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“I felt so untrustworthy of my ability to get pregnant”: Women’s Embodied Uncertainties and Decisions to Become Pregnant

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ABSTRACT

This paper identifies "embodied uncertainties"—possibilities of aging and infertility lodged within the body—as informing women's conceptualizations of their reproductive bodies and their decisions about and approaches to getting pregnant. Using data from semi-structured interviews with a small sample of highly educated, professional, white women who had given birth within 18 months prior, this paper argues that (bio)medicalized risk discourses and neoliberal logics of responsible choice-making lodge uncertainty and the possibility of failure within women's reproductive bodies. As they attempt to reconcile childbearing with professional and financial constraints, women may identify their bodies as laden with embodied uncertainties and may subsequently adopt strategies for becoming pregnant that seek to mitigate those embodied uncertainties, such as by trying to conceive before feeling completely ready for a pregnancy. Ultimately, (bio)medicalization and neoliberalism have transformed reproductive aging and infertility into individualized concerns and foreclosed recognition of the institutional failures that create conflicts of aging, careers, and childbearing in women's lives.

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INTRODUCTION

The medicalization of reproductive aging and infertility has produced not only a proliferation of reproductive technologies that promise to remedy fertility difficulties, but also risk discourses surrounding the maternal body. In both medical discourses and popular culture, messaging intended to warn women about "the biological clock" and aging-related fertility decline exerts pressure on women to have children before reaching older age. In this context, aging is one of several factors that contributes to the *possibility* of infertility, women are called upon to locate themselves within a matrix of reproductive risk factors, and fertility difficulties stand ready for treatment by a barrage of medical professionals and specialized treatments. Encouraged to become managers of their reproductive bodies, women are left to overcome the challenges of merging childbearing, education, and work as individuals.

At an individual level, women have coopted the language of medicalized reproductive aging and infertility and, as I explore in this paper, extended medicalized discourses of reproductive aging and infertility into anticipatory states as they attempt to reconcile childbearing with other goals and uncertainties. While making decisions about whether, when, and how to become pregnant, women may identify aging and infertility as *embodied uncertainties* and subsequently make decisions that seek to mitigate those embodied uncertainties. For example, in response to pressures to produce children before the onset of aging-related fertility decline, some women seeking to combat the possibility of infertility are turning to medical interventions such as egg freezing (van de Wiel 2015). However, as the current study demonstrates, embodied uncertainties (1) include but are not restricted to aging-related fertility decline and (2) call upon women to make uncertainty-mitigating decisions that include but are often far subtler than interventions with medical technologies. Whether based on

past experiences with or the possibility of fertility difficulty, uncertainty and anticipation infuse women's experiences of their bodies and decisions about becoming pregnant.

Women's perceptions of embodied uncertainties are also rooted in neoliberal logics of choice and responsibility. Neoliberal logics encourage individuals to internalize risk and subsequently assign responsibility for health maintenance to individuals. In this context, medicalized notions of risk emerge as an empowering discourse through which individuals can identify and mitigate risk factors, even before harm is actualized. Neoliberal logics task subjects with responsibly choosing from among an array of options, and women in particular are responsibilized with making "appropriate" reproductive choices. I argue that neoliberal risk logics have transformed reproductive aging and infertility into individualized concerns, push women to mitigate embodied uncertainties through adoption of the calculating language of medicalized risk, and foreclose recognition of the institutional failures that create conflicts of aging, careers, and childbearing in women's lives.

In a context of medicalized reproduction and neoliberal risk assessments, women's bodies emerge as sites of contested and gendered uncertainties. Women across geographic and temporal contexts have lived with the specter of failing their reproductive duties as women, and the embodied uncertainties of contemporary women comprise another iteration of demographically and geohistorically specific gendered anxieties. For highly educated, middle class, white women with professional jobs, institutional failures to adjust workplace policies and cultures for women, pressure to "have it all," and relatively high awareness of infertility and access to fertility treatments all infuse reproductive activity with the weight of choice. For these women, uncertainties in their interactions with the economy, the workplace, and the state culminate in the body through a ubiquitous neoliberal rhetoric of choice that assigns

responsibility for decision-making and failures alike to the individual. Thus, as women's bodies become loaded with uncertainty in distinctly gendered formulations that demand attention and interventions at the individual level, women's experiences of embodied uncertainties demonstrate the limits of empowerment through neoliberalism.

This paper seeks to answer the following research questions: How does the (bio)medicalization of pregnancy-related risks inform white, highly educated, professional women's decisions about and approaches to getting pregnant? How do uncertainties and anticipations become lodged in women's bodies in the reproductive context? I argue that women understand their bodies as sites of multilayered reproductive uncertainties, anticipate aging and infertility before they happen, and engage in reproductive decision-making that seeks to mitigate these embodied uncertainties. These flows of risk awareness, anticipation, and mitigation make legible women's internalization of medicalized risk discourses and neoliberal logics of choice and responsibility. Ultimately, women are left to experience and respond to embodied uncertainties at the individual level.

LITERATURE REVIEW

Motherhood, work, and fertility

In 2019, 72.3% of American mothers participated in the labor force (United States Bureau of Labor Statistics 2020). The challenges of merging work and motherhood are well-documented. Despite the privileges of high pay and relative flexibility afforded by their jobs, highly educated, middle class, white mothers in professional jobs contend with employers' expectations of complete devotion to work (Blair-Loy 2003) while facing a "second shift" of labor at home (Hochschild and Machung 2012). In the U.S., liberal feminism has amplified a

tension between care work and professional achievement in women's lives (Folbre 2001:4). As a result, overwhelming and incompatible demands made of working mothers push some with ample resources to survive out of the labor force (Stone 2007).

Hays (1996) has demonstrated the conflicting demands placed upon working mothers' behavior: in the workplace, women's behavior should be motivated out of self-interest, and in the family context, women should act selflessly. The ideology of intensive mothering holds women responsible for devoting maximum emotional, financial, labor, and time resources to their children while performing professionally; meeting these demands typically requires middle-class resources (Fox 2006). Denbow (2015) demonstrates that these conflicting demands on women's lives emerge from neoliberalism's expectations of self-interested behavior in the market and selfless behavior in the maternal context. Thus, as it calls upon individuals to self-govern, neoliberalism makes conflicting demands on mothers' behavior and decision-making (105-6).

These tensions between unpaid care work and paid work pervade women's processes of becoming pregnant. Research has long acknowledged that women with careers that take longer to establish may postpone childbearing for longer than other women (Ranson 1998). Maternal role incompatibility theory suggests that for women who work, competing demands on energy and time may reduce or delay fertility. Although women in more professional careers (defined as those with high autonomy, complexity, prestige, and supervision responsibilities) do not want fewer children than other women do,[1] they are more likely to postpone or forego family formation due to the opportunity costs of childbearing and work-childbearing conflicts (Shreffler 2017).

[1] On the false binary of intended and unintended pregnancies, see Aiken et al. (2016); Bachrach and Newcomer (1999); Gómez et al. (2019); Hakim (2003); McQuillan, Greil and Shreffler (2011); Santelli et al. (2009); Shreffler et al. (2015); Stanford et al. (2000). For the effects of gender on intended and actual fertility, see Kaufman and Bernhardt (2012); Shreffler, Pirretti and Drago (2010).

As education level and income increase, women have fewer children and are more likely to give birth for the first time at or after age 30 (Martinez, Daniels and Febo-Vazquez 2018; Weeden et al. 2006). Women with higher levels of education have lower completed fertility due to the opportunity costs of childbearing, prioritization of non-family goals, and declining fecundity after multiple postponements (Morgan and Rackin 2010; Musick et al. 2009). Declining birth rates for women under 30 across all educational brackets have long been interpreted as evidence of increasing work-life competition (Martin 2000).[2] For middle class women with professional careers, participation in the labor force and long periods of education create conflicts not only with family responsibilities, but also with family formation and completed fertility.

Constructing and communicating fertility risk

As women navigate competing family and professional aspirations, fertility emerges as a site of limitation and risk. Entwined medical, cultural, and media discourses construct women's reproductive aging, infertility, and, ultimately, bodies as risks requiring calculated management. Medical discourses and practitioners provide the basis of the maternal body's construction as laden with risk. Through processes of (bio)medicalization,[3] (in)fertility has been reconceptualized as a medical condition definable through risk factors and in need of individualized, technoscientific interventions (Clarke et al. 2003; Greil, McQuillan and Slauson-Blevins 2011). (Bio)medicalization hinges on risk discourses that categorize bodies and lifestyles according to their potential for harm and subsequently assign responsibility for harm to

[2] For differences in the transition to adulthood and attendant fertility regimes in college graduates and non-college graduates, see Cherlin, Talbert and Yasutake (2014).
[3] For distinctions between medicalization and biomedicalization, see Clarke et al. (2003).

individuals (Lupton 1993). In the context of fertility, aging and other embodied factors become legible as risk factors. In turn, individual women may identify infertility as a consequence of delaying parenthood and willingly turn to medicalization to remedy reproductive difficulties (Friese, Becker and Nachtigall 2006). Through risk discourses, (bio)medicalization categorizes individual maternal bodies as more or less laden with risk and charges women with managing reproductive risk on an individual level.

Additionally, reproductive technologies contribute to women's understandings of embodied risk and risk mitigation. Technologies such as amniocentesis (Rapp 2000), egg freezing (van de Wiel 2015), fertility monitoring and fertility extension technologies (FMETS; Baldwin 2019), and in vitro fertilization promise to diagnose, assess, and overcome the risks of advanced maternal age and infertility. The increasing availability of these reproductive technologies, including to those not discursively categorized as "infertile," such as unpartnered individuals or queer couples, entails increasing medicalization of bodies and pregnancies (Martin 2010:528-9).

As a culturally amplified countdown to the end of a woman's most fertile years, the notion of "the biological clock" communicates aging and infertility as risks to be intentionally avoided. By invoking biological clock language and imagery, media discourses enforce normative notions of appropriate maternal age and load the maternal body with risk. In the U.K. context, Shaw and Giles (2009) demonstrate that media discourses that negatively frame motherhood postponement construct an "optimum age" for childbearing and produce anxiety in older women trying to become pregnant (226). As a result, women deemed older may use risk discourses about aging and decreasing fertility when making fertility decisions.

American media discourses similarly encourage women to pursue pregnancies by and while loading their bodies with the potential for reproductive failure. A 2002 *TIME Magazine* article on older motherhood included a warning from Pamela Madsen, then Executive Director of the American Infertility Association, about the hidden risks and disappointments lying within women's bodies: "'Those women who are at the top of their game could have had it all, children and career, if they wanted it…The problem was, nobody told them the truth about their bodies'" (Gibbs 2002). Or, consider a 2001 bus advertisement campaign by the American Society for Reproductive Medicine. With the message that women "in their twenties and early thirties are most likely to conceive" accompanied by a baby bottle in the shape of an hourglass (Kalb 2001), the campaign provided passersby with an ideal maternal age, presented childbearing as an inevitability in women's lives, and loaded the maternal body with risk of failure in the face of poor reproductive decision-making. As these advertisement campaigns demonstrate, medical, cultural, and media discourses coalesce to construct the maternal body as full of risk, prone to failure, and in need of proper, time-sensitive management.[4]

Anticipating fertility difficulty

Through anticipation, women link their possible reproductive futures to the present. For Adams, Murphy and Clarke (2009), "[a]nticipatory regimes offer a future that may or may not arrive, is always uncertain and yet is necessarily coming and so therefore always demanding a response" (249). Indeed, through "anticipatory logic," women are called on to combat their possible future infertility in the present. Martin (2010) names "anticipated infertility" as "the condition in which one believes one may be infertile in the future" (529) and argues that the

[4] For an example of European advertising campaigns about reproductive aging represented in popular American media, see Sussman (2019).

emergence of anticipated infertility as a discursive category creates a medical responsibility to intervene through methods such as egg freezing (530-1). Locke and Budds (2013) describe that in response to medical and popular discourses of aging-related fertility decline, some women pursue pregnancy before they feel completely prepared in order to mitigate aging-related risks.

Most work on how women anticipate and contend with the possibility of aging-related fertility decline focuses on subsequent medical interventions, such as egg freezing (van de Wiel 2015) or fertility monitoring and fertility extension technologies (FMETs; Baldwin 2019). These interventions transform the potentially maternal body into "a site of anticipation" (van de Wiel 2015:124), construct reproductive aging as "a pathological liability in need of monitoring and management," and create new gendered anxieties around reproductive responsibilities (Baldwin 2019). As it informs pregnancy timing and reproductive technology use, anticipation constitutes a powerful affective component of women's reproductive decision-making processes. This paper demonstrates that anticipation informs women's approaches to and decisions about becoming pregnant even outside of reproductive technology use.

RESEARCH METHODS

This paper is based on semi-structured interviews with 12 women in the Portland, Maine area between July and December 2019.[5] All participants had had a child within 18 months of the interview. Their ages ranged from 30 to 41, and all participants were white. Two had undergraduate degrees, five had master's degrees, and five had doctoral degrees. All participants had long-term partners who were men; 11 were married and one was not married. Four participants had one child, seven participants had two children, and one participant had three

[5] This study was reviewed and approved by the Bowdoin College Institutional Review Board.

children. Age at first birth varied between 29 and 37. Time since most recent birth varied between three weeks and 18 months.

Participants were enrolled through purposive sampling (Kuzel 1999). Posters advertising the study were displayed in public settings that attract parents of young children and families generally: midwifery centers, childcare centers, preschools, libraries, indoor playgrounds, restaurants, cafes, banks, and churches. Administrators of several childcare centers and preschools circulated information about the study to parents via email. Additional participants were recruited through snowball sampling.

Participants selected the interview location that was most convenient for them. Interviews were conducted in conference rooms, public libraries, cafes, and at participants' homes. I began interviews by asking respondents to describe their current family and to tell me how they decided to have their most recent child. Subsequent questions attempted to break down and contextualize these decisions by asking about partners' attitudes, childcare situations, distributions of care and domestic labor, extended families, finances, perceptions of social norms, processes of becoming pregnant, social networks, and work-life balance. Each interview lasted about one hour. I recorded and transcribed each interview. Interviews were analyzed with two stages of coding. Coding began with line-by-line analysis and then broadened to larger themes (see King and Horrocks 2010:153-9). All respondents have been assigned pseudonyms to protect their identities.

Although this study is limited in its sample size, its goal is not to provide representative findings, nor does it purport to do so. Instead, this study is concerned with contributing to theoretical understandings of the pressures facing a specific group of relatively privileged American women: middle class, professional, white women with college- and graduate-level

educations. Interview questions did not directly inquire about women's conceptualizations of their bodies, anticipation of fertility difficulties, or uncertainty about their bodies' abilities to become and stay pregnant. Instead, these themes pervaded women's own narratives about their reproductive decision-making processes and subsequently provided the focus of my research. As a result, this study queries the often-overlooked tensions and uncertainties that form the background to women's reproductive lives and that women voice in their own narratives.

This study is also limited in participants' heterogeneity of age at first birth and professional life. Comparison of experiences of embodied uncertainty between women with and without diagnosed fertility difficulties is beyond the scope of this study.

RESULTS

When trying to become pregnant, women may consider their aging or potential for infertility as real or anticipated obstacles. For some women, aging-induced fertility loss or more general possibilities of fertility difficulties are prominent considerations in deciding when and how to try to become pregnant. Anticipations of infertility may be grounded in concerns about aging, past experiences with fertility difficulties, or the unknown nature of infertility before one tries to become pregnant. Because these concerns are lodged in the body and take on a range of meanings in women's fertility decision-making processes, I refer to this constellation of factors as embodied uncertainties. Embodied uncertainties inform women's strategies for becoming pregnant, exert pressure on aging women to make quick decisions about their childbearing intentions, and interact with financial, professional, and other uncertainties in women's lives to inform women's experiences of and decisions about getting pregnant.

Women's strategies for contending with uncertain (in)fertility

Facing uncertainty about their ability to conceive based on a range of potentialities and anticipations, women may adopt strategies intended to diffuse embodied uncertainties and increase their chances of conceiving. Women understand these strategies as maximizing their chances of having a(nother) child, even if the timing would deviate from their preferences.

After experiencing difficulties with fertility, some women understand their potential for fertility as uncertain. After becoming pregnant with her first child took several years, Zoe came to understand her body as "untrustworthy" and adapted her approach to achieving subsequent pregnancies. Knowing that she wanted multiple children, Zoe did not resume birth control after giving birth to her first child.

> So, with both Brooks and Troy, we didn't try. It's this funny thing in terms of fertility for me where it's like I tried so hard for three years to get pregnant with Marshall, and then I didn't try to get pregnant with Brooks or try to get pregnant with Troy, I just didn't try to *not* get pregnant with either of them. And so, I think that I felt so untrustworthy of my ability to get pregnant that I didn't want to jinx it by—this sounds ridiculous, but I didn't want to jinx it by trying to *not* get pregnant ever again. [Laughs.] But I think that if I had more faith in my ability to time things, then we would have waited a little bit longer to have Troy, to just have a little bit more financial flexibility. (Zoe, 34)

Fertility difficulties left Zoe feeling uncertain about her body's ability to become and stay pregnant in the future. In order to mitigate embodied uncertainty in her desire for additional children, she forewent resuming birth control after her first birth. Zoe's strategy was ultimately successful: although her latest birth occurred before she felt financially prepared, she overcame fertility uncertainties and had her child.

For Zoe, the embodied uncertainty of trying to become pregnant for several years engendered intense emotional uncertainty. In order to put an end to the uncertainties of trying to become pregnant, Zoe established an age limit at which she would stop trying to conceive.

> [W]hen I was having a hard time getting pregnant with Marshall, I got to this place where I felt like, I needed it to not just be about me and my body. And I was like, 'at the point that I turn 30, if I'm not pregnant and haven't been able to successfully stay pregnant, then I need us to start looking into adoption, because I can't have the pressure of us being parents only be about my ability to ovulate and conceive.' […] I think 30, for some reason, for me, was the line where I was like, 'we need to open up all options so that the pressure just'—I just felt so much pressure—I felt like it was all-consuming. Every time I went to the bathroom, every time I went pee, I would be like, 'am I bleeding?' It was just all-consuming. I just remember being like, 'I'm getting so fatigued that I'm going to need to call it quits.' (Zoe, 34)

For Zoe, difficulty becoming pregnant engendered emotional pressure and intensified the uncertainty surrounding her body. Deciding on an age at which she would stop her efforts to become pregnant allowed her to envision an end to intertwined embodied and emotional uncertainties.

For women who have experienced fertility difficulties, contending with an uncertain ability to achieve subsequent pregnancies may push them to try to get pregnant before they feel completely ready for another child. Here, initiating the process of trying to have a child as soon as possible boosts one's (perceived) odds of becoming pregnant and attempts to mitigate embodied uncertainties of (in)fertility. Fallon draws a distinction between "being fine if it happened" and "actively trying":

> But for both of our children, it took us a long time to get pregnant, so once we thought we wanted to have a second, we started trying right away, but it still took, gosh, I don't know. Let me think about when we would have started trying. Not really actively trying, we would have been fine if it happened starting in April, and then I didn't get pregnant until December. (Fallon, 39)

Having experienced a difficult process of becoming pregnant with her first child, Fallon began trying to have a second child as soon as she and her partner agreed that they wanted additional children. Fallon describes an intermediate zone between trying to *not* become pregnant and trying *to* become pregnant, one in which she did not feel completely prepared to have another child but would have preferred becoming pregnant then to not becoming pregnant again at all. In order to contend with uncertain fertility, Fallon carved out a zone of permission in which she allowed herself to possibly become pregnant before feeling completely ready and conceptualized her approach in contrast to strategies of "actively trying."

For some women who have not experienced infertility, uncertainty about their body's capacity for fertility pushes them to try to become pregnant as early as possible. For these women, contending with their potential for infertility is not rooted in past experiences but still requires mitigation through intentional approaches to getting pregnant. For Brooklyn, stories about other women unexpectedly encountering fertility difficulties pushed her to try to get pregnant as soon as she could.

> For some reason, I had it in my head that it was going to be hard to get pregnant. I don't know why. Just because you hear stories, you hear horror stories, and I think as a woman, you don't know, right? There's women who have been on birth control their whole life, and [are] so afraid. 'Oh god, I could get pregnant. I'm going to be so safe.' And then they

> find out they actually can't have kids. It's like, 'oh my god. I had *no* idea.' It's funny to have something, have this huge unknown be within your body, right? Like, 'here I am. I'm living my life. I think I'm healthy, but actually, I have absolutely no idea if this is going to work or not.' And that felt, that feels a little scary sometimes. So, that was pushing me. I think, 'if I can't have kids, I want to know now. [Laughs.] I want to find that out.' And so, that was a kind of anxiety that I was having. […] We got pregnant the very first time we gave ourselves. […] And that was surprising. Also, because here I am, built this whole thing up about how hard it was going to be to get pregnant [laughing], I wasn't sure if I could have kids, and then I got pregnant immediately! (Brooklyn, 34)

Hearing stories about other women's difficult experiences with unexpected infertility left Brooklyn feeling uncertain about her own ability to get pregnant. As a result, she sought to start trying for a child as soon as possible not just to have children during a specific period in her life, but to break through embodied uncertainty and discover the "truth" of her (in)fertility. For Brooklyn, experiencing fertility as an uncertain property of her body meant that trying to getting pregnant would relieve her embodied uncertainty and thus should happen as soon as possible.

When contending with uncertainties of aging and possibilities of infertility, some women strategically seek assisted reproductive technology (ART) interventions early in their process of trying to become pregnant in order to mitigate embodied uncertainties. Expecting fertility difficulties, Fallon used intrauterine insemination after about three months of trying to conceive.

> And I did actually do one, with our son, the younger one, because we knew we were going to have these [fertility] issues and because I thought the timing was even more important because I'm getting older, I did try one round of IUI, which is intrauterine insemination, but it didn't work. But then, a month later, I got pregnant naturally. So, it

> was a bit, yeah, it was interesting. The only intervention we did didn't end up working for us. [Laughs.] (Fallon, 39)

Anticipating difficulty getting pregnant based on past experiences with infertility and her knowledge of an aging-fertility tradeoff, Fallon recounts using intrauterine insemination *before* experiencing the anticipated difficulty. Here, embodied uncertainties of infertility and aging produced intense anticipation. Seeking medical interventions such as intrauterine insemination allowed Fallon to boost her chances of getting pregnant and to mitigate the uncertainty and anticipation attached to her body.

Uncertainties about aging as pressure to decide

Some women experience awareness of their aging and corresponding decreases in fertility as pressures to decide whether or not to have children. Medical discourses that describe older mothers in terms of "advanced maternal age" and "geriatric pregnancies" help construct this awareness of aging and contribute to pressures to decide. For Tatiana, knowing that she would fit into medicalized categories of older mothers made her feel that she needed to urgently decide whether to have a child or not.

> So, I got pregnant with Judith at 34, and if you are going to be 35 or older when you give birth, you're considered advanced maternal age. And there's just some weird stuff that that does mentally to you, to have that label. And that's the nice version of the label. Other times, it's a geriatric pregnancy. [Laughs.] […] There's just some really stupid names. I think it put more pressure on me to make the decision. And I wasn't ready before then. (Tatiana, 40)

For Tatiana, the labels of "advanced maternal age" and "geriatric pregnancy" loaded aging with uncertainty and risk to fertility. As a result, deciding whether to have a child or not needed to happen quickly in order to minimize the uncertainty and risk that her body carried. Amplified by medical discourses and labels, awareness of aging may push some women to make fertility decisions quickly.

By intensifying women's perceptions of aging's risks to fertility, medical discourses of "geriatric pregnancies" may also encourage women to consider their aging as a risk to be managed and weighed against other factors. Although Dinah reported feeling that the risks associated with childbearing at 35 were too low to warrant the label "geriatric pregnancy," she nonetheless understood having her child before age 35 as a way to minimize risks to her pregnancy.

> So, as soon as you turn 35, gynecologists refer to it as a geriatric pregnancy, which is pretty ridiculous. Because, I mean, 35, you know. Even risks of things like ovarian cancer are not very high. And I'm very risk-averse. And I very much wanted an easy pregnancy, a healthy pregnancy, an easy birth, which I didn't have, but that's besides the point. And I wanted to do everything possible to have a healthy baby and give my baby the best possible chances I could. (Dinah, 32)

Dinah feels that even though medicalized discourses overstate aging's risks to fertility, they name an important constellation of risks to be prevented. Dinah's self-identification as "risk-averse" makes visible the extension of medicalized risk discourses into women's everyday lives, as well as the ways in which these discourses compel women to adopt risk calculations in their reproductive decisions. When Dinah wanted to have a child, she perceived a tension between her aging, which increased pregnancy-related risks and therefore pushed her to have children soon,

and other factors that pushed her to delay childbearing, such as a lack of health insurance. Having a child before reaching the discursively pathologized age of 35 allowed Dinah to feel that she avoided the embodied risks of aging and infertility associated with older mothers. Here, medical labels reinforce women's awareness of their aging and push some women to consider aging as a risk to be managed by having children before they reach too advanced an age.

Compounding uncertainties

Women's experiences of embodied uncertainties often intertwine with—and are rooted in—other sources of uncertainty. For many, additional uncertainties and anticipations—namely, financial and professional—layer onto and inform women's embodied uncertainties and the strategies for becoming pregnant that they engender. When contending with multiple uncertainties, women may attempt to become pregnant during specific windows of time or potentially face so many obstacles to having a child that they rush to do so when barriers are lowest. These strategies reflect women's efforts to minimize the overlapping and interacting uncertainties at play in their lives.

Many women perceived their bodies' aging and potential for (in)fertility to exist in tension with their educational and professional trajectories. For Lenora, getting pregnant was a matter of waiting for graduate school to end, but ensuring that she didn't jeopardize her or her husband's fertility by waiting too long. Behind this balancing act, Lenora also maintained an awareness of her body's uncovered potential for (in)fertility.

> And then, as I got later in grad school, we were like, 'so, when should we have kids?' And we were like, 'definitely once I'm done with grad school.' And then, when I was done with grad school, he's like, 'I'm getting old,' and I was like, 'okay, but I need some

> time. Grad school was terrible. I need a little bit of time for that.' And he was like, 'okay. That makes sense.' And so, that was kind of our compromise. I would say we're both relatively laid-back people, so it was never an intense or serious discussion. It was just like, what works for both of us. And also, you know, when you decide to have kids, the scary thing is, you don't know, if you start trying to get pregnant, you could get pregnant immediately, or you could never get pregnant. So, that was a big factor too, of 'will we be able to have a kid if we want to?' My parents had a lot of trouble conceiving both me and my sister, which is why we're seven years apart. So, that was kind of a thought in the back of our mind. 'I want to have a little bit of time, for sure. And then, you know, we may have more. We'll see.' But it ended up working out pretty well. But that was one of the biggest uncertainties, of 'well, we decided we're ready, but who knows if it'll actually happen.' (Lenora, 35)

Lenora's process of deciding when to have a child involved balancing several embodied and professional factors: waiting for the end of and recovering from graduate school, considering her and her husband's aging, and reckoning with possibilities of infertility. Even though she did not experience any fertility difficulties, the possibility of experiencing them influenced her decision about when to have a child.

When balancing uncertainties of aging and (in)fertility with professional uncertainties, women may try to time their pregnancies within specific windows. Perceiving tensions between prioritizing having children before aging damages their fertility and getting acclimated to a new job or receiving a promotion, women make compromises that allow them to minimize both embodied and professional uncertainties. For Fallon, deciding to wait a predetermined amount of

time at a new job before trying to have a child allowed her to balance reduced chances of getting pregnant due to aging with her professional goals.

> I just can't imagine having kids earlier than this. I had a friend who had a kid when we were in grad school, and I just can't—grad school or in my postdoc, even. I mean, I'm glad I waited as far as timing for my career, but biologically, it's not good to do that, because then your chances of getting pregnant are lower. […] So, based on my age, I knew that there was no way I was going to wait until after I got tenure. I am definitely too old. So, I know when I started [this job], I said, 'I want to get through my first two years of prepping new classes, until everything's sort of settled down a little bit, and then we would start trying.' So, that's what we did. We waited until basically [the] end of my second year. And then, it worked out. And then the timing worked out well, because I ended up having my daughter in the middle of my sabbatical leave. So, the timing there was helpful, too, that I wasn't in the middle of a busy semester or something. So, I don't know if it makes sense now, in retrospect, but I was just like, 'those first two years are going to be really difficult. I want to make sure that I get through those first two years and then we'll start trying.' And then, we did, but then it took almost a year before we got pregnant. So, ideally, everything would have happened a year earlier than it did, but it worked out fine. (Fallon, 39)

Anticipation of aging and professional goals existed in tension with each other and informed Fallon's process of deciding when to have a child. In order to reduce uncertainty about her ability to get pregnant due to aging, Fallon made a plan to try to get pregnant during a specific point in her career. Fallon's strategy for timing her pregnancy balanced age-induced risks to her fertility and pregnancy-induced risks to her career.

Women who experience compounded uncertainties, such as the layering of financial and professional factors onto embodied uncertainties, may face so many obstacles to becoming pregnant that they must rush to become pregnant when barriers are cumulatively lowest. Dinah recalled wanting to have a child but first needing to find permanent instead of freelance work in order to obtain health insurance.

> The desire for financial stability and also to have kids [drove me to find permanent work instead of independent consultancies]. I mean, knowing the risks, the longer you wait, obviously, it's more risky to have children. And not knowing how long it's going to take, I didn't want to delay it for too long. So, I figured, I mean, for a lot of other reasons, but a big factor was knowing that I needed health insurance. So, that kind of drove me to start looking for more permanent work. Getting full-time work with one organization rather than trying to find consultancies. (Dinah, 32)

For Dinah, wanting to have a child meant needing health insurance through a permanent position. The ensuing process of finding a position not only yielded professional uncertainty but also heightened Dinah's awareness of her aging and its risks to her fertility.

> So, [timing the pregnancy was important] not in the sense of time of the year, but, I couldn't get maternity leave at my current job because I had just started. So, you don't qualify for paid maternity leave until you've been there for, I want to say, 18 months or a year. So, I waited until that to start trying to get pregnant. And then, after that, it was sort of like, 'well, okay. I guess I qualify now, so.' And it happened pretty quickly. It took us two months to get pregnant. So, yeah, I think if I had known that it would be so easy, or that we wouldn't have any complications, that maybe I would've waited a little bit longer, just because I hadn't really been at my job very long. (Dinah, 32)

After contending with embodied, financial, and professional barriers, Dinah had a child as soon as permitted under her workplace's maternity leave policy. Working through compounded barriers and quickly becoming pregnant, however, left Dinah feeling that she had rushed through the transition and perhaps had had her child earlier in her professional trajectory than she would have preferred. The process of overcoming compounded uncertainties and barriers created a rush to become pregnant.

DISCUSSION

When trying to become pregnant, white, highly educated women in this study contend with embodied uncertainties, a constellation of aging- and infertility-related factors that they perceive as potentially threatening their ability to conceive. Whether grounded in concerns about aging-related costs to fertility, previous experiences of fertility difficulty, or the possibility of undetected infertility, embodied uncertainties inflect women's understandings of their bodies and direct their approaches to becoming pregnant.

Why do white, highly educated women experience so many uncertainties around becoming pregnant, and uncertainties lodged in the body in particular? While infertility is typically constructed and studied as affecting middle- and upper-class women (Bell 2009:690), most of the women in this study had no personal history to provoke concerns about infertility. Instead, these women contended with "anticipated infertility," what Martin names as "the condition in which one believes one may be infertile in the future" (2010:529). Instead of turning to medical interventions such as fertility monitoring, fertility extension technologies, and egg freezing (see Baldwin 2019; van de Wiel 2015), however, most of the participants in this study regard the possibility of infertility as an uncertainty to be mitigated through attention to aging's

risks to fertility and through careful, and typically earlier, timing of pregnancies (see Locke and Budds 2013). Even without personal histories of embodied fertility difficulties, women conceptualize their bodies as containing the potential for infertility and mold their strategies for becoming pregnant around those uncertainties.

Women's discussions of how and when they decided to try to have a child reveal the extent to which multilayered embodied, emotional, economic, and professional uncertainties permeate women's lives, as well as the extent to which women seek to mitigate these uncertainties through risk awareness and calculations. In a context of delayed transitions to adulthood (Cherlin, Talbert and Yasutake 2014), neoliberal societies' demands that women organize their family decisions around both rationality and emotionality (Denbow 2015:105), and the growing impossibility of achieving the good life, women are forced to anticipate uncertainty in all parts of their lives. Fueled by an awareness of numerous medical interventions that promise to remedy infertility, these women understand aging and infertility as possibilities to mitigate through strategic planning. Reproductive aging in a (bio)medicalized and neoliberal context calls upon women to be aware and calculative of risks at the individual level, and these rationalities infuse not only women's decisions about their fertility but also their understandings of their bodies.

In the face of competing demands on women's lives—to succeed professionally, to achieve financial stability, and to find a partner and have children, all before becoming "too old"—women feel not just that they must "have it all," but that they must do so before their bodies inevitably fail them. Even when distributed with the intention of enhancing women's awareness of their fertility, warnings that women should reproduce "before it's too late" push women to locate uncertainty and distrust within their bodies. I concur with Locke and Budds'

assessment, in the Northern English context, of the tension between "problematic" risk discourses about reproductive aging and important information about aging-fertility tradeoffs:

> We argue that the current risk discourses around decreasing fertility are problematic and, as is the case here, can have profound implications on women's decision-making regarding the timing of their pregnancies; effectively 'scaring' women into making decisions before they feel ready. On the other hand, we recognise that without such messages, women may unknowingly risk the chance to become a mother by 'delaying' pregnancy past the point where they are no longer able to have children. (2013:539)

Purporting to care for women's reproductive health and informed decision-making, medical and public discourses alike must reconceptualize how to discuss and disseminate information about reproductive aging without loading women's bodies with uncertainty, risk, and potential failure.

In her assertion that "[t]he economic environment becomes the human's primary ecology" (2017:10), Murphy suggests that neoliberal infrastructures submerge individuals within calculative logics that assign differential values to individual bodies and lives. In anticipating that their bodies have the potential to fail them, and indeed in feeling that they must account for these potential failures as they try to become pregnant, women absorb and use neoliberal calculative logics to evaluate their bodies. In contrast to "the phantasy that women, sex, and family might provide special generative possibilities for escape from capitalism" (Murphy 2017:144), capitalism's process of valuation through economization loads women's bodies with neoliberal assumptions of rationality, calculation, and responsibility in distinctly gendered forms. As a result, neoliberal logics extend to women's bodies and family decisions through embodied uncertainties and the risk-calculative logics that they inspire. By assigning women responsibility for reconciling education, professionalism, partnership, and childbearing in their lives, neoliberal

regimes map responsibility onto women's bodies and decisions while turning away from recognition of structural barriers to more easily reconcilable family and professional lives. Women's investments of uncertainty in their bodies thus take on meaning as one way in which contemporary regimes of neoliberal economic (e)valuation permeate women's decisions about their lives and concepts of self.

CONCLUSION

While experiencing embodied uncertainties, women anticipate difficulty getting pregnant, locate that potential for difficulty within their bodies through aging or other causes of infertility, and adopt strategies for becoming pregnant that seek to minimize those embodied uncertainties. To combat the possibility of infertility, women seek to mitigate embodied risks by turning to "passive" approaches to getting pregnant, such as foregoing birth control after the birth of a child; beginning to try for a child before they feel completely ready; or seeking out ART interventions early in the process of trying to become pregnant. Bolstered by medical labels of "advanced maternal age" and "geriatric pregnancies," awareness of aging's potential risks to fertility pushes some women to make fertility decisions on a predetermined timeline and to engage risk-calculative logics that weigh the risks associated with aging against factors pushing them to delay childbearing, such as career development or lack of health insurance. When compounded with professional or financial uncertainties, embodied uncertainties push women to make compromises that mitigate intersecting risks, such as timing a pregnancy to minimize aging-related risks to fertility while making concessions to maximize the chances of receiving a professional promotion.

Women's experiences of embodied uncertainties and anticipated infertility make clear the extent to which multilayered uncertainties permeate women's lives and map the potential for failure onto women's bodies. In a context of (bio)medicalized risk discourses and neoliberal logics of responsible self-governance, women's bodies become sites of uniquely gendered reproductive risks, uncertainties, and possibilities for management. On a discursive level, divesting women's bodies of disproportionate uncertainty and risk requires the reformulation of medical, cultural, and media communications of reproductive aging and fertility risks. On a structural level, institutional and policy changes that reduce conflicts of childbearing and professionalism in women's lives may unload women's bodies of reproductive risk. Ultimately, if women among our society's most privileged—white, middle class women with advanced degrees and professional jobs—experience multilayered difficulties and uncertainties in reconciling childbearing, economic stability, and work responsibilities, then women with fewer resources are left to face different iterations of those same challenges with even less outside assistance. Interrupting the individualization of responsibility for reconciling family and work may ease the burdens of women across society.

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