

**“Doing it Right”:
Childbearing Norms among Low-Income Women over the Life Course**

Laurie James-Hawkins, University of Colorado at Boulder
Christie Sennott, University of Colorado at Boulder

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Age norms regarding both teenage childbearing and reproductive sterilization have been extensively studied. Yet, no work has examined the ways in which these reproductive norms are connected over the reproductive life course and the extent to which norms surrounding the timing of these events may disproportionately disadvantage low-income women. Drawing on qualitative data from 40 interviews conducted with low-income women in the Denver Metro area of Colorado, we investigate how early childbearing and early desire for sterilization are connected and how they relate to the accelerated reproductive life course typical of low-income women. Although half the women in the sample were teen mothers the dominant view of teen childbearing was overwhelmingly negative. Despite, or perhaps because of their experiences, women interviewed both expressed adherence to dominant norms which dictate postponing until after reaching ones 20s, and discussed ways in which they perpetuate these norms with their peers and children. The data clearly illustrate the impact social norms about the timing of the beginning and ending of childbearing on the lives of low-income women.

Research from the United States has demonstrated the power of social norms to influence individual's choices and behaviors in the timing of childbearing over the life course (Burton & Bengston, 1985; Burton, 1996; Bute & Jensen, 2010). Life course research on age norms emphasizes that the timing of life events is important. For example, although typical behavior may vary by socioeconomic status or other demographic factors, the ideal timing of pregnancy is considered to be in the 20s by most people (Bute and Jensen, 2010; Cherlin, et al., 2008; Neugarten and Hagestad 1976). In addition, norms dictate that women retain the ability to reproduce at least throughout their 20s and early 30s, the normatively accepted period for childbearing (Harrison and Cooke, 1998). It is important to remember that although most women may not strictly follow these reproductive norms, the norms are culturally and socially defined and thus provide a cultural roadmap that has implications for attitudes and behavior (Hagestad, 2003; Kendall et al., 2005).

The influence and content of particular age-related (i.e., timing) norms about childbearing may vary based on women's socioeconomic status, race/ethnicity, or sexuality, among other factors. Indeed, previous research has demonstrated that when the normative pathway to family formation is not accessible, individuals often create attainable (and justifiable) alternatives (e.g., Burton, 1996; Edin & Kefalas, 2005). In the context of economic disadvantage, an adaptive and alternative reproductive life course has developed in which women enter into many familial life transitions early, including beginning and ending childbearing at earlier ages (George, 1993; Gassanov, Nicholson, and Koch-Turner, 2008). Despite variance in the timing of reproductive events, there are often negative consequences for women who deviate from the dominant normative path in U.S. society. For example, women who have a child early, such as in their teenage years, are often ostracized, given unwanted advice, publicly condemned, and judged as failures as punishment for deviating from the norms endorsed by the dominant group – white, middle-class, educated adults (Bute & Jensen, 2010; Cherlin et al., 2006; Geronimus, 2003; Gregson, 2009; Hanna, 2001; Whiteley & Kirmayer, 2008). Similarly, women may also experience sanctions and barriers at the end of their reproductive lives if they desire to end childbearing in their 20s or early 30s (Zite, Philipson, and Wallace, 2007).

Understanding how low-income women view and experience social norms about the proper timing and context of childbearing is important because oftentimes their reproductive behaviors are characterized as

deviant and they are sanctioned if they (desire to) begin or end childbearing early. Studies have shown that the accelerated reproductive life course, while often adaptive in disadvantaged social environments, is depicted by the larger society as problematic and at odds with dominant reproductive norms (Burton, 1996, Bute and Jensen, 2010; Gassanov, Nicholson, and Koch-Turner, 2008; Geronimus. 1996; 2003); however, this view has been disputed (Lawlor and Shaw, 2002). In addition, dominant norms are based heavily on age, and the accelerated reproductive life course is in clear violation of traditional age norms (Roscoe and Peterson, 1989; Settersen, 2003; Settersen and Hagestad, 1994). A deeper understanding of how women view both their own childbearing experiences, larger social norms about childbearing, and the potential disconnect between the two will provide insight into how to construct policies to assist low-income women in successfully navigating the reproductive health system and achieving their reproductive goals.

In this study we drew on in-depth qualitative interviews to investigate low-income women's perceptions of social norms about the timing and context of childbearing over the life course. We explored women's experiences during two key points in the life course when their reproductive choices or outcomes were constrained by social norms about the proper timing and context of childbearing: starting and stopping childbearing early. Our findings confirmed that despite their intentions to follow dominant social norms regulating the timing of childbearing, low income women were often unsuccessful. Most had their first birth as a teenager and several attempted to end their reproductive careers early, often facing institutional and other barriers in the process. Interestingly, although women characterized their childbearing experiences as overwhelmingly negative – often because of their inability to fall in line with larger societal norms – they maintained their support of larger societal norms about the timing of childbearing. They encouraged their own children to follow these norms and continued to regard them as ideal patterns of childbearing behavior, despite, or perhaps because of, their own reproductive experiences. To our knowledge, no other study has drawn on women's perceptions of childbearing timing norms at both the beginning and end of the reproductive life course to illustrate the challenges low income women face and the effects of failing to meet reproductive timing expectations.

BACKGROUND

Fertility Timing Norms and the Accelerated Life Course

Despite increasing individualization in the life course in the United States (Shanahan 2000), previous research has confirmed that there remains a widely accepted timeline for life events such as family transitions (Hagestad, 2003; Liefbroer and Billari, 2010; Setterson, 2003). Specifically, in regards to reproduction, women are expected to finish high school and often even college, marry in their early 20s, and then have children in their mid to late 20s (Bute & Jensen, 2010). This prescribed timeline carries with it a distinction between on-time events (those occurring within the prescribed timeframe and in the prescribed order) and off-time events (those occurring earlier or later than the prescribed time frame, or in the wrong order), and people are generally aware of where their own experiences fall (Neugarten, Moore, and Lowe, 1965; Setterson and Hagestad, 1994). Having children prior to the completion of schooling or marriage is considered to be off-time and at odds with the dominant middle class norms dictating the appropriate timing and sequencing of life course events (Gregson, 2009; Hareven, 1994; Hogan, 1985; Marsiglio, 1993). Although these norms remain dominant, they are becoming more flexible as the transition to adulthood has become extended in recent decades and comparatively more individuals experience disordered transitions (Shanahan, 2000).

Individuals whose life events and transitions conform to the dominant norm generally experience less stress and receive more social support (Cherlin, et al., 2008; Setterson and Hagestad, 1994). Thus, women experiencing off-time reproductive events such as teen childbearing or early voluntary sterilization are likely to have to contend with stigma or discrimination (Bute and Jensen, 2010). For example, Gregson (1999) reported that teen mothers often experienced significant social disadvantage, especially upon their return to school after having a child. Gregson also noted that teen moms regularly face disapproval and prejudice from those who are there to help them, such as social service providers and teachers (1999). Similarly, women who attempted to obtain sterilization in their early 20s frequently faced disapproval from their doctors and may even have been disallowed from having the procedure or told that they should postpone sterilization in case they decided to have more children later on (Borrero et al, 2008; Campbell, Sahin-Hodoglugil, and Potts, 2006; Gilliam et al. 2008; Zite, Wuellner, and Gilliam, 2005, 2006).

Starting Childbearing Early

Scholars have noted that because “early” childbearing is socially defined, its definition may change over time in tandem with changes in childbearing norms, such as the age at first birth, which has risen in recent decades in most developed countries (Furstenberg, 2003; Gregson, 2009; Kendall et al., 2005). Hence, the definition of an appropriate age at first birth varies across cultures, time, and cohorts, which has led some to question the framing of teen pregnancy as a public health problem (Lawlor & Shaw, 2002). Recently, scholars have suggested that current research “no longer supports the notion that teenage childbearing is a devastating event” (Hoffman, 1998, Pp. 239). For example, experiencing a teen birth is liable to cause some level of economic or educational disadvantage for young women, but often not to the extent that it was once thought to be (Hoffman 1998; Geronimus and Korenman, 1992).

Early in the 20th century, premarital childbearing before the age of 20 was commonly followed by a marriage (commonly termed a “shotgun wedding”) that took place before the child was born. This essentially masked the high rates of teen pregnancy and birth that existed then in much the same form as they do today (Furstenberg, Brooks-Gunn, and Morgan, 1987). However, as marriage and childbearing became more and more disconnected in the 1960s and 70s, the American public began to define teenage pregnancy as a social and public health problem (Furstenberg, Brooks-Gunn, and Morgan, 1987). This negative view of early childbearing increased over time. By 1996, scholars agreed that teen mothers “are exposed to strong messages that teenage childbearing is unacceptable and destructive behavior deserving of stigmatization and punishment” (Geronimus 1996: p. 346). These trends continue today.

Indeed, the literature on teen childbearing today strongly supports the notion that teenage parents, and teen mothers specifically, experience high levels of stigmatization in the United States (Bute & Jensen, 2010; Gregson, 2009; Hanna, 2001; Mollborn, 2007, 2010; Whitley, 2008). Much of this research identifies teen childbearing as stigmatized in today’s society (Bute & Jensen, 2010; Cherlin et al., 2008; Geronimus, 2003; Hanna, 2001; Mollborn, 2009, 2010). Despite this, many teenage mothers, especially those from minority groups, may view teen childbearing as adaptive given their social contexts and the experiences of their mothers and grandmothers (Burton, 1996; Geronimus, 1996, 2003). In these contexts, early childbearing may function adaptively or even be optimal for young women (Bute & Jensen, 2010; Edin and Kefalas, 2005;

Geronimus, 2003; Geronimus & Korenman, 1992; Mollborn, 2010; Kendall et al., 2005). However, regardless of the perceived benefits of early childbearing in a specific context, young mothers are also aware of the dominant childbearing timing norms that strongly encourage women to wait to have children until after their teen years. Furthermore, young women internalize these norms, and therefore express regret if they fail to follow the normative path (Bute & Jensen, 2010; Cherlin et al., 2008; Edin & Kefalas, 2005; Gregson, 2009; Kendall et al., 2005). This internalization of dominant middle class norms postponing childbearing – and often marriage as well – frequently causes young mothers to question themselves and their parenting skills and to experience anxiety and fear that their child will be removed from their care (Gregson, 2009; Hanna, 2001; Whitley & Kirmayer, 2008). Young women’s knowledge of the dominant norms and their perceived violation of these norms may also lead teen mothers later in life to emphasize these same dominant norms with their children, engaging in a “do as I say not as I do” rhetoric (Burton & Bengston, 1985; Cherlin et al., 2008).

Teenage childbearing is inextricably linked to poverty and social disadvantage (Cherlin et al., 2008; Edin & Kefalas, 2005; Geronimus, 1996, 2003; Gregson, 2009), and some authors have identified what they term a *reproductive underclass* consisting of mostly low income women who deviate from middle class reproductive norms (Marsiglio, 1993; Jencks, 1991). This moralization of teen pregnancy and its framing as a personal failure has contributed to the identification of teenage pregnancy as a social problem (Furstenberg, 2003; Geronimus, 1996; Hanna, 2001). This problem is defined by Rhode as “a cultural permissiveness, a decline in parental authority, and a weakening of community sanctions against illegitimacy” (pp. 651). As a result, teen mothers experience a disconnect between the normative path that they know they should follow and the path that is accessible and even adaptive within their own context (Bute & Jensen, 2010; Cherlin et al., 2008; Geronimus, 1996, 2003).

Ending Childbearing Early

Beginning childbearing early often leads women to complete their desired family size earlier than women who adhere to dominant reproductive life course norms (Burton & Bengston, 1985; Burton, 1996; George, 1993). This creates an age-condensed fertility structure in which women desire to permanently stop childbearing –

many times through sterilization – at an age considered off-time by society (Borrero et al., 2008; Burton, 1996). In some cases this leads marginalized groups to develop their own fertility norms in which the group's norms regarding early childbearing transitions may have a greater influence on behavior than dominant societal norms (Bute and Jensen, 2010). Furthermore, the increasing age at first birth in the United States has lengthened the normative childbearing timeline prompting an increase in U.S. sterilization age norms (Chan and Westhoff, 2010).

Prior to 1972, female sterilization was highly regulated and generally only performed as a medical necessity (Lawrence et al., 2011; Rothman, 1977; Zite, Wuellner, and Gilliam, 2006; Zite, Philipson, and Wallace, 2007). The federal government addressed this issue in 1972, enacting regulations requiring a minimum eligibility age of 21 for sterilization and a minimum 30-day waiting period before the procedure could be performed (Harrison and Cooke, 1988; Zite, Wuellner, and Gilliam, 2006; Zite, Philipson, and Wallace, 2007). While these regulations did to some extent to protect women from forced sterilization, many women seeking sterilization believe that they also present significant barriers to obtaining the procedure (Borreo et al., 2008; Campbell, Sahin-Hodoglugil, and Potts, 2006; Gilliam et al., 2008). The history of forced sterilization of poor and minority women in the U.S. along with the federal regulations enacted to prohibit this are likely to contribute to physicians' hesitation about performing these procedures on younger women today (Zite, Wuellner, and Gilliam, 2006; Zite, Philipson, and Wallace, 2007). Thus, doctors may be abiding by societal norms about sterilization, such as high age and parity requirements (Borreo et al., 2007; Campbell, Sahin-Hodoglugil, and Potts, 2006; Thurman and Janecek, 2010; Zite, Wuellener, and Gilliam, 2005), which fail to take into account the changes in reproductive behavior over the last 30 years. In addition, low income women may encounter additional barriers to obtaining the procedure compared to women with greater resources (Zite, Wuellner, and Gilliam, 2005). Institutional requirements, such as the overly complex paperwork required for sterilization paid by Medicaid, have limited poor women's ability to successfully acquire the procedure (Gilliam et al., 2008; Thurman, Ries, and Janecek, 2010; Zite, Wuellner, and Gilliam, 2006; Zite, Philipson, and Wallace, 2007). This is highly problematic because many poor women believe that sterilization would have a significant positive impact on their lives (Cushman et al., 1988).

Women are more likely to face barriers to sterilization if they are young (Borrero et al. 2007; Lawrence et al., 2011; Thurman, Ries, and Janecek, 2010; Zite, Wuellner, and Gilliam, 2005; Zite, Philipson, and Wallace, 2007), have fewer children (Borrero et al. 2007; Lawrence et al., 2011; Thurman et al., 2009; Thurman, Ries, and Janecek, 2010), are less educated (Zite, Philipson, and Wallace, 2007), have public or no insurance (Thurman, Ries, and Janecek, 2010), and/or have a low income (Campbell, Sahin-Hodoglugil, and Potts, 2006; Zite, Philipson, and Wallace, 2007). Women have also identified doctors themselves as barriers to sterilization (Borrero, 2008; Campbell, Sahin-Hodoglugil, and Potts, 2006; Gilliam et al., 2008), as doctors may adhere to dominant norms about the proper timing of childbearing and refuse to perform the procedure.

Overall, dominant social norms about the timing of the beginning and the end of the reproductive life course strongly affect poor and minority women who are more likely to follow an age-condensed life course structure in regards to childbearing (Burton and Bengston, 1985; Burton, 1996; George, 1993). This research seeks to understand how women navigate their reproductive lives in contexts where alternative reproductive norms and life course trajectories are the norm in their communities. Understanding how women perceive the effect of non-normative reproductive experiences in their lives and the ways in which they negotiate and understand their own experiences within the dominant normative reproductive context is critically important, given the high rate of unintended and off-time pregnancies in the U.S. today (Trussell and Wynn, 2008).

THE STUDY

This paper draws on data from individual semi-structured interviews conducted in the Denver, Colorado metropolitan area in September and October 2008, which investigated contraceptive use and unintended pregnancy among low income women. All participants were female, between the ages of 18 and 44, and were either on Medicaid at the time of the interview or within the previous year. Only African American and White women were recruited for the study. Survey research conducted in the Denver metro area prior to these interviews indicated that decisions around pregnancy planning were substantially different in the Latina population. For this reason, it was determined that only White and Black women would be interviewed, and the Latina population would be investigated in future research. Other racial and ethnic groups were not

prevalent in the region. Sample requirements included being between age 18 and 44, Black or White, on Medicaid currently or within the past year, heterosexually active within the past year, and not medically or biologically sterile. Women were recruited in two ways: First, flyers advertising the study were posted at public transportation stops serving low-income neighborhoods. Second, a notice was posted on the free classified advertising website Craigslist (www.craigslist.com) with the same information. Women were offered \$50 to participate in the interviews, which typically lasted 30 to 60 minutes.

Women who responded to recruitment ads were screened by phone to confirm they fit the sample requirements. Interviews took place at participants' homes or a local public library and were conducted by a White woman in her late 30s. Participants filled out a short questionnaire prior to the interview in which they were asked to estimate their income, indicate the number of household members supported by that income, confirm their Medicaid status, pregnancy status, marital status, and to indicate how important it was to them to avoid pregnancy. In total, 20 women aged 18 to 29, and 20 women aged 30 to 44 were interviewed. No one refused to participate in the study.

Interviews were recorded and written informed consent was obtained from each respondent. Interviews were transcribed and then coded using NVivo qualitative software. Both authors read the entire set of transcripts and coded interviews for the main themes. Although the initial study did not set out to examine life course norms regulating the timing of reproduction, these themes emerged through the coding process. Additional codes were then developed based on the timing of reproductive events, particularly at the beginning and end of the reproductive life course. Both authors coded independently and then discussed discrepancies until resolution was reached. Institutional Review Board approval for this project was obtained from a university.

Approximately half of the study's respondents were White and half were African American (n=20 and n=20, respectively). The average age was 28. Almost half of the sample was single; the other half were either married (16 percent) or in a serious relationship (37 percent). All but 7 of the respondents have children or were pregnant at the time of the interview. The average number of children was just over 2 and, the women in the sample combined had a total of 88 children. Avoiding pregnancy was a main concern of

respondents: 75 percent reported that it was very or somewhat important for them not to get pregnant. Fifty percent of the sample experienced a teenage birth and finally, 20 percent had unsuccessfully sought a sterilization procedure at one point in their lives. All names in this paper have been changed to protect the confidentiality of respondents.

RESULTS

Overall, respondents largely subscribed to dominant societal norms about the timing of childbearing, although most did not follow this timeline in their own lives. This was apparent in two main ways. First, because they did not follow the normative reproductive path, many women felt that they had not “done it right.” Respondents who experienced a teenage birth by and large reported suffering from stigma from both their families and from the wider society. This led many women in the sample to want “better” for their children and thus to actively obtain contraceptives for their teen children or strongly encourage them to practice safe sex. Second, respondents resisted the imposition of societal and institutionalized norms about the proper timing of sterilization on their lives by doctors and the medical establishment. This led to frustration with their lack of power, and in many cases women were unable to end their reproductive lives on their own terms. Hence, regardless of their own reproductive experiences, respondents were cognizant of the dominant social norms regulating the timing of childbearing over the life course and in many instances worked to reinforce those norms with others in their lives.

Dominant Childbearing Timing Norms

Although having a child as a teenager was not a sample requirements most women in our sample had teen pregnancies. In general, the population sampled – low income, Medicaid recipients – have a higher prevalence of teen pregnancy (Mollborn 2007). In addition to being a major shock, since all of these pregnancies were unplanned, these events were typically followed by negative consequences, including shame, stigma, sanctioning from family members and others, and difficulty reaching future goals. For example, Lafonda found out she was pregnant for the first time at age 12 and said she was: “Scared. I was a little kid. Not a little girl, but at 12 you really don’t know anything. I was very scared and scared to talk to my Dad.” Similarly,

Tashawndra, 14 years old when she had her first child, stated unequivocally that her first pregnancy was a mistake *because* it occurred during her teenage years: “I had my baby when I was a teenager. It was a mistake.”

Respondents clearly articulated the stigma they felt upon finding out they were pregnant as a teen. Several women mentioned common stereotypes applied to young, single mothers and described their desires to avoid those labels. For instance, Lafonda said that she was engulfed in fear after finding out she was pregnant at age 12 because of “what everyone would think.” Lakella, who had her first child at 16, echoed these fears in her concern that being a teen mother would subject her to the popular characterizations of young, disadvantaged mothers. She said, “I didn’t wanna be the baby-maker that keeps having kids, you know?” Destinee, who had her first child at age 17, also expressed concern about what people would think of her as a teenage mother: “There’s probably someone that’s looking at me and saying, ‘She has no morals,’ just like I look at some people like that: ‘You just sleep with thousands of people.’”

Others felt that teen births were disadvantageous because they forced women to alter their future goals and plans. When asked how she felt about her first pregnancy, Brenda first emphasized her disappointment at the situation:

I was devastated, just because I was 19 and I had just graduated and I had planned a whole different place for my life. My mom, she had gotten pregnant really young, my sisters got pregnant really young. And I thought, ‘I’m not going to do that, I’m not going to do that.’ And it ended up happening. I was a little older than they were but in the same sense I was like, ‘I’m not ready. I don’t want to have a child.’

She then went on to discuss how the pregnancy prompted her to change her plans from attending college to looking for a job:

I had graduated and it was probably about a year after I had graduated and I was just about to say, ‘Okay, well I’m gonna go to college, I’m gonna do this.’ And at that point when I found out, I just was like, ‘I don’t know what to do now...’ ended up moving back in with my mom...It was more like, ‘okay, gotta get a job, gotta get a decent job to get the money to figure what I’m gonna do.’

Kristen, who got pregnant for the first time at age 24, also highlighted this unanticipated consequence of an early pregnancy: “Yeah, when you’re younger you don’t really think, like, you know, what could happen. Everyone knows, but you just...I wasn’t supposed to have kids yet. It wasn’t one of my plans.”

Teen pregnancies were overwhelmingly characterized as negative events in respondents’ lives. However, some women successfully postponed their first birth until after their teenage years and were proud of this. For instance, Chanel, who had her first pregnancy in her early 20s, highlighted the importance of childbearing timing norms by emphasizing that she did *not* have her child during her teen years. When asked how she felt about her first pregnancy she said, “I felt good. My first [pregnancy] was well into my 20s, early 20s, so it wasn’t a teen pregnancy.” Charmonique had her first pregnancy at age 23 and also felt that *not* being a teenage mother was an accomplishment. She said her pregnancy was less of an issue because she was older: “Yeah, and I was of age; I was 23, 24, something like that. So, I didn’t have one when I was 18 so that was really important to me, not to have children at a very early age.” That these women, both of whom experienced unintended pregnancies, were proud of postponing that event until after their teenage years is reflective of the weight given to dominant norms about childbearing timing in low income women’s lives. At the same time, their pride in postponement of childbearing highlights the strong local group expectations that women like them typically end up as teenage mothers.

Respondents’ family members also appeared to have internalized dominant norms about the proper timing of childbearing, given the way they treated women who experienced an early birth. Thus, family members played a major role in women’s own determinations of whether their reproductive experiences were normative or acceptable. Sue reflected on her family’s reaction to finding out she was pregnant at age 15: “I got thrown out of my house. At that point I was going from house to house and then I went to a shelter and they are the ones who helped me get into prenatal care.” Annette described feeling chastised by her family for getting pregnant as a teenager: “I was still under 18 [at the time of the first pregnancy] so I guess I was considered juvenile but I was emancipated. It was like a slapping, like they slap you on the hand kind of thing.” Rachel, whose first pregnancy was at 17, described feeling as though her mother was trying to cause her to miscarry:

At 17 I was scared to death to tell my mother. Oh, I was really scared to death. All these things were going on and then my mom was not very happy with that when I did tell her. She was not. I kind of think, and I'm not saying this to be for sure or I don't know if that was really her intentions, but I think she tried to get me to do things so that I could have the miscarriage.

Other women reported that their families implicitly demonstrated their support of dominant childbearing timing norms by regulating respondents' sexual behaviors. For example, Quanesha, an 18 year old woman with no children, said: "When my mom first found out that I was sexually active, she went to go take me to the doctor and I got on the Depo [Provera] shot." Rachel, whose first pregnancy was at 17, also described her mother's enforcement of birth control: "My mother put me on birth control when I was 15 because I was sexually active." She continued: "My mother didn't want me to get pregnant, which I did get pregnant at 17, but that pregnancy was a miscarriage." Brenda, who had her first child at age 19, had similar experiences with her Aunt whom she was living with when she became sexually active:

I talked to her about having sex and she asked if I was using condoms and I said yes. And she said: 'You need something else because your mom got pregnant. So we need to make sure, you know, you're not gonna do that.' So that first relationship that I had, where we were using condoms, that was the one when I went and got the Depo [Provera]. And that was with my aunt, she took me to go and get the Depo.

Despite the prevalence of early childbearing events in the lives of both the women interviewed and their families, they all clearly subscribed to the dominant norms regarding postponing childbearing until after the teenage years.

Perpetuation of Dominant Norms

Although scholars have argued that the accelerated reproductive life course may be adaptive in contexts in which women have few economic or other opportunities (Edin & Kefalas, 2005), none of the women in our sample who experienced an early birth regarded this experience positively. In fact, most respondents argued that teenage childbearing was extremely detrimental for both young women and their larger society. Many remarked that teens were not grown up enough to engage in sexual activity and face the consequences,

reinforcing dominant norms about the proper timing of childbearing (after the teenage years) even though their own experiences belied those norms. When asked what they thought about half of U.S. pregnancies being unplanned, more often than not women (incorrectly, given empirical evidence) pointed the finger at teens themselves as the root of the problem. Even though most of the women's reproductive experiences were themselves non-normative – or perhaps because of this – respondents largely agreed with the view of teen pregnancy as a social problem and laid the blame on young women.

Stacy, who had three children and four abortions by age 23, stated that unplanned pregnancy “usually involves young people who are irresponsible.” Norma, a 24 year old woman with no children, echoed this sentiment stating that “younger women aren't responsible.” Geraldine, a 29 year old woman with one child and ten previous pregnancies – some during her teen years – agreed: “If you're not old enough...you shouldn't be doing it [having a child].” Jamashia, an 18 year old woman who was pregnant at the time of the interview, also felt teens were the cause of the high unplanned pregnancy rate. She said: “I think it's a bad thing, because a lot [of pregnancies] can be teens, young people that could've waited. So, I think it's actually bad unless you planned it and wanted it to happen.” It seems that in many cases, these views are likely to contradict women's own experiences. For example Geraldine got pregnant two different times during her teenage years, once while taking birth control pills and once while getting the Depo Provera shot. Thus, even when young women are attempting to avoid pregnancy, other factors may complicate their ability to do so. At the same time, the majority of the sample indicated that they had not planned *any* of their births. This disjuncture between women's experiences and their expectations of others reinforces the salience of larger norms about childbearing timing in respondents' lives as well as highlighting the weak links between norms and behaviors.

The Right Time to Have a Child

The right time to have a child was defined by most respondents as within a stable relationship, preferably a marriage. Young, single women still in school were judged as unfit to have children. This view held even though many respondents had their own children under these circumstances. For example, Betty who was herself a teenage mother said: “Well I mean, if they're teens and they're not married or anything and all of a

sudden they're a teenage mother or they have AIDS or an STD or something like that, that's horrible, you know, and changes the whole rest of their life." Ashlee, who had her first child at age 16, echoed this sentiment saying: "If you in school, don't mess that up by not using birth controls and end up having a baby then you have to worry later on, 'Ok I got a child, I done messed up my career.'" Katie, who got pregnant at age 18, used her sister's experience to highlight the ideal – and normative – progression of transitions:

Like, my sister just had a baby. They got married in June and first they bought their home...and then she waited for awhile and she quit taking her pills and you know, I thought, 'oh God, is she gonna get to have this baby?' Finally, God said 'well I guess maybe you're ready'...Now I have a niece that's a week old. I have a picture of her. That's a really good scene. My sister really did it right. I'm proud of her.

When asked about the right time to have a baby, Katie went on to say: "Maybe when it's a couple that is financially stable and both are wanting a child and are financially capable of caring for the child and it's wanted, and it's a stable relationship, and it's going to be hopefully a happy home style." Geraldine, whose first child was born when she was in her late teens, concurred that the best time to have a child was: "If you're in a good marriage or a good relationship with somebody and it's been a long term thing. And you've finished the goals that you have in your life. And you're ready to settle down and you have the patience and the time for a child."

Not My Child

Our data show that women viewed childbearing norms as important influences on their thinking about future childbearing – whether this occurred in their own lives or was reflected in their hopes for their children. Many respondents demonstrated the influence of dominant social norms in their lives by referring to the socially normative timing of events as "doing it right." Women often acknowledged that their own actions, while justifiable within their own life course and social context, did not fit with the widely-accepted reproductive norms. This prompted women to ensure that their children and relatives not make the same "mistakes" they had made in their reproductive lives. Although they were careful to say that they did not regret having their children, respondents also emphasized that early childbearing was not what they wanted for their sons and

daughters. As shown above, women expressed concern about what their own family members would think about an early pregnancy – indicating that family members were aware of, and subscribed to, the dominant social norms regarding the appropriate time for childbearing. Respondents largely mimicked these sentiments, expressing the same concerns for their own children and the desire that their children conform to dominant reproductive timing norms.

Katie, 44 who had her first child at age 18, spent much of her interview discussing her attempts to make sure her teenage daughter was using contraception. She said that birth control was: “Important, very important.” Additionally, she discussed how she was: “Trying to communicate sensibleness in my daughter’s case...being a little more on top of what could happen and what the outcome of it could be...I mean, what an unwanted pregnancy could do to a [teen]...” Lakella, 35 who had her first child at age 16, also discussed her attempts to make sure that her teenage children avoided early childbearing:

...I have a 16 year old. And I’m constantly talking to her, asking, ‘What’s going on? What are you doing? What do we need to do?’ And she’s like, ‘Nothing, nothing, nothing...’ I don’t want any surprises so I think when you’re ready you need to talk to somebody about it and let’s go. Let’s get on this pill.

Unlike most of the respondents who were focused solely on their teenage daughters, Lakella was also concerned about her teenage son and the possibility that he could father a child while still in his teens. To try to ensure that he was having safe sex, she provided him with condoms and discussed his responsibility to protect himself. The concern about children “doing it right” was not isolated to women with teenage children. Women with younger children were also alarmed by the possibility that their young children might someday experience an early pregnancy. Sarah, 36 and a mother of 4 young girls, said:

I would provide my child birth control. If they want to have sex they’re gonna have sex. Regardless of whether you like it or not they’re going to. So, parents are in denial. They’re gonna do it regardless of whether you like it or not. So do you wanna be a grandmother when you’re child is only 13 years old?

Women subjected not only their own children, but other young people, including relatives and friends, to these efforts. Those with close family members such as sisters or brothers with teen children were particularly likely to emphasize responsibility among younger relatives who might be sexually active. For example, Chanel, 32, had the following to say about her niece:

I have a 16 year old niece and she just had her first encounter and I asked her ‘Did you use something?’ She’s my oldest sister’s daughter, but my oldest sister is in her 50s so there’s a big age difference between them. She doesn’t talk to my sister that way, so I told her ‘You can come to me, I’m Aunt Chanel. I’m the hip, young auntie. I know what you’re going through.’ So I asked her if she used something. I don’t care what she says; no matter what, you use something. You come to me, I will take you.

(Did she use something?)

Yes, thank God. I will give it to you, if you need it, here you go. If he says something about condoms, if you want me to take you to the doctor or the clinic, okay, I will take you. It’s not just pregnancy. She sees what I go through with my two young ones. But there’s all kinds of diseases out there too so I tell her, ‘You don’t want to have to go through that.’ She’ll say, ‘I know, I know,’ and I’ll say, ‘No. Do you know?’

Sue, 33 who had her first child at age 15, also discussed her worry about potential unplanned pregnancies among her nieces. Similar to Chanel, Sue drew on her own experiences with her children to persuade her nieces to use contraceptives by making it clear to them what it’s like to be parent.

“Look here girl; you don’t want to have to deal with that.’ Either you do the birth control, like I told my niece, you do it. I don’t care what method it is. Otherwise, you’re gonna have to deal with the babies running around, screaming, hollering and crying. Sometimes I let ‘em [my children] cry, I go in the room and close the door like I don’t hear ‘em. And she [my niece] is calling me, ‘You better take him!’ And I say, ‘See, now if he was yours, then what would you do? You couldn’t give them to nobody, right?’ I always do that to her.

Lakella, 35, described her efforts to educate her friends' children about using contraceptives and avoiding pregnancy: "A couple of my friends have teenage daughters. So I talk to them all the time about it. I'm always in their business, asking them about kids, and 'Do you want 'em? When? Make sure you're stable. What are you taking?'" These women are clearly perpetuating dominant norms regarding the timing of childbearing, despite their own experiences often being at odds with those norms. It is interesting that they engage in this perpetuation while at the same time being careful to validate their own childbearing experiences within their social context.

Ending the Reproductive Life Course

Due to the prevalence of teen births in this sample, 20 percent of the respondents wished to stop childbearing comparatively early in their reproductive life cycle (usually during their early 20s). This is a high number given the fact that women who were sterilized were excluded from the sample. The desire to end childbearing was most often translated into a decision to obtain sterilization via tubal ligation. However, because respondents were young, doctors often disallowed women from being permanently sterilized, ostensibly because of dominant childbearing norms. In many of these cases, women then went on to have additional children, which was not only challenging for them, but also often caused a financial burden. Women who attempted to be sterilized acted in both normative and non-normative ways. Their actions were normative in that they had achieved their desired number of children (or for some, more than their desired number). This was often because they had been unsuccessful at regulating their childbearing by using contraceptives. Therefore, they sought more a permanent way to stop having children. At the same time, their actions were viewed as deviant by medical providers because they sought to permanently stop childbearing at such a comparatively young age.

Several respondents described their strong desires to undergo a tubal ligation. For example, Charmonique, a 35 year old single woman with three children, mentioned sterilization when asked about her ideal form of birth control. She said: "I've been meaning to get my tubes tied for 12 years." When asked when it is important to use birth control, Roshawna, a 40 year old married woman with 13 children, said: "To

be honest, I don't think it's important at all. Because if you don't want to have any more kids, get your tubes tied, clipped and burned."

Other women indicated that they had considered sterilization but were not sure that they were old enough to do so. These comments are indicative of their internalization of dominant norms about the proper time to end childbearing. Chanel, age 32 and single with three children, did not want to have another child, but still felt that she was young and might change her mind:

I thought about getting my tubes tied but then thought, I'm young but I'm not that young, do I still want to wake up in the middle of the night with a new born? But what if I get married? What if...I meet someone and he wants babies? I always thought of that, that I would love to have a baby by my husband, not just a baby daddy. I did think about that [sterilization] but decided not to get my tubes tied, decided to wait.

Lakella, 35 and single with 2 teenage children, also discussed the possibility of meeting someone later on, even though she also was unsure about wanting more children.

I was really thinking about getting a tubal ligation, so...

(What made you decide not to do that?)

I think, divorcing the kids' dad. I was like, you know, I'm not gonna go through this. I might meet somebody, I don't know. I'm 35, I might meet somebody and we might want another baby, I don't know.

Markeisha, 25 and divorced with two children, also expressed the hope that someday she might meet someone with whom she would want to have more children: "So, I really prefer to get my tubes tied, but I just have to go with the flow I guess. I mean, that's if, you know, my knight in shining armor doesn't come rescue me."

While many women had considered sterilization but opted not to go through with it yet, several others desired to have the procedure but encountered barriers, many of which were based on their age. Markeisha, a divorced 25 year old with 2 children, reflected on her experience after her second child: "I actually wanted to get my tubes tied, after I had him. I'm like 'Can we please?' and they told me 'No' because I wasn't old enough." When asked what age she needed to be to have the procedure, she was told, "Twenty-five. Twenty-

five or twenty-six and if you're not that age you have to have, I think it's four children or more before you qualify to get your tubes tied." Similarly, Annette, 34 years old and married with two children, wanted a tubal ligation after her first child and was refused on the basis of age. "I told them 'just yank everything out. I'm sick of having kids.' They said, 'You're too young.' You know what, it's my body, my decision, I do believe. And they just wouldn't do it." Annette subsequently had an unplanned pregnancy. Ashlee, 40 years old and single with 9 children, was told that a tubal ligation simply was not necessary, despite her difficulty with preventing pregnancy using contraception. "I wanted them to tie my tubes after the last one and they wouldn't do it. She said there was no reason to...She said I may change my mind." These interactions with medical professionals illustrate the difficulty women face when they attempt to stop their childbearing at an age that is not considered appropriate.

Aside from barriers based on age, institutional hurdles rendered sterilization out of reach for many women. Markeisha, 25 years old and divorced with two children, said:

"I go to a Catholic hospital so they wouldn't have done it. They would have had to send me somewhere else. I prefer getting my tubes tied over the IUD, but they want me to try other options first. So they're kind of procrastinating on letting me do it. They're giving me the run-around."

Like Markeisha, Ashlee, 40 years old and single with 9 children, experienced barriers based on the religious affiliation of her Catholic hospital. "Unfortunately I had [my child] at St. Anthony's Central. They wouldn't do a [tubal ligation] there."

Other respondents were dissuaded from pursuing sterilization by doctors themselves. Annette, 34 years old and married with two children, was convinced by her doctor that tubal ligation was not an effective method of birth control. "I thought about tying, burning, cut, tie, burn. But they said you still can get pregnant off of that. I said, oh yeah, my luck, fertile myrtle." Desta, a pregnant, single 32 year old mother of three other children, overheard similar advice being given to a friend of hers, which convinced her to forget about sterilization as a viable method.

I had talked about getting my tubes tied after this baby. But a friend of mine just had a baby and we were at the hospital and the doctor came in and was telling her the big risk of getting your tubes tied,

what not, this and that. And I had to think about that. Like, ‘No, I don’t think I want that.’ They said that 1 out of 50 women do end up getting pregnant in their tubes; and if you get a tubal pregnancy that could consist of you getting a whole hysterectomy. I don’t want that.

Many women’s opinions about sterilization differed from those of their family members. Markeisha, 25 years old and divorced with two children, disagreed with her mother about whether or not to be sterilized:

I just don’t want any more... I am done. And my mom tells me all the time ‘Well, why get your tubes tied? What if you do meet someone and you guys are very happy and you’re now spending the rest of your life together and they want kids?’ I’m like, ‘That’s too bad, we are going to have to adopt.’ I know it’s kind of selfish and I might get the baby fever if I meet the right person, but right now I know my life is not where it needs to be to have three kids... I can’t do it.

Markeisha went on to say: “I’m 25 now. I don’t want to be 30 and pregnant. I don’t want to do that.” Thus, women were often faced with the decision to end their reproductive lives early – if it was even allowed – or to risk having future children that they did not want. Overall, respondents experienced a number of barriers when they expressed a desire to end their reproductive life course early. Much of this disapproval was based on the idea that women may still meet a man later in life and want to have more children.

DISCUSSION

These data clearly demonstrate the influence of social norms about the proper timing of childbearing in women’s lives, and especially so for those who were unable to abide by dominant reproductive norms. At the beginning of the reproductive life course, dominant norms did not influence women’s behavior, yet these norms did impact women’s attitudes and how other people evaluated their behavior. In contrast, norms constrained women’s behavior at the end of the reproductive life course as others (e.g. doctors and relatives) disagreed with their desires to end childbearing early. The majority of our respondents had unplanned births during their teenage years and yet, most did not view their actions as adaptive in their particular contexts. Rather, they were stigmatized for getting pregnant early (off-time), and as a result of these experiences, their support for widely accepted societal expectations about the timing of reproductive events was usually bolstered. This internal support of dominant norms negatively affected their conceptions of self, but also

impacted their children as women worked to avoid becoming grandmothers early. Rather than developing an alternative reproductive life course as some scholars have suggested, these women instead attempted to fit their behavior into the dominant normative framework by regulating the behavior of their children.

Women also demonstrated their support for dominant reproductive norms by stigmatizing and blaming teen mothers. One might expect that because getting pregnant as a teen was a familiar experience for most of these women, they would support young mothers and offer encouragement. Instead, discussions of unplanned pregnancies revolved around young women's irresponsible behavior and immaturity. Thus, the cycle of shame will continue for teen women who find themselves pregnant, even though as noted above, teen pregnancies have been somewhat common for decades. The main difference today is that a teen pregnancy by no means leads to a marriage as it did in the past. Thus, teen women are the visible culprits, often blamed for teen pregnancies while the fathers of their children are allowed to remain invisible and escape the stigma attached to off-time childbearing. This serves to further demonize young disadvantaged women as they are often the ones most at risk for early pregnancies.

As most women in our sample began childbearing early, they also often desired to end their reproductive lives early. However, women faced substantial barriers in this endeavor. Institutional barriers limited women's ability to be sterilized as regulations enacted during the 1970s explicitly supported the dominant reproductive timing norms. Respondents expressed much frustration at their lack of agency when it came to controlling their own bodies. Many had been unsuccessful at regulating their risk of pregnancy through contraceptives and thus, sought to end their ability to have future children that they did not want. Because most were comparatively young when they attempted to be sterilized, some doctors refused outright to perform the procedure, often suggesting that women might meet a man in the future, which would motivate them to have another child. This was even the case with women who had multiple children before their early 20s and who were struggling to support these children, many of whom were on Medicaid.

Women in our study experienced strict regulation of their bodies at both of the key times in the reproductive life course (beginning and end of childbearing) investigated. When the beginning of their childbearing did not accord with dominant reproductive timing norms, women were stigmatized and their

plans and goals for the future were often halted. When respondents' desired to end their childbearing too early, they experienced similar stigma and outright refusal from the medical community to allow sterilization. At both of these times, women's agency and control over their own bodies was severely restricted. This has implications for women's ability to achieve their reproductive goals, especially for women who are unsuccessful at using other contraceptive methods for whatever reason.

Our results demonstrate that the accelerated reproductive life course is a relevant concept for low income women at both the beginning and end of the reproductive life course. In fact, beginning their reproductive life course early led many women in this sample to desire to also end it earlier than conventional standards. However, although these events have been accelerated in women's lives, rather than justify their actions in their discussions about their experiences, women tended to support the dominant norms about the timing of childbearing, especially at the beginning of the reproductive life course. Because our sample excluded women who successfully obtained sterilization, this may not be true for all low income women. Therefore, we find little evidence that the accelerated reproductive life course has been a positive experience for the women in this study, although that may not be the case for all women in similar circumstances.

There are several limitations of our study that should be noted. First, our qualitative sample was drawn from a particular population (women on or formerly on Medicaid) in one geographical area. These sample restrictions limit our ability to generalize our findings to larger populations of low income women or even Medicaid users. Furthermore, because recruitment occurred at public transportation stops and online, women using these resources had a higher likelihood of participating in this study. Women who do not have access to these resources would have been excluded from participation. However, the public transportation system in the Denver metro area is well developed and widely accessed and the internet is accessible at public libraries. Therefore, these methods of recruitment are appropriate for the context and are not likely to have excluded a significant proportion of low income female Medicaid users. Second, because our sample did not include women who were already sterilized, the accounts women provided of their interactions with medical providers may be distinct from the larger population of women who desire to be sterilized. However, even women in our sample who did not yet desire sterilization (or had not tried to obtain sterilization) expressed

concerns about being able to have the procedure should they want to in the future. Thus, we feel that these results, while they cannot be generalized to women who have been sterilized, are nonetheless reflective of larger patterns among low income women. Third, we cannot discuss the experiences of women of other racial/ethnic groups as only White and African American women were included in the sample.

This study is the first of its kind to connect norms about childbearing at the beginning and end of the reproductive life course. In doing so we identify a number of the social barriers women encounter in making non-normative choices about the reproductive timeline. Additionally, this study emphasizes the extent to which low income women's attitudes and behaviors are affected by dominant middle class norms even in contexts where most women's experiences do not reflect these norms. These findings have implications for scholars interested in the effects of poverty on women's reproductive timing and behaviors over the life course. In addition, our findings suggest that new policies addressing barriers experienced by low income women in learning about and obtaining contraceptives as well as accessing sterilization when desired are needed. Furthermore, future research which investigates the influence of dominant reproductive norms on women of other races and ethnicities over the reproductive life course is needed. Studies that focus on teen mothers and their feelings both about their teen pregnancy and about their reproductive futures would help to develop a fuller understanding of these patterns among young women. Also, studies examining the impact of reproductive life course norms on men would provide information about how these norms may influence relationship formation and dissolution. Finally, it is unclear the extent to which these patterns are limited to low income women. Research investigating the barriers experienced by women of a variety of socioeconomic statuses and sexualities would help to clarify this.

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