PARTNERED DECISIONS? SEEKING HELP IN THE CASE OF INFERTILITY

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ABSTRACT

The following paper uses data on couples from the *National Study of Fertility Barriers* to examine how fertility preferences and intentions and the importance of parenthood relate to infertility help-seeking. Because the experience of infertility is referred to as a "dyadic process," help-seeking cannot be understood solely by one partner's characteristics. Focusing on couples who have met certain prerequisites (e.g. couples who are married and have health insurance) and framing help-seeking as a decision made within couples is one avenue suggested to highlight couple dynamics that may be important to the experience of infertility and help-seeking behavior.

INTRODUCTION

The experience of infertility is associated with a complex set of medical and social factors, which has increasingly been acknowledged over the past few decades (Greil 1997). Medical and social examinations of infertility most definitely interact with one another, but offer different conceptual definitions and implications (Greil et al. 1988). The medical examination of infertility is relatively discrete, referring mainly to an individual with a specific characteristic. The social examination approaches infertility as more of a process concerning identifying a problem, deciding whether or not to seek help, reacting and coping after a diagnosis, and a potentially life-long impact of redefining oneself as infertile (Matthews and Matthews 1986; Greil et al. 1988; Lorber and Bandlamudi 1993; Greil 1997). Consequently, social definitions of infertility expand the focus and can include both private and public influence on the individual

and the couple. A call to examine more thoroughly this social process of infertility has been a consistent theme of the infertility literature (Kalmuss 1987; Greil et al. 1988; Greil 1991a; Greil 1991b; Greil 1997; White et al. 2006).

One aspect of the social process of infertility, which remains largely unstudied, is the interaction between female and male partners when deciding to seek medical help. White et al. (2006) suggest that this interaction is potentially very important in promoting or deterring help-seeking behavior. Because of data limitations regarding both non-help-seekers and male partners, previous studies have tended to look at the demographic determinants of using infertility services or relied on samples drawn from infertility clinics or support groups to examine social processes of infertility after help-seeking had occurred (Kalmuss 1987; Greil et al. 1988; Greil 1991a; Greil 1991b; Lorber and Bandlamudi 1993).

While studies of demographic determinants of infertility service use and qualitative analyses of couples from infertility clinics and support groups offer a balanced approach to both macro and micro-level processes of infertility help-seeking, they cannot tell us about the help-seeking process for couples who do not end up using infertility services. This research question requires us to incorporate attitudes and intentions of male and female partners in both help-seeking and non-help-seeking[1] couples. Taking this approach, this study examines help-seeking as a decision-making process that is influenced by both individual and dyad level factors of a couple faced with infertility.

BACKGROUND

While studies of help-seeking for any condition can typically be justified in terms of a single person perspective, help-seeking for infertility is potentially subject to unique factors that

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[1] It is potentially problematic to label couples as non-help-seekers given that help-seeking could occur via non-medical ways such as support groups or religious counsel. For simplicity, we keep this language, but note that it is really only distinguishing between people that and do not use medical services to address infertility.

necessarily incorporate both partners of an infertile couple. This section draws on previous infertility research in order to discuss issues distinctly relevant to infertility help-seeking such as the ambiguity of the infertility condition, the public-private divide of help-seeking, and the gendered experience of infertility.

The Case of Infertility Help-Seeking

Infertility help-seeking can be distinguished from other types of medical help-seeking in several ways. First, infertility is a rather vague medical problem: it presents itself as the lack of a symptom (i.e. lack of pregnancy) rather than a condition in the traditional sense (e.g. fever, chills, aches and pains). As a result, there may not be a clear reason for seeking help. Similarly, before an individual or couple seeks help, they may be unsure whether the problem resides with the male or female partner or both. Infertility also does not typically pose a threat to one's physical health – although it may be a result of other physical conditions. All of these factors make cues and justifications for help-seeking somewhat ambiguous (Greil 1991b).

The Private-Public Divide of Help-Seeking. The act of medical help-seeking in general can be seen as a crossing of boundaries in that it involves disclosure of a personal condition to individuals outside of one's typical primary network of relationships. This disclosure through help-seeking may also solidify a stigmatized identity related to the medical problem in question (Berger et al. 2005). In the case of infertility, relatively private fertility intentions and issues involving physical intimacy require disclosure to an outside party (i.e. a medical professional) in order for couples to make progress towards achieving intentions. Additionally, the analogy of infertility as a stigmatized identity has long been received in the literature (Miall 1986; Greil 1991). Infertility, then, moves between the privacy of the intimate relationship and the more public --and potentially stigmatizing-- nature of disclosure in seeking medical help. In tandem

with this private-public divide is that the experience of infertility has been labeled a "dyadic process" (Greil et al. 1988): the onset, cognition, and outcome involve not only the individual afflicted with the medical problem but also affects the fulfillment of social roles within the couple and larger society. The implications of both the above-mentioned issues are that the decision to seek help cannot be driven wholly by one partner within the relationship.

Gendered Experiences of Infertility. While infertility has been labeled a 'dyadic process,' many studies done on couples from infertility clinics and support groups have also acknowledged that it is a very gendered process. Greil (1997) offers a useful review of the gendered nature of infertility experiences, pointing to the following studies: 1) Ulbrich et al. (1990) suggest that the transition to non-parenthood may be easier for men than for women; 2) Greil et al. (1988) and Greil (1991a) observe that women feel the effects of infertility more directly, while men feel the effects via partners reacting to infertility and subsequent stress on the relationship; 3) Andrews et al. (1992) conclude that women feel the impact of infertility as a distinct life problem, whereas men experience infertility similar to other life problems; and 4) multiple studies (refer to Greil (1997) for all references) indicate that women may be equally distressed whether or not they physically have the impairment and that infertility is generally more stressful for women than men.

Consequently, although the decision to seek help may be influenced by both partners, the female partner may act as the primary decision maker in seeking medical help because she disproportionately experiences the effects (Greil et al 1988; Greil 1991a; Greil 1991b; Lorber and Bandlamudi 1993). This study, then, is not suggesting equal influence of both partners, but rather that both partners have at least some influence in the decision-making process because of the private-public divide and inherent dyadic process of infertility. The next section reviews a

previously conceptualized model of infertility help-seeking and examines how to expand upon existing research by framing and measuring infertility help-seeking as a decision-making process within a couple faced with infertility.

A FRAMEWORK FOR INFERTILITY HELP-SEEKING

Existing Approaches

White et al. (2006) posit a model of infertility help-seeking that includes symptom salience, life course factors, individual and social cues, and enabling and predisposing factors that both directly affect help-seeking and work through a key mediating variable of perception of a fertility problem (see Figure 1 below). Their framework is based largely on the *Behavior Model of Health Services Utilization* (Anderson 1968), but also reflects more recent help-seeking research that "emphasized the need to consider the social contexts in which health decisions are made" (p. 1032) as well as including items more specific to infertility.

Figure 1. Help-Seeking Model

Source: White, Lynn, Julia McQuillan, Arthur Greil, and David R. Johnson. 2006. "Infertility: Testing a Help-seeking Model." *Social Science and Medicine*. Vol 62.p.1033.
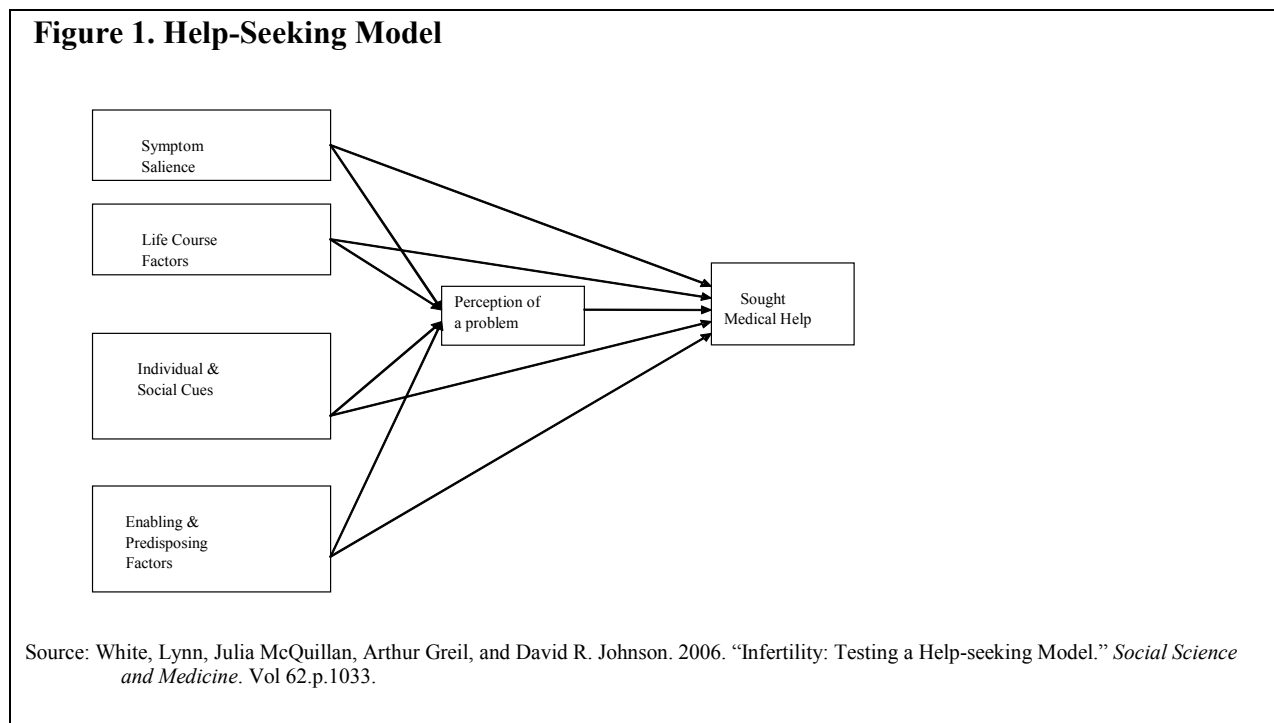
The influence of the male partner in White et al.'s model (2006) is located within the construct of 'social cues.' In testing their help-seeking model, they did not have data available to

examine male partners, however, they specifically acknowledged a need for "further research to identify pathways that lead women toward or away from treatment […] in particular, interactions with husbands or partners – that affect the perception of a problem" (p. 1040).

Building on White et al.'s (2006) model helps to simplify the examination of help-seeking. Informed by past infertility studies and the more general help-seeking literature, White et al. (2006) enumerate factors that indicate whether help-seeking is a potential outcome for couples faced with infertility. Examining couples who meet those conditions allows one to focus more on the couple dynamics of the help-seeking process rather than the demographic determinants of help-seeking. The next section discusses some generally agreed upon prerequisites of infertility help-seeking based on previous research.

Prerequisites of Infertility Help-Seeking

A logical necessary condition for infertility help-seeking is the desire and intent to have a child. Couples who are actively trying to conceive will most likely notice and respond to failed attempts sooner than those who are not trying (Kalmuss 1987). The complexity of the relationship between preferences, intentions, and help-seeking enters when fertility intentions are viewed as a moving as opposed to fixed target (Voas 2003). While long-term individual fertility preferences may not change, intentions are typically affected by the constraints of one's current circumstances (Axinn and Yabiku 2001). Greater intentions may produce greater urgency in seeking treatment; intentions may also be altered, however, once a couple experiences infertility, without medical help-seeking ever entering the picture.

Because intentions are potentially more dynamic across time, relying on preferences may provide more insight into the relevance of help-seeking behavior. Since this study used lifetime definitions of both infertility and help-seeking, there is the possibility that intentions were

changed or reduced after help-seeking behavior occurred dependent on results from tests or treatments. One cannot necessarily make the same assumption that preferences, which are more ideal in nature, would also be reduced to zero. Thus, preferences are perhaps a more valid indication of whether help-seeking behavior is relevant to a couple.

Moving beyond fertility preferences and intentions, White et al. (2006) observe, "marriage is often a trigger for normative childbearing" (p.1034). In their descriptive findings, they note, "almost no never-married infertile women reported seeking medical help" (p. 1037). They also suggest certain predisposing conditions of help-seeking such as "education, health locus of control, general health, and attitudes toward treatment" (p. 1032) while enabling conditions include "income, health insurance, and location [of the treatment facility]" (p. 1032). Implicit from this is that infertility help-seekers are largely composed of married, higher SES, insured persons with knowledge of, access to, and willingness to use healthcare services.

Reviewing some key theories of help-seeking, White et al. (2006) note that "from the beginning it has been assumed that cognition plays an important role in treatment seeking" (p. 1032). Following from this, perception of a fertility problem is central to their model. Indeed, their descriptive findings show that 77% of women who perceived a problem sought treatment, whereas only 20% of women who did not perceive a problem sought treatment. Although a few factors such as symptom salience and health locus of control were significantly related to help-seeking behavior after controlling for perception of a problem, most other factors that were initially related to help-seeking appeared to be mediated by perception of a problem. From these findings, White et al. (2006) suggest that "factors that deter help-seeking work primarily on women who have made the cognitive leap to perceiving that they have a fertility problem" (p. 1039). While White et al. (2006) focus on women, perception of a problem is potentially relevant

to both partners, given that there are both male and female factors of infertility. Although perception of a problem from either partner is a more inclusive and potentially more confounding definition of the problem, it is also more indicative of the dyadic nature of infertility and the aforementioned ambiguities related to help-seeking.

Some of the above-mentioned findings indicate more defined thresholds in terms of engaging in help-seeking behavior. These include marital status, insurance status, and perception of a fertility problem. Preferences and intentions are potentially more complexly related to help-seeking, although one can assume that if both partners within a couple prefer no children, then it will be highly unlikely for them to engage in behavior to help them have a baby. Couples where at least one partner was surgically sterile also present a problem given that this study uses lifetime definitions of infertility and help-seeking and there is a potential complication of when the surgery occurred in relation to the timeline of infertility and help-seeking. Consequently, this study focuses on married, insured couples who have perceived a fertility problem (but are not surgically sterile) and have not jointly indicated that they do not want children.

Although using the sample selection criteria necessarily limits the generalizability of findings, this also helps to reach the overall aim of the study, which is to focus more on the interactions between male and female partners than the determinants of help-seeking. In other words, by reducing the sample to a more homogenous group of couples that already meet some of the prerequisites of help-seeking it is potentially more feasible to discount the possibility that there are other barriers (e.g. access to health services) to help-seeking beyond couple dynamics.

Another issue to address here is that it is potentially problematic to use current characteristics alongside lifetime definitions of infertility and help-seeking. Fertility problems may have occurred with a previous partner; therefore, assessing lifetime help-seeking behavior

with the current partner is inappropriate. White et al. (2006) suggest, "the net result of using current circumstances to predict cumulative behavior is to underestimate the strength of relationships observed" (p. 1034). Thus, while there may be issues situating help-seeking with current partners, the effect is likely to be reduced if partners irrelevant to past help-seeking behavior are included. Additionally, since the occurrence of help-seeking is rare outside of marriage, indicating whether it is the first marriage for both partners should help to minimize this issue. The next section discusses how to incorporate couple dynamics by using a decision-making model to examine infertility help-seeking.

Infertility Help-Seeking as Decision-Making

While White et al. (2006) present a broad framework of infertility help-seeking, the purpose of this study is to look more intently at couple dynamics of help-seeking. A useful way to incorporate these dynamics is to view infertility help-seeking as a decision-making process within a relationship. This section turns to the close-relationship decision-making literature for guidance on this aspect of help-seeking.

Godwin and Scanzoni (1989) introduce a context-process-outcome model for decision-making in relationships. Context refers to individual and couple level characteristics that describe the relationship environment in which a particular issue is being decided (e.g. SES, race, religious preference). Process refers to factors specifically involved with negotiating the outcome; for example, Godwin and Scanzoni (1989) examine the amount of control by each partner when making decisions. Outcome is the final decision or behavior resulting from the negotiation process.

Using the context-process-outcome framework from Godwin and Scanzoni (1989), we can start to fill in what we do and do not know about infertility help-seeking. Many studies on

infertility and general help-seeking have contributed to identifying the context portion of the framework (Anderson (1968); Kalmuss (1987); White et al. (2006)). White et al. (2006) have incorporated these into their model as predisposing and enabling conditions and life course cues.

The outcome is whether a couple decides to seek help for infertility. While this appears to be easily quantifiable, actions can range from simply talking to a doctor about how to have a baby to having tests to pursuing treatment. One would expect that these different levels of help-seeking have different implications for partner involvement. If a woman is simply talking to her doctor about having a baby, her partner may not necessarily influence this type of action as much or even have knowledge of it. Moving to higher levels of help-seeking such as tests or treatment would most likely require both partners to be more involved due to the greater amount of time and cost needed to pursue them.

The process component of infertility help-seeking is necessarily the 'weakest link' resulting from previous data limitations and the need to provide a framework to examine factors beyond demographic determinants. The process component is where this paper seeks to make the largest contribution. The following section proposes a few factors to examine in order to begin filling in the process section of infertility help-seeking.

The Help-Seeking Decision

While a couple's help-seeking decision may be informed and negotiated across a number of different factors, some factors appear to be more centrally linked to the specific decision to seek help for infertility. Framing infertility help-seeking as not only a decision, but also a decision about achieving fertility acknowledges the relevance of focusing first on fertility preferences and intentions and the importance of parenthood to the couple.

Fertility Preferences and Intentions. Fertility preferences and intentions have a rather obvious link to help-seeking behavior. As was previously mentioned, couples trying to conceive will most likely notice and respond to failed attempts sooner (Kalmuss 1987). On the other hand, couples who agree that they do not want children are highly unlikely to engage in help-seeking behavior. Complexities may arise, however, because of the potentially dynamic nature of intentions (Axinn and Yabiku (2001); Voas (2003)), as well as situations where one partner wants children and the other does not.

Like the "dyadic process" of infertility, a major theme in the fertility literature has been a call to bring the male partner [back] into the analysis. Information on men's fertility preferences and intentions is necessary to understand whether a woman does or does not meet her own fertility goals (Voas 2003). Several authors suggest that personal preferences interact within unions to become couple fertility intentions (Voas 2003; Schoen et al. 1999). Thomson et al. (1990) and Schoen et al. (1999) observe that partners who agree have a much greater chance of achieving their intentions than partners who disagree; they did not find a significant gender effect, in the case of disagreement, for a particular partner to have more sway with the outcome. Using data from the U.S. National Survey of Families and Households, Thomson (1997:347) found that couple disagreement "shifted intentions toward not having a child" as a sort of default state.

Since male partners play an important role in couple fertility decisions, they most likely play an important role in the response to infertility. If the default state for fertile couples who disagree about fertility preferences or intentions is not to seek pregnancy, then it may follow that the default for infertile couples who disagree is not to seek medical help. Additionally, one would assume that those couples with joint preferences and high intentions might also have a

greater chance of taking action when faced with infertility than those couples with dissimilar preferences or low intentions.

Importance of Parenthood. Although related to fertility preferences and intentions, the importance of parenthood is a separate dimension of a fertility decision. This is the value placed on fulfilling the social role of being a parent. White et al. (2006: 1034) hypothesized that greater *Value of Motherhood* may lead women to "pay more attention to signals of infertility," which would translate into greater propensity to seek help. Although they did not find direct support for this, it is useful for this particular study to examine the importance of parenthood in terms of both partners' attitudes: one would expect that if both partners indicate a greater importance of becoming parents they would be more likely to seek help when faced with infertility. Similar to fertility preferences and intentions, it is both the direction of attitudes and agreement between partners that matters. The next section more explicitly examines the notion of partner agreement

Moving Beyond the Individual

Examining the dyadic process of infertility help-seeking requires additional considerations beyond the direct effects of both partners' attitudes and intentions. In other words, it is not only important that both partners indicate high or low intentions to have a child, but it is important that they agree about intentions in order for help-seeking to occur. Assessing direction of individual level attitudes or intentions, even when including both partners only really examines those attitudes and intentions relative to other male or female partners. To examine the dyadic process, we also need an indication of how partners relate to one another and how this in turn relates to help-seeking behavior.

Including an indication of agreement between female and male partners offers an indirect way to measure couple interaction: agreement suggests that a particular issue either has already been negotiated within the relationship or that the partners share similar attitudes if and when negotiations arise in the future. Scanzoni and Godwin (1990) note "whatever the degree of agreement before negotiations, acceptable outcomes are characterized by a high degree of shared consensus after negotiations" (p. 240). Whether as an indication of de facto agreement or a productive negotiation process, both interpretations can plausibly contribute to a similar outcome; thus, there is not necessarily an issue with the potential temporal disorder of when the agreement was achieved in relation to when outcome behavior occurred.

To summarize, we intend to look at how fertility preferences and intentions and the importance of parenthood relate to infertility help-seeking behavior. Greater fertility intentions and a higher importance placed on parenthood for both partners should be associated with help-seeking occurring and that this relationship will intensify at higher levels of action. Symmetrical influence of female and male partners is not expected given that previous research has shown the female partner as the primary decision-maker, but male partners will potentially play a larger role in higher levels of help-seeking (tests or treatment) compared to simply talking to a doctor. Moving beyond individual level characteristics, agreement between partners' attitudes, preferences, and intentions may indicate couple interaction or negotiation that provides a necessary base for help-seeking to occur. It is also expected that couple agreement will become increasingly relevant at higher levels of help-seeking action since we also expect the male partner to become more involved in the decision.

METHOD

Data

This paper uses data from the *National Study of Fertility Barriers* (NSFB) – a nationally representative, random digit dialing (RDD), telephone survey designed to address social and psychological aspects of infertility. The NSFB includes information on both help-seekers and non-help-seekers as well as interviews with a subset of male and lesbian partners. Because the NSFB is currently in progress, the data used in this paper is from the first wave of interviews. Sample selection was based on several criteria outlined previously: 1) both partner interviews were completed, 2) the couple was married, 3) the couple had health insurance, 3) either partner perceived a fertility problem, but neither was surgically sterile, and 4) the couple did not jointly indicate a preference for no children. The final sample included 229 couples fulfilling these criteria.

To assess whether findings from this sample of couples could be generalized to the larger group of women fulfilling the criteria (excluding the necessity of a male partner interview attached) a stepwise logistic regression was run using whether or not a partner was interviewed (yes/no) as the outcome and female partner and union characteristics as predictors. Four variables were identified in the final step as being significantly different between women with and without a male partner interviewed. Women in the final sample of couples were more likely to be White (odds ratio = 2.47), and had greater fertility intentions (odds ratio = 1.53). They were also much less likely to talk to a doctor about a fertility problem (odds ratio = .321), but more likely to have sought tests if they did (odds ratio = 1.95). Given that fertility intentions and help-seeking behavior are central to this paper, we caution the generalizability of findings, but maintain the importance of having the male partner included in analyses.

Measures

 The following sections enumerate the specific measures of this study using Godwin and Scanzoni's (1989) context-process-outcome framework for infertility help-seeking.

 Outcome Measures. The outcome of interest was help-seeking behavior. This was constructed by combining three separate measures: 1) *Ever been to doctor or clinic to talk about ways to help have baby* (yes/no), 2) *You or partner ever receive tests (yes/no)*, and 3) *Ever seek treatment to get pregnant* (yes/no). Increasing levels of action are inherent in the survey design because eligibility for the second and third levels of help-seeking is contingent on a 'yes' response to the first level. Help-seeking for level 1 and level 3 were assessed separately by both female and male partners, whereas level two was asked only of the female partner but indicated that the response should include if either her or her partner had tests. Help-seeking was constructed as a couple level measure using both female and male partner reports. If either partner responded 'yes', then that help-seeking action was considered to have occurred for the couple. This was done in order to retain as many couples who sought help, but perhaps did not have collective dyadic recall of the behavior occurring – a potential issue given the use of a lifetime definition of help-seeking. The final help-seeking measure had four levels of mutually exclusive categories: *None, Talked to a Dr., Had Tests, Treatment*.

 Context Measures. Although this study focuses on the decision-making process, certain context variables do not have clearly defined thresholds for help-seeking behavior. These were controlled for in the final analyses. Contextual controls were divided into female partner characteristics, male partner characteristics, and union characteristics. Both female and male partner characteristics included the following measures: race (*White/Non-white*), Catholic (*yes/no*), and parental status (for the female partner this was her own biological parenthood that

may not have included the current male partner as the biological father; for the male partner this was an indication if he had children from a previous relationship).

Additional context measures were included for the female partner concerning her employment status (*Full-Time, Keeping House, Other*), age (years), self-assessed health (four categories ranging from 'poor' to 'excellent'), and whether she indicated having a regular doctor (yes/no). These measures reflect the assumption that help-seeking is likely more contingent on some of the female partner's characteristics due to the previously acknowledged gendered and disproportional experience of infertility within the couple as well as the fact that, regardless or male of female factor infertility, most tests and treatments physically occur on the female partner (Greil 1991b).

Union characteristics included length of time living together (years), whether it was a first marriage for both partners (yes/no), and a twelve-category measure of total family income ranging from 'under $5,000' to '$100,000 or more.'

Process Measures[2]. Two factors were identified for the decision-making process: fertility preferences and intentions and the importance of parenthood. Although fertility preferences were referred to in conjunction with intentions, for the purposes of this paper, they were constructed as a separate measure and will be subsequently discussed in the section on agreement measures. Fertility intentions and the importance of parenthood were constructed at the individual level for both partners.

Fertility Intentions consisted of three items: *Like to Have a Baby* (four categories ranging from 'definitely no' to 'definitely yes'); *Intend to Have Baby* (yes/no); *Certainty of*

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[2] While the term 'process' here may appear somewhat conflicting due to the use of cross-sectional versus over-time data, the term is reserved to be consistent with the components of Godwin and Scanzoni's (1989) framework. It is inferred that these factors played a role in the negotiation process, but in their current form, they are not assumed to be displaying the actual process per se.

Intentions, based on the response to *Intend to Have Baby* with six categories ranging from 'very sure, do not intend' to 'very sure, intend.' All items were coded so that higher values indicated greater intentions to have a child. Because these items did not have similar response categories, they were first standardized and then scaled.

Importance of Parenthood was composed of six items concerning the importance of fulfilling the social role of 'parent' to one's self, one's partner, and one's parents:1) Having children is important to me feeling complete as a woman/man, 2) I always thought I would be a parent; 3) Life will be or is more fulfilling with children; 4) It is important for me to have children; 5) It is important to my partner or spouse that we have children, and 6) It is important to my own parents that I have children. All items had four response categories ranging from 'strongly disagree' to 'strongly agree.' Items were coded so that a higher score indicated a greater value placed on parenthood.

Agreement Measures. Additional considerations were required for these measures because there are many potential ways to both define and measure agreement. Because this study was exploring the possibility of agreement between partners as a necessary condition for help-seeking, multiple measures were constructed to examine the potential explanatory power via different approaches[3]. After some preliminary analyses, difference scores appeared to give the most insight into couple dynamics.

Three types of difference scores were used in final analyses. A dichotomous measure was computed for whether partners agreed on their number of ideal children (yes/no). For the two scales, both relative and directional difference scores were used. Relative difference measures

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[3] Three separate approaches were initially examined: an intraclass correlation measure of dyadic similarity, difference scores, and interaction terms between male and female partners.

were constructed by first taking the absolute value of the difference between partners' scores. These scores were then multiplied by negative one so that the greater the difference, the more negative the value. Directional measures were constructed by subtracting the male partner score from the female partner score so that a positive score indicated a female partner scored higher – this was done in keeping with the notion that the female partner may be the primary decision-maker in help-seeking. Because difference scores cannot be simultaneously analyzed with all of their original indicators, we constructed couple level scales so that we could include both direct and agreement measures in the same analyses.

Missing Data

Types of Missing. Missing data is present under three circumstances in the *NSFB*: 1) user missing from 'don't know' and 'refuse' responses; 2) missing due to irrelevance of certain questions to the specific respondent; and 3) a planned missing element on certain scales where respondents were randomly assigned two-thirds of the set of questions to answer (see Johnson et al. (2006) for more information on planned missing designs for survey research).

Strategy. User missing data from 'don't know' responses was recoded when considered appropriate. Respondents who answered 'don't know,' or 'leave it up to God or nature' for fertility intentions were recoded in a neutral category. Respondents who indicated that their parents were deceased when asked about the importance of grandchildren to their parents were also recoded as a neutral category to reflect the ambivalent nature of this influence on childbearing behavior.

The remaining missing data was largely from the planned missing design, which was specifically relevant to the *Importance of Parenthood* scale used in this study. Because planned

missing is built in as a randomized feature of the survey design, this fulfilled the missing at random (MAR) assumption (Allison: 2002). Missing data due to planned missing was imputed using the Missing Values Analysis Expectation Maximization algorithm in SPSS version 16.

The imputation was informed by the larger sample of women who met the sample selection criteria but did not necessarily have a male partner interview attached. The imputation model included all variables used in the final analyses. Scales and agreement measures were constructed after missing data was imputed.

Data Analysis Strategy

The outcome of interest was help-seeking behavior measured by four mutually exclusive levels of action: 1) none 2) talked to a doctor, 3) had tests, and 4) treatment. Multinomial logistic regression was used in order to compare across different levels of help-seeking action. Nested models were also fit to the data to examine the effects of controlling for partner and union characteristics.

RESULTS

Descriptive Findings

Table 1 shows the descriptive statistics for the 229 couples in this study. Help-seeking behavior was largely concentrated at both extremes with 42% of couples taking no action and 41% pursuing treatment. On average, the female partners' *Fertility Intentions* and *Importance of Parenthood* scales were higher than the males'. Interestingly, less than half of the couples (46%) agreed on their number of desired children.

Table 1. Descriptive Statistics for Full Sample (n= 229 couples)

	Mean	Range	SD
Helpseeking			
None	0.42		
Talked to a doctor	0.10		
Had tests	0.07		
Treatment	0.41		
Female Partner Characteristics			
Non-white	0.20		
Catholic	0.25		
FT Employed	0.57		
Keeping House	0.18		
Other Employment	0.25		
Biological parent	0.60		
Age	35.01 years	25 to 45 years	5.64
Self-assessed health	3.27	2 to 4	0.62
	(good health)		
Has regular doctor	0.87		
Fertility Intentions (scale)	1.08	(-)4.05 to 3.44	2.31
Importance of Parenthood (scale)	24.80	9 to 30	4.58
Male Partner Characteristics			
Non-white	0.21		
Catholic	0.24		
Has children from previous union	0.10		
Fertility Intentions (scale)	0.00	(-)5.02 to 2.81	2.82
Importance of Parenthood (scale)	24.35	7 to 30	4.53
Union Characteristics			
Time living together (years)	7.95 years	0 to 24 years	5.43
First marriage for both partners	0.79		
Family income (median)	10.00	2 to 12	
	($60,000 to $74,999)	($5,000 to $100,000+)	
Partners agree on # children	0.46		

Table 2 displays the same statistics broken down by type of help-seeking behavior. We see a similar pattern of higher female partner scores on average for both scales. The percent of couples that agree on desired number of children increases at higher levels of help-seeking behavior: 39% at no action, 44% where at least one partner talked to a doctor, and 59% for couples where at least one partner had tests done – although it decreases slightly for couples who have had treatment (53%).

Table 2. Descriptive Statistics by Helpseeking Type

	None (n=96 couples)			Talked to a Doctor (n=23 couples)			Had Tests (n=17 couples)			Treatment (n=93 couples)		
	Mean	Range	SD	Mean	Range	SD	Mean	Range	SD	Mean	Range	SD
Female Partner Characteristics												
Non-white	0.21			0.22			0.18			0.18		
Catholic	0.20			0.35			0.35			0.25		
FT Employed	0.64			0.7			0.71			0.44		
Keeping House	0.15			0.09			0.06			0.26		
Other Employment	0.22			0.22			0.24			0.3		
Biological parent	0.62			0.61			0.53			0.59		
Age	33.41 years	25 to 45 years	5.33	35.96 years	25 to 45 years	6.11	36.41 years	27 to 45 years	5.58	36.17 years	25 to 45 years	5.53
Self-assessed health	3.33 (good health)	2 to 4	0.56	3.13 (good health)	2 to 4	0.63	3.12 (good health)	2 to 4	0.78	3.26 (good health)	2 to 4	0.66
Has regular doctor	0.82			0.87			0.94			0.89		
Fertility Intentions (scale)	1.21	(-)4.05 to 3.44	2.23	0.77	(-)4.05 to 3.44	2.41	1.22	(-)4.05 to 3.44	2.67	1	(-)4.05 to 3.44	2.33
Importance of Parenthood (scale)	24.27	10 to 30	5.00	22.96	13 to 30	4.9	25.65	16 to 29	3.95	25.65	9 to 30	3.93
Male Partner Characteristics												
Non-white	0.21			0.3			0.18			0.18		
Catholic	0.26			0.3			0.24			0.19		
Has children from previous union	0.05			0.17			0.18			0.11		
Fertility Intentions (scale)	0.00	(-)5.02 to 2.81	2.80	-0.48	(-)5.02 to 2.81	3.01	(-).133	(-)5.02 to 2.81	3.03	0.147	(-)5.02 to 2.81	2.78
Importance of Parenthood (scale)	23.61	10 to 30	4.78	22.74	7 to 29	5.37	25.18	12 to 29	4.19	25.34	13 to 30	3.87
Union Characteristics												
Time living together (years)	6.06 years	0 to 19 years	4.67	7.26 years	0 to 23 years	5.5	10.18 years	1 to 24 years	6.48	9.67 years	1 to 23 years	5.32
First marriage for both partners	0.80			0.74			0.77			0.79		
Family income (median)	10.00 ($60,000 - $74,999)	2 to 12 ($5,000 to $100,000+)		10 ($60,000 to $74,999)	4 to 12 ($15,000 to $100,000+)		10.00 ($60,000 to $74,999)	6 to 12 ($25,000 to $100,000+)		11 ($75,000 to $100,000)	6 to 12 ($25,000 to $100,000+)	
Partners agree on # children	0.39			0.44			0.59			0.53		

Multivariate Models

Several models were run to gauge different aspects of individual and couple level influence on help-seeking behavior. Nested models were used to examine how individual level effects were potentially affected by controlling for partner and union characteristics. Because numerous models were run and multiple comparisons made, this discussion focuses on select results for *Fertility Intentions* and *Importance of Parenthood* as well as a few additional findings of interest. Given that each comparison was made between a lower and a higher level of help-seeking action, interpretations are presented in terms of higher versus lower action within as well as across comparisons. Tables 3 and 4 show these select coefficients net of controls that were previously discussed. Tables 5 and 6 in the Appendix display the full results. As was suggested by Kenny et al. (2006), we used a more liberal criteria for significance (p<.10) taking into account the inherently correlated nature of the dyad.

Fertility Intentions. Intentions were not significantly related to help-seeking for either partner alone, nor were they in the expected direction for both partners. Solo female partner intentions ('F Only' models in Table 3) had a consistently positive relationship with the higher level of help-seeking action in each comparison, with the exception of having tests versus treatment. Solo male partner intentions ('M Only' models, Table 3) had an inconsistent relationship with help-seeking behavior. Controlling for both partners' characteristics ('F+M' and 'Union 1' models, Table 3) appeared to both amplify and alter the directions of the relationships: the female partner's intentions became negatively associated with almost all higher levels of action in each comparison while the male partner's intentions became more consistent and positively related to each higher level of action. Generally characterizing across comparisons, these opposite relationships for female and male partners appeared to intensify as

help-seeking moved from between actions closer in range to one another (no action versus talking to a doctor) to actions that were more removed (no action versus treatment) and also as action moved further up the help-seeking spectrum (talked to a doctor versus treatment; had tests versus treatment). This suggested that partners' intentions were not working in tandem to affect help-seeking behavior, which was further reinforced by the fact that the couple level intentions scale ('Union 2' model, Table 3) was not significant in any of the help-seeking comparisons.

The male partner's intentions appeared to have a stronger relationship with each higher action as that action moved further towards treatment and as both actions in the comparisons increased. In the comparison between the two most disparate types (no action versus treatment), male partner's intentions were significant though only in the models controlling for both partners' characteristics ('F+M' and 'Union 1', Table 3). This suggested that it was potentially a couple dynamic of intentions more than the male partner's intentions driving treatment seeking. For the same comparison (no action versus treatment), couple agreement ('Agree' model, Table 4) was positive and significantly related to seeking treatment: in other words, couples who sought treatment had more similar intentions compared to those who did not seek any type of medical help. The directional difference score ('F-M' model, Table 4) for this comparison was also significant: this suggests that in couples that sought treatment, male partner's intentions were more likely to be greater than female partner's intentions compared to couples who did not seek any help. The greater intentions of the male partner relative to female partner appeared to be consistently related to higher action occurring (though not significant) across all other comparisons as well.

In summary, the relationship between fertility intentions and help-seeking was not as straightforward as we expected: partners appear to have opposite relationships, which become

amplified once they are simultaneously taken into account, couple agreement is important, but the male partner's intentions also appear to have a greater effect on help-seeking action, especially as the level of action increases.

Importance of Parenthood. For both partners, *Importance of Parenthood* had significant effects at the individual level ('F Only' and 'M Only' models, Table 3) although the female partner had significant solo effects across more of the comparisons than the male partner (no action versus had tests; talked to a doctor versus had tests). Similar to fertility intentions, the male partner's importance of parenthood had a stronger relationship to each higher level of action as the action moved toward treatment and was significant in the comparisons between the more disparate types of action (no action versus treatment; talked to a doctor versus treatment).

Not all effects were in the expected direction: comparisons at both ends of the help-seeking spectrum (no action versus talked to a doctor; had tests versus treatment) indicated negative relationships to the higher level of action in each set for both partners alone as well as after controlling for one another ('F+M' and 'Union 1' models, Table 3). Controlling for partners did reduce the individual effects, suggesting that, unlike fertility intentions, importance of parenthood was operating in a similar way for both partners. This was supported by the significance of the couple level scale across all comparisons where one or both partner's individual level scales were previously significant as well as the fact that the couple level scale was in the same direction as both partners' scales for each comparison.

Agreement between partners ('Agree' model, Table 4) showed a similar pattern as the individual level effects and was significant in the two comparisons between the more disparate types of action (no action versus treatment; talked to a doctor versus treatment). Partners in treatment seeking couples had more similar attitudes than those that either did not seek help or

just talked to a doctor. These significant agreement effects appear in addition to the significant effects for the couple level scale. None of the directional difference scores were significant across any comparisons indicating that there was not a stronger effect of one partner's attitudes in situations where partners disagreed.

In summary, although the relationship between importance of parenthood and help-seeking behavior was more in line with our expectations than fertility intentions, it was also more complex than we originally suggested. Partners' attitudes appeared to be working in tandem and, in two comparisons, agreement between partners was positively related to treatment seeking above and beyond the direct couple measure of attitudes. The direction of the relationships, however, was not consistently positive in relation to higher levels of action within each comparison.

Table 3. Select Logit Coefficients from Nested Models of Help-Seeking

	None v. Talked to a Dr. (n = 96, 23)				None v. Had Tests (n = 96, 17)				None v. Treatment (n = 96, 93)			
	F Only	F + M	Union1[a]	Union2[b]	F Only	F + M	Union1[a]	Union2[b]	F Only	F + M	Union1[a]	Union2[b]
Female Partner Characteristics												
Fertility Intentions (scale)	0.01	-0.04	-0.04		0.06	-0.02	-0.05		0.03	-0.12	-0.16	
Importance of Parenthood (scale)	-0.04	-0.04	-0.04		0.16 **	0.14	0.15 *		0.12 ***	0.09 **	0.11 **	
Male Partner Characteristics												
Fertility Intentions (scale)	-0.03	0.06	0.05		-0.02	0.08	0.14		0.00	0.16 *	0.21 **	
Importance of Parenthood (scale)	-0.03	-0.01	-0.02		0.09	0.11	0.11		0.09 ***	0.10 **	0.10 **	
Couple Scales												
Fertility Intentions (scale)				0.08				0.33				0.26
Importance of Parenthood (scale)				-0.32				1.55 **				1.22 ***

* p<.10. **p<.05. ***p<.01.
a Includes both partners plus union characteristics.
b Builds on previous model but changes the individual level scales to couple level scales.

Table 3. Continued

	Talked to a Dr. v. Had Tests (n = 23, 17)				Talked to a Dr. v. Treatment (n = 23, 93)				Had Tests v. Treatment (n = 17, 93)			
	F Only	F + M	Union1[a]	Union2[b]	F Only	F + M	Union1[a]	Union2[b]	F Only	F + M	Union1[a]	Union2[b]
Female Partner Characteristics												
Fertility Intentions (scale)	0.05	0.02	-0.01		0.03	-0.07	-0.11		-0.02	-0.09	-0.11	
Importance of Parenthood (scale)	0.20 **	0.18 *	0.18 *		0.16 ***	0.13 **	0.14 **		-0.04	-0.04	-0.04	
Male Partner Characteristics												
Fertility Intentions (scale)	0.01	0.02	0.09		0.03	0.10	0.15		0.02	0.08	0.06	
Importance of Parenthood (scale)	0.12	0.12	0.13		0.12 **	0.11 *	0.12 *		0.00	-0.01	-0.01	
Couple Scales												
Fertility Intentions (scale)				0.25				0.19				-0.06
Importance of Parenthood (scale)				1.88 **				1.54 **				-0.34

* p<.10. **p<.05. ***p<.01.
a Includes both partners plus union characteristics.
b Builds on previous model but changes the individual level scales to couple level scales.

Table 4. Select Logit Coefficients from Multinomial Models with Measures of Agreement

	None v. Talked to a Dr. (n = 96, 23)		None v. Had Tests (n = 96, 17)		None v. Treatment (n = 96, 93)	
	Relative[a]	F-M[b]	Relative[a]	F-M[b]	Relative[a]	F-M[b]
Couple Scales						
Fertility Intentions	-0.05	-0.01	0.13	0.20	-0.01	0.10
Importance of Parenthood	-0.22	-0.33	1.32 **	1.56 **	1.05 **	1.26 ***
Couple Agreement						
Fertility Intentions (hi = agree)	0.01		0.15		0.25 *	
Imp. of Parenthood (hi = agree)	-0.04		0.17		0.12 *	
Fertility Intentions (pos = female effect)		-0.05		-0.10		-0.18 *
Imp. of Parenthood (pos = female effect)		-0.01		0.02		0.00

*p<.10. **p<.05. ***p<.01.

[a]Relative is the absolute difference between partners multiplied by (-) 1.

[b]F-M is the directional difference score of the male partner subtracted from the female partner.

Table 4. Continued

	Talked to a Dr. v. Had Tests (n = 23, 17)		Talked to a Dr. v. Treatment (n = 23, 93)		Had Tests v. Treatment (n = 17, 93)	
	Relative[a]	F-M[b]	Relative[a]	F-M[b]	Relative[a]	F-M[b]
Couple Scales						
Fertility Intentions	0.18	0.21	0.04	0.11	-0.14	-0.10
Importance of Parenthood	1.53 **	1.89 **	1.27 **	1.59 **	-0.26	-0.30
Couple Agreement						
Fertility Intentions (hi = agree)	0.13		0.24		0.11	
Imp. of Parenthood (hi = agree)	0.21		0.17 **		-0.05	
Fertility Intentions (pos = female effect)		-0.05		-0.13		-0.08
Imp. of Parenthood (pos = female effect)		0.03		0.01		-0.01

*p<.10. **p<.05. ***p<.01.

[a]Relative is the absolute difference between partners multiplied by (-) 1.

[b]F-M is the directional difference score of the male partner subtracted from the female partner.

Additional Findings. There were a few interesting additional findings. Partners'
agreement on desired number of children did not appear to play a role in the type of help-seeking
behavior that occurred. Although the descriptive statistics in Table 2 show an increase in the
percent of partners agreeing at higher levels of help-seeking action, this aspect of agreement was
not significant in any of the comparisons made (see Table 6 in the Appendix). One other
interesting finding concerned whether a respondent was Catholic. This appeared to work in
opposite ways for females and males (see Table 5 in the Appendix). For the female partner,
being Catholic was positively related to pursuing any form of help-seeking versus none, although
this changed to a negative relationship when both actions in the comparison moved towards
treatment. For the male partner, being Catholic was consistently negative in relation to all higher
levels of action. Controlling for both partners' characteristics appeared to amplify these
somewhat opposite effects. Additionally, if the female partner was Catholic, the couple was
significantly more likely to have had tests compared to no action. If the male partner was
Catholic, the couple was significantly less likely to seek treatment compared to no action. Given
the limited number of Catholics in the sample, it was not feasible to further break down this
finding by examining the effects of both partners being Catholic or of couples where either the
male or female partner was Catholic. However, this suggested an interesting question for further
research.

DISCUSSION AND CONCLUSION

We examined how individual and couple level aspects of fertility intentions and the
importance of parenthood related to help-seeking behavior. We expected that greater fertility
intentions and a greater importance of parenthood of both partners would be positively

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associated with some help-seeking action occurring and this relationship would intensify as the

level of action increased; that female and male partners would not have symmetrical influence on

help-seeking behavior because the female partner was potentially the primary decision-maker,

but that male partners would have increasing influence at higher levels of help-seeking action.

Both fertility intentions and the importance of parenthood had more complex relationships to

help-seeking behavior than what we initially suggested, although the importance of parenthood

was closer in line with our expectations.

Fertility intentions appeared to be working in opposite ways for female and male

partners, and this was more pronounced after controlling for both partners' characteristics.

Couple agreement on intentions was significant for treatment seeking couples versus couples that

did not seek help, but the male partner's intentions appeared to have a greater effect on help-

seeking occurring, especially as the level of action increased. This finding seems contrary to

previous research that shows the female partner as the primary decision-maker for infertility

help-seeking (Greil et al. 1988; Greil 1991a; Greil 1991b; Lorber and Bandlamudi 1993).

Another possible explanation for this is that female and male partners' intentions in the context

of infertility may reflect different meanings. Female partner's intentions may convey how certain

she is about her ability to have a child rather than how certain she is that she wants to have a

child. This is similar to the notion by Axinn and Yabiku (2001) that intentions may be more

dynamic and influenced by everyday constraints. In light of this, the male partner's intentions

may simply be more consistent under the stress of infertility, while the female partner's

intentions may vary more since she disproportionately feels the affects (Greil 1997).

Unlike fertility intentions, partners' attitudes about the importance of parenthood

appeared to be working in tandem although they were not consistently positive in relation to

higher levels of action across the board. Comparisons at either end of the help-seeking spectrum (no action versus talked to a doctor; had tests versus treatment) showed negative relationships to the higher level of action in each set for both partners. The movement between these actions may be more ambiguous with additional factors entering the picture. In the case of moving between tests and treatment, if tests revealed that treatment was not a viable option this would necessarily be more salient in relation to behavior than attitudes about having children.

We suggested that couple agreement as a proxy for negotiation between partners would provide a necessary base for help-seeking action to occur and that this would be more relevant at higher levels of help-seeking action since the male partner should be more involved. In most instances, couple agreement, though not always significant, was positively related to a higher level of help-seeking action occurring. Agreement was significant in the comparison between the two more disparate types of action (no action versus treatment). Couples who sought treatment were significantly more likely to agree on both fertility intentions and the importance of parenthood compared to couples who did not seek help. Couples who sought treatment compared to those who simply talked to a doctor were also significantly more likely to agree on the importance of parenthood.

While these findings definitely show that agreement is important in treatment seeking, whether this is a proxy for the negotiation process between partners is less clear without more specific information on partners' communication. One obvious point of negotiation – the number of desired children -- was not related to help-seeking behavior even though descriptive findings showed that less than half of all couples agreed, but the percent agreeing increased at higher levels of help-seeking action. The lack of significant findings for this point of agreement,

however, may be more indicative that infertility help-seeking cannot be reduced to a fertility decision.

Overall, these findings highlight that information on both partners is crucial to understanding the dyadic nature of infertility and help-seeking, and it is apparent that couple dynamics cannot be easily represented by any single measure or model. A more complete picture arises out of examining multiple aspects of how partners relate to one another as well as to other couples across different levels of help-seeking.

Limitations

Although this study addressed some issues of prior research by including male partners and non-help-seeking couples, limitations need to be considered. Cross-sectional data is somewhat problematic – a better indication of couple dynamics and relevance of attitudes to help-seeking behavior could be gained from data over multiple time points (the NSFB is in the process of collecting a second wave) and more clear trajectories of infertility and help-seeking for both partners. This study is also somewhat limited in the generalizability of its findings given the sample selection criteria, however, we suggest that it provides useful insight into the dyadic process of infertility as well as some indications for further research questions. Finally, although we focused primarily on fertility-related dimensions of infertility help-seeking there may be many factors that enter into help-seeking (e.g. religious denomination) – these can hopefully be explored more fully with information on both partners of infertile couples.

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APPENDIX

Table 5. Logit Coefficients from Nested Multinomial Logistic Regression Models of Help-Seeking

	None v. Talked to a Dr. (n = 96, 23)								None v. Had Tests (n = 96, 17)							
	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.
Female Partner Characteristics																
Non-white (non-Hisp white omitted)	-0.03	0.59	-0.99	0.88	-1.09	0.93	-1.11	0.93	-0.14	0.71	-0.12	1.13	-0.09	1.10	-0.05	1.11
Catholic (all other denominations omitted)	0.72	0.54	1.09	0.71	1.07	0.72	0.97	0.70	0.62	0.60	1.27 *	0.78	1.25	0.81	1.16	0.80
Keeping House (FT employed omitted)	-0.64	0.84	-0.43	0.85	-0.47	0.87	-0.46	0.86	-1.17	1.12	-1.16	1.13	-1.41	1.16	-1.39	1.16
Other Employment Status (FT employed omitted)	0.05	0.60	0.12	0.61	0.09	0.64	0.07	0.64	0.08	0.67	0.13	0.70	0.09	0.74	0.09	0.74
Biological Parent?	0.26	0.58	0.26	0.62	0.22	0.63	0.19	0.62	-0.75	0.60	-0.88	0.64	-1.10 *	0.67	-1.16 *	0.67
Age	0.07	0.05	0.08 *	0.05	0.06	0.06	0.07	0.05	0.12 **	0.06	0.13 **	0.06	0.02	0.07	0.03	0.07
Self-Assessed Health (hi = better health)	-0.43	0.39	-0.49	0.41	-0.57	0.44	-0.60	0.43	-0.64	0.42	-0.66	0.43	-0.64	0.46	-0.62	0.45
Regular Doctor?	0.14	0.71	0.02	0.73	-0.06	0.74	-0.04	0.73	1.36	1.09	1.29	1.12	0.94	1.13	0.94	1.13
Fertility Intentions (scale)	0.01	0.12	-0.04	0.17	-0.04	0.18			0.06	0.14	-0.02	0.19	-0.05	0.21		
Importance of Parenthood (scale)	-0.04	0.06	-0.04	0.06	-0.04	0.07			0.16 **	0.08	0.14	0.09	0.15 *	0.09		
Male Partner Characteristics																
Non-white (non-Hisp white omitted)	0.40	0.54	1.22	0.83	1.36	0.87	1.34	0.86	-0.36	0.70	-0.08	1.13	0.06	1.10	-0.02	1.10
Catholic (all other denominations omitted)	0.21	0.52	-0.78	0.73	-0.81	0.73	-0.75	0.72	-0.08	0.63	-0.91	0.86	-1.13	0.90	-1.07	0.90
Has children from previous relationship?	1.21	0.74	1.14	0.79	1.10	0.83	1.12	0.82	1.42 *	0.81	1.41	0.88	2.05 **	0.99	1.96 **	0.98
Fertility Intentions (scale)	-0.03	0.09	0.06	0.14	0.05	0.14			-0.02	0.10	0.08	0.16	0.14	0.17		
Importance of Parenthood (scale)	-0.03	0.05	-0.01	0.06	-0.02	0.06			0.09	0.07	0.11	0.08	0.11	0.08		
Union Characteristics																
Time living together (years)					0.02	0.06	0.02	0.06					0.20 ***	0.07	0.19 **	0.07
First marriage for both partners					-0.01	0.65	0.04	0.64					-0.28	0.85	-0.23	0.82
Total family income					0.05	0.15	0.05	0.15					0.06	0.18	0.06	0.18
Couple Scales																
Fertility Intentions (scale)							0.08	0.34							0.33	0.40
Importance of Parenthood (scale)							-0.32	0.46							1.55 **	0.64

* p<.10. **p<.05. ***p<.01.

[a] Includes both partners plus union characteristics.

[b] Builds on previous model but changes the individual level scales to couple level scales.

Table 5. Continued

	None v. Treatment (n = 96, 93)								Talked to a Dr. v. Had Tests (n = 23, 17)							
	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.
Female Partner Characteristics																
Non-white (non-Hisp white omitted)	-0.08	0.40	-0.06	0.64	0.04	0.67	0.03	0.66	-0.11	0.84	0.87	1.30	1.01	1.28	1.05	1.29
Catholic (all other denominations omitted)	0.10	0.38	0.71	0.49	0.60	0.51	0.45	0.49	-0.10	0.71	0.17	0.91	0.18	0.94	0.19	0.93
Keeping House (FT employed omitted)	0.91 **	0.43	0.89 **	0.45	0.77	0.48	0.85 *	0.47	-0.53	1.32	-0.73	1.34	-0.94	1.36	-0.92	1.36
Other Employment Status (FT employed omitted)	0.75 **	0.38	0.85 **	0.41	0.91 **	0.44	0.90 **	0.43	0.03	0.81	0.01	0.83	0.00	0.88	0.02	0.88
Biological Parent?	-0.68 *	0.37	-0.77 **	0.40	-0.89 **	0.42	-0.95 **	0.42	-1.02	0.75	-1.14	0.80	-1.32	0.82	-1.35 *	0.81
Age	0.11 ***	0.03	0.12 ***	0.03	0.03	0.04	0.04	0.04	0.05	0.07	0.05	0.07	-0.04	0.08	-0.04	0.08
Self-Assessed Health (hi = better health)	-0.23	0.26	-0.24	0.27	-0.34	0.30	-0.35	0.30	-0.21	0.51	-0.16	0.52	-0.07	0.55	-0.03	0.54
Regular Doctor?	0.82 *	0.46	0.85 *	0.48	0.52	0.51	0.49	0.51	1.21	1.24	1.27	1.26	1.00	1.28	0.98	1.28
Fertility Intentions (scale)	0.03	0.08	-0.12	0.12	-0.16	0.12			0.05	0.16	0.02	0.23	-0.01	0.24		
Importance of Parenthood (scale)	0.12 ***	0.04	0.09 **	0.05	0.11 **	0.05			0.20 **	0.09	0.18 *	0.10	0.18 *	0.10		
Male Partner Characteristics (M only)																
Non-white (non-Hisp white omitted)	-0.25	0.38	0.01	0.64	0.21	0.67	0.15	0.65	-0.77	0.80	-1.30	1.26	-1.30	1.23	-1.36	1.22
Catholic (all other denominations omitted)	-0.34	0.36	-0.87 *	0.49	-1.04 **	0.52	-0.95 *	0.51	-0.29	0.74	-0.13	1.01	-0.32	1.04	-0.33	1.04
Has children from previous relationship?	0.87	0.59	0.86	0.66	1.44 **	0.72	1.33 *	0.71	0.21	0.88	0.27	0.95	0.95	1.08	0.84	1.07
Fertility Intentions (scale)	0.00	0.06	0.16 *	0.10	0.21 **	0.10			0.01	0.12	0.02	0.18	0.09	0.19		
Importance of Parenthood (scale)	0.09 ***	0.04	0.10 **	0.05	0.10 **	0.05			0.12	0.08	0.12	0.09	0.13	0.09		
Union Characteristics																
Time living together (years)					0.16 ***	0.05	0.15 ***	0.04					0.17 **	0.09	0.17 **	0.08
First marriage for both partners					-0.17	0.49	-0.03	0.47					-0.27	0.96	-0.27	0.93
Total family income					0.22 **	0.11	0.21 **	0.11					0.01	0.21	0.01	0.21
Couple Scales																
Fertility Intentions (scale)							0.26	0.24							0.25	0.47
Importance of Parenthood (scale)							1.22 ***	0.37							1.88 **	0.72

* p<.10. **p<.05. ***p<.01.

[a] Includes both partners plus union characteristics.

[b] Builds on previous model but changes the individual level scales to couple level scales.

Table 5. Continued

	Talked to a Dr. v. Treatment (n = 23, 93)								Had Tests v. Treatment (n = 17, 93)							
	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.	F only	S.E.	F + M	S.E.	Union1[a]	S.E.	Union2[b]	S.E.
Female Partner Characteristics																
Non-white (non-Hisp white omitted)	-0.05	0.61	0.93	0.93	1.14	0.96	1.14	0.95	0.06	0.71	0.06	1.14	0.13	1.09	0.08	1.09
Catholic (all other denominations omitted)	-0.62	0.54	-0.38	0.71	-0.47	0.72	-0.52	0.71	-0.52	0.59	-0.55	0.74	-0.65	0.77	-0.71	0.77
Keeping House (FT employed omitted)	1.54 *	0.82	1.32	0.84	1.24	0.86	1.32	0.86	2.07 *	1.10	2.06 *	1.11	2.18 **	1.12	2.24 **	1.12
Other Employment Status (FT employed omitted)	0.70	0.60	0.73	0.61	0.82	0.65	0.83	0.65	0.67	0.65	0.71	0.67	0.82	0.70	0.81	0.70
Biological Parent?	-0.94	0.59	-1.03 *	0.63	-1.11 *	0.64	-1.14 *	0.63	0.08	0.58	0.11	0.61	0.22	0.63	0.21	0.63
Age	0.04	0.05	0.04	0.05	-0.03	0.06	-0.02	0.06	-0.01	0.05	0.00	0.06	0.01	0.07	0.02	0.07
Self-Assessed Health (hi = better health)	0.20	0.39	0.26	0.41	0.23	0.45	0.25	0.44	0.41	0.41	0.42	0.41	0.30	0.42	0.27	0.42
Regular Doctor?	0.67	0.74	0.83	0.77	0.58	0.79	0.54	0.78	-0.54	1.10	-0.44	1.12	-0.42	1.13	-0.44	1.12
Fertility Intentions (scale)	0.03	0.12	-0.07	0.17	-0.11	0.18			-0.02	0.13	-0.09	0.18	-0.11	0.19		
Importance of Parenthood (scale)	0.16 ***	0.06	0.13 **	0.07	0.14 **	0.07			-0.04	0.08	-0.04	0.09	-0.04	0.09		
Male Partner Characteristics																
Non-white (non-Hisp white omitted)	-0.65	0.55	-1.21	0.87	-1.15	0.88	-1.19	0.87	0.12	0.70	0.09	1.15	0.14	1.09	0.17	1.08
Catholic (all other denominations omitted)	-0.54	0.54	-0.09	0.75	-0.23	0.77	-0.20	0.76	-0.25	0.63	0.04	0.85	0.09	0.89	0.12	0.88
Has children from previous relationship?	-0.34	0.68	-0.28	0.76	0.33	0.85	0.21	0.84	-0.56	0.74	-0.55	0.79	-0.61	0.88	-0.63	0.87
Fertility Intentions (scale)	0.03	0.09	0.10	0.14	0.15	0.15			0.02	0.10	0.08	0.15	0.06	0.16		
Importance of Parenthood (scale)	0.12 **	0.05	0.11 *	0.06	0.12 *	0.06			0.00	0.07	-0.01	0.08	-0.01	0.08		
Union Characteristics																
Time living together (years)					0.14 **	0.06	0.13 **	0.06					-0.03	0.07	-0.04	0.07
First marriage for both partners					-0.16	0.67	-0.07	0.66					0.11	0.82	0.20	0.79
Total family income					0.17	0.16	0.16	0.16					0.16	0.17	0.15	0.17
Couple Scales																
Fertility Intentions (scale)							0.19	0.36							-0.06	0.38
Importance of Parenthood (scale)							1.54 **	0.49							-0.34	0.62

* p<.10. **p<.05. ***p<.01.

[a] Includes both partners plus union characteristics.

[b] Builds on previous model but changes the individual level scales to couple level scales.

Table 6. Logit Coefficients from Multinomial Models with Difference Score Measures

	None v. Talked to a Dr. (n = 96, 23)				None v. Had Tests (n = 96, 17)				None v. Treatment (n = 96, 93)			
	Relative[a]	S.E.	F-M[b]	S.E.	Relative[a]	S.E.	F-M[b]	S.E.	Relative[a]	S.E.	F-M[b]	S.E.
Female Partner Characteristics												
Non-white (non-Hisp white omitted)	-1.12	0.97	-1.11	0.94	0.13	1.10	-0.02	1.11	0.19	0.68	0.08	0.68
Catholic (all other denominations omitted)	1.00	0.71	1.08	0.71	1.12	0.82	1.23	0.81	0.46	0.52	0.59	0.51
Keeping House (FT employed omitted)	-0.44	0.87	-0.44	0.87	-1.35	1.16	-1.36	1.17	0.86 *	0.49	0.81 *	0.49
Other Employment Status (FT employed omitted)	0.11	0.64	0.08	0.64	0.04	0.75	0.08	0.74	0.91 **	0.44	0.90 **	0.44
Biological Parent?	0.13	0.62	0.22	0.63	-1.13 *	0.69	-1.10	0.67	-0.88 **	0.43	-0.89 **	0.43
Age	0.07	0.05	0.06	0.06	0.01	0.08	0.02	0.08	0.02	0.04	0.03	0.04
Self-assessed Health	-0.64	0.43	-0.57	0.44	-0.64	0.46	-0.62	0.46	-0.40	0.31	-0.33	0.31
Regular Doctor?	-0.07	0.75	-0.06	0.74	1.15	1.15	0.93	1.13	0.74	0.52	0.51	0.51
Male Partner Characteristics												
Non-white (non-Hisp white omitted)	1.41	0.90	1.43	0.88	0.19	1.11	0.15	1.12	0.31	0.67	0.24	0.68
Catholic (all other denominations omitted)	-0.77	0.73	-0.84	0.73	-1.16	0.91	-1.12	0.90	-1.07 **	0.53	-1.05 **	0.52
Has children from previous relationship?	1.14	0.82	1.09	0.84	1.88 *	0.98	2.03 **	0.99	1.31 *	0.71	1.44 **	0.72
Union Characteristics												
Time living together (years)	0.01	0.06	0.02	0.06	0.21 **	0.08	0.19 ***	0.08	0.17 ***	0.05	0.16 ***	0.05
First marriage for both partners	0.08	0.64	0.00	0.65	-0.31	0.86	-0.28	0.85	-0.19	0.49	-0.13	0.49
Total family income	0.04	0.15	0.05	0.15	0.13	0.18	0.06	0.18	0.27 **	0.11	0.21 *	0.11
Couple Scales												
Fertility Intentions	-0.05	0.39	-0.01	0.37	0.13	0.44	0.20	0.43	-0.01	0.27	0.10	0.26
Importance of Parenthood	-0.22	0.48	-0.33	0.46	1.32 **	0.64	1.56 **	0.65	1.05 **	0.39	1.26 ***	0.37
Couple Congruence												
Agree on number of kids?	0.40	0.54	0.36	0.52	0.51	0.61	0.56	0.61	0.33	0.36	0.41	0.36
Fertility Intentions (hi = agree)	0.01	0.17			0.15	0.22			0.25 *	0.14		
Imp. of Parenthood (hi = agree)	-0.04	0.07			0.17	0.12			0.12 *	0.07		
Fertility Intentions (pos = female effect)			-0.05	0.15			-0.10	0.17			-0.18 *	0.10
Imp. of Parenthood (pos = female effect)			-0.01	0.05			0.02	0.07			0.00	0.04

*p<.10. **p<.05. ***p<.01.

[a]Relative is the absolute difference between partners multiplied by (-) 1.

[b]F-M is the directional difference score of the male partner subtracted from the female partner.

Table 6. Continued

	Talked to a Dr. v. Had Tests (n = 23, 17)				Talked to a Dr. v. Treatment (n = 23, 93)				Had Tests v. Treatment (n = 17, 93)			
	Relative[a]	S.E.	F-M[b]	S.E.	Relative[a]	S.E.	F-M[b]	S.E.	Relative[a]	S.E.	F-M[b]	S.E.
Female Partner Characteristics												
Non-white (non-Hisp white omitted)	1.25	1.30	1.09	1.29	1.31	0.99	1.19	0.96	0.06	1.08	0.09	1.09
Catholic (all other denominations omitted)	0.12	0.95	0.15	0.94	-0.54	0.73	-0.49	0.72	-0.66	0.77	-0.64	0.77
Keeping House (FT employed omitted)	-0.91	1.37	-0.92	1.36	1.30	0.87	1.25	0.86	2.21 **	1.12	2.17 *	1.13
Other Employment Status (FT employed omitted)	-0.07	0.89	0.00	0.88	0.80	0.66	0.82	0.65	0.87	0.71	0.82	0.70
Biological Parent?	-1.26	0.83	-1.32	0.82	-1.01	0.64	-1.11 *	0.64	0.24	0.64	0.22	0.64
Age	-0.05	0.09	-0.05	0.09	-0.04	0.06	-0.03	0.06	0.01	0.07	0.01	0.07
Self-assessed Health	0.00	0.55	-0.05	0.56	0.24	0.44	0.23	0.45	0.24	0.42	0.28	0.42
Regular Doctor?	1.22	1.30	0.99	1.28	0.81	0.81	0.56	0.79	-0.41	1.14	-0.43	1.13
Male Partner Characteristics												
Non-white (non-Hisp white omitted)	-1.22	1.25	-1.28	1.24	-1.10	0.91	-1.18	0.89	0.12	1.09	0.10	1.10
Catholic (all other denominations omitted)	-0.39	1.06	-0.27	1.04	-0.31	0.78	-0.21	0.76	0.09	0.89	0.07	0.88
Has children from previous relationship?	0.74	1.07	0.94	1.09	0.17	0.84	0.35	0.86	-0.57	0.88	-0.60	0.88
Union Characteristics												
Time living together (years)	0.20 **	0.09	0.18 **	0.09	0.16 **	0.06	0.14 **	0.06	-0.04	0.07	-0.03	0.07
First marriage for both partners	-0.39	0.98	-0.28	0.96	-0.28	0.68	-0.14	0.67	0.12	0.84	0.14	0.83
Total family income	0.08	0.21	0.01	0.21	0.23	0.16	0.17	0.16	0.15	0.17	0.16	0.17
Couple Scales												
Fertility Intentions	0.18	0.52	0.21	0.50	0.04	0.40	0.11	0.38	-0.14	0.40	-0.10	0.40
Importance of Parenthood	1.53 **	0.73	1.89 **	0.73	1.27 **	0.53	1.59 **	0.50	-0.26	0.61	-0.30	0.62
Couple Congruence												
Agree on number of kids?	0.11	0.74	0.21	0.72	-0.07	0.55	0.05	0.54	-0.18	0.59	-0.16	0.59
Fertility Intentions (hi = agree)	0.13	0.25			0.24	0.19			0.11	0.21		
Imp. of Parenthood (hi = agree)	0.21	0.13			0.17 **	0.08			-0.05	0.12		
Fertility Intentions (pos = female effect)			-0.05	0.20			-0.13	0.15			-0.08	0.16
Imp. of Parenthood (pos = female effect)			0.03	0.08			0.01	0.05			-0.01	0.07

*p<.10. **p<.05. ***p<.01.

[a] Relative is the absolute difference between partners multiplied by (-) 1.

[b] F-M is the directional difference score of the male partner subtracted from the female partner.