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Childlessness – psychological consequences of decisions taken while experiencing infertility

Abstract

The aim of this article is to present the results of original research into psychological consequences for women choosing intentional childlessness as a way of coping with infertility. The study included 87 women who decided to remain childless. Tools used in the study were: the original Attitudes towards Own Infertility Scale; the HDS-M Scale (Zigmond, Snaith); the original Scale for Assessment of Hope as an Emotional State; the Satisfaction with Life Scale SWLS (Diener et al.); the Rosenberg Self Esteem Scale (SES). Significant correlations were foundbetween variables included in the study were found. The analysis comparing psychological variables with sociodemographic variables showed that only the length of time since diagnosis is related to the level of hope. The analysis comparing childless women with those undergoing infertility treatment revealed statistically significant differences in the level of acceptance of one's infertility (higher in childless women) and in the perception of social support and its types (women undergoing infertility treatment perceived a higher level of support) The cluster analysis indicated that there are three characteristics on which the effectiveness of coping with infertility depend. The conclusions of the study are extremely important in the process of preparing preventive psychology programs for women who make a conscious decision to remain childless.

Keywords

infertility, childlessness, effectiveness of coping

Streszczenie

Celem artykułu jest przedstawienie wyników autorskich badań nad psychologicznymi konsekwencjami dla kobiet decydujących się na wybór świadomej bezdzietności jako sposobu radzenia sobie z niepłodnością. Badaniem objęto 87 kobiet, które zdecydowały się pozostać bezdzietnymi. Użyte narzędzia to: autorska Skala Ustosunkowania do Własnej Niepłodności; Skala HDS-M (Zigmond, Snaith); autorska Skala Oceny Nadziei jako Stanu Emocjonalnego; Skala Satysfakcji z Życia (SWLS) (Diener i wsp.); Inwentarz Samooceny (SES) Rosenberga. Analiza wyników badań wykazała, że istnieją istotne korelacje pomiędzy wyróżnionymi zmiennymi. Ponadto, po kolejnych analizach korelacyjnych pomiędzy zmiennymi psychologicznymi oraz socjodemograficznymi, ustalono, że jedyny istotny związek zachodzi pomiędzy czasem wiedzy o własnej niepłodności a poziomem nadziei. Po dokona-

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niu porównań wyników kobiet bezdzietnych z kobietami leczącymi bezpłodność, stwierdzono statystycznie istotne różnice w poziomie akceptacji własnej niepłodności (wyższy poziom u kobiet bezdzietnych) i percepcji wsparcia społecznego oraz jego rodzajów (wyższy poziom wsparcia spostrzegany jest przez kobiety leczące niepłodność). Wyniki analizy skupień wskazują, że istnieją trzy grupy kobiet bezdzietnych charakteryzowanych poprzez skuteczność radzenia sobie z niepłodnością. Wnioski z badania są niezwykle istotne dla planowania programów psychoprofilaktycznych dla kobiet świadomie decydujących się pozostać bezdzietnymi.

Słowa kluczowe
bezdzietność, niepłodność, efektywność radzenia sobie

Introduction

Experiencing infertility is a situation resembling a psychological crisis. It represents a groundbreaking turning point in one's life as it influences one of the most crucial aspects of human existence, namely the drive for procreation (Holas, Radziwoń, Wójtowicz 2002; Bielawska-Batorowicz 1990; 1991; 2006; Baor, Bickstein 2005; Dembińska, 2014a).

Infertility is a problem not only for an individual experiencing it, but also for the whole of society. There are 9 million women of childbearing age in Poland. Taking into account the fact that in our area of civilization the infertility rate among couples amounts to approximately 15% (i.e. one in every six marriages), it can be estimated that over one million couples in Poland are faced with reproduction problems. Diagnosing and treating infertility is a long-term process and there in no guarantee of success. No individual prognoses are made – when assessing the chances of a given couple to fall pregnant and give birth, doctors use so-called statistical approximation, i.e. a percentage probability, depending on the cause of infertility and the treatment method used. Therefore, uncertainty seems to hover in the background in a situation of infertility. Infertility is a challenge for couples (including women) experiencing this condition. It is a crisis situation that triggers remedial action. This action follows three different strategies: 1. adoption, 2. treating infertility, 3. giving up on having children, i.e. conscious infertility (Bielawska-Batorowicz 2006). Each of the above-mentioned strategies provide experiences accompanying the decision making process.

The majority of people who learn about their procreation problems make a decision about starting treatment. Adoption and conscious infertility are only secondary choices. Many studies have revealed the psychological consequences of infertility treatment in women.Women deciding to start it are exposed to many negative consequences related to different aspects of their lives. Negative emotions appear (anxiety, sadness, a sense of guilt, shame, anger, lability of hope as a state, mood swings). The whole situ-

ation may pose risks to good marital relations (deteriorating relations, reduced satisfaction with sex life) and relations with other people (a sense of loneliness). It can also become a source of moral dilemmas, especially in the case of religious women (a sense of violating norms established by God and the Catholic Church). Women experiencing infertility lose self-confidence and their sense of dignity due to medical procedures related to their bodies and sexuality. They subordinate their lives to treatment, and their professional career is often affected by the necessity to attend numerous medical appointments, which results in a fear of losing their job and getting into financial danger (Domar, Gordon, Garcia-Velasco et al., 2012; Dembińska, 2014a; Dembińska, 2014b). Among women treated for infertility, psychological stress is perceived as the main reason for early abandonment of medical therapy (Olivius et al., 2004; Rajkhowa et al., 2006; Brandes et al., 2009; Van den Broeck et al., 2009; Domar, Gordon et al., 2012).

We still know very little about the consequences of long-term infertility, also among those who decided to remain childless (Wischmann, Korge, Scherg et al., 2012).

Data from these studies show that when it comes to coping with infertility, the best indicators of a positive prognosis, especially for women, are an acceptance of the condition and an ability to give it a positive meaning, actively searching for alternative solutions, and, most importantly, not cutting oneself off from the society (Lechner et al., 2007). On the other hand, the situation of being childless may have a negative impact on a couple's future if the couple constantly mention the condition and discuss it, together with its causes, and if both partners are overwhelmed by a feeling of helplessness and if they believe that children are the only thing that can make their lives meaningful (Verhaak et al., 2007a,b; Kraaij et al., 2008).

The goal of this work is to present the results of original research into psychological consequences for women choosing the third strategy – intentional childlessness. In order to present the scale of the problem and the predispositions of Polish women experiencing procreation issues towards certain treatment choices, the study subjects were asked about accepting or not accepting respective infertility treatment methods and about the probability of them not taking up treatment as the first decision in the process of struggling with this condition (Dembińska, 2013b).The aim of the study was to learn about infertile women's opinions regarding the most controversial issues connected with assisted reproduction, and to compare opinions of women at different stages of infertility (women being treated for infertility, but also women going through adoption procedures, women raising a child – born thanks to treatment or adopted, and women who decided to remain childless and gave up medical treatment or adoption).

Table 1. Acceptance and admissibility of various types of assisted reproductive techniques

Types of assisted reproductive techniques	"YES" – acceptance and willingness to use this technique in the future	"NO" – rejection and lack of willingness to use this technique in the future
Artificial partner insemination	765 (86.5 %)	119 (13.5%)
Artificial insemination by a donor	538 (60.9 %)	346 (39.1%)
In vitro fertilization with a patient's own cells	714 (80.8 %)	170 (19.2 %)
In vitro fertilization with donor sperm	390 (44.1 %)	494 (55.9 %)
In vitro fertilization with donor egg cells	363 (41.1 %)	521 (58.9%)
In vitro fertilization with an adopted embryo	358 (40.5 %)	526 (59.5 %)
None of the above	32 (3.6 %)	852 (96.4 %)

Source: the author's own research (Dembińska 2013b)

The results of the study of infertile women's opinions regarding their acceptance of various assisted reproduction techniques. Techniques where the partner's cells are used were very widely accepted (over 80% both in the case of insemination and IVF), contrary to the techniques where a donor's cells are used (accepted by approx. 40% of the subjects). In the study, 32 subjects, i.e. 3%, claimed to accept no ART. Therefore women who were against ART probably did not start any treatment and instead chose adoption or gave up on having a child (Dembińska, 2013b).

Materials and methods

The study group included 88 women who decided to remainchildless. The results ofchildless womenwill becompared with the results of470 women treated forinfertility (Dembińska, 2014b).The sociodemographic variables that diversified the study group were: treatment time, time since diagnosis, treatment method, infertility factor and type of infertility (Table 2).

Table 2 Characteristics of the subject group

Variables		N 89.	Percentage
Treatment method	Pharmacological treatment/diagnosis	24	21.12
	Artificial partner insemination	22	19.36
	IVF/ICSI	24	21.12
	Becoming an egg recipient	2	1.76
	Does not undertaketreatment	15	13.2
Time since diagnosis	– less than year	5	5.7
	2–5 years	30	34.1
	– over 5 years	53	60.2
Infertility factors	Female infertility	28	31.8
	Male infertility	14	15.9
	Infertility in bothpartners	15	17
	Undiagnosed Infertility	31	35.2

Source: Own research

The following tools were used:

1. Acceptance of one's own infertility Scale (AOIS) – an original tool based on the Acceptance of Illness Scale (AIS) The. reliability of this scale, measured by Cronbach's alpha, is 0.844. Because of the peculiarity of infertility as an illness, i.e. in most cases it is hardly experienced outside of procreation activities, some of the AIS items were removed and replaced with questions that concerned the experience of infertility. High scores on the AOIS scale represent worse acceptance of one's own infertility, while low scores are achieved by people who are better at dealing with their condition.
2. The HDS-M Scale (Zigmond, Snaith; Polish version by: M. Majkowicz, K. de Walden-Gałuszko, G. Chojnacka-Szawłowska, 1994) measuring anxiety, depression and aggression/irritation.
3. The Scale for Assessment of Hope as an Emotional State (an original tool). Hope as an emotional state at the same time encompasses the fear that things are going to get worse and the yearning for improvement (Lazarus, 1994). It is a bimodal characteristic spanning from joy to sadness. When the yearning to achieve a desirable goal becomes a certainty, the hope turns into joy, while when this target moves away, the hope becomes despair. Hope is measured here by means of an original questionnaire determining the level of hope now and a month ago (cf. Dembińska, 2013a).
4. The Satisfaction with Life Scale (SWLS) prepared by Diener et al. (1985). The Polish version is by Jurczyński (2001). Satisfaction with life is defined as a general assessment of quality of life in relation to criteria set by oneself (Shin, Johanson, 1978). Subjective well-being comprises three elements: level of satisfaction with

life , positive feelings and lack of negative feelings (Diener, 1984; Pavot, Diener, 1993). The assessment of satisfaction with life is the result of a comparison of one's situation with standards set by oneself. If the result of the comparison is satisfactory, a feeling of satisfaction ensues.

5. The Self-Esteem Scale SES by Rosenberg (Polish version: Dzwonkowska, Lachowicz-Tabaczek, Łaguna; 2008). Self-esteem is a relatively constant predisposition understood as a conscious (positive or negative) attitude toward oneself.
6. The original Scale of Perception of Social Support in Infertility takes into account emotional, informational and instrumental support from one's family and friends and medical personnel. Perception of Social Support is the individual's ability to perceive the supportive, i.e. the desired support, the nature of other people's behaviors. The individual compares the desired support with the support received. It is a type of interaction or exchange taken up by one or two parties and resulting in an exchange of emotions, information, action tools and material goods (Kahn, 1979, Sęk, 1986; 1993). The eliability of this scale as measured by Cronbach's alpha is 0.81.

Procedure

The study group was recruited by the Infertility Treatment and Adoption Support Society "Nasz-Bocian". The studies were anonymous, participation was voluntary, and each participant could quit at any time. It was also possible to contact the researcher after answering the study questions to discuss objections and concerns – some participants used this opportunity. The study did not violate the principles of ethical research.

The study results were subjected to statistical analysis. To carry out this analysis, the following methods were used: the Spearman's correlation coefficient, the Mann-Whitey test and cluster analysis. The significance level of $p<0.05$ was used to determine the existence of statistically significant differences or relations.

Results

The author conducted a statistical analysis to look for relations between the perception of social support and other variables included in the study (Table 3). It indicated positive correlations of the perception of social support with self-esteem and hope. It also indicated negative correlations with levels of depression as well as acceptance of one's infertility. (Because of the reversed scale in the questionnaire measuring this item, this relation shows that higher social support means better acceptance of one's infertility). There was no correlation between the perception of social support (and its types) and anxiety & irritation. Relations between

satisfaction with life and the perception of social support (and its types) show that this satisfaction is correlated only with perception of support from significant others. What seems important is the fact that institutional support is not correlated with any of the variables.

Table 3 Correlations of perception of social support (and its types) with psychological variables: acceptance of one's infertility, self-esteem, satisfaction with life, anxiety, depression, irritation, hope.

Spearman's Rho	2	3	4	5	6	7. Acceptanc of one's infertility	8. Self-esteem	9. Satisfacion with life	10.Anxiety	11. Depression	12.Irrtation	13. Hope
1. Percepction of social support	0,891**	0,900**	0,730**	0,703**	0,671**	–0,246*	0,414**	No correlation	No correlation	–0,251*	No correlation	0,327**
2. Perception of emotional support		0,796**	0,503**	0,726**	0,603**	No correlation	0,320**	No correlation	No correlation	–0,299*	No correlation	No correlation
3. Perception of informational support			0,511**	0,734**	0,634**	–0,233*	0,414**	No correlation	No correlation	–0,268	No correlation	0,292**
4. Perception of material support				0,841**	0,671**	–0,246**	0,330**	No correlation	No correlation	No correlation	No correlation	0,243*
5. Perception of the support from the family and friends					No correlation	–0,293**	0,440**	0,236*	No correlation	–0,332**	No correlation	0,294**
6. Perception of the support from medical personnel/ adoption						No correlation	No correlation	No correlation	No correlation	No correlation	No correlation	No correlation

*Correlation significant at the 0.05 level (2-tailed)

**Correlation significant at the 0.01 level (2-tailed)

Source: Own research

Analysis of correlations between the variables included in the study (Table 4) also indicated positive relations between the following variables:

- self-esteem vs. satisfaction with life;
- levels of anxiety and depression (and both these variables) vs. acceptance of one's infertility.

Negative relations were identified between the following variables:

- acceptance of one's infertility vs. self-esteem, satisfaction with life and hope,
- anxiety and depression vs. self-esteem and satisfaction with life.

No correlations were found between:

- irritation vs. other variables,
- hope vs. self-esteem and satisfaction with life.

Table 4 Correlations between variables included in the study: acceptance of one's infertility, satisfaction with life, self-esteem, depression, anxiety, hope.

Spearman's Rho	2	3	4	5	6	7
1. Acceptance of one's infertility	–0,638**	–0,355**	0,464**	0,551**	No correlation	–0,472**
2. Self-esteem		0,413**	–0,464**	–0,623**	No correlation	No correlation
3. Satisfaction with life			–0,586**	–0,576**	No correlation	No correlation
4. Anxiety				0,720**	No correlation	–0,250**
5. Depression					No correlation	–0,452**
6. Irritation						No correlation

*Correlation significant at the 0.05 level (2-tailed)

**Correlation significant at the 0.01 level (2-tailed)

Source: Own research

The author also searched for relations between psychological variables and sociodemographic variables used to characterize women who decided to remain childless, i.e. the type of infertility and the reason for infertility (Table 5). The analysis indicated no statistically significant differences in the levels of psychological variables in the groups of subjects selected according to the type of and reason for infertility.

Table 5 Intergroup differences in the levels of variables in women taking part in the study, depending on the type and reason of infertility

Psychological variables	Sociodemografic variables	Chi-square	df	Asymptotic significance
Percepction of social support	Infertilitytype	1,507	1	0,220
	Infertilityfactor	2,992	3	0,393
Perception of emotional suport	Infertilitytype	0,603	1	0,409
	Infertilityfactor	4,134	3	0,247
Perception of informational suport	Infertilitytype	0,936	1	0,333
	Infertilityfactor	1,097	3	0,778
Perception of material support	Infertilitytype	2,028	1	0,154
	Infertilityfactor	1,098	3	0,760
Perception of the support from the family and friends	Infertilitytype	2,506	1	0,113
	Infertilityfactor	1,090	3	0,0701
Perception of the support from medical personnel/ adoption	Infertilitytype	0,006	1	0,939
	Infertilityfactor	1,081	3	0,700
Acceptance of one'sinfertility	Infertilitytype	3,566	1	0,059
	Infertilityfactor	7,267	3	0,064
Self-esteem	Infertilitytype	0,484	1	0,484
	Infertilityfactor	1,536	3	0,674
Satisfaction with life	Infertilitytype	0,911	1	0,340
	Infertilityfactor	0,937	3	0,816
Depression	Infertilitytype	0,677	1	0,411
	Infertilityfactor	5,586	3	0,134
Anxiety	Infertilitytype	1,498	1	0,221
	Infertilityfactor	1,646	3	0,649
Hope	Infertilitytype	1,176	1	0,278
	Infertilityfactor	3,991	3	0,262
Irritation	Infertilitytype	1,306	1	0,253
	Infertilityfactor	0,384	3	0,943

Source: Own research

The analysis of psychological variables in relation to the length of time since diagnosis revealed differences only in the level of hope (Table 6). In women deciding to remain childless, the shorter the time since diagnosis, the higher the level of hope. The analysis

indicated no relations between the length of time since diagnosis and the level of the other psychological variables in the group of women taking part in the study.

Table 6. Intergroup differences in the levels of variables in women taking part in the study, depending on the time since diagnosis

Variables	Chi-square	df	Asymptotic significance
Percepction of social support	0,683	2	0,711
Perception of emotional support	3,043	2	0,218
Perception of informational support	0,496	2	0,780
Perception of material support	0,479	2	0,787
Perception of the support from the family and friends	1,255	2	0,534
Perception of the support from medical personnel/ adoption	0,015	2	0,993
Acceptance of one's infertility	0,595	2	0,743
Self-esteem	5,224	2	0,073
Satisfaction with life	0,947	2	0,623
Depression	0,541	2	0,763
Anxiety	0,897	2	0,693
Hope	6,610	2	0,037
Irritation	2,534	2	0,282

Source: Own research

The statistical analyses which were carried out comparing women undergoing treatment with women deciding to remain childless revealed statistically significant differences (Table 7) in: the acceptance of one's infertility ($\alpha = 0.000$); the perception of social support ($\alpha = 0.000$) and its types identified during the study: support from significant others ($\alpha = 0.003$), institutional support ($\alpha = 0.000$), emotional support ($\alpha = 0.000$), informational support ($\alpha = 0.001$) and material support ($\alpha = 0.002$). There were no significant differences ($\alpha > 0.05$) in relation to the levels of hope, anxiety, depression, irritation and satisfaction with life. Women who decide to remain childless are more willing to accept their infertility, but declare a lower perception of social support than women undergoing infertility treatment.

Table 7. Psychological variables in the group of women treated for infertility and the group who decided to remain childless (Mann–Whitney U test)

Variables	U Manna-Whiteya	Z	Asymptotic significance
Percepction of social support	15259,500	−4,054	0,000
Perception of emotional support	14886,500	−4,365	0,000
Perception of informational support	16527,500	−3,178	0,001
Perception of material support	16658,500	−3,084	0,002
Perception of the support from medical personnel/adoption	15439,500	−3,941	0,000
Perception of the support from the family and friends	12692,000	−1,738	0,082
Acceptance of one's infertility	15527,500	−3,859	0,000
Hope	18210,500	−1,951	0,051
Anxiety	19286,500	−1,170	0,242
Depression	19014,000	−1,364	0,172
Irritation	20792,000	−0,099	0,921
Self-esteem	20278,000	−0,457	0,648
Satisfaction with life	19878,500	−0,743	0,458

Source: Own research

In order to characterize the group being studied in more detail, the author performed a cluster analysis (Table 8) during which the group of infertile women was divided into three subgroups, with different psychological factors representing the effectiveness of the coping process:

A subgroup of women ineffectively coping with the infertility problem comprised women perceiving little support from significant others. This group was also characterized by lower acceptance of their infertility, lower self-esteem, lower satisfaction with life, lower hope, and higher levels of anxiety and depression. This subgroup consisted of 33 people.

A subgroup of women coping moderately well with the infertility problem. This subgroup consisted of 22 people. They demonstrated average levels of analyzed variables compared to other participants.

A subgroup of women effectively coping with the infertility problem comprised women perceiving a lot of support from significant others. This group was also characterized by higher acceptance of one's infertility, higher self-esteem, higher satisfaction with life, higher hope, and lower levels of anxiety and depression. This subgroup consisted of 34 people.

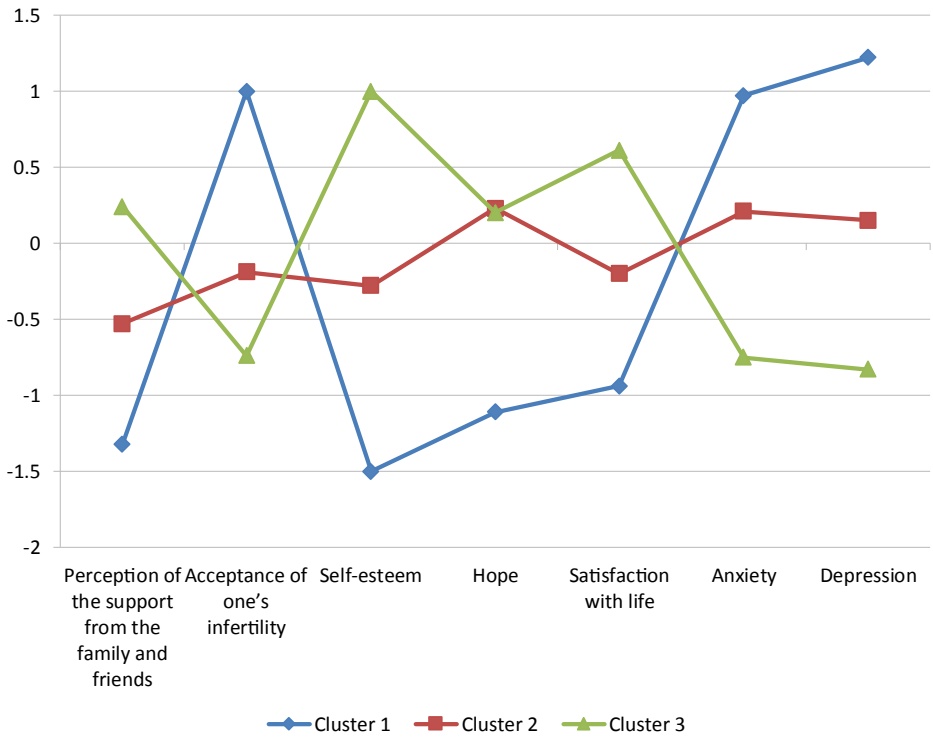
No statistically significant differences were found in relation to the following variables: age, perception of institutional support, irritation.

Table 8. Analysis of variance for the clusters found in the group of childless women

Variables	Average Cluster 1 (n=33)	Average Cluster 2 (n=22)	Average Cluster 3 (n=34)	F	significance
Age	0,40	0,81	0,26	2,35	0,101
Perception of the support from the family and friends	−1,32	−0,53	0,24	22,01	0,001
Perception of the support from medical personnel/adoption	−0,71	−0,40	−0,23	2,14	0,124
Acceptance of one's infertility	1,00	−0,19	−0,74	35,75	0,001
Self-esteem	−1,50	−0,28	1,00	94,19	0,001
Hope	−1,11	0,23	0,20	21,93	0,001
Satisfaction with life	−0,94	−0,20	0,61	28,43	0,001
Anxiety	0,97	0,21	−0,75	37,01	0,001
Depression	1,22	0,15	−0,83	57,11	0,001
Irritation	−0,34	0,15	−0,13	2,06	0,134

Source: Own research

Figure 1. Analysis of variance for the clusters found in the group of childless women



Source: Own research

Discussion

For most women taking part in the study, childlessness treated as one of the strategies for coping with infertility is a decision made only after a period of ineffective treatment. Only 15 women out of 89 constituting the study population (= over 13%) have not started any infertility treatment. It may mean that this small group of women is troubled by different problems than the ones faced by women undergoing treatment, as these problems constitute mostly experiences from the recent and more remote past that this group has had to deal with. This hypothesis is backed up by the analyses quoted in this study – childless women do not differ from women undergoing treatment when it comes to levels of depression, anxiety, hope, irritation, self-esteem and satisfaction with life. The only identified differences concerned acceptance of one's infertility and the perception of social support and its types.

Childless women are more willing to accept their infertility, which is hardly a surprise – their decision to stop or renounce treatment and to give up on adoption can be interpreted as a sign of higher acceptance of one's life without a child. The cluster analysis facilitated the division of the study group into subgroups depending on the individual's effectiveness in coping with infertility – one of the variables characterizing these subgroups is acceptance of one's infertility. Moreover, the established correlations indicate that women accepting their infertility have lower levels of anxiety and depression, and higher levels of self-esteem, satisfaction with life and hope. The above findings are crucial for professionals providing psychological help for infertile people , as the goal of this help is to make the customers accept their situation in every possible way.

When it comes to social support, childless women perceive less support than those undergoing treatment. Infertility, being a condition related to procreation, concerns not only individuals and couples, but also family and social relations in general. When partners have procreation problems, their parents cannot become grandparents. It may also be a difficult situation for the couple's friends – they may have problems showing compassion or sharing experiences with the infertile couple, as at the same time they often become parents themselves. The social relations of an infertile couple may influence their decision about further treatment. It cannot be excluded that social relations place another burden on couples struggling with infertility. The results of Danish studies (Vassard, Lund, Pinborget al., 2012) indicate that for both women and men a low level of family support, especially in relation to infertility, was connected with quitting the treatment. Moreover, frequent conflicts with partners and friends also increase the risk of stopping the therapy. The above-mentioned Danish studies may explain some differences between Polish women undergoing treatment and those deciding to remain childless. Still, we need to remember the specific nature of Polish society when it comes to the

perception of the infertility problem. On one hand, the Catholic Church restrictively opposes assisted reproduction techniques (cf. Radkowska- Walkowicz, 2012; cf. Dembińska, 2012) and cultivates an image of the Polish Mother; on the other, it perceives family as a powerful social force and a source of tradition. This is also a reason for the stigmatization of infertile people – couples feel social pressure to have a biological child. People struggling with unplanned childlessness very often internalize social norms and stigmatize themselves for not having a child (Przybył, 2003). On the other hand, adoption, although it is a difficult and challenging choice, is perceived as a natural and commonly accepted remedy for fertility problems. It is widely believed that adoption is a very positive act, because it helps a disadvantaged child. Rejecting adoption as a way of coping with unwanted childlessness is perceived as a sign of selfishness (Dolińska, 2014). Therefore, in Poland a decision to remain childless is extremely difficult. It very often results in a sense of being condemned by others and a sense of opposing social norms and traditions. It may suggest that in Poland the lower perception of social support by women deciding to remain childless (compared to women undergoing treatment) is a consequence of their decision, not the reason behind it.

Another important issue connected with social support concerns institutional support. In the case of adoption, this is provided, under applicable laws, by adoption centers, while in the case of infertility treatment, medical personnel can be the source of the support. Moreover, clinics offer psychological consultancy for those interested in such services. However, people consciously deciding to remain childless cannot count on any organized help and support. This finding is also supported by the study results – no variables are correlated with the perception of institutional support, and it also does not differentiate subgroups in the cluster analysis.

The results obtained throught his study constitute important guidelines for designing support programs for women consciously deciding to remain childless, and also for women undergoing infertility treatment who need to prepare themselves for the necessity of making such a decision and bear its consequences. If we want to solve the problem of psychosocial burdens of patients treated for infertility, it is also crucial to make medical personnel aware of the importance of social support and the quality of a couple's relationship. Both partners should be given an opportunity to fully engage themselves in the therapy (Boivinet al., 2012; Vassard, Lund, Pinborg et al., 2012). Taking care of a partner relationship and gathering social support from significant others during infertility treatment may serve as prevention measures against possible problems connected with a decision to remain consciously childless.

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