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## **Conceiving Time? Women who do or do not conceive**

*Sarah Earle and Gayle Letherby*

### **ABSTRACT:**

This article explores the importance of time for an understanding of women's experiences of reproductive identity. In order to do this we draw on data from two separate qualitative research projects. The first project is concerned with the experiences of conception, pregnancy, childbirth and early motherhood in primagravidae, whilst the second focuses on the experiences of individuals (especially women) who defined themselves (at the time of the fieldwork, or some time previously) as 'involuntarily childless' and/or 'infertile'. These two areas are usually treated as separate; however this article explores similarities between them in terms of time and medicalisation. Our central concern then is with exploring the similarities of experience for women who do or do not conceive.

### **KEY WORDS:**

Conception; control of the body; medicalisation; time; women's reproductive health.

## **Conceiving Time? Women who do or do not conceive**

*Sarah Earle and Gayle Letherby*

### **Introduction**

This article explores the importance of time for an understanding of women's experiences of reproductive identity, drawing on data from two completed qualitative sociological research projects. The first project is concerned with the experiences of conception, pregnancy, childbirth and early motherhood in primagravidae, whilst the second focuses on the experiences of individuals (especially women) who defined themselves (at the time of the fieldwork, or some time previously) as 'involuntarily childless' and/or 'infertile'.<sup>i</sup> These two areas are usually treated as separate; however this article explores similarities between them in relation to the medicalisation of reproductive time. Our central concern then is with exploring the similarities of experience for women who do or do not conceive.

Petchesky (1980: 691) argues that:

... women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions which they themselves create but under social conditions and constraints which they, as mere individuals, are powerless to change.

With this in mind, women's perceptions of reproductive choice and control are explored by drawing on the experiences of respondents. The article begins with an outline of some of the main theoretical concerns, focusing on the relevance of control, time and the medicalisation of women's bodies. Then following an outline of methods and methodological issues, the main body of this article is concerned with the experience of both groups of respondents. Reproductive experiences are explored by drawing on the concepts of control, medicalisation and time. In writing about time

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<sup>i</sup> We write 'infertility' and 'involuntary childlessness' in single quotation marks to highlight problems of definition.

and reproduction Pizzini (1992: 68) has argued that: 'Anyone who thinks about time in relation to pregnancy and childbirth will realise that they raise many fascinating questions'. We agree with this and extend this analysis to the experiences of women who do or do not conceive.

Comparing the experiences of the two groups of respondents enables the highlighting of similarities in experiences between women who do or do not conceive. Women who are medically defined or who define themselves as 'involuntarily childless' and/or 'infertile' are perceived as desperate and helpless (Pfeffer 1993). Whilst accepting that this stereotypical image as the defining characteristic of the 'infertile'/'involuntarily childless' should be challenged (e.g. Pfeffer and Woollett 1983, Franklin 1990, Pfeffer 1993) it is clear that some individuals who define themselves as 'infertile'/'involuntarily childless' so sometimes also define themselves as desperate (see Letherby 1997). Furthermore, these feelings of desperation are sometimes shared by women who have not defined themselves as 'infertile'/'involuntarily childless' and who go on to achieve healthy pregnancies (see Earle 1998).. Nonetheless, whilst recognising that there are similarities between these two groups of women there are, of course, stark differences. Not least, women who achieve pregnancy and parenthood 'naturally' are considered to be the norm, whilst those who do not are defined as medically and socially deviant. In this article, though, the focus is on the similarities between two experiences usually viewed as completely different.

### **Controlling Reproduction?**

It is commonly assumed that the issue of reproductive health is 'women's business' and arguably for some women, this assumption has been instrumental in their control over reproduction. It has also been the cornerstone of many feminist campaigns, which have demanded the right for women to 'control their own bodies' (Petchesky 1986, Himmelweit 1988, Kitzinger 1992). Yet, it is possible to argue that reproductive control is merely an illusion in that reproductive experiences often have to be understood within the context of contemporary social and medical discourses which influence the choices and control that women have. Differences between women are relevant here. In the United Kingdom (UK) poverty and social exclusion remains the

single most important factor in determining women's reproductive health. For example, almost twice as many of the poorest women in society will give birth to a still born or premature baby when compared to women in other social groups (Acheson 1998). There is also considerable inequality in access to reproductive health care, including access to family planning, maternity care, 'infertility' treatments, and so on. Inequality can also be found with respect to minority ethnic women, lesbian women, and others (DiLapi 1989, Press *et al.* 1998). Across the world similar patterns of inequality are evident (Franklin and Ragoné 1998).

Women's reproductive rights are clearly worth defending. Alongside this, it should be acknowledged that 'rights' can only be realised within favourable social and economic conditions and that, at any given time, some women will have little, or no, choice or control over reproduction. Despite claims of women having increasing and considerable control over reproduction (in the West at least), in reality, there are many interrelated factors that mitigate against this, including societal expectations, social exclusion and relationships with others, both in medical encounters and within familial and intimate relationships (Earle and Letherby 2003).

### **Reproductive bodies, medicalisation and control**

It has long been argued that we now live in a world that is increasingly medicalised (Zola 1972). The medicalisation of women's bodies in particular has been widely documented and discussed by feminist scholars who suggest that, 'scientific [medical] discourses have come to articulate the authoritative social theories of the feminine body' (Jacobus *et al.* 1990: 1). Ehrenreich and English (1976) have suggested that medical ideology constitutes women as psychologically and socially vulnerable and, therefore, in need of medical surveillance and control. Physiologically, women's bodies are also seen as weak, thus conception, pregnancy, childbirth, infertility and menopause have come to be defined as 'medical problems' requiring 'expert' advice and intervention (Turner 1995 [1987]).

Many writers have sought to develop a critique of the medical monopoly of human reproduction. For example, there is a wealth of literature focusing on the medicalisation of childbirth; suggesting that this disembodies and disempowers

women (Oakley 1980; 1984, Kent 2000) and that many pre-natal technologies serve to objectify women (Ettore 2002). Grosz (1993: 199) argues medicalisation has been characterised as the making of a 'body pliant to power'. Brown and Webster (2004: 70) provide a further example of how science and technology can lead to the 'disembodiment' of the reproductive body:

A chapter title of a book by Robertson (1996) is called 'Farming the uterus: non-reproductive uses of reproductive capacity'. This notion of 'farming' nicely captures the sense in which the reproductive body is a site through which biological material and information is harvested for scientific, medical and commercial purposes.

Knowledge of the body is fluid and susceptible to change over a time/space continuum. Many writers have noted that our perception of the body is socially constituted (Turner 1992; 1995; Shilling 1993), and Douglas (1973: 93) argues that, 'the social body constrains the way the physical body is perceived'. Following on from this, it seems clear that embodied practices are also situated within specific historical, cultural and institutional settings (Kent 2000). Thus, women's perceptions of medical power and control are also socially situated; as Lock and Kaufert (1998) suggest any discussion of medicalisation and power must be grounded in time and place.

Although researchers are correct to highlight how the medicalisation of women's bodies has undoubtedly served to (re)define women in negative ways, it could also be argued that there has been a tendency to overlook the extent of women's agency (Fox and Worts 1999). Analyses of women's perceptions and experiences of reproduction highlight numerous examples of resistance, agency and autonomy (Franklin & Ragoné 1998; Lock and Kaufert 1999; Greil 2002). It must also be acknowledged that women often choose medical and technological solutions to remedy these 'medical problems'. For example, in writing about childbirth, Martin (1989) highlights that some of the women in her study actively sought medical interventions, especially pharmacological analgesia. Similarly, studies of pregnancy suggest that many women welcome, and now expect, prenatal testing and diagnosis to be performed routinely

(Press & Browner 1997; Taylor 1998). However, these choices must be understood within the context of women's lived experiences and within the specific time/space continuum in which these decisions are made. As Brown and Webster (2001: 79) argue:

The arena within which reproduction takes place is no longer that of kinship and biomedicine alone but the wider domains of industrialization, information innovation, product development and the political machines . . . that endeavour to order it.

### **Time and reproduction**

Grosz (1999) argues that, historically, time has been represented as an *a priori* category. Adam (1990) and Davies (1996) propose a critique of the unidirectional taken for granted nature of time, arguing that our understanding of time is not a 'fact', but an ideal. It is argued that whilst we have one dominant and narrow way of looking at time - in terms of clock time and linear time - there are a plurality of times and temporalities. In writing about health, illness and time, Freund and Maguire (1999: 89-90) suggest that:

Control over time – our own or other people's – is a form of power. Powerful persons have the ability to regulate other people's time and labour. The ability to manage our own schedules is limited by our position in society ... Time is socially organised, and the ability to schedule time and to manage it is socially distributed. Those with more power have more control over time.

If it is accepted that life involves a complicated weaving of differently gendered temporal structures, times and timing, the notion of 'embodied' time is needed to locate individuals in their bodies.

Concepts of time are useful in helping to understand human reproduction and, specifically, the experiences of women who do or do not conceive. Women's

reproductive bodies are constrained by time and Grosz (1999: 134) argues that women are, 'granted no space or time of their own'. As Adam (1990: 99-100) notes:

...irreversible time dominates in studies of the life cycle. This applies irrespective of whether the life cycle is conceptualised as a cumulative development of growth and decay or in terms of unidirectional successive stages.

The concepts of a 'life cycle' and a 'life course' are useful for understanding women's experiences and perceptions of conception; the concept of a life cycle, 'implies fixed categories in the life of the individual and assumes a stable social system, whereas [the life course] allows for more flexible biological patterns within a continually changing social system' (Cohen 1987: 1). In the context of individual and family life the life cycle approach cannot account for factors such as 'death, divorce, cohabitation and premarital pregnancy' which 'disturb the chronological order of life course stages and create [individual lives and] family forms which differ from the ideal' (Cotterill 1994: 112; see also Murphy 1987).

Of course, as Mills (2000) suggests, the study of time and the life course is not new. The life course approach encompasses social and demographic changes as well as biological events and emphasises the relationship between different phases (Arber and Cooper 2000). In using this approach we can see that an individual's voyage from birth to death is not a simple unidirectional journey but one with 'false starts, changes in direction and hidden obstacles' (Hockey and James 1993: 50).

When using the life course approach, theorists often still draw on ages and/or phases which are based on 'expected' biomedical events (for example, see Laslett 1989; Arber and Cooper 2000; for further discussion see Exley & Letherby 2001). This tendency to refer to biomedical ages/phases, even in life course analyses, is reflected in the difficulty individuals' experience when assessing their own lives; in particular, a difficulty with describing their own experiences without reference to 'expected' life events. The metaphor of a 'biological clock' is a common one (noted by Martin 1989) and a fear of ageing and body dysfunction are salient to women's experiences of conception. Whilst it is possible to accept the distinction between a life cycle and a



life course as a valid one, the data suggest that conception, pregnancy and motherhood are considered to be fixed categories in the life of the individual and as part of a 'normal' life cycle/course. Thus, although the notion of a life cycle is regarded as a generally outmoded concept, it is still useful for exploring conception from the perspective of women themselves. As Busfield points out, 'having children is a core component of a woman's identity' and, like marriage, a crucial component of 'the life cycle or life course' (1987: 67). In the modern Western world, most individuals grow up expecting to have successful pregnancies exactly when they want them, thus pregnancy loss and 'infertility' affect people's and societies' expectations of women who do or do not conceive (Oakley *et al* 1990).<sup>ii</sup>

Connecting time, medicalisation and reproduction, Simonds (2002) argues that time is power and that the conceptualisation of time within the medicalisation of human reproduction is central to the experiences of procreating women. Thus, as Thomas (1992: 56) argues:

In the social and cultural construction of the events of a woman's reproductive and sexual anatomy and in the medical speciality of obstetrics and gynaecology time is literally "of the essence". It is fundamental to the constitution, organization and interpretation of symptoms and to the delineation of the normal, the abnormal and the pathological.

This article suggests that time is integral to the experiences of women who do or do not conceive. Perceptions and experiences of conception are structured by the idea that there are fixed bio-social stages in the life of an individual. Our data analysis shows that concepts of time such as calendar time, symbolic time, time as commodity and time as process are all relevant to understanding experiences of our respondents. Drawing on Adam's (1992) analysis of 'time running out' as an exclusive aspect of clock-time we extend this to the concept of clock/calendar time which better

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<sup>ii</sup> Exley and Letherby (2001) have written about 'infertility' and 'involuntary childlessness' as lifecourse disruption elsewhere.

illustrates temporal experiences of trying to conceive (see, for example, Posthill 2002). Symbolic time has been extensively discussed elsewhere in relation to power between doctors and others (for example, Pritchard 1992; Pizzini 1992) and this concept is a useful one in trying to understand the medicalisation of reproductive time and the body. Time as a commodity and time as a process are interwoven in the data in that attempting and achieving pregnancy is structured by objective and subjective definitions of time. In this sense time as a commodity becomes a ‘thing’ or an object whereas time as a process relates to the biological and social rhythms of human reproduction.

## **Research Methods**

### ***The Pregnancy and Childbirth Study***

The focus of the pregnancy and childbirth research (PCB study) was on women’s perceptions and experiences of the body during the pregnancy process, that is: during conception, pregnancy, childbirth, and the early post-natal period. Ethical approval for the project was granted by the Local Research Ethics Committee (LREC) and approval was also granted by a University Ethics Committee. Nineteen women were recruited to the study group between six and fourteen weeks of pregnancy through twelve different ante-natal clinics in the West Midlands, UK. Local midwives and general practitioners acted as gatekeepers in all of these settings. The aims of the project were explained verbally and in writing to respondents at the time of recruitment and respondents were asked to sign a consent form. Consent was then verbally renegotiated prior to and during interviews. Nineteen women were interviewed and their ages ranged from sixteen to thirty years of age, with the majority of women being in their mid-twenties.

### ***The ‘Infertility’ and ‘Involuntarily Childless’ Study***

In the ‘infertility’/‘involuntarily childless’ research (IIC study) respondents were self-selecting and were recruited using several methods: through adverts and letters in national and local newspapers; support group magazines; and through snowballing. The project was approved by the University Ethics Committee and 65 women were

recruited to the study group<sup>iii</sup>. As no respondents were recruited via health or social care providers LREC approval was not required. The aims of the project were explained verbally and in writing to respondents at the time of recruitment and respondents were asked to sign a consent form. Consent was then verbally renegotiated prior to and during interviews. Twenty-four women who defined themselves as ‘infertile’ and/or ‘involuntarily childless’, at the time of the research or previously, were interviewed and a further forty-one women who defined themselves similarly were involved in the research via correspondence. These women either lived a distance away and/or preferred to write about their experience rather than talk about it. The study group included people who were childless through non-medical reasons and (i) cases where the source of ‘infertility’ was with their male partners, themselves or both or unknown; (ii) cases where ‘infertility’ was the primary problem and cases where ‘infertility’ was secondary as the result of endometriosis or some other physical problem. It also included parents; through unaided biological means, as a result of assisted conception, through adoption and step-parents and non-parents. The majority, but not all, had had tests or some medical treatment that related to their ‘infertility’ and/or ‘involuntary childlessness’. Twenty of the sixty-five women in the IIC study group were mothers: twelve biologically (five following medical assistance) and eight socially. The youngest respondent was 25 and the oldest 72.

### ***Representation***

As well as differences of experience and age, different socio-economic groupings were also represented in each study, to include women in a variety of occupations, unemployed women, women who had retired, and women who were not seeking employment. Some differences were not represented though; in both study groups respondents were predominantly white and predominantly heterosexual. In the PCB study women from a variety of backgrounds were encouraged to participate and special efforts were made to include ante-natal clinics situated within ethnically diverse areas. As the IIC study recruited respondents via advertisements in national and local newspapers and in ‘infertility’ support group magazines - and respondents were self-selecting - this influenced the representation of diversity within this project.

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<sup>iii</sup> Eight men also participated in the research but they are not the focus of this article.

Writing specifically about research on ‘infertility’, Woollett (1996) suggests that it is impossible for any research in this area to represent the experiences of all, and we would suggest that this is true for all research (also see Evans 1995). As Attar (1987: 33) notes experiential material is valuable:

Sometimes, the point we want to make may indeed be that our experiences differ, and that no one woman can represent another. But this should not be taken to mean that we have wholly different concerns ... When a woman writes about experiences which have not been shared by most of her readers ... there will still be connections.

Yet, we accept that this article and our research (like much research) need to be read as illustrative rather than as representative.

### ***Data Collection and Analysis***

As Stanley and Wise (1983: 167) argue ‘the best way to find out about people’s lives is for people to give their own analytical accounts of their own experiences’. In-depth semi-structured interviews (combining a life-history approach with some standard questions) constituted an important data source in both projects; which was supported in the IIC study by correspondence (see Letherby and Zdodrowksi 1995, for further discussion). All interviews were audio tape-recorded with the consent of each individual and then transcribed *ad verbatim*. We each took a processual approach (i.e. series of interviews with each person) to obtain access to different viewpoints on experience over time. In the IIC study, each respondent was interviewed between one and five times or wrote between one and four letters. In the PCB study, respondents were interviewed three times at specific stages of the pregnancy and following childbirth across a period of approximately eleven months. The 1<sup>st</sup> stage interviews were conducted as soon as possible after the confirmation of pregnancy (between six and fourteen weeks), the 2<sup>nd</sup> stage interviews were conducted towards the end of the pregnancy (between thirty-four and thirty-nine weeks) and the 3<sup>rd</sup> stage between six and fourteen weeks after childbirth.

**Table 1 Table of respondents represented in this article (alphabetical)**

<b>Name</b>	<b>Age</b>	<b>Study</b>	<b>Method of data collection</b>
Angela	19	PCB	Interview
Bernie	38	IIC	Correspondence
Carol	32	IIC	Interview
Carolyn	30	IIC	Interview
Charmaine	23	PCB	Interview
Dawn	Mid 40s	IIC	Letter
Fiona	Mid 30s	IIC	Correspondence
Gaynor	27	PCB	Interview
Gloria	36	IIC	Interview
Ida	72	IIC	Interview
Jill	28	PCB	Interview
Kay	25	PCB	Interview
Laura	32	IIC	Interview
Linda	24	PCB	Interview
Melanie	Mid 30s	IIC	Correspondence
Pat	Mid 30s	IIC	Correspondence
Sue	42	IIC	Correspondence
Tania	24	PCB	Interview
Tracey	28	IIC	Interview
Tricia	26	PCB	Interview
Trudy	29	PCB	Interview

Issues that emerged in early interviews (and letters) were explored further in later interviews (and letters) with each respondent. Also, issues that were raised by the respondents early in the fieldwork period were explored with others later on. We each sought to generate and formulate theory from empirical data using a grounded theory 'style' (Glaser and Strauss 1967). As Strauss and Corbin (1990: 23) argue:

A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed and provisionally verified through systematic data collection and analysis of the data pertaining to the phenomenon. Therefore, data collection, does

not begin with a theory, than prove it. Rather one begins with an area of study and what is relevant to that area is allowed to emerge.

Data were analysed using a system of ‘open coding’, which involved sorting the data into analytical categories by ‘breaking down, examining, comparing, conceptualising and categorising data’ (Strauss and Corbin 1990: 61). These categories of data were then compared and contrasted to generate themes; these themes form the basis for analysis and discussion.

Stanley and Wise (1990: 22) argue that, ‘researchers cannot have ‘empty heads’ in the way inductivism proposes’. So it is important to acknowledge the intellectual and personal presence of the researcher in all stages of the research process (Cotterill and Letherby 1993). Bearing this in mind, the main body of this article is concerned with a small part of the ‘findings’ from our research: that which relates to issues of time and control in relation to women who do or do not conceive.

All respondents have been given pseudonyms and we have included respondents’ ages in the data section of the article as these are relevant to the discussion.

## **Data and Discussion**

### ***Getting pregnant; good, bad and right times***

Getting pregnant and having children is expected to happen at particular ages and stages, as well as in particular social and sexual circumstances, in an individual’s life (Cussins 1998; Henrikson and Heyman 1998), but time passes, even when this ‘expected’ event does not happen. Thus, time can come to be seen as a precious commodity that ‘runs out’. Therefore, experiences of conception are constituted in ‘the knowledge that there are good, bad and right times for doing things’ (Adam 1989).

However, data from the PCB study suggest that there never seems to be a ‘good’ time to conceive. Many respondents expressed ambivalence about getting pregnant and

although many of them were extremely pleased to be so, they expressed anxiety about the future. For example:

Charmaine: I started to worry then. The future, money, am I old enough?  
Am I responsible enough? Do I want to give up going out?  
[PCB study, age 23]

Linda: ... half of me thought 'oh great, we've done it, we're gonna have the baby', but then I started to think, 'oh God, what have I let myself in for?' You do get like, that niggly feeling like, oh, you know, loss of freedom, you know, money, you know, how we're going to feel towards one another.  
[PCB study, age 24]

Other PCB respondents were less ambivalent and considered their pregnancy to have occurred at a 'bad' time. Tricia was travelling abroad with her husband when she discovered that she was pregnant and this meant returning home:

Tricia: I was dismayed really, because partly, it wasn't planned and partly because the travelling we had done just before, that was really rough . . . we were planning to come home in October so we didn't know whether to come home straight away. We were obviously worried about the fact that we were in a foreign place and that if I had a spontaneous abortion, that kind of thing, it was dangerous as the medical facilities aren't marvellous here.  
[PCB study, age 26]

Angela described her pregnancy as 'annoying', but this is not surprising considering the problems she had; she lost her job and her boyfriend had left her. She said:

Angela: Shocked, what else? Wrong timing I suppose, a bit annoyed. . . I just thought about what I was going to do you know, 'cause I was working in a job where, um, you couldn't be pregnant

doing it ... being a busy restaurant so, my job really, up and running...he sacked me...mostly because of that [being pregnant].

[PCB study, age 19]

Our data would suggest that whilst there is *never* a ‘good’ time to get pregnant and have a baby and *sometimes* a ‘bad’ time, there is *often* a ‘right’ time. For the PCB respondents, the right time to have a baby seemed to be based on a number of interrelated factors. For example, respondents needed to find the balance between their desire to conceive and their desire to do other things. As Oechsle and Geissler (2003: 79) state: ‘individuals are faced with the tasks of relating their personal identity, their life goals and the perceptions of time on which these are based to social time structures’. Respondents were also faced with the need to balance their own desires with that of others:

Tania: I never planned on having kids because I wanted to work and do something with my life but I wanted kids as well. I was mixed up about it and I thought ‘it isn’t fair [on my boyfriend], getting a house and getting married’ so I thought, ‘that’s it, there’s no going back’.

[PCB study, age 24]

Even when respondents had not planned a pregnancy, pregnancy was welcomed if it was considered to have come at the ‘right’ time:

Tricia: I am married, I have a stable job, there was just no reason why I shouldn’t have the baby. Really, we were very happy when it had sunk in.

[PCB study, age 26]

Respondents in the IIC study also talked about decisions and choices in relation to the ‘right time’ to have children; here though, the emphasis was always weighted towards the concern not to leave it ‘too late’. As one respondent stated:



Pat: I would like a child now, because, (a) I feel mature enough to bring it up well, (b) I don't want to be an 'old' mother (c) I am aware that physically, I am past child-bearing age and don't want to leave it too late, for fear of damage to both the baby and to my own body/figure.

[IIC study, mid 30s]

Laura: ... I was 28 at the time and at that time I felt I didn't want to be too old on being a first time mum.

[IIC study, age 32]

Whilst the life course can be fluid, life course analyses suggest that reproductive success is a normative expectation (Oakley, et al., 1990; Earle and Letherby, 2003; Ettore 2004). As Ettore (2004: 316) notes:

Temporal formulations for normal reproduction are organised at a collective level ... rather than a source of energy, time becomes somewhat of a burden for those whose biological clocks are perceived as not synchronised with their reproductive ones.

In relation to this, our data suggest that as well as there being 'good', 'bad' and 'right' times to conceive there is also an awareness of time 'running out' and that time is a 'precious commodity'. As Menzies (2000: 80-1), who theorises about her own experience of infertility states:

More and more North American women (particularly white, middle-class women like myself) live as I have, as an extension of an overflowing schedule, email and voice mail boxes, using contraceptives to freeze-frame child-bearing ... Women cannot take the integrity of this time zone and a presumed female capacity to re-enter it at will for granted. That is what my experience of becoming infertile taught me: that sometimes it's too late.

***Trying to get pregnant or waiting for conception***

A distinct feature of the contemporary approach to getting pregnant is that it is something that usually involves action: individuals are now expected to ‘take control’ of their reproductive lives in order to demonstrate their maturity (Katz-Rothman 1994: 83). Drawing on Giddens’ (1981) time-space analysis of institutions as defined social practices that have broad spatial and temporal extensions Ettorre (2002: 103) suggests that ‘reproduction is a structured social practice that has a wide spatial and temporal expanse’. Common to both groups of respondents was the tendency to describe themselves as ‘trying’ to get pregnant. Time here is a process understood by women through reference to calendar time as the following accounts indicate:

Kay: We’d been *trying* for a baby for about a year but I didn’t know I was pregnant until I was two months.

[PCB study, age 25]

Dawn: My husband and I after two years *trying* unsuccessfully of having a baby (sic) went for medical help. My age was going against me fast, at that time approaching 34 and childless.

[IIC study, mid 40s]

Bio-medical views and experiential evidence shows that control over reproduction lessens with age and time (Oakley et al., 1990, Inhorn and vanBalen 2002, Earle and Letherby 2003). Respondents in the IIC study, recognising that the process of time passing brought the end of their fertile years closer, talked and wrote about ‘trying’ earlier, going for treatment sooner and being more assertive about treatment if they had their time over again. When asked if they had any advice for others, the following comment by Tracey was typical:

Tracey: You’re never too young to have [children]. Don’t leave it too long, it may be too late.

[IIC study, age 28]

Respondents in the PCB study were likely to conform to the contemporary calendar based model of planned conception advocated by health professionals; a model which stresses optimum health and well-being prior to any attempt to conceive (Shorney 1990; Bamfield 1989). So they followed a healthy diet and took regular exercise which they believed would help them to achieve successful conception. Others sought professional pre-conception advice as Gaynor's example illustrates:

Gaynor: We planned four or five months ahead, which is probably a good thing because it gave me a chance to have a chat with the doctor and I wouldn't have known that it helps to take folic acid tablets before you conceive.

[PCB study, age 27]

Preparing for pregnancy is not a new phenomenon. However there are aspects of planning and preparation for conception that are specific to time and place. Given technological developments, and public perceptions of what 'infertility' and 'involuntary childlessness' represent, it also seems to be the case that a woman (or man) who discovers today that it may be difficult for them to have children is likely to have very different medical experiences and be subject to very different social expectations than an individual who discovered the same forty years ago (Pfeffer 1993). This was evident from the accounts of older women that were interviewed in the IIC study. Molly said:

Molly: We were late in getting married and my husband said if we couldn't have any of our own we wouldn't have anybody else's. None ever came along. . . . Well my mum used to say "if you've none to make you laugh, you've none to make you cry". Why should you get pressure? It's your business.

[IIC study, age 69]

Ambivalence was a more acceptable response to the experience of 'infertility' and 'involuntary childlessness' prior to the development of technological 'cures'. Ida, who had a miscarriage nearly fifty years ago, also supports this:

Ida: I just carried on. I don't think I could go in for it [treatment]. It's against nature. My mum said if you are going to have you will have. If things had been different when I'd been younger then I don't know. There is a pressure nowadays it seems, from the media.

[IIC study, age 72]

It is important not to assume from this that women today *always* actively plan pregnancy. There were a number of respondents in the PCB study who described themselves as merely waiting for pregnancy. Jill's account is clearly very similar to that of Molly's and Ida's (with the proviso of course that there is still time):

Jill: It was one of those things, if it happened it happened and if it didn't it wasn't a problem, and we are very pleased about it. But if it didn't happen it was something we were not going to get anxious about. Does that make sense? We had got plenty of time, not in any hurry, but if it happened tomorrow it wouldn't have been a problem at all.

[PCB study, age 28]

The similarities between these experiences illustrate the importance of time as process and the significance of clock time/calendar time within contemporary experiences of conception perhaps suggesting a transition from a naturally defined manner of reproductive time to a socially and medically defined one (Simonds 2002). Whilst clock time/calendar time is dominant it is important to recognise, as Adam (1992: 157) has argued that, 'we also are clocks ... The rhythms of our body ... need to be recognised in conjunction with our socially constructed clock time'.

### ***Losing the illusion of reproductive control***

Despite the myths that that getting pregnant and having children is easy, reproduction experts now agree that the human reproductive system is remarkably inefficient (see Hull *et al* 1985). The fact that women can usually control reproduction in terms of not getting pregnant gives an illusion of control over the timing of conception that does

not exist. Realising that this is not the case is a hard lesson to learn (Oakley *et al* 1990):

Trudy: I think you spend so many years trying not to get pregnant that you feel one month without any contraception that you'll get pregnant. People don't realise how difficult it is to get pregnant, so the first month when I didn't I was thinking oh no, I'm going to have problems.

[PCB study, age 29]

Women begin to realise that time is a commodity which runs out and over which they have little control. Waiting 'too long' for conception to happen can lead to feelings of disappointment, anger and frustration. As much of the research on miscarriage and 'infertility' points out, the inability to achieve conception and a successful pregnancy can be associated with feelings of personal failure as a woman (Pfeffer 1987; Oakley *et al* 1990).

Kay: I thought it would take a month or so, not a year.

Interviewer: How did you feel during those months?

Kay: Suicidal!

[PCB study, age 25]

Gloria: There are times when I don't feel like a real woman. I wonder how am I ever going to feel that whole.

[ICC study, age 36]

The development of the New Reproductive Technologies (NRTs) can also increase an individual's lack of control in relation to treatment regimes and technological invasion of the body (e.g. Pfeffer and Woollett 1983; Franklin 1997, Brown and Webster 2004). As time passes and a pregnancy is not achieved, the life experience of individuals may become increasingly medicalised. For example:

Fiona: I often felt that intercourse was in danger of becoming a mechanical exercise - a means of injecting sperm rather than an expression of our love for each other.

[IIC study, mid 30s]

Bernie: I think the worst thing about all of this is the strain it puts on your love life. It gets to the time in your cycles when you know it's best and one of you is tired or you just don't 'fancy it' you feel as if you have wasted a whole month.

[ICC study, age 38]

Sometimes the process of medicalisation negates the fears that women have. Although pregnant women are expected to seek medical advice at the earliest time, even before a conception is attempted, ironically a woman who thinks she might be infertile may be sent away to keep trying until the medically defined 'right' time. As Pizzini (1992: 72) states: 'Temporal institutional organisation is able to take place through the sequences of "timing"', for example:

Melanie: I felt alone with a problem that became greater and greater month by month. And yet, in medical terms there wasn't a problem - statistically, it is quite normal to take a year or more to conceive. It was as though I was worrying about something that I shouldn't yet officially worry about.

[IIC study, mid 30s]

Carol: I went back about three times and asked the doctor if there was any way I could have kids or not. The doctor said I would have to be trying for over two years before they could do any tests. I just wanted to put my mind at rest, I just wanted to know

whether I could not but he said “you’ve got to try for two years”.

[IIC study, age 32]

There is a general view that doctors can provide ‘miracle cures’ (for example, see Franklin 1997). Indeed, there are many examples of the way in which medical interventions challenge and subvert the temporal expectations of the reproductive body: contraception and post-menopausal pregnancy and birth being two of these. Although there may be some ambivalence towards the medical profession many women turn to medicine in the mistaken belief that doctors can control everything (see Darke 1996, Franklin and Ragone 1998, Letherby 2003). In many ways the medical profession often appears to collude with this view, for example, as Laws (1983: 20) points out: ‘The only way to deal with female experience is to put it in the category which is easy to recognise - sickness’. This is often compounded by the fact that a woman with no physical problem, but with an ‘infertile’ male partner, can be medically recorded as ‘suffering’ from male factor infertility (Pfeffer 1993).

As Roth (1963: xvii) notes ‘... both patients and physicians tend to develop norms about how long given aspects of treatment should take’ and thus construct ‘timetable norms’ around the treatment process. In his research Frankenberg (1992) argues that the medical world can be described as a waiting culture, in part defined by the power asymmetry between patients and their doctors. Within this ‘cultural performance’ (Frankenberg, 1992) time is a symbolic sign where the severity of the treatment is often reflected in the length of time patients have to wait. As Adam (1990) argues, waiting is about knowledge and expectancy, and knowing that temporality forms an integral part of our everyday living. Yet, waiting is not always an inevitable phenomenon if we consider who waits for whom and for how long; in some waiting situations, power differentials are evident. This is apparent in the fact that waiting for a doctor’s appointment is expected, yet if we keep them waiting, we are likely to be expected to apologise for this, or even lose the appointment. Respondents in the IIC study gave examples of how the passing of time was relevant to their experience of trying to conceive and waiting for treatment:

Carolyn: The most difficult things for me were the length of time each part of an investigation took and the waiting to see if it had worked.

[IIC study, age 30]

Bernie: After a year of trying we went to see our GP who wasn't really very helpful and told us we should go away for three more months and come back if nothing had happened. After three months, we went back to our GP, who gave us a referral letter to take to the local hospital. We really became very positive that something might now happen, but our hopes were dashed when the hospital told us that there was a nine months waiting list for a first appointment. I went back to see our GP, who said I could try other hospitals if I wanted to. I rang round a few and found that one in [place name] had a four months waiting list, so we managed to get an appointment.

[IIC study, age 38]

As Frankenberg (1992: 1) rightly suggests: 'It does not require a very introspective patient to see the surface connection between time and his or her experience of medicine'. These accounts demonstrate the importance of time as symbolic marker of the 'cultural performance' of trying to conceive.

## **Conclusions**

There is now a growing and established body of work on the relationships between time, health and illness, as well as some consideration of time within the context of human reproduction. However with some exceptions, in much of the literature on the medicalisation of reproduction, time is often just an implicit aspect of theoretical analysis, rather than an explicit one. The aim of this article has been to add to a more explicit consideration of time as a tool for understanding experiences of human reproduction, focusing specifically on women's perceptions of conception. Whilst there are a plurality of times and temporalities we have drawn on those most relevant to the experiences of women who are trying to conceive.



Oechsle and Geissler (2003) have argued that individuals must relate their personal identities and their own life goals to what they call the 'social time structure'. Ettore (2004) also suggests that the temporality of human reproduction is organised at a collective level. As our data have shown respondents make sense of the process of getting pregnant within the context of 'good', 'bad', and 'right' times to conceive in that getting pregnant is expected to occur at a particular age and at a particular stage of the life course. This social time structure, thus, establishes a normative expectation against which to measure reproductive goals.

We have argued that whilst preparation for pregnancy is not a new phenomenon, there are aspects of preparing for pregnancy that are specific to time and space. Data analysis shows that the concepts of clock time/calendar time can be useful in understanding normative expectations of reproductive success within the life course (Busfield 1987; Oakley *et al.* 1990). The concept of clock time/calendar time is also relevant to an understanding of time as both commodity *and* process, and within this context, time can be understood as both an external and socially constructed commodity, as well as an internal and physiological corporeal rhythm (Adam 1992). Within the contemporary context of reproduction individuals are expected to 'take control' of reproductive biology. However, time can be understood as both 'natural' and biological, as well as a defined social practice (Giddens 1981, Simonds 2002).

Contemporary discourses on taking control of reproduction mask the fact that the reproductive body can be remarkably inefficient. Our data indicate that as respondents begin to lose control over the body, illusions of reproductive control begin to dissipate. As we have argued above, time becomes a commodity which can threaten personal identity against normative life course expectations. For women who cannot conceive, their lives may become increasingly medicalised. The concept of time as symbolic power has been used to explore the cultural performance (Frankenberg 1992) of conception within the context of institutional, organisational and professional medical management of human reproduction (Pritchard 1992, Pizzini 1992). Here, 'timetable norms' come into being whereby the reproductive experience becomes subject to temporal negotiations between doctor and patient (Roth 1963).

As suggested in this article, and contrary to popular beliefs, experiences of women who do or do not conceive are not dissimilar. Both groups of women enter into the process of conception with socially defined expectations. They all also have an illusion of control over reproductive time and the body. Indeed, women in the modern Western world have never seemed to have such control over reproduction and the medicalisation of the reproductive experience has added to this perception; for example the availability of free contraception, home pregnancy testing, ‘ovulation kits’ and the NRTs creates the illusion that women can control conception (although of course this control is not available to all). However, reproductive time is influenced by biological experience as well as social and medical definitions. For example, some pregnancies are unplanned and many women have to wait longer than they expect to conceive. Furthermore, those who seek medical assistance often feel a distinct lack of control throughout the treatment process. Indeed, none of us has that much control – there is no ‘magic bullet’. As Sue, who got pregnant after taking drugs to stimulate ovulation, wrote:

Sue: I still have no idea if I’m fertile or not. Were my hormone problems temporary? As I’m 42 now, and I don’t want any more children, I suppose I’ll never know. Clearly, in relation to our reproductive biology many of us never have that much information let alone knowledge.

[IIC study, age 42]

Whilst we, like others, have argued that there is a need to locate individuals in their bodies in order to understand human reproduction in the contemporary world, to do so successfully there is a need to locate individual experiences within wider social structures and to recognise the dynamic relationship between biological and social norms and expectations. Individual experiences of reproductive choice and control are influenced by medical definitions and experiences which in turn are influenced by, and effect, biological and social conceptions of time.

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