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ORIGINAL ARTICLE

Bad, Pathetic and Greedy Women: Expressions of Surrogate Motherhood Stigma in a Russian Online Forum

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Abstract

Gestational surrogacy, in which the surrogate mother is not biologically related to the child she is carrying, is the most common type of surrogacy today. Although technologically well-developed and legal in many countries, it is stigmatized socially because it provokes and even contradicts basic traditional concepts of family, motherhood, and gender roles. The present study examines the types and expressions of the surrogacy stigma in Russia, applying a dual-pathway stigma model to a qualitative content analysis of 15,602 posts on a Russian-language online forum for surrogate mothers. Our findings reveal that the women's choice to become surrogate mothers initiated a social process in which these women experienced four types of stigma: Bad mothers, bad wives, pathetic losers, and greedy women. Surrogate mothers described the experience and internalization of stigma as threatening their social roles in the traditional family and financial realm alike. Our study places surrogacy stigma in the context of the post-Soviet financial and social climate as experienced and expressed by participants. Furthermore, understandings of the essence of perceived surrogacy stigma may help professionals develop a more nuanced and accurate approach for psychological and social care and may lead to increased accuracy in media, law, and political representation of members of this vulnerable group.

Keywords Stigma · Surrogacy · Social support · Online self-help group · Gender · Online communities · Reproductive technologies · Post-soviet society

Commercial gestational surrogacy is a process in which the intended parents, who cannot have children naturally, pay a third party, the surrogate mother (SM), to carry their externally fertilized embryo. Although commercial gestational surrogacy is currently illegal in most parts of the world, it is legal in Russia, Ukraine, Kazakhstan, Georgia, Armenia, and in some states in the United States (Twine 2015). Despite the advanced and well-developed technology involved in the process, surrogacy is stigmatized socially because it provokes—and even contradicts—basic traditional concepts of family, motherhood, and gender roles (Abrams 2015). The conceptualization of surrogacy is shaped by social, cultural, and economic conditions in each country (Twine 2015).

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A global discourse on the moral judgment of surrogacy ranges from perceiving SMs unfavorably as "bad mothers" who "sell their children" to "privileged women" to viewing them positively as women who help childless couples and deserve payment for their services (Arvidsson et al. 2017). To date, studies of surrogacy stigma have captured the experiences of SMs in Western countries (Abrams 2015; Poote and van den Akker 2009) and in India (Arvidsson et al. 2017; Bailey 2011; Karandikar et al. 2014; Pande 2009), where commercial surrogacy was outlawed on December 19, 2018. The current study places surrogacy stigma in the context of the post-Soviet financial and social climate, as expressed by those who experienced it. Based on a content analysis of 12,895 posts in a Russian-language online forum for SMs, in the present paper we explore discussions and the management of surrogate motherhood in Russia.

Surrogacy Stigma

Goffman (1963, p.3) describes stigma as an "attribute that is deeply discrediting," reducing the bearer "from a whole and

usual person to a tainted, discounted one." Most researchers today agree that stigma is socially constructed and concerns an attribute that marks an individual as different or "other." Being stigmatized comes at a high cost because individuals who experience it may suffer psychological harm or chronic physiological stress responses (Miller 2005; Quinn and Chaudoir 2009; Sawyer et al. 2012).

Stigma and stigmatization depend on four general and essential processes: (a) distinguishing certain characteristics and labeling differences, (b) associating human differences with negative attributions or stereotypes, (c) separating "us" from "them," and (d) experiencing status loss and discrimination (Link and Phelan 2001; Pescosolido and Martin 2015). Stigma occurs when several interrelated components converge and the dominant culture takes action to label and stereotype undesirable behaviors or characteristics. These measures, in turn, engender isolation and status loss or discrimination for those identified as "others" (Link and Phelan 2001 2014). Stigma thus represents the three-way intersection of cultural differentiation, identity formation through social interaction, and social inequality (Pescosolido and Martin 2015).

Perception—the way people come to realize and understand—of one's stigmatized status has been reviewed extensively (e.g., Pescosolido and Martin 2015). Research that takes the perspective of the stigmatized illustrates that people may grasp and become conscious of their stigma in different ways. The present study examines the expressions of perceived surrogacy stigma in support forums, using the dual-pathway model (Mickelson and Williams 2008; Mickelson et al. 2017). According to this model, *internalized* perceived stigma is defined as a woman's negative feelings (e.g., embarrassment, shame or deviance) about her surrogate motherhood, whereas *experienced* perceived stigma refers to actual personal experience with prejudice and discrimination. This dual path of stigma experience is connected to mental health outcomes. Mickelson and Williams' (2008) model relates internalized perceived stigma to depression, primarily through lower self-esteem and self-efficacy. Experienced perceived stigma, on the other hand, is found to be related to depression primarily through impaired social support. Mickeslon's and Williams' (2008) rationale for the internalized pathway is based on the work of Corrigan et al. (2006), who demonstrated that agreeing with and accepting stereotypes held by the public can damage one's self-worth and perceived sense of competence. Insofar as the experienced stigma pathway is concerned, the rationale declares that an individual's awareness of social stereotypes as well as actual experiences of prejudice and discrimination have been shown to impact social relationships negatively, leading the stigmatized to withdraw from social interactions (Mickelson et al. 2017). Identifying the ways in which members of the surrogacy support forum discuss their perceived stigma experience can inform health professionals working with SMs and suggest new interventions aimed at improving surrogate mothers' mental health outcomes.

Although reproductive technologies are often situated at the center of the feminist bioethics debate—focusing on choice, control, and connection—we would like to emphasize that we approach surrogacy from a stigma point of view. Nevertheless, it is important to note that there is no unified feminist view of surrogacy. Some scholars consider it a technology that liberates women from childbearing on their way to gender equality but also as a means of gaining control over women's bodies (Ahmed 2010; Franklin 2013). Surrogacy in particular is often condemned as an exploitation of women's reproductive labor (Munjal-Shankar 2014). This moral diversity within feminist bioethics, argues Tong (2018, p. 5), has led to political fragmentation that in fact may impede "efforts of feminist bioethics to advocate for a public policy that is good enough (i.e., 'moral' enough, 'feminist' enough) for nearly all women to accept" and allows for policy directions less appealing to women.

Not all forms of deviation generate stigma, nor is it created by negative public attitudes alone. Stigma is widely associated with surrogate motherhood, but the degree of stigmatization varies across cultures. In Israel, for example, surrogacy is state-regulated and motherhood is considered a civic function. Consequently, SM is not a stigmatized occupation there (Teman and Berend 2018; Twine 2015). Conversely, surrogacy is more stigmatized in the United Kingdom, where only 8 of 187 British women surveyed were willing to consider becoming SMs for relatives, friends or strangers (Poote and van den Akker 2009). Finally, Indian SMs are usually poor rural women who face a great deal of stigma (Arvidsson et al. 2017; Karandikar et al. 2014; Pande 2009).

Surrogacy stigma studies highlight three principal stereotypes of SMs: Prostitutes, bad wives, and bad mothers. Arvidsson et al. (2017) conducted 27 semi-structured individual interviews and 15 focus group discussions with women and men in the Assam province of India and found diverse views about surrogacy. Only a few informants considered SMs worthy of respect for helping childless couples, whereas a majority—and most prominently low-income informants—perceived them as "bad women" or "prostitutes," mostly because they lacked knowledge concerning the technology and associated surrogacy with sexual intercourse. A similar stigma was ascribed to surrogacy in studies by Pande (2009 2010 2014) and by Karandikar et al. (2014).

Even when informants are aware that surrogacy does not involve sexual intercourse, they may perceive SMs as bad wives: Giving birth is strongly linked to marriage, but in the case of surrogacy, the woman who does so is not married to the biological father of the child (Arvidsson et al. 2017; Unnithan 2013). In one survey, for example, infertile Iranian women attested that married women should not be SMs (Rahmani et al. 2011). As for motherhood, many of the

Indian informants in the study by Arvidsson et al. (2017) described SMs as bad mothers, that is, women who violate the norms of motherhood because they give away "their own children." Although some high-income informants were empathetic about the SMs' "emotional suffering from giving up the motherhood role" (p. 7), many informants in lower socioeconomic groups claimed that SMs violate the values of Indian society by turning maternity into an economic transaction.

These three stereotypes are constructed through a multifaceted framework of messages and experiences, including interactions with friends, family, community, and society. SMs often report experiencing stigma that may engender social ostracism and impair family relationships. For example, although husbands and partners of participating SMs in the United Kingdom and United States were generally supportive of their partners, more than half the SMs in Abrams' (2015) study experienced increased conflict in their extended family relationships as a result of their decision to become SMs. Similar results were reported by Karandikar et al. (2014) in which all 15 Indian SMs interviewed attested that although the reactions of family members to surrogacy varied from negative to relatively supportive, those of community members were always negative, resulting in ostracism. In one such instance, the participating SM was forced to leave her village.

Numerous studies investigated the stigma accompanying surrogacy in India, but few examine the situation in Western countries. For example, Twine (2015, p. 47) only mentions "some anecdotal evidence from journalistic reports that some U.S. Black surrogates have to manage the stigma that their Black relatives attach to surrogacy, especially if they are carrying the child for White Europeans or European-Americans." We indeed lack empirical data regarding the manner in which White European SMs cope with stigma. Therefore, the coping styles of Russian surrogates (representing White women who carry babies for White clients) may extend our knowledge about surrogacy stigma.

Surrogacy in Russia

Surrogate maternity programs in Russia are legal and accessible to both residents and foreigners. It is estimated that 400–500 children are born to SMs annually (Svitnev 2016). To be eligible for surrogacy, the intended parents (a married couple or single individuals) must be unable to have children of their own, as corroborated by a medical evaluation (van den Akker 2017). A potential SM need not be married but must be a mentally and physically healthy woman aged 20–35 years-old with 1–3 healthy children of her own. Reproduction clinics instruct SMs to think of pregnancy as paid work (Rivkin-Fish 2013). Compensation typically ranges between US $10,000 and $20,000 (Weis 2017), as contrasted with $20,000–$30,000 in the United States and $2000–$10,000 in India (Bailey 2011).

To understand the context of surrogate motherhood in Russia, it is important to consider the dominant gender order under previous political regimes. Motherhood was supported by the state and evolved into what was called the "working mother gender contract" (Temkina and Zdravomyslova 2003, p. 53). In particular, this contract assumed that women fulfilled a combination of family and work functions, for which the state provided the necessary support (health care, benefits for working mothers, free childcare) and guaranteed preservation of their jobs (Zhurzhenko 2001). As a result of this policy, Soviet women were well-educated and employed; in 1970, for example, 65% of working-age women had a secondary education and 82% were employed (as compared with 65% and 88% of men, respectively, during that same year). The working mother gender contract, supported by Communist ideology as applicable to a vast majority of Soviet women, broke down with the demise of the Communist regime (Zhurzhenko 2001). The recession that accompanied the Soviet regime's collapse meant that income was no longer guaranteed (Ibragimova and Guseva 2017). Furthermore, post-communist reforms resulted in a rise in neoconservative gender ideology that depreciated female labor and demanded women return to their "natural predestination" as wives and mothers (Sperling 2015, p.75; Stickley et al. 2008, p. 454). Thus, in 2014, despite the high level of education among Russian women (93.5% of women over 25 years-old had a secondary education), only 64.8% of the women were employed (OECD 2015). These changes resulted in the feminization of poverty, gender inequality (Silverman and Yanowitch 2000), and high rates of domestic violence against women (Johnson 2018). In more affluent families, husbands as sole breadwinners took control over monetary resources, while wives lost power in the household (Ibragimova and Guseva 2017).

Under this financial strain, surrogacy offers financial opportunities to young and healthy Russian mothers. Weighing the risk against the expected income, they opt for the precarious work of surrogacy to resolve their financial difficulties (Weis 2017). However, Russian surrogates experience significant social pressure. Because of the economic disparity between the SM and the intended parents, the latter control all aspects and stages of surrogate motherhood, from conception to delivery. Rivkin-Fish (2013) found that many of the intended parents keep the SMs within their own homes or in nearby dedicated apartments to monitor and control them. Moreover, surrogates are forced to leave their own children for the duration of the arrangement (Rivkin-Fish 2013). Russian surrogates often cloak themselves in silence over their work, fully aware that others might reject them on moral grounds. To manage their stigma, they may seek support from their counterparts in online discussion groups.

Online Social Support

When individuals practice a stigmatized occupation that threatens to ruin their reputations, they find it necessary to control, manage, and neutralize the stigma associated with their work (Goffman 1963; Thoits 2011; Zeligman et al. 2016). To reduce stigma and avoid discriminatory behavior, a stigmatized person is likely to search for others who share the same fate (Goffman 1963; Thoits 2011; Zeligman et al. 2016). In the modern era, online communities provide a sense of space, shared practice, shared resources and support, shared identities, and interpersonal relationships (Baym 2015) for stigmatized individuals. Computer-mediated communication provides a sense of immediacy through text and images rather than through physical proximity and non-verbal cues. As a result, members meet fellow sufferers, escape their isolation in the physical world, and offer one another support from similar others (DeAndrea 2015; Yeshua-Katz 2018; Zeligman et al. 2016).

Previous research suggests that online support groups offer advantages over other forms of support because they enable one to remain anonymous and overcome logistic obstacles (Wright and Bell 2003). Stigmatized individuals can reap the benefits of joining a group of similar "others": Feeling less isolated and less different, disclosing a secret part of their lives, sharing experiences, learning from those of others, and receiving empathy. Few studies so far have asked if SMs actually experience and internalize surrogacy stigma and have explored how these issues come to the fore in social media to which stigmatized individuals turn in the digital era. To address this gap, the current study employed content analysis of an online support forum for Russian SMs to explore the following research question: What types of stigma experiences are voiced and discussed by members of this online support forum?

Method

Data Collection

To assess the experiences of Russian-speaking SMs, as communicated online, we chose the Kangaroo Island site (https://www.ostrovkenguru.ru/board/)—a Russian-language discussion platform dedicated to fertility issues. Its motto is: "Pregnancy by the rules or not: For all will-be moms" ["Беременность по правилам и без. Мамами будут все!"]. As of January 1, 2018, the forum had over 8400 members, 55 sections (sub-forums), 6099 topics, and more than 1.5 million posts. Besides discussion boards, Kangaroo Island offers online professional consultations and message boards with surrogacy ads. We chose Kangaroo Island because it has an extensive "Donation and Surrogate Motherhood," all site contents can be accessed without website membership, and the website archives all its forums so that its data are explicitly public.

Before collecting data, we obtained Institutional Review Board approval to conduct the study that was exempt from further review because it relied on publicly accessible documents that do not require registration. Nevertheless, considering that "people may operate in public spaces but maintain strong perceptions or expectations of privacy" (Markham and Buchanan 2012, p. 6), we protected the identity of users in two ways. First, we changed users' nicknames. Second, all quotes cited here were translated from Russian to English by the first author, a native Russian speaker. Together this strategy helps prevent the expose of users' identities and correspondence.

Data Analysis

To identify the themes emerging from the online discussion group, we conducted an inductive thematic analysis (Braun and Clarke 2006; Pfeil and Zaphiris 2010) of the "Donation and Surrogate Motherhood" ["Донорство и суррогатное материнство"] section on the website. This section included 3082 threads and 222,369 posts (on 2.05.2018). A *thread* (sometimes called a *topic*) is a collection of posts, usually displayed from oldest to latest. A *post* is a user-submitted message. Posts are contained in threads, where they appear as blocks one after another. We excluded 2704 threads (8864 posts) that were about hiring or offering SMs services, resulting in a sample size of 213,505 posts. The first author, a native Russian speaker, read all 278 remaining threads online between May 2 and September 11, 2018. Of these, she exported 51 threads (15,602 posts) that expressed surrogate motherhood stigma. These posts were converted to MS Word and translated into English. Then, we imported these data set into Atlas Ti (qualitative analysis software).

To identify the specific themes presented in the online discussion group, we coded the ideas conveyed within each post by analyzing units—words, sentences or paragraph-long statements—that provided context for the ideas within each post (e.g., "the stigmatized characteristics the SMs possess," "identity of the stigmatizers," "motivations of stigma development"). In the beginning we concentrated on "stigma-type codes" describing the stigma's essence. Through discussion and comparison of the 16 codes generated, we narrowed down overlapping categories and agreed on four final stigma categories: bad mother, bad wife, pathetic loser, and greedy woman. For example, "a woman leaving her biological children for the sake of working as a SM" and "a woman giving away the child whom she gave birth to" turned into a "bad mother." Then both authors read them again and coded them together according to Mickelson and Williams' (2008) dual-pathway model of stigma, inquiring (a) whether the stigma experience described can be coded as internalization and acceptance of SM stereotypes and prejudice and (b) whether participants actually experienced overt behaviors of rejection and devaluation by stigmatizers.

During analysis, we employed two measures to enhance the study's credibility and trustworthiness (Golafshani 2003; Lincoln and Guba 1985). First, we discussed definitions of categories, as well as interpretations of their meaning. Second, we split the data in two halves so that each author worked on 25 threads, reading and rereading them in detail, and coded them for the presence of each stigma type and for the presence of stigma internalization or experience (0 = experience; 1 = internalization). Five threads (1632 posts) were randomly chosen as a control of Krippendorff's alpha (Hayes and Krippendorff 2007) to estimate inter-coder reliability and were examined by both authors (see Table 1 for reliability levels).

Results

Our analysis of the SM forum revealed four stigma types: (a) Bad mother, (b) bad wife, (c) pathetic loser, and (d) greedy woman. Table 1 displays coding definitions and examples for each theme. The forum included messages from actual SMs, SM candidates, and surrogacy clients (biological mothers) who discussed these four types of surrogacy stigma. The unit of analysis for what we report here is posts (i.e., statements within larger threads of initial posts and responses to each opening post).

Bad Mother

This stigma was mentioned clearly in 51 posts representing 10 threads and posted by 41 different forum users. At its core lay the belief that the experience of carrying someone else's child and subsequent separation from it destroys a woman both physically and mentally. According to this idea, motherhood begins with pregnancy; hence a woman who experiences fetal movements and the process of childbirth and still does not feel like the baby's mother is a defective mother:

> I talked with friends about one acquaintance: Her uterus had been removed and only a surrogate can carry a child for her. My friends unanimously said: "That's insane!! A decent woman cannot carry, give birth and then give a child away!" I said: "But it's not her baby and she knows in advance what she's getting into." They: "Well, genetically it's is not hers. But the baby has grown for nine months inside her. And what about the kicks?" I was about to say: "Look, there's an insane and inadequate woman in front of you," but I stopped myself. I imagined their faces if they knew that I had already been a surrogate. (Nyra83)

As the quote indicates, Nyra83 experiences surrogacy stigma when her friends argue that the absence of a genetic connection does not justify the SM's separation from the baby. She describes her own experience as former SM who handed the child to the biological parents "insane," claiming later that she will remain the child's mother forever.

Similarly, Luci is blamed by her mother for losing her ability to be a good mother to her own children as a result of her surrogacy experience:

Table 1 Overview of coding, definitions, and reliability

Themes	Definitions	Examples	Krippendorf's α	% Agreement	Posts *n*
Bad Mother	Surrogate mothers are women who violate the norms of motherhood because they give away "their own children"	"My mom said that I'm a child trafficker. Although she understands that the child is not mine, she believes that it's impossible to carry it and then give it away."	.88	93.3%	51
Bad Wife	By becoming a surrogate mother, a woman humiliates her husband	"First and foremost, it is at such moments that the SMs' husbands find it most difficult to give their consent. They fear condemnation by others for being healthy men who let their wives do 'that work' instead of working harder themselves."	.82	91.7%	36
Pathetic Loser	A surrogate mother earns money through indecent and physically revolting practices	"I don't think this is work. I don't consider this a morally acceptable job for myself, nor does being a prostitute. Forgive me, that turned out to be an ugly parallel. Therefore, I cannot understand the surrogate mothers themselves, but I fully imagine the grief and despair of those women who use the services of such 'incubators.'"	.84	91.3%	38
Greedy Woman	The surrogate mother is an immoral woman who receives disproportionately large sums of money for an easy job.	"Today, my mother said that a neighbor approached her and asked: 'So, Maria was going to give birth for a million?' Where do people get these numbers, I wonder?"	.85	91.6%	67

> My mother told me: "You were brainwashed in this clinic to lose your maternal instinct. You have given that child away and you do not love your own children now!" It's good that I don't take my mother seriously, but it's still horrible. (Luci)

Or, as the user we call Vera notes:

> I wanted to become a surrogate but did not dare tell my mother. When I finally told her, she said that cleaning restrooms is better than that. She called me a child trafficker. Although she understands that the child is not mine, she believes that it is impossible to carry it and then give it away.

It appears that in post-Soviet realities, surrogate mothers experience overt rejection, resulting in their symbolic exclusion from motherhood by other women—their mothers, girlfriends, and even female physicians: "I'm very upset when I hear words of reproach from doctors. Recently, one of them told me: 'As a doctor, I accept surrogacy, but as a woman, as a mother, I can never accept it!' ...It hurts" (Rimma). The doctor believes that a SM has the right be a reproduction vessel but refuses to accept her as a person.

In this context, it should be emphasized that only a few forum participants treated surrogacy as motherhood: "All the children I gave birth to are in my heart. I consider myself a mother of four children" (Limon). A majority of participants in the forum rejected the bad mother stigma, explaining that they did not consider themselves the mothers of the children they bore but view surrogacy as a kind of professional care work. As Poni writes: "I'm not a mother to a baby; I'm more like a nanny. I take care of it while it's inside my body, before it is time to give the child to his mom and dad." Similarly, Alla writes: "I love the princess in my belly, but this is different. There are no maternal feelings. This child already has loving parents who are waiting for her appearance. And I have my own children."

Regarding their own children, the participants rejected the bad mother stigma they experienced and positioned themselves as responsible and dedicated mothers. For example, Anya emphasized that "moving to the biological parents' home during pregnancy is only possible with my own children." Like some other SMs, she deemed participating in the surrogacy program as a maternal act: "I carry other people's children to provide a better life for my own kids."

Bad Wife

The second type of stigma, mentioned in 38 posts representing nine threads and 27 unique forum users, was the perception that by becoming an SM, the woman is a bad wife who humiliates her husband. Of the 38 forum participants discussing the bad wife stigma, 20 posted that participation in the surrogacy program may discredit their husbands, as Toni14 wrote:

> He agreed to start the process, but two weeks before the transfer, he suddenly said that he cannot accept my being pregnant with someone else's child. He did not want to hear about it either. He said I should choose either him or surrogacy! He is worried about being ashamed among his friends!

SMs not only experience the threat of stigma voiced by their husbands, as illustrated in the prior remarks, but also internalize it, as DOLL noted: "I'm more concerned about the way people might judge and offend him, asking how he could allow it!"

Moreover, in 31 of the posts in this category, the SMs write about the need to protect their husbands from a stigmatizing environment:

> I'm afraid to talk to my mother, scared of her judgment and of the risk that she will turn her back against me. But my primary concern is that my husband does not want us to tell her either. He is scared that she will berate him for allowing me to do it. (Mommy)

Because contracts force the SMs to abstain from sexual activity at least during the first trimester (while some clients require no sex throughout pregnancy), surrogate motherhood also means that SM's husband will have to suffer sexual abstinence: "My poor husband. How will he have sex with me? I'm already huge like a hippopotamus and he will know that there's someone else's baby inside..." (Seora).

The above quotes illustrate the SMs' deep concerns for their husbands' public and self-image as a result of their decision to become SMs. Some of these concerns are voiced and/or actually experienced by the husbands, but as the remarks quoted earlier illustrate, fear of gossip and blame by others and the associated internalization of the bad wife stigma are central components of the SMs' statements.

Pathetic Loser

This stigma, mentioned in 36 posts across 11 threads and from 24 different forum users, originates in the assertion that SMs chose to earn money through pathetic practices. For example, Lena revealed: "The physician at the clinic asked me: 'Is this how you earn a living?' It doesn't seem like much, but her tone was… I felt a little uncomfortable." The purported indecency of choosing to become an SM was also revealed in a post by a member nicknamed Chinese:

> Yesterday, I chatted with friends about the reasons behind my choice to become a surrogate mother. They asked me: "Is there absolutely no other way [for you]

> to make money? Do you have to breed like a cat?" It was so insulting, even though I do love cats.

User Tara32 echoed the same stigma: "My husband agreed to participate in the program but said proudly that he makes money with his hands, not like me, with 'that place.'"

The previous quotes highlight the actual experience of being criticized for choosing surrogacy as a source of income. The doctor's scorn of the immoral way to make money, the friends who literally compare the SM to a breeding animal, and a husband who belittles his wife's effort because it involves reproductive organs. In addition, as Sea indicates below, health professionals only justify surrogacy as a means of escaping a desperate financial crisis:

> I was very surprised when during the procedure the senior nurse (such a nice woman) looked at me with pity and asked: "Are you married?" "Yes," I answered. She: "Oh really? In our clinic all surrogates are unmarried! How many children do you have?" Me: "One." Nurse: "Our surrogates have two, some even three (children) and of course they need to feed them ..." I was amazed that even top health professionals consider surrogacy pitiful.

Along with the medical staff, even the clients of the SMs (i.e., the bio-mothers) devalue SMs as unreliable workers and reckless women, as Pellar (a bio-mother) writes:

> The surrogate must stay with us for the whole pregnancy period. I want to be absolutely sure that our SM doesn't drink and smoke and has a healthy lifestyle. I want to be sure that she won't, excuse me, fuck someone during this time, work in the garden, lift weights or walk back from the store with wet feet... And I want to control all this myself.

This bio-mother describes the SM as an object in need of constant control and surveillance to protect the entrusted fetus. Contesting this stigma, the participants emphasized that although money is an important incentive, the true motive for their participation in the program is the enjoyment of the "work process"—they like carrying a child and realize the exceptional importance of what they do. Hence, the forum's participants experience the stigma of choosing a dirty job but refuse to internalize the stigma they bear.

Greedy Woman

Finally, 67 posts, representing 14 threads and 439 unique forum users, maintain that the SM is a greedy woman who receives disproportionately large sums of money for an easy job. Most such stigmatizers were relatives of SMs. According to DOLL:

> One day, my brother-in-law called me to discuss business. All of a sudden, he burst out with anger and jealousy, claiming that I was already in good financial shape, but now I also "hit the jackpot." His cynicism killed me. I hung up and haven't talked to him since then.

Similarly, Laura wrote:

> After the divorce, my ex-husband paid me alimony through the courts. When I gave birth as a SM, he stopped paying alimony for our child and said: "You are rich now. Alimony is worth pennies for you and I will not pay for the child any longer."

As the prior quotes demonstrate, the income from surrogacy leads to overt expressions of jealousy and contempt, and some SMs experience actual negative results like losing child support. Surrogates are perceived as receiving large sums of money undeservedly. In case of Helga Lass, her discrediting as SM led to the following demands by family members:

> My mother and sister look at my belly with contempt. They never ask about my health, about my pregnancy, whether it's a boy or a girl. Their attitude hurts me so much. They hinted that if I shared the money, our relationship will improve.

Or, as Kate divulged:

> My sister-in-law (I still love her) said that if I gave birth for free, that would be all right. But if I take money for it, then I'm ... it begins with the letter "s" [slut] ... well, in short, a bad girl.

Greedy woman stereotypes may also serve customers' interests and are often advanced by some bio-mothers, such as Luna:

> Dear surrogate mommies! It is clear that you are practicing "motherhood" for money. Aren't you touched by the tears and problems of those you call BIO [biological donors]? You can always play with feelings of people who trust you. And your skyrocketing fees? Now, who of you surrogates would lower her fees so that my child can be born?

Toledo, another bio-mother, claimed:

> We spend a lot of money. It doesn't come easy to us. We sell our cars and take out loans to afford having a baby carried for us. For you, if there is a miscarriage, it is only money unearned and a little hormonal stress, but for bio-parents, it's a tragedy.

As the previous quotes demonstrate, the SM is perceived as greedy and heartless. Unlike the bio-mother, she is lucky to be able to carry and give birth to a baby, but she profits nevertheless from the grief and despair of infertile women. When the SM does not offer her services for free or even reduce her fees, she is blamed for being selfish, greedy, and inhuman.

Forum participants rejected this stigma. Cram, for example, justified the financial cost as the result of a difficult financial situation: "Not all surrogates are materialistic, greedy and rapacious. If the state provided the surrogate's family with housing as remuneration for the baby, I would give birth free of charge. We need a home, so this is a desperate measure." Others claimed that the fee is relatively low: "The fee divided by nine months is the salary of a good accountant" (Solia) or "On average, it's the cost of a midsized imported car" (Dunett).

SM forum users also tried to fight the greedy woman stigma they experienced by extending the discussion beyond the cost/benefit approach. For example, Sea writes:

> I believe that this is an act of mutual assistance: I needed money and the BIO [biological donors] needed help in carrying a child. We help each other and that's fine. I need this money to provide my children with better living conditions... You can't get far with plain altruism, but I'm convinced that all the surrogates want to help. In the end, when everything turns out fine and everyone is happy, surrogates feel it too.

Sea refutes overt rejection and criticism, framing surrogacy as mutual assistance rather than mutual exploitation. Accordingly, the SMs' desire to help childless couples is strong and sincere, as also is her need to earn money.

Discussion

In the present study we examined expressions of perceived surrogacy stigma posted in Russian-language support forums using the dual-pathway model (Mickelson and Williams 2008; Mickelson et al. 2017). Our findings reveal that the women's choice to become SMs initiated a social process in which SMs are singled out and labeled differently and their choice of livelihood is associated with four negative attributes: bad mother, bad wife, pathetic loser, and greedy woman. These four types of stigma, as actually experienced and discussed by participating SMs, constitute overt prejudice and judgment encountered in one's close environment. The members of SMs' social networks are often direct and harsh in using these labels to devalue and reject them. On experiencing such overt stigma, SMs respond by actively combatting these labels in the designated online discussion forum.

Of the four types of stigmas, bad wife is the only one that is not only experienced but also internalized—involving expressions of negative feelings such as embarrassment or shame concerning their own husbands' public image. Women's comments point at a heavy emotional load that this kind of stigmatization causes them on a daily basis. By placing these findings in the context of Mickelson and Williams' (2008) model, it is quite possible that most stigmatized SMs experience depression, especially if they lack social support. Moreover, those termed "bad wife" may also develop low self-esteem and self-efficacy as a result of internalizing their stigma. Further research is needed to explore these possibilities.

The four types of stigma found in our study adversely affect the SMs' social role in two spheres: the traditional family and the career and finance realm. Bad mother and bad wife labels place surrogacy stigma in the context of traditional family roles: According to this view, surrogacy *is* motherhood, but of a dysfunctional and immoral variety because the SM is impregnated by a man who is not her husband and gives the baby away (similar findings were reported by Pande 2010). In line with Goffman's (1963) concept of stigma, the SM's role damages a woman's identity: She loses her legitimacy to function as a biological mother to her own children. In this sense, bad mother entails loss of femininity because womanhood is strongly associated with motherhood in the Russian culture. The bad mother label perpetuates the SM stigma, leading to the disdain, "othering," and social isolation of SMs. The SMs' own mothers may even convey such attitudes to female health professionals.

Similarly, the bad wife label leads to isolation of SMs because it deprives them of their husbands' support. Because the backbone of post-Soviet masculine identity is paid work (Ashwin and Isupova 2018), the bad wife stigma portrays SMs' husbands as unable to provide for their wives within their traditional breadwinner role, thereby likely compromising the husbands' good name, social status, and very manhood. Again, further research is needed to examine these possible connections.

The pathetic loser label places surrogacy at the bottom of the occupation pyramid: Surrogacy is labeled as totally unprofessional and self-destructive work. It is considered "dirty work," an indicator of moral and social failure, a job that is "physically, socially and morally tainted which threatens to 'spoil their identity'"—a situation encountered by exotic dancers and prostitutes as well (Hughes 1959, p. 122). Instead of holding a job that requires professional knowledge and skills, SMs purportedly generate income by commercializing their reproductive organs. Hence, surrogacy is perceived as failure to have a "normal," respectable job. By choosing a pitiful source of income, the SM is dehumanized and compared to a "breeding cat."

Conceptualization of surrogacy as "dirty work," as proposed by Pande (2009), was not corroborated by empirical evidence in her own study: Indian surrogates rejected their status as contract laborers, employing discourse that

minimized this role and identity. Our findings suggest that such framing is more relevant for Russian surrogates. Unlike Western and Asian SMs, post-Soviet forum participants construe surrogacy as paid work that may be not highly respected but carries an important social function. Similar findings were described by Weis (2017) who interviewed surrogates in St. Petersburg. Her results showed that surrogacy in Russia is culturally framed and socially organized as an economic exchange, demonstrating how such framing induces SMs to perceive surrogacy as gainful employment.

The greedy woman label, relating to the ostensibly indecent and rapid monetization of the tragedy of infertile women, is attached to SMs by both their relatives and the bio-mothers who pay for their services. They consider the SMs' reward too high relative to the risks and efforts involved and both claim their right to benefit from it: Bio-mothers may try to reduce the prices, and relatives of SMs may expect the income to be shared with them. This finding highlights the way stigma enables control of women's bodies and challenges the source of their income. Those who deploy this stigma claim that profits from commercial surrogacy should not belong to the SM alone, but to her entire clan or community.

Our findings highlight surrogacy as an example of the ways in which modern technology challenges social norms of motherhood, women's bodies, family roles, and paid work. They also show how post-Soviet society reacts to this challenge by imposing blame and stigma on SMs, emphasizing the cultural context within which reproductive technologies are practiced. Russian society responded to the introduction of the new global surrogacy practice as it did to the debuts of other new technologies, always placing it within local contexts. As anthropologist Arjun Appadurai (1996) reminds us, the movement of technologies around the globe is a deeply historical yet inherently localizing process: Technologies are not implemented uniformly around the world, nor are their effects simply "Westernizing" or "colonizing" in nature. New technologies are appropriated by people throughout the world, and global technologies—reproductive in this case—are always imbued with local meaning.

Surrogacy and the technology that enables it are intertwined with two local post-Soviet social ideologies—patriarchy and capitalism—whereby accumulation of capital perpetuates gender oppression (Arruzza 2014). Patriarchy is deeply rooted in the Russian culture. Justified by myths and stereotypes, it widens its reach through structural and symbolic violence so that inequalities appear natural and even unavoidable. Capitalism's development on the ruins of post-Soviet society strengthened patriarchal gender ideology. The women in our study had to fill the void left by elimination of the Soviet-era working mother contract. Moreover, women's opportunities in the Russian labor market are limited: Male-dominated occupations are better paid and considered more prestigious than jobs primarily held by women, thus legitimizing gender division and inequality in employment and naturalizing gendered power structures.

In this context, healthy young women participate in new forms of reproductive labor to escape financial hardships resulting from the shift to a capitalist economy. Under conditions in which their productive labor is discounted and underpaid, they switch to reproductive labor. This shift also enables those who wish to become mothers to acquire surrogate reproductive services; nevertheless, although the purchase of reproductive services by biological parents may slowly become accepted by society, the women who provide these services may continue to face negative social consequences.

Limitations and Future Research Directions

Our study has several limitations. First, it examined only the types of stigma discussed in the online forum, that is, only those that concerned SM forum participants, without determining their prevalence and that of other possible stigmas prevailing in Russian society as a whole. Second, our study explores neither forum members' experience in coping with stigma nor their interactions in attempting to manage it. Moreover, we examined mediated expressions of stigma experiences but did not determine what motivated members to join the forum and post such expressions online.

Future studies should observe interactions among forum members and examine the manner in which computer-mediated communication enables exchange of social support types and use of online stigma coping strategies (Yeshua-Katz 2018). Furthermore, we recommend asking forum members about their motivations for using it and the benefits derived from it.

Practice Implications

Our findings indicate the importance of informing health professionals working with this group of women that stigma poses a potential threat to SMs' mental health. Because the offline support network fails to provide the necessary support for SMs, the more effective strategy of coping with the stigma would be to provide them with face-to-face and online support groups that create a safe space to negotiate their new identity.

Information about communication strategies and SMs' personal experiences with stigma may be useful not only for health professionals, psychologists, and social or community workers, but also for journalists, attorneys, politicians, and scholars who address reproductive technologies. Understandings of the logic and essence of perceived stigma may help professionals develop a more nuanced and accurate approach for psychological and social care and may lead to increased accuracy in media, law, and political representation of this vulnerable group. Moreover, understanding the cultural origin and socioeconomic foundations of such stigmas may help feminist activists construct stigma-free surrogacy discourse.

In this respect, it is important to note that many scholars believe knowledge plays a significant role in reducing stigma. Thornicroft (2006) offers the model of the three social-psychological aspects of stigma—knowledge, attitudes, and behavior—while Pande (2009) suggests that providing correct information about the procedure—that the SM has not had sexual relations with the bio-father, nor is she genetically related to the baby in any way—may reduce surrogacy stigma. Our findings contradict this assumption: Analysis reveals that the SMs discussed the difficulties of explaining and coping with negative attitudes expressed by those whom they considered "informed" individuals—their family and friends, reproductive clinic staff members, and the babies' biological parents. Hence, we conclude that informing the public about surrogate motherhood may not reduce the stigma attached to it. Similar results were found concerning the stigma of mental illness: An increase in popular knowledge does not necessarily improve attitudes or behavior toward people with mental disorders (Pescosolido 2013; Stuart 2016; Thornicroft et al. 2007).

Conclusion

Although Russian surrogates voluntary and willingly sell their reproductive labor (Weis 2017), our findings—similar to Twine's (2015) analysis of surrogacy as a situation parallel to prostitution and slavery—show that Russian surrogacy stigma is an instrument of patriarchal and capitalistic oppression. Women become SMs within a stratified system of gender and class inequalities, within which market forces constrain women's choices. By gaining a deeper insight and studying surrogate mothers' descriptions of their experiences with stigmatization, we should enhance our efforts at helping those who struggle with this uncomfortable social situation.

Compliance with ethical standards

Conflict of Interest The authors declare that they have no conflict of interest.

References

Abrams, P. (2015). The bad mother: Stigma, abortion and surrogacy. *Journal of Law, Medicine & Ethics, 43*(2), 179–191. https://doi.org/10.1111/jlme.12231.

Ahmed, S. (2010). Killing joy: Feminism and the history of happiness. *Signs: Journal of Women in Culture and Society, 35*(3), 571–594. https://doi.org/10.1086/648513.

Appadurai, A. (1996). *Modernity al large: Cultural dimensions of globalization* (Vol. 1). Minneapolis: University of Minnesota Press.

Arruzza, C. (2014). *The capitalism of affects.* Retrieved on December 4, 2019 from http://publicseminar.org/2014/08/the-capitalism-of-affects/.

Arvidsson, A., Vauquline, P., Johnsdotter, S., & Essén, B. (2017). Surrogate mother –praiseworthy or stigmatized: A qualitative study on perceptions of surrogacy in Assam, India. *Global Health Action, 10*(1), 1–10. https://doi.org/10.1080/16549716.2017.1328890.

Ashwin, S., & Isupova, O. (2018). Anatomy of a stalled revolution: Processes of reproduction and change in Russian Women's gender ideologies. *Gender & Society, 32*(4), 441–468. https://doi.org/10.1177/0891243218776309.

Bailey, A. (2011). Reconceiving surrogacy: Toward a reproductive justice account of Indian surrogacy. *Hypatia, 26*(4), 715–741. https://doi.org/10.1111/j.1527-2001.2011.01168.x.

Baym, N. K. (2015). Social media and the struggle for society. *Social Media & Society, 1*(1), 1–2. https://doi.org/10.1177/2056305115580477.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self–stigma of mental illness: Implications for self–esteem and self–efficacy. *Journal of Social and Clinical Psychology, 25*(8), 875–884. https://doi.org/10.1521/jscp.2006.25.8.875.

DeAndrea, D. C. (2015). Testing the proclaimed affordances of online support groups in a nationally representative sample of adults seeking mental health assistance. *Journal of Health Communication, 20*(2), 147–156. https://doi.org/10.1080/10810730.2014.914606.

Franklin, S. (2013). *Biological relatives: IVF, stem cells and the future of kinship.* Durham, NC: Duke University Press. Retrieved from http://www.oapen.org/record/469257.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Touchstone (Simon & Schuster).

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597–606 https://nsuworks.nova.edu/tqr/vol8/iss4/6.

Hayes, A. F., & Krippendorff, K. (2007). Answering the call for a standard reliability measure for coding data. *Communication Methods and Measures, 1*(1), 77–89. https://doi.org/10.1080/19312450709336664.

Hughes, E. C. (1959). *Men and their work.* Glencoe: Free Press.

Ibragimova, D., & Guseva, A. (2017). Who is in charge of family finances in the Russian two-earner households? *Journal of Family Issues, 38*(17), 2425–2448. https://doi.org/10.1177/0192513X15623588.

Johnson, J. E. (2018). *The gender of informal politics: Russia, Iceland and twenty-first century male dominance.* Cham, CH: Palgrave Macmillan. https://doi.org/10.1007/978-3-319-60279-0

Karandikar, S., Gezinski, L. B., Carter, J. R., & Kaloga, M. (2014). Economic necessity or noble cause? A qualitative study exploring motivations for gestational surrogacy in Gujarat, India. *Affilia, 29*(2), 224–236. https://doi.org/10.1177/0886109913516455.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* London: Sage.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363.

Link, B. G., & Phelan, J. C. (2014). Stigma power. *Social Science & Medicine, 103*, 24–32. https://doi.org/10.1016/J.SOCSCIMED.2013.07.035.

Markham, A., & Buchanan, E. (2012). *Ethical decision-making and internet research recommendations from the AoIR ethics working committee. Recommendations from the AoIR ethics working committee* (Version 2.0). Retrieved from http://www.aoir.org.

Mickelson, K. D., Biehle, S. N., Chong, A., & Gordon, A. (2017). Perceived stigma of postpartum depression symptoms in low-risk first-time parents: Gender differences in a dual-pathway model. *Sex Roles, 76*(5–6), 306–318. https://doi.org/10.1007/s11199-016-0603-4.

Mickelson, K. D., & Williams, S. L. (2008). Perceived stigma of poverty and depression: Examination of interpersonal and intrapersonal mediators. *Journal of Social and Clinical Psychology, 27*(9), 903–930. https://doi.org/10.1521/jscp.2008.27.9.903.

Miller, C. T. (2005). Social psychological perspectives on coping with stressors related to stigma. In S. Levin & C. Van Laar (Eds.), *Stigma and group inequality: Social psychological perspectives* (pp. 21–44). Mahwah: Lawrence Erlbaum Associates. https://doi.org/10.4324/9781410617057.

Munjal-Shankar, D. (2014). Identifying the "real mother" in commercial surrogacy in India. *Gender, Technology and Development, 18*(3), 387–405. https://doi.org/10.1177/0971852414544009.

OECD. (2015). *Education at a glance 2015: OECD indicators*. https://doi.org/10.1787/eag-2015-en

Pande, A. (2009). Not an 'angel', not a 'whore': Surrogates as 'dirty' workers in India. *Indian Journal of Gender Studies, 16*(2), 141–173. https://doi.org/10.1177/097152150901600201.

Pande, A. (2010). "At least I am not sleeping with anyone": Resisting the stigma of commercial surrogacy in India. *Feminist Studies, 36*(2), 292–312. Retrieved from https://www.claradoc.gpa.free.fr/doc/420.pdf.

Pande, A. (2014). *Wombs in labor: Transnational commercial surrogacy in India*. New York: Columbia University Press.

Pescosolido, B. A. (2013). The public stigma of mental illness what do we think; what do we know; what can we prove? *Journal of Health and Social Behavior, 54*(1), 1–21.

Pescosolido, B. A., & Martin, J. K. (2015). The stigma complex. *Annual Review of Sociology, 41*(1), 87–116. https://doi.org/10.1177/2F0022146512471197.

Pfeil, U., & Zaphiris, P. (2010). Applying qualitative content analysis to study online support communities. *Universal Access in the Information Society, 9*(1), 1–16. https://doi.org/10.1007/s10209-009-0154-3.

Poote, A. E., & van den Akker, O. B. (2009). British women's attitudes to surrogacy. *Human Reproduction, 24*(1), 139–145. https://doi.org/10.1093/humrep/den338.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*(4), 634–651.

Rahmani, A., Sattarzadeh, N., Gholizadeh, L., Sheikhalipour, Z., Allahbakhshian, A., & Hassankhani, H. (2011). Gestational surrogacy: Viewpoint of Iranian infertile women. *Journal of Human Reproductive Sciences, 4*(3), 138–142. https://doi.org/10.4103/0974-1208.92288.

Rivkin-Fish, M. (2013). Conceptualizing feminist strategies for Russian reproductive politics: Abortion, surrogate motherhood, and family support after socialism. *Signs: Journal of Women in Culture and Society, 38*(3), 569–593. https://doi.org/10.1086/668606.

Sawyer, P. J., Major, B., Casad, B. J., Townsend, S. S. M., & Mendes, W. B. (2012). Discrimination and the stress response: Psychological and physiological consequences of anticipating prejudice in interethnic interactions. *American Journal of Public Health, 102*(5), 1020–1026. https://doi.org/10.2105/AJPH.2011.300620.

Silverman, B., & Yanowitch, M. (2000). New rich, new poor, new Russia: Winners and losers on the Russian road to capitalism. *New York: Routledge.* https://doi.org/10.4324/9781315500812.

Sperling, V. (2015). *Sex, politics & Putin: Political legitimacy in Russia*. Oxford: Oxford University Press.

Stickley, A., Kislitsyna, O., Timofeeva, I., & Vågerö, D. (2008). Attitudes toward intimate partner violence against women in Moscow, Russia. *Journal of Family Violence, 23*(6), 447–456. https://doi.org/10.1007/s10896-008-9170-y.

Stuart, H. (2016). Reducing the stigma of mental illness. *Global Mental Health, 3*, e17. https://doi.org/10.1017/gmh.2016.11.

Svitnev, K. (2016). Gestational surrogacy in the Russian Federation. In E. S. Sills (Ed.), *Handbook of gestational surrogacy: International clinical practice and policy issues* (pp. 232–240). Cambridge: Cambridge University Press.

Teman, E., & Berend, Z. (2018). Surrogate non-motherhood: Israeli and US surrogates speak about kinship and parenthood. *Anthropology & Medicine, 25*(3), 296–310. https://doi.org/10.1080/13648470.2017.1401825.

Temkina, A., & Zdravomyslova, E. (2003). Gender studies in post-soviet society: Western frames and cultural differences. *Studies in East European Thought, 55*(1), 51–61. https://doi.org/10.1023/A:1021857831011.

Thoits, P. A. (2011). Resisting the stigma of mental illness. *Social Psychology Quarterly, 74*(1), 6–28. https://doi.org/10.1177/0190272511398019.

Thornicroft, G. (2006). From stigma to ignorance, prejudice. In G. Thornicroft (Ed.), *Shunned: Discrimination against people with mental illness* (Vol. 399, pp. 170–204). New York: Oxford University Press. https://doi.org/10.1093/med/9780198570981.001.0001.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *British Journal of Psychiatry, 190*(3), 192–193. https://doi.org/10.1192/bjp.bp.106.025791.

Tong, R. (2018). *Feminist approaches to bioethics*. New York: Routledge. https://doi.org/10.4324/9780429500503.

Twine, F. W. (2015). *Outsourcing the womb*. New York: Routledge. https://doi.org/10.4324/9781315720128.

Unnithan, M. (2013). Thinking through surrogacy legislation in India: Reflections on relational consent and the rights of infertile women. *Journal of Legal Anthropology, 1*(3), 287–313.

van den Akker, O. B. A. (2017). *Surrogate motherhood families*. Basingstoke: Palgrave Macmillan. https://doi.org/10.1007/978-3-319-60453-4.

Weis, C. C. (2017). *Reproductive migrations: Surrogacy workers and stratified reproduction in St. Petersburg* (doctoral dissertation). De Montfort University, Leicester. https://www.dora.dmu.ac.uk/handle/2086/15036.

Wright, K. B., & Bell, S. B. (2003). Health-related support groups on the internet: Linking empirical findings to social support and computer-mediated communication theory. *Journal of Health Psychology, 8*(1), 39–54. https://doi.org/10.1177/1359105303008001429.

Yeshua-Katz, D. (2018). Childless in an IVF-nation: Online stigma-coping strategies in support groups for childless Israeli women. *Information Communication & Society, 21*(10), 1436–1452. https://doi.org/10.1080/1369118X.2017.1324504.

Zeligman, M., Barden, S. M., & Hagedorn, W. B. (2016). Posttraumatic growth and HIV: A study on associations of stigma and social support. *Journal of Counseling & Development, 94*(2), 141–149. https://doi.org/10.1002/jcad.12071.

Zhurzhenko, T. (2001). Free market ideology and new women's identities in post-socialist Ukraine. *European Journal of Women's Studies, 8*(1), 29–49. https://doi.org/10.1177/135050680100800103.