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More than a Physical Burden: Women's Emotional and Mental Work in Preventing Pregnancy

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Abstract

In the United States, responsibility for preventing pregnancy in heterosexual relationships disproportionately falls on women. While the biotechnological landscape of available methods may explain the assignment of the physical burden for contraception to women, this does not mean that the concomitant time, attention, and stress preventing pregnancy requires must also be primarily assumed by women. Building on work identifying healthcare providers as contributors to the construction of normative ideas about reproduction, this study analyzed 52 contraceptive counseling visits with women who reported they did not want future children for the construction of responsibility for the mental and emotional aspects of contraception. Offering a case of how gender inequality is (re)produced through clinical encounters, findings demonstrate that clinicians discursively constructed these responsibilities as women's and point to structural aspects of the visit itself that reify this unequal burden as normal. Results are consistent with research identifying the broader feminization of family health work in heterosexual relationships. To the extent that the distribution of the mental and emotional responsibilities of preventing pregnancy is both a product of and contributor to gender inequality, this analysis yields insight into the production—and possible deconstruction—of (reproductive) health care as a gendered social structure.

Keywords

contraception; fertility; gender; sex; health work

Introduction

In the United States (U.S.), responsibility for preventing pregnancy in heterosexual relationships disproportionately falls on women (Fennell, 2011; Fields, 2008; Luker, 1996; Reich & Brindis, 2006; Weber, 2012). The typical American woman will spend three decades of her life trying to avoid pregnancy (Boonstra, Gold, Richards, & Finer, 2006) and will, at some point, rely on prescription contraception to do so (Jones, Mosher, & Daniels, 2012). This constitutes unpaid work, what Bertotti (2013) termed *fertility work*. After all, people use contraception in order to have sex, they do not have sex in order to use contraception (Higgins & Smith, 2016). In practice, this work is performed primarily and sometimes exclusively by women, making it women's work. Fertility work encompasses not

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only the physical burdens of contraception, including side effects (Littlejohn, 2013), but also the associated time, attention, and stress (Bertotti, 2013). The contours of these non-physical aspects and the extent to which they are discursively constituted as primarily the responsibility of the woman in a heterosexual sexual relationship (i.e. feminized) have not been articulated.

The biotechnological landscape of extant contraceptive methods may offer some justification for the social placement of the physical burden of contraception on women (Fennell, 2011): all but one highly effective method operate exclusively in female bodies. However, it does not automatically follow from this that women must also assume primary responsibility for the other components of fertility work, i.e. the time, attention, and stress of preventing pregnancy. It is possible, in other words, that the mental and emotional responsibilities for pregnancy prevention be shared by men and women or even primarily assumed by men, even as most methods physically operate in female bodies. Research finds that men and women are equally engaged in discussions over whether to use contraception and which method to use (Grady, Klepinger, Billy, & Cubbins, 2010), and they collectively attend to a method's impact on sexual pleasure (Higgins & Hirsch, 2008). Beyond these initial contraceptive decisions, scholars have further identified some uncommon contraceptive behaviors in which men take the lead role in preventing pregnancy, as in the case of preemptive vasectomy (Terry & Braun, 2012), or diligently work with their female partners to jointly take responsibility for long-term contraception (Fennell, 2011; Sassler & Miller, 2014). Though rare, these cases demonstrate that responsibility for the time, attention, and stress associated with fertility work does not have to exclusively fall on women.

Nonetheless, research that touches on the gendered distribution of these mental and emotional aspects of fertility work suggests that, indeed, this work is primarily assumed by women. Fennell (2011), for example, found that the responsibility for the ongoing maintenance involved in contraceptive use was discursively and in practice assigned to women in the majority of the committed heterosexual couples she studied. Sassler and Miller (2014), too, found that women were responsible for the management of contraceptive use in most of the heterosexual couples they interviewed. This may be part of a broader pattern of women assuming responsibility for health behavior work within heterosexual couples (DeVault, 1994; Reczek & Umberson, 2012; Umberson, 1992).

While these considerations of the emotional and mental aspects of contraceptive use have focused on the construction of responsibility within sexual relationships, research has not investigated its production and/or reification in other interactions. Recent work has identified health care providers of contraceptive counseling as contributors to normative ideas about when women should become pregnant (e.g., when they are financially secure; Stevens, 2015) and shown how such counseling may operate differently than other medical encounters, depending more explicitly on gendered understandings of knowledge (Lowe, 2005). This suggests that the contraceptive counseling visit is a useful site to investigate the contours of the time, stress, and attention components of fertility work as well as to examine whether and how those responsibilities are discursively marked as belonging to women.

Drawing on 52 contraceptive counseling visits with women who did not desire future children, thereby representing women for whom all available methods—i.e. the contraceptive pill, patch, ring, injection, and implant, hormonal and copper intrauterine devices [IUDs], male and female sterilization, the diaphragm, condoms, withdrawal, and natural family planning—might be an option, this analysis identifies some of the ways the time, attention, and stress burdens of pregnancy prevention manifest. It shows that the mental and emotional burdens of contraception are related to but distinct from the physical responsibilities. Offering a case of how gender inequality is discursively and structurally (re)produced through clinical encounters, results demonstrate that the clinical visit constructs the mental and emotional responsibilities for contraception as reasonably women's through both discursive processes and structural practices. To the extent that the assignment of these responsibilities to women is also a product of and contributor to gender inequality, these findings yield insight into the production of (reproductive) health care as a gendered social structure (Dovel, Yeatman, Watkins, & Poulin, 2015).

Method

Participants

This analysis draws on a unique dataset of contraceptive counseling visits among women of reproductive age seeking family planning services at one of six clinics in the San Francisco Bay Area between August 2009 and January 2012. The recruitment sites were family planning, primary care, and general gynecology clinics. They included both clinics that served primarily uninsured patients and large multi-site providers whose patient base was almost exclusively insured patients. All patients at these clinics had access to all available methods at no or minimal cost through insurance or public programs. At each clinic, potential patient participants were approached by a research assistant before their family planning visit and invited to join the study, described as an examination of patient-provider communication about contraception. Patients were eligible if they spoke English, were not currently pregnant or wanting to be pregnant, and self-identified as Black, White, or Latina (with this criterion designed to enable the larger study to address questions of counseling disparities). These eligibility criteria meant that the sample was not representative of the clinics' patient populations.

Procedure

Patients who were eligible and interested in participating in the study then completed written informed consent regarding their participation, including consent for recording their contraceptive counseling visit. All clinician participants also completed written consent, which took place prior to patient recruitment. Study protocols were approved by the institutional review board at the University of California, San Francisco. The study collected data on 342 contraceptive counseling visits, representing 342 patients and 38 clinicians.

The entirety of participants' contraceptive counseling visit was audio recorded, using a device left in the room; no member of the study team observed these visits. Although some patients and clinicians made reference to the presence of the recording device in the exam room, these sessions proceeded, on the whole, like typical counseling sessions despite the

presence of the recorder. This data collection strategy had the advantage of being unobtrusive, but meant that communication via body language, facial expressions, or gestures was not captured. Given the strong possibility that the presence of an observer in a medical encounter related to private issues including sex and sexuality would influence clinician and patient behavior, the study team judged the loss of in-person data collection was outweighed by expectation of how their presence might negatively affect the counseling visit. All recordings were transcribed verbatim.

Patient participants also completed a pre-visit questionnaire that was separate from their initial eligibility screening. It included questions about their past and current contraceptive use, fertility intentions, pregnancy history, and general demographics. They were remunerated for their time with a $25 gift card.

Data Analysis

Because contraceptive methods differ in their associated mental and emotional burdens, the analysis below was restricted to visits with patients for whom all available methods might be an option so as to enable useful comparison across patient-clinician discussions of different methods. Male and female sterilization, as procedures that permanently end fertility, are the most restrictive in terms of the profile of women for whom they might be appropriate; only women who do not want future children would consider sterilization. This analysis was thus restricted to visits with patients who reported in their pre-visit questionnaire that they did not want future children.

Transcripts were analyzed by the author in Atlas.ti 7 using the time, attention, and stress of fertility work as sensitizing concepts (Charmaz, 2006). The initial code list for these elements of contraception was based on the literature on the logistics of using contraception (e.g., scheduling, refills). As the initial code list was applied to the transcripts, emergent codes from the data related to the focal area of interest (e.g., emotional stress of intrauterine device [IUD] placement) were added to the list. Transcripts were iteratively coded until no new codes related to the mental and emotional burdens of contraception emerged. Once all transcripts were fully coded at this topic level, excerpts were sorted by whether they a) described or defined an aspect of the mental and emotional work of contraception, or b) discursively constructed or challenged the burden as gendered. I then applied modified grounded theory techniques (Charmaz, 2006) to identify patterns in each of these excerpt groups, which guide the presentation of findings below. To protect participant anonymity, pseudonyms are used below.

Results

Patient and Clinician Characteristics

Fifty-two patients reported desiring no future children, yielding 52 counseling visits with 30 clinicians for this analysis. Patients ranged in age from 19 to 53 years old (Table 1). Although the older age ranges, from age 36 to 53, represented nearly half of the participants, over a quarter of participants were age 25 or younger. Just about half (n = 25) of participants identified as white, nearly a third as Latina, and the remaining fifth as African-American.

Participants' highest educational attainment ranged, with nearly one-quarter reporting graduate education and over one-quarter reporting a high school degree or equivalent. The population was skewed toward lower income brackets, in part because one of the clinics primarily served college students, with 30% (n = 16) reporting annual household incomes below $14,000 and another 23% reporting incomes between $14,000 and $25,000. Nonetheless, higher incomes were also represented; just under one-fifth of patient participants reported annual household incomes above $85,000.

Participants had a variety of reproductive histories. Just over one-quarter (n = 14) had never been pregnant, just under one-quarter (n = 12) had a single pregnancy, and the rest had been pregnant two or more times. Of the total 115 pregnancies among the 38 women in the sample who had been pregnant, 49 (43%) ended in live births, 56 (49%) in abortion, and ten (9%) in miscarriage. This distribution of pregnancy outcomes is consistent with outcomes reported by the full sample of 342 patients (42% live births; 46% abortion; 12% miscarriage).

Of the 30 clinicians represented across these 52 visits, there were 29 women and one man. Clinicians ranged in age from 35 to 74 years old. Most (70%) identified as white, with six identifying as Asian/Pacific Islander, two as Latino/a, and one as biracial (white and Native American). There were no African-American clinicians. Eighteen clinicians were nurse practitioners, eight were physicians, two were certified nurse midwives, and two were physician assistants. Sixteen of these clinicians appear in only one of the 52 sessions, eight in two sessions each, four in three sessions, and two in four sessions.

Recognizing the Time, Attention, and Stress of Fertility Work

In over half of the visits (n = 31), clinicians talked to patients about the importance of the regular activity required with individual contraceptive methods. These activities were tied to the physical labor of contraception and yet distinct, representing a separate set of mental and emotional work to prevent pregnancy. One part of this mental and emotional activity was the attention patients had to pay to the method on a regular basis. For example, in talking to a patient about the pill, Brenda emphasized,

> The main thing is try to take it at the same time. Then you get in the habit. You don't miss it. You really do lose effectiveness with this particular pill if you're missing days.

Clinicians also talked to patients about the regular attention required for properly using the contraceptive patch, ring, and injection. Other ongoing attention work was presented as a check to ensure the method is working. For example, several clinicians recommended that their IUD-using patients periodically feel for the IUD's strings. As Susan explained to her patient,

> We want you to be able to feel inside your vagina so that you know that the IUD's still there, because every now and then—it's not common—but every now and then, your body will dispel them [the IUD] for whatever reason. So, once a month after your period, they ask you to reach inside and feel the string.

Even the rarely discussed diaphragm was presented in terms of the attention required to use it: Nancy noted the regular attention required with the diaphragm to her patient, suggesting that the vigilance the method demanded made it unappealing: “it’s hard [because] you have to be very motivated [to use it consistently].” Clinicians, in other words, discussed the attention methods required as basic features, all related to the physical work of using a particular method.

Another aspect of the regular work of using contraception clinicians discussed was time. They described methods as easy or quick to use and talked about how patients would need to acquire refills of most methods on a regular basis. Sometimes, clinicians acknowledged that this could be an inconvenience. Ananda, for example, warned one patient about the potential annoyance of having to come in to the clinic every three months for her contraceptive injection, even as the clinic sought to mitigate that inconvenience:

> If you want to go that route, you get a shot and then three months later you get another. There are nurses [who do] it, so you do not need to have a doctor’s appointment, so it tends to be pretty fast. It’s efficient when you get here to do it, but it is just a hassle of coming here.

In their counseling, clinicians presented information about the time and attention requirements of contraceptive methods, offering this information as potentially informative of patients’ contraceptive decision-making. In so doing, they articulated responsibilities associated with contraception that were integral to the physical work of using a method, but still fundamentally mental and emotional tasks.

Patients described another aspect of the emotional and mental burdens of preventing pregnancy to their clinicians: stress. There were two kinds of stress expressed in the visits. First, there was the stress of denied self-knowledge and the inability to be “natural.” Sophia, a 37-year-old patient, for example, explained to her clinician that she had been reliably taking the contraceptive pill for nearly 21 years and was interested in a tubal ligation. By her account, tubal ligation was appealing not just as a highly effective means to prevent pregnancy but also because it was hormone-free and would enable her to just be “normal”:

> I think I wanna limit any hormones or anything that’s- I just want the most natural thing possible I guess because I don’t even know how I normally am because I’m 37 and since I was 16 I’ve been on the pill…I don’t even know how I am on a monthly basis anymore because it’s been so long. It’s been over 20 years.

In Sophia’s estimation, artificially regulating her fertility for over half of her life means she does not know what “normal” is for her. Her missing bodily knowledge is hypothetical and unknowable until she ceases contraceptive use but her perception that her body is not “natural” nonetheless constitutes a stress.

Patients also talked about a second kind of stress: the emotional stress of commencing contraception, including fear of the physical aspects of a method such as side effects and method-associated pain. Evelyn, a 37-year-old patient, explained to her clinician that she had concerns about the side effects of hormonal contraception:

> I've been on the pill before and I don't want to do that again. […] I'm a writer and there's a couple things—when I'm ovulating, my writing goes really well and I know this sounds crazy but I'm sort of worried about being out of touch with my hormones.

Five other patients told their clinicians they were "skeptical" or "scared" of the side effects of hormonal methods. It is important to note that these were volunteered statements; aside from one exception (discussed below), clinicians did not present the hormonal component of methods as an appropriate decision point in patients' contraceptive decision-making. Given research finding that the experience of side effects—and anticipation of that experience—can affect women's use of contraception (Littlejohn, 2012, 2013), it is reasonable to expect that other patients had similar fears of side effects that they did not voice.

Thirteen patients articulated fears about physical pain associated with commencing a method. Patients most often articulated fears regarding IUD placement, like one 26-year-old patient who told her clinician five times "I'm scared!" As with other fears expressed, women sometimes phrased their concerns about pain in a way that communicated doubt over the legitimacy of their feeling of fear. Nicole, another 26-year-old patient, for instance, told her clinician about the IUD placement, "I'm probably more nervous than I should be." Patients also expressed concern about how painful the contraceptive injection would be and whether it is painful to insert and remove the contraceptive ring. Together these articulated fears about the physical experience of contraception illustrate some of the emotional and mental stress using contraception entails for women. They further suggest that such stress can arise precisely because women assume the physical burden of contraception.

A handful of clinicians not only acknowledged the time and attention burdens on patients of using contraception, they recognized the importance of these burdens for patients' contraceptive decision-making. Some leveraged this awareness to encourage patients to choose methods that required relatively lower amounts of time and attention. Clinicians like Brenda described the IUD as an excellent contraceptive method because it requires little to no ongoing attention on the part of the patient: "[it] is kind of like a put-it-in, forget-about-it [method]." Melissa made a similar point to her patient about the IUD, even suggesting that with an IUD, she, as the clinician, would assume some of that burden: "It could be great for you, because it's, first off, effortless on your part: I put it in and then it just sits there." On the ring, Linda highlighted the low amount of time and attention it requires: "You put it in once and take it out once is the only time you have to think about it." Similarly, Helen spoke positively of the contraceptive injection, explaining that "you get the shot in your arm every three months and that's all you have to do." Some clinicians, in other words, understood that using contraception is a burden and made the case for particular methods based on their comparatively lower time and attention burden.

Two clinicians were explicit in identifying method logistics as an important point of comparison for patients' contraceptive decision-making. In one case, when a patient inquired about the differences in efficacy among prescription methods, Cheryl discouraged her from choosing based on efficacy. Instead she encouraged her patient to choose based on the logistics of using the method:

> I wouldn't pick based on that. I'd pick it more on how you want to take it and first of all just choosing that you want to be on something hormonal as opposed to continuing with just condoms.

Similarly, Luciana counseled a patient, "really the best method is the method that you think is going to work for you, and that you are going to be able to take." Clinicians like Luciana and Cheryl focused on the particulars of how and when patients would use a method, emphasizing that patients had to attend to whether those method logistics would work for their lives. Such counseling not only recognized the emotional and mental aspects of using contraception, it also emphasized the importance of patients considering the time, attention, and stress particular methods require in their contraceptive selection process.

Normalizing the Mental and Emotional Burdens

In addition to acknowledging the mental and emotional work of preventing pregnancy, in the contraceptive counseling visits, clinicians mostly constructed this work as reasonably belonging to women. Clinicians responded to the expected challenges of meeting the time and attention requirements of contraceptive methods by problem-solving with patients, offering strategies for ensuring correct use. For instance, Kathleen suggested ways to remember to take the daily pill to her patient, saying:

> The other thing with pills sometimes I do find that people have come up with new ways to remind themselves. They set their cell phone to alarm or they have little things that pop up on their computer, reminder stuff.

Elizabeth encouraged her patient to enlist the help of her partner to remember to take the daily pill: "you and your boyfriend […] can work together or set your alarm on your phone or something." Clinicians also detailed ways patients could use their phone's calendar function to schedule their use of the ring or their contraceptive injection shots.

Clinicians engaged in problem-solving, too, with patients who expressed fear about pain associated with IUD placement. Most recommended advance consumption of over-the-counter medication. For example, Lin strategized with her patient, Laura, about her fears:

Laura The only reason I'm worried about the IUD is it's so nerve-wracking.

Lin Try and take some Motrin.

Laura My friend actually told me that helped.

Lin Do you have over-the-counter Advil at home?

Laura Yeah.

Lin Take two or three of those. And would you be really nervous?

Laura Yeah.

Lin Take a little bit of like Sudafed.

Laura I don't even know what that is, but-

Lin It makes you a little bit high though. Like if you took it, you'd have to have someone waiting for you.

Laura Okay.

Some clinicians also sought to soothe patients by insisting that they did not need to worry about the pain. Denise assured her patient, "Oh, you're gonna be fine." Similarly, drawing on her own experience of IUD placement, Tammy told her patient, "I'm not worried about you, I've had this twice. I know that the anticipation, I think, is probably the worst part." Clinicians similarly downplayed the likelihood of potential side effects, using the uncertainty that a particular patient would experience a side effect as a means to assuage patient concerns (Littlejohn & Kimport, in press). In these ways, clinicians mostly tried to meet patients' needs, supporting them in finding a method they could use consistently and correctly to prevent pregnancy. Yet by approaching this emotional and mental work with management strategies rather than by challenging that women bear this responsibility, clinicians also tacitly reified this disproportionate burden as reasonable.

Although clinicians generally did not question that these responsibilities were assigned to women, one did. Joyce followed her suggestion of vasectomy to a patient with a rare acknowledgment of the way the burden of contraceptive labor falls primarily on women. She said, "It's not fair. A lot of responsibility for birth control they put on women's side." Joyce's critique of the unequal burden for fertility work, however, was unique across the transcripts.

In one other case, the clinician validated her patient's desire to retire her responsibility for her marriage's fertility work, positing that it is reasonable for a woman to *not* want to bear the burden of fertility work. During a postpartum visit following the birth of her second child, Rosa, a 39-year-old patient, volunteered that she and her husband felt their family was complete and expressed an interest in a vasectomy: "I was thinking about that. I think we're going to do a vasectomy." Notably, although vasectomy takes place entirely in a male body, Rosa signaled collective responsibility for contraception in her use of the first person plural "we." Later, she allowed that she and her husband were not entirely in agreement about pursuing a vasectomy, saying, "I think he would rather that I do the IUD. But I would rather that he do the vasectomy." Explaining her preference for the vasectomy, Rosa described the many years of reproductive labor she has undertaken—and her clinician, Lin, agreed that her desires were reasonable:

Rosa I took the pill for a couple years and I don't want to do anything anymore.

Lin Yeah. You just want your body to be, you know.

Rosa Yeah, in its natural state.

Lin Yeah. Yeah. I don't blame you.

Rosa I had 2 pregnancies. And a C-section.

Lin Yeah. And you have to recover from all of that.

Rosa I just feel like, you know, I've been through a lot already. But I don't want to go through more. Like I really don't want one more thing to do.

In their conversation, Lin supported Rosa's construction of pregnancy prevention as a responsibility that should be shared, saying encouragingly, "You know what? He might get the vasectomy then." As their conversation continued, however, it became clear that Lin is hard-pressed to facilitate this outcome.

When Rosa asked details about the vasectomy surgery, Lin initially was not even sure where it would take place—hazarding a guess that it would happen at a different clinical site—or whether the patient's husband would need to take time off work. Clinicians like Lin, who counsel women on contraception, are at a disadvantage in counseling on vasectomy because it is outside the set of surgeries they are typically trained to perform or talk to patients about; urologists and family medicine physicians usually perform vasectomies. To better answer Rosa's questions, Lin leaves the exam room to retrieve a pamphlet that she then shared with Rosa, the two of them learning together about the vasectomy process. Overall, the discussion of contraception during this visit is awkward, because Rosa's desired method does not work in her body and Lin does not counsel on or perform vasectomies. But the conversation proceeds nonetheless, with the patient and provider using the visit to learn more about the vasectomy process so the patient can inform—and persuade—her husband. In essence, in order for Rosa to cease her fertility labor in the future, she has to devote time and attention to understanding vasectomy in the present.

Similarly, in counseling a 41-year-old patient with two children and a history of two abortions who said in her visit that she did not want any more children, Jennifer noted the patient's various medical difficulties that limit her contraceptive options and floated the idea of vasectomy. She advocated for this method, instructing the patient to convey her endorsement of the method to her husband:

> I know there's a lot of men who are really not into that [vasectomy]. My husband and I watched it because for me it was very interesting and it was just really snip-snip and that was it, you know. He goes back to work the next day. But a lot of men are really worried. I think there's a big myth in the community with men where they think it's going to decrease their libido, but that's all myth. So you can tell him that I said that.

Jennifer marshalled medical reasons for encouraging the patient's husband to have the procedure, but also drew on personal experience, as she, like Lin, did not counsel on or perform vasectomies. Despite these clinicians' medical endorsement of choosing vasectomy, they were both constrained by the structure of contraceptive counseling visits to interact with only the patient and not the person who would actually undergo the vasectomy. The patients' husbands were not in the room, and so the responsibility, time, stress, and attention required to convince them still lay with the patients.

In both of these cases, part of the reason the patient was saddled with this non-physical fertility work owed to the structural fact that contraceptive counseling visits in the U.S. do not typically include men (although, in some countries, vasectomy counseling visits do include female partners; Moses & Oloto, 2008). The lack of partner participation implicitly underscores and normalizes women's non-physical fertility work and points to the overall dearth of engagement with men around issues of reproduction (Almeling & Waggoner, 2013). These encounters functioned to convey and construct the mental and emotional burdens of fertility work as normal and appropriately accruing to women, even when the contraceptive method worked in a male body.

Fertility Work as Normative

In their counseling, clinicians not only normalized women undertaking the immediate mental and emotional tasks of using contraception. They also discursively legitimized women assuming responsibility for non-physical fertility work in perpetuity. Methods like female sterilization, which ends a woman's fertility, and vasectomy, which ends fertility at the couple level, also end women's fertility *work* for the life course or duration of the sexual relationship. In contrast, methods that preserve a woman's fertility, at the individual or couple level, require ongoing fertility work—including the time, attention, and stress of contraception. In the visits, clinicians regularly expressed doubt or dismissed women's desire not to have future children, thereby reifying ongoing fertility, and the attendant mental and emotional burdens of contraception, as normative.

All 52 patients in this analysis reported in their pre-visit survey that they did not want future children, representing 15% of the parent study population. This notable percentage suggests that a not insignificant number of women of reproductive age do not want to have any future pregnancies. Clinicians, however, tended to treat patient statements that they desired no (more) children with surprise and doubt. Some patients had to articulate this preference more than once. For instance, one patient had to state her intent to never have children three times. Even after the third articulation, her clinician provided her with information on how a particular method would not negatively affect her future fertility. The clinician's reference to preserving the patient's future fertility reflects an expectation that women will engage in fertility *work* throughout their reproductive years.

When clinicians did absorb a patient's statement about not desiring future children, many responded with expressions of surprise that marked these statements as outside the expected norm. For instance, when her patient explained, "I'm talking to my boyfriend and we're both like very very—we don't want children ever," Cheryl deviated from her heretofore professional language and expressed surprise, responding, "Ever? Oh wow!" This patient's stated fertility intentions flummoxed Cheryl later in the visit as well when she counseled the patient on general wellness. Offering what sounds like a standard introduction to the importance of a multivitamin, Cheryl stumbled as she promoted the necessity of folic acid, a vitamin that prevents some birth defects that occur very early in pregnancy:

> I would definitely get a multivitamin with that has a little iron in it, because definitely being a vegetarian. And also 'cause you need folic acid- Well, I know you don't want to get pregnant, but if you were to be you'd want to be taking folic

> acid in the pill- in the multivitamin. And if you're not a big dairy person, then umm… you need calcium also.

Confusing the oral contraceptive pill with the multivitamin and then losing her train of thought, Cheryl scrambled to communicate in this instance. This stands in contrast to other parts of her counseling—those unaffected by the patient's fertility intentions—which were smooth. Cheryl's decreased surety in this excerpt suggests that she has to remake her standard script to accommodate a woman who does not want to become pregnant in the future.

Clinicians were most surprised by and doubtful of younger and childfree patients' expressions of the desire for no future children. In one visit, when a 21-year-old patient with no history of pregnancy volunteered to Angela that she was considering a tubal ligation for her birth control, Angela responded pessimistically:

> In order to get—I think we've talked about this before—in order to get a tubal ligation, you have to see a doctor and you're probably not gonna find anyone who's gonna do it on you because of your age. They're gonna think you might change your mind in five years.
>
> And it's not reversible, so you'd have to really find somebody who's gutsy enough to do it for you. And most people won't. I couldn't, I-- you'd have to make an appointment with somebody who's a doctor who does surgery. And they have to feel, like, comfortable doing that to someone your age.

Using words like "gutsy," Angela spoke discouragingly of her patient's ability to receive a tubal ligation, sourcing her pessimism in the patient's young age. The patient is constructed by Angela and unnamed "others" as likely to change her mind because she is so young. Yet their interaction also suggests that the patient has expressed some consistency of interest in sterilization, with the clinician saying "I think we've talked about this before." Ultimately, the patient leaves the appointment planning to use the contraceptive pill, a method that requires her to engage in ongoing fertility work.

The presumption that childfree women will ultimately want children was not reserved for women in their 20s, suggesting that doubt about patients' certainty was not simply a function of biases around age. When her clinician asked whether she planned to have children, Michelle, a 40-year-old patient with a history of three abortions, explained that she had never wanted children, but never found someone who believed her:

> I have often thought of having my tubes tied. When I tried to approach my doctors before they were just like, "You're too young. You're too young." Even in my 30's. "You'll change your mind. You'll want to have kids." I knew I wouldn't.

Michelle's experience and clinicians' responses to other patients in the sample suggest that disbelief in the permanence of desiring to remain childfree was widespread. Because of clinicians' doubt of patients' desires, women like Michelle had to engage in fertility work for years or even, in this instance, decades.

Clinicians' discouragement of sterilization for childfree women may have been grounded in research showing a high rate of sterilization regret among younger women (Hillis et al., 1999) as well as heteronormative expectations that (most) women will want to become mothers. Yet women with children were not exempt from the normative expectation that they preserve their fertility and, by implication, continue fertility work. Recently postpartum, Alexandra, a 34-year-old patient with two children, explained to her clinician that she was disappointed she could not have a sterilization procedure at the time she gave birth:

> So I was ready to get my tubes tied, but they said you need 24 to 72 hour notice, before the C-section. So I was a little disappointed that I couldn't just get that done.

Her clinician then discusses sterilization as future birth control, but presents the method negatively, suggesting that Alexandra could change her mind:

> The thing about something permanent is it's permanent. I mean you want to [think] for the future. Heaven forbid you actually wanted a third baby. I know that's not in your plans for now, but just so you know.

As above, this positions women's statements of a lack of fertility desire as temporary and possibly false. Moreover, the clinician frames the potential lost opportunity for a third child —should the patient desire one—as of significant consequence, privileging preserving the opportunity for childbearing over other concerns. Clinicians presented preserving fertility as normal and unexceptional and, as a consequence, women's ongoing fertility work, with its mental, emotional, and physical burdens, was likewise constructed as normal and unexceptional.

Discussion

In the U.S., the burden of preventing pregnancy falls disproportionately on women (Fields, 2008; Luker, 1996; Reich & Brindis, 2006; Weber, 2012). In addition to women usually bearing the physical consequences of the work of preventing pregnancy, including method side effects (Littlejohn, 2012, 2013) and reduced sexual acceptability (Higgins & Smith, 2016), I show here some of the ways women undertake emotional and mental tasks related to preventing pregnancy and how exchanges between clinicians and patients in the contraceptive counseling visit establish the assignment of this mental and emotional labor to women (i.e. feminization) as both normal and unexceptional. In illustrating how gender inequality is discursively and structurally (re)produced in the clinical encounter, these findings are consistent with research revealing ways health care providers can perpetuate normative expectations around pregnancy and motherhood (Lowe, 2005; Stevens, 2015).

In addition to identifying these discursive contributions, this examination of counseling visit discussions reveals structural contributors to this unequal distribution of non-physical fertility work. For one, who is in the room likely contributes to the discursive assignment of this labor to women. Because contraceptive counseling visits do not typically include men (Shih, Dubé, & Dehlendorf, 2013), clinicians in this sample who aimed to meet patients' goal of preventing pregnancy reasonably focused on the patient in front of them and methods for which she could ensure proper use. For two, in these visits, patients and clinicians alike were constrained by the range of available contraceptive methods. Currently,

the only contraceptive technologies that work on male bodies are vasectomy and condoms. This biotechnological fact, however, is itself the product of normative expectations about gendered responsibility for fertility work. The assumption that women are responsible for fertility work has encouraged decades of research focus on the development of female body-based contraceptives and medical interventions with women without parallel research and counseling infrastructure for men (Daniels, 2006; Oudshoorn, 2004). This structural outcome, in turn, makes the discursive assignment of the responsibility for preventing pregnancy to women seem like common sense.

Although this analysis was restricted to women who articulated a desire in their pre-visit questionnaire not to have future children, there is no reason to think these discourses ascribing responsibility for the mental and emotional burdens of contraception to women are tied to these patients' desire not to have future children. Indeed, these social practices and structures related to health are derived from an unequal gender order that extends beyond patients themselves, even as they contribute to that inequality (Dovel, et al., 2015; Reczek & Umberson, 2012). Health behavior research outside of reproductive health suggests this is a broader trend. For example, research finds that women typically perform more family health behavior work than men in heterosexual marriages, which is the result of both discursive and structural factors, including the social structure of heterosexuality (DeVault, 1994; Reczek & Umberson, 2012; Umberson, 1992).

In addition to contributing to the trend of feminizing health work, the construction of the mental and emotional work of contraception as primarily women's may have implications for women's selection and continuation of a contraceptive method. As clinicians tacitly acknowledged by mentioning the time and attention various methods require, a method's mental responsibilities influence patients' method selection. Moreover, they may impact patients' ability to physically adhere to correct usage of a method. Women's lived experience of the time, attention, and stress of preventing pregnancy represents an important area of investigation for understanding method discontinuation (e.g., Hoggart & Newton, 2013). Such examinations may be particularly important given that discontinuation of a method is associated with increased unintended pregnancy (Vaughan, Trussell, Kost, Singh, & Jones, 2008) and abortion (Dehlendorf, Harris, & Weitz, 2013) rates.

At a practical level, there are opportunities to reduce, shift, share, or entirely remove the mental and emotional burdens of pregnancy prevention—and thus undercut the unequal division of reproductive labor. Some clinicians were already doing this, in part. For example, some encouraged patients to select long-acting reversible contraceptive (LARC) methods by highlighting that such methods do not require regular refills, clinical visits, or even remembering to use the method on a daily, weekly, or monthly basis. Clinicians could do more to reduce the time and attention burdens of LARC methods by, for example, supporting IUD self-removal (Foster et al., 2014) and thereby obviating a clinical visit to remove the device.

Such routes to reducing the mental and emotional burdens of contraception, however, are limited: they continue to construct the assumption of the physical burdens of contraception as indivisible from the mental and emotional responsibilities, assigning responsibility for all

fertility labor to women. Moreover, they are tied to particular methods, the profiles of which (including mechanism, potential side effects, and location in the body) may or may not meet individual women's needs (Coombe, Harris, & Loxton, 2016). Health care professionals should also consider ways the time, attention, and stress of non-LARC methods can be reduced. For example, changes to how oral contraception is dispensed, such as providing women with a one-year supply (Foster et al., 2006) or making it available over-the-counter (Grossman et al., 2013) can reduce the amount of time, attention, and stress women undertake in using the pill by eliminating regular trips to refill prescriptions and clinical visits and enabling men to procure it. Efforts to enable self-injection of the contraceptive injection (Prabhakaran & Sweet, 2012) could similarly reduce and/or shift the mental and emotional burdens of contraception.

Clinicians' encouragement that patients consider LARC must also be examined in light of their discursive focus on patients preserving their fertility (see also Kimport, Dehlendorf, & Borrero, 2017). By promoting LARC and discouraging sterilization, clinicians privileged methods that reduce but do not eliminate patients' fertility work. And even as this approach may reduce the time and attention women must pay to contraception, it cannot address the stresses some women described, such as fear of side effects and pain at IUD placement. Indeed, male sterilization, as a highly effective male body-based method, is arguably the only method that enables a woman to bypass these stresses and also be highly confident about avoiding pregnancy. Yet unlike in other countries (e.g., the U.K.; Moses & Oloto, 2008), vasectomy is underutilized in the U.S.: male sterilization is less than half as popular (6%) as reliance on female sterilization (17%) (Shih, Turok, & Parker, 2011). Clinicians should examine their counseling for implicit assumptions about the importance of women preserving their fertility, especially as such counseling could impede women's selection of sterilization methods.

Contraceptive counseling visits could also include men *when appropriate*, noting that in some scenarios it is imperative that women be able to choose and use contraceptive methods without their partner's knowledge (Mathenjwa & Maharaj, 2012). Vasectomy counseling in other countries sometimes includes female partners (Moses & Oloto, 2008). Other fields of medicine, too, offer possible models of working with couples, rather than individuals, such as counseling for infertility, which frequently takes place at the level of the couple. Clinicians could also consider learning to counsel on and perform vasectomy (Shih, Zhang, Bukowski, & Chen, 2014), enabling them to better serve patients in monogamous sexual relationships who do not want future children.

By making discursive and structural changes to the contraceptive counseling visit, clinicians have the unique opportunity to institutionally model ways in which fertility work can be undertaken not only by women alone, but also by couples together or even by men alone. Diversifying *how* fertility work is distributed can upend the reification of pregnancy prevention as women's work, with the potential to better meet women's reproductive desires. Such shifts in behavior and practice may also help contest and undo the construction of (reproductive) health care as a gendered social structure.

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Table 1.

Patient Characteristics

	Patients (n=52)
Age (in yrs)	
25 and under	15
26–35	12
36–45	23
46+	2
Race	
African-American	11
Latina	16
White	25
Highest educational attainment	
<HS or equivalent	1
HS or equivalent	14
Some college or AA	16
4-year degree	9
More than 4-year degree	12
Annual Income (in $)	
0–14K	16
14,001–25K	12
25,001–50K	5
50,001–85K	9
85K+	10
Pregnancy History	
0	14
1	12
2+	26