in their experience of novelty in the world and tend to have a shared conception of the fundamental nature or structure of that world (1981: 377). He identifies a series of factors that affect such orientations, and on the basis of these and his laboratory observations, develops a typology of family constructions of reality (1981: 13-77). Reiss also argues that family crises threaten such orientations and at the same time provide a basis around which families rebuild and reorganize (1981: 191). This framework, focusing as it does on family constructions of reality, is closely allied with the perspective of Berger and Kellner described previously, and appears particularly useful in interpreting and explaining the social

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reconstructions that take place as a couple cope with their involuntary childlessness. Reiss's theory suggests that the ease with which an involuntarily childless couple deal with their infertility may well be contingent on whether they have been able, during their marriage, to develop their *own* distinctive family construct to deal with such crises and on the particular way that construct predisposes them to deal with the problems and frustrations related to involuntary childlessness.

A fundamental tenet of the reality construction approach is that *significant other people* are of paramount importance in defining the "objective" reality of one's situation. It follows from this that the nature and type of reality reconstruction that accompanies infertility and involuntary childlessness is considerably influenced by the way in which it is defined by those close to the affected couple. Given that children are necessary for the social continuity of a family, the pronatalist pressures applied by extended family members can frequently be intense. In the light of our previous discussion, it should also be noted that the two sets of kin involved may have quite different "constructs" for explaining and dealing with such situations. Given the patrilineal character of our society, the response of the husband's family may be particularly important to the infertile couple. However, the type and intensity of an extended family's reaction may be influenced by a wide range of factors, including whether or not there are other grandchildren to carry on the family name, and the extent to which each kin group has a child-oriented lifestyle.

INVOLUNTARY CHILDLESSNESS AND IDENTITY TRANSFORMATION

Involuntary childlessness not only affects a couple's view of the nature of reality, it also significantly influences their self-concept and identity. Stryker (1964, 1968), has emphasized the importance of having a theory that explains "the question of self-conception or identity in relation to the family" (1964: 163) and "why it is that some experience little difficulty in modifying the salience of a family identity they hold, while for some such modification occurs—if at all—only with considerable stress" (1968: 558). Stryker attempted to deal with such issues by formulating a series of propositions based on the theory of self and identity found in symbolic interactionism. He also suggested that the occasion of first pregnancy and the assumption of parenthood would be an ideal situation in which to test such a theory, given the significance of this event for the development of a distinctive family identity (1968: 563-564). The following discussion applies symbolic interac-

tionist theory as developed by Stryker and others to the processes of identity transformation produced by infertility and involuntary childlessness. It demonstrates that involuntary childlessness and nonparenthood are likely to have as significant an impact on family and personal identities as parenthood itself.

Identity is "situated," in that it is a person's sense of who he/she is in relation to a particular situation (Stone, 1962: 93). McCall and Simmons analyze the nature of "role identities" (1966) from this perspective. They argue that each person has an interwoven system of role-identities—one for each social position occupied. They further suggest that these are organized in a "salience hierarchy" that is determined by prominence, need of support, intrinsic and extrinsic gratification received, and the opportunity for that identity to be profitably enacted (1966: 84-85). Stryker (1968, 1980), applying this theory to the family, has added to this the concept of "commitment" as essentially an intervening variable and has reasoned that the ranking of any identity in such a salience hierarchy is influenced by one's commitment to it, *vis-à-vis* one's various other identities (1968: 560-563; 1980: 61 and 81-85). On the basis of this premise, he developed a series of 12 propositions or hypotheses.

Many of Stryker's propositions can be related to the particular problems of identity salience and commitment surrounding infertility and involuntary childlessness. For example, his hypothesis that "the greater the commitment premised on an identity, the higher that identity will be in the salience hierarchy" (1980: 83-85) suggests that those couples for whom "commitment to parenthood" is greatest are the ones whose identity is most likely to be threatened by infertility. His hypothesis that those who have a large network of persons supporting a particular identity are likely to rank that identity high in their own salience hierarchy suggests that those whose families and friends emphasize the importance of children are likely to be most inclined toward parenthood and are, therefore, the ones most likely to be affected by a threat to that identity.

However, Stryker's hypotheses that "the higher an identity in the salience hierarchy, the greater the probability that a person will actively seek out opportunities to perform in terms of that identity" (1980: 84) does not consider the impact that a failure to "perform" may have on identity. Involuntary childlessness is such a failure to perform, which may lead to what we would term "identity shock." The impact of such identity shock would appear to be related to the extent to which a person is committed to the identity of bio-

logical parenthood. Stryker hypothesizes that "the greater the commitment, the higher the identity salience, the greater impact the quality of role performance will have on self-esteem" (1980: 84). In the context of infertility and involuntary childlessness, this can be reformulated to read: the greater the commitment to biological parenthood, the greater will be the identity shock brought about by infertility and involuntary childlessness, and the more negative the affect on self-esteem.

This negative impact stems partially from the fact that infertility is an example of what Goffman referred to as a "spoiled identity" (1963: 12, 143-144). In the only existing work on infertility that focuses on identity, Miall (1985, and in press) examined the extent to which infertile women "self-label" themselves as stigmatized and deviant. While the literature on deviance and stigma suggests that stigmatized persons come to accept themselves as stigmatized as a result of negative responses from others, Miall (1985: 393-396) found that the majority of infertile women in her sample labeled themselves as "failures" even without being aware of any form of outside rejection or disapproval. This suggests that infertility (at least for women) may have a greater effect on social identity than many other types of stigma.

Stone (1962; 1981) observed that, in most social interactions, identity is frequently "announced" through the media of discourse and appearance, and he particularly singled out sexual identity in this regard. However, unlike many other physical handicaps, infertility is not readily apparent. Given this, involuntarily childless couples can frequently choose how, when, and to whom to reveal their condition. But, particularly in situations where they act as a couple or as a family, the childless are frequently required by normative pressure to explain their situation, if only so that others will be able to "identify" them and know how to relate to them in the particular situation. Scott and Lyman's (1968) distinction between "excuses" and "justifications" is useful in distinguishing the voluntarily childless from the involuntarily childless on the basis of the rhetoric that they employ in such situations. Whereas "excuses are accounts in which one admits that the act in question is bad, wrong, or inappropriate, but denies full responsibility . . . justifications are accounts in which one accepts responsibility for the act in question, but denies the pejorative quality associated with it" (1968: 48). It is likely that the voluntarily childless will attempt to justify their behavior. In contrast, the involuntarily childless will feel called upon to provide excuses for their "failure" to have children. Their values and orientations, as well as those of their friends

and family, are likely to be such that their childlessness is considered inappropriate. All they can do is deny full responsibility for their condition. Indeed, Scott and Lyman note that some of the most common types of excuses are those that make reference to "uncontrollable bodily functions." That the involuntarily childless must "ask to be excused" is one more aspect of their loss of control.

INVOLUNTARILY CHILDLESSNESS AND ROLE READJUSTMENT

The preceding discussion has emphasized the "validated" aspect of identity. In doing so it has demonstrated the close relationship between identity and role relationships. As Stone states, "to have an identity is to join with some and depart from others, to enter and leave social relations" (1981: 188-189). Consequently, to understand fully the nature and impact of involuntary childlessness and nonparenthood, it is necessary to go beyond a focus on the couple involved and examine their social role relationships with other persons. The term *role* is used here to describe the constructed behavior of persons in social relationships, and the focus is on how actors "play" roles in the context of the normative expectations held by others (cf. Turner, 1962).

The link between identity transformation and role relationships is best described as a process of identification. We see this as including both the *identification of others* as alike or different from oneself and the subsequent *identification with* those regarded as similar to oneself. For involuntarily childless couples, the timing and extent of acceptance that one is like other infertile couples and unlike parents varies with the diagnosis and treatment regimen. An early diagnosis of sterility may quickly force such a redefinition on some couples. For most, the infertility investigation process is slow, and they have a lengthy period in which to readjust their identifications. In the interim, they may develop a wide range of "identification strategies." Some become vicariously involved in parenthood through increased contact with the children of relatives and friends. Others become increasingly involved in work-related activities, even to the point that they begin to regard their childlessness as having certain advantages in much the same way that voluntarily childless couples do. If this happens they may stop offering excuses for their childlessness and begin to use their infertility as a justification for it. Such persons may find themselves receiving far greater acceptance than the voluntarily childless, whose justifications are frequently seen by others as self-serving and who are unlikely to rouse the elements

type of status passage with different distinguishing characteristics. Two obvious comparison groups already identified by Glaser and Strauss are those who suffer from a particular chronic illness (1971: 145) and those involved in the transition to parenthood itself (1971: 83).

The theory of status passage is also particularly useful in explaining the interaction that takes place between infertile couples undergoing infertility treatment, and medical personnel. Glaser and Strauss emphasize the role of the "agent" who largely controls the passage of the "passagee." Those who treat infertile couples frequently serve in this role of agent responsible for announcing to the couple their stage in the passage as well as its likely destination. Such medical personnel may also give the infertile couple an outlet for some of their frustration. Whereas their failure to conceive could only enhance their sense of loss of control and frustration with themselves, the "failure" of a fertility investigation to produce either evidence of the cause of infertility and/or a solution to it can partly be blamed by the couple on the attending physician. It is even possible that the physician, by serving as an object for their frustration, may sometimes serve a latent function of unifying the couple undergoing treatment.

CONCLUSIONS

This article began with the observation that the "transition to nonparenthood" experienced by involuntarily childless, infertile couples has generally been ignored by family scholars, even though the transition to parenthood and the behavior of voluntarily childless couples has now been quite well studied. In much the way that Rossi (1968) first outlined the process of becoming a parent, this article has attempted to describe and explain the process of becoming a "non-parent." While this analysis has been grounded in the concepts concerning general human behavior developed by symbolic interactionists, we have also attempted to integrate works that focus specifically on explaining various aspects of family development. The empirical validity of many of the statements contained here still needs to be established. Our hope is that this work will provide a foundation on which such research can be based.

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of pity that the involuntarily childless frequently receive.

Some involuntarily childless couples who still maintain a strong identification with parenthood may begin to consider ways of experiencing parenting through adoption. This suggests that the transition to nonparenthood involves two relatively distinct facets: the relinquishing of the possibility of biological parenthood and the increasing awareness of and even acceptance of the possibility of social parenthood through adoption. It is this redefinition of oneself and of the type of parenting relationship that one is willing to accept that adoption social workers describe as the psychological "resolution" of an infertility problem (Kraft et al., 1962: 622; Mazor, 1979: 109; Menning, 1977: 113-117; Renne, 1976). Most such social workers look for this type of resolution before being willing to consider an infertile couple as potential adoptive parents (Bradley, 1967: 93; Brieland, 1984: 79; Castle, 1982: 10; Child Welfare League of America, 1978: 60-70; McNamara, 1975: 15-17). However, it is significant that a large proportion of those wishing to adopt a child continue their infertility investigation. While this is due in part to the shortage of children available for adoption, for some involuntarily childless couples the experience of social parenthood may not be sufficient to resolve their desire for biological parenthood. If so, any empirical investigation of the transition to nonparenthood must consider both dimensions separately.

In a comprehensive analysis of family roles, Burr, Leigh, Day, and Constantine (1979) emphasize that role relationships are central to our understanding of the social-psychological nature of the family. They develop a range of propositions related to role strain, ease of role transitions, consensus on and clarity of role expectations, role satisfaction, and role enactment (1979: 57-88). However, they focus only on those situations in which family members have the option of choosing between competing roles. Their propositions are founded on the premise that people have social choices to make concerning various possible roles and that problems of role strain, role transition, and so on arise when choices must be made. Burr et al. do not seem to have considered the possibility that actors might be unable to assume the roles they desire most, no matter how much social and personal gratification they might foresee from doing so. Yet that would appear to be the common condition of many involuntarily childless couples. What is needed are propositions that outline the problems that occur when one is incapable of making a "role transition," no mat-

ter how great the anticipated gratification from that role might be, and which examine the "role strains" that are brought about by the inability to assume a desired role. We refer to such strains and problems of transition as "role blocking," a phenomenon not limited to involuntary childlessness. Somewhat similar processes occur when persons are unable to assume a variety of desired and anticipated roles in the workplace or in society at large because of their own inability, cultural norms, or the deliberate blocking actions of others. Role losses associated with aging and retirement present similar situations.

A set of propositions related to this "role blocking" as experienced by the involuntarily childless would include the following general hypotheses:

1. When involuntarily childless couples are unable to assume the anticipated and desired role of parenthood, there is an associated increase in their level of role strain.
2. This strain is likely to be directly proportional to the role privileges and rewards that such couples attribute to parenthood.
3. The role strain produced by such involuntary childlessness will, in most cases, lead such couples to redefine their situation in such a way that their desired goals become more congruent with the range of possible alternatives still available to them (e.g., adoption, artificial insemination, or *in vitro* fertilization).
4. Such redefinitions will in turn lead to a series of role transitions. However, the greater the perceived role strain that arises from involuntary childlessness, the more difficult will it be for such couples to make such transitions.
5. The more time involuntarily childless couples have to adjust to such strains, the more likely they are to receive anticipatory socialization to such transitions, and thus the easier will such transitions become.

This conception of role transition has much in common with the idea of "status passage" developed by Glaser and Strauss (1971). Their distinctions between desirable and undesirable, reversible or irreversible, and voluntary versus involuntary status passages are helpful in explaining involuntary childlessness. It can be seen as an involuntary, undesirable, and frequently irreversible status passage. This set of characteristics would likely make it unique in any taxonomy of status passages. Thus, empirical research on involuntary childlessness could well benefit from a control group of persons experiencing some other

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