Being Childfree: The Role of Self-Stigma

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Table of Contents

List of Tables

List of Figures

List of Appendices

Abstract

The childfree lifestyle has been gaining increasing mainstream and academic attention, as more people choose not to have children. Although there are rising numbers of childfree individuals, stigma remains abundant. The purpose of this set of exploratory studies was to examine experiences of stigma and self-stigma in childfree people. In Study 1, we examined experiences of stigma and self-stigma in childfree people using qualitative thematic analysis. Community members (N = 222) were recruited to complete an electronic survey. Results revealed that most participants experienced childfree related stigma and self-stigma, with multiple factors contributing to its development and negative effects. Participant responses also supported the development of a quantitative scale to measure childfree self-stigma, which was subsequently created for Study 2. In Study 2, we quantitatively examined stigma and self-stigma in childfree people, primarily by conducting t-tests, z-tests, and bivariate correlations suited to the exploratory nature of the data. Childfree community members (N = 440), as well as childfree university students (n = 125) and non-childfree university students (n = 512) were recruited. Questionnaires in Study 2 addressed self-stigma, quality of life, trust in healthcare, autonomy, and personality. The self-stigma scale performed well psychometrically. Main findings further revealed that self-stigma was negatively correlated with quality of life and autonomy in the community sample. Further, individuals who had experienced childfree related stigma in the healthcare system reported reduced trust in healthcare overall. Primary strengths of the project include the large samples and two-pronged approach to examining the constructs, while limitations included the cross-sectional and correlational design of the research. This work supports self-stigma theory and also highlights the ongoing stigma that childfree people face and the significant challenges and consequences this poses.

Being Childfree: The Role of Self-Stigma

Introduction

Recent population data on declining birth rates demonstrate that many people are not having children. Among these individuals without children, a growing subset identify as childfree (Brown, 2021; Hintz & Brown, 2020). The term "voluntary childlessness" refers to individuals who are childfree – people who choose to refrain from having children (Houseknecht, 1987). This term encompasses individuals who do not want children procured through biological, adoptive, or any other means (Hintz & Brown, 2019). Voluntary childlessness contrasts with individuals who are involuntarily childless: people who want to have children but struggle with infertility or other health issues that prevent procreation or pregnancy (Houseknecht, 1987). It should be noted that other social barriers (e.g., financial security) may also act to prevent individuals from having children, thus contributing to the overall number of involuntarily childless individuals (Neal & Neal, 2023).

Some consider the terms "voluntary childlessness" and "childfree" to be synonymous, and there has been inconsistent usage in the literature regarding what terminology may be most appropriate. There are, however, some distinct differences that are worth considering. The term voluntary childlessness has a longer history in terms of academic literature; though this is an advantage in the context of amassing and organizing research within the area, it is also inherently deficit-focused in nature (i.e., child-less). In contrast, the term childfree has been gaining significant traction recently in academic language; furthermore, it is the preferred term of those whom it represents, being more affirming in nature (Neal & Neal, 2023). The term "childless" has also sometimes been used interchangeably with "childfree"; however, it has more frequently been used to describe involuntary childlessness (e.g., Bays, 2016). Recent authors in this area,

Neal and Neal (2023) recommend that the term childfree be used more consistently in the literature given its advantages as described above.

When discussing the concept of being childfree, future intent and degree of commitment are relevant considerations. Individuals who are currently not parents but who intend to have children at some later point (i.e., not-yet-parents) differ from individuals who are currently childfree and who intend to remain so (Callan, 1983; Houseknect, 1987). Both subsets of people at that stage do not have children, but their lifestyle intentions (i.e., pursuing parenthood or voluntary childlessness) differ greatly (Neal & Neal, 2023). Similarly, though future intent may be present, this does not capture the degree of commitment to this choice. Some individuals may be staunchly childfree with a high degree of commitment to this lifestyle choice and have known their preference from a young age (Miettinen & Szalma, 2014). Researchers have coined these individuals as "early articulators", in that a firm choice and commitment to being childfree is determined earlier in life. This contrasts with individuals who eventually consider themselves to be childfree after repeatedly postponing having children (i.e., perpetual postponers; Clark et al., 2018; Houseknect, 1987). Alternatively, other individuals may intend to remain childfree but with low commitment, in that they are open to having children later if the opportunity arises. It is important to note that the nature of this choice is fluid, and that future intent and degree of commitment can change over the course of one's life (Neal & Neal, 2023). Some initially adamant childfree individuals may later pursue parenthood, while others who initially wanted children may subsequently turn to a childfree lifestyle (Moore, 2017). Likewise, individuals facing involuntarily childlessness related to issues with infertility may eventually identify as childfree, as they grow to accept, appreciate, and pursue a lifestyle without children (Neal & Neal, 2023; Waren & Pals, 2013).

Although coined decades ago, the concept of being childfree has historically been a neglected area of study (Veevers, 1973), though it has gained increasing traction in recent years. From an academic perceptive, this interest has been inspired by declining birth rates, as well as an increasing number of individuals who are delaying the decision to have children, or who are forgoing the decision altogether (Ashburn-Naldo, 2017; Bays, 2016; Gibney et al. 2017). From public perception, knowledge and greater acceptance regarding this lifestyle choice has been increasingly showcased on social media, leading to what some have called a "no-kids movement" that is booming (Savage, 2023).

Beyond mere public perception, there is also quantitative evidence that more people are choosing a childfree lifestyle. The Centers for Disease Control (CDC) has documented a trend in declining birth rates in the United States, China, Japan, as well as several European countries (Ashburn-Naldo, 2017). In 2020, the United States reported the lowest number of births since 1979 (Ashburn-Naldo, 2017). Although many suppose that declining birth rates are partly explained by individuals delaying the choice to have children due to a variety of factors (e.g., prioritizing education or increased economic stability), there is also evidence to suggest that the number of lifetime childfree individuals is increasing (Gibney et al., 2017; Miettinen & Szalma, 2014). Some estimates suggest that 20% of women in the United States and up to 24% of women in Australia will remain childfree (Ashburn-Naldo, 2017; Graham, 2015). Another recent study that examined the prevalence of childfree people in Michigan, US, found that 27% of adults identified as childfree (Neal & Neal, 2021). More recently, a third of individuals in Canada between the ages of 15 to 49 years reported the intention to have zero children (Statistics Canada, 2022). Thus, the growing minority of childfree individuals provides momentum to examine this historically understudied population.

Despite the impetus to review and add to the literature in this under-researched area, some of the childfree research to date presents with shortcomings and considerations that should be noted prior to delving further into an examination of the literature. First, there are limited quantitative studies on voluntary childlessness, particularly in respect to specific topic areas within this literature (e.g., stigma, predictive factors; Bahtiyar & Sakalli, 2019; Miettinen & Szalma, 2014). Additionally, many researchers have excluded men from their participant samples; much of the discourse in this area has centered around women (Miettinen & Szalma, 2014). Most research has also involved white, non-diverse samples, though there is some evidence that rates of voluntary childlessness differ between ethnicities (Boyd, 1989). A further complicating factor is that some research studies do not define the "childlessness" construct and have seemingly amalgamated all childless individuals into one category in their analyses (i.e., voluntarily childfree and involuntarily childless), thus conflating the findings. Similarly, some individuals who do not have children at the time of the research studies (i.e., "not-yet-parents") but who intend to do so, have also been grouped into the "non-children" groups. Finally, the literature is largely multidisciplinary, in that studies have addressed this topic through the lens of population predictive factors (e.g., Miettinen & Szalma, 2014), health factors (e.g., Graham, 2015), feminist and women's studies (e.g., Peterson, 2015), and media studies (e.g., Hintz & Haywood, 2021), to name but a few. Consequently, there is not a unified body of literature on this topic that stems from a distinct field. Although this certainly demonstrates breadth within the area, which can be conceptualized as a strength, it also may mean that there is limited breadth. Most of the childfree research to date on voluntary childlessness falls into four categories: one, characteristics of childfree individuals; two, motives to pursue voluntary childlessness; and three, health and well-being related consequences of childlessness, particularly in elderly populations

(Albertini & Mencarini, 2012). More recent research has placed a particular emphasis on a fourth area, which involves examining stigma (Koropeckyj-Cox et al., 2018).

Characteristics of Voluntary Childlessness

The childfree literature has often focused on characteristics of individuals who choose this lifestyle choice (Abma & Martinez, 2006; Callan, 1983; Husnu, 2016; Lee & Zvonkovic, 2014; Miettinen & Szalma, 2014). Studies focused on this lens have typically involved population-level surveys or data that provide a retrospective look at various characteristics, though some have involved small-scale surveys (e.g., participants within a single community or university setting), or qualitative interviews. One of the more consistent findings in the literature relates to demographic characteristics of childfree individuals, in that they tend to have higher education, higher income, and higher-level employment (Abma & Martinez, 2006). Some research has also demonstrated that voluntary childlessness is more commonly favoured by men than women, though this has not been a consistent finding in the literature (Miettinen & Szalma, 2014). Childfree individuals tend to score lower on religiosity and what would be considered traditional family values or views (Abma & Martinez, 2006; Miettinen & Szalma, 2014). Certain religious groups that might be considered more conservative, such as Mormons and Catholics, tend to have higher rates of childbearing and fertility and thus lower levels of voluntary childlessness (Uecker et al., 2021). There is also evidence to suggest that rates of voluntary childlessness are influenced by geographic location, with higher rates of childfree individuals in urban rather than rural settings (Miettinen & Szalma, 2014). Finally, childfree intentions can further be influenced by family context, such as the size of one's family, number of siblings, or types of family interactions one experiences during childhood (Callan, 1983; Miettinen & Szalma, 2014). However, in considering the above research, Miettinen and Szalma (2014) note

that there are few quantitative studies relevant to this research area, and that they often present contradictory findings. Another complicating issue is that some population data studies that examine characteristics of childfree people do not, or cannot, always differentiate between the voluntarily childfree versus involuntarily childless (Matthews & Desjardins, 2017). As discussed previously, it is important to keep these considerations in mind when interpreting the proposed demographic and social factors of this population.

Motives

In addition to characteristics associated with being childfree, researchers have also questioned the motivations behind the choice itself (Clarke et al., 2018; Houseknect, 1987; Matthews & Desjardins, 2017; Park, 2005; Peterson, 2015). Much of the research in this area has involved qualitative interviews to determine self-reported motives and provide in-depth explanations on the reasons for this choice (Peterson, 2015). A consistently reported motive to be childfree involves the lifestyle and freedom it offers. This freedom is described at the individual level (e.g., greater opportunity for self-fulfillment, an easier ability to be spontaneous), at a social level (e.g., the ability to dedicate more time toward establishing social networks or toward the quality of one's marriage), and at a practical level (e.g., increased financial stability, decreased household tasks; Betancur et al., 2023; Houseknect, 1987; Peterson, 2015).

Other motives have included not wanting or liking children, wanting to reject commonly upheld notions of womanhood or what constitutes a "family", as well as fears associated with pregnancy and childbirth for women (Clarke et al., 2018; Peterson, 2015). More global concerns associated with overpopulation, climate change, or other widespread issues have also been reported (Callan, 1983; Sabrina et al., 2021). Additionally, many women report being childfree to dedicate more time toward their career aspirations (Betancur et al., 2023; Peterson, 2015).

Others cite poor childhood experiences as a motivating factor; some described being parentified as older siblings, where they were forced into early caregiving or younger relatives, while others had parents who were unable to play active roles in their lives (Betancur et al., 2023; Clarke et al., 2018). Even more turbulent childhood experiences have also been discussed as reasons to remain childfree; for instance, some individuals have cited experiences of childhood abuse, and being unable to protect hypothetical children from facing the same fate, as an important reason to not have children (Betancur et al., 2023).

Finally, several motives associated with personality factors have also been reported as reasons to refrain from having children. In one qualitative study, participants shared that their desire not to have children partly stemmed from stable personality traits involving introversion (e.g., wanting peace and quiet at home; Park, 2005). Others reported a tendency to feel anxious, sensitive, impatient, or perfectionistic; participants stated that the stressors and demands of parenting did not seem congruent with these elements of personality, thus the desire to remain childfree (Park, 2005).

Health and Well-Being

Mental and physical health and well-being outcomes across the lifespan have also been studied in childfree populations (Chang et al., 2010; Dykstra & Keizer, 2009; Graham, 2015; Holton et al., 2010). Research in this vein has typically involved larger-scale population studies or longitudinal data and is thus mostly quantitative. There have been conflicting findings on whether childfree individuals fare better in terms of health outcomes in comparison to parents (Graham, 2015; Koropeckyj-Cox, 1998). Some researchers have added nuance to the discussion by describing how partner status better predicts psychological well-being in fathers and childless men, rather than parental status (i.e., poorer outcomes are associated with being single; Dykstra

& Keizer, 2009). Other researchers have added further nuance still by suggesting that health outcomes differ across the lifespan for childfree women, in that mental and physical health outcomes are poorer for childfree women than mothers earlier in life (e.g., 25 to 44 years), but that this trend reverses in older adulthood (e.g., 65 years and older; Graham, 2015). This finding is consistent with other research, which suggests that for women in their early 30s, mothers had greater well-being and life satisfaction than childfree women (Holton et al., 2010). Theories for this change across the lifespan involve the role of societal pressures and stigma during peak reproductive years, as women in pronatalist societies are expected to have children and face negative consequences when this expectation goes unmet (Graham, 2015). Indeed, research by Huijts and colleagues (2013) suggests that a country's social context partly explains the psychological well-being of childfree individuals, in that less tolerant societal norms are associated with poorer well-being. This is echoed by Tanaka and Johnson (2016), who suggest that childfree individuals in pronatalist societies have lower happiness and satisfaction than childfree individuals in countries where pronatalist norms are not as deeply entrenched.

Much of the health and well-being related research has also focused on the elderly, following the widely held and more traditional assumption that children should act as caregivers and key forms of social support for their elderly parents (Albertini & Mencarini, 2012; Chang et al., 2010; Cheng et al., 2014). In line with this, concerns have been raised for childfree seniors, following the assumption that poorer mental health and well-being outcomes would be predicted by a lack of children, and thus a lack of "built-in" sources of financial, emotional, social, and health-related support. Chang and colleagues (2010), however, found no difference in psychological well-being between parents and the childfree elderly, and that poor mental health (e.g., depression) in seniors was instead predicted by being single, having poor physical health,

and lower education. Further, they determined no difference in psychological well-being or quality of care received between parents or childfree seniors with disabilities (Chang et al., 2010). Similarly, some research suggests no difference in reported social isolation between the elderly childfree and elderly parents, though childfree seniors were more likely to lack specific types of support, such as personal and household care in the context of worsening health (Albertini & Mencarini, 2012). These more informal tasks (e.g., personal care, household care) are often conducted by children or other close contacts rather than caretakers in professional roles, particularly when financial resources are limited. This could partly account for this difference. As a final consideration in relation to health-related outcomes for childfree people, it is important to remember that much of the existing research has been correlational and not causal in nature. Thus, it is not possible to definitively state that certain decisions around procreation demonstrate a causal link with health and well-being outcomes.

Stigma

More recently, researchers have turned their focus to the stigma associated with being childfree. To understand stigma associated with the childfree population, it is important to first consider the different conceptualizations, definitions, components, and types of "stigma" in general, before applying it to this specific area (Link & Phelan, 2001; Sheehan et al., 2017). One ongoing criticism within the stigma literature involves the lack of a consistent definition of "stigma", including the fact that many researchers neglect to provide any definition at all (Link & Phelan, 2001). This lack of or inconsistent understanding of the concept may in part relate to the vast nature of the stigma literature, in terms of how the concept corresponds and is studied in the context of many different areas, ranging from mental illness stigma (Catalano et al., 2021), stigma associated with specific illnesses (e.g., HIV; Eaton et al., 2019), to stigma associated with

procreative choices (e.g., voluntary childlessness; Morison et al., 2015), among others. Given that the concept of stigma is researched on a multidisciplinary level, this logically results in differing conceptualizations across disciplines. Link and Phelan (2001) discuss how variation within the definition of "stigma" itself likely reflects inherent differences across topics associated with stigma, but that these differences should be clarified within different contexts.

One frequently cited definition of stigma is derived from Goffman's early influential work, which positions "stigma" as a relationship between "an attribute and a stereotype" (Goffman, 1963, p. 4; Link & Phelan, 2001). In this definition, one or more of a person's attributes is considered "deeply discrediting", which results in the global view that said person is tainted or less worthy in some inherent way due to this specific attribute (Goffman, 1963; Link & Phelan, 2001). More recent work by Corrigan and colleagues (2012) and Sheehan and colleagues (2017) understands the conceptualization of stigma through the socio-cognitive model. In line with the socio-cognitive model, stigma formation is perceived to result from three components: stereotypes, prejudice, and discrimination (Sheehan et al., 2017). Stereotypes are attitudes held by the general public, whereas prejudice involves an individual's emotional reaction associated with an agreed upon stereotype; discrimination, in turn, is the resulting behaviour associated with the stereotypes held and feelings of prejudice (Sheehan et al., 2017). More simply, then, stigma can be thought of as formed from cognitive (i.e., stereotypes), affective (i.e., prejudice), and behavioural (i.e., discrimination) components. As an example, and to put this into context for voluntary childlessness, a person might believe the commonly held stereotype that childfree individuals are selfish (Morison et al., 2015). Consequently, the individual may feel resentment toward childfree people by perceiving them as selfish (i.e., prejudice) and behave differently around them, such as purposefully excluding them from certain social settings due to their

childfree status (i.e., discrimination; Turnbull et al., 2016). Behaviours which constitute discrimination can include acts of avoidance and withdrawal (e.g., avoiding a stigmatized person), coercion, and segregation. Importantly, stigma is usually formed based on public opinion that is supported in a certain culture or environment, wherein the collective opinion upholds the stereotypes held about a group of people. This corresponds with the formation of prejudicial feelings and discriminatory action (Corrigan et al., 2012; Sheehan et al., 2017).

Evolutionary perspectives have also examined the origins of stigma and provide a different lens on the construct (Kurzban & Leary, 2001). Kurzban and Leary (2001), for instance, posit that stigma forms not only in line with a characteristic or attribute that is perceived to be discrediting (e.g., Goffman, 1963) but that this characteristic also provides a basis for social exclusion. Importantly, social exclusion is proposed to result due to "evolved adaptions designed to cause people to avoid interactions that are differentially likely to impose fitness costs" (Kurzban & Leary, 2001, pg. 188). In the context of evolutionary theory, the term "fitness costs" is in reference to reproductive success. Differences of opinion or other superficial differences between people that result in rejection or social avoidance would not constitute stigma, then, from an evolutionary perspective (Kurzban & Leary, 2001). Rather, the function of this social exclusion, representing an evolved adaption, is to prevent perceived fitness costs. Being childfree could also be discussed in relation to kin selection, whereby not having children may support the continuation of the genealogical line; in other words, childfree individuals within a family may have greater capacity to support the development of their kin's offspring, thus increasing the resource allocation available to a child, improving their chances of thriving. Thus, from evolutionary theoretical perspectives, being childfree may support the family unit and

continuation of a genealogical line in some ways, whereas in other contexts being childfree could act as an affront on evolutionary-based personal reproductive goals.

Researchers have also demonstrated that certain factors can influence or amplify the formation of stigma. Some such factors are visibility, controllability, fear, and familiarity (Sheehan et al., 2017). Visibility refers to whether a stigmatized individual can be identified based on appearance, such as if a childfree person is identified based on a visible lack of children. Controllability or responsibility refers to the extent to which the stigmatized person's "difference" is deemed to be under the person's control or own agency (e.g., a perceived difference between voluntary versus involuntary childlessness). Fear includes dangerous stereotypes about an individual, in that they are perceived as potentially harmful to others or society. And, finally, familiarity entails whether one has experience with or knowledge about a member of a stigmatized group (Sheehan et al., 2017). Greater visibility, perceived controllability, and fear-related stereotypes are associated with increased stigma, whereas increased familiarity is associated with reduced stigma (Sheehan et al., 2017). The perception of increased controllability has been associated with anger-based discriminatory responses, to punish those who are identified as different, whereas low controllability has often resulted in pity instead (Corrigan, 2000). This is consistent with the childfree literature, in that people who are involuntarily childless often receive pity, whereas those who are willingly childfree tend to experience stigma (Bays, 2016). Given that a lack of children can be a visible absence in certain contexts (e.g., family functions), and that the choice to be childfree generally has high controllability, it is evident how these factors may increase stigma toward childfree individuals. Similarly, as childfree individuals represent a minority in society, particularly in certain social, cultural, or religious groups, familiarity may also be low.

In addition to examining stigma's different components, it is also pertinent to consider different types of stigmas. There are, of course, many types of stigmas that could be reported on here. However, only those that were deemed pertinent to voluntary childlessness will be discussed. Public stigma, what has been described to this point, involves the public perception of a stigmatized group (Sheehan et al., 2017). This contrasts with self or internalized stigma, which has often been conceptualized as when a stigmatized individual incorporates public stigma into their own self-view and self-concept (Corrigan et al., 2012; Sheehan et al., 2017). For self-stigma to form, stigma theory posits that the stigmatized person must first hold an awareness of the public stigma, then consequently agree with the public stigma, and finally apply it to themselves (Sheehan et al., 2017). This, in turn, may be followed by some degree of negative impact or harm, in response to the self-stigma (Corrigan et al., 2012). In the context of voluntary childlessness, this might include a childfree person initially gaining awareness of the commonly held stereotype that childfree individuals are selfish (Caitlin, 2022; Morison et al., 2015). This childfree person would then have to agree with the public stereotype, and in turn incorporate it into their own self-concept (e.g., "I am selfish for being childfree"). Often, there is some degree of psychological harm associated with self-stigma, such as a loss of self-esteem, in that many people feel devalued by society and thus inherently less capable or worthy (Catalano et al., 2021; Corrigan et al., 2012).

There are other forms of stigma, outside of public and self-stigma, which are also worth mentioning. The term "double" or "multiple stigmas" describes individuals with multiple statuses related to their identity that may be stigmatized (Sheehan et al., 2017). This could involve an individual experiencing stigma associated with their childfree status in addition to experiencing stigma related to their ethnicity, sex, gender, sexuality, or minority condition (e.g.,

disability, mental illness). Given the heteronormative view of motherhood and fatherhood as being inherently associated with womanhood and manhood, it is possible that LGBTQ+ people face multiple forms of stigma associated with their sexuality and procreative choices (Salinas-Quiroz et al., 2020). Research demonstrates that fewer gay men and lesbian women have parenting intentions as compared to their heteronormative peers (Clarke et al., 2018; Tate et al., 2019). There are many potential reasons related to this difference in parenting intentions, though some researchers suggest that the discrimination associated with the process of "coming out" and seeking the means to have children (e.g., adoption, surrogacy) could partly dissuade LGBTQ+ individuals from parenthood (Tate et al., 2019). Moreover, in one of the few studies that compared lesbians and heterosexual women, including women who wanted children and those who were childfree, childfree lesbians were perceived most negatively compared to all other groups (Rowlands & Lee, 2006). Even within the childfree literature, LGBTQ+ people have largely been ignored and even purposefully excluded. This has included narratives that their childfree status is somehow less meaningful, as not having children is a common assumption associated with non-heteronormativity (Clarke et al., 2018).

Other demographic factors such as culture, religion, and ethnicity could also contribute to additional stigma for childfree individuals. Being more conservative in terms of religious views, political orientation, and normative gender roles attenuate voluntary childlessness (Waren & Pals, 2013). Thus, childfree individuals belonging to cultural or religious groups that tend to be more conservative may face additional stigma for being childfree in line with cultural norms. Indeed, Durham (2008) found that religion was an important consideration when childfree individuals were determining whether to share their lifestyle choices with family members. However, and as noted previously, there is limited research in examining the intersectional

nature of voluntary childlessness, as much of the literature has focused on white, heterosexual women (Boyd, 1989; Miettinen & Szalma, 2014).

Finally, structural stigma is another type of stigma that is relevant to this topic. Structural stigma represents policies at a governmental or institutional level that restrict opportunities for a certain minority group (Sheehan et al., 2017). Structural stigma can be further conceptualized as intentional or unintentional in nature. Intentional structural stigma could relate to policies that explicitly separate or stigmatize certain groups based on upheld stereotypes (Sheehan et al., 2017). In the context of voluntary childlessness in healthcare settings, this could resemble policies around requested sterilization procedures. Indeed, many physicians have reportedly prevented women from receiving such procedures in line with their goals of being childfree, based on the assumption that they would inevitably want children at a later point and regret their decision (Hintz & Brown, 2019; Lalonde, 2018). Unintentional structural stigma, on the other hand, represents stigma that occurs without specific intention or policy (Sheehan et al., 2017). In terms of our previous example (i.e., childfree stigma in the healthcare field), unintentional stigma could be reflected by poorer quality of care or biased understandings of patient profiles.

In line with the different forms of stigma presented here, it is also important to consider that many of these may fall under what can be termed “experienced stigma” versus “anticipated stigma” (Earnshaw & Quinn, 2012; Hintz & Brown, 2019). Experienced stigma refers to situations, events, or conversations (i.e., experiences) wherein stigma and discriminatory action are perceived to have occurred. Anticipated stigma, on the other hand, refers to the concern that once a stigmatized identity or characteristic becomes obvious or known, that poor treatment will follow (Earnshaw & Quinn, 2012). Research demonstrates that having experienced stigma may result in greater anticipatory stigma, which in turn can result in psychological distress.

Internalized or self-stigma, including negative beliefs about oneself in line with stereotyped views, may also contribute to anticipated stigma (Earnshaw & Quinn, 2012). Childfree individuals may have experienced stigma (e.g., encountered stereotyping that childfree people are selfish), and have internalized this message (e.g., "I am selfish"). Consequently, the culmination of experienced and self-stigma may contribute to greater anticipation that they will face stigma in future situations in respect to their childfree status, which could influence their wellbeing in turn.

Stigma and Voluntary Childlessness

Numerous research studies have demonstrated that childfree individuals and childfree women especially are stigmatized (Bays, 2016; Durham, 2008; Morison et al., 2015; Mueller & Yoder, 1999). The literature in this area is more diverse in terms of methodology, in that some researchers have used qualitative methods (e.g., informant interviews, case studies, opinion pieces), whereas others have used quantitative methods (e.g., small-scale surveys). Many of the stereotypes presented in this literature tend to fall into two categories: one, that not having children represents a moral failing (e.g., Catilin, 2022; Mueller & Yoder, 1999), and two, that it demonstrates a defect in character or personality (e.g., Kemkes, 2009; Morison et al., 2015). Each stereotype will be described subsequently in detail.

The stereotype that being childfree represents a moral failing has been linked with pronatalist assumptions. Pronatalist assumptions involve the idea that having children is a natural and necessary stage of one's life, and a marker of typical development (Hintz & Brown, 2020; Morison et al., 2015). These assumptions promote the idea that parenthood is associated with "rightness" and "selflessness", and that deviating from parenthood suggests the inverse of these traits. The concept that womanhood or manhood requires one to be a mother or father also relates

to such pronatalist norms. This discussion around morality is evidenced with the example of comments from the late Pope Francis, wherein he stated that people lose a part of their humanity in not pursuing parenthood (Caitlin, 2022). Researchers have also highlighted societal perceptions of voluntarily childfree individuals as lacking psychological fulfillment or purpose in life, as children are theorized to provide an essential meaning to one's existence (Ashburn-Naldo, 2017; Mueller & Yoder, 1999). Further, moral outrage was found to mediate the relationship between perceived fulfillment and parental status, suggesting that having children is societally considered a moral imperative (Ashburn-Naldo, 2017). This is consistent with Lalonde's (2018) work, wherein she suggests that moral duty can encompass a perceived civic duty, where having children is thought to be an obligation to one's state or society. Therefore, having children can be seen not only as a biological imperative but as a moral one too, where refusing to have children implies a failing in both areas.

This perceived moral and civic duty to have children also relates to the coined term of the "motherhood mandate". Although men and women alike experience childfree-related stigma in this regard, some authors suggest that women in particular face the greater brunt of these stereotypes. Briefly, the term "motherhood mandate" describes a set of beliefs and assumptions that being a mother is integral to being a woman (Gotlib, 2016; Russo, 1979). Although there is increasing awareness that men must play a role in the lives of their children, in many cultures and settings the established norms are for women to manage the majority of responsibilities associated with childrearing. Further, the expectation is not only for women to have and manage children, but that they must also feel fulfilled in their primary role as a motherly provider, rather than in other secondary roles, such as belonging to the workforce (Russo, 1979).

There are likely many underlying reasons why the concept of being childfree is so deeply connected with women, and less so connected with men, some of which are hypothesized upon here. Evolutionarily, women have taken the leading role when it comes to raising children; this dates back to hunter-gather societies. This cycle has been perpetuated throughout history, with a shift to more egalitarian parenting styles only happening more recently with women's rights movements. Biologically, the imperative for conception is also more heavily placed on women, who carry the fetus and are often tasked with care (e.g., nursing) following birth. In this way, children are often socially and culturally more intrinsically linked with mothering than with fathering. Some of the above reasons may explain why the absence of children is more notable for women than men, as the default understanding is for a woman to present with children. In turn, the stigma against the choice to be childfree may be more explicitly directed at women, which is likely amplified by sexism more generally.

Stigma against childfree people is not only upheld in popular culture, but also in more formalized policies and laws at institutional levels. This can involve policies that affect access to reproductive freedom (i.e., abortion) as an avenue of bodily autonomy (Adair & Lozano, 2022; Planned Parenthood, 2025). Public discourse that perpetuates the motherhood mandate can also be observed at broader levels, such as the perceived responsibility women have to state and country to bear children. Here, researchers have outlined the perception that women are supposedly responsible to have children to maintain a population that can contribute to the workforce (Gotlib, 2016). The underlying theory is that a reduction in workforce poses a threat to the collective consumer population, jeopardizing structures related to healthcare for aging populations and economic markets. Some authors also point to overarching challenges that women face in entering the workforce (e.g., gender-based wage gaps and reduced hiring), or

other incentives to remain at home provided by governmental policies (e.g., baby bonuses); they suggest that this is another form of the motherhood mandate – the idea that women are better suited to mothering in the home than working, with organizational processes such as these making it harder for women to pursue careers versus motherhood (Szekeres et al., 2023). Ultimately, the concept of the motherhood mandate supports the overarching stereotype that one's morality is determined by motherhood status, resulting in childfree women being perceived as "less-than".

In addition to the discussion on morality, research has also addressed how stigmatizing evaluations of childfree individuals often relate to perceptions of personality. Negative evaluations of childfree individuals tend to fall into several categories: one, that they are deficient (e.g., lacking in some way); two, psychologically damaged; or, three, irresponsible, immature, or selfish (e.g., putting one's needs before that of a hypothetical child; Morison et al., 2015). This echoes previous work by Mueller and Yoder (1999), who posited that childfree individuals were perceived to be more selfish, atypical, bitter, and less emotionally well-adjusted. As mentioned previously, recent comments from Pope Francis echo these beliefs, as evidenced by his statement that childfree individuals are "selfish" for not having children, representing a current example of how these types of stereotypes are circulated and upheld at the global level (Caitlin, 2022).

Studies that have compared parents with childfree individuals also highlight the ongoing stigma (Ashburn-Naldo, 2017; Bays, 2016; Mueller & Yoder, 1999). In a study that compared mothers, involuntarily childless, and childfree individuals, mothers were more likely to be perceived as warm and non-competitive, whereas childfree women were rated as more competent than warm (Bays, 2016). Similarly, mothers were more admired than childfree

women, whereas childfree women were more likely to elicit feelings of envy and disgust (Bays, 2016). Research by Kemkes (2008) also highlights how perceptions about childlessness can act as a cue for stereotype formation in relation to personality. In Kemkes' study (2008), after viewing photos of men and women with and without children, participants rated the people in the photos on perceived physical and social attributes, as well as personality traits (e.g., maturity, honesty, self-confidence, and faithfulness; Kemkes, 2008). Men and women depicted with children were perceived to be more faithful, honest, mature, and generous as compared to men and women depicted without children, despite there being no explanation regarding the connections between people in the photos (i.e., there was no description of family ties between the photographed people; Kemkes, 2008). In effect, the proximity of the children in the pictures and the underlying assumption that they were relatives of the men and women contributed to the reported perceptions of personality (Kemkes, 2008). Interestingly, these assumptions of increased maturity, honesty, and faithfulness were made by both men and women in their judgement of both male and female participants. In the context of this topic, it is also important to state that many childfree individuals may choose this lifestyle path due to aspects of their personality that are not compatible with raising children. Although this in itself may be an interesting line of research, the primary issue at hand in the literature reviewed here is the frequently held and questionable opinion that childfree people inherently have negative personality attributes.

Beyond these more general stereotyped attitudes and resulting feelings of prejudice that are commonly upheld in pronatalist societies, researchers have also studied the expression or manifestation of stigma (i.e., discrimination). This has typically involved discrimination in personal, professional, and healthcare settings. One study examined forms of perceived exclusion

due to voluntary childlessness, where exclusion was reported on in both personal (e.g., social) and professional (e.g., workplace) settings (Turnbull et al., 2016). In terms of personal settings, many women reportedly faced pressure to have children to belong to a social group and felt the need to justify the acceptability of their childfree choice. The choice to have children, on the other hand, typically does not require social justification (Lalonde, 2018; Turnbull et al., 2016). In the workplace, childfree women reported a subordination of their needs in lieu of individuals with children. This took the form of having their needs ranked as secondary (e.g., employees with children receiving greater flexibility in work and annual leave for childcare purposes), as well as greater exclusion from shared professional resources (Turnbull et al., 2016). Further, some researchers have highlighted the occurrence of stigma and acts of discrimination in healthcare settings. Childfree women seeking sterilization procedures have faced stigma from healthcare professionals in the form of "repeated denials, humiliation, procedural hoops, and questioning of the legitimacy of their request" (Hintz & Brown, 2019, p. 62). In effect, this represents a refusal of bodily autonomy and reproductive freedom (Lalonde, 2018), which becomes particularly poignant when other bodily autonomy procedures, like abortion, are also banned. These refusals can occur despite many legitimate reasons for requesting sterilization, which can be personal (e.g., procreative freedom), practical (e.g., adverse reactions or allergies to contraceptives), and health-related (e.g., medical conditions where pregnancy could be harmful; Hintz & Brown, 2019; Lalonde, 2018; Richie, 2013). Indeed, one study found that 22% of childfree women in the United States faced difficulty in accessing healthcare, demonstrating a subculture of stigma within this this setting (Turnbull et al., 2016).

Another related but understudied expression of stigma towards childfree individuals involves the concept of "bingo-ing" (Hintz & Brown, 2020). "Bingos", as described by Hintz

and Brown (2020), include "any statement made by an out-group member that challenges a person's own understanding of their beliefs, values, lifestyle, or identity not held in common with…the person perpetuating the bingo" (p. 244-245). This includes childfree individuals facing statements such as "You'll change your mind", "It's different when it's your own", or "What if your parents hadn't had kids?" (Hintz & Brown, 2020, p. 247). This type of response or "bingo" typically occurs in the context of a childfree person sharing their intentional choice to refrain from having children. The term "bingo" or "bingo-ing" originates from the idea that one could fill a metaphorical bingo card, where each square represents a common or predictable response that one might experience in relation to their childfree status. Hintz and Brown (2020) further specify how the "bingo-er", in making such statements about a childfree lifestyle, is in effect demanding an explanation for perceived violations to social norms. In this case, childfree individuals are defying pronatalist norms and expectations around family life by choosing not to have children (Hintz & Brown, 2020). Much like having other aspects of one's life questioned, as has been reported by LGBTQ+ individuals for example, experiencing bingos related to one's childfree status could be perceived as a manifestation of stigma, albeit one that is more normalized and casual in its presentation (Hintz & Brown, 2020).

Stigma Resistance

Research also demonstrates that the stereotyping and acts of discrimination against childfree people are not lost on them. Several studies have examined ways in which childfree people act in resistance to the stigma associated with their life choices, including strategies used to cope with or counter these experiences. Yeshua-Katz (2018) describes this resistance along a continuum, drawing on previous stigma research in proposing this conceptualization in the context of being childfree. Stigma internalization is at one end of the continuum, representing

self-stigma and the internalization of negative conceptions of childfree individuals. As described previously, childfree individuals with self-stigma would theoretically believe and have internalized stereotypes about childfree people (e.g., they are selfish) into their own self-concept (Yeshua-Katz, 2018). At the other end of the continuum is stigma-challenging behaviours or resistance; these individuals openly oppose and disagree with negative evaluations of childfree people, actively rejecting the stigma. Finally, stigma avoidance represents the middle ground and is positioned somewhere between stigma internalization and stigma challenging approaches. This includes avoidance behaviours associated with childfree stigma, which can include concealing one's procreative choices and avoiding situations where it might be questioned (Yeshua-Katz, 2018). One additional coping strategy not incorporated into this continuum involves group identification. This consists of childfree individuals relating more to other individuals belonging to the same marginalized group and seeking their support as opposed to non-childfree peers (Yeshua-Katz, 2018).

In line with this continuum, there are several strategies that childfree people undertake that could be conceptualized as falling within stigma challenging or avoidance behaviours. Controlling the narrative, providing justifications, and redefining the situation were specific strategies identified during interviews with childfree peoples as ways in which they counter experiences of stigma (Park, 2002). By controlling the narrative, childfree individuals reported the ability to pass as "normal"; they could imply having children in the future despite having no intention or plan to do so. People who postpone the decision to be childfree, or who wait until older age to openly declare their childfree status, may face less confrontation due to the extended length and gradual nature of this transition (Callan, 1983). Other strategies included providing vague or limited information, which could leave the underlying reason for childlessness up for

interpretation (Park, 2002). This type of strategy could also lead one to imply involuntary childlessness, which is more likely to be met with sympathy and pity than voluntary childlessness. These strategies would likely reflect an avoidance approach (Yeshua-Katz, 2018).

The use of justifications was another reported strategy, which involved providing a reason behind the decision to not have children. Justifications tended to involve themes of self-fulfillment (e.g., elaborating on the freedoms of a childfree lifestyle) or condemning the condemners (e.g., flipping the narrative by suggesting it is selfish to have children for personal gain; Park, 2002). Participants also endorsed redefining the situation as a strategy in countering stigma. This involved specifying how having children should be a choice, rather than an assumed self-evident part of life, and that there were many positives associated with being childfree that extend beyond the individual (e.g., serving society in ways other than parenthood, stemming population growth; Park, 2002). Strategies that involved justifications and redefining the situation likely best reflect a stigma challenging approach. Interestingly, most of these strategies to counter stigma were typically discussed in the context of childfree people having experienced uncomfortable conversations, wherein their choices were queried or delegitimized in conversational, social, or even healthcare settings (Yeshua-Katz, 2018). In other words, these strategies were reactionary to experiencing stigma, and were less likely to be spontaneously initiated by childfree people without due cause.

Existing Gaps

Despite the research presented above, there are gaps in the childfree literature, especially in respect to certain factors associated with stigma. As mentioned, much of the earlier literature faced challenges with terminology, where it was unclear what childfree versus childless constituted; indeed, the first framework for studying childfree individuals was only published in

2023 (i.e., Neal & Neal, 2023), two years after the initial conception of this dissertation. Much of the research to date has also been qualitative; although there are many significant strengths to qualitative research, this has left the area somewhat unbalanced, resulting in few established quantitative measures that examine childfree-ness and the associated stigma (Bahtiyar & Sakalli, 2019). Further, little research has addressed the psychological consequences of facing such stigma in line with stigma theory (i.e., self-stigma), including the potential negative consequences associated with self-stigma itself (e.g., mental distress; Blackston & Stewart, 2012). Because of these gaps, it is also difficult to say whether certain constructs may be a result of childfree stigma or bidirectional in nature. Finally, there is a paucity of research in respect to whether certain groups, such as women of colour and the LGBTQ+ community, face additional stigma in conjunction with their childfree status, and how this intersectionality translates to experiences of stigma (Blackstone & Stewart, 2012; Tate et al., 2019).

Study 1

To the best of our knowledge, self-stigma is an underdeveloped research area in the context of voluntary childlessness. As described previously, self-stigma involves the internalization of stigma that is publicly upheld (Corrigan et al., 2012; Sheehan et al., 2017). It is suggested that this process occurs in stages, with an individual first being made aware of a stereotype, subsequently agreeing with the stereotype, and finally applying it to themself (Catalano et al., 2021). These experiences may also be followed by the stigmatized individual experiencing some degree of harm related to the self-stigma. For a person who is childfree, this could involve the internalization of commonly held stereotypes about childfree people, such as being perceived as selfish (e.g., Mueller and Yoder, 1999), morally flawed (e.g., Caitlin, 2022), or having a defective personality (e.g., Morison et al., 2015). With exposure to such stereotypes,

childfree people may grow to accept and internalize this type of messaging, which can in turn affect other aspects of mental health and well-being. Because little research has examined potential self-stigma in the context of voluntary childlessness, this represented a gap in the literature that needed to be addressed prior to examining the potential consequences of self-stigma (i.e., Study 2).

Purpose and Research Questions

Considering the paucity of research on this topic, the first study (i.e., Study 1) was exploratory and mostly qualitative in nature. The purpose of Study 1 was to examine potential self-stigma in childfree people, related to experiences of stigma and anticipated stigma. Thus, the first research question was as follows: How does self-stigma manifest in childfree individuals? A secondary goal of the study was to recruit a diverse range of participants, as we aspired to amplify experiences of stigma in the context of different intersectional identities. Given the limitations of the research area to date, it was hoped that this study would begin to address this gap by being as inclusive in its recruitment strategy as possible. The second research question, then, was as follows: How are stigma and self-stigma experienced by childfree people from a diverse range of backgrounds? As the study was largely explorative and theory generating, rather than theory testing, there were no specific hypotheses associated with the research questions. Generally, we predicted that childfree people who have experienced or been exposed to stigma toward voluntary childlessness would report experiencing self-stigma to some degree, and that experiences would vary across different intersectional identities. A final purpose of this study was to inform quantitative research in Study 2, which will be described in greater detail later.

Method

Participants

Participants included community members primarily residing in Canada and the United States who were 18 years of age or older. As this study addressed potential anticipated stigma, experiences of stigma, and self-stigma associated with being childfree, participants included individuals who were childfree or considering being childfree. Consequently, individuals with children or those planning to have children were not eligible for this study. Altogether, 225 individuals participated in the study. After initial data cleaning, three individuals were removed for not meeting study criteria (i.e., they reported having children or did not report their age). This resulted in a sample that exceeded our initial sample size requirements (i.e., 222 participants).

Several factors were considered in respect to sample size requirements. First, it is important to note that most qualitative research studies do not report strategies associated with sampling, nor do they describe or justify the sample size eventually reached, which has been cited as a limitation of the field (Mthuli et al., 2021). Thus, there are no universally agreed upon guidelines for sample size estimates within qualitative research. This consistent omission partly stems from controversy in the literature as to whether sample sizes can or should be calculated a priori (e.g., Blaikie, 2018), and, further, what sample sizes might be considered acceptable in qualitative research (Boddy, 2016). For instance, Malterud and colleagues (2016) suggest that sample size should be continually revisited throughout the data collection process, rather than established firmly a priori; these revisiting efforts are to determine when a sufficient sample size has been reached based on the study question, and to assess the potential for new knowledge to be acquired (i.e., based on the concept of information power). Other authors have proposed that sample sizes should be estimated based on prior research in the area (Blaikie, 2018). Mthuli and

colleagues (2021) suggest that sample sizes tend to range from 2 to 60 participants depending on the research strategy (e.g., narrative research versus grounded theory studies), whereas Boddy (2016) states that sample sizes greater than 30 make it difficult to capture in-depth themes from interviews. However, other forms of data collection (e.g., open-ended survey questions) may require more participants. Tran and colleagues (2016) found that research with open-ended questions, rather than informant interviews, required a sample of at least 150 participants to ensure sufficient data saturation. Other exceptions where qualitative research may require larger samples can occur in the context of informing the development of a quantitative measure (Boddy, 2016). In this case, Boddy (2016) argues that a greater number of participant responses may provide a more representative view of the construct, which helps inform scale development.

In the context of this study, convenience sampling was used to recruit potential participants who met the eligibility criteria for the study (i.e., individuals who were, or were considering being, childfree). Further, as the study design involved open-ended survey questions, more participants were needed than what is typical of qualitative research. As Study 1 was meant to inform Study 2, which included the development of a quantitative measure, this also increased the desired sample size. With these considerations in mind, an initial sample size of at least 150 participants was proposed, which was quickly exceeded in our recruitment efforts. Participants were recruited from the community using various online advertising methods. This involved posting study advertisements on social media (e.g., Facebook, Instagram) and on online forums (e.g., Reddit) that discussed matters related to being childfree. In this way, recruitment specifically targeted individuals who engaged with content geared toward a childfree lifestyle. To review the advertising materials, see Appendix D.

The sample consisted of relatively young individuals (M = 33.82 years, SD = 8.04 years) who were mostly female (94.1%), white (79.3%), and identified as women (83.8%). In respect to sexual orientation, most participants were either heterosexual (59.5%), bisexual (22.1%), or pansexual (10.8%). Participants were often married or common-law (42.8%), single (32.0%), or in an otherwise committed relationship (21.2%). The sample was also relatively educated, with most having completed some degree of post-secondary schooling (88.3%). Similarly, many participants were employed (88.3%), with approximately a third reporting a higher annual household income (i.e., $100,000 or more after taxes; 31.1%). Finally, most participants reported not having any religious affiliation, such as identifying as atheist or agnostic (68.5%). For further sample demographic characteristics, see Tables 1 and 2.

Regarding childfree status, most participants identified as being childfree (93.7%), whereas a remaining minority were undecided though still considering being childfree (6.3%). Furthermore, many participants were either extremely committed (69.4%) or very committed (25.7%) to this lifestyle choice. Commitment was rated using a 1-5 Likert-type question (from “not at all committed” to “extremely committed”; see Table 3). Participants who were undecided were retained in the study due to the degree of commitment noted to the lifestyle, albeit while still identifying as undecided.

Table 1: *Demographic Characteristics of Participants*

Characteristic		Value*	
Age in years, mean (*SD*)		33.82	(8.04)
Sex			
	Female	209	(94.1)
	Male	12	(5.4)
	Prefer not to say	1	(.5)
Gender Identity			
	Agender	1	(.5)
	Genderqueer/Fluid	6	(2.7)
	Man	10	(4.5)
	Non-binary/Non-conforming	19	(8.6)
	Woman	186	(83.8)
Sexual Orientation			
	Asexual	9	(4.1)
	Bisexual	49	(22.1)
	Demisexual	1	(.5)
	Gay	3	(1.4)
	Lesbian	3	(1.4)
	Pansexual	24	(10.8)
	Straight (heterosexual)	132	(59.5)
	Prefer to not say	1	(.5)
Race/Ethnicity			
	African/African American	7	(3.2)
	Caribbean	4	(1.8)
	East Asian	2	(.9)
	Hispanic/Latino/a	8	(3.6)
	Indigenous (First Nations, Inuit, or Metis)	2	(.9)
	South Asian	3	(1.4)
	White (Caucasian)	176	(79.3)
	Mixed (i.e., more than one ethnicity)	15	(6.8)
	Additional category not listed	1	(.5)
	Prefer not to say	4	(1.8)
Marital status			
	Single	71	(32.0)
	Married/Common-Law	95	(42.8)
	Separated/Divorced	8	(3.6)
	In a Committed Relationship	47	(21.2)

*Values shown are raw frequencies (%) except where otherwise indicated.

Table 2: *Participant Education, Employment, and Income Information*

Characteristic		Value*	
Educational Background			
	Some High School	2	(.9)
	High School Completed	24	(10.8)
	Some College or Undergraduate	34	(15.3)
	College or Undergraduate Completed	95	(42.8)
	Some Post-Secondary	16	(7.2)
	Post-Secondary Completed	51	(23.0)
Employment Status			
	Employed Full-Time	172	(77.5)
	Employed Part-Time	24	(10.8)
	Unemployed	26	(11.7)
Annual Household Income			
	Under $5,000	4	(1.8)
	$5,000-9,999	3	(1.4)
	$10,000-14,999	5	(2.3)
	$15,000-19,999	6	(2.7)
	$20,000-24,999	10	(4.5)
	$25,000-29,999	5	(2.3)
	$30,000-34,9999	7	(3.2)
	$35,000-39,999	10	(4.5)
	$40,000-44,999	16	(7.2)
	$45,000-49,999	-	-
	$50,000-59,999	20	(9.0)
	$60,000-69,999	18	(8.1)
	$70,000-79,999	19	(8.6)
	$80,000-89,999	15	(6.8)
	$90,000-99,999	14	(6.3)
	$100,000 and over	69	(31.1)

*Values shown are raw frequencies (%) except where otherwise indicated.

Table 3: *Childfree Status*

Characteristic		Value*	
Childfree Status			
	Yes	208	(93.7)
	No	-	-**
	Undecided	14	(6.3)
Plan to have children			
	Yes	-	-
	No	207	(93.2)
	Undecided	15	(6.8)
Wish you could have children			
	Yes	-	-
	No	210	(94.6)
	Undecided	12	(5.4)
Commitment to childfree lifestyle	Not at all committed	1	(.5)
	Somewhat committed	1	(.5)
	Slightly committed	9	(4.1)
	Very committed	57	(25.7)
	Extremely committed	154	(69.4)

*Values shown are raw frequencies (%) except where otherwise indicated.

**Dashes are used instead of zeros to denote that any participants who responded affirmatively to the question were removed from the dataset (e.g., no parents or participants intending to have children were kept in the dataset following data cleaning).

Measures

Demographic questionnaire. Demographic questions included age, sex, gender, sexual orientation, ethnicity, and income, among others. Questions that pertained to sex, gender, and sexual orientation were informed by recommendations from Vanderbilt University (2022). The question about ethnicity was modelled from Oliver's (2021) work, whereas the income question was modelled from Statistics Canada's (2019) question structure (see Appendix A).

Childfree status. Questions about childfree status were also included. These involved close-ended questions related to whether one is voluntarily childfree versus involuntarily childless, as well as the intention to be childfree (i.e., if the person was still in the decision process regarding having children or not). Questions about the degree of commitment to a childfree lifestyle were also posed. Some of these questions were drawn from Neal and Neal's (2021) work, and their breakdown of childfree, childless, parents, and not-yet-parent groups (see Appendix B). Their framework was later published in 2023 (Neal & Neal, 2023), after data collection was already underway.

Experiences of stigma. Open-ended questions about experiences of stigma were posed (e.g., "Please describe the impact that experiencing this stigma has had on you"). Other related questions included the anticipation of future stigma occurring (e.g., anticipated stigma), as well as potential self-stigma. Some follow-up questions were also structured as multiple choice to better inform quantitative measure selection in Study 2 (see Appendix C).

Procedure

The study was reviewed and approved by the Lakehead University Research Ethics Board (#1469467). Participants were directed to the survey link on SurveyMonkey, an online survey platform. Participants viewed an information letter (Appendices E) and consent form

(Appendix F) prior to engaging in the study. All participants viewed questionnaire materials in the same order, following the structure of the items as presented in Appendices A through C. Following this, they viewed a debriefing form after study completion (Appendix G). The average survey duration was approximately 15 minutes, depending on how much information participants chose to provide in the open-ended text boxes. No funding could be provided as an incentive for participation, which was outlined at the outset of the survey; there was, however, an invitation to participate in a gift card draw should they wish to do so. Data were collected in early 2023.

Theoretical Foundations and Data Analyses

There were several relevant theoretical foundations in the context of data analysis. As described in the literature review, stigma and self-stigma theory (e.g., Corrigan et al., 2012; Sheehan et al., 2017) informed the study conception and design, including item development. This study also aligned with feminist theory, as demonstrated by the fact that the role of gender, sex, and sexual orientation were considered important components to address in studying intersectional experiences of childfree stigma (Braun & Clarke, 2020). Further, the literature review highlighted the ways in which childfree women specifically experience heightened stigma, which supported our intention to recruit as many childfree women as possible. Overall, these theoretical underpinnings supported the conceptualization of themes within participant narratives during the data analysis stage, as well as the subsequent presentation of the findings.

As Study 1 largely involved open-ended questions, qualitative analysis was the primary method of examining the data. The analysis was conducted by this writer (see Appendix H for their positionality statement). The overall data analysis process was informed by recommendations made by Vaismoradi and colleagues (2013) and Braun and Clarke (2006), which are guides frequently referenced in the qualitative research literature. The data was

interpreted within the context of each individual question, rather than grouping themes across the entirety of the study. All participant responses were initially read twice to gain familiarity with the dataset, with no coding or grouping applied at this stage. Responses were then identified or grouped based on some element of similarity (e.g., the expression of a common stereotype). These responses were then revisited at multiple points to identify other potential commonalities (e.g., feeling as if one is constantly being stereotyped, or being stereotyped at a specific location, like at work). Given that coding is an iterative process, themes were returned to at various points, with consideration of whether participant responses were being appropriately captured, without exaggerated input or assumption on the part of the coder.

Results: Aim 1

The first aim of this study was to examine self-stigma in childfree individuals (i.e., How does self-stigma manifest in childfree individuals?). To analyze the formation of self-stigma, it was critical to examine experiences of stigma and anticipated stigma, and their perceived effects.

Experiences of Stigma

Quantitative Analyses

Most participants reported experiencing childfree-related stigma (87.8%). When asked where this stigma occurred, participants endorsed experiencing it from family (67.1%), in social settings or with friends (62.6%), from strangers (51.8%), in the workplace (54.1%), in medical environments (42.8%), and from an intimate partner (23.4%). Of these six areas of potential stigma, participants regularly experienced stigma from multiple avenues ($M = 3.79$, $SD = 1.45$; see Table 4). These data are based on results obtained from quantitative, forced response (i.e., multiple choice) questions, which were posed prior to the qualitative questions.

Table 4: *Experiences of Stigma*

Characteristic		Value*	
Experienced Stigma			
	Yes	195	(87.8)
	No	14	(6.3)
	Unsure	13	(5.9)
Stigma Location			
	Workplace	120	(54.1)
	Social Setting/Friends	139	(62.6)
	Family	149	(67.1)
	Intimate Partner	52	(23.4)
	Medical Environment	95	(42.8)
	Stranger	115	(51.8)
	Other Category Not Listed	5	(2.3)

*Values shown are raw frequencies (%) except where otherwise indicated.

Qualitative Analyses

Responses from the question exploring stigma are discussed first (i.e., "If you indicated experiencing stigma in one or more of the above environments, what happened in this situation?"). Overarching themes included context, patronizing comments, stereotyping, exclusion and isolation, threats and violence, and constancy (see Figure 1). Block quotations from participant responses are presented with a pseudonym, as well as age and sex.

Context. Many participants spoke about the context in which stigma occurred, such as the physical locations or individuals engaging in the stigmatizing behaviour. Subthemes falling included experiencing stigma 1) in the family, 2) in the workplace, 3) in medical settings, 4) from strangers, 5) in social settings with friends, and 6) from intimate partners.

Family. Experiencing stigma from or within the family was frequently reported. Participants received negative reactions from family members in general about the decision to be childfree (e.g., "backlash from family after my decision to be childfree") or in family-specific contexts (e.g., being pressured "at a family reunion"). Many comments pertained to children

being owed for the sake of preserving the family lineage (e.g., “my family wants me to have a child so I could have offspring to keep the family name going”).

Workplace. Multiple participants discussed stigma in the workplace, which included stigmatizing comments from individual co-workers, as well as systematic discrimination from management. Comments from co-workers were often dismissive (e.g., “Coworkers [told] me I would change my mind about not having children”), or perpetuated negativity toward a childfree lifestyle (e.g., “A woman at work told me I was selfish for not wanting children”). Systemic examples of discrimination placed greater organizational pressure on childfree individuals (e.g., “At work, I’m expected to work extra overtime and more holiday shifts because I don’t have kids”) or furthered the notion that employees who are parents have greater needs than those of childfree individuals (e.g., “I am expected to comply with the scheduling needs of the parents – never the other way around”). Some stigma was formalized (e.g., “I’ve had bosses who had rules against giving holidays off to people who have no kids”) or impeded career advancement (e.g., “I’ve been passed up for work promotions due to being childfree, this was explicitly stated”). These examples represent structural stigma - stigma perpetuated at the institutional level.

Medical. Many participants reported experiencing stigma in medical settings. This included inappropriate comments made by medical professionals (e.g., “When asking a gyno to sterilize me at 26 [they said] your future husband won’t love you if you don’t give him his children”). Relatedly, participants spoke about care they were denied. Sometimes this care was denied in relation to the choice to be childfree (e.g., “I was told by a doctor that I was too young to know what I wanted and that she would never give me a referral to talk with a doctor to become more informed about sterilization”). In other situations, medical care pertaining to another medical condition was denied given their childfree status (e.g., “I’ve had doctors refuse

to give me a tubal ligation or care for my endometriosis because someday a man might want to use my body for reproduction"). Though much of this medical discrimination related to sterilization, some related to more seemingly mundane forms of treatment (e.g., "my obgyn at the time…was hesitant to provide the birth control option that I requested, IUD, in case my boyfriend wanted me to have a baby").

Strangers. Some participants reported experiences of stigma involving strangers (e.g., [I was] told by strangers that I'll change my mind, as if I don't know myself or my body"). Participants also described being treated differently by strangers (e.g., "[they] found I didn't have kids and dismissed my comments or beliefs as if I was too naïve to understand").

Friends. Several participants described experiencing stigma from friends. Some experiences were described in a seemingly more amicable manner (e.g., "Friends used to make jokes and tell me I would change my mind").

Intimate partners. Participants described stigma they experienced from romantic partners. Experiences often detailed a relationship break-down, where the other partner did not accept the participant's childfree choice (e.g., a participant's ex-partner "once told (me) that I was a waste of a good woman, and they had no desire to see me further"). Some individuals also reported experiencing violence from a romantic partner in relation to their childfree choice (e.g., "I've had a past partner try to sabotage my birth control").

Patronizing Comments. Patronizing comments typically included others dismissing the choice to be childfree, or else questioning the legitimacy of said decision.

Dismissing Choice. Many participants received dismissive comments for being childfree (e.g., "Random people I have never met will always tell me I'll change my mind or that I'll feel different in the future"). Some participants shared how they were told more forcefully or

pressured that having children is an inevitability (e.g., “Typical family pressure regarding “when” we would be having children, not believing that not having children is a real option”).

Questioning Consequences of Choice. Multiple participants described how others questioned their choice. This sometimes took the form of querying potential regret (e.g., “Family, friends, and strangers [are] always saying how I’ll regret not having kids”). Other times this line of questioning was directed toward care in senior years (e.g., “They would say I’d be lonely when I grow old or I’ll have no one to take care of me or I’ll die alone”). Others voiced how they were pitied or told they would never be fulfilled without children:

“I face constant comments online from strangers or in person from my family: “You’re still young, you’ll change your mind”, “Something is wrong with you”, “I pity you”, “You’re not mature enough to make this decision”, and some pressure about why I absolutely must have children because otherwise my life will be meaningless and I’ll never experience true love and happiness”. [Sandy, Woman, 22]

Stereotyping. Many individuals discussed being confronted with stereotypical views about their childfree lifestyle. These stereotypes involved the perception of negative character traits and lower overall worth for being childfree. They also related to the meaning of “family” and gender expectations (e.g., what it means to be a woman).

Negative Character Traits. Many participants encountered attacks on their personal character, maturity, and capability (e.g., “When I asked my doctor about looking into a more permanent form of birth control I was told I was too young [31] and that he [the doctor] would have to talk to my husband before helping me get the procedure done”). Comments pertaining to selfishness were also frequently reported (e.g., “Close family members have told me I’m a “selfish monster” simply for choosing not to have kids”). Other stereotypes involved childfree

people being seen as inherently abnormal, mean, or hating children (e.g., "I've been yelled at because the assumption has been there that if I don't have children, I just hate them").

Lower Worth. Several participants described facing stereotypes regarding their perceived worth (e.g., "Men have told me that I am less valuable as a woman (human in general) because I do not want to have kids. I was told my life was worth less than the life of a woman who has or wants to have kids").

Meaning of Family. Some participants faced comments about not having or belonging to a family (e.g., "I have been told that my husband and I are not a family because we have no children"). This sometimes resulted in being treated differently (e.g., "At work, time off was prioritized for those who had children and it was assumed I could just pick up the slack because I didn't have a "family").

Gender Expectations. Multiple participants expressed comments pertaining to gender expectations (e.g., "Actually, a man did say once that it was the woman's job to provide children for the man. As if that was the only thing that a woman was good for"). These views sometimes turned to a perceived attack against women when gender-based expectations went unmet:

"I have had multiple people (family, friends, strangers and coworkers) tell me I have nothing to offer society or the world because I am in their eye "Defective as a woman" because I am capable of having children but happily choosing not to". [Deborah, Woman, 21]

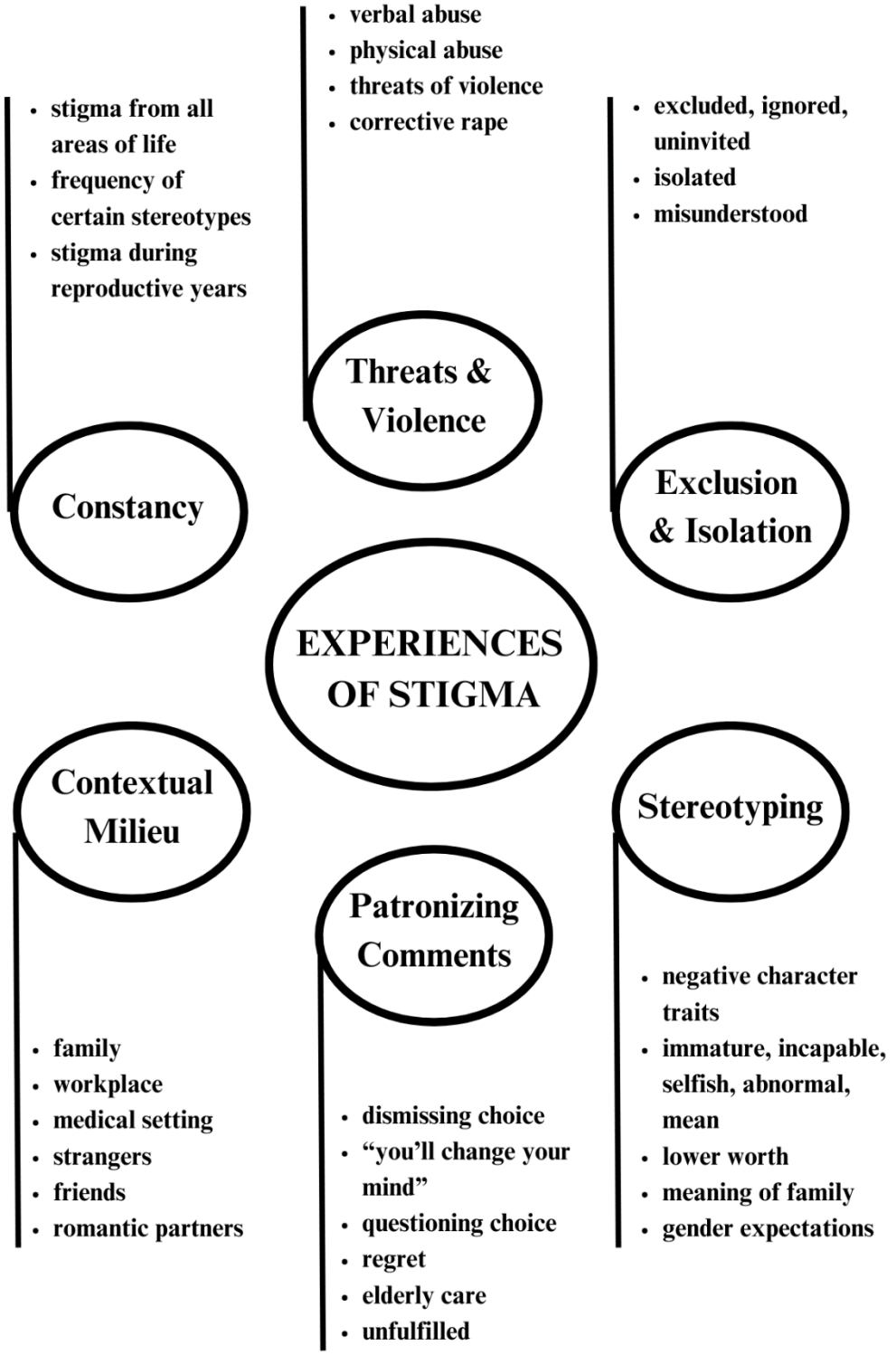
Exclusion and Isolation. Several participants expressed being excluded or feeling isolated from others (e.g., "…been ignored and not invited to social events due to not having children"). Other participants felt isolated, often in the context of other individuals not understanding or accepting their choice to be childfree:

"In 99% of situations, people (co-workers, strangers, etc.) feel comfortable asking about WHY I don't have children, and then challenge my active/continuing decision to not have them when they don't have any context or understanding of my personal life. It's invasive and pretty damn isolating." [Madison, Woman, 38]

Threats and Violence. Another theme included experiencing verbal or physical aggression, or the threat of such violence occurring. Participants described experiences of verbal aggression (e.g., "when I was 18 years old, I expressed to my dad that I was going to be childfree…He was angry and followed me around my home, screaming at me, threatening to throw me out"). Others endured physical assault (e.g., "I have experienced violence from family members specifically for being childfree, being slapped/hit when I said I wasn't going to have children ever, when physical violence was not the norm"). Others still faced threats of violence (e.g., "I've been threatened with corrective rape for being childfree on several occasions").

Constancy. Finally, a common theme was the perceived constancy of encountering childfree-related stigma (e.g., "There are simply too many situations where this has happened to me over my life that it would take too long to describe them all"). Some participants shared specific stigmatizing experiences that they encountered on multiple occasions (e.g., "So many times I've been told that I'm wrong, I'll change my mind, God said to have kids, the list goes on"). Other participants noted how stigma was most commonly experienced during reproductive years (e.g., "Throughout my life, until I turned 40, there was consistent pressure and disappointment when I continued to be childfree").

Figure 1: Experiences of Stigma



Effects of Stigma

Quantitative Analyses

Participants were asked about the effects of experiencing stigma. Many participants strongly agreed that stigma could affect self-esteem (29.3%), self-efficacy (22.8%), sense of autonomy, (47.0%), sense of purpose in life (38.7%), trust in healthcare (57.1%), mental health (48.8%), and overall happiness (33.5%). Additionally, participants reported that trust in healthcare (27.3%) and sense of autonomy (26.1%) may be most affected (see Table 5). Again, these data are based on our quantitative, multiple-choice questions.

Table 5: *Effects of Stigma*

Characteristic		Value*	
Effects of Stigma	Item range: 1 (strongly disagree) - 5 (strongly agree)	Mean	(*SD*)
	Self-Esteem	4.04	(*.91*)
	Self-Efficacy	3.73	(*1.10*)
	Sense of Autonomy	4.14	(*1.09*)
	Sense of Purpose	4.02	(*1.11*)
	Trust in Healthcare	4.25	(*1.07*)
	Mental Health	4.27	(*.94*)
	Overall Happiness	4.05	(*.96*)
Most Affected Area			
	Self-Esteem	11	(6.8)
	Self-Efficacy	6	(3.7)
	Sense of Autonomy	42	(26.1)
	Sense of Purpose	19	(11.8)
	Trust in Healthcare	44	(27.3)
	Mental Health	18	(11.2)
	Overall Happiness	17	(10.6)
	Other Not Listed	4	(2.5)

*Values shown are raw frequencies (%) except where otherwise indicated.

Qualitative Analyses

Participants were asked to describe the consequences of experiencing the above stigmatizing situations (i.e., "Please describe the impact that experiencing this stigma has had on you"). The following overarching themes were identified: individual challenges, interpersonal challenges, and system-level challenges (see Figure 2). Some participants reported experiencing little to no effect from encountering childfree-related stigma

Individual Challenges. Many participants described experiencing internal challenges because of the stigma they endured, consisting of negative emotions and cognitions. These included subthemes of 1) being negatively emotionally affected, 2) feeling judged and objectified, 3) having reduced self-worth, and 4) questioning the choice to be childfree.

Emotional Effect. Commonly reported emotions included anger, annoyance, and frustration (e.g., "It is extremely frustrating to feel like my opinion or decision holds no merit"), feeling sad or hurt (e.g., "It has really hurt my feelings"), or feeling anxious (e.g., "…sometimes I genuinely worry that someone will try to force a pregnancy on me because I've said that I am actively choosing not to have children"). Other emotions included feeling embarrassed, confused, guilty, exhausted, and lonely.

Judgement. Some participants reported feeling judged for their childfree status (e.g., "I felt judged and look[ed] down upon"). This sometimes included feeling objectified (e.g., "Just a reminder of how I'm a woman and…that it is my duty in life as being in a female body to be a fricken baby factory").

Lower Worth. Several participants mentioned that experiencing stigma reduced their self-worth (e.g., "[it] did make me feel less valuable and that I had no worth or purpose in this life").

Self-Doubt. Finally, participants described beginning to question their life choices (e.g., "It makes me question my choice to be childfree. I know it's the correct decision for myself but when people question it, it in turn makes me question my own decision").

Interpersonal Challenges. Many participants reported social challenges. Subthemes included avoidance and isolation and relational difficulties.

Avoidance and Isolation. Some participants felt isolated or ostracized (e.g., "I have felt out of place for my whole life"), while others intentionally engaged in avoidance (e.g., "I tend to distance myself"). Many participants asserted that avoidance was tied to anticipated stigma (e.g., "I am also very defensive when talking about my life and career plans with new people as I expect them to have negative or condescending attitudes about my choice to be childfree").

Relational Difficulties. Relational challenges were often described in respect to specific contexts, such as with family members (e.g., "It has negatively affected my relationship with multiple family members"), friends (e.g., "I feel disconnected from my closest friends"), and intimate partner relationships (e.g., "It has made me unwilling to get into many serious committed relationships because of the fear that I will be stuck in an unhappy life and expected to preform my womanly duty").

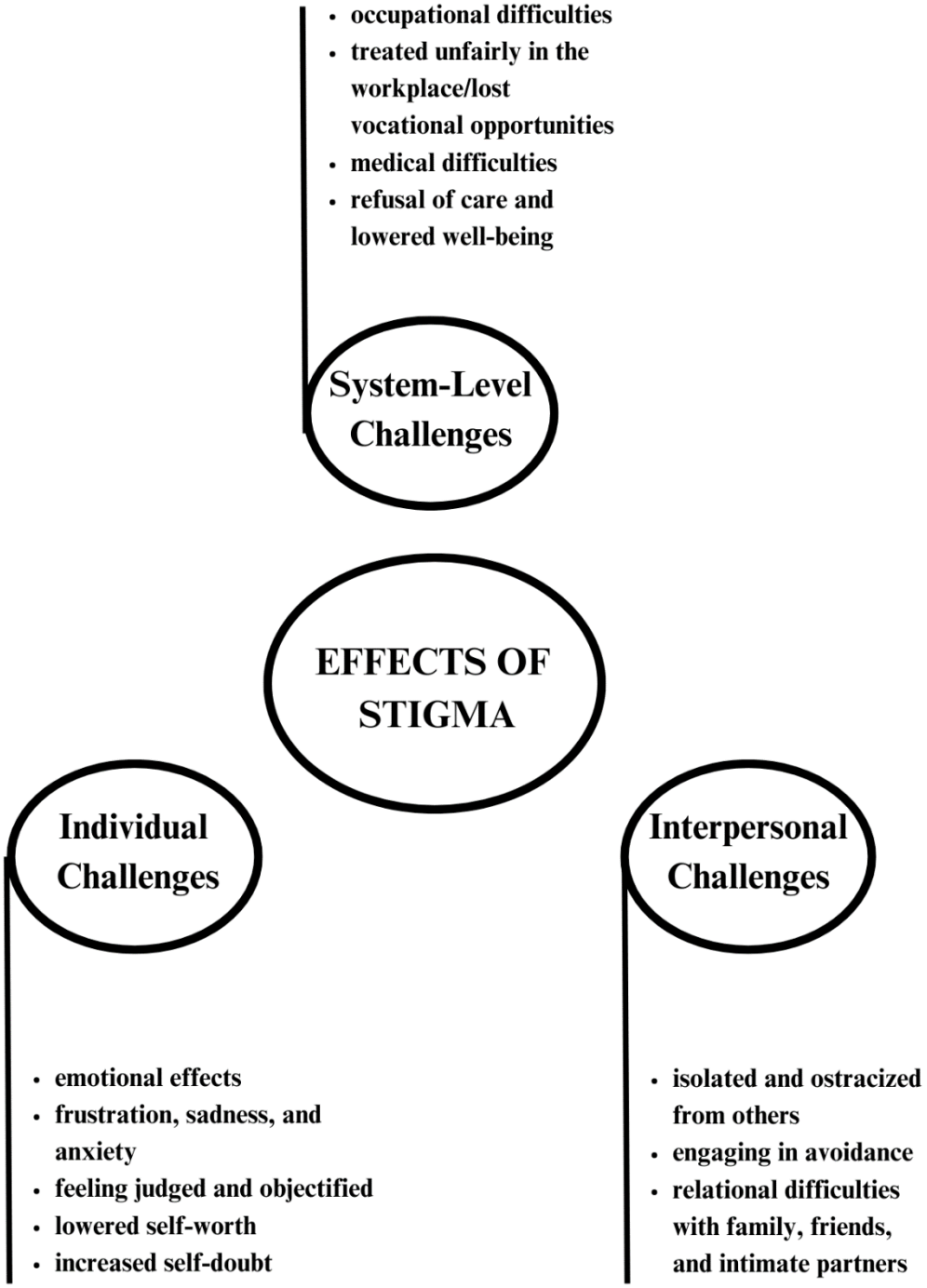
System-Level Challenges. Challenges associated with occupational and medical related difficulties due to experiencing childfree-related stigma were discussed.

Occupational Difficulties. Participants described being treated unfairly in the workplace (e.g., "I…feel very taken advantage of in the workplace") and that they had lost opportunities due to their childfree status (e.g., "I have lost economic value [wages/promotions]").

Medical Difficulties. Many participants reported health and mental health consequences of experiencing stigma. Health-related difficulties often pertained to being refused care (e.g., "I

have been outright denied medical care that was needed [and] I am permanently disabled now in part because of that refusal"). Others noted how stigma had an impact on their mental health (e.g., "The medical stigma affected me terribly, I was diagnosed with major depressive disorder").

Figure 2: Effects of Stigma



Anticipated Stigma

Quantitative Analyses

As per our quantitative results, most participants reported anticipating future experiences of stigma (60.7%). Participants expected stigma to occur in the workplace (38.7%), in social settings with friends (41.0%), in the family (39.6%), from an intimate partner (13.5%), in medical environments (36.0%), and from strangers (34.2%; see Table 6.) More participants reported experiencing stigma than anticipating future stigma in general, $z = 8.87$, $p < .001$.

Table 6: *Anticipated Stigma*

Characteristic		Value*	
Anticipated Stigma			
	Yes	108	(60.7)
	No	55	(30.9)
	Unsure	15	(8.4)
Anticipated Stigma Location			
	Workplace	86	(38.7)
	Social Setting/Friends	91	(41.0)
	Family	88	(39.6)
	Intimate Partner	30	(13.5)
	Medical Environment	80	(36.0)
	Stranger	76	(34.2)
	Other Category Not Listed	3	(1.4)

*Values shown are raw frequencies (%) except where otherwise indicated.

Qualitative Analyses

Many participants anticipated further stigma. Participants were subsequently asked the following question: “How has worrying about this potential future stigma affected you?” Responses were categorized into themes, such as anticipatory negative experiences, mitigating strategies, negative personal impact, constancy, and no or limited effect (see Figure 3).

Anticipatory Negative Experiences. Many participants specified the type of stigmatizing experiences they anticipated. Some spoke more generally about these expectations (e.g., "I am not going to get the quality of care, respect, and consideration that child having people do"). Others provided examples specific to various contexts, such as in medical settings (e.g., "In medical environments I feel like I will be denied what I think is right for my body because I actively choose to do nothing with my reproductive system"), in the workplace (e.g., "I guess I'm just apprehensive that I won't professionally get the same treatment as coworkers with nuclear families"), in social settings (e.g., "…I'm secretly concerned I will be isolated as I age and my peers have children"), and in respect to dating or romantic life (e.g., "It has made me more wary of having sex…I worry about possibly getting pregnant and being forced to carry to term, especially since Roe v Wade has been overturned in the US").

Mitigating Strategies. Participants shared mitigating strategies they engage in to reduce future stigma. This included avoidance and not disclosing one's childfree status (e.g., "I don't open up to others until I know their stance on childfree people. I am more guarded in general"). Others intentionally isolated to protect from stigma (e.g., "It amplifies my (diagnosed) anxiety. Sometimes I cancel plans, especially if there's likely to be a lot of parent/child emphasis at an event"). Others still described generating self-defence strategies, such as reasons they choose to be childfree (e.g., "I have to prepare evidence to support my lifestyle").

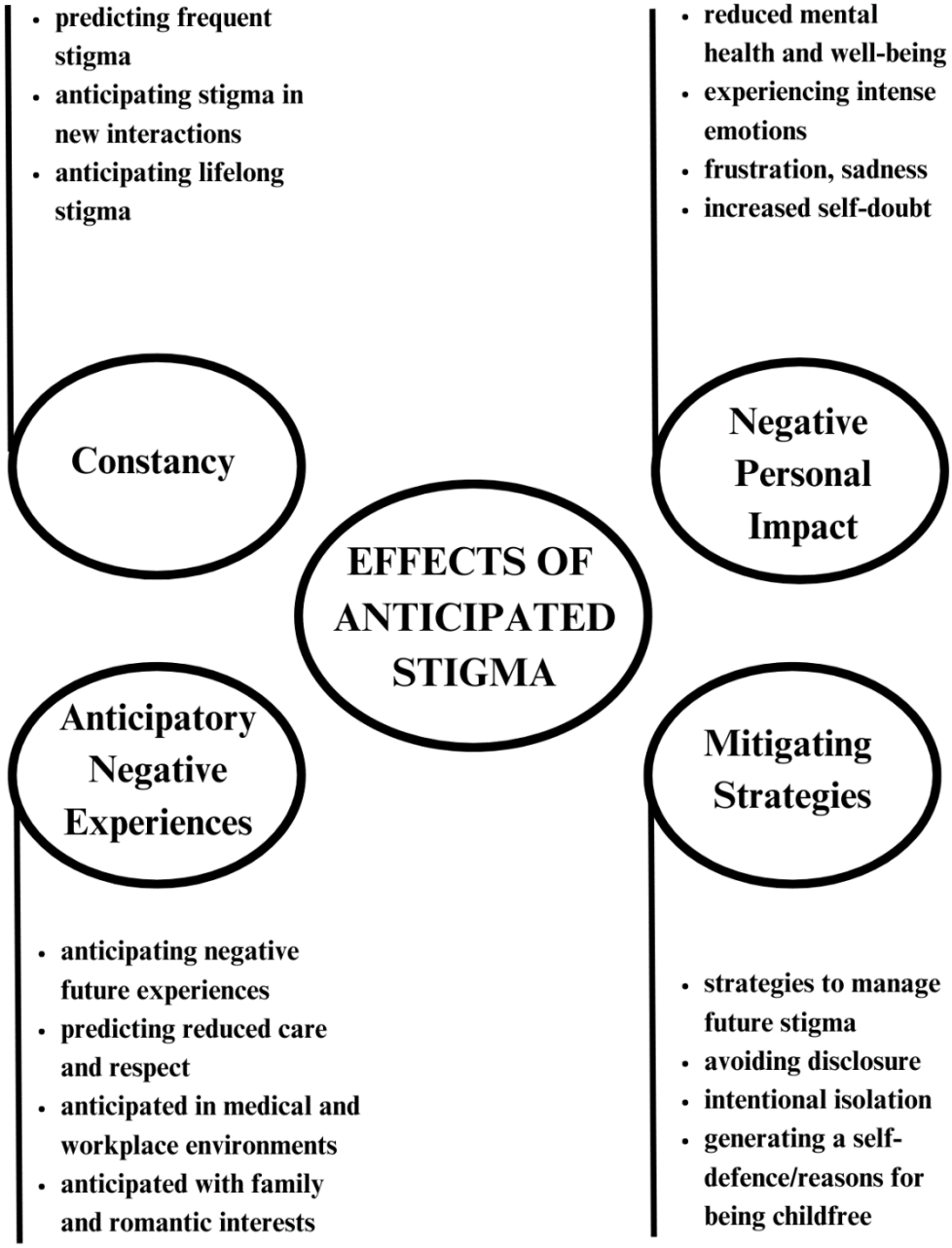
Negative Personal Impact. Many participants described the negative personal impact that anticipating stigma has had. Some noted poor mental health, such as increased feelings of anxiety (e.g., "It has definitely increased my anxiety"), experiencing intense emotions (e.g., "I get extremely irritated for being dismissed as I have in the past and I know that it will happen in

the future"), or feelings of general sadness (e.g., "…I just can feel the unhappiness"). Sometimes, this also led to self-doubt (e.g., "It makes me doubt my thoughts").

Constancy. Participants described the longevity and frequency of anticipating stigma. Some spoke about the day-to-day frequency with which they anticipate stigma (e.g., "It's just always something I think about before every new interaction"), whereas others discussed it in the context of their overall lifespan (e.g., "…feeling like I'll probably be expected to explain myself for the rest of my life"). Although this is similar to the "anticipatory negative experiences" theme, it is separated to highlight the frequency at which interactions such as these are expected to occur and the mental weight this may pose.

No or Limited Effect. Finally, several participants noted that they anticipate experiencing stigma but that it has had no or minimal effect (e.g., "I anticipate continuing to experience this stigma, but generally do not worry about it").

Figure 3: Effects of Anticipated Stigma



Self-Stigma

After identifying experienced and anticipated stigma, and their effects, participants were asked about self-stigma (i.e., Do you think childfree people could experience self-stigma?). The following themes were identified: the negative personal impact of self-stigma and factors that increase self-stigma (see Figure 4). In addition to these two themes, it is worth noting that most participants affirmed that childfree individuals experience self-stigma (e.g., "I certainly experienced self-stigma"). Others stated that although it occurs, they might not have experienced it themselves (e.g., "Yes, I believe childfree people could experience self-stigma, but I don't necessarily experience it").

Negative Personal Impact. Many participants discussed stereotypes that could be internalized through a self-stigmatizing process, self-doubt, and negative emotions associated with these experiences overall.

Stereotyping. Participants described the stereotypes which they had internalized, or which others could internalize due to self-stigma. These included being seen as incapable or inadequate (e.g., "For many years in my mid twenties and thirties I felt like a failure in my personal life"), defective (e.g., "Women often wonder why they don't like kids or have no motherly instinct and worry they're defective in some way"), and having lower worth (e.g., "Yes, I feel like I'm not as important as others with kids"). Some stereotypes also pertained to character qualities, such as being seen as mean (e.g., "I often struggle with seeing myself as…possibly meaner…than my peers who have kids"), lazy (e.g., "I sometimes feel lazy… for not wanting kids"), or selfish (e.g., "I think if someone is told they are selfish or defective repeatedly they will start to believe that about themselves").

Self-Doubt. Self-doubt was a reported consequence of self-stigma. Some participants spoke about this concept as something that could happen to a childfree individual (e.g., "Having your decisions questioned regularly could definitely lead to some self-doubt"), whereas others described the self-doubt they personally felt (e.g., "Yes I do…it myself. I question my life choice of not having children [then] I start questioning other choices that I have made").

Emotional Effect. Participants discussed the range of emotions that arise from self-stigma. These included anger (e.g., "I just get angry about it"), guilt (e.g., "I felt guilt for not having baby fever"), self-hatred (e.g., "It made me hate myself"), and shame (e.g., "I feel like a terrible daughter. Like I've disappointed my very kind and loving family. I feel like a fuck up, like I'll never fit in anywhere. It truly breaks me down").

Contributing Factors. Some participants highlighted factors that could contribute to self-stigma, including the constancy of stigma, societal pressure, and timing.

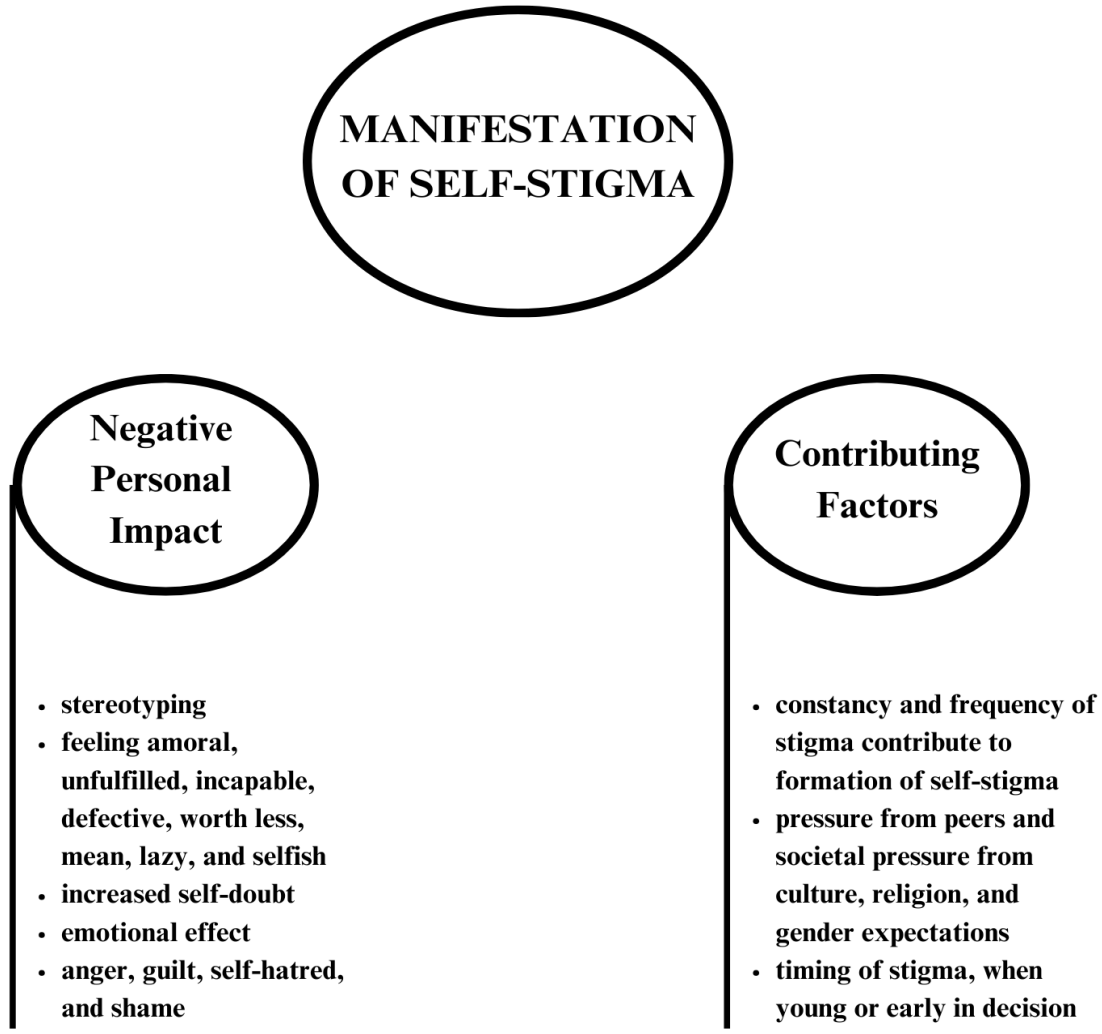
Constancy. The frequency of public stigma was suggested to contribute to the development of self-stigma (e.g., "If you are continually being told something, after a while you might start to believe it"). Others also noted the constancy and many avenues whereby stigma could occur (e.g., "You have the whole world, including people that you care about, questioning your decision-making abilities. They undermine and invalidate your choice").

Societal Pressure. Participants described how societal pressure could contribute to the development of self-stigma. This included pressure from peers (e.g., "Peer pressure is a real thing, and it makes you doubt yourself when everyone around you is telling you you're doing something wrong"). Others noted how culture, religion, and gender expectations could also contribute (e.g., "In most areas of the world, people are expected to have children. Particularly

for women such as myself, we are socialized to find motherhood to be the ultimate goal in life. It is hard to not internalize that message, and even harder to resist it").

Timing. Finally, participants spoke about timing, and how different timepoints could contribute to the facilitation of self-stigma. Some discussed being susceptible to self-stigma at earlier ages (e.g., "Oftentimes when I was younger, I found myself having to justify this decision to myself to combat the self-stigma I felt"). Others referenced timing in respect to deciding to be childfree (e.g., "I think [it] comes at the beginning of the realization that [you] don't want children before you form that solid confidence that you've made the right decision for yourself").

Figure 4: Manifestation of Self-Stigma



Results: Aim 2

A secondary goal of Study 1 was to recruit a diverse range of participants, given limitations in existing research surrounding sampling. Further, we hoped to explore how stigma may manifest differently across individuals with varying social locations.

Qualitative Analyses

Culture

Participants were asked about how culture factored into their experiences of childfree-related stigma (i.e., Has culture played a role in the stigma you have experienced for being childfree? This could include your own culture, or the culture of the person/people involved in the stigmatizing experience). Overwhelmingly, participants expressed that their various cultures support the expectation to have children. Themes included cultural expectations in respect to representation in mainstream media, race and ethnicity, sex and gendered expectations, religious messaging, conservatism, and physical location, as well as the intersecting nature of these components (see Figure 5).

Representation in Mainstream Media. This theme pertained to a perceived lack of appropriate representation in media regarding a childfree lifestyle. Some participants discussed mainstream popular culture, mostly in respect to the lack of childfree representation in the media (e.g., “I rarely see childfree people or couples displayed in any form of media”). Additionally, media that did showcase a childfree lifestyle was perceived to perpetuate common stereotypes (e.g., “A lot of the media, TV, movies, but also books/fiction, I see and even consume has messages that having kids is the only way to have a fulfilling life and being childless is equivalent to shallow, selfish, or empty”).

Sex and Gendered Expectations. This theme addressed the dynamic nature of childfree-related expectations based on sex. Participants discussed how culture shapes expectations on having children, mostly pertaining to stigma toward women who choose a childfree path (e.g., "There's this idea that having children is the ultimate outcome of womanhood for so many people, and when it's not the path of some women, those women are social pariahs"). Participants also discussed how marriage and child-rearing factored into gendered expectations (e.g., "Of course, the cultural role of a woman is still to marry, have children, and settle down").

Race and Ethnicity. Many participants discussed their ethnic or racial background in relation to experiencing childfree stigma (e.g., American, African American/Black, Australian, Caribbean, Chinese, Hispanic, Indian, Indigenous, Mexican, Polish, Polynesian, Puerto Rican, Russian, and White). Participants spoke about how ethnic background and cultural norms contribute to stigma in general (e.g., "Indian culture treats you like a black sheep if you don't want kids"). One self-identified Indigenous participant noted the cultural expectation to have children based on historically poor treatment of Indigenous peoples (e.g., "I've had other Indigenous folks get mad that I'm "perpetuating genocide" by choosing not to have kids. Being Indigenous does not obligate me to make more human beings"). Some participants described how cultural expectations are upheld by others belonging to the same culture (e.g., "I am Mexican, Mexicans are known for having rather large families. My decision to not have kids goes against my family's beliefs"), whereas some participants noted having familial support that was less tolerated from the wider culture (e.g., "I'm mixed Polynesian and we have huge families. I'm criticized by other Polynesians, but I have the full support of my immediate family members"). Some participants discussed how different ethnicities within a larger culture can propel stigma (e.g., "In the black American culture, a woman is considered more valuable if she

has a child"). Finally, others expressed how certain cultures prioritize the concept of "family", perpetuating the need to have children (e.g., "…my mother's side of the family is all Polish and the culture in Poland is very pro-children and focused on the sanctity of the nuclear family").

Religious Messaging. Participants discussed the impact of religion and culture in terms of how it affects childfree-related stigma. Some participants noted experiences of stigma they experienced from individuals of specific religious backgrounds (e.g., Christian, Catholic, Evangelical, Mormon, and Anabaptist). Others highlighted how religions perpetuate stigma more generally:

"I grew up in an extremely religious environment where women…are expected to reproduce and be housewives. Deviating from that is a sin, and therefore basically everyone I grew up with either harasses me about children or is disgruntled". [Madison, Woman, 38]

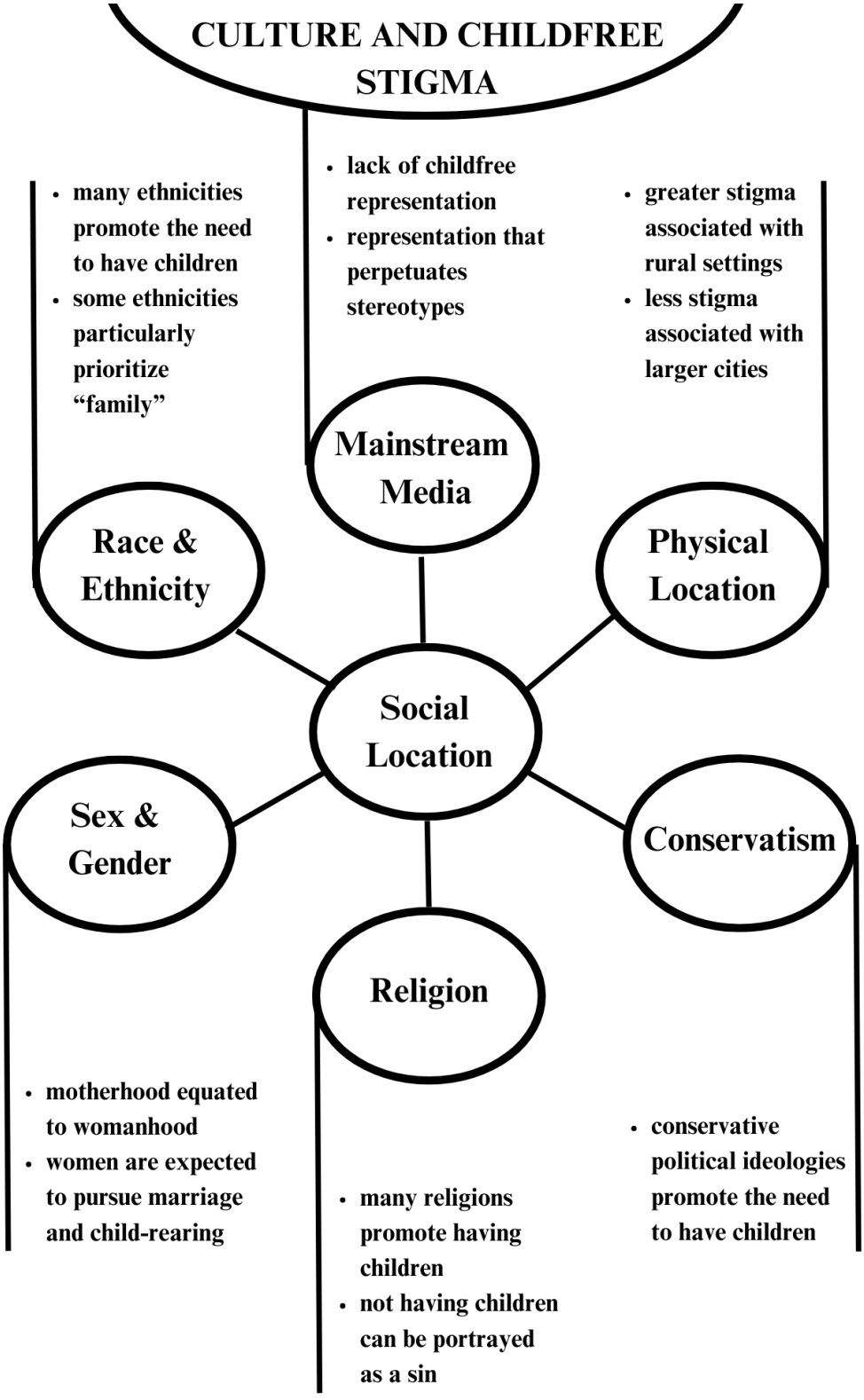
Conservatism. This theme addressed how political ideologies can be a factor in this discussion. Several participants mentioned conservative political ideologies as contributing to childfree-related stigma (e.g., "I…currently live in a rural, red, conservative area. There is a lot of push to have kids out here, as that's just what you do").

Physical Location. Participants also described cultural shifts in respect to one's physical setting. Some perceived more stigma in rural rather than urban areas (e.g., "I come from a small town where having children is just part of their lifestyle. I tend to not run across as much stigma in a larger city setting where there are more childfree people").

Social Location. Finally, participants detailed how the intersectionality of multiple components of one's background could contribute to childfree-related stigma overall:

"I live in a statistically conservative area where it is expected to be a housewife and a mother, and come from a Puerto Rican culture where none of my female family members worked outside of home making to care [for] their 2-4 children". [Dakota, non-binary, 26]

Figure 5: How Culture Contributes to Childfree Stigma



Sexual Orientation

Participants were asked how sexual orientation contributed to childfree-related stigma (i.e., Has sexual orientation played a role in the stigma you have experienced for being childfree? This could include your own sexual orientation, or the sexual orientation of the person/people involved in the stigmatizing experience). Themes included 1) expectations based on sexual orientation, 2) perpetration of stigma, 3) asexual and childfree (see Figure 6). Many participants shared that they did not perceive sexual orientation to have been a contributing factor in their experiences of childfree-related stigma.

Expectations Based on Sexual Orientation. Participants referenced childfree stigma pertaining to expectations that were based on their sexual orientation. Many participants shared that being heterosexual resulted in stigma (e.g., "Yes. As a straight female it is expected that I should want to have children"). This pressure also occurred in heterosexual relationships (e.g., "Yes. I am a cis-gender, heterosexual woman married to a cis-gender heterosexual man. People seem to think more that it is unnatural and weird to not reproduce when you are the perfect picture of a traditional couple otherwise"). Some participants who had relationships with men and women expressed that this pressure heightened in heterosexual relationships (e.g., "Yes. Being married to a man caused more people to expect that I would want a child. Once I was divorced and dating a woman, people were less likely to pressure me about it").

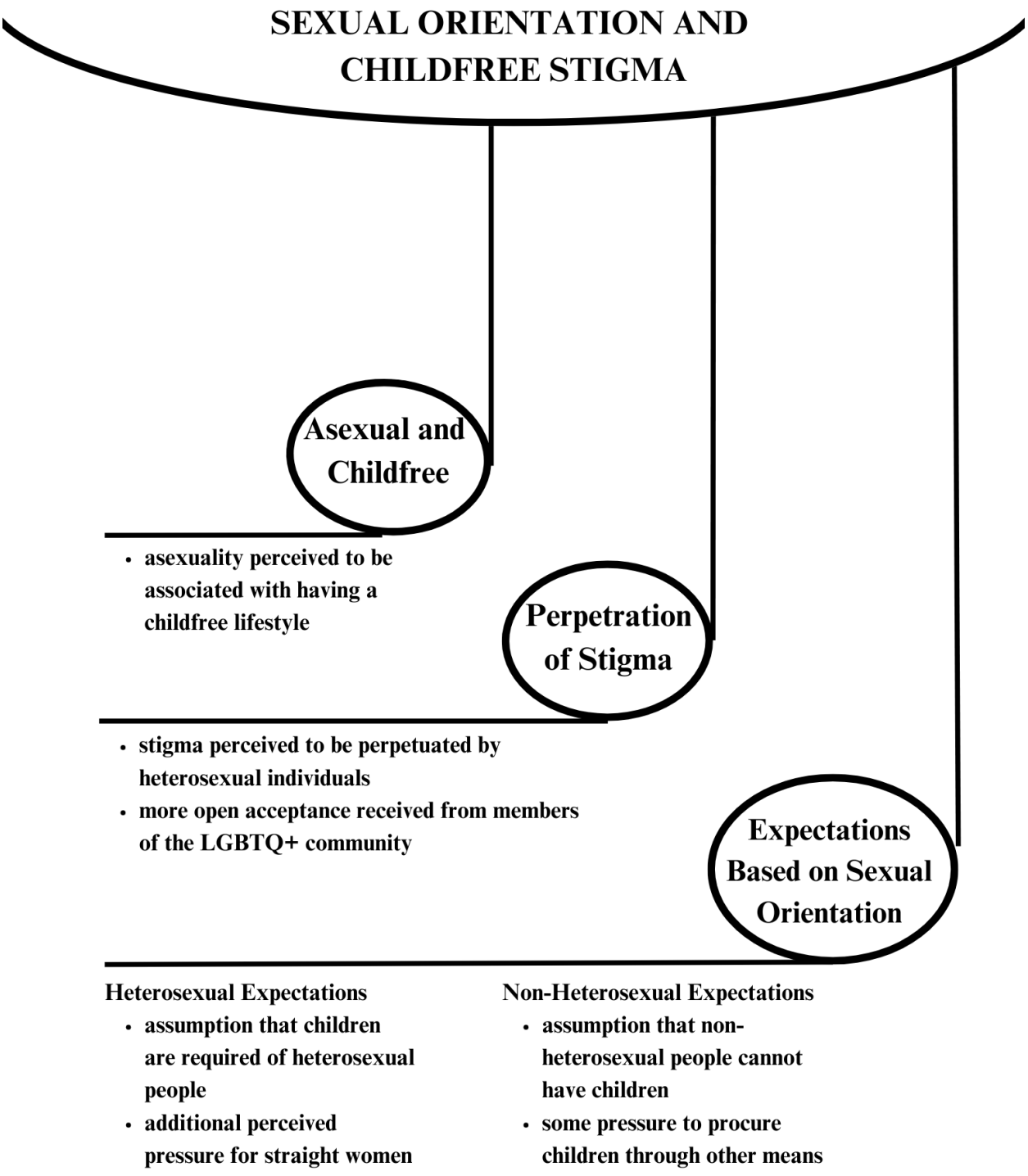
Some participants experienced childfree stigma in the context of being openly queer or gay (e.g., "I have been accused of choosing to be gay to avoid having kids/doing [it] to deny relatives grandchildren"). This stigma often rested upon the assumption that queer individuals could not have children (e.g., "My mom was upset about me being queer because she wanted to be a grandmother"). Alternatively, some participants were still pressured to have children,

despite being gay (e.g., “Yes, I’m [married] to a woman but this doesn’t stop people from hassling me to adopt or foster children. I think especially the fact that we are women means in their minds that children are what we would both want”).

Perpetration of Stigma. Several participants stated that the stigma they experienced was mostly perpetuated by straight individuals (e.g., “The stigma I receive most often comes from heterosexual people”). Others shared that LGBTQ+ individuals tended to be more accepting of their childfree status (e.g., “I feel like lgbtq+ people are more understanding. I haven’t been judged by anyone in that community for not wanting kids”).

Asexual and Childfree. Some participants expressly described their asexuality, which related to their childfree status (e.g., “I am a lesbian on the asexual spectrum and my partner is also asexual”). Others noted how many asexual individuals may naturally be inclined toward a childfree lifestyle (e.g., “I think many asexual or demisexual people are also childfree”).

Figure 6: How Sexual Orientation Contributes to Childfree Stigma



Discussion

Aim 1

Study 1 had two aims: the first was to explore how self-stigma manifests in childfree individuals. The theoretical underpinnings of self-stigma are based on the understanding that one first experiences or encounters public stigma, where these experiences may then result in an individual applying the stigma to themselves (i.e., self-stigma; Sheehan et al., 2017). Anticipated stigma may also contribute to this process. Therefore, experiences and effects of stigma, anticipated stigma, and self-stigma were explored.

Experiences and Effects of Stigma

Most participants (i.e., nearly 90%) identified experiencing stigma, which occurred in a variety of contexts and had multiple negative effects. Stigma in an interpersonal context was perpetuated by family members, friends, romantic partners, and strangers. This involved being excluded and ignored, which resulted in feelings of isolation and a general sense of being misunderstood. Others described relational conflict and deep-rooted feelings of being judged or stereotyped (e.g., being seen as immature, incapable, selfish, abnormal, or mean). Some participants were expressly told that they had lower worth due to not having children. During these stigmatizing situations, participants reported receiving patronizing comments, where others dismissed or actively questioned and argued against their choice to be childfree. Questioning tended to take the form of listing reasons why being childfree was an incorrect choice (e.g., experiencing eventual regret, not having care in senior years). Many stereotypes also perpetuated more traditional views of women, centering perceived social value as being tied to motherhood.

These findings are consistent with literature that has identified pressure to procreate from personal relationships. Researchers have noted that significant pressure comes from family

members to continue the family genealogical line or "give" parents grandchildren (Betancur et al., 2023; Salgado & Magalhaes, 2024). Many have also discussed the relational breakdown that can occur within intimate relationships when this pressure is present. Betancur and colleagues (2023) noted the need for romantic partners to agree about childfree status, and how conflict in this area tends to result in separation or domestic conflict. Indeed, childfree individuals tend to choose partners with the same lifestyle aspirations (Attbridge & Lesch, 2020); many would rather end a romantic relationship than change their childfree status for a partner (Salgado & Magalhaes, 2024).

Some participants reported more extreme interpersonal experiences of stigma that included violence (i.e., verbal and physical abuse), which was a direct consequence of sharing their childfree status with others. Sometimes threats of violence also ensued, including corrective rape (i.e., forcibly impregnating a woman against her will to "fix" her). Consequences of these experiences included the termination of relationships and upsetting emotions, such as genuine fear that these threats would come to pass. There has been limited research regarding outward violence being directed toward childfree individuals. Harrington (2019) noted that she has observed allusions to rape as a means to "fix" childfree women, consistent with our findings, though little else has been explored in the literature to our knowledge.

Over half of our participants described higher-level, systemic stigma that occurred in the workplace, and which pertained to workplace policies (e.g., staff scheduling and sick leave). Some participants' needs were treated as secondary to employees with children, whereby they were expected to work more hours or receive less vacation or personal leave, consistent with research from a number of authors. For instance, Turnbull and colleagues (2016) reported that parental employees' needs were prioritized over childfree employees regarding flexible work

scheduling, ability to take leave, and professional credibility. Filippi and colleagues (2024) also discussed how many work-life balance policies are structured around the needs of "families" (i.e., employees who are parents); results from their study determined that female employees who were parents were deemed to be more deserving of work-life balance policies than female childfree employees. These findings echo the overall sentiment that many childfree employees, men and women alike, feel penalized at work and treated unfairly by being expected to carry a greater workload due to not having children (Perrigino et al., 2018; Verniers, 2020).

Other forms of stigma in the workplace included comments from colleagues that were stigmatizing or demeaning. More outward levels of discrimination were also shared; namely, some participants reported lost wages or advancement opportunities as a consequence of childfree-related stigma. These findings are consistent with work by Vernier (2020), who discussed how childfree women are more likely to face incivility in the workplace due to the stereotypes associated with being childfree. Although some stereotypes about childfree women (i.e., the belief that they are more "career-driven") have been hypothesized to act as strengths, this has not resulted in the perception that childfree women are more successful or competent at work. Indeed, female childfree employees may be dismissed for advancement positions resulting from the belief that parents need greater economic benefits (Verniers, 2020).

Similarly, medical stigma reported by participants occurred at the individual and systemic level, which included receiving inappropriate comments from healthcare workers and the blatant refusal of health care. Over 40 percent of our participants experienced stigma within this context. Denial of healthcare requests was sometimes directly related to being childfree (e.g., voluntary sterilization associated with one's childfree status), though sometimes pertained to an entirely separate condition related to reproductive freedom (e.g., seeking contraception associated with

an underlying health condition, like endometriosis). The denial of healthcare requests associated with voluntary sterilization has been previously documented (e.g., Eisenberg & Brummett, 2023; Hintz & Brown, 2019; Lemke et al., 2023; Salgado & Magalhaes, 2024), demonstrating that our findings are consistent with the literature. Researchers have noted that there are extra tasks demanded of childfree women when advocating for their reproductive freedom, such that many have prepared extensively when making such a request in an effort to be perceived as genuine (Eisenberg & Brummett, 2023). In other words, childfree women perceive that their autonomy to make reproductive decisions has to be earned rather than freely given as per the frequency and severity of stigma in the healthcare system.

When asked quantitatively about how stigma may have affected them, participants reported reduced trust in healthcare most frequently. Some participants experienced physical health consequences associated with not receiving appropriate medical care, while others noted significant mental health challenges associated with trying to function within a stigmatizing medical system. Many participants also described the personal impact these denials had, resulting in a sense of judgement, shame, self-doubt, and general objectification. These findings are in line with what Eisenberg and Brummett (2023) described as heightened distress in childfree women who were concerned about not having their reproductive decisions honored. Other research has also demonstrated that childfree women who are able to obtain voluntary sterilization experience greater quality of life and psychological well-being than those who cannot (Lemke et al., 2023). Finally, Lalonde (2018) noted that requesting and being denied sterilization can result in shame and humiliation, and that the risk of regretting sterilization is not worth the oppression women experience when their reproductive freedom is dismissed.

Finally, participants overwhelmingly expressed the constancy of these experiences. Participants experienced stigma from at least three separate sources on average. Some described these experiences as day-to-day, while others reported greater stigma during childbearing years. Many noted how the impact of these frequent experiences affected their sense of autonomy. In contrast, some participants expressed little negative effect associated with experiencing stigma, stating that they do not allow the judgement of others to influence them. In consideration of our findings and existing research on childfree-related stigma, it is apparent that childfree stigma does not discriminate and can occur in every aspect of life (i.e., from family, friends, romantic partners, strangers, employers, medical professionals, and religious and political leaders).

Anticipated Stigma

Interestingly, nearly 90 percent of participants reported experiencing stigma, while only two thirds of participants anticipated further stigma (i.e., over 60 percent). A similar trend was noted across most settings (i.e., in the workplace, from family, friends, and strangers), where less stigma was anticipated than what was reported having been experienced. In contrast, a consistent percentage of participants reported experiencing stigma in medical settings and expecting it to occur again. Although it is only possible to speculate on the underlying reasons behind these differences, it is worth discussing briefly. It is interesting that participants generally demonstrate a more positive perspective on the future. Possibly the stigma they experienced in these settings was deemed to be a unique occurrence (i.e., thus not likely to be repeated); alternatively, perhaps circumstances have changed such that stigma is not anticipated as highly (e.g., setting boundaries with family, having constructive conversations with friends, or changing workplaces). It could also reflect a personality characteristic, where a more optimistic outlook on life is valued.

These more optimistic impressions, however, are not held in the medical environment, where most participants anticipate stigma occurring anew. This may indicate a general impression that there is less willingness or ability for there to be meaningful change in these settings. It is also possible that medical stigma is more poignant than other stigmatizing interactions (e.g., having healthcare requests refused versus an uncomfortable conversation with a stranger), such that it is more readily remembered and thus anticipated. In their research, Hintz and Brown (2019) noted that over half of their sample had prepared for a medical appointment to combat potential, anticipated stigma. These preparations involved learning about stigmatizing interactions other childfree people had experienced from medical providers and consequently preparing their own evidence to support their medical request. It is possible that having access to shared experiences of medical stigma may also result in childfree individuals expecting it to happen to themselves.

Relatedly, participants spontaneously discussed the strategies they used to manage stigma, which was a perceived consequence of anticipating future stigma. Some discussed refraining from sharing their childfree status until trust was established, or else avoiding some social interactions altogether. Others described developing defensive strategies, should their childfree status be shared and not received well. Most of these strategies centered around providing a response or justification regarding their childfree status; these ranged from providing a superficial excuse or deflection to try and change the subject, sharing a justification or genuine reason focused on facts, or having a quippy retort (i.e., “clapback”) ready to respond to common stereotypes cited about being childfree.

Our participants’ experiences are consistent with research conducted by Park (2002) regarding stigma management strategies in childfree individuals. One of the strategies discussed

in her research included "passing" (i.e., purposefully not sharing one's childfree status to "pass" as a parent or not-yet-parent); another strategy was labelled as identity substitution, whereby childfree individuals changed the topic from their childfree status to a different aspect of their lives (e.g., deflecting the conversation). Finally, many strategies discussed by Park (2002) included providing justification for the choice to be childfree, such as sharing facts that supported the lifestyle choice (e.g., self-fulfillment, not having the biological drive) or "condemning the condemners" (e.g., flipping the narrative and discussing how *having* children could be considered selfish). Ultimately, many of these same strategies were consistently reported by both our participants and Park's (2002) study; they are also similar to findings noted by Hintz and Brown (2019) where childfree individuals were preparing to defend their medical decisions. Ultimately, this showcases the longevity and consistency of many stigma management strategies employed by childfree individuals.

In general, participants shared that anticipating future stigma resulted in frustration, sadness, and increased self-doubt, as well as having an overarching negative impact on their mental health and well-being. This is consistent with research in mental health stigma, where anticipated stigma has been linked to lower self-esteem (Catalano et al., 2021). Our participants also noted that they commonly anticipated stigma, where for some it was an ongoing expectation in daily life. Other participants shared that although they expected to be stigmatized, they did not perceive there to be a significant or negative impact overall, highlighting some inherent strength or skills related to stigma resistance.

Manifestations of Self-Stigma

Most participants experienced self-stigma or affirmed that one could experience it in the context of being childfree. Participants described beginning to believe negative stereotypes about

themselves (e.g., that it is morally wrong to not have children, or that childfree people are inadequate, defective, mean, selfish, lazy, and have lower worth than parents). They also noted the development of self-doubt as a component of self-stigma – questioning their ability to make such an important life decision. Further, many described the negative emotional outcomes of self-stigma, such as feeling anger, guilt, shame, and self-hatred.

Our findings shed light on factors that may influence the development of self-stigma. Participants noted that the constancy of being exposed to stigmatizing experiences influences the development of self-stigma; if the messaging that someone is inherently flawed comes from multiple areas within a person's life, one can imagine how self-stigma may begin to manifest. Relatedly, participants described how widespread societal pressure (e.g., based on expectations from one's peers, culture, religion, and gender) could also contribute to the development of self-stigma. In other words, we are generally socialized to value parents, where this messaging is cemented at a young age and increasingly supported throughout the lifespan. Lastly, the concept of timing was brought forward as a factor in the development of self-stigma: experiencing stigma at a younger age may make one more susceptible to the internalization of stigmatizing messaging. Some participants described a period of heightened vulnerability during the early phases of one's decision-making process, when one is first considering being childfree; stigma during this early stage was proposed to make one more vulnerable to the internalization of negative messaging, when childfree people may not be as confident in their decision.

As noted previously, there is little childfree research in this area that is framed within the context of self-stigma theory. Although some studies on childfree stigma may have posed questions pertaining to the effects of experiencing stigma more broadly, few have specifically included a line of questioning that has named and explored self-stigma as a construct. By

developing our questions in this way, with supporting stigma and self-stigma theory, these results shed light on how the internalization of negative messaging toward childfree individuals can influence one's sense of self. Further, the discussion on factors that could contribute to the development of self-stigma in this population adds additional nuance, reflecting potential ways in which childfree people could be especially vulnerable.

Aim 2

The second aim of Study 1 was to examine accounts of childfree stigma from an intersectional lens. Many researchers have expressed that most analysis has addressed the experiences of white, heterosexual, childfree women (Hayfield et al., 2019). Consequently, there have been multiple calls made to include more diverse samples in research (e.g., Blackstone & Stewart, 2022; Hayfield et al., 2019; Morison et al., 2016). Although our recruitment efforts did not yield an especially diverse sample in some ways, we intentionally posed questions regarding how culture and sexual orientation have played a role in childfree-related stigma, to examine these constructs with greater consideration for diversity. It is also worth noting the many queer individuals who participated in this research (i.e., only 60% of the sample self-identified as heterosexual), which adds to the current literature by amplifying often marginalized voices.

Culture

Childfree-related stigma in the media was one of the themes identified in the data; participants discussed how there is limited representation of childfree lifestyles in the media more generally, and that existing representations often perpetuate stereotypes. This is consistent with research by Hintz and Haywood (2021) who analyzed how being childfree has been represented in news articles in the United States over the prior three decades. Findings from their analysis noted a recent increase in articles that discussed the morality of being childfree, where

the focus of these media sources was to brand a childfree lifestyle as immoral. Hintz and Haywood (2021) also noted how news articles placed a greater focus on childfree women, and that men and non-cisgender individuals tend to be left out of the discourse, suggesting how some of these stereotypes may be more directed at certain individuals.

Relatedly, the role of gender was another factor discussed in relation to culture. Participants commented on the cultural understanding of what it means to be a woman, and how motherhood is often intrinsically associated with this concept. Many noted the normative expectations placed on women, including milestones such as entering into marriage, childrearing, and general management of the household. These comments are consistent with what feminist authors have described as "the motherhood mandate", which denotes the idea that a woman's value hinges upon her procreative ability (Koropeckyj-Cox & Pendell, 2007). Cultural messaging often suggests that the act of having a child can be considered a rite of passage to womanhood, integral to feminine identity (Salgado & Magalhaes, 2024). Research has also shown that men tend to hold less favourable attitudes toward being childfree compared to women (Koropeckyj-Cox & Pendell, 2007). Other research studies have described how women are often more vulnerable to social scrutiny associated with a childfree lifestyle than men (Salgado & Magalhaes, 2024).

Many participants discussed race and ethnicity in the context of culture. Participants from a variety of ethnicities (e.g., American, African American/Black, Australian, Caribbean, Chinese, Hispanic, Indian, Indigenous, Mexican, Polish, Polynesian, Puerto Rican, Russian, and White) shared how their culture did not tend to support childfree lifestyles and valued pronatalist norms. Although more research is required within this area, some authors have discussed childfree stigma within the context of various cultures that tend to favour pronatalist norms, such as

Portuguese (Salgado & Magalhaes, 2024), South African (Attbridge & Lesch, 2020), Israeli, and British cultures (Shenkman et al., 2021) to name but a few. These studies support our findings that pressure to have children appears to resonate cross-culturally. Some of our participants also discussed how they received support from their immediate families in the context of cultures that generally did not accept a childfree lifestyle, while others did not. Many further reported how cultures valued the preservation of family, where having children was a required component of what it means to be and have a "family". This also appears consistent with current research; for instance, Moultrie (2021) described how Black childfree women in the United States faced cultural pressures associated with the concept of family; here, she noted how many of her Black, childfree participants were able to create family from friendships, partnerships, or more distant relatives (e.g., nieces and nephews) as a way to rewrite the concept of "family" within their cultural experience.

Religiosity also factored into experiences of stigma. This included experiencing stigma from religious individuals and discussing how many religions purport that being childfree is sinful. Participants also referred to gendered expectations within some conservative religious groups, where the role of women is to serve the husband by providing him with children. Many authors have reported similar findings. For instance, Ciesielski (2024) explored whether religiosity may be associated with childfree prejudice. They discussed how religiosity itself (e.g., believing in a higher power) may not be associated with the perpetuation of stigma; rather, the traditional lifestyle and rules that are often imposed by religion on the "correct" ways of living may contribute to stigma (Ciesielski, 2024). Similar findings were discussed by Uecker and colleagues (2021), who noted that having a higher value for the organizational components of

religion is associated with more negative beliefs toward being childfree. Thus, it is perhaps religious authoritarianism as opposed to religion overall that contributes to stigma.

Conservatism and right-wing ideologies perpetuating childfree stigma was also discussed by participants; several described how they perceived greater stigma from individuals and social settings where conservative values were favoured, which was often in more rural settings. Again, this has been showcased in other research. Ciesielski (2024) noted how right-wing authoritarianism and political beliefs predicted greater prejudice toward childfree people. They hypothesized that more conservative beliefs and ideologies tend to support traditionalism and pronatalism. The very act of living a different lifestyle, such as being childfree, may represent a perceived threat to conservative values that surround family and parenthood (Ciesielski, 2024; Koropeckyj-Cox & Pendell, 2007). Uecker and colleagues (2021) also noted that individuals belonging to more conservative religions (e.g., Protestants, Catholics, and Mormons) tend to place greater value on having children and hold greater stigma toward being childfree. Current examples from mainstream media also support this trend, such as highly popularized comments from Republican J.D. Vance (i.e., he described childfree people as “very deranged” and “sociopathic”; Maher & Bradner, 2024). His comments demonstrate how childfree stigma is upheld and normalized at broader levels, and how it is often associated with holding more conversative values.

Finally, it is worth noting how no cultural elements exist within a vacuum. Participants described how multiple components of their identity factored into their experiences of childfree-related stigma and self-stigma, from ethnicity, to gender, to location and associated political values of the geographical area. Future research in this area may therefore benefit from considering whether to examine one factor in isolation (e.g., childfree stigma associated with

one's religious background), or else more broadly considering the multiple components of social location. One final factor to be discussed within the context of this study is sexual orientation.

Sexual Orientation

Sexual orientation factored into our participants' experiences of childfree stigma. Some participants drew upon their own sexual orientation in their response. For example, individuals in heterosexual relationships or those passing as such (e.g., a bisexual woman dating a man) expressed that they experienced pressure to have children, in line with societal expectations. Some non-heterosexual participants shared that they experienced backlash for their sexuality, stemming from the assumption that they would be inherently childfree (i.e., the belief that if you are gay, you cannot have kids). This resulted in stigmatization directed toward multiple levels of their identity, where some were accused of being gay as a means to publicly validate their choice to be childfree; in this way, they were stigmatized both for their sexual orientation and childfree status. Other participants noted that they continued to experience pressure to have children through other means (e.g., adoption), and that childfree-related stigma persisted even in the context of being publicly open about their sexual orientation. When discussing these experiences, some participants reported stigma being generally perpetuated by heterosexual individuals, and that there was greater acceptance from the LGBTQ+ community. Others stated that sexual orientation had not factored into their experiences of childfree stigma in any way, and that if it had, there was limited personal impact. Lastly, some participants described how asexuality was complementary to a childfree lifestyle.

Our findings are relatively consistent with the limited literature within this context. Researchers have discussed the publicly held assumption that LGBTQ+ individuals are naturally inclined to not want children (Hayfield et al., 2019). Some members of the LGBTQ+ community

have been able to use this discourse to their advantage, as a means to support their childfree status; here, some LGBTQ+ childfree women have conveyed that they lack an innate desire for motherhood and thus have little choice in the decision to be childfree, absolving them from pressure to choose to have children, akin to how they may describe their sexuality (i.e., sexual orientation not being a choice; Attwood & Lysch, 2020). This can be considered a stigma management strategy, where individuals position themselves as being subject to their own innate or biological drives to *not* have children (Clarke et al., 2018). Although in some instances this may decrease childfree-related stigma, many have noted that women continue to face pressure to have children regardless of their sexual orientation and greater acceptance of LGBTQ+ individuals overall (Hayfield et al., 2019). Researchers have also reported that LGBTQ+ individuals experience less pressure from within-community peers to have children, consistent with our findings that stigma is perceived to come more often from heterosexual individuals (Clarke et al., 2018). Some research has also shown the cumulative effect of multiple stigmas, which was reported on in our study, where both sexual orientation and childfree status can result in more elevated stigma and greater difficulty in connecting with others who do not have these same identities (e.g., childfree lesbians can be perceived particularly harshly; Clarke et al., 2018; Rowlands & Lee, 2006).

Strengths and Limitations

As with any research, our study has strengths and limitations. One strength includes the intentional consideration of factors pertaining to diversity. As previously noted, this level of nuance has often been lacking in the literature; asking participants more broadly about how culture and sexual orientation have factored into their experiences may provide new avenues for further research to explore in greater detail. Further, our consideration of sexual orientation in

conjunction with 40 percent of our sample identifying as LGBTQ+ allows us to uplift and share non-heteronormative experiences in this area. Specifically, this sheds light on the compounding impact that multiple stigmatized identities can have, adding to the stigma literature both in respect to childfree and LGBTQ+ status. As noted previously, this continues to be an underrepresented area in the literature, and our findings are relevant in beginning to address this gap. Additional strengths were the nature of our data collection (i.e., survey) and the inclusion of brief quantitative questions. Much of the research within the childfree literature has involved interviews with a correspondingly small number of participants. Structuring our research as an open-ended survey allowed us to capture a greater range of experiences, adding and breadth to our findings.

Limitations of the study align with typical recruitment challenges. Participants recruited through convenience sampling leads to questions surrounding generalizability. Advertising our study in online childfree groups, though helpful in recruiting participants, may have also influenced the findings. For instance, individuals who have experienced stigma may be more likely to seek out support from groups of like-minded people; they may also be more invested in detailing these experiences through research. It is worth considering the potential that our findings somewhat inflate the rate of stigma that childfree people face or the potential severity of such experiences more broadly. Although we were not trying to ascertain the frequency of such stigma, some might perceive this as a limitation. Additionally, our methodology (i.e., open-ended survey responses) limited the potential depth of our findings and the opportunity to follow-up with participants for more context in some of their responses.

Finally, it is worth commenting on the sex-related distribution of our sample. The majority of participants were women, which raises the question of why this gender gap continues

to be observed in research. Is the pressure of the motherhood mandate significant enough to encourage women to participate in studies such as these more so than men? Are childfree women more likely to seek online childfree groups for support, given the stigma they face, where online research studies may be advertised thus resulting in a higher turnout? The absence of men, in this sample and in other research, makes one wonder about the potential differences in stigmatizing experiences overall based on sex and how disruptive the stigma may be. Unfortunately, we can only hypothesize on this matter given the issue at hand: men are often absent from this conversation.

Conclusion

Childfree individuals experience stigma frequently and from multiple sources. They also anticipate future stigma occurring. This, in turn, results in the formation of self-stigma, which has negative and wide-reaching consequences. Such stigma is influenced by various components of one's cultural identity, including media, gender, ethnicity, religion, conservatism, as well as sexual orientation. Considering the overarching impact that childfree-related stigma can pose, there is merit to examining the potential mental health concerns associated with these experiences. These are subsequently explored in Study 2.

Study 2

As mentioned, there is limited research on self-stigma in the context of voluntary childlessness, which represents a gap in the literature. This is concerning given the potential consequences of self-stigma. Existing research on self-stigma in other areas (i.e., mental illness) suggests that it is negatively associated with self-esteem (e.g., a belief in one's inherent worth), self-efficacy (e.g., a belief in one's ability to function and adapt well to different circumstances), and well-being (Catalano et al., 2021; Park et al., 2019; Rose et al., 2018). Of note, self-stigma has also been associated with poorer quality of life related to both physical and mental well-being (e.g., Abo-Rass et al., 2020). Other psychological outcomes have been examined in the context of mental illness and self-stigma; namely, self-stigma has been associated with increased depressive symptoms, including hopelessness and suicide ideation. Further, self-stigma has been linked to reduced help-seeking behaviour and treatment adherence (Abo-Rass et al., 2020; Catalano et al., 2021; Park et al., 2019; Rose et al., 2018). These relationships have been demonstrated across the lifespan, from adolescents (e.g., Rose et al., 2018) to seniors (e.g., Abo-Rass et al., 2020). Therefore, although there is limited research to draw upon in the context of being childfree, it is possible that childfree people experience self-stigma and its negative consequences. Although the nature of these associations may vary across context, it is possible that there are overarching relationships between self-stigma and various constructs that transcend the specific details of a person's situation.

Purpose and Research Questions

There were several key aims of this largely exploratory study, as it built momentum from Study 1. First, we aimed to quantitatively examine self-stigma. To address this goal, we developed a measure of self-stigma in the context of being childfree, which was informed from

inductive methods (i.e., results from Study 1) and deductive methods (e.g., literature review). The primary research question from Study 1 was echoed here in the context of our quantitative study: How does self-stigma manifest in childfree individuals? Although this question was exploratory, we generally predicted that childfree people would experience self-stigma to some degree given the many public and societal examples of stigma against voluntary childlessness (e.g., Ashburn-Naldo, 2017; Caitlin, 2022; Hintz & Brown, 2019). To the best of our knowledge, only one other study to date (i.e., Yeshua-Katz, 2018) has proposed the concept of self-stigma emerging in the context of voluntary childlessness.

A second purpose of the study was to examine the relationships between experienced stigma, anticipated stigma, and self-stigma in the context of voluntary childlessness. The following research questions were included in line with this aim: One, is there a positive relationship between experiences of stigma and self-stigma; and two, is there a positive relationship between anticipated stigma and self-stigma? We predicted that exposure to stigma or the anticipation of stigma would be associated with the development of self-stigma in childfree people. Here, we considered stigma theory and the proposed formation of self-stigma, which involves holding an awareness of public stigma prior to internalizing and applying it (Sheehan et al., 2017). We suggested that childfree individuals may be more readily aware of stigma if they had experienced it firsthand. Being more aware of existing stigma could also be associated with greater anticipation of future stigma. A heightened awareness of the stigma may then relate to the internalization and development of self-stigma.

A third purpose of this study was to examine potential factors that could be associated with self-stigma. As discussed previously, self-stigma has been related to decreased self-esteem, self-efficacy, well-being, mental health, and treatment-seeking behaviour in other research areas.

Consequently, we imagined that similar relationships may also emerge in the context of being childfree. Because this was a relatively novel research area, however, we were initially unsure which constructs to explore. Thus, our general research question was as follows: What factors might exist in relation to stigma and self-stigma in the context of voluntary childlessness? To arrive at our chosen factors, we first considered existing childfree research; for example, given the stigma demonstrated in the healthcare field toward childfree people (e.g., Hintz & Brown, 2019), we predicted that experiences of childfree stigma and self-stigma could be associated with decreased trust in the healthcare system. We also used data collected in Study 1 to identify potentially relevant constructs that could be associated with self-stigma. Upon consideration, we chose to explore factors associated with quality of life, autonomy, and trust in healthcare.

It is worth acknowledging that none of our goals and research questions in Study 2 included formal hypotheses. This was intentional and consistent with exploratory research (Scheel et al., 2021). The overarching vein of this study was to lay the groundwork to support the application of self-stigma theory in the context of voluntary childlessness, and to further propel this research area overall. It is a general critique of the literature and psychological field that in the quest to develop testable hypotheses, which is often fuelled by pressure to publish positive findings, many researchers neglect to conduct the sufficient initial work prior to being able to test hypotheses (Scheel et al., 2021). This includes various tasks involving concept formation, measure development, and establishing relationships between concepts, among others (Scheel et al., 2021). In other words, hypotheses are created before researchers are ready to test them. As this study was exploratory, the purpose was to lay the groundwork by examining the relevant constructs (e.g., self-stigma in the context of voluntary childlessness), developing a valid measure of the construct, and establishing relationships between concepts (e.g., experiences of

stigma, anticipated stigma, and self-stigma) in line with existing stigma theory. Consequently, there was not sufficient research to support the generation of testable hypotheses at the time of study conception, which is why we structured the set of studies in this way.

Therefore, and to reiterate plainly our overarching goals, the general research questions for this quantitative and exploratory study were: 1) How does self-stigma manifest in childfree individuals? 2) Is there a relationship between stigma, anticipated stigma, and self-stigma in childfree individuals? And 3) Is self-stigma associated with certain demographic factors, quality of life, autonomy, and trust in healthcare in childfree individuals?

Supplementary Analyses

A supplemental aim of the study was to compare childfree people (and those considering being childfree) to parents and not-yet-parents on several different factors (i.e., trust in medical systems, autonomy, and measures of personality). As discussed in the introduction, many existing stereotypes about childfree people relate to personality. Stereotypes about childfree people include the notion that they are selfish, bitter, immature, and less emotionally adjusted (Caitlin, 2022; Morison et al., 2015). However, the foundations for these stereotypes are formed largely from conjecture and public opinion as opposed to established quantitative research – a curse common to many stereotypes. The few studies that have addressed this area have either openly stigmatized childfree individuals (e.g., Peterson, 1980), or else largely failed to differentiate between childfree, childless, and not-yet-parents in their analyses. In other words, these studies have grouped their participants into people with children (i.e., parents) and people without children (i.e., childfree, childless, and not-yet-parents), thus calling into question the validity of their findings and their ability to comment specifically on these different groups.

Additionally, the few studies that were designed with appropriate distinctions between participants and which quantitatively examined personality typically reported little difference in measures of personality (e.g., Avison & Furnham, 2015; Neal & Neal, 2021). They have also examined personality using the popularized Five Factor Model of personality (McCrae et al., 1998). Therefore, to query the stereotypes and to expand upon research in this area, we quantitatively examined potential personality differences across groups using the HEXACO model of personality. This was with the goal of broadening the literature by exploring an understudied area, and by also using a different model of personality to potentially provide convergent validity to the existing research.

Method

Participants

Participants were drawn from two subsamples: one, community members who were primarily living in Canada and the United States; and two, Lakehead University students from the Thunder Bay and Orillia campuses. For the community sample, we recruited only childfree participants. For the student sample, we recruited both individuals who were childfree or considering being childfree, as well as parents or those planning to be parents. Given the young average age of participants typically drawn from university samples, we anticipated that most participants from the Lakehead University sample would fall into the categories of individuals considering being childfree or considering parenthood. We also imagined that some participants could be parents or "early articulators" of their childfree choice. In the community sample, where participants tend to be older on average than university samples, we anticipated that more participants would be staunchly childfree and committed to this choice, with some still in the decision process regarding this lifestyle choice.

In terms of sample size estimates, it was important to consider the different aims of Study 2, both in terms of scale development and potential proposed analyses. There is no gold standard sample size for scale development (Boateng et al., 2018). Some guidelines have included a proposed ratio of participants to scale items (i.e., 10 participants for every 1 scale item; Boateng et al., 2018). Other recommendations involve a minimum of 300 participants. Conversely, some authors have suggested a sliding scale of sample size acceptability, ranging from 100 participants considered as "poor" to upwards of 500 and 1000 participants considered as "very good" and "excellent". Ultimately, the overarching recommendation is that a larger sample size is preferred but that certain minimum standards (i.e., ten to one ratio) need to be met (Boateng et al., 2018).

It was also important to consider sample sizes in respect to potential analyses, such as correlational research more generally. For example, to establish a relationship between constructs, a sample size of 138 participants would yield a power of .95 in detecting a significant bivariate correlation. Given the general lack of quantitative research in this area, an effect size of 0.3 was used as a conservative estimate in our power analysis. Similarly, in examining potential differences between parents and childfree participants, a sample of 105 participants per group would yield a power of .95 to detect a significant difference between two means (i.e., *t*-test). With these considerations in mind, both in terms of scale development and our potential analyses, we aimed to recruit at least 400 participants in the childfree or considering childfree category and 400 parents or not-yet-parents, across both subsamples.

Ultimately, these sample size estimates were met. In terms of the community sample (i.e., childfree participants only), 486 participants were recruited. Following the removal of participants for failing or not responding to attentional checks, or for not meeting eligibility requirements, a working dataset of 440 participants was achieved. The sample was relatively

young (*M* = 36.19 years, *SD* = 11.53, range = 18-79), mostly female (91.1%), white (81.3%), and identified as women (84.1%). Participants were primarily located in the United States (48.2%) or in Canada (35.7%). For further demographic information, see Tables 7 and 8. Of this sample, 408 (92.7%) participants did not intend to have children, while another 32 (7.3%) were undecided though primarily leaning toward being childfree. Most participants identified as childfree (*n* = 405, 92.0%), with most being very or extremely committed to this choice (*n* = 392, 96.8%; see Table 9).

In terms of the student sample (i.e., childfree and non-childfree participants), 650 participants were recruited from the Lakehead University student population. A working dataset of 637 was achieved after removing participants who failed the attentional checks. The sample was young (*M* = 22.43 years, *SD* = 6.01 years, range = 18-53), mostly female (78.6%), and largely White (62.6%), Black/African American (9.9%), or South Asian (9.6%). For further participant demographic information, see Table 10. Of this sample, 512 (80.4%) participants identified as being a parent or primarily leaning towards becoming a parent, and 125 (19.6%) participants identified as childfree or primarily leaning towards being childfree (see Table 11).

When examining the student subsamples separately, the childfree/leaning childfree participant sample consisted of predominantly female participants (83.2%) and was mostly White (69.6%), Black/African American (4.8%), South Asian (4.8%), and East Asian (4.8%). Additionally, the childfree sample was mainly single (60%) or in a committed relationship (32%). The parent/leaning parent sample was also predominantly female (77.3%) and mainly consisted of White (60.9%), Black/African American (11.1%), and South Asian (10.7%) participants. The parent/leaning parent sample similarly reported being largely single (57.2%) or in a committed relationship (31.1%).

It is worth stating here that due to the differences between the community and childfree student samples, we decided against combining samples for further analysis. Although both groups of childfree individuals, there were some notable differences in respect to age, location, and general life development (e.g., a Canadian undergraduate student sample compared with adults located in the United States). For these reasons (i.e., being too dissimilar), analyses pertaining to childfree-related themes were kept separate.

Table 7: *Community Sample - Demographic Characteristics of Participants*

Characteristic		Value*	
Age in years, mean (*SD*)		36.19	(11.53)
Sex			
	Female	401	(91.1)
	Intersex	1	(.2)
	Male	35	(8.0)
	Prefer not to say	3	(.7)
Gender Identity			
	Genderqueer/Fluid	4	(.9)
	Man	39	(8.9)
	Non-binary/Non-conforming	19	(4.3)
	Two-Spirit	1	(.2)
	Woman	370	(84.1)
	Prefer not to say/Additional category not listed	7	(1.6)
Sexual Orientation			
	Asexual	36	(8.2)
	Bisexual	79	(18.0)
	Gay	3	(.7)
	Lesbian	8	(1.8)
	Pansexual	30	(6.8)
	Straight (heterosexual)	265	(60.2)
	Prefer to not say/Additional category not listed	19	(4.3)
Race/Ethnicity			
	Arab	3	(.7)
	Black/African American	12	(2.7)
	East Asian	9	(2.1)
	Indigenous (First Nations, Inuit, or Metis)	7	(1.6)
	Latin American	15	(3.4)
	South Asian	6	(1.4)
	Southeast Asian	7	(1.6)
	White (Caucasian)	356	(81.3)
	Additional category not listed	23	(5.3)
Marital status			
	Single	141	(32.0)
	Married/Common-Law	187	(42.5)
	Separated/Divorced	18	(4.1)
	Widowed	3	(.7)
	In a Committed Relationship	91	(20.7)

*Values shown are raw frequencies (%) except where otherwise indicated.

Table 8: *Community Sample - Participant Demographics Continued*

Characteristic		Value*	
Educational Background			
	Some High School	3	(.7)
	High School Completed	29	(6.6)
	Some College or Undergraduate	72	(16.4)
	College or Undergraduate Completed	201	(45.8)
	Some Post-Graduate	45	(10.3)
	Post-Graduate Completed	89	(20.3)
Employment Status			
	Employed Full-Time	172	(77.5)
	Employed Part-Time	24	(10.8)
	Unemployed	26	(11.7)
Location			
	Canada	157	(35.7)
	United States	212	(48.2)
	Other	71	(16.1)
Annual Household Income			
	Under $5,000	12	(2.8)
	$5,000-9,999	7	(1.6)
	$10,000-14,999	5	(1.1)
	$15,000-19,999	8	(1.8)
	$20,000-24,999	14	(3.2)
	$25,000-29,999	7	(1.6)
	$30,000-34,9999	21	(4.8)
	$35,000-39,999	21	(4.8)
	$40,000-44,999	20	(4.6)
	$45,000-49,999	17	(3.9)
	$50,000-59,999	28	(6.4)
	$60,000-69,999	38	(8.7)
	$70,000-79,999	41	(9.4)
	$80,000-89,999	30	(6.9)
	$90,000-99,999	28	(6.4)
	$100,000 and over	139	(31.9)

*Values shown are raw frequencies (%) except where otherwise indicated.

Table 9: *Community Sample - Childfree Status*

Characteristic		Value*	
Childfree Status			
	Yes	405	(92.0)
	No	-	-**
	Undecided	35	(8.0)
Plan to have children			
	Yes	-	-
	No	408	(92.7)
	Undecided	32	(7.3)
Commitment to childfree lifestyle	Not at all committed	-	-
	Somewhat committed	6	(1.5)
	Slightly committed	7	(1.7)
	Very committed	102	(25.2)
	Extremely committed	290	(71.6)

*Values shown are raw frequencies (%) except where otherwise indicated.

**Dashes are used instead of zeros to denote that any participants who responded affirmatively to the question were removed from the dataset (e.g., no parents or participants intending to have children were kept in the dataset following data cleaning).

Table 10: *Student Sample - Demographic Characteristics of Participants*

Characteristic		Value*	
Age in years, mean (*SD*)		22.43	(6.01)
Sex			
	Female	500	(78.6)
	Male	135	(21.2)
	Prefer not to say	1	(.2)
Gender Identity			
	Genderqueer/Fluid	2	(.3)
	Man	139	(21.9)
	Non-binary/Non-conforming	11	(1.7)
	Two-Spirit	2	(.3)
	Woman	478	(75.0)
	Prefer not to say/Additional category not listed	3	(.5)
Sexual Orientation			
	Asexual	16	(2.5)
	Bisexual	66	(10.4)
	Gay	8	(1.3)
	Lesbian	9	(1.4)
	Pansexual	16	(2.5)
	Straight (heterosexual)	496	(78.0)
	Prefer to not say/Additional category not listed	20	(3.1)
Race/Ethnicity			
	Arab	3	(.5)
	Black/African American	63	(9.9)
	East Asian	18	(2.8)
	Indigenous (First Nations, Inuit, or Metis)	42	(6.6)
	Latin American	12	(1.9)
	South Asian	61	(9.6)
	Southeast Asian	11	(1.7)
	West Asian	3	(.5)
	White (Caucasian)	399	(62.6)
	Additional category not listed	25	(3.9)
Marital status			
	Single	368	(58.0)
	Married/Common-Law	59	(9.3)
	Separated/Divorced	9	(1.4)
	In a Committed Relationship	199	(31.3)

*Values shown are raw frequencies (%) except where otherwise indicated.

Table 11

Student Sample: Participant Childfree and Parental Status

Childfree and Parental Status		Frequencies (%)
Parental status	Yes	48 (7.5)
	No	588 (92.3)
Plan to be a parent	Yes	375 (58.9)
	No	63 (9.9)
	Undecided	151 (23.7)
Childfree status	Yes	61 (9.6)
	No	42 (6.6)
	Undecided	110 (17.3)
Lifestyle leaning	Childfree	64 (10.0)
	Parent	46 (7.2)
Overall sample	Childfree/leaning	125 (19.6)
	Parent/leaning	512 (80.4)

Measures

Demographic Questionnaire. The same demographic questionnaire used in Study 1 was used here, for both community and student samples. Please refer to the previous description of this measure (Appendix A).

Childfree and Parental Status Questions. The same questions from Study 1 about childfree status were used in Study 2. These questions were posed to both the community and student samples. Additional questions asked whether participants intended to be childfree or parents (e.g., "Do you have, or have you ever had, any biological or adopted children?"). As noted previously, some of these questions were drawn from Neal and Neal's (2021) work and are also in line with their subsequent framework (i.e., Neal & Neal 2023), pertaining to their breakdown of childfree, childless, parents, and not-yet-parent groups (see Appendix I).

Childfree Experiences of Stigma. Questions related to potential experiences of stigma were posed to childfree participants across both the community and student samples. These questions were informed from what has been reported in the literature (e.g., stereotypes of the childfree) and from qualitative experiences of stigma reported in Study 1. Many of the questions from Study 1 were repeated here (see Appendix J).

Childfree Self-Stigma Scale. The self-stigma measure was meant to examine potential self-stigma in childfree participants. It was developed for this study and informed from inductive methods (i.e., qualitative responses in Study 1) and deductive methods (e.g., literature review). Existing measures of stigma were particularly consulted (e.g., Bahtiyar-Saygan & Sakalli-Ugurlu, 2019), as they represent examples of other measures created to examine potential stigma toward voluntary childlessness from non-childfree people. These, in turn, could reflect thoughts or beliefs that lead to the development of self-stigma in childfree individuals.

Ultimately, seventeen items were created based on the above methods. From these seventeen items, item content related to potential self-stigmatizing beliefs associated with morality, personality, family, and society. Response options ranged from 1 (strongly disagree) to 7 (strongly agree); thus, a score of 17 to 119 was possible, with a range of 102. Higher scores reflected greater self-stigma. Reliability (i.e., Cronbach's alpha) for the community sample was .85 and .90 for the student sample. Information related to the statistics of the scale are presented in the results (see Appendix K).

Lifestyle Attitudes Scale. Participants who were parents or who intended to be parents completed an adapted version of the Self-Stigma Scale. The only differences included the initial description and questionnaire instructions. Given that the scale assesses attitudes in non-childfree individuals, it was only included in the student sample. Higher scores reflected greater

stigmatizing attitudes held toward childfree individuals. The reliability was .90. As with the Self-Stigma Scale, further statistics are presented in the results section (see Appendix L).

Brief HEXACO Inventory (BHI). All participants in the student sample completed a measure of personality: the Brief HEXACO Inventory (de Vries, 2013). The 24-item BHI represents a short personality measure informed by the HEXACO model of personality (i.e., HEXACO-PI-R). The BHI includes items that address the six personality domains of the HEXACO model, including 1) honesty-humility, 2) emotionality, 3) extraversion, 4) agreeableness, 5) conscientiousness, and 6) openness to experience (de Vries, 2013). Five response options range from strongly disagree to strongly agree. Higher scores in each domain represented a higher perceived degree of said attribute. Reliability estimates were computed for the different personality domains, and were .48 (honesty-humility), .38 (emotionality), .48 (extraversion), .33 (agreeableness), .53 (conscientiousness), and .48 (openness to experience; see Appendix M).

Scale of Psychological Well-Being (PWB) – Autonomy Subscale. One of Ryff's (1989) psychological well-being scales was used – the Autonomy Subscale (see Appendix N). All participants from both samples completed the measure. The Autonomy Subscale poses questions about self-determination and being independent of social pressures (e.g., "I have confidence in my opinions, even if they are contrary to the general consensus"). Six response options for each subscale range from "Strongly disagree" to "Strongly agree (Ryff, 1989). Higher scores reflected greater perceived autonomy. Reliability was .80 in the community sample and .85 for the student sample. Due to one item performing poorly in the community sample (i.e., "I tend to be influenced by people with strong opinions"), it was removed from the scale for future analyses. This revised, thirteen-item scale resulted in a reliability of .86 in the community sample. The same item did not perform poorly in the student sample and was thus not removed.

Multidimensional Trust in Health Care Systems Scale (MTHCSS). The MTHCSS measures three aspects of trust in the health care system: (1) trust in health care providers (e.g., physicians), (2) trust in health care institutions (e.g., hospitals), and (3) trust in health care payers (e.g., insurance; Egede & Ellis, 2008). There is an overall scale score, as well as subscale scores related to the above three aspects (i.e., health care providers, institutions, and payers). The 17-item, self-report scale includes questions about trust in the health care system across the three subscales (e.g., "I can trust my health care provider's judgements concerning my medical care"), with five response options, ranging from "Strongly disagree" to "Strongly agree" (Egede & Ellis, 2008; see Appendix O). Higher scores reflected greater trust within the healthcare system. All participants from both samples who reported having some kind of primary health care provider completed the measure. Reliability for the community sample was .92 (overall scale), .93 (medical provider subscale), .74 (medical institution subscale), and .89 (medical payer subscale). For the student sample, the reliability was .90 (overall scale), .92 (medical provider subscale), .57 (medical institution subscale), and .82 (medical payer subscale).

Mental Health Quality of Life Scale (MHQol). The MHQoL is a brief measure that assesses mental health, psychological well-being, and quality of life (van Krugten et al., 2022). Seven items address self-image, independence, mood, relationships, daily activities, physical health, and thoughts about the future. These seven items have four response options, with higher scores reflecting greater perceived well-being within each area. One additional item asks about psychological well-being specifically and is rated from 0 (worst imaginable well-being) to 10 (best imaginable well-being). Only participants from the community sample completed this measure, with a reliability of .79 (see Appendix P).

Inattentive Responding Items. Several items were developed to assess for potential inattentive responding. These items required participants to read a simple question and respond in a certain way (e.g., “This is a system check item: please click “disagree” and move to the next question”). Three items were developed overall, with four response options each, and dispersed throughout the surveys (please see Appendix Q). To review a list of all study questionnaires and to see which participants completed what measures, see Table 12. Additionally, please see the previous participant subsection for details pertaining to how many participants were removed based on failing inattention checks.

Table 12

Questionnaire Organization Across Participant Samples and Subsamples

Study 2 Measures	Community Sample		Student Sample	
	Childfree subsample	Non-childfree subsample	Childfree subsample	Non-childfree subsample
Demographic Questionnaire	Yes	-*	Yes	Yes
Childfree and Parental Status Questions	Yes	-	Yes	Yes
Childfree Experiences of Stigma Questions	Yes	-	Yes	
Childfree Self-Stigma Scale	Yes	-	Yes	
Lifestyle Attitudes Scale		-		Yes
Brief HEXACO Inventory		-	Yes	Yes
Scale of Psychological Well-Being - Autonomy	Yes	-	Yes	Yes
Multidimensional Trust in Healthcare Systems Scale	Yes	-	Yes	Yes
Mental Health Quality of Life Scale	Yes	-		
Infrequent Responding Items	Yes	-	Yes	Yes

*Dashes are used instead of zeros to denote that any participants who responded affirmatively to the question were removed from the dataset (e.g., no parents or participants intending to have children were kept in the dataset following data cleaning).

Procedure

As in Study 1, participants were recruited from Lakehead University as well as from the community. Similar recruitment methods detailed in Study 1 related to the university sample (e.g., Sona system) and the community sample (e.g., social media recruitment) were employed here. Please refer to the Procedure subsection from Study 1 for further details. The sole difference for Study 2 was that people who were not childfree were also recruited and included in the study for the student sample only. Advertisement posters were created to recruit participants (see Appendix R). Upon receipt of REB approval (#1469673), participants viewed an information letter (Appendices S and T). They also reviewed the same consent form used in Study 1 and had access to a debriefing form upon completing the study (Appendix U).

Data Analyses

The data were cleaned and screened prior to conducting any analyses. This involved examining for missing entries and accuracy (Tabachnick & Fidell, 2013). The data were also examined for careless or non-purposeful responding by using the infrequency items. Once the data were cleaned, analyses pertaining to our research aims were conducted. The first aim involved scale building and development, which was conducted in line with Boateng and colleagues' recommendations (2018). Psychometric properties of the scale were reviewed by examining internal consistency (i.e., Cronbach's alpha), as well as computing item-total correlations for all scale items. These were computed to examine how each item performed and whether there was any merit to removing certain items from the scale. Of note, although there has been discussion on whether to report Omega rather than Alpha, the latter was reported to be consistent with the extant body of literature and in line with the researchers' familiarity. For the

sake of interest and to ensure appropriate calculations were conducted, Omega calculations were computed and no meaningful differences were found regarding the alpha values reported here.

The second and third aims of the study involved a series of exploratory *t*-tests, *z*-tests, and bivariate correlations to examine the potential associations between experienced stigma, anticipated stigma, and self-stigma, and to examine the relationships between self-stigma and our additional variables of interest. In respect to our supplementary analyses, a final series of bivariate correlations and *t*-tests were conducted. In detailing these many proposed analyses, it is worth noting the potential for an increased error rate. In being mindful of this, we set a declared alpha of .01 rather than .05 to reduce the potential for type I error.

Results

Aim 1: Scale Building and Development

The first aim was to develop a scale to measure self-stigma in childfree individuals. It was also administered to non-childfree individuals; in this case, the scale evaluated stigmatizing attitudes that participants held toward childfree individuals (i.e., the Lifestyle Attitudes Scale). Higher scores reflected greater self-stigma or agreement with stigmatizing beliefs.

Self-Stigma Scale

The mean on the Self-Stigma Scale in the community sample, completed by 431 childfree participants, was $M = 23.75$ ($SD = 9.11$), with a reliability (Cronbach's alpha) of .85. Mean scores for the individual items ranged from 1.12 to 2.19. The minimum overall score was 17 and the maximum was 85. The mean on the Self-Stigma Scale in the student sample, completed by 125 childfree participants, was $M = 27.06$ ($SD = 12.20$), with a reliability of .90. Mean scores for individual items ranged from 1.19 to 2.41. The minimum overall score was 17 and the maximum was 75. See Table 13 for overall scale statistics.

The mean on the Self-Stigma Scale in the student sample (i.e., named the Lifestyle Attitudes Scale for this sample), completed by 505 non-childfree participants, was $M = 35.57$ ($SD = 18.60$), with a reliability of .94. Mean scores for individual items ranged from 1.57 to 2.84. The minimum overall score was 17 and the maximum was 108. See Table 14 for further scale statistics. Given these statistics, no changes were made prior to conducting the analyses.

Table 13

Self-Stigma Scale Item-Total Statistics

Scale Items	**Community Sample**			**Student Sample**	
	Abbreviated Item Description	Corrected Item-Total Correlation	Cronbach's Alpha if Item Removed	Corrected Item-Total Correlation	Cronbach's Alpha if Item Removed
Item 1	*Being childfree goes against rules of nature*	*.44*	*.84*	*.55*	*.90*
Item 2	*Need a child for a meaningful life*	*.59*	*.83*	*.62*	*.90*
Item 3	*Being childfree is morally wrong*	*.44*	*.84*	*.70*	*.90*
Item 4	*Not having children is a mistake*	*.59*	*.83*	*.72*	*.89*
Item 5	*Childfree people hate children*	*.38*	*.85*	*.54*	*.90*
Item 6	*Childfree people are selfish*	*.48*	*.84*	*.66*	*.90*
Item 7	*Childfree people prioritize work*	*.43*	*.84*	*.64*	*.90*
Item 8	*Childfree people are immature*	*.64*	*.83*	*.71*	*.90*
Item 9	*Childfree people are lazy*	*.52*	*.84*	*.63*	*.90*
Item 10	*Childfree couples have relationship problems*	*.50*	*.84*	*.64*	*.90*
Item 11	*A family is incomplete without children*	*.71*	*.83*	*.64*	*.90*
Item 12	*Everyone should be a parent*	*.57*	*.84*	*.49*	*.90*
Item 13	*Responsible to preserve family name*	*.60*	*.83*	*.62*	*.90*
Item 14	*Childfree people are less valuable*	*.64*	*.83*	*.71*	*.90*
Item 15	*Childfree people won't have senior care*	*.50*	*.84*	*.46*	*.91*
Item 16	*Parents should be prioritized*	*.20*	*.85*	*.51*	*.90*
Item 17	*Voluntary sterilization should be banned*	*.13*	*.85*	*.36*	*.90*

Table 14

Lifestyle Attitudes Scale Item-Total Statistics

Scale Items	**Student Sample**		
	Abbreviated Item Description	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Item 1	*Being childfree goes against rules of nature*	*.66*	*.94*
Item 2	*Need a child for a meaningful life*	*.73*	*.94*
Item 3	*Being childfree is morally wrong*	*.76*	*.93*
Item 4	*Not having children is a mistake*	*.76*	*.93*
Item 5	*Childfree people hate children*	*.57*	*.94*
Item 6	*Childfree people are selfish*	*.74*	*.94*
Item 7	*Childfree people prioritize work*	*.64*	*.94*
Item 8	*Childfree people are immature*	*.79*	*.93*
Item 9	*Childfree people are lazy*	*.76*	*.94*
Item 10	*Childfree couples have relationship problems*	*.65*	*.94*
Item 11	*A family is incomplete without children*	*.76*	*.93*
Item 12	*Everyone should be a parent*	*.66*	*.94*
Item 13	*Responsible to preserve family name*	*.75*	*.93*
Item 14	*Childfree people are less valuable*	*.69*	*.94*
Item 15	*Childfree people won't have senior care*	*.59*	*.94*
Item 16	*Parents should be prioritized*	*.49*	*.94*
Item 17	*Voluntary sterilization should be banned*	*.62*	*.94*

Aim 2: Stigma, Anticipated Stigma, and Self-Stigma Relationships

The second aim was to explore relationships between stigma, anticipated stigma, and self-stigma. We conducted initial descriptive analyses, followed by a series of *z*-tests and *t*-tests. When equal variances could not be assumed, Levene's Test for Equality of Means was reported.

Experienced Stigma

Most participants in the community sample (n = 346, 78.6%) experienced childfree-related stigma. An additional 8.4% (n = 37) were unsure whether they had experienced stigma, with 13% (n = 57) reporting no stigma. In contrast, only 43.5% (n = 54) participants in the childfree student sample experienced stigma. Eleven other participants (8.9%) were unsure whether they had experienced stigma, while fifty-nine (47.6%) did not experience stigma. Participants also reported on where they experienced stigma (see Table 15). More community participants experienced stigma than student participants, $z = 7.60$, $p < .001$.

Anticipated Stigma

Many participants in the community sample experienced anticipated stigma (n = 251, 57.2%). Approximately a third of individuals reported not experiencing anticipated stigma (n = 152, 34.6%), while a further thirty-six participants (8.2%) were unsure. More community members experienced stigma than anticipated further stigma, $z = 6.86$, $p < .001$.

In the student sample, less than half of participants anticipated stigma (n = 57, 45.6%). Fifty-four (43.2%) did not experience anticipated stigma, with an additional fourteen (11.2%) being unsure (see Table 16). A similar percentage of student participants experienced stigma and anticipated further stigma, $p > .05$.

Self-Stigma

Stigma and Self-Stigma. Self-stigma was measured by the Self-Stigma Scale developed for this study. In the community sample, participants who experienced stigma in general (i.e., Yes/No) had higher self-stigma scores (M = 24.00, SD = 9.57) than those who did not (M = 21.95, SD = 4.34), $t(161.82) = 2.64$, $p = .009$. Further, participants who were stigmatized by family members had higher self-stigma (M = 24.46, SD = 10.10) compared to those who did not (M = 22.00, SD = 5.71), $t(386.81) = 3.19$, $p = .002$. Otherwise, self-stigma scores did not differ by type of stigma experienced, $p > .05$.

In the student sample, self-stigma scores did not differ based on whether participants reported experiencing stigma in general, nor based on type of stigma experienced ($p > .05$). Students had significantly higher self-stigma (M = 26.92, SD = 12.15) than community members *(*M = 23.75, SD = 9.11), $t(163.16) = 2.69$, $p = .008$.

Anticipated Stigma and Self-Stigma. In the community sample, higher self-stigma scores were reported by those who anticipated stigma in general (M = 24.57, SD = 10.05) compared to those who did not (M = 21.73, SD = 5.30, $t(385.74) = 3.67$, $p < .001$. Participants who anticipated stigma from friends had higher self-stigma (M = 25.96, SD = 11.66) than those who did not (M = 22.05, SD = 6.03), $t(261.59) = 4.18$, $p < .001$. Further, participants who anticipated stigma from family had higher self-stigma (M = 25.15, SD = 10.75) than those who did not (M = 22.52, SD = 7.19), $t(341.27) = 2.94$, $p = .004$.

In the student sample, self-stigma scores did not differ based on whether participants reported anticipating stigma generally or in specific settings ($p > .05$).

Table 15

Experienced Stigma – Study 2 Childfree Participants

		Community (N = 440)*	Student (n = 125)**
Experienced Stigma			
	Yes	346 (78.6)	54 (43.5)
	No	57 (13.0)	59 (47.6)
	Unsure	37 (8.4)	11 (8.9)
Experienced Stigma Locations			
	Workplace	244 (55.5)	20 (16.0)
	Social setting	271 (61.6)	40 (32.0)
	Family	313 (71.1)	56 (44.8)
	Intimate partner	83 (18.9)	13 (10.4)
	Medical environment	184 (41.8)	16 (12.8)
	Stranger	221 (50.2)	22 (17.6)
	Other	7 (1.6)	1 (.8)

*Total number of participants in community sample (i.e., all participants are childfree/leaning childfree).

**Total number of participants within the student sample who are childfree/leaning childfree (i.e., not all student participants are childfree).

Table 16

Anticipated Stigma – Study 2 Childfree Participants

		Community (N = 440)*	Student (n = 125)**
Anticipated Stigma			
	Yes	251 (57.2)	57 (45.6)
	No	152 (34.6)	54 (43.2)
	Unsure	36 (8.2)	14 (11.2)
Anticipated Stigma Locations			
	Workplace	204 (46.4)	26 (20.8)
	Social setting	191 (43.4)	45 (36.0)
	Family	205 (46.6)	64 (51.2)
	Intimate partner	84 (19.1)	39 (31.2)
	Medical environment	196 (44.5)	25 (20.0)
	Stranger	145 (33.0)	24 (19.2)
	Other	13 (3.0)	1 (.8)

*Total number of participants in community sample (i.e., all participants are childfree/leaning childfree).

**Total number of participants within the student sample who are childfree/leaning childfree (i.e., not all student participants are childfree).

Aim 3: Factors Associated with Stigma and Self-Stigma

The third aim of the study was to explore factors that may be associated with stigma and self-stigma. Variables of interest included demographic information, quality of life, trust in healthcare, and sense of autonomy. A series of bivariate correlations and *t*-tests were conducted to showcase the relationships between these constructs.

Demographic Variables

In the community sample, self-stigma differed based on geographic location. Canadians had higher self-stigma ($M = 26.90$, $SD = 12.45$) than Americans ($M = 21.94$, $SD = 5.79$), $t(205.94) = 4.61$, $p < .001$. Canadians also had higher self-stigma than those in the "Other" category ($M = 22.03$, $SD = 5.94$), $t(223.16) = 3.98$, $p < .001$. In respect to other demographic variables of interest, neither age, sex, education, income, nor strength of religious beliefs was associated with self-stigma.

In the student sample, strength of religious beliefs was positively correlated with self-stigma, $r(124) = .34$, $p < .001$. In respect to other demographic variables of interest, neither age, sex, nor income, was associated with self-stigma. Analyses addressing education and geographic location were not conducted for the student sample due to attenuation (i.e., the sample included university-aged students located in northwestern Ontario).

Quality of Life

Stigma. Psychological well-being was assessed using the Mental Health Quality of Life Scale (van Krugten et al., 2022). Only community members were administered this scale. Quality of life scores did not differ based on whether participants had experienced stigma, nor differed by stigma type (i.e., where it was experienced), $p > .05$.

Self-Stigma. Self-stigma was negatively correlated with quality of life $r(424) = -.18$, 95% CI [-2.71, -.09], $p < .001$. Of the seven scale items that assessed different aspects of quality of life (i.e., self-image, independence, mood, relationships, daily activities, physical health, future outlook), all items were negatively correlated with self-stigma apart from mood and physical health.

Trust in Healthcare

Stigma. Trust in healthcare was measured using the Multidimensional Trust in Healthcare Systems Scale (Egede & Ellis, 2008). In the community sample, trust in healthcare scores did not differ based on whether participants had experienced stigma in general (i.e., Yes/No). Yet, participants who experienced stigma in a medical environment had less trust ($M = 51.68$, $SD = 12.21$) than those who had not ($M = 57.05$, $SD = 10.66$), $t(373) = 4.54$, $p < .001$.

In the student sample, healthcare related trust did not differ based on whether someone had experienced stigma in general (i.e., Yes/No). However, participants who had experienced stigma from the medical system had less trust ($M = 50.43$, $SD = 7.13$) than those who had not ($M = 57.30$, $SD = 10.42$), $t(113) = 2.38$, $p = .02$.

Self-Stigma. Self-stigma was not significantly correlated with trust in healthcare in either sample, $p > .05$.

Autonomy

Stigma. Autonomy was measured with Ryff's (1989) psychological well-being scale - the Autonomy Subscale. We used a revised version (i.e., thirteen items) following the removal of one item that performed poorly in the community sample only. In the community sample, participants who had experienced stigma in a social setting reported greater autonomy ($M = 61.91$, $SD = 9.57$) than those who had not ($M = 59.43$, $SD = 9.32$), $t(402) = 2.56$, $p = .01$.

Similarly, participants who experienced stigma from a stranger had higher autonomy (M = 62.73, SD = 9.70) than those who had not (M = 59.14, SD = 9.04), $t(402) = 3.85$, $p < .001$.

In the student sample, no significant differences were found that fell within the alpha set for our analyses (i.e., $p = .01$).

Self-Stigma. In the community sample, autonomy was negatively correlated with self-stigma, $r(403) = -.28$, 95% CI [-.37, -.19], $p < .001$. In the student sample, self-stigma and autonomy were not significantly correlated (see Table 17).

Table 17

Factors Associated with Self-Stigma

Variables of Interest	**Community**	**Students**
Demographic Variables	Canadians had higher self-stigma than all other participants	Strength of religious beliefs was positively correlated with self-stigma
Quality of Life	Self-stigma was negatively correlated with quality of life	Scale not administered
Trust in Healthcare	No significant differences	No significant differences
Autonomy	Self-stigma was negatively correlated with autonomy	No significant differences

Supplementary Analyses

Additional exploratory analyses were computed to examine potential differences between childfree and non-childfree participants in the student sample. Analyses with community members were not conducted, as there was no appropriate sample with which to contrast them.

Trust in Healthcare

Childfree participants had less trust in healthcare (M = 56.46, SD = 10.31) than parents or those intending to be parents (M = 59.71, SD = 11.31), $t(577) = 2.81$, $p = .005$.

Autonomy

Autonomy did not significantly differ between childfree participants and parents or those intending to be parents, $p > .05$.

Personality

Personality analyses were computed based on scores from the Brief HEXACO Inventory. Being childfree was associated with lower scores (M = 11.52, SD = 2.16) than being non-childfree (M = 12.12, SD = 2.40) on the factor of agreeableness $t(632) = 2.51$, $p = .01$. The effect size, as measured by Cohen's d, was $d = .25$, reflecting a small effect. Additionally, being childfree was associated with higher scores (M = 15.20, SD = 2.69) than being non-childfree (M = 14.20, SD = 2.52) on the factor of openness to experience $t(631) = 3.88$, $p < .001$. The effect size was $d = .39$, reflecting a small to medium effect. No significant differences ($p > .05$) were observed with respect to the remaining personality factors (i.e., honesty-humility, emotionality, extraversion, and conscientiousness; see Table 18). For the means and internal consistencies of the BHI pertaining to the overall student sample, please see Table 19.

Table 18

Comparisons between Childfree and Non-Childfree Participants

Variables of Interest	**Childfree**	**Non-Childfree**
Trust in Healthcare	Lower trust in healthcare	Higher trust in healthcare
Autonomy	No significant differences	No significant differences
Personality	Lower agreeableness Higher openness to experience	Higher agreeableness Lower openness to experience

Table 19

Obtained Means and Internal Consistencies of the BHI

Measure scale (range possible)	**Mean (*SD*)**	**Cronbach's Alpha**
Honesty & Humility Total Score (4-20)	14.71 (*2.86*)	.48
Emotionality Total Score (4-20)	12.40 (*2.63*)	.38
Extraversion Total Score (4-20)	14.13 (*2.58*)	.48
Agreeableness Total Score (4-20)	12.00 (*2.36*)	.33
Conscientiousness Total Score (4-20)	13.27 (*2.74*)	.53
Openness to Experience Total Score (4-20)	14.39 (*2.58*)	.48

Discussion

Aim 1

The first aim of Study 2 was to develop a scale to measure self-stigma in childfree individuals. A secondary purpose of the measure was to assess stigma held toward childfree individuals. Psychometric properties of the scale, which was administered to both childfree and non-childfree participants, demonstrated that it performed well across student and community samples. Consequently, no revisions were made prior to conducting further analyses (i.e., no items were removed). In reflecting on the strengths and potential limitations of the scale, there was breadth in responses (i.e., range) and high reliability (i.e., Cronbach's alpha). Significant effort also went into item creation to ensure content validity (i.e., content derived from data in Study 1 as well as a literature review). For any future iterations of the scale, and prior to establishing a version available to other researchers, it would be helpful to pursue feedback on scale content and item wording from childfree individuals.

Scale items demonstrated face validity, such that childfree participants were aware of what the questions were attempting to measure. That being said, the scale could benefit from some revisions in respect to phrasing and structure of the items, as well as consideration of reading level. Further research to examine other psychometric characteristics of the scale such as additional forms of reliability and validity (e.g., test-retest reliability) could also be pursued. Additionally, all scale items were keyed in a certain direction; for potential future iterations of the scale, it could be worth considering the benefits of balancing with reverse-keyed items as a means to address acquiescent, complacent, or socially desirable responding patterns, though there is some controversy as to the benefits of using either method universally (Vigil-Colet et al., 2020). Further, most scale items addressed stigma related to childfree individuals directly (i.e., "People who choose not to have children are selfish"), while only one item assessed stigma via

comparison (i.e., “Parents should get priority sick leave and vacation time over people who choose not to have children”). It may be worth considering whether further comparative questions could be included to assess for stigmatizing beliefs that may not be as easily captured through direct questioning, as one way to mitigate potential socially desirable responding.

Finally, it is worth noting that original item content was derived from themes and common stereotypes noted in the literature review, which were also reflected in participant responses in Study 1. This pertained to items related to perceived morality of childfree people, supposed “negative” personality traits, as well as stigma experienced from one’s family and society at large. Relatedly, an exploratory factor analysis (EFA) was conducted to determine whether there was statistical support for separate factors pertaining to item content; the proposed factors were morality, personality, family, and societal stigma. Our results did not support this and, rather, suggested a single factor conceptualization.

Aim 2

The second aim of Study 2 was to explore relationships between stigma, anticipated stigma, and self-stigma in childfree individuals. Most participants in the community sample (i.e., nearly 80%) experienced stigma in general; further, many experienced stigma from multiples areas of life and particularly from family and peers, consistent with findings from Study 1. Most community members rated themselves as extremely or very committed to their childfree lifestyle. Interestingly, less than half of childfree participants in the student sample reported having experienced stigma, though commonly endorsed areas of stigma also included family members and peers. Of those who identified as childfree, only half were very committed to this lifestyle choice. It is fair to say, then, that our community sample represented individuals who

were more staunchly childfree, while our student sample was largely compromised of individuals leaning toward this lifestyle choice though still undecided.

More community members reported stigma than students. Although we can only speculate on factors that could have contributed to the discrepancy, it is worth discussing briefly. The first is considering the means of recruitment: community participants were recruited via online childfree groups. As discussed in the context of Study 1, individuals who have been stigmatized for their lifestyle choice may be more likely to join like-minded groups of individuals online for support; they may also be more inclined to discuss the difficulties they have faced for their lifestyle choice. In contrast, our other sample consisted of undergraduate students who happened to be childfree or leaning toward this lifestyle choice. Thus, a selection bias may have partly contributed to these differences.

Other demographic variables are also worth considering (e.g., age). Student participants were approximately 14 years younger on average than the community sample. It is possible they were less likely to experience pressure to have children, being young themselves. They also inherently had fewer opportunities to experience stigma, given that they had lived for less time than their community member counterparts. Further, given many indicated that they were still unsure about their childfree status, perhaps they were spared or less aware of derogatory comments made toward childfree people, if their status was less established or observable to others. This stage of life (i.e., being a student) might also have fewer expectations attached to it regarding child-rearing (e.g., when one is completing education, there may be fewer expectations to be married, have an established career, and thus be in a place where one might anticipate children). As per stigma theory, the degree to which a discrediting factor is visible influences the formation of stigma; in other words, if childfree status is less easily identified, stigma is less

likely to occur (Sheehan et al., 2017). As with any speculation, it is also possible that unnamed third factors influenced this discrepancy for which we did not account.

Fewer community members anticipated future stigma than reported experiencing it, which is a trend consistent with our findings in Study 1. Again, this demonstrates that despite experiencing stigma, many individuals did not anticipate it happening again, which could perhaps be due to a change in circumstances, a tendency for optimism, or other factors not considered. Interestingly, this trend was not observed in the student sample, where a consistent number of participants both experienced and anticipated future stigma.

In the community sample, participants who experienced stigma and anticipated stigma had greater self-stigma. This supports Corrigan's (2012) self-stigma theory, in that self-stigma is naturally associated with and derived from stigma itself (Sheehan et al., 2017). Interestingly, this finding did not emerge in the student sample, where no significant relationships between stigma, anticipated stigma, and self-stigma were found. However, when the groups were compared, students had significantly higher self-stigma than the community sample. This supports our qualitative results from Study 1, wherein participants shared that people may be more susceptible to self-stigma at certain periods, such as when they are younger or initially considering a childfree lifestyle. Most of our community sample was staunchly childfree, whereas half of our student sample was only *leaning* toward this lifestyle choice. Further, our student sample was younger than our community sample, as discussed. This convergence in our findings lends support to the idea that self-stigma may develop or be more impactful at certain periods in life.

Stigma theory also suggests that anticipated stigma is linked to greater psychological distress, and that this is true for individuals with concealed stigma identities, such as being childfree. Further, stigma that is centralized – when the discrediting attribute constitutes a core

component of one's self concept – also influences the potential for psychological distress to develop (Quinn & Chaudoir, 2009). This may help to explain why community participants, who were largely very committed to a childfree lifestyle, demonstrated self-stigma that was associated with experienced and anticipated stigma.

Aim 3

Our third aim was to explore whether certain factors may be associated with stigma and self-stigma in childfree individuals. This included examining whether demographic variables, quality of life, trust in healthcare, and autonomy could be implicated. In respect to demographic variables, differences were observed between the community and student samples. In the community sample, no significant differences were found in respect to most demographic variables outside of location: Canadians demonstrated higher self-stigma than all other participants. Given this research is truly exploratory, we can only hypothesize as to why these differences were observed. Perhaps there is a cultural disposition, where Canadians are more aware of stigma or are more likely to impose these negative beliefs on themselves. It is also worth noting that due to our sample size, minor differences may have been significantly but not practically different, which could be the case here.

In the student sample, strength of religious beliefs was positively correlated with self-stigma. This is consistent with qualitative data from Study 1, where participants reported that many religions perpetuated childfree stigma, with frequent religious messaging being that not having children is a sin. As discussed, other researchers have found that involvement with religious groups has resulted in childfree-related stigma, and that some religious leaders perpetuate stigma as well (Caitlin, 2022; Ciesielski, 2024; Uecker et al., 2021). It is easy to surmise how self-stigma is developed, when one simultaneously holds religious beliefs within a

religion that perpetuates stigma. It is possible that similar findings were not observed in the community sample, given that most participants identified as non-religious.

Self-stigma was associated with poorer quality of life in the community sample; students were not administered this measure. Similarly, self-stigma was negatively correlated with autonomy amongst community participants, though this was not replicated in the student sample. The community-based results are consistent with literature that has examined self-stigma in other contexts (i.e., mental illness), where increased self-stigma tends to be associated with reduced well-being (Dubreucq et al., 2021). Research has also demonstrated that self-stigma is associated with decreased self-respect and self-efficacy, leading to a "why try" approach, wherein individuals who experience self-stigma may not believe they are able to improve their condition in life or face challenges effectively; as a result, they may not act upon opportunities available to them due to these underlying beliefs (Corrigan et al., 2016). These findings may help to explain why autonomy is also lower when self-stigma is heightened, wherein the ability to make choices independently could be compromised. It is possible that these results were not observed in the student sample given the key difference between the groups (i.e., a staunchly childfree group versus those considering the lifestyle choice).

Interestingly, trust in healthcare was not significantly correlated with self-stigma in either sample. However, experiencing childfree-related stigma in a healthcare setting was associated with decreased trust in healthcare in both community and student samples. The relationship between experiencing stigma and reduced trust makes logical sense; if one is treated poorly, it stands to reason that an element of trust is lost. It is harder to explain, however, why self-stigma was not a relevant factor within this context. Regardless, this finding showcases that the actions of healthcare providers matter more than whether an individual has internalized stigma, in

respect to trustworthiness. This creates impetus for anti-stigma approaches within healthcare settings to mitigate potential stigmatizing actions from occurring.

Supplementary Analyses

Several additional analyses were conducted with the student sample only, to examine whether there were meaningful differences between childfree and non-childfree participants regarding several variables of interest. The first was trust in healthcare, where we found that childfree participants had significantly less trust than non-childfree participants. Again, this finding makes logical sense, given the preponderance of childfree stigma experienced and reported on in medical systems. This is supported by data from our current study (e.g., childfree participants from both samples reported less trust in healthcare following stigma within the medical context), as well as from multiple studies detailing childfree-related stigma experienced in medical settings (e.g., Hintz & Brown, 2019; Hintz, 2022). Further, this type of stigma may be particularly poignant given the current political climate and consistent attacks on reproductive freedom (e.g., the overturning of Roe versus Wade in the United States - the constitutional right to abortion; Totenberg & McCammon, 2022). Thus, data from a variety of sources support the reasoning behind why childfree individuals may be less trustful of a system that has historically denied them equitable care.

No significant differences were found in respect to autonomy between childfree and non-childfree participants. Given that many other factors can also influence the development of autonomy (e.g., age – all participants were undergraduate students), it is possible that other variables such as this may help to explain the lack of differences between groups.

The final area of interest was to examine whether certain personality traits were associated with being childfree using the HEXACO model of personality. Within our student

sample, childfree participants were less agreeable and more open to new experiences than non-childfree participants. No other significant differences were observed regarding the other HEXACO factors. One could argue that these findings make conceptual sense considering openness to experience is associated with less social conformity (i.e., choosing a childfree lifestyle), while agreeableness is linked to greater social conformity (i.e., having children as per the status quo; Lee et al., 2010). Our findings are also consistent with prior research in this area; Avison and Furnham's (2015) study examining personality differences revealed that childfree participants scored lower in agreeableness and higher in openness to experience than non-childfree participants. It is also important to consider that the differences observed were statistically significant but likely do not reflect practically relevant differences. To be clear, the differences in scores on the two measures (i.e., agreeableness and openness to experience) constituted a one-point difference or less on scales with a range of sixteen, which may not represent meaningful differences. This study also used self-report data; therefore, self-stigma may have influenced the childfree participants' responses (i.e., childfree participants scoring themselves as lower in perceived agreeableness).

Interestingly, very low reliability estimates (i.e., internal consistencies) were noted across all personality factor scores on the HEXACO measure. This results in questionable validity for the associated findings, and also represents valuable information for researchers who may wish to use this scale in the future and who are considering its psychometric merit. Moshagen and colleagues (2019) also noted that the Brief HEXACO Inventory (de Vries, 2013) tends to report lower internal consistencies, whereas other shortened versions of the HEXACO-PI-R (i.e., 60-item and 96-item) have higher reliability. This poses a common challenge that researchers face - balancing the length of measures used in research, while not compromising on the quality and

psychometric properties of the instruments. Thus, it is possible that the shortened version used here, which only has four items per personality construct, may have influenced the reliability of the findings.

Ultimately, very few meaningful differences were found with respect to personality profiles between childfree and non-childfree individuals, which flies directly in the face of many entrenched stereotypes held against childfree people. These findings demonstrate that negative personality traits do not accompany a childfree lifestyle, and that the few personality differences observed do not appear to be meaningful. Our findings also expand upon the limited field of childfree and personality research to date, most of which has used the Five Factor Model of personality, adding convergent validity to the literature.

Strengths and Limitations

A major strength of the study includes the use of a measure developed specifically for this project. Its creation was informed by inductive and deductive methods; further, its psychometric properties demonstrated that it performed well across multiple samples. Another strength is the nature of this work (i.e., quantitative). Although there are many strengths and important assets of qualitative research, which have largely propelled the topic of childfree experiences forward in academic spheres, the field has a dearth of quantitative studies with which to buttress the overall findings. This study helps to address this gap within the literature. Findings that were consistent across our qualitative and quantitative avenues also support the strength of our overall results, where triangulation results in greater confidence in its validity. Furthermore, having two childfree samples (i.e., community members who were staunchly childfree and students who were largely in the initial stages of making this decision) added

breadth to our discussion, showcasing how experiences may differ between samples or during different stages of the decision-making process to be childfree.

Limitations of the study include that some of our findings between groups (i.e., community vs. student childfree participants) may be due to the nature of the cohorts themselves rather than any meaningful difference. There were several notable differences (e.g., age, marital status), which reflect one's overall stage of life. Any of these factors could influence the types of stigmatizing experiences one might have, as well as how they could be perceived. Similarly, many of our results may reflect significant but not practically relevant differences. Although in some areas this may actually support the overall spirit of the research (e.g., by demonstrating few meaningful personality differences between childfree and non-childfree individuals), this may also pose a threat to the validity of our findings overall. Further, our research design may have benefitted from some additional questions, such as asking participants about how much the stigma *affected* them quantitatively, or else by restructuring some or our existing questions into Likert-style rather than discrete (i.e., Yes/No) response options. Finally, although much of stigma theory implies some directionality (i.e., first becoming aware of stigma, experiencing it, and *then* developing self-stigma), our study cannot comment on causality. Because this is correlational and cross-sectional research, our findings cannot shed light on the directionality of stigma leading to self-stigma, even though the associations unearthed support stigma theory in general.

Overall Discussion

Implications

This series of studies resulted in several important findings. Qualitative results from Study 1 highlighted the constant and widespread nature of stigma experienced by childfree

people, which translates across different societies and cultural milieus. Our qualitative findings also showcased that childfree individuals experience self-stigma, that there are numerous challenges associated with this, and that people may be particularly vulnerable when they are younger or earlier in their decision-making process. These results were echoed by our quantitative findings in Study 2: childfree people experience significant stigma, self-stigma, and associated challenges with both, such as reduced trust in healthcare, well-being, and autonomy. Multiple methods that resulted in similar findings adds strength and validity to the overall research project and supports the notion that stigma and self-stigma are real challenges that childfree people face on a regular basis.

With increasing rates of individuals choosing a childfree lifestyle, research on the consequences of experiencing stigma in this underrepresented population is timely and important. In terms of potential scientific contributions, this project adds to the quantitative literature through the application of self-stigma theory. The creation of a scale to quantitatively measure self-stigma in this population may serve as a useful tool to guide new or more refined measure development in future studies. Further, our effort to consider diverse experiences was partly able to uplift and broaden the conversation around culture and sexual orientation in this context, which has largely been absent from research in this area.

Future Research

Researchers may consider further exploring the consequences associated with childfree stigma and self-stigma; doing so using both quantitative and qualitative methods may serve to increasingly showcase the breadth (e.g., how frequently this occurs) and depth (e.g., how meaningful it is to individuals) of these experiences. Longitudinal research could also help to delineate the process by which self-stigma occurs in some individuals, and to clarify what

protective factors may shift blame and shame from becoming internalized. Capitalizing on what these strengths may be could support preventative strategies, which childfree people could use to arm themselves against the prejudice that exists throughout society. Additionally, further research attention in this area may support the merit of anti-stigma campaigns; efforts such as these, particularly in certain areas (e.g., in the workplace and medical sectors), may help to reduce systematic stigma from occurring and have trickle-down effects that influence interpersonal interactions as well.

Conclusion

Reproductive justice is undoubtedly at risk. With the recent overturning of the constitutional right to abortion in the United States, and ongoing difficulty accessing equitable reproductive healthcare, it is critical that conversations continue to shed light on these challenges. Although the focus of this research was largely developed within the realms of psychological research and stigma theory, the underlying inspiration for this project was fuelled by the need for greater academic focus on reproductive justice. Much of the research on reproductive freedom frames the experience from a non-childfree lens (Adair & Lozano, 2022). However, to advocate for reproductive justice means intentionally including all relevant voices, including those of childfree women. By exploring the stigma that childfree individuals face, we hope to contribute to this literature and advocate through the application of psychological stigma theory. Further, through the dissemination of this project, we aim to demonstrate how direct assaults against reproductive freedom are inextricably linked with the freedom to pursue a childfree lifestyle, and that there can be significant consequences to one's psychological well-being when this freedom is opposed and when stigma is maintained through various societal mechanisms. It is our sincere hope that this project can inform and inspire in respect to

reproductive justice and ultimately instill the following message: the worth of any individual does not depend on whether they have children.

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Appendix A: Demographic Questions

Demographic Questionnaire

1. What is your age?
    a. Open response (18+)
2. What was your biological sex at birth?
    a. Female
    b. Intersex
    c. Male
    d. Prefer not to say
    e. Additional category not listed (please specify):
3. What is your gender identity?
    a. Genderqueer/fluid
    b. Man
    c. Non-binary/non-conforming
    d. Two-spirit
    e. Woman
    f. Prefer not to say
    g. Additional category not listed (please specify):
4. What is your sexual orientation?
    a. Asexual
    b. Bisexual
    c. Gay
    d. Lesbian
    e. Pansexual
    f. Straight (heterosexual)
    g. Prefer not to say
    h. Additional category not listed (please specify):
5. What is your ethnicity?
    a. Arab
    b. Black/African American
    c. East Asian (e.g., Chinese, Korean, Japanese)
    d. Indigenous (e.g., First Nations, Metis, Inuit)
    e. Latin American
    f. South Asian (e.g., East Indian, ~~Pakistani~~, Sri Lankan)
    g. Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai)
    h. West Asian (e.g., Iranian, Afghan)
    i. White
    j. Additional category not listed (please specify):
6. What is the highest level of education you have completed?
    a. Elementary school

   b. Some high school
   c. High school completed
   d. Some college or undergraduate
   e. College or undergraduate degree completed
   f. Some post-graduate (e.g., Masters, Doctoral)
   g. Post-graduate completed
7. What is your marital status?
   a. Single
   b. Married/Common-law
   c. Separated/divorced
   d. Widowed
   e. In a committed relationship (not married or common law)
8. What is your work/employment status?
   a. Employed full-time
   b. Employed part-time
   c. Unemployed
   d. Retired
9. Are you currently a student at a university or college?
   a. Yes
   b. No
10. What is your annual household income after taxes?
   a. Under $5,000
   b. $5,000-9,999
   c. $10,000-14,999
   d. $15,000-19,999
   e. $20,000-24,999
   f. $25,000-29,999
   g. $30,000-34,999
   h. $35,000-39,999
   i. $40,000-44,999
   j. $50,000-59,999
   k. $60,000-69,999
   l. $70,000-79,999
   m. $80,000-89,999
   n. $90,000-99,999
   o. $100,000 and over
11. What is your religious affiliation?
   a. Buddhist
   b. Christian/Catholic
   c. Eastern Orthodox (e.g., Shinto, Jainism)

   d. Jewish
   e. Muslim
   f. Protestant
   g. Sikh
   h. No religious affiliation (e.g., atheist, agnostic)
   i. Additional category not listed (please specify):
   j. None of these
12. What is the strength of your religious beliefs?
   a. Not applicable (e.g., atheist, agnostic)
   b. Not strong at all
   c. Not very strong
   d. Somewhat strong
   e. Very strong
   f. Extremely strong
13. Where do you currently reside?
   a. Canada
   b. United States
   c. Other (please specify)

Appendix B: Childfree Status Questions

1. Do you have or have you ever had, any biological or adopted children?
    a. Yes
    b. No
2. Do you plan to have any biological or adopted children in the future?
    a. Yes
    b. No
    c. Undecided
3. Do you wish you had or could have biological or adopted children?
    a. Yes
    b. No
    c. Undecided
4. Do you consider yourself to be childfree? For your consideration, the definition of "childfree" is as follows:
   Being "childfree" refers to individuals who choose to refrain from having children. This includes individuals who do not want children through biological, adoptive, or any other means.
    a. Yes: I am childfree.
    b. No: I have children or intend to have children.
    c. Undecided: I am considering being childfree but have not completely decided.
5. How committed are you to a childfree lifestyle?
    a. Not at all committed
    b. Somewhat committed
    c. Slightly committed
    d. Very committed
    e. Extremely committed

Appendix C: Experiences of Stigma

As you know, we are hoping to hear about experiences related to being childfree. When we say "childfree" we are referring to individuals who choose to refrain from having children. This includes individuals who do not want children through biological, adoptive, or any other means. Some people who are childfree have experienced some form of stigma related to this choice. This could involve facing certain stereotypes about being childfree, dealing with questions about the legitimacy of your choice to not have children, or experiencing discriminatory actions toward you (being treated differently because you are childfree).

We also want to acknowledge the concept of intersectionality, in that some people may face stigma in line with multiple aspects (or intersections) of their identity. This could include experiencing stigma related to being childfree as well as stigma associated with one's sex, gender, sexual orientation, ethnicity, or disability, among other identities. If relevant to this childfree discussion, please feel welcome and encouraged to share any potential experiences of stigma that involve these other aspects of your identity as well.

We truly appreciate hearing about any experiences that you are willing to share. Being able to amplify these stories through research will help in addressing stigma toward being childfree. This is a short survey, but there are a lot of opportunities to share many details about your experience, should you wish to take the time to do so. Please know that your contribution will greatly support this work – thank you.

1. Have you experienced **stigma** related to being **childfree**?
    a. Yes
    b. No
    c. Unsure

**Skip logic: A "yes" or "unsure" response will direct participants to question 2. A "no" will direct participants to question 9.*

2. **Where** have you experienced this stigma? Please select all that apply:
    a. In the workplace/a professional environment
    b. In a social setting (with friends, acquaintances)
    c. In the family (family function, family interactions)
    d. From an intimate partner (spouse/partner, boyfriend/girlfriend/significant other, romantic date)
    e. In a medical environment (from any healthcare professional or healthcare setting)
    f. From a stranger/someone who you just met
    g. Other (please specify)

3. If you indicated experiencing stigma in one or more of the above environments, what happened in this situation? Please feel welcome to **describe a situation** in which you faced this stigma, in as many words as you wish:
    a. Open response

4. Please describe the **impact** that experiencing this stigma has had on you:
    a. Open response

5. If there is **another scenario** where you experienced stigma associated with being childfree that you wish to share with us, please feel welcome to describe it here. Otherwise, skip this question:
    a. Open response

6. Has **culture** played a role in the stigma you have experienced for being childfree? This could include your own culture, or the culture of the person/people involved in the stigmatizing experience. If so, please share your thoughts here:
    a. Open response

7. Has **religion and spirituality** played a role in the stigma you have experienced for being childfree? This could include your own religion/spirituality, or the religion/spirituality of the person/people involved in the stigmatizing experience. If so, please share your thoughts here:
    a. Open response

8. Has **sexual orientation** played a role in the stigma you have experienced for being childfree? This could include your own sexual orientation, or the sexual orientation of the person/people involved in the stigmatizing experience. If so, please share your thoughts here:
    a. Open response

9. Do you ever **worry about** or **anticipate** experiencing stigma toward being childfree in the future?
    a. Yes
    b. No
    c. Unsure

**Skip logic: A "yes" or "unsure" response will direct participants to question 10. A "no" will direct participants to question 12.*

10. **Where** do you **worry about or anticipate** experiencing this stigma? Please select all that apply:
    a. In the workplace/a professional environment
    b. In a social setting (with friends, acquaintances)
    c. In the family (family function, family interactions)
    d. From an intimate partner (spouse/partner, boyfriend/girlfriend/significant other, romantic date)
    e. In a medical environment (from any healthcare professional or healthcare setting)
    f. From a stranger/someone who you just met
    g. Other (please specify)

11. How has worrying about this potential, future stigma **affected** you?
    a. Open response

12. In general, do you think that experiencing **stigma** related to being **childfree** could affect people in certain ways? Could this type of stigma have an impact on (please select all that apply):
    a. Self-esteem (how someone feels about themself)
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    b. Self-efficacy (someone's belief in their ability to achieve their goals)
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    c. Sense of autonomy (being confident in making important life decisions)
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    d. Sense of purpose in life (having goals and direction)
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    e. Trust in healthcare (seeking care and believing you will be treated well)
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    f. Mental health
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)
    g. Overall happiness and wellbeing
    (Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree)

13. If you selected **more than one** of the options in the previous question, please let us know which item is most important in your opinion (i.e., in which area do you think childfree people are affected the most by experiencing stigma). Please only select **one** option.
    a. Self-esteem (how someone feels about themself)
    b. Self-efficacy (someone's belief in their ability to achieve their goals)
    c. Sense of autonomy (being confident in making important life decisions)
    d. Sense of purpose in life (having goals and direction)
    e. Trust in healthcare (seeking care and believing you will be treated well)

f. Mental health
g. Overall happiness and wellbeing
h. Other (please specify)

14. Sometimes, people who have faced stigma also experience **self-stigma**. Self-stigma involves the internalization of the negative stereotypes or discrimination that you have faced. **For instance, one stereotype about childfree people is that they are selfish or amoral for not having children. People with self-stigma may start to believe or question whether these stereotypes are true.**
    Do you think childfree people could experience self-stigma? Please share your opinion with us in as many words as you wish:
    a. Open response

15. If you could choose **one important "take-home" message** about being childfree that you would like society to know, what would it be?
    a. Open response

16. Is there anything else we did not ask about that you think would be relevant to this topic area? Please let us know:
    a. Open response

Appendix D: Advertisement Poster

the "Being Childfree" study.

to be "**childfree**" means not wanting children/choosing not to have children by any means

are you childfree? still seriously deciding if you want children? if so, this study might be of interest to you

Eligibility: You must be 18+ and residing in Canada or the United States

details:

time to complete:
15min - 1 hour

format:
online survey

compensation:
draw for an e-gift card

contact:

researcher contacts:

- Dwight Mazmanian, PhD, C. Psych: dmazmani@lakeheadu.ca
- Research team and Doctoral Student, Erika Puiras: hhab.laboratory@gmail.com

survey: https://www.surveymonkey.com/r/BeingChildfree_LU

Appendix E: Information Letter

Dear Potential Participant:

Thank you for your interest in the "Being Childfree" study. You have been invited to participate in this study so that we can better understand experiences associated with being childfree, including potential experiences of stigma. Taking part in this study is voluntary. Before you decide whether you would like to participate in this study, please read this information carefully.

WHAT IS THE PURPOSE OF THIS STUDY?

The main purpose of this study is to gather experiences associated with being childfree. *Being "childfree" refers to individuals who choose to refrain from having children. This includes individuals who do not want children through biological, adoptive, or any other means.* We would also like to hear from people who are considering being childfree, but who may not have fully decided upon this lifestyle path yet. We are particularly interested in whether childfree people experience or witness stigma toward this lifestyle choice, and how this affects them.

WHAT INFORMATION WILL BE COLLECTED?

Participants will be asked general questions, such as information about their demographics. They will then be asked questions about their experience as a childfree person, and whether they've experienced or witnessed stigma toward people who are childfree.

WHAT IS REQUESTED OF ME AS A PARTICIPANT?

This online study will be hosted on Momentive (previously known as SurveyMonkey). The survey may be completed at a time and location of your choosing. It is anticipated that the session will last between 15 minutes to 1 hour. Participants must be at least 18 years of age and currently residing in Canada or the United States.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

You are under no obligation to participate and are free to withdraw at any time without prejudice to pre-existing entitlements. Your decision to participate will also not affect your academic or work status. You may refuse to answer any question or questions while partaking in this study.

WHAT ARE THE RISKS AND BENEFITS?

There are no known physical risks associated with participating in the study. However, should you need some extra support, you may contact Crisis Services Canada at 1-833-456-4566. If you are in the United States, you may text the Mental Health America Hotline at 74174, where you will be linked with appropriate services. Potential direct benefits of participating in the study include assisting in research that aims to better understand voluntary childlessness. Potential indirect benefits include the educational experience of participating in psychological research.

As a token of our appreciation, individuals completing the study can enter a draw to win one of four electronic gift cards, valued at $25.00 CAD.

HOW WILL MY PARTICIPATION BE ANONYMOUS?

This study is anonymous. All data will be coded with a number, and no identifying information will be collected. No identifying information will be associated with any of the data, analyses, or methods of dissemination. This means that the principal investigator (Dr. Dwight Mazmanian) will not know who has participated. Only the research team will have access to the data. However, please know that Momentive is hosted by a server located in the USA. The US Patriot Act permits U.S. law enforcement officials, for the purpose of antiterrorism investigation, to seek a court order that allows access to the personal records of any person without the person's knowledge. In view of this, we cannot absolutely guarantee the full anonymity of your data. With your consent to participate in this study, you acknowledge this.

WHAT WILL MY DATA BE USED FOR?

The data in this research is being collected as a part of doctoral dissertation project. The findings will be used for research publications and/or presentations at scholarly conferences. Your identity will remain anonymous throughout these processes. All data will be securely stored on secure, password-protected computers for five years.

HOW CAN I RECEIVE A COPY OF THE RESEARCH RESULTS?

A summary of the results can be made available to you by email once the study has been completed. If you are interested in receiving an overview of the findings, please email the researchers at [eppuiras@lakeheadu.ca] with the subject heading "Results Summary Request – Being Childfree". We will email you a copy of the Results Summary once it is made available, which may take up to two years after you complete the survey.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Your participation in this research is completely voluntary, and should you choose not to participate, you may do so without consequence or the need for justification. You may discontinue your participation at any time without explanation or penalty. However, once you submit your data, it cannot be withdrawn due to its anonymity.

RESEARCH TEAM CONTACT INFORMATION:

If you have any further questions regarding this study, you may contact:
The research team: hhab.laboratory@gmail.com; eppuiras@lakeheadu.ca
Dwight Mazmanian, PhD, Professor, Lakehead University: dmazmani@lakeheadu.ca

RESEARCH ETHICS BOARD REVIEW AND APPROVAL:

This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Lakehead University Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Thank you for your interest and participation. It is greatly appreciated!

Appendix F: Consent Form

MY CONSENT:

I agree to the following:

- ✓ I have read and understand the information contained in the Information Letter
- ✓ I agree to participate and am at least 18 years of age
- ✓ I understand the risks and benefits to the study
- ✓ That I am a volunteer and can withdraw from the study up until the data is submitted, and may choose not to answer any question
- ✓ That the data will be securely stored at Lakehead University for a minimum of 5 years following completion of the research project
- ✓ I understand that the research findings will be made available to me once the study is completed, upon request
- ✓ I will remain anonymous
- ✓ All of my questions have been answered

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

I have read and agree to the above information and, by completing and submitting this survey, agree to participate.

If you consent to participate in the study, please click the "Next" button at the bottom of the page to continue.

Appendix G: Debriefing Form

Thank you for your participation in this research project on "being childfree" and voluntary childlessness. Past research has indicated that individuals who are childfree experience stigma about this lifestyle choice. However, little information is currently available about how these experiences might affect childfree individuals. We hope that this study will provide information on the effects of stigma and self-stigma in this underrepresented population, which may inform anti-stigma approaches.

Information about Study Results

A summary of the results can be made available to you by email once the study has been completed. If you are interested in receiving these research results, please email the research team at [eppuiras@lakeheadu.ca] with the subject heading "Results Summary Request – Being Childfree". We will email you a copy of the Results Summary once it is made available, which may take up to two years after you complete the survey.

Compensation

If you participated as a student from Lakehead University, you can elect to receive one bonus credit toward an eligible psychology course, as a token of our gratitude. If you choose to receive the bonus mark, your instructor at Lakehead must allow the acquisition of bonus marks and you must have signed up through the Sona System. If you are not a Lakehead University student, you may elect to enter a draw to win one of four electronic gift cards valued at $25.00 CAD. Please click here to enter the draw.

Contact Information

If you have specific questions about the survey you may contact the principal investigator, Dwight Mazmanian, Ph.D., C. Psych [dmazmani@lakeheadu.ca, 807-343-8257].

Other Resources

If completing this survey has raised any mental health concerns that you would like to discuss, you may contact Crisis Services Canada at 1-833-456-4566. If you are in the United States, you may text the Mental Health America Hotline at 74174, where you will be linked with appropriate services for your situation. Please print or save a copy of this letter for your records.

With sincere thanks,
Dr. Dwight Mazmanian and the research team

Appendix H: Positionality Statement

It is important to consider the positionality of the researcher in conducting this work (Braun & Clarke, 2020). I am a white, bisexual, childfree woman with a chronic disability (e.g., invisible illness). As elements of my identity are stigmatized, I felt compelled to conduct this research to uplift the voices of fellow childfree people. I valued the opportunity to provide childfree participants with an outlet to speak about how various elements of their identity (e.g., sexual orientation, culture) may have been targeted, potentially amplifying experiences of stigma. Because my research is important on a personal level, it was important to consider how my positionality in conducting this research may have affected the overall project. For instance, because I openly indicated to participants that I am childfree, it potentially helped to foster a sense of trust and willingness to engage in the study. Similarly, because I am an in-group member who has experienced childfree stigma, I may be able to contribute a level of insight to strengthen the project that would not be achieved if I were not childfree. These experiences likely influenced the types of questions I posed and how I interpreted participant responses. Alternatively, it is also likely that my personal experience at being on the receiving end of childfree-related stigma may have primed my coding schema when considering participant responses. Ultimately, it is important to recognize the role of the researcher and the lens that they bring to the project, which I have attempted to delineate in considering my personal location and how it may influence how I interact with this project.

Appendix I: Parent and Childfree Identification Questions

1. Do you have or have you ever had, any biological or adopted children?
    a. Yes
    b. No
2. Do you plan to have any biological or adopted children in the future?
    a. Yes
    b. No
    c. Undecided
3. How committed are you to a lifestyle that involves having children?
    a. Not at all committed
    b. Somewhat committed
    c. Slightly committed
    d. Very committed
    e. Extremely committed
4. Do you consider yourself to be childfree? For your consideration, the definition of "childfree" is as follows:
   Being "childfree" refers to individuals who choose to refrain from having children. This includes individuals who do not want children through biological, adoptive, or any other means.
    a. Yes: I am childfree.
    b. No: I have children or intend to have children.
    c. Undecided: I am considering being childfree but have not completely decided
5. How committed are you to a childfree lifestyle?
    a. Not at all committed
    b. Somewhat committed
    c. Slightly committed
    d. Very committed
    e. Extremely committed

Appendix J: Experiences of Stigma

Some people who are childfree have experienced some form of stigma related to this choice. This could involve facing certain stereotypes about being childfree, dealing with questions about the legitimacy of your choice to not have children, or experiencing discriminatory actions toward you (being treated differently because you are childfree).

1. Have you experienced **stigma** related to being **childfree**?
    b. Yes
    c. No
    d. Unsure
2. **Where** have you experienced this stigma? Please select all that apply:
    d. In the workplace/a professional environment
    e. In a social setting (with friends, acquaintances)
    f. In the family (family function, family interactions)
    g. From an intimate partner (spouse/partner, boyfriend/girlfriend/significant other, romantic date)
    h. In a medical environment (from any healthcare professional or healthcare setting)
    i. From a stranger/someone who you just met
    j. Other (please specify)
3. When you have experienced this stigma, how have you dealt with it? Please provide as much or as little detail as you would like:
    a. Open response.
4. Do you ever **worry about** or **anticipate** experiencing stigma toward being childfree in the future?
    a. Yes
    b. No
    c. Unsure
5. **Where** do you **worry about or anticipate** experiencing this stigma? Please select all that apply:
    a. In the workplace/a professional environment
    b. In a social setting (with friends, acquaintances)
    c. In the family (family function, family interactions)
    d. From an intimate partner (spouse/partner, boyfriend/girlfriend/significant other, romantic date)
    e. In a medical environment (from any healthcare professional or healthcare setting)
    f. From a stranger/someone who you just met
    g. Other (please specify)

Appendix K: Self-Stigma Scale

As a person who is childfree or considering being childfree, you may have encountered stigma related to this lifestyle choice. Sometimes, people who are discriminated against may begin to agree with some of the stereotypes held about them. This is called self or internalized stigma. Please indicate to what extent you agree with the following statements, from strongly disagree to strongly agree.

1. Choosing not to have children goes against the rules of nature.
2. People must have a child to have a meaningful life.
3. Choosing not to have children is morally wrong.
4. Choosing not to have children is a mistake.
5. People who choose not to have children must not like children.
6. People who choose not to have children are selfish.
7. People who choose not to have children prioritize work above all else.
8. It is immature to choose not to have children.
9. People who choose not to have children are lazy.
10. If a couple chooses not to have children, they must have problems in their relationship.
11. A family without children is incomplete.
12. Every person should experience parenthood.
13. People have a responsibility to have children to carry on the family name and legacy.
14. People who choose not to have children are less valuable to society.
15. People who choose not to have children won't have anyone to take care of them in old age.
16. Parents should get priority sick leave and vacation time over people who choose not to have children.
17. Voluntary sterilization should be banned for people who choose not to have children.

Response options: 1 (Strongly disagree), 2 (Somewhat disagree), 3 (Slightly disagree), 4 (Neither agree nor disagree), 5 (Slightly agree), 6 (Somewhat agree), 7 (Strongly agree)

Appendix L: Lifestyle Attitudes Scale

Many people have opinions about lifestyle choices, including around the decision to have children. Please indicate to what extent you agree with the following statements, from strongly disagree to strongly agree.

1. Choosing not to have children goes against the rules of nature.
2. People must have a child to have a meaningful life.
3. Choosing not to have children is morally wrong.
4. Choosing not to have children is a mistake.
5. People who choose not to have children must not like children.
6. People who choose not to have children are selfish.
7. People who choose not to have children prioritize work above all else.
8. It is immature to choose not to have children.
9. People who choose not to have children are lazy.
10. If a couple chooses not to have children, they must have problems in their relationship.
11. A family without children is incomplete.
12. Every person should experience parenthood.
13. People have a responsibility to have children to carry on the family name and legacy.
14. People who choose not to have children are less valuable to society.
15. People who choose not to have children won't have anyone to take care of them in old age.
16. Parents should get priority sick leave and vacation time over people who choose not to have children.
17. Voluntary sterilization should be banned for people who choose not to have children.

Response options: 1 (Strongly disagree), 2 (Somewhat disagree), 3 (Slightly disagree), 4 (Neither agree nor disagree), 5 (Slightly agree), 6 (Somewhat agree), 7 (Strongly agree)

Appendix M: Brief HEXACO Inventory

Instructions: Please indicate to what extent you agree with the following statements, using the following answering categories: 1 = strongly disagree, 2 = disagree, 3 = neutral (neither agree, nor disagree), 4 = agree, and 5 = strongly agree.

1. I can look at a painting for a long time.
2. I make sure that things are in the right spot.
3. I remain unfriendly to someone who was mean to me.
4. Nobody likes talking with me.
5. I am afraid of feeling pain.
6. I find it difficult to lie.
7. I think science is boring.
8. I postpone complicated tasks as long as possible.
9. I often express criticism.
10. I easily approach strangers.
11. I worry less than others.
12. I would like to know how to make lots of money in a dishonest manner.
13. I have a lot of imagination.
14. I work very precisely.
15. I tend to quickly agree with others.
16. I like to talk with others.
17. I can easily overcome difficulties on my own.
18. I want to be famous.
19. I like people with strange ideas.
20. I often do things without really thinking.
21. Even when I’m treated badly, I remain calm.
22. I am seldom cheerful.
23. I have to cry during sad or romantic movies.
24. I am entitled to special treatment.

Appendix N: Autonomy Subscale

1. Sometimes I change the way I act or think to be more like those around me.
2. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.
3. My decisions are not usually influenced by what everyone else is doing.
4. I tend to worry about what other people think of me.
5. Being happy with myself is more important to me than having others approve of me.
6. I tend to be influenced by people with strong opinions.
7. People rarely talk me into doing things I don't want to do.
8. It is more important to me to "fit in" with others than to stand alone on my principles.
9. I have confidence in my opinions, even if they are contrary to the general consensus.
10. It's difficult for me to voice my own opinions on controversial matters.
11. I often change my mind about decisions if my friends or family disagree.
12. I am not the kind of person who gives in to social pressures to think or act in certain ways.
13. I am concerned about how other people evaluate the choices I have made in my life.
14. I judge myself by what I think is important, not by the values of what others think is important.

Response options: (1) Strongly disagree, (2) Moderately disagree, (3) Slightly disagree, (4) Slightly agree, (5) Moderately agree, (6) Strongly agree.

Appendix O: Multidimensional Trust in Health Care Systems Scale (MTHCSS)

1. My health care provider is usually considerate of my needs and puts them first.
2. I have so much trust in my health care provider that I always try to follow his/her advice.
3. I trust my health care provider so much that whatever he/she tells me, it must be true.
4. Sometimes, I do not trust my health care provider's opinion and therefore I feel I need a second one.
5. I can trust my health care provider's judgements concerning my medical care.
6. My health care provider will do whatever it takes to give me the medical care that I need.
7. Because my health care provider is an expert, he/she is able to treat medical problems like mine.
8. I can trust my health care provider's decisions on which medical treatments are best for me.
9. My health care provider offers me the highest quality in medical care.
10. All things considered, I completely trust my health care provider.
11. Health care payers are good at what they do.
12. When needed, health care payers will pay for your to see any specialist.
13. When questioned about what treatments are covered, health care payers are honest with their answers.
14. Health care payers will pay for everything they are supposed to, including treatment that is expensive.
15. Health care institutions only care about keeping medical costs down, and not what is needed for my health.
16. Healthcare institutions provide the highest quality in medical care.
17. When treatment my medical problems, health care institutions put my medical needs above all other considerations, including costs.

Response options: (1) Strongly disagree, (2), (3), (4), (5) Strongly agree

Appendix P: Mental Health Quality of Life Scale

Please indicate below which statements best describe your situation today by choosing one answer in each of the seven subjects.

1. SELF-IMAGE

a. I think very positively about myself

b. I think positively about myself

c. I think negatively about myself

d. I think very negatively about myself

2. INDEPENDENCE *(For example: freedom of choice, financial, co-decision making)*

a. I am very satisfied with my level of independence

b. I am satisfied with my level of independence

c. I am dissatisfied with my level of independence

d. I am very dissatisfied with my level of independence

3. MOOD

a. I do not feel anxious, gloomy, or depressed

b. I feel a little anxious, gloomy, or depressed

c. I feel anxious, gloomy, or depressed

d. I feel very anxious, gloomy, or depressed

4. RELATIONSHIPS *(For example: partner, children, family, friends)*

a. I am very satisfied with my relationships

b. I am satisfied with my relationships

c. I am dissatisfied with my relationships

d. I am very dissatisfied with my relationships

5. DAILY ACTIVITIES *(For example: work, study, household, leisure activities)*

a. I am very satisfied with my daily activities

b. I am satisfied with my daily activities

c. I am dissatisfied with my daily activities

d. I am very dissatisfied with my daily activities

6. PHYSICAL HEALTH

a. I have no physical health problems

b. I have some physical health problems

c. I have many physical health problems

d. I have a great many physical health problems

7. FUTURE

a. I am very optimistic about my future

b. I am optimistic about my future

c. I am gloomy about my future

d. I am very gloomy about my future

PSYCHOLOGICAL WELL-BEING

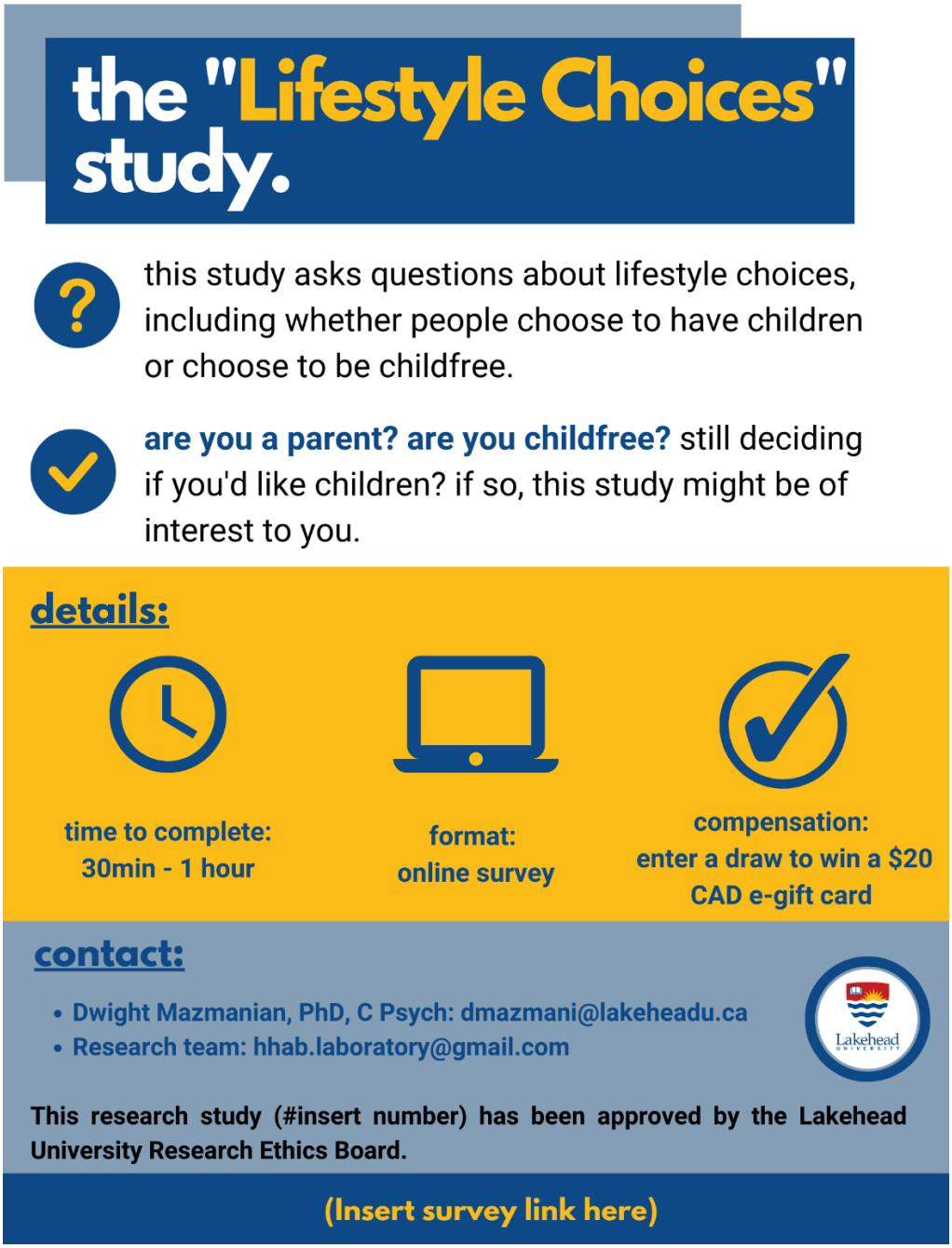
On the scale below, please indicate how you rate your psychological well-being. 0 represents the worst imaginable psychological well-being, while 10 represents the best imaginable psychological well-being.

0 1 2 3 4 5 6 7 8 9 10

Appendix Q: Inattentive Responding Items

1. This is a system check item: please click “disagree” and move to the next question.
    a. Strongly disagree
    b. Disagree
    c. Agree
    d. Strongly agree
2. This is a system check item: please click “0” and move to the next question.
    a. 0
    b. 1
    c. 2
    d. 3
3. This is a system check item: please click “Maybe” and move to the next question.
    a. Yes
    b. No
    c. Maybe
    d. I don’t know

Appendix R: Advertisement Poster



Appendix S: Information Letter – Lakehead University

Dear Potential Participant:

Thank you for your interest in the "Lifestyle Choices" study. You have been invited to participate in this study so that we can better understand attitudes associated with certain lifestyle choices. Taking part in this study is voluntary. Before you decide whether you would like to participate in this study, please read this information carefully.

WHAT IS THE PURPOSE OF THIS STUDY?
The main purpose of this study is to gather participants' attitudes toward certain lifestyles. You will be asked questions about your own lifestyle, including whether you plan to have children or be childfree (i.e., choose not to have children). You will also be asked about your opinion on lifestyle choices that might be different from your own. Anyone is welcome to complete this study – whether you plan to have children, plan to be childfree, or if you are still deciding what path might be best for you.

WHAT INFORMATION WILL BE COLLECTED?
Participants will be asked general questions, such as information about their demographics. You will then be asked questions about your attitudes toward other lifestyles, and whether you've experienced or witnessed stigma toward certain lifestyles. Questions about other psychological factors will also be included in the survey.

WHAT IS REQUESTED OF ME AS A PARTICIPANT?
This online study will be hosted on SurveyMonkey. The survey may be completed at a time and location of your choosing. It is anticipated that the session will take 30 minutes to 1 hour. Participants must be at least 18 years of age and currently residing in Canada or the United States.

WHAT ARE MY RIGHTS AS A PARTICIPANT?
You are under no obligation to participate and are free to withdraw at any time without prejudice to pre-existing entitlements. You may refuse to answer any question or questions while partaking in this study.

WHAT ARE THE RISKS AND BENEFITS?
There are no known physical risks associated with participating in the study. However, should you need some extra support, you may contact Crisis Services Canada at 1-833-456-4566. If you are in the United States, you may text the Mental Health America Hotline at 74174, where you

will be linked with appropriate services. Potential direct benefits of participating in the study include assisting in research that aims to better understand stigma toward certain lifestyle choices. **As a token of our gratitude for participating in this research, participants can sign up for a draw to win one of five $20 CAD e-gift cards to a location of your choice (Walmart, Starbucks, Indigo).** If you elect to enter the draw, you will be asked for your email to be informed should you win. This contact information is collected separately from your survey responses to maintain anonymity.

HOW WILL MY PARTICIPATION BE ANONYMOUS?

This study is anonymous. All data will be coded with a number, and no identifying information will be collected. No identifying information will be associated with any of the data, analyses, or methods of dissemination. This means that the principal investigator (Dr. Dwight Mazmanian) will not know who has participated. Only the research team will have access to the data. However, please know that SurveyMonkey is hosted by a server located in the USA. The US Patriot Act permits U.S. law enforcement officials, for the purpose of antiterrorism investigation, to seek a court order that allows access to the personal records of any person without the person's knowledge. In view of this, we cannot absolutely guarantee the full anonymity of your data. With your consent to participate in this study, you acknowledge this.

WHAT WILL MY DATA BE USED FOR?

The data in this research is being collected as a part of doctoral dissertation project. The findings will be used for research publications and/or presentations at scholarly conferences. The data may also be used for future research. Your identity will remain anonymous throughout these processes. All data will be securely stored on secure, password-protected computers for seven years.

HOW CAN I RECEIVE A COPY OF THE RESEARCH RESULTS?

A summary of the results can be made available to you by email once the study has been completed. If you are interested in receiving an overview of the findings, please email the researchers at [hhab.laboratory@gmail.com] with the subject heading "Results Summary Request – Lifestyle Choices". We will email you a copy of the Results Summary once it is made available, which may take up to two years after you complete the survey.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Your participation in this research is completely voluntary, and should you choose not to participate, you may do so without consequence or the need for justification. You may discontinue your participation at any time without explanation or penalty. However, once you submit your data, it cannot be withdrawn due to its anonymity.

FUNDING DISCLOSURE:
We gratefully acknowledge that this research is funded by the Ontario Women's Health Scholar Award and the Ontario Graduate Scholarship, which were both awarded to the doctoral student involved with this research project.

RESEARCH TEAM CONTACT INFORMATION:
If you have any further questions regarding this study, you may contact:
The research team: hhab.laboratory@gmail.com
Dwight Mazmanian, PhD, Professor, Lakehead University: dmazmani@lakeheadu.ca

RESEARCH ETHICS BOARD REVIEW AND APPROVAL:
This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Lakehead University Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Thank you for your interest and participation. It is greatly appreciated!

Appendix T: Information Letter – Community Members

Dear Potential Participant:

Thank you for your interest in the "Lifestyle Choices" study. You have been invited to participate in this study so that we can better understand attitudes associated with certain lifestyle choices. Taking part in this study is voluntary. Before you decide whether you would like to participate in this study, please read this information carefully.

WHAT IS THE PURPOSE OF THIS STUDY?
The main purpose of this study is to gather participants' attitudes toward certain lifestyles. You will be asked questions about your own lifestyle, including whether you plan to have children or be childfree (i.e., choose not to have children). You will also be asked about your opinion on lifestyle choices that might be different from your own. Anyone is welcome to complete this study – whether you plan to have children, plan to be childfree, or if you are still deciding what path might be best for you.

WHAT INFORMATION WILL BE COLLECTED?
Participants will be asked general questions, such as information about their demographics. You will then be asked questions about your attitudes toward other lifestyles, and whether you've experienced or witnessed stigma toward certain lifestyles. Questions about other psychological factors will also be included in the survey.

WHAT IS REQUESTED OF ME AS A PARTICIPANT?
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will be linked with appropriate services. Potential direct benefits of participating in the study include assisting in research that aims to better understand stigma toward certain lifestyle choices. **As a token of our gratitude for participating in this research, participants can sign up for a draw to win one of five $20 CAD e-gift cards to a location of your choice (Walmart, Starbucks, Indigo).** If you elect to enter the draw, you will be asked for your email to be informed should you win. This contact information is collected separately from your survey responses to maintain anonymity.

HOW WILL MY PARTICIPATION BE ANONYMOUS?

This study is anonymous. All data will be coded with a number, and no identifying information will be collected. No identifying information will be associated with any of the data, analyses, or methods of dissemination. This means that the principal investigator (Dr. Dwight Mazmanian) will not know who has participated. Only the research team will have access to the data. However, please know that SurveyMonkey is hosted by a server located in the USA. The US Patriot Act permits U.S. law enforcement officials, for the purpose of antiterrorism investigation, to seek a court order that allows access to the personal records of any person without the person's knowledge. In view of this, we cannot absolutely guarantee the full anonymity of your data. With your consent to participate in this study, you acknowledge this.

WHAT WILL MY DATA BE USED FOR?

The data in this research is being collected as a part of doctoral dissertation project. The findings will be used for research publications and/or presentations at scholarly conferences. The data may also be used for future research. Your identity will remain anonymous throughout these processes. All data will be securely stored on secure, password-protected computers for seven years.

HOW CAN I RECEIVE A COPY OF THE RESEARCH RESULTS?

A summary of the results can be made available to you by email once the study has been completed. If you are interested in receiving an overview of the findings, please email the researchers at [hhab.laboratory@gmail.com] with the subject heading "Results Summary Request – Lifestyle Choices". We will email you a copy of the Results Summary once it is made available, which may take up to two years after you complete the survey.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Your participation in this research is completely voluntary, and should you choose not to participate, you may do so without consequence or the need for justification. You may discontinue your participation at any time without explanation or penalty. However, once you submit your data, it cannot be withdrawn due to its anonymity.

RESEARCH TEAM CONTACT INFORMATION:

If you have any further questions regarding this study, you may contact:
The research team: hhab.laboratory@gmail.com
Dwight Mazmanian, PhD, Professor, Lakehead University: dmazmani@lakeheadu.ca

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This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Lakehead University Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Thank you for your interest and participation. It is greatly appreciated!

Appendix U: Debriefing Form

Thank you for your participation in this research project on lifestyle choices. Past research has indicated that individuals who are childfree experience stigma about this lifestyle choice. However, little information is currently available about how these experiences might affect childfree individuals. We hope that this study will provide information on the effects of stigma in this underrepresented population, which may inform anti-stigma approaches.

Information about Study Results

A summary of the results can be made available to you by email once the study has been completed. If you are interested in receiving these research results, please email the research team at [hhab.laboratory@gmail.com] with the subject heading "Results Summary Request – Lifestyle Choices". We will email you a copy of the Results Summary once it is made available, which may take up to two years after you complete the survey.

Compensation

If you participated as a student from Lakehead University, you can elect to receive one bonus credit toward an eligible psychology course, as a token of our gratitude. If you choose to receive the bonus mark, your instructor at Lakehead must allow the acquisition of bonus marks and you must have signed up through the Sona System. If you are not a Lakehead University student, you may elect to enter a draw to win one of four gift cards valued at $25.00 CAD.

Contact Information

If you have specific questions about the survey you may contact the principal investigator, Dwight Mazmanian, Ph.D., C. Psych [dmazmani@lakeheadu.ca, 807-343-8257].

Other Resources

If completing this survey has raised any mental health concerns that you would like to discuss, you may contact Crisis Services Canada at 1-833-456-4566. If you are in the United States, you may text the Mental Health America Hotline at 74174, where you will be linked with appropriate services for your situation. Please print or save a copy of this letter for your records.

With sincere thanks,
Dr. Dwight Mazmanian and the research team