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Fertility-Related Perceptions and Behaviors Among Low-Income Women: Injunctive Norms, Sanctions, and the Assumption of Choice

Robin E. Jensen[1] and Jennifer J. Bute[2]

Abstract

In this article we explore elements of the theory of normative social behavior (TNSB) through interviews with low-income women (N = 30) in a Midwestern U.S. state about their experiences with and perceptions of fertility-related norms. Using grounded theory and matrix analysis as analytical lenses, we found that individuals sometimes learn of injunctive norms and social sanctions separately, might be more likely to comply with a norm if they learn about norms and sanctions in concert, and might be more likely to engage in norm compliance if they learn about two different types of sanctions, short- and long-term, along with the injunctive norm. We also found that a number of important barriers can limit one's ability to choose to comply with a norm. In conclusion, we discuss implications for continued theorizing of the TNSB in light of the experiences of traditionally marginalized populations.

Keywords

fertility / infertility; gender; health behavior; health care, access to; interviews, semistructured; pregnancy, maternal health; sexual health; women's health

People seem to be influenced by social norms (i.e., what they perceive other people want them to think or do). In recognition of this situation, Rimal and Real (2005) proposed the theory of normative social behavior (TNSB). The TNSB emphasizes the role that communication plays in the creation of normative perceptions and draws on the idea that people often intend to behave in ways they think others behave (Lapinski & Rimal, 2005; Rimal, 2008). The last several years have seen an influx of health-related research framed by the TNSB and social norms marketing approaches. The vast majority of these studies have focused on college student perception of underage drinking (Cameron & Campo, 2006; Campo & Cameron, 2006; Cho, 2006; DeJong et al., 2006; Gomberg, Schneider, & DeJong, 2001; Lederman, Stewart, & Russ, 2007; Real & Rimal, 2007; Rimal, 2008; Rimal & Real, 2003, 2005; Russell, Clapp, & DeJong, 2005). Other research explored college student perception of social norms and skin self-exam performance, organ donation, and yoga practice (Jensen & Moriarty, 2008; Marshall & Feeley, 2006; Rimal, Lapinski, Cook, & Real, 2005). Research that engaged noncollege student samples looked at social norms as they played out in the context of condom use, injection drug use, and alcohol consumption during pregnancy (Boer & Westhoff, 2006; Davey-Rothwell & Latkin, 2007; Glik, Prelip, Myerson, & Eilers, 2008). Taken as a whole, the researchers in these studies have reported mixed results concerning the descriptive and predictive potential of the model, an observation which suggests that some elements of the TNSB require further explication.

With the present study, we aimed to clarify the TNSB by drawing from semistructured interviews (N = 30) with low-income women in a Midwestern U.S. state about their experiences with fertility and sexuality-related issues such as sexual initiation/activity, birth control, conception, and childbearing. In another publication, we reported on the ways that low-income women described their perceptions of norms, and we found that, in some cases, they seemed to be contending with different norms than those reported

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in existing literature (Bute & Jensen, in press). We found that low-income women generally perceived certain norms in ways that aligned with the literature on dominant descriptive norms for the general population, and that low-income women described various types of normative influence related to their unique social location. Yet, we sensed that additional, more nuanced theorizing was necessary to fully understand the complex interplay between social norms and health-related behaviors. Thus, in the present research we extended our earlier findings by exploring particular aspects of the TNSB and problematizing the assumption of choice implied in much social norms research.

Social norms surrounding fertility and sexuality provide a rich health-oriented context in which to better understand fundamental assumptions of normative models of behavior. As women make sense of decisions related to sexuality and childbearing, they compare their behaviors to social norms about desired and ideal conduct. However, contradictory and evolving norms concerning the onset of sexual intercourse and the appropriate time to have children can pose dilemmas for women. For example, dominant norms in the United States suggest a strong preference for delayed sexuality and childbearing (Geronimus, 2003), yet individuals in marginalized groups (e.g., low-income; minority) often negotiate distinctive norms that encourage early sexuality and childbearing to promote economic and reproductive success (Browning & Burrington, 2006; Denner, Kirby, Coyle, & Brindis, 2001; Geronimus). For instance, Erviti, Castro, and Collado (2004) reported that although the general population in Mexico tended to support women's right to choose to terminate a pregnancy, low-income Mexican women often felt that others did not believe it was appropriate for them to terminate a pregnancy. Those who did purposefully terminate a pregnancy generally faced social sanctions from health workers for so doing. In another study of marginalized women and fertility-related behavior, Barnes and Murphy (2009) found that HIV-positive women often reported facing two conflicting messages about having children (expectations that they would not have children because of their medical condition, and expectations to have children based on the socially valued identity of motherhood). HIV-positive mothers explained the process of weighing these expectations and making health decisions based on the behavior that seemed most likely to have the fewest sanctions. Given the central role norms seem to play in shaping fertility and sexuality-related behaviors, this context offers a window into normative processes, as does the sample population, because of the unconventional normative formations that might confront traditionally marginalized individuals.

Literature Review

The Theory of Normative Social Behavior

The TNSB is grounded in several key assumptions. First, the TNSB differentiates between collective norms—norms that exist at a group level—and perceived norms—how individuals interpret collective norms (Lapinski & Rimal, 2005). Second, the TNSB differentiates between descriptive norms—individual beliefs about what most people do—and injunctive norms—individual beliefs about what others expect a person to do (Lapinski & Rimal). As Kallgren, Reno, and Cialdini (2000) explained, injunctive norms refer to perceptions about what one ought to do. By contrast, descriptive norms refer to beliefs about what is being done by most people in a collective.

The TNSB further highlights the differences between descriptive and injunctive norms by positioning them separately and at different levels of influence. Descriptive norms and their influence on behavior constitute the center of the model. Injunctive norms are positioned as one of several "underlying cognitive mechanisms" serving as potential moderators of the descriptive norm's direct influence on behavior (Rimal & Real, 2005, p. 391). This positioning of variables functions argumentatively, implying that injunctive norms do not have a direct effect on behavior but that they have the potential to enhance or detract from the influence that descriptive norms have on behavior. Outcome expectations, group identity, ego involvement, behavioral identity, and behavioral intent (Rimal, 2008) are situated beside injunctive norms as possible moderating factors that might either increase or decrease the influence of the descriptive norm on behavior.

As we explored social norms in the context of fertility and sexuality, we were particularly interested in how women learned about and understood the potential consequences of violating norms. More specifically, we were interested in exploring the idea that perceived injunctive norms are significant to individuals only because individuals perceive that their violation will result in a negative outcome (i.e., social sanctions). In discussing the TNSB, Bendor and Swistak (2001) argued that without the threat of social sanctions, perceived injunctive norms are meaningless. In this respect, the TNSB implies that individuals learn about injunctive norms and the consequences of violating said norms simultaneously. Because injunctive norms and social sanctions have the potential to influence health-related behaviors, we wanted to better understand how women described their experiences with learning about social sanctions, and whether they typically learned about outcome expectations when they learned about expected norms. We posed the following research questions: How do low-income women describe

the relationship between perceived injunctive norms and social sanctions when discussing fertility-related experiences? Do low-income women describe perceived injunctive norms and social sanctions as linked with behavior when discussing fertility-related experiences?

Another element of the TNSB that warrants continued attention is the assumption that compliance with normative expectations is largely a matter of choice. Although the TNSB posits that several variables moderate the influence of descriptive norms on behavior and that particular attributes of behaviors make normative influence more or less relevant, the model implies that individuals make rational choices when it comes to following expected norms. By assuming that behaviors are based solely on individual decisions, previous work might have overlooked the social and structural factors that tend to constrain individual choices. Thus, in this study we posed the following research question: Do low-income women discuss barriers to following norms when describing their fertility-related experiences? In the subsequent section, we lay out the methods used to answer this research question.

Methods

Recruitment

After our project received institutional review board approval, we recruited participants in cooperation with a separate project on health literacy among individuals living at or below 200% of the poverty line. Staff members from two statewide university extension programs asked women enrolled in these programs if they might be interested in participating in a study conducted by a public university in their state. Women who expressed interest in the fertility study received a consent form that explained the study and completed an information sheet. We then contacted volunteers to schedule telephone interviews.

Data Collection

Scholars have noted that interviews are a useful and appropriate method for studies of traditionally marginalized individuals who might lack the confidence or ability to provide written responses (Collins, 1990; Madriz, 2001; Muturi, 2005). We used telephone interviews to accommodate the unique living conditions of the women who volunteered for our study. Many women in the sample dealt with day-to-day hardships such as temporary housing, unreliable transportation, and unpredictable work schedules. Rather than complicate these circumstances by asking women to travel to an interview site or provide an interview site themselves, we used telephone interviews to minimize any inconvenience to participants. Even though many women in our sample lived in challenging and unstable environments, all of them had access to a telephone. Conducting telephone interviews allowed women the flexibility of participating in the study at a time of their choice without the trials of coordinating transportation, childcare, or work schedules. Telephone interviews also allowed participants to reveal highly personal information in a familiar and comfortable setting (Reymert & Hunskaar, 1994).

We conducted all interviews. After explaining the informed consent process, the interviewer asked a series of questions to collect demographic information. The interview guide included questions designed to explore (a) access to fertility-related information, (b) interpersonal interactions with friends or family members about fertility-related issues, (c) interpersonal interactions with health care providers about fertility-related issues, (d) formal and informal sexual education experiences, and (e) societal and individual expectations about sexuality and pregnancy. Interviews lasted between 20 and 90 minutes, and were tape recorded and transcribed. Participants received a $30 retail gift certificate for their participation in the study.

Participants

Participants ranged in age from 18 to 48 years, with an average age of 29 years. Six women were married, 9 were divorced, and 15 were single at the time of the interview; three of the single women were engaged to be married. All but 2 women in the sample had one or more children. One of the 2 women who did not have children was pregnant at the time of the interview.

Women reported a variety of racial/ethnic backgrounds. Seventeen women self-identified as White, 8 as Black or African American, 2 as Hispanic, and 3 as mixed heritage. In terms of education, 3 women had earned an associate's or bachelor's degree, 12 had completed some college, 9 had completed high school, and 6 women reported less than a high school education. Fifteen women were employed outside the home and reported occupations ranging from cashier to staffing assistant. Seven women were homemakers or stay-at-home mothers, and 3 women were students. Five women were disabled or unemployed at the time of the interview. Fifteen of the women were on Medicaid, 8 had employer-based health insurance, 6 did not have health insurance of any kind, and 1 reported that she was unsure about whether or not she had health insurance.

Health literacy was a potential challenge for the women in the sample, because only 3 had completed a college degree and 6 had not completed high school. Although

questions about specific health conditions were not part of the standard demographic survey, many participants described a wide range of daunting experiences with fertility-related issues: at least 10 women in the sample had experienced a miscarriage, and 5 of these women had experienced multiple miscarriages. Two women had sought abortions for unintended pregnancies, and at least 5 women had been diagnosed with a sexually transmitted infection. Several women described fertility-related problems or health conditions such as ovarian cysts, endometriosis, and various complications with their pregnancies (e.g., preeclampsia).

Data Analysis

We used techniques of grounded theory analysis to explore and extend elements of the TNSB. Although grounded theory procedures are used widely for the inductive generation of data-driven theory (Walker & Myrick, 2006), grounded theory techniques can also be used to develop more refined formal theories. Corbin and Strauss (2008) noted that refining an already existing theory using constant-comparative techniques involves an attempt to uncover how the existing theory's concepts play out in new or diverse situations. We used variables explicated in the TNSB as sensitizing concepts that informed our approach to data analysis. Based on the findings from our interviews, we then developed a set of recommended clarifications to the existing model.

We conducted an iterative analysis process (Corbin & Strauss, 2008; Patton, 2002) to explore women's perceptions of and experiences with fertility-related norms. We wrote and exchanged detailed field notes after every interview to discuss theoretical possibilities and methodological adjustments on a continuous basis during the process of data collection. After identifying recurring themes in the data, we decided to focus our analysis on participants' discussion of norms and how those discussions might help to explicate the TNSB. At this point, we developed a set of research questions that guided our rereading of all 30 transcripts. We wrote research memos during this rereading process that we then used as a basis for open coding (Corbin & Strauss) in which we developed categories, and we created an audit trail (Lincoln & Guba, 1985) consisting of field notes, interview transcripts, and research memos.

To further the process of organizing and interpreting our data, we then engaged in a descriptive matrix analysis. Guided by data exhibition procedures originally delineated in the work of Miles and Huberman (1984), matrix analysis involves identifying information from the data pertinent to the inquiry at hand, displaying that data so each participant's or demographic category's responses are evident for every key theme, question, or issue in the analysis, and drawing substantive conclusions. The visual representation of participant responses also enables the identification of patterns of responses and makes accessible complex narrative data (Liddle, Carlson, & McKenna, 2004).

We began the matrix analysis by reducing the data to account for participants' answers to our three research questions. To decide which narrative elements from the interviews should be included in each category, we developed definitional decision rules to guide our decision making (Marsh, 1990). With the first rule, we delineated evidence of perceived injunctive norms as participants' discussions about how others around them "expected" them to act. With the second rule, we identified social sanctions in the interviews as participants' references to real or expected behavioral outcomes with negative social ramifications. Finally, with the third rule, we identified barriers to choice as any discussion of issues, events, or ideas that hindered participants from deciding whether they would behave in normative ways. To create the matrix proper, we cross-listed participant rows with demographic and substantive columns. Then we paraphrased participant information and answers, entering them in the appropriate matrix points and drawing conclusions from the resulting visual display. By analyzing the stories of the women in the sample in this way, we were able to use their unique experiences as a guiding lens for explicating previous research on social norms. We were also able to inspect the data for sample variation according to participant demographics (e.g., age, race, fertility history), and concluded that our findings were fairly consistent across demographic variables. In the following section, we outline our findings in light of TNSB variables and concerns. We identify all participants with pseudonyms to protect their anonymity.

Results

The key areas of the TNSB we were interested in analyzing through the lens of interviews with low-income women about fertility-related issues included perceived injunctive norms, social sanctions, and barriers to choice. Because the TNSB theorizes that perceived injunctive norms are meaningless without the threat of social sanctions (Bendor & Swistak, 2001)—and thus implies that the two are learned in concert—we were interested in exploring how women themselves describe the connection between these constructs, specifically if they learned them at around the same time and if they seemed to link injunctive norms and social sanctions to behavior. In addition, we were interested in exploring the assumption of free choice that undergirds the TNSB by assessing whether women discuss barriers

to individual decision making concerning their fertility-related experiences.

Perceived Injunctive Norms and Social Sanctions

Our initial interest was in understanding how low-income women described the relationship between perceived injunctive norms and social sanctions when discussing their fertility-related experiences. Only 4 of the participants in this project recalled that they learned about both injunctive norms and social sanctions in concert (as the TNSB would predict). One of these participants was 38-year-old Rose, an African American, divorced mother of three who became pregnant with her first child as a teenager. Rose learned about sexually transmitted infections (STIs) in her school's sex education class and subsequently "made a vow with my girlfriends [who were also in the class] that we were going to be abstinent, we were going to be celibate until we got married." At that point, Rose knew that her teacher and friends expected her to practice abstinence, and they discussed STIs as an outcome (that would result in social sanctions) of not following those expectations. Although Rose ended up breaking her vow (and she suspected her friends did, as well), she felt that knowing others' expectations for her and the sanctions of not following those expectations played a role in her decision to remain monogamous with her high school boyfriend and eventual husband. Twenty-five-year-old Tammy (a White, divorced mother of three and former adolescent mother) remembered learning that her mother expected her to be on birth control as a teenager and not to get pregnant. Being one of 11 siblings herself, Tammy knew the consequences of getting pregnant and taking care of a baby, not only because of her day-to-day life with young siblings but also because of her mother's reminders that she did not need "another mouth to feed." Ultimately, though, Rose and Tammy's stories, in which there seemed to be connections between learning injunctive norms and learning social sanctions, were exceptions.

For 10 participants, representing a variety of subject positions, it was more difficult to communicate when and how, exactly, they learned about injunctive norms—or if they learned about them at all—and thus it was also difficult for us to decipher if or how learning those norms was connected to learning social sanctions. For instance, 18-year-old Aisha (a single African American who first had sex as a young teenager) learned implicitly that her family "would definitely not [have] want[ed] me having sex at a young age or before marriage." But because her parents and grandmother never told her this message directly—or discussed the potential social sanctions of premarital sex—the context and timeline for when Aisha learned about injunctive norms and/or social sanctions is unclear. Similarly, Cassandra—a 20-year-old Hispanic woman who was, at the time of the interview, unmarried and pregnant with her first child—could not recall ever learning expectations or sanctions about fertility-related issues from others, although she did remember learning about various birth control methods in a high school health class. One could potentially argue that such lessons implicitly taught her either that the hardships of teen pregnancy were a sanction of sex or that using birth control—as well as having sex as a teenager—was an injunctive norm her teachers and peers had for her. However, Cassandra did not offer enough discursive evidence in her interview to point to either of these interpretations of her experiences.

In the cases of 16 participants representing a range of ages, races, and fertility backgrounds, their responses revealed that they remembered learning perceived injunctive norms separately from social sanctions. For example, Sharon—a 37-year-old White, divorced mother of two—recalled that her mother explicitly encouraged her to avoid sex until marriage, but she was unwilling to say much more than "Don't do it," even when Sharon was contemplating having sex in college (something she ended up doing without the protection of condoms). Thirty-three-year-old Alex—a mixed-race mother of one who had recently divorced her abusive husband—also remembered her parents telling her "Don't do it" as a teenager, but not necessarily why they had this expectation that she would not have sex. She noted that it was only years later that her parents told her that "they were really scared I was going to have a kid then because I was so promiscuous." Although Alex's parents had a clear sense of the social sanctions she could face if she did have sex, they did not discuss those sanctions with her when they initially discussed their expectations for her.

Similarly, Lena—a 32-year-old, African American mother of two—recalled that, although she learned some of the consequences of norm violation when she discovered that her high school teacher expected her to wait to have sex, she did not learn until much later "the whole realm of getting pregnant—the beginning, the start, and to the end, 18 years later after you have these children." Lena believed that learning about the process of pregnancy and the hardships of childrearing (i.e., the long-term social sanction) would have "been my motivation to not have children, to use a condom at every time, you know." Her differentiation between different types of social sanctions according to their short- or long-term effects was one that several participants made, and one that we take up more concretely in the next section. Overall, we found that only 4 participants in this study offered a narrative expressing that they learned about injunctive

norms in concert with the social sanctions of violating those same norms. Ten participants either did not learn about injunctive norms and/or social sanctions at all, or learned about them in a way that was too subtle for us to distinguish the connections between norms and sanctions. The remaining 16 participants explicitly remembered learning injunctive norms and social sanctions separately (and thus their experiences might not be adequately represented by the TNSB).

Connecting Norms and Consequences to Behaviors

Our second major interest in this study was in understanding if and how low-income women described perceived injunctive norms and social sanctions as linked to behavior when discussing fertility-related experiences. Two themes emerged indicating that learning about perceived injunctive norms and social sanctions in concert (as the TNSB implicitly theorizes) might increase the likelihood of conformity to the norm, and that injunctive norms tend to be most convincing (and thus connected to behavioral compliance) when communicated in light of two different types of social sanctions: short- and long term.

First, participants noted that individuals (both themselves and others they knew) who did not learn about perceived injunctive norms and social sanctions in concert seemed less likely to conform to the perceived injunctive norm. In Sharon's previously mentioned situation, learning the perceived injunctive norm to abstain from premarital sex (but not the social sanctions of defying that norm) failed to keep her from having sex before marriage:

> Sharon (S): [My grandparents] didn't really talk to me about it, but I knew that they wouldn't have approved of me having premarital sex.
> Interviewer (I): Right, but never really had direct conversations. How did you pick up on that—the fact that they might not approve of it?
> S: Well, just because of the value system that I was raised with: that you didn't have sex before marriage and just be a, quote, "good girl." I was raised with Christian values, and they just didn't believe it was right.
> I: Having those values and knowing those beliefs, did those affect how you acted, or decisions you made at all?
> S: Sometimes. Afterwards, I would really feel ashamed.

Sharon noted that feeling ashamed about her behavior had multiple negative health implications because not only did she defy the injunctive norm by having sex, she was often too embarrassed to insist that her partners use condoms. Similarly, 24-year-old Bettina—a single, African American mother of four who first became pregnant at age 15—learned that her mother, brother, and doctor expected her to use birth control or practice abstinence to avoid getting pregnant while in high school, but she did not learn about the social sanctions of defying that norm until after she was already pregnant. She said, "I was taking my pills and then I started forgetting to take them," and that was when she conceived her first child. At that point, her brother told her that "he was real disappointed in me because he was loving coming to see me when I was swimming. I was a good swimmer in high school, so he had high hopes for me." Bettina's narrative implied that she might have been more likely to remember to take her pills if her brother had initially laid out both the injunctive norm that she not become pregnant and the social sanction of a thwarted swimming career.

For the 4 participants who learned about injunctive norms and social sanctions in concert, only one complied with the norm. Twenty-two-year-old Melanie—a single, mixed-race mother of two—did follow the injunctive norm set out for her by family members after she gave birth to her first child. They explicitly told her their expectation that she not have another baby as a teenager, and they laid out the problems (social sanctions) she would have if she defied that norm: "My mom, she talked to me about her being pregnant with, about me and my brother, and how she had miscarriages, and how she went through that, and stuff like that." After hearing the consequences of another teen pregnancy, as well as the injunctive norm that she avoid an immediate pregnancy, Melanie followed her family members' advice to get on birth control, and she did not have another child for three and a half years. In her case, the combination of learning the injunctive norm and learning the social sanctions of defying the norm seemed to encourage norm compliance.

For the other three participants who learned norms and sanctions in concert, it could be argued that they followed some, but not all, elements of the norm. For example, Rose made this point in her interview by noting that she did have sex while in high school, but she waited longer to have sex with her boyfriend, was monogamous when she had sex, and eventually married that person as a result of learning about potential outcomes with concomitant social sanctions and injunctive norms. She explained:

> When I heard about all of the diseases, I was thinking, [my boyfriend] had been sexually active before, and I had been dating this guy for a year, and I was not sexually active with him. And I was hearing of the chlamydia, the syphilis, just the sexually

> transmitted diseases. It just, it made me freeze, like, "Oh my gosh!" Yeah, and they were showin' pictures. So I held out a little while longer.

Although Rose did not follow the injunctive norm, she altered her behavior to reduce her chances of catching and then living with an STI, which was the major social sanction she encountered when she initially learned her teacher's and friends' expectations for her.

A second theme that emerged from the interviews concerning behavior was that participants differentiated between two different types of potential outcomes, short and long term, and felt that learning about both, along with the injunctive norm, was important for affecting behavior. Alex, who was discussed earlier and had a long history of STIs, listed a number of topics that teenagers should be told about having sex. She encouraged teachers to explain that "this is what happens when you have sex with a partner who's dirty. This is what happens when you have sex with a partner who has an STD [STI]." She went on to explain that a discussion of consequences must take into account both short- and long-term social sanctions to be effective:

> It seems like kids have this misconceived idea of the short term: "I'm pregnant, I'm going to have this baby, and then everything's going to be okay." And they don't see the long term of you gotta get up at two o'clock in the morning and feed that kid or change the diaper, and go back to bed and get up two hours later.

Twenty-four-year-old Anita (a single, Hispanic mother of two with a history of multiple abortions) echoed Alex's call, explaining that she learned the short-term consequences of getting pregnant as a teenager—being grounded or beaten by her parents—but not necessarily the long-term consequences—feeling emotionally abandoned by a sexual partner. Anita felt that understanding another long-term social sanction, the difficulty of getting an education as a single mother, would have kept her from getting pregnant as a teenager. She wished she had learned that "at 24, it's impossible for me to make plans to do anything, even regarding a four-hour class a day and working. It's just a mess every day—a chaos every day."

Marge—a 43-year-old, White single mother of two—also argued that young people needed to learn the intense, lengthy social sanctions of pregnancy. In her case, her parents' injunctive norm that she be married and employed when she became pregnant was not coupled with a discussion of social sanctions. She felt that the lack of discussion regarding long-term sanctions in particular played a role in her defying the injunctive norm (she became pregnant while she was unmarried and unemployed). To keep other young people from a similar fate, she suggested explaining to them:

> You have sex, you don't use protection, come up pregnant, you got nine months of this. They don't explain all that, and then the guys out here, whatever. They both need to be held responsible at that time. They need to be taught at school. There needs to be some kind of class. I keep telling this to my boyfriend. They need to come up with some kind of class at school, like when they hit junior high. Partner the boys and girls up. This girl and this guy, whatever. During this class, during the day, they're partners. At the beginning of the year, you get her pregnant. You have paper money—I don't care what you do—you have $100. You only make that every week, but then you have all these bills. Each day, make them go through nine months. Until you're nine months and have a baby. See how much money you have left, see what your life is. That girl has to keep contact, you have to keep contact with that girl all the time.

Three other participants made similarly impassioned calls for detailing the experience of both short- and long-term social sanctions of injunctive norm violation, thus indicating their belief that, when perceived injunctive norms were coupled with discussions of both types of social sanctions, norm compliance was more likely to follow.

Norms and Choice

Our third interest in this study involved understanding whether low-income women discussed barriers to following norms when describing their fertility-related experiences. Twenty-six of the 30 participants mentioned at least one factor that seemed to limit their behavioral choices, including the evolving nature of social norms, relational dynamics that regulate decisions, access to credible information, and access to adequate health care.

Five participants' responses suggested that injunctive norms were ever-evolving constructs that shifted dramatically and sometimes conflicted over the course of a woman's lifetime, thus making it difficult for women to choose to follow them or not. Dominant norms that promote delayed sexuality and childbearing in the United States (Geronimus, 2003) dictate that women should not have sexual intercourse or become pregnant until they are married or in a committed relationship. Yet descriptive norms about sexuality also suggest that most people have sex before marriage (Strano, 2006). Once women get married, preferred norms change, and pronatalist preferences

encourage childbearing. Participants' narratives in this study revealed that conception and childbearing after marriage are also rife with specific and constantly changing injunctive norms. Thirty-eight-year-old Geanie—a White, married mother of three—described inquiries she received about having children shortly after she was married: "People do that, 'How long have you been married? When are you going to have children?' I just think your peers, and the public, and family ride your case about it and get into your business." Geanie felt as if it was almost impossible for her to follow others' expectations because they were so specific, demanding that childbearing be timed in certain ways after marriage. For instance, although her in-laws wanted her to have children eventually, they were highly critical when she became pregnant "too soon" after getting married: "My ex-husband's parents had the long lecture of, 'Babies cost money, don't you know what you're doing,' da, da, da, da, da. They made me feel terrible." Geanie's story demonstrates that being married is often an expected necessary condition of pregnancy, but not necessarily a sufficient condition for satisfying injunctive norms.

Once a woman has children, she is often expected to space the births of multiple children appropriately (i.e., children should not be born too close together or too far apart). Forty-eight-year-old Rita—a divorced, African American mother of three grown children—was criticized for having two of her children just months apart, a criticism she found surprising because she was neither single nor lacking a home of her own. She recalled,

> Especially this person, after I just had my daughter, and then I'm pregnant. I had my daughter in January, and then I'm pregnant again in June. But I was married. Like I said before, anyone should be pregnant should be a married woman. I mean, as I said, if I wasn't married, but even if I wasn't married, like I said, I don't believe in abortion. But here I am, a married woman, livin' on my own, and this person said this to me. And it really did hurt, but it was like, "Oh, well. That's how they think."

Sally—a 40-year-old, divorced, African American mother of three—also encountered an injunctive norm about the details of having children as a married adult when she was critiqued by family members and friends for having a third child when her two oldest children were in high school. She explained, "Well, a lotta people, they were like, 'Wow, I can't believe you . . . 'cause your older kids are so much more older, I bet that that's an experience.'" And not only did injunctive norms delineate that women space their children in fairly specific ways, they also suggested that women (perhaps low-income women in particular) limit their overall family size. Tammy's recollection of a conversation with her sister illustrated the normative expectation not to have too many children:

> Tammy (T): Yeah, she [her sister] asked me if I was done and going to get my tubes tied, and I told her that I wasn't. A lot of people asked me if [I was] done, if [I was] gonna get fixed and stuff. I [had] been telling them, "No," that I want[ed] to get the implants.
> Interviewer (I): Why do you think people ke[pt] asking you that?
> T: Because I got four kids.

Tammy's sister might have been especially anxious that Tammy limit her family size because they both grew up in an unusually large family themselves and experienced hardships as a result. However, Tammy was asked repeatedly if she was "done" by a variety of people, including medical professionals, and thus encountered this specific injunctive norm in situations where people did not know about her background but perhaps thought that having more than four children was not acceptable.

Although norms prescribed that women should delay childbearing until marriage and then have a certain number of kids, women were also judged for waiting too long to have children. When Bettina (mentioned previously) was asked to describe typical expectations for when women should have children, she said,

> I would say in the late twenties, but I have seen people in their mid-thirties and late forties having kids, and it concerns me. They should not have kids after 35. A lot of what I see coming from the medical community is if you have a child after 35, your risks for a number of things go up: child deformities, learning disabilities, Down syndrome, pregnancy complications, Braxton Hicks, movement of uterus, collapsing uterus.

Bettina's view of social norms seemed to be influenced by public discourse about the risks of advanced maternal age and age-related infertility (see Harter, Kirby, Edwards, & McClanahan, 2005). Overall, the experiences of women who coped with normative expectations about fertility and sexuality illustrated that normative expectations for ideal behaviors shifted considerably as women aged or encountered changing circumstances, making it challenging to navigate which behaviors were appropriate or ideal. For a woman to choose to follow or not follow a norm, she had to be fluent in a complex array of changing expectations.

Beyond the complicated task of negotiating evolving fertility norms, women also encountered a host of other

factors that limited or even erased their individual agency in making personal choices. Complex relational dynamics inhibited individual choices for at least 5 participants who faced controlling or even violent sexual partners (see Zoller, 2005). Nineteen-year-old Lachelle—an engaged, mixed-race mother of one—coped with the social and personal sanctions of becoming a teenage mother after her boyfriend raped her when she was 15. In a less extreme case, Leigh—a 24-year-old, married, White mother of two—dated a man who hid her birth control pills from her for a period of 3 months. Leigh expected, but did not choose, to get pregnant during this time. In these situations, women had limited control over fertility-related behaviors; thus, their compliance with or violation of social norms was not solely a matter of personal choice. Although one could argue that such relational dynamics are interpersonal rather than normative (Lapinski & Rimal, 2005), the concomitant consequences for violating norms (e.g., social ostracism for becoming pregnant at 15 years of age) are social in nature and are thus inextricably linked to normative expectations.

Six women recalled receiving inadequate or misleading health information that might have affected their compliance with normative expectations. Terri, for example, lamented the lack of information she had about how to use oral contraceptives when she started taking them at age 12. When Terri's father took her to a physician to get a prescription, the doctor told her father how the birth control pills worked. But the doctor did not relay this same level of information to Terri, who was out of the room during the explanation. Terri recalled, "They told my dad; they didn't tell me nothin' about it. They just told me that this is how you need to take it, this is when you need to take it, and that's it." Consequently, Terri was unaware that she had to take a pill every day to prevent pregnancy, and she become pregnant at 14. Melanie, who received no formal sexual-health education in school, explained that her mother and sister did not discuss sex and pregnancy with her until after she became pregnant with her first child at the age of 18. And Jaime—a 32-year-old, divorced White mother of two with a history of two miscarriages—described an encounter with a health care provider who gave her inaccurate information during her first pregnancy. After experiencing excessive bleeding, Jaime sought care at a hospital emergency room where she was told that she was having a "false pregnancy," only to find out years later that she had actually experienced a miscarriage:

> [They] said that I wanted to be pregnant so bad that it [the "false pregnancy"] happened. But then now they tell me that that's not possible—that I was actually pregnant because that happened when I was 18. I don't know if they just told me that so that I wouldn't be upset, or what it was.

Without accurate information about her own health condition, Jaime could not make decisions that either did or did not align with injunctive norms.

Another barrier to following perceived social norms was lack of access to adequate health care. Six of the 30 women in the present study's sample had no health insurance at the time of the interview, 1 was uncertain whether she was still covered by her father's medical plan, and at least 4 others who were insured at the time of the interview had only intermittent health insurance in the past. Thus, many of the interviewed women had limited options when it came to seeking health care. Rebecca, who was a White 23-year-old and engaged to be married, desperately wanted to fulfill the pronatalist norm of having a child. In fact, she and her fiancé had been trying to conceive for several years. After feeling severe pain in her abdomen and visiting an emergency room, Rebecca found out that she had a large cyst on her ovary and that she would be unable to have children until she had surgery to remove the cyst. At the time of her interview, Rebecca had no health insurance coverage. She had just applied for Medicaid and hoped that she would qualify and that the necessary treatment would be covered. Even some women who did have insurance coverage expressed uncertainty about what, exactly, their insurance would cover. Anita, for example, was not sure whether her Medicaid policy provided coverage for contraceptives, and, if so, what types of contraceptives were included. This sort of uncertainty about coverage made it more difficult for her to make decisions that aligned with perceived injunctive norms.

In summary, individual choices about following social norms regarding fertility-related issues were constrained for women by evolving norms, relational dynamics, lack of access to credible health information, and lack of access to adequate health insurance and care. As Zoller (2005) noted and as the present findings reiterate, when it comes to issues like fertility, sexuality, and family planning, there cannot be a discussion of women's choices in terms of social norms without also acknowledging the sociopolitical context of those choices.

Discussion

Our goal in this study was to consider assumptions of the TNSB that seemed to warrant continued consideration in light of interviews with low-income women about fertility and sexuality-related norms. Using qualitative interviews allowed us to explore the complex interplay between social norms and health behaviors. Implications for the TNSB

from this study invite both future research and perhaps even a reconceptualization of some constructs in the model to better guide health research, campaigns, and interventions.

First, our examination of fertility-related norms suggested that although injunctive norms and outcome expectations (e.g., social sanctions) are intertwined in the TNSB (i.e., injunctive norms are meaningless without concomitant sanctions for violations), individuals do not always learn about norms and consequences simultaneously. In fact, the women in our sample who learned about the potential consequences of norm violations at the same time that they learned about the norm itself were the exception rather than the rule. In discussing the connection between injunctive norms and behavior, some participants expressed a belief that individuals who did not learn about perceived injunctive norms and potential outcomes simultaneously were less likely to conform to the norm. In several cases, participants were quite specific about this topic, calling for more explicit discussions of potential ramifications, particularly in efforts to promote norm compliance; they differentiated between short- and long-term consequences, noting that both needed to be communicated when laying out injunctive norms.

Taken together, these results suggest that normative messages that communicate only the norm itself might be oversimplified. Women in our study reflected on their experiences and speculated that they might have made different behavioral choices if they had had a fuller understanding of the potential consequences, especially the long-term consequences, of violating normative expectations (e.g., the challenges of pursuing higher education after becoming a teenage mother). In terms of the TNSB, the experiences of women in our sample suggest that future research should continue to untangle the interplay between injunctive norms and outcome expectations. More specifically, researchers must ask whether learning about an injunctive norm and the potential consequences of violating that norm simultaneously increases behavioral compliance with the norm. Our findings suggest that this might be the case, but additional exploration is necessary for understanding these variables and their relationships.

Next, participants in this study suggested that compliance with a normative behavior might not always be related to rational decision making. In some cases, multiple factors affected violation of or compliance with normative behaviors, including an understanding of the norms themselves—which can change and shift over time—relational factors, and access to adequate information and health care. Although these factors could certainly play a role in the normative processes of any individual, individuals representing traditionally marginalized groups such as those who are low income might be especially likely to confront these decision-reducing factors (Marmot & Wilkinson, 1999). In this respect, the TNSB as it is currently mapped out might be less predictive overall for low-income or otherwise marginalized groups. Accounting for these limitations in the TNSB and similar health-belief models would not only help to alleviate this discrepancy but also offer more predictive accuracy in efforts to understand the relationship between social norms and various health-related behaviors.

The present study has both strengths and limitations. A major strength is that, by drawing from qualitative interviews with individuals representing unique subject positions, the results emerged with respect to the lived experiences of those individuals. Their day-to-day understanding of norms and normative negotiation would be especially difficult to parse using quantitative methods. This attention to gaining a sample of hard-to-reach, often undersurveyed individuals (i.e., low-income women) worked to expand the reach of normative models of health communication and behavior. This study was limited by the challenges of inquiring about the subtle micro-processes of normative interaction. Communicating about detailed distinctions among normative types is difficult even in academic spheres, but we worked to overcome this challenge by translating our normative interests into questions using vernacular rhetoric and also identifying conceptual ideas in the participants' own words.

With regard to the implications of this study for the TNSB, a number of compelling future research directions are suggested. Researchers must continue to explore the following findings before reenvisioning variables in the TNSB: (a) individuals do not always learn about injunctive norms and potential social sanctions simultaneously; (b) when individuals learn about injunctive norms and consequences separately they might be less likely to comply with perceived norms; and (c) there is a difference between the communication of short- and long-term social sanctions. All together, these findings make a case for continued attention to perceived injunctive norms to assess whether they are, indeed, often central to individual normative perceptions and behaviors. Such a program of research will continue to refine the TNSB and thus enhance understandings of the interaction between normative communication and health behavior.

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