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Pushing for the perfect time: Social and biological fertility☆

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ABSTRACT

This study explores how women consider embodied knowledge about their "biological clocks" alongside personal and professional goals as they make decisions about whether, when, and how to have children in the future. Based on 71 in-depth interviews with childless women between the ages of 25 and 40, the author proposes a holistic understanding of fertility inclusive of the biological limitations of the body as well as sociocultural factors including access to family leave, childcare, finances, housing, employment, and relationship status. By expanding our understanding of fertility to include the social, we can better understand why women considering having children advocate for social structural changes just as much as—if not more than—increased access to reproductive technologies.

Introduction

Deciding whether, when, and how to have a child is an embodied process involving calculations about one's ability and desire to conceive, gestate, birth, and raise a child (Lampi, 2011; Sassler, Miller, & Favinger, 2008). Reproductive decision-making involves assessments about educational, career, relationship, and financial goals (Gerson, 1985; Hewlett, 2003; Wyndham, Figueira, & Patrizio, 2012). It also involves evaluations of biomedical information and assumptions about one's body, the impact of aging on fertility, and the effectiveness of reproductive technologies (Boivin, Bunting, & Gameiro, 2013; Hvidman et al., 2015).

How women make these calculations—given advances in assisted reproductive technologies that enable conception and pregnancy, even among those with compromised fertility—is an underexplored process. This paper, based on 71 semi-structured interviews with childless women, explores how women consider embodied knowledge and structural constraints as they make decisions about future childbearing. By "embodied knowledge," I refer to the signs, information, and intuitions individuals perceive from their own bodies. As Brigitte Jordan describes in her study of childbirth, a laboring woman has knowledge from "what her body tells her, what she knows (and displays) by virtue of her bodily experience" that frequently competes with procedural, expert, or technology-derived knowledge (Jordan & Davis-Floyd, 1993:152). For the women in this study, perceived biological timelines must be reconciled with social structural conditions including access to family leave, childcare, finances, housing, employment, and relationship status. Because the "ability" to conceive, bear, and raise a child is not purely biological but also hinges upon the social environment, a holistic understanding of fertility is required that goes beyond the physical body. In vitro fertilization (IVF), third-party egg transfer, and egg freezing may extend the period of time in which one is capable of conceiving and birthing a child, but such manipulations of the body fail to address social factors contributing to delayed childbearing. By expanding our concept of fertility to include the social, we can better advocate for the social and cultural changes that would help women achieve their personal, professional, and familial goals.

I describe how women who are even minimally aware of age-related fertility decline view their ability to conceive a biological child as finite, even if a precise "deadline" is obscure or unknown. This is evident in their articulations of a "biological clock," a "magical age" of 35, and discussions of a closing window of time in which conception is possible without medical intervention. Childless women's self-perceptions and desires about their own future childbearing demands a *biosocial* approach to fertility that recognizes the interaction between biological functions and social environment (Jordan & Davis-Floyd, 1993; Rabinow, 1996). *Biological* fertility—the physical ability to conceive and carry a child to full term—is distinct from *social* fertility—the ideal social arrangements that enable a woman to be supported in childbearing and childrearing. Below, I describe how women reconcile competing deadlines and timelines as they contemplate whether or not to have children in the context of their aging bodies and declining fertility, and analyze to what extent women want medical interventions that can enhance their ability to conceive. While the bodily manipulations offered by reproductive medicine may give individual women more time to contemplate their family-building decisions, they ultimately reshape normative standards regarding the timing of reproduction.

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Extending women's fertility through technology may be one solution to resolving conflicting timelines, but does not eliminate structural and personal barriers to autonomy in childbearing and parenthood.

Background

This paper represents one aspect of a larger project on the reproductive decision-making of childless women. For this analysis, I draw on two strands of literature: (1) research on changes in the family as it pertains to delayed childbearing and work-family balance; and (2) sociological and anthropological insights on medicalization of infertility. Literature regarding "diverging destinies" contrasts the childbearing patterns of poor and less educated women with those of middle-class women (Martin, 2000; McLanahan, 2004). Within the United States, researchers find trends of nonmarital birth at earlier ages for women with less than a bachelor's degree (Cherlin, Ribar, & Yasutake, 2016; Edin & Kefalas, 2005), and delayed marriage and childbearing for educated and middle-class women (Balasch & Gratacós, 2011; Matthews & Hamilton, 2014; Weeden, Abrams, Green, & Sabini, 2006). For the latter, a mismatch exists between social expectations for women's educational, career, and relationship goals and the biological realities of fertility (Brand & Davis, 2011; Brewster & Rindfuss, 2000; Wu & MacNeill, 2002). The mean age at first birth in the United States is 26.3, an increase of almost five years since 1970, reflecting the growing number of women postponing their first births past the age of 35, and a declining birth rate for women under 25 (Martin, Hamilton, & Osterman, 2014; Matthews & Hamilton, 2014).

Sociological and economic literature on work-family balance as it relates to fertility intentions and behavior reveals difficulties individuals face in balancing desired family outcomes with educational and career goals (Baker, 2010; Bass, 2015; Gerson, 1985; Shreffler, Pierretti, & Drago, 2010). The drive to achieve status and identity through intensive parenting may also contribute to delayed childbearing, making the cultural requirements of modern parenting appear particularly high or out of reach (Bianchi, 2011; Hays, 1996). Women who do not have children may organize their personal and professional lives depending on whether or not they plan to have children in the future (Bass, 2015; Gerson, 1985).

For women in the United States, social and employer policies can exacerbate work-life conflicts, and may even affect those who do not yet have children, especially by those who anticipate difficulties balancing work with family. The United States is the only country in the Organisation for Economic Co-operation and Development (OECD), for example, that does not offer any form of universal paid maternity or paternity leave (OECD Social Policy Division, 2016). According to the U.S. Department of Labor (2015), only 12% of Americans working in the private sector have paid family leave benefits, and those earning the lowest wages have the least access to paid time off related to family care (Bureau of Labor Statistics, 2014). Although statewide and municipal policies vary, the United States also lacks universal and national policies for sick leave, subsidized childcare, or vacation time, all of which contribute to increased pressure on working parents. Lack of policies supportive of raising a child may influence individuals' occupational choice (insofar as selecting employers based on benefits in anticipation of future childbearing) and family planning decisions.

Perceptions of one's biological capacity may also impact reproductive decision-making. Medical sociologists and anthropologists note how infertility, once a private social problem, has become medicalized and subject to medical treatment (Friese, Becker, & Nachtigall, 2006; Greil, McQuillan, & Slauson-Blevins, 2011). Survey- and interview-based studies identify varying amounts of awareness by women and men regarding age-related fertility decline and treatment. Men and women display significant knowledge gaps about age-related fertility decline and factors influencing fertility (Hammarberg et al., 2013). One survey of 3000 childless women finds that even though over 90% were aware of age-related fertility decline, they were far less knowledgeable about the costs and effectiveness of fertility treatments (Daniluk, Koert, & Cheung, 2012).

In a prior study of "anticipated infertility," I analyzed how discourse about egg freezing by clinicians and journalists transforms technology into a medical solution for future infertility for women undergoing cancer treatments as well as for those who delay pregnancy for nonmedical reasons (Martin, 2010). However, an interview-based study with childless women reveals that childbearing decisions are less affected by awareness of age-related fertility decline than they are by social and economic factors (Lavender, Logan, Cooke, Lavender, & Mills, 2015). Furthermore, even when women experience difficulty conceiving, they do not always identify as "infertile" since clinical definitions may not correspond with self-conceptions (Bell, 2014; Johnson & Fledderjohann, 2012). Women make assumptions about their bodies and the ease or difficulty of conceiving based on their age, prior pregnancies, mothers' childbearing history, or length of menstrual periods. In this study, I find two distinct ways that childless women describe their potential abilities to have children: socially and biologically. Rather than merely anticipating a clinically based diagnosis of "infertility"—privileging their body's capacity to conceive and bear a biological child—childless women incorporate a culturally normative understanding of what circumstances would be adequate for conception, pregnancy, and raising children.

Methods and sampling

This is a qualitative study approved by the Penn State University Institutional Review Board. Between 2012 and 2014, I conducted 71 in-depth, semi-structured interviews in person, by phone, and on Skype, with childless women between the ages of 25 and 40 in the United States. I asked participants about reproductive intentions, awareness and attitudes regarding assisted reproductive technologies (ARTs), and questions about relationship status, education, and career. Each interview lasted approximately 1 h, and was audio recorded with the permission of the participants. Interviews were professionally transcribed, and then I thematically and inductively coded and analyzed transcripts using Atlas.ti. All names that appear in this paper have been changed.

Bell (2014) has noted the homogeneity of women—primarily white, affluent, and heterosexual—included in most fertility studies, since participants are frequently recruited from populations seeking medical treatment for infertility. Because I did not want the sample to comprise only help-seeking women who were actively attempting to conceive, or who necessarily want to have children at all, I did not recruit through fertility clinics or Internet message boards. I initially recruited by word of mouth through my own social networks, and from there used chain referral sampling to recruit participants who met the criteria for age and childlessness status, working from the assumption that childless women in the 25–40 year age range would likely know other similarly-aged childless women (Biernacki & Waldorf, 1981). Participants spread the word among their own networks, and individuals interested in taking part in the study then contacted me by email. Only if they met the criteria were they invited to take part in the study. To compensate for the limitation of a small nonprobability sample, I aimed to include a geographically dispersed sample that was diverse in terms of race/ethnicity, age, relationship status, and sexual orientation. I recruited and conducted interviews until both a diverse sample and data saturation had been achieved (Morse, 1995) (Table 1).

While there is diversity of age, race, sexual orientation, relationship status, and geography in the sample, there is an overrepresentation of highly educated women. This is a consequence of the sampling method, but it is also reflective of the "diverging destinies" trajectory of postponed childbearing among educated and professional women (McLanahan, 2004; Mills, Rindfuss, McDonald, & te Velde, 2011). A study by the Pew Research Center finds that the average age of first birth for U.S. women with at least a master's degree was over 30, with a significant portion (20%) having their first child over the age of 35