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**An Interpretative Phenomenological Analysis exploring the experiences of mothers who relate to the term ‘Gender Disappointment’**

**Abstract**

**Background:** In a western context little is known about what it means to associate with the term gender disappointment - feelings of despair around not having a child of the desired sex.

**Aims:** Explore the lived experiences of British women who identify with the term gender disappointment.

**Methods:**  Six mothers of only sons who desired a daughter participated in a semi-structured interview via an online platform.

**Results:** An Interpretative Phenomenological Analysis (IPA) identified themes which relate to (i) pity, societal expectations of unfulfillment and concerns relating to future mother son relationship (ii) feelings of guilt and shame and (iii) barriers to seeking help and benefits of talking.

**Conclusions:** More awareness relating to gender disappointment and the negative impact it has upon maternal wellbeing is needed. Mothers who identify with gender disappointment would benefit from support from health visitors to enable them to access the help they need.

**Keywords:** Gender disappointment, maternal mental health, guilt, shame, talk therapies, help-seeking

**Key points**

Gender Disappointment is an emerging phenomenon where women have a sex preference for their child and report anguish and overwhelming sadness when the desired sex is not realised.

When discussing their experiences of gender disappointment, the mothers in this research reported that there is a societal assumption that being a mother to only sons is an unfulfilling and pitying experience. This negatively impacted upon the women’s expectations of the bond they expected to have with their sons. The mothers also explored how their desire for a daughter led to a deep-rooted sense of grief and shame which disabled their ability to share their experience and seek support. A lack of personal knowledge and perceived professional knowledge around gender disappointment was also presented as a help-seeking barrier. Given the wide-reaching implications maternal wellbeing has upon mother and baby it is important that women who identify with gender disappointment feel able to seek help from healthcare professionals who they perceive to have understanding and knowledge around gender disappointment.

**Reflective questions**

1. How could you use an antenatal visit to discuss societal expectations of mothering of girls and/or boys?
2. How might raising awareness of gender disappointment prepare women (who may or may not know the sex of their child) for motherhood?
3. How might you make a sensitive inquisitive inquiry with a mother about their feelings towards the sex of their child in a post-natal contact?
4. What could you do which actively encourages a mother to talk openly about their feelings without fear or judgment?

**Introduction**

Gender preference is well documented within Asian contexts where a male preference has been historically evident (Kapoor & Kumar, 2017; Smith et al., 2018). Within these contexts, where male sex preferences have not been realised, increased depressive symptoms have been reported in mothers (Klainin & Arthur, 2009). Within Western countries higher levels of depression have been associated with the birth of male children (Lagerberg & Magnusson, 2012). Less is known about gender preferences in a Western context but given the potential for psychological distress and links to post-natal depression (Reck et al., 2009) this area warrants further study.

The phenomenon of Gender Disappointment (GD) originated within an online community of women wanting to influence the sex of their yet to be conceived infant. A parent’s GD stems from an understanding that relationship fulfilment is dependent on a child’s sex (Groenewald, 2016; Hendl & Browne, 2019) and GD has been discussed as an anguish due to having not conceived a child of the desired sex (Monson & Donaghue, 2015). The experience has been reported as a shameful struggle accompanied by mourning and grief (Groenewald, 2016), often talked about as a form of postnatal depression. It has been suggested that GD can become so intense that it can influence life changing decisions such as seeking, often illegal, sex selection treatment (Whittaker, 2011).

Women who identify with GD sit outside of the maternal ‘master narrative’ of accepted maternal responses to motherhood (Kerrick & Henry, 2017) in which the women must approach motherhood with unconditional acceptance and joy (Morison, 2011). A failed comparison to the ‘good mother’ cultivates shameful feelings (Gilbert, 2011). Russell (2006) reported an alignment between the psychological struggle of maternal shame and an identification as a bad or failing mother. Shameful emotions have, in conjunction with a negative self-perception, a negative impact on the psychological wellbeing of mothers (Barr, 2015) in terms of the development of prenatal (Wilson, 2013) and postnatal depression (Dunford & Granger, 2017) and maternal bonding (Gilbert, 2016).

The effect of not addressing the mental health difficulties associated with the perinatal period are documented (O’Hara & McCabe, 2013) and psychosocial factors are presented as a reoccurring risk factor (Eastwood et al., 2021). However, when community and professional support includes empathy (Jenkins et al., 2014), an openness to listen (Raine et al., 2010), reassurances (Fawsitt et al., 2017) and the mother is provided with the right information at the earliest opportunity (Ledward, 2019), their psychological distress is alleviated.

Seeking support assumes that the woman identifies a difficulty, however, some women may not recognise what they are feeling (Nakku et al., 2016) and are unable to seek help (Gardner et al. 2014). Moreover, there is a perception by mothers that their psychological distress will not be understood (Kola et al., 2020; Nakku et al., 2016). This then perpetuates a fear that they will be stigmatised, thus silencing them (Gardner et al., 2014). Additionally, a societal perception of what mental health is may heighten a sense that a health professional cannot or will not help them, fuelling a lack of trust (Baldisserotto, 2020; Hadfield et al., 2019; O’Mahony & Donnelly, 2012). Whereas, a non-judgemental approach by health professionals has shown to validate the women’s distress (Kola et al., 2020). However, women who associate with the term GD suggest that they are unable to share their experience due to the taboo surrounding it (Groenewald, 2016). Yet, the benefits of sharing the experience of GD have been reported (Lagerberg & Magnusson, 2012). GD is not widely recognised; however, support provision should be offered even in the absence of care pathways (Khalid & Hirst-Winthrop, 2020). Therefore, the aim of this study was to explore the experience of mothers who relate to the term GD and understanding help-seeking actions, or lack thereof.

**Method**

The study used an IPA qualitative approach to enable a detailed, specific, personal understanding of each participant’s unique lived experience of GD (Lagerberg & Magnusson, 2012). Using a phenomenological stance it considered the personal experience through an exploration of how experiences are lived (Braun & Clarke, 2013).

*Data collection*

In line with IPA requirements, a small, homogeneous sample was used to generate a rich and detailed data set (Pietkiewicz & Smith, 2014). As outlined in table one participants included six British mothers, who were raising two or more children of the same gender in secular household, and identified with the term GD. The inclusion criteria did not dictate the sex of the women’s children; however, all participants were mothers of only boys. Participants were excluded if there were currently suffering from PND or had a child under the age of 1 year old to reduce possible psychological distress which may be heightened within this sample.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Pseudonym** | **Age in years** | **Sex of Children** | **Number of Children** | **Ages of children in years** |
| Jasmin | 37 | Male | 2 | 3 and 7  |
| Sally | 40 | Male | 2 | 3 and 5 |
| Elizabeth | 41 | Male | 2 | 3 and 5 |
| Helen | 39 | Male | 2 | 5 and 7 |
| Connie | 41 | Male | 3 | 4, 7 and 10 |
| Olivia | 34 | Male | 2 | 2 and 5 |

Table 1: Participant information

All participants responded to recruitment information which was shared online by a UK perinatal fitness expert and a clinical psychologist specialising in maternal mental health. All the mothers who expressed interest in the study participated in dyadic semi-structured interviews facilitated by the first author via an online platform such as zoom. The interviews invited the mothers to discuss 1) their hopes and expectations for their family 2) their experiences and feeling of GD 3) their relationships with their support network. All participants gave full informed consent to participate in the study and were de briefed afterwards. The study conformed to the British Psychological Society’s ethical standards and was approved by the University's ethics committee.

The interviews were transcribed verbatim and during this process any names mentioned were changed to protect the identities of all participants and their families. The women were also assigned a pseudonym to protect their identity. Transcripts were analysed using the six-stage process outlined by Smith et al. (2009). This involved reading each interview transcript multiple times to identify important themes. Themes which ran across the interviews then informed the analysis. Extracts from the interviews which best represented the themes were analysed closely using the principles of IPA.

**Analysis**

Themes identified in the analysis are outlined in figure 2.

*Figure 1: Superordinate and subordinate themes*

**Society and gender**

The women’s experiences of societal expectations were often negative, there was a sense that they must be unfulfilled as a mother.

 ***Pity***

The women portrayed a shared an understanding that it must be extremely disappointing to be having another boy.

*Like, it's amazing to me how often I got like pitying looks and people have expectations about what boys are like and, you know, it’s always;” oh, you’ve got your hands full”*

*Connie*

Connie suggests a sense of what it feels like to be pitied; a sense that she is being judged through both *looks* and comments as needing sympathy. Comments alluding to hard work, creates a sense that life would be easier if she had a girl. Connie’s experience of negative societal e*xpectations* around being a mother to only boys was *always* encountered. This consistent judgment suggests a consensus that Connie is missing a part of being a mother.

***Unfulfillment***

A commonality was presented in the societal expectation of assumed unfulfillment due to having only sons.

*‘everybody was really fixated on whether I would find out and kind of assumed that I'd want to have a girl next. And I found it quite overwhelming’*

*Sally*

Sally illustrates an obsessive *fixated* assumption held by *everyone* that she would want to have a girl, implying that she must be unfulfilled by only having sons. The magnitude of this assumption caused Sally to feel *overwhelmed*, which may initiate feelings of confusion and negativity. Helen reflected on this further.

*‘I think it is that expectation that people go: are you going to try for a girl as though you're missing out, or yeah, as though Harry is not fulfilling our family’*

*Helen*

Helen recounts an expectation that women want to try and conceive a daughter to prevent them from *missing out* on a fundamental aspect of being a mother. There is a sense that only a daughter can bring completeness and fulfilment.

***Future mother-son relationship***

Society also played a role in shaping further mother-son relationship expectations. All the women feared that their relationships would be lacking.

*‘You do hear about boys that are close to the mums, but then you also hear like;*

*“oh no if they are too close to their mum, that's a bad thing”’*

*Helen*

Helen’s thoughts centre on conflicting messages relating to an acceptable limit of closeness. There is a sense that Helen needs to carefully manage her future relationships with her sons; especially as a close relationship will be *bad*. Ideas around future relationships were shared by Connie.

*‘I came to this realisation that actually to be* *a fully formed man you have to separate yourself from your mother in some way’*

*Connie*

Connie’s *realisation* concerning the implied requirement for a *separated* relationship sets the scene for possible feelings of anxiety around the relationship and an implied contrast with daughters who remain close. Moreover, there is a need to distance herself from her son for his benefit.

**Who am I?**

When reflecting upon their reactions to not having a daughter there was a common sense of guilt and shame.

***Guilt***

Elizabeth recounted the moment she found out that her second child would be a boy

*‘I was completely shocked by my reaction, like I was just devastated. There’s like no other way of saying that. I just I just started sobbing and just so surprised that I felt like that. I was not expecting it at all… I felt, really guilty’*

*Elizabeth*

The suggestion of acute distress indicates the level of Elizabeth’s guilt. This highlights a sense that Elizabeth felt that she did not have the right to feel the way she did and that her feelings were wrong. This may inhibit her from sharing her feelings, thus compounding the guilt. Connie also discusses a perceived sense that her grief was inappropriate:

*‘I would cry with like the grief of this and that just felt like the wrong thing to do’*

*Connie*

Despite the perceived intense emotional pain, Connie suggested guilt may prevent her from expressing and addressing her feelings due to feared criticism.

***Shame***

When considering her emotional response to gender disappointment Jasmin reflected: ‘*there is a real shame attached’.* Shepresented a struggle around a suggested inability to be happy for those expecting a daughter:

*‘the jealousy is what was surprised me the most, actually being jealous of` my sister-in-law, I was mortified with myself that I couldn't just be happy for her, it was awful’*

*Jasmin*

Jasmin indicates a heightened disbelieve that she is *jealous* of someone so close to her. Jasmin’s reflection of being *mortified* indicates a dual level of shame around her feelings of unhappiness towards her sister-in-law and that her own emotions were unworthy and removed from her view of herself. She presents an inability to understand her own emotions. Her confusion around her feelings suggests a sense of worthlessness and questioning around her own self.

Elizabeth also reflected upon coming to terms with not having conceived a daughter. She presented a time that was and *even now is still really painful.* She talks of the emotional pain she experienced and how she *couldn’t sleep I was just like crying.* Elizabeth presented an isolated scene, *I’ve barely told anyone*, in which she experienced a *real deep sense of sadness.* Like Jasmin, Elizabeth also described a process of self-reflection.

*‘I did feel like I’m a bad person for having these thoughts, so there was there was an element of disliking myself’*

*Elizabeth*

Elizabeth presents a sense of discomfort and disapproval of herself. Elizabeth suggests that her reaction was not acceptable, there is a sense that finding out you are having a son does not warrant the level of emotion she found herself expressing. Negative self-concept centring on feelings of being a *bad person* may instigate further adverse feelings relating her ability to be a good mother. The suggested shame may also bear a component of negativity towards the son and could inhibit bonding.

**Sharing the experience**

The women shared a sense that there was a lack of recognition around GD which presented as a barrier to sharing their experience. Despite feeling unable to talk about their distress around GD, the women sensed there would be benefits if they did.

***Lack of recognition***

While seeking medical support to facilitate the conception of a daughter, Oliva reported perceived dismissal of her experience:

*‘I know there is judgement because I picked up on it a little bit and I saw one consultant and he was a bit like, you've got two healthy boys and you're going through all of this’*

*Olivia*

Olivia reflects upon the consultant's lack of recognition and inability to understand the extent to which GD was affecting her. She suggests that the consultant felt her actions were unwarranted,perhaps a denial of her experience. The perceived lack of understanding from a medical professional alludes to sense of alienation.

***Barriers to talking***

There was a common expression that talking would be beneficial but the women faced several barriers.

*‘I’d really benefit from kind of joining something like that (online forum) … but what if this is not secure, this is not private enough because if somebody saw I feel like literally my world would be over’*

*Olivia*

Oliva suggests that she is unable to reach out for help because of fears of identification. The detrimental magnitude of people knowing is perceived to be so great that it is impossible for her to share. This suggests Olivia views her experience to be so far from expected, that she would face negative judgment and ostracisation. There is a sense that having GD is shameful secret, however, Elizabeth suggests talking may be possible if the recipient understands:

*‘I really tried to find someone who was a specialist in it, I wanted someone who was a specialist in this area, but I couldn't find anyone’*

*Elizabeth*

Having specialist understanding around GD appeared a fundamental criterion to facilitate sharing, possibly to prevent feared ostracisation and judgement around her experience. However, the indication of scarcity may imply significant abnormality around her GD experience and route her feelings further in a sense of negativity and confusion.

***Positives of talking***

Sally sought professional help and reflected upon the benefit of talking with a healthcare provider.

*‘to know that actually lots of people go through it (GD) and just for you to feel normal, not some monster’*

*Sally*

Through talking Sally felt less alone. The suggestion that before talking she felt monstrous may have prevented the normalisation of her experience. Through normalisation, help-seeking behaviours may be facilitated and a sense of understanding around experience developed.

Jasmin had not shared her experience with anyone, yet she felt if she was able to, that talking would enable her to move forward positively.

*‘Once, you've said something out loud and not like just in your head, because that would be a bit weird, you tend to be able to let things go better’*

*Jasmin*

Jasmin presents a perceived positive outcome upon sharing challenging thoughts, suggesting that talking may enable a sense of resolution or clarity. Thus, the possibility of moving forward from a place of difficult emotions.

 The women illustrate a perceived lack of societal, professional, and importantly personal recognition of GD. This prevented the women’s experiences being validated, preventing help-seeking behaviour. However, where professional help seeking took place, the women reported the benefits of normalisation and an ability to move forward from a place of emotion turmoil.

**Discussion**

This study aimed to explore the experience of women who relate to an aspect of motherhood that is not yet widely acknowledged or understood, Gender Disappointment. The analysis presented issues relevant to healthcare professionals that will now be discussed in turn.

First, the analysis highlighted the impact of societal views relating to the expectation that mothering boys would be unfulfilling. The limitations placed on the mother son relationship(Ellemers, 2018) perpetuated the negative perception of being a mother to only sons. This illustrates the need to healthcare professionals to understand the degree of influence society holds over the maternal journey (Morgenroth et al., 2021).

A perceived violation of social norms was also evident as the women spoke about feelings of guilt and shame around their experience of GD (Gilbert, 2011). The women’s experiences of a grief embedded in absence of a longed-for daughter echo findings reported by Groenewald (2016). However, grief for this reason is not accepted by society (Monson & Donaghue, 2015) and it does not align with the maternal ‘master narrative’ (Kerrick & Henry, 2017). Consequently, the women perceived their experience to be an unacceptable maternal response and this resulted in a sense of shame (Russell, 2006).

The women’s shame also created a barrier to sharing their GD experience. Despite the women reporting intense emotions, confusion, and guilt around their experience, they felt unable to seek professional help. The women expressed a sense that their own knowledge of GD was limited, as was that of their community and health professional support network. A lack of information was a suggested cause for this. The women feared dismissal, stigma and ostracisation if they were to share their experience. Despite these fears, the women recognised that sharing their distress would be beneficial in enabling them to move forward, while bringing a sense of normalisation to their experience.

These findings concur with existing research establishing that a lack of available information can accentuate maternal psychological turmoil (Nakku et al., 2016), in turn creating a help-seeking barrier. NICE (2008) guidance highlights the importance of early information sharing. When women do not have access to information, they may be unable to establish if their situation constitutes a genuine mental health problem (Baldisserotto, 2020; Hadfield et al., 2019) accentuating a fear of dismissal by health care providers (Kola et al., 2020) and further preventing help seeking. Thissupports findings that professional training is significant (Ganann et al., 2020)

This study emphasised that sharing maternal experiences of psychological distress facilitates normalisation, belonging and understanding (Ganann et al., 2020; Guy et al., 2014; Kola et al., 2020; Raymond et al., 2014), consequently supporting recovery (Lagerberg & Magnusson, 2012). Although Lagerberg & Magnusson (2012) reported the benefits of discussing child sex preferences with a professional, however a suitable specialist professional or care pathway was not identified. These findings have been upheld by this study and highlight the importance of establishing who women can approach if needing support in relation to GD.

*Conclusion*

This study draws upon the experiences of a small homogenous group of women to provide a further exploration of the phenomenon of GD. Although the findings cannot be widely generalised the analysis raised important issues for further consideration. A perceived negative societal message around being a mother to only boys was illustrated by the women. The societal narrative suggesting that being a mother to only boys was an unfulfilling experience brought the women to feel a sense of loss around their motherhood journey. The women felt that because they yearned for a daughter as well as their sons that they were failing in their conformity to the maternal ‘master narrative.’ This created feelings of deep-rooted shame, moreover, accentuating their emotional turmoil. The women expressed a lack of personal and perceived professional knowledge around GD which perpetuated an inability to seek help. To understand the phenomenon of GD more fully the significance of sex-based differences alongside societal influences must be established. This study illustrated the heightened emotions associated with GD; questions are raised as to if the term ‘disappointment’ is appropriate for the magnitude of these emotions. A lack of knowledge around GD was established and therefore further research is needed to explore healthcare providers knowledge of GD.

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