AG AboutGender
2025, 14(28), 465-486

From childbirth as an event to childbirth as an experience. The "embodied motherhood penalty" as a new perspective in fertility studies

Alessandra Minello
University of Padua, Italy

Abstract

Childbirth is often treated as a demographic event, yet for women it is a profoundly embodied experience that can reshape well-being, identity, and reproductive choices. Moving from childbirth as an event to childbirth as an experience allows for a deeper understanding of how physical and emotional dimensions of birth influence not only fertility trajectories but also broader aspects of women's lives.

Drawing parallels with the well-documented "motherhood penalty" in the labour market, where women experience systematic disadvantages due to caregiving responsibilities, the concept of an "Embodied Motherhood Penalty" (EMP) is proposed. This penalty reflects the physical and emotional toll that childbirth can have on women, potentially leading to delayed or reduced fertility, but also shaping family overall well-being and, potentially, other life domains. To address this gap, the paper calls for a multidisciplinary approach that includes perspectives from sociology, psychology, and feminist theory. Such an approach would ensure that women's bodies and experiences are no longer marginalized, offering a more holistic understanding of fertility behaviours. By placing women's embodied experiences at the centre of the framework, the paper complements existing economic and policy explanations and deepens our understanding of fertility and family life. It calls for public policies that promote respectful, person-centred, and well-being-oriented maternal care.

Keywords: fertility, body, motherhood penalty, well-being, experience, childbirth.

Corresponding Author: Alessandra Minello, alessandra.minello@unipd.it
DOI: 10.15167/2279-5057/AG2025.14.18.2427

Introduction[1]

In recent years, several disciplines have increasingly recognized the importance of women's embodied experiences, emphasizing how the body represents not only a biological reality but also a site of agency, identity, and citizenship (Casalini, 2014). Demographic research – traditionally centred on structural, economic, and behavioural determinants – has also begun to move in this direction. Yet, the subjective and physical dimensions of childbirth remain relatively underexplored. Given the centrality of fertility and reproduction to the field, integrating women's embodied experiences can offer valuable insights into how the physical and emotional realities of childbirth shape reproductive choices and well-being.

While anthropological and feminist scholars have long examined reproduction as an embodied and socially embedded process (Bledsoe, 2002; Inhorn & van Balen, 2002; Ginsburg & Rapp, 1995), this perspective remains marginal within mainstream quantitative fertility research in high-income countries. Analyses often prioritize structural and economic determinants while paying limited attention to the emotional and embodied aspects of reproduction. This limited focus constrains our understanding of fertility decisions, overlooking childbirth as a potential source of trauma and a key determinant of women's health and well-being.

To address this gap, and to complement existing economic and policy explanations, the paper introduces a theoretical framework that places the childbirth experience at the centre of fertility studies. It proposes moving from a view of *childbirth as an event* – a discrete, measurable occurrence – to a view of *childbirth as an experience* – a deeply embodied process with lasting effects on women's mental and physical health. The concept of an *Embodied Motherhood Penalty* (EMP) captures the physical and emotional costs of childbirth that may deter further childbearing and influence women's broader life trajectories.

By incorporating these embodied and experiential dimensions, fertility research can move toward a more holistic understanding of reproduction – one that integrates subjective well-being, health outcomes, and family dynamics into demographic analysis.

[1]This article has been produced within the framework of the project funded by the European Union – "FORTIES Fertility Over fortIES. A mixed-method comprehensive approach to understand parental well-being and trajectories of late and latest-late fertility" (CUP C53D23008830001), PRIN PNRR 2022 – Mission 4, Component 2, Investment 1.1. The views and opinions expressed, however, are solely those of the author and do not necessarily reflect those of the European Union or the European Commission. Neither the European Union nor the European Commission can be held responsible for them.
The author warmly thanks the FORTIES team colleagues — particularly Livia Elisa Ortensi, Anna Caterina Leucci, Francesca Tosi, and Elena Vettoretto — for their support and for the many ideas shared throughout the project. Gratitude is also extended to the editor and the anonymous reviewers, whose insightful comments substantially improved the quality of this article.

Integrating embodied childbirth into fertility research

Recent developments in demographic trends toward low and delayed fertility across high-income countries have revived interest in the factors shaping fertility behaviour. Over the past decades, sociological and demographic research has expanded beyond investigating the causes of high or low fertility rates to also examine the trajectories of individuals who remain without children, whether by choice (*childfree*) (Gillespie, 2003) or not (*childless*) (Rowland, 2007). When attention has focused on fertility trajectories, however, this renewed demographic focus has largely centred on economic aspects. The prevailing emphasis has been on job security, financial stability, and economic uncertainty, which are undeniably critical in understanding fertility trends (Fahlén & Oláh, 2018; Kristensen & Lappegård, 2022). Alongside these economic considerations, there has been renewed attention to public policies aimed at addressing low fertility rates (Billingsley & Ferrarini, 2014; Gauthier, 2007). More recently, the COVID-19 pandemic (Aassve et al., 2020) and the ongoing environmental crisis (Muttarak, 2021), with their economic implications, have emerged as significant external shocks that have reshaped demographic interpretations and considerations, also in relation to fertility.

Notably, research has consistently shown that the postponement of childbirth is a major demographic trend in the Global North (Sobotka, 2004), with a growing consensus that economic factors play a crucial role (van Wijk & Billari, 2024). At the same time, it is increasingly evident that as families delay having children, assisted reproductive technologies (ART) are frequently used to meet fertility goals, leading to substantial shifts in fertility patterns (Beaujouan, 2020; Lazzari et al., 2023). ART, however, has been described as the expropriation of reproduction from the body, since it represents the process of progressive separation between sexuality and procreation (Lombardi, 2016). Also, the demographic studies focusing on ART often overlook the embodied experiences of women undergoing these treatments: the impact on women's reproductive decision-making is reduced to mere statistical outcomes, rather than understood in its full emotional and physical complexity. This approach aligns with some of the most prominent and widely recognized interpretative frameworks in demographic studies on fertility, which tend to emphasize socioeconomic factors and focus on the more structured aspects of the debate.

In the latter half of the 20th century, two dominant theoretical frameworks emerged to explain fertility patterns: the New Home Economics (NHE) developed by Becker (1964), and the Second Demographic Transition (SDT) articulated by van de Kaa (1987) and Lesthaeghe (1995).

The NHE perspective originates from economic theory, specifically focusing on the costs and benefits of childbearing decisions. Becker (1981) approaches fertility behaviour from a strict microeconomic standpoint, framing it as an individual action aimed at maximizing utility. Utility

maximization suggests that an increase in economic resources could have mixed implications for fertility. On one hand, women's employment boosts household income, potentially encouraging higher fertility (the income effect). On the other hand, as employment reduces the available time for childcare, balancing work and parenthood may lead to competing priorities (the substitution effect). The application of a rigid economic framework to fertility behaviour tends to create a simplified and somewhat unrealistic model of family decision-making. Partners are seen as calculating the economic costs and benefits of having a child, discounting immediate costs based on the anticipated future utility (Caldwell, 1982).

The SDT, introduced by van de Kaa (1987) and Lesthaeghe (1995), offers a contrasting perspective on fertility, rooted in sociological theories of value change and individualization. Despite its focus on cultural shifts, economic strategies remain central to the theory. In postmodern societies, individuals — particularly women — tend to prioritize career development and personal fulfilment over family life and childbearing.

Overall, “Generally speaking, in these two frameworks the demand for fertility is conceived as being determined by permanent (household) income, the [economic] opportunity cost of children, tastes, and self–realization needs” (Vignoli et al., 2020, p. 31).

In 1987, Dirk Van de Kaa, the framer of the SDT theory, noted that most key variables influencing reproductive decisions had likely already been identified, implying that the understanding of why individuals opt for larger or smaller families was well-established. At the same time economists often emphasize the significant contributions their field has made in understanding fertility, with statements such as "The economics of fertility has been a success story" (Doepke et al., 2023, p. 152). However, this success does not imply that all aspects of human agency have been adequately considered. Notably absent is a focus on the experiential dimensions, particularly the transition to parenthood and the embodied experiences of mothers.

Some progress has been made recently in approaching the issue with a framework that takes gender differences into account: the critical role of gender equity, both within households and at the societal level, in understanding fertility trends and cross-national differences (McDonald, 2000) has been introduced. Theories such as multiple equilibria (Esping-Andersen & Billari, 2015) or the gender revolution (Goldscheider et al., 2015) suggest that periods of very low fertility rates could be a temporary outcome, following the increase in female participation in the workforce. Moving from a rigid division of roles within the traditional family model to a redefinition of roles in the public sphere, with the expectation that this revolution will also reach a new equilibrium in the private sphere (England, 2010; Esping-Andersen, 2015). Some researchers have questioned how women's new roles could be reconciled with emerging fertility dynamics, proposing interpretive frameworks that account for the various possible trajectories. Catherine Hakim, in her Preference Theory (2000), offers a distinction between women who are oriented toward the family (home-

centred) and women more oriented toward the labour market (work-centred), whose main goal is personal and professional achievement. The fertility rate of the first group is likely to be higher than that of the second.

Even when the issue has been approached with gendered considerations in mind, however, the central focus has often remained on economic factors. Human actions, instead, typically represent a blend of various ideal types of agency (Weber, 1978), and fertility decisions, in particular, reflect a complex interplay of interests, values, opportunities, and social relationships. Fertility behaviours are not purely determined by economic considerations.

Despite the introduction of the gendered approach economic factors remain central in fertility studies. They no longer simply play a determining role, but rather a unique one role (van Wijk & Billari, 2024), deeply influencing reproductive decisions and family policies. However, this perspective can be challenged, as overly reductive.

However, a large body of literature now extends the study of fertility trajectories beyond the limits of purely economic explanations. The role of cultural, psychological, and relational factors, including political attitudes (e.g. Arpino & Mogi, 2024), uncertainty about the future (e.g. Vignoli et al., 2020), environmental concerns, and the influence of social networks or intergenerational ties (e.g. Balbo et al., 2013) have been explored. Recent studies have also emphasized how fertility intentions and behaviours are shaped by values, trust (Aassve et al. 2016), and relations or divisions of care duties (Mills et al., 2008), demonstrating that economic determinants are only part of a complex system of motivations. Well-being has been introduced into the picture: examining longitudinal data from Germany, Margolis, and Myrskylä (2015), as an example, discovered that the changes in subjective well-being during the transition to parenthood can forecast the likelihood of having more children: a decline in well-being right after the first birth is linked to having a lower chance of a second child. Focusing on ART, Goisis and colleagues (2023) show that women who undergo medically assisted reproduction face elevated risks of mental health challenges over the life course, while Köksal and Goisis (2023) find that the process itself can generate loneliness and emotional strain. These studies indicate that assisted reproduction entails not only biomedical but also profound emotional dimensions — further reinforcing the need to integrate women's subjective experiences into demographic analyses of fertility and well-being. At the same time, the embodied and emotional dimensions of childbirth, as discussed in this paper, have not yet been fully integrated into fertility research. This article therefore does not aim to challenge existing explanations, but rather to complement them by highlighting how the subjective experience of motherhood contributes to women's well-being and fertility trajectories.

From childbirth as an event to childbirth as an experience

Childbirth is, indeed, the main objective of demographic fertility studies but is classically approached as a fundamental life course *event* rather than a crucial *experience* deeply affecting the women's body and mind. Other disciplines, ranging from neuroscience to, even, economics, including psychology, have long explored the role of experiences and the associated emotions in shaping future decisions (e.g., Coricelli et al., 2005; Kahneman & Tversky, 1979; Lerner et al., 2015). Demography has largely neglected this perspective up to now.

While not all women aspire to motherhood, and not all mothers experience pregnancy, for those who do, childbirth is often idealized and seen as a moment of beauty and fulfilment, leading to a veneration of childbirth (Jones, 2012). Kukla observed that many women in recent times experience childbearing as a form of "maternal achievement test," with its "symbolic importance" heightened to the point that it "seems to function as a decisive test of a woman's mothering abilities" (Kukla 2008, p. 74).

This idealization is deeply embedded in cultural narratives that present pregnancy and childbirth as the pinnacle of feminine achievement, a "moment of beauty" to which many women are encouraged to aspire. The mythologization of childbirth as a natural, serene, and transformative experience is reinforced by various societal messages, despite the diverse realities that women may face (Bobel, 2002; Rich, 1976). The glorification and mythologization of motherhood and the associated biological processes have been critiqued in feminist literature for perpetuating a one-dimensional view of women's reproductive roles. Bobel (2002) critiques the idealization of "natural" motherhood, noting how societal pressures can obscure the complex realities of pregnancy and childbirth.

This romanticized image often overlooks the physical pain, emotional turmoil, and medical complications that can accompany childbirth, even if in high-income nations, the birthing process is typically associated with rare and unforeseen complications.

Nevertheless, there are many aspects connected with childbirth itself that, together with the above-mentioned ART process — with its emotional and psychological implications — should be considered while looking at fertility as an experience.

A key element of this perspective, contrasting with the idealized "moment of beauty" narrative, is the widespread prevalence of traumatic childbirth, which is increasingly being recognized as an international public health issue (Beck et al., 2018). Research indicates that up to 30% of women perceive childbirth as a traumatic experience (Rodríguez-Almagro et al., 2019). Trauma related to reproductive experiences is not confined to childbirth or delivery but can occur at any stage of the fertility journey. This trauma can result in long-lasting psychosocial effects, including anxiety,

tokophobia, bonding difficulties, relationship strains, and even post-traumatic stress disorder (Rodríguez-Almagro et al., 2019; Watson et al., 2021).

Traumatic childbirth experiences can shape reproductive choices through multiple, intertwined mechanisms—psychological, relational, and institutional. At the psychological level, negative or traumatic births are often associated with post-traumatic stress symptoms, anxiety, and fear of future childbirth, which can significantly reduce fertility intentions (Ayers & Pickering, 2001; Nilsson et al., 2018). These experiences may also alter women's self-perception as mothers, challenging feelings of competence and trust in their own bodies (Beck, 2004). On a relational level, traumatic births can strain couple dynamics and diminish perceived partner support, further discouraging plans for another pregnancy (Fenech & Thomson, 2014). Finally, institutional responses play a crucial role: when women perceive a lack of empathy, continuity of care, or validation from healthcare providers, this can amplify feelings of vulnerability and mistrust toward the medical system, contributing to the decision to avoid further pregnancies (Harris & Ayers, 2012; Hollander et al., 2017). These mechanisms suggest that reproductive decisions following a traumatic birth cannot be understood solely as individual or rational choices, but rather as deeply embodied reactions shaped by emotional recovery, relational contexts, and institutional experiences. Perceived mistreatment during childbirth, for instance, can trigger emotional distress and erosion of trust in healthcare institutions, which may in turn deter further childbearing. Empirically, these associations remain difficult to isolate. Existing studies often rely on retrospective data and self-selected samples, pointing to the need to address recall bias—whether by refining its treatment or by considering alternative frameworks such as associative recall models (Kahana, 2012) — alongside issues of unobserved confounding and potential reverse causality.

From a demographic viewpoint, it is important because, on the one hand, women who endure substantial physical pain, fatigue, or mental health challenges following childbirth may choose to delay or forgo subsequent pregnancies to safeguard their overall health and well-being (Declercq et al., 2013; Kendall-Tackett, 2007). On the other hand, research outside the field of demography suggests that a decline in subjective well-being, due to the traumatic event, may reduce fecundity and increase the risk of miscarriage and stillbirth, ultimately leading to a lower overall reproductive outcome (Zemishlany & Weizman, 2008).

Past literature preliminary attempted to study the connection between trauma and fertility trajectories. Gottvall and Waldenström (2002) found that women with a negative experience of their first birth, assessed through a global measure of women's childbirth experiences, had fewer subsequent children and a longer interval to the second baby. The study was based on 617 Swedish women, 10% of them declared they had a negative childbirth experience, but the specific factors that led women to view their first delivery as a negative experience were not thoroughly examined. Beck and Watson (2010), with a qualitative study conducted on 35 American mothers, highlighted

the strategies the mothers employed to heal from trauma and regain a sense of agency over their bodies, eventually facilitating the decision to have another child. These studies represent some of the earliest attempts to explore the link between childbirth-related trauma and subsequent reproductive behaviour, moving toward the research direction theorized in this paper.

The medicalization of childbirth also plays a significant role. Medicalization refers to the process by which natural experiences are treated primarily as medical events requiring clinical intervention. The increased use of caesarean sections has become a global trend. The rates have dramatically increased worldwide over the past few decades. Over the years, caesarean section rates have surged globally, rising from approximately 7% in 1990 to 21% today, far exceeding the World Health Organization's (WHO) recommended 10–15% as the optimal rate (Betran et al., 2021). The medicalization of childbirth can contribute to feelings of disempowerment and dissatisfaction for many women, as their agency is reduced in favour of medical protocols (Walsh, 2012; Davis-Floyd, 2003). As for ART, where the sense of losing control over their bodies or feeling disillusioned by the medicalization of reproduction (Gameiro et al., 2014) can lead to an overall negative perception of childbirth, medicalization might influence women's decisions about future pregnancies. Feminist scholars have long critiqued this dynamic, arguing that it contributes to the disempowerment of women (Jones, 2012; Oakley, 1984). The experience-centred approach aims to restore the woman's voice and emphasize her autonomy in the childbirth process (Davis-Floyd, 2003) but also to study its consequences. The body is a *chiasm* (Merleau-Ponty, 2004) as both a "subject-body" that actively experiences and shapes the world and as one that is shaped by its own history, cultural background, and social environment. This dual role means the body is influenced by external social norms and practices while also driven by internal, instinctive responses and the essence of "embodiment" itself. This idea of the "body-as-chiasm" is especially relevant to childbirth, which is a deeply physical experience while also shaped by cultural expectations and practices.

Considering childbirth as an experience, in fact, means paying attention to all the potential dynamics involved in that experience and all the various factors that can influence the well-being of the parturient and her support system during this critical life event. On this note, the one on obstetric violence[2] is a complex and debated topic that is meeting growing attention in social science. Research suggests that disrespect and abuse in facility-based childbirth represent a critical cause of suffering for women, a crucial barrier to skilled care utilization (Bowser & Hill, 2010), and hence, possibly, an additional mechanism for experiences to change fertility trajectories.

[2] In scientific literature, the use of the term obstetric violence, as opposed to "disrespect and abuse" or "mistreatment", is already subject to definition (Lévesque & Ferron-Parayre 2021; Chervenak et al., 2024). In this paper, the term *violence* is used when the discussion departs from the existing literature or follows the terminology employed in the key papers and reference documents.

Highlighting the multidimensional aspects of mistreatment[3], such as psychological and physical violence by medical staff toward women giving birth, is essential for a complete understanding of this issue (Shabot, 2021). When examined and quantified, mistreatment during childbirth reveals that many women worldwide undergo inadequate treatment, which encompasses abusive, neglectful, or disrespectful care (Bohren et al., 2015). Some of these aspects are related to the economic level and healthcare systems, as well as the availability of resources since the systemic level plays a role in mistreatment (e.g., Freedman & Kruk, 2014; Abuya, 2015). Obstetric violence is gaining increasing attention in other domains (O'Brien & Rich, 2022) and is highly connected to perceived trauma. It is, therefore, crucial to identify and measure the experiences in the context of potential mistreatment that contribute to a traumatic birth and to understand their role in fertility trajectories. Even without considering the extreme case of obstetric violence, it has long been recognized that the role played by medical professionals in shaping the childbirth experience can be crucial. Doris Haire's pioneering work, *The Cultural Warping of Childbirth* (1972), was among the first to critique the American health system for its tendency to transform childbirth into a pathological event, with the routine application of numerous technocratic interventions, rather than a natural physiological process.

When focusing on the mother's embodied experience during childbirth, it's important to acknowledge that the birth process also inherently involves several other dimensions. The baby's physical condition – whether it is born healthy or facing medical challenges – plays a pivotal role in the overall experience of childbirth. The mother's concerns about the baby's survival and well-being can significantly shape her emotional and psychological state during and after labour (Beck, 2004).

Additionally, the relationship between the mother and her partner, if present, also greatly influences her childbirth experience. The partner's support, both emotional and physical, can alleviate feelings of isolation and fear during childbirth, thus contributing positively to maternal well-being (Evans et al., 2023). The absence of such support, on the other hand, may exacerbate feelings of vulnerability or disempowerment, with potentially long-term consequences.

Finally, childbirth experiences are not uniform but vary significantly depending on social position and identity. As Patricia Hill Collins (1994) argued, motherhood must be understood through the intersecting lenses of race, class, and gender, which shape both the constraints and the meanings of reproductive experiences. Recent research confirms the relevance of an intersectional approach for understanding maternal health and well-being. For instance, Dillaway

[3] The World Health Organization (2014) defined these multidimensional aspects referring to outright physical abuse, profound humiliation, and verbal abuse, coercive or unconsented medical procedures, lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, denial of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.

and Brubaker (2006) show how women from different social locations narrate childbirth and medicalized practices—such as the use of epidurals – in distinct ways, reflecting broader systems of inequality. More recently, Bohren and colleagues (2024) demonstrate that applying an intersectional framework to maternal health helps uncover how power and privilege – alongside oppression and exclusion – intersect to shape inequalities in reproductive outcomes. Factors such as age, social class, ethnicity, sexual orientation, and disability profoundly influence how motherhood is experienced and supported, affecting both access to resources and subjective well-being.

This non-exhaustive list of topics shows that the experience of childbirth extends beyond the moment of birth itself. In this context, the focus is on a range of life experiences that may not ultimately lead to the birth or arrival of a child. For instance, miscarriage and voluntary pregnancy termination can have implications not only for well-being but also for subsequent fertility experiences (Bhattacharya & Bhattacharya 2009; Maine, 1979; Patel et al., 2024; Quenby et al., 2021; Studnicki et al., 2022).

A deeper understanding of how women's well-being is affected by their body experiences could provide critical insights into how these experiences shape their fertility choices over time.

The embodied motherhood penalty as a new perspective

There is a need, therefore, for a broader conceptual framework that encompasses all theoretical perspectives and reflections on the experience of childbirth. This paradigm should consider not only childbirth itself but also every bodily experience related to the journey towards motherhood, examining its effects on individual choices that collectively shape the demographic dimension of fertility, but also other dimensions of women's lives.

Thanks to the feminist movements of the 20th century, particularly the efforts of earlier movements to guarantee abortion or groups like the Boston Women's Health Book Collective (1973), women's voices and their embodied experiences began to be reclaimed in discussions about their health. Reproductive health was brought back into the centre of medical and societal discourse, as "a set of principles protecting individuals' rights in autonomously making decisions on whether, when and in what circumstances to become a parent" (Bracke, 2022, p. 752). Women now have the option to prioritize their mental well-being and bodily integrity over motherhood, supported by the principle of bodily autonomy endorsed by the United Nations (1999; 2017). Bodily autonomy pertains to a woman's or girl's right to make autonomous decisions regarding her own body and

reproductive functions, encompassing intimate aspects of physical and psychological integrity. Motherhood or having multiple children is just one of many possible life paths.

The *EMP* can be defined as a potential and cumulative disadvantage in women's subsequent reproductive agency and choices, arising from embodied experiences during pregnancy, childbirth, and the postpartum period — including but not limited to trauma. It is not a synonym for any postpartum difficulty, nor a claim that embodiment alone explains low fertility, nor a moral judgment on women's choices regarding childbirth or medical intervention. Instead, it operates through physical and psychological mechanisms, such as post-traumatic stress; relational mechanisms linked to couple dynamics and perceived support; and institutional mechanisms such as trust in the healthcare system and satisfaction with care – all of which vary by social position. Within this framework, the embodied perspective encompasses not only the experience of childbirth itself but also the route to it – including assisted reproduction treatments, untreated menstrual or gynaecological disorders, miscarriages, and pregnancy terminations for medical reasons. These embodied experiences are not isolated events: their effects can accumulate over time. It corresponds to a dynamic and stratified process rather than a single event. The physical and emotional strain of ART cycles, for example, may compound that of childbirth, while positive or empowering birth experiences can, conversely, mitigate previous embodied burdens.

By placing the childbirth experience at the centre of analysis, the EMP argues for a more holistic understanding of fertility one that prioritizes the subjective, lived reality of women and all the dimensions intervening in their choices about motherhood. This framework aims to indicate how embodied and emotional dimensions of motherhood influence reproductive choices. The term does not refer solely to *traumatic birth experiences*, but more broadly to the enduring reduction in women's subjective well-being and reproductive agency that can result from negative, painful, or insufficiently supported transitions to motherhood. In this sense, traumatic childbirth constitutes one possible *manifestation* – though not the only one – of the EMP.

Beyond individual well-being, reproductive choices are deeply embedded in social and cultural expectations surrounding motherhood. In many societies, motherhood remains a core marker of feminine identity and social recognition, creating strong normative pressures on women to become mothers (Hays, 1996; Gillespie, 2003). Such expectations can lead women to internalize motherhood as a moral obligation rather than a personal choice, blurring the boundary between desire and conformity and also shaping the way they experience childbirth. These social pressures often coexist with structural constraints – such as limited work–family reconciliation policies, but also more related to childbirth as for example the widespread use of epidural anaesthesia – that reinforce the notion of motherhood as both a duty and a sacrifice (Badinter, 2010). Recognizing these dynamics is essential to fully understand how cultural norms shape reproductive decision-making and the EMP.

The use of the word *penalty* follows the logic of the "motherhood penalty" in the labour market: it signals a systematic disadvantage that arises not by individual choice but as a consequence of social, institutional, and relational mechanisms. Here, the "penalty" refers to the cumulative physical and psychological costs of childbirth that may constrain women's subsequent fertility choices, mirroring how economic penalties limit professional trajectories. The analogy is heuristic rather than causal: it aims to expand theorizing by incorporating the embodied and psychosocial dimensions of reproductive behaviour alongside economic and structural factors. This perspective includes a focus on well-being and extends it: it aligns with the broader perspective that well-being is multidimensional, incorporating more than just happiness or life satisfaction (Ruggeri et al., 2020). The focus on well-being, as mentioned, is already high in demographic research: the positive connection between well-being and both fertility behaviours and intentions has been generally theorized and demonstrated across numerous demographic studies (Aassve et al., 2015; Spitzer et al., 2021). Mencarini and colleagues (2018) showed that elevated levels of subjective well-being are linked to an increased likelihood of having a child across various high-income countries. However, well-being was often theorized and measured as connected with overall, economic, relational and life satisfaction, while demographic research has largely neglected the increasing emphasis women place on the well-being and integrity of their bodies, including reproductive healthcare. This perspective emphasizes that the trade-off between motherhood and well-being is not purely economic but also physical, emotional, and institutional. Women who experience distress, fear, or inadequate care during childbirth may perceive another pregnancy as a threat to their bodily or mental integrity. Others, even without overt trauma, may still feel penalized by persistent fatigue, relational strain, or systemic inequities in maternal healthcare, potentially leading women to delay or avoid subsequent pregnancies (Declercq et al., 2007, 2013; Kendall-Tackett, 2007). The *EMP* thus captures a continuum of embodied experiences that might affect not only short-term fertility intentions but also long-term trajectories of health, partnership, and self-perception, since the severity and duration of these conditions can vary significantly (APA, 2023; Ramsay, 1990;) and can be connected with social inequalities. The penalty can manifest as post-traumatic stress disorder and affect intimate relationships (Ayers et al., 2006), or emerge through complex reproductive trajectories, particularly among women of lower socioeconomic status (Johnson et al., 2023; Johnson & Simon, 2021).

Focusing on mothers' well-being before and after childbirth highlights parallels with the challenges faced in the labour market after childbirth, frequently referred to as the "motherhood penalty" (e.g., Budig & England, 2001; Casarico & Lattanzio, 2023; Correll et al., 2007). The term "penalty" in the context of the labour market refers to systematic disadvantages that mothers face, such as reduced wages or career progression due to their caregiving roles. The career-motherhood trade-off has been widely explored (Adda et al., 2017; Kahn et al., 2014): having children reduces

the accumulation of work-related skills (human capital) and women who spend time away from work due to child-rearing may experience a depreciation in their skills, leading to lower wages (or career progression). Career-oriented women may opt to renounce or stop childbearing to maintain focus on professional goals and aspirations and preserve their careers from experiencing further motherhood penalty (McQuillan et al., 2008).

The concept of the motherhood penalty has already been accompanied by reflections and investigations into its linkage with maternal well-being (Hynes et al., 2004; Nomaguchi & Milkie, 2020), and also with demographic outcomes.

The connection between well-being, bodily experiences and fertility choices is, instead, still almost unexplored.

There is room for social, economic and demographic theory to incorporate mechanisms alongside labour-related factors that mirror economic principles but apply to other domains. This would serve as both a tribute to past theories and a foundation for future theoretical frameworks that place the embodied experience of women at the centre. Costs and benefits may be considered, but it is essential to recognize that human agency extends beyond purely economic calculations. The well-being and integrity of their bodies, including decisions surrounding reproductive healthcare, represent costs that women may be unwilling to bear – or to bear again – especially if they have encountered negative experiences on their paths toward motherhood.

The idea of a "penalty" suggests a loss of agency or a reduction in future opportunities: women who experience negative childbirth may have fewer choices regarding whether or when to have more children due to concerns about their health and well-being. While previous theories on reproductive experiences, such as the one referring to “reproductive careers” (Johnson et al., 2018) look at inequalities to understand the past embodied experiences, the EMP projects the experiences as a driver of the future trajectories. This mirrors the way in which economic penalties limit career advancement for mothers, as described by Budig and England (2001) and Abendroth and colleagues (2014). Finally, as mentioned, certain groups of women – whether due to ethnic group, socioeconomic status, or other factors (Declercq et al., 2013) – are more likely to suffer negative childbirth experiences or trajectories (Johnson et al., 2023), or higher medicalization and lack of support thus potentially face greater penalties in terms of their health and fertility outcomes. This mirrors the way the motherhood penalty in the labour market disproportionately affects women in marginalized groups (Casarico & Lattanzio, 2023). Finally using the term "penalty," we are also drawing attention to the societal expectations that continue to shape women's roles. In the same way that the motherhood penalty highlights the burden placed on women to balance work and family life, the EMP emphasizes the pressure on women to endure physically and emotionally challenging childbirth experiences while also being expected to continue

reproducing. This reflects broader societal narratives about motherhood that fail to adequately support women's well-being (Kendall-Tackett, 2007).

Conclusions

Moving forward requires a profound conceptual shift in the way fertility studies approach the subject of individual reproductive choices. At the heart of this shift lies the need to move from viewing childbirth merely as an event to understanding it as an embodied experience – one that profoundly shapes women's well-being, sense of agency, and future reproductive choices and family trajectories. Recognizing childbirth as an experience rather than a discrete event allows for a richer understanding of the mechanisms linking physical and emotional recovery and identity. While the economic, sociocultural, and policy perspectives have provided fundamental insights, they have often come at the cost of underestimating the embodied experience of women, particularly during childbirth. This perspective, closing this gap, should be understood as complementary rather than alternative to the others. As the younger generations that are more attuned to their own mental and physical well-being (APA, 2018) become adults, this exclusion creates a gap in our understanding, as the subjective experiences of women – ranging from physical trauma to psychological challenges – might play a significant role in shaping their reproductive choices.

The call for a new research paradigm is not only a methodological issue but also a disciplinary one. Quantitative fertility studies on high-income countries, rooted largely in economics and demography, have historically prioritized factors such as income, job security, and policy interventions. The Embodied Motherhood Penalty does not deny the importance of economic factors. Indeed, fertility is known to be procyclical (Goldstein et al., 2013; Sobotka et al., 2011), increasing during periods of economic growth and declining during recessions. However, it questions whether the economic lens is the only perspective through which to view individual choices about becoming a mother (or having additional children). This perspective aligns with a growing body of literature that examines other dimensions of fertility. The EMP proposed in this paper underscores the fact that the physical and emotional toll of childbirth can act as a significant deterrent to future childbearing and possibly extend its effects towards other family events.

Thus, future fertility and family research must, hence, adopt a more holistic framework that integrates the embodied experiences of women into demographic analyses. This means going beyond abstract calculations of costs and benefits and addressing the real, lived experiences of women. A multidisciplinary approach that combines insights from demography, sociology,

psychology, and feminist theory is essential to ensure that women's bodies and voices are no longer marginalized in these discussions. Only by embracing this broader perspective will we develop a more nuanced and comprehensive understanding of fertility trends in contemporary society. From an empirical perspective, future research should adopt a longitudinal approach to capture how childbirth experiences affect not only short-term fertility choices but also long-term trajectories of well-being, employment, and family life. This would allow for a better understanding of the lasting effects of maternal experiences and the cumulative nature of the EMP (McLeish & Redshaw, 2017). Integrating such a perspective would also make it possible to examine how cultural norms and gendered expectations shape women's agency and emotional responses over time. Beyond fertility outcomes, the concept of the EMP can also inform broader research on maternal health, relationship quality, and institutional trust, highlighting how embodied reproductive experiences shape women's well-being and social participation throughout the life course across diverse socio-institutional contexts and from an intersectional perspective. Finally, future research should explicitly examine how embodied disadvantages vary across key social moderators such as socioeconomic position, race or migrant status, age, parity. Linking these stratifying dimensions to specific mechanisms – such as differential exposure to mistreatment, unequal access to supportive care, or varying baseline levels of institutional trust – would allow the *Embodied Motherhood Penalty* framework to guide empirical designs and hypothesis testing in a more analytically robust way.

This shift not only enriches the academic discourse but also has the potential to influence public policies that more effectively support women's reproductive health and well-being. By reframing childbirth as an embodied experience and placing the EMP at the forefront, future fertility research has the potential to influence public policies that genuinely support women's reproductive health and well-being. Three key policy levers emerge from this perspective: care models, mental health, and accountability. Concerning care, ensuring continuity in midwifery-led care and implementing respectful maternity care standards are essential to prevent negative or traumatic experiences during childbirth. Particular attention should be devoted to disadvantaged groups, for whom fragmented care and limited access to support personnel amplify risks of mistreatment and psychological distress. Strengthening integrated and continuous care pathways could therefore mitigate embodied costs and restore women's trust in healthcare institutions. In terms of mental health, universal postpartum screening and trauma-informed services should be incorporated into maternal health systems as routine components of care, extending beyond the immediate postnatal period. A holistic understanding of maternal health – covering both physical and emotional recovery – would align with the World Health Organization's (2016) call to broaden maternal health indicators to include emotional well-being and quality of care, as well as with Renfrew and colleagues' (2014) framework on midwifery and quality care. Regarding accountability, embedding

women's experiences of care into national monitoring systems can enhance transparency and learning within health institutions. This includes integrating experience-of-care indicators into performance assessment, establishing clear and accessible complaint mechanisms, and ensuring that episodes of obstetric violence are addressed not as isolated failures but as systemic signals of institutional weakness. A shift toward this holistic and accountable framework could promote more equitable parental leave and postnatal support policies – acknowledging the emotional, physical, and temporal dimensions of care that shape women's reproductive trajectories.

In essence, integrating these considerations into demographic research opens up opportunities for policy innovations that not only recognize but actively support women's embodied experiences throughout their reproductive lives.

References

Aassve, A., Mencarini, L., & Sironi, M. (2015). Institutional change, happiness, and fertility. *European Sociological Review, 31*(6), 749-765.

Aassve, A., Billari, F. C., & Pessin, L. (2016). Trust and Fertility Dynamics. *Social forces*, *95*(2), 663–692.

Aassve, A., Cavalli, N., Mencarini, L., Plach, S. & Livi Bacci, M. (2020). The COVID-19 pandemic and human fertility. *Science, 369*, 370-371.

Abendroth, A., Huffman, M., & Treas, J. (2014), The Parity Penalty in Life Course Perspective. *American Sociological Review*, 79, 1014-993.

Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A., Mbehero, F., Njeru, A. & Bellows, B. (2015) Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One 10*(4), e0123606.

Adda, J., Dustmann, C. & Stevens, K. (2017). The Career Costs of Children. *Journal of Political Economy*, *125*(2), 293-337.

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a result of childbirth?. *Birth*, *28*(2), 111–118.

APA – American Psychological Association (2018). Stress in America: Generation Z. Stress in America™ Survey.

APA – American Psychological Association (2023). Maternal Mental Health: A Brief Look at the Impact of Birth Trauma. Washington DC: American Psychological Association. https://www.psychiatry.org/news-room/apa-blogs/maternal-mental-health-and-birth-trauma

Arpino, B. & Mogi, R. (2024). Is Intending to Have Children Rightist? A Research Note on Political Ideology and Fertility Intentions. *Statistics, Politics and Policy*, *15*(2), 117-136.

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, health & medicine*, *11*(4), 389–398.

Badinter, É. (2010). *Le conflit: La femme et la mère*. Paris: Flammarion.

Beaujouan, E. (2020). Latest-Late Fertility? Decline and Resurgence of Late Parenthood Across the Low-Fertility Countries. *Population and Development Review, 46*, 219-247.

Beck, C. T. (2004**).** Birth trauma: In the eye of the beholder. *Nursing Research*, *53*(1), 28-35.

Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing research, 59*(*4*), 241–249.

Beck, C. T., Watson S., & Gable R. K. (2018). Traumatic childbirth and its aftermath: Is there anything positive?. *Journal of Perinatal Education, 27*(3),175-184.

Becker, G. S. (1964). *Human capital: A theoretical and empirical analysis, with special reference to education*. Chicago: University of Chicago Press.

Becker, G. S. (1981). *A treatise on the family*. Cambridge MA: Harvard University Press.

Betran, A. P., Ye, J., Moller, A. B., Souza, J. P., & Zhang, J. (2021). Trends and projections of caesarean section rates: global and regional estimates. *BMJ global health*, *6*(6), e005671.

Bhattacharya, S., & Bhattacharya, S. (2009). Effect of Miscarriage on Future Pregnancies. *Women's Health, 5*(1),5-8.

Billingsley, S., & Ferrarini, T. (2014). Family Policy and Fertility Intentions in 21 European Countries. *Journal of Marriage and Family*, *76*, 428-445.

Bobel, C. (2002). *The Paradox of Natural Motherhood*. Philadelphia, PA: Temple University Press.

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F. S., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine, 12*(6), e1001847.

Bohren, M. A., Iyer, A., Barros, A. J. D., Williams, C. R., Hazfiarini, A., Arroyave, L., Filippi, V., Chamberlain, C., Kabakian-Khasholian, T., Mayra, K., Gill, R., Vogel, J. P., Chou, D., George, A. S., & Oladapo, O. T. (2024). «Towards a better tomorrow: Addressing intersectional gender power relations to eradicate inequities in maternal health». *eClinicalMedicine, 67*, 102180.

Boston Women's Health Book Collective. (1973). *Our Bodies, Ourselves*. New York: Simon and Schuster.

Bracke, M. A. (2022). Women's Rights, Family Planning, and Population Control: The Emergence of Reproductive Rights in the United Nations (1960s–70s). *The International History Review, 44*(4), 751-771.

Budig, M., & England, P. (2001). The Wage Penalty for Motherhood. *American Sociological Review*, *66*, 204-225.

Caldwell, J. C. (1982). *Theory of fertility decline*. New York: Academic Press.

Casalini, B. (2014). Dal corpo rivoltante al corpo in rivolta. Note su femminismo, abiezione e politica. *AG AboutGender, 3*(6), 189-212.

Casarico, A., & Lattanzio, S. (2023). Behind the child penalty: understanding what contributes to the labour market costs of motherhood. *Journal of Population Economics*, 1-23.

Chervenak, F. A., McLeod-Sordjan, R., Pollet, S. L., Katz, A., Warman, A., & Grünebaum, A. (2024). Obstetric violence is a misnomer. *American Journal of Obstetrics & Gynecology, 230*(3, Supplement), S1138-S1145.

Collins, P. H. (1994). Shifting the center: Race, class, and feminist theorizing about motherhood. In E. N. Glenn, G. Chang & L. R. Forcey (Eds.), *Mothering: Ideology, Experience, and Agency* (pp. 45–65). New York: Routledge.

Coricelli, G., Critchley, H. D., Joffily, M., O'Doherty, J. P., Sirigu, A., & Dolan, R. J. (2005). Regret and its avoidance: a neuroimaging study of choice behavior. *Nature Neuroscience*, *8*, 1255–1262.

Correll, S., Bernard, S., & Paik, I. (2007). Getting a job: Is there a motherhood penalty?. *American Journal of Sociology, 112*(5), 1297–1338.

Davis-Floyd, R. (2003). *Birth as an American Rite of Passage* (2nd ed.). Berkeley: University of California Press.

Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2013). *Listening to Mothers III: Pregnancy and Birth*. Childbirth Connection.

Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2007). Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences: Conducted January-February 2006 for Childbirth Connection by Harris Interactive(R) in partnership with Lamaze International. *Journal of Perinatal Education, 16*(4), 9–14.

Dillaway, H., & Brubaker, S. J. (2006). Intersectionality and childbirth: How women from different social locations discuss epidural use. *Race, Gender & Class, 13*(3/4), 16–41.

Doepke, M., Hannusch, A., Kindermann, F., & Tertilt, M. (2023). The economics of fertility: A new era. *Handbook of the Economics of the Family*, *1*(1), 151-254.

England, P. (2010). *The gender revolution: Uneven and stalled*. *Gender & Society*, *24*(2), 149–166.

Esping-Andersen, G. (2015). *Families in the 21st century*. Copenhagen: Nordic Council of Ministers.

Esping-Andersen, G., & Billari, F. C. (2015). Re-theorizing family demographics. *Population and Development Review*, *41*(1), 1–31.

Evans, K., Pallotti, P., Spiby, H., Evans, C., & Eldridge, J. (2023). Supporting birth companions for women in labour, the views and experiences of birth companions, women and midwives: A mixed methods systematic review. *Birth (Berkeley, Calif.)*, *50*(4), 689–710.

Fahlén, S., & Oláh, L. S. (2018). Economic uncertainty and first-birth intentions in Europe. *Demographic Research, 39*, 795-834.

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past: A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185–193.

Freedman, L. P., & Kruk, M. E. (2014). Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet, 384*(9948), e42-e44.

Gameiro, S., Verhaak, C. M., Kremer, J. A. M., & Boivin, J. (2014). Why do patients discontinue fertility treatment? A systematic review of reasons and predictors of discontinuation in fertility treatment. *Human Reproduction Update, 18*(6), 652–669.

Gauthier, A. (2007). The impact of family policies on fertility in industrialized countries: a review of the literature. *Population Research and Policy Review*, *26*, 323-346.

Gillespie, R. (2003). Childfree and Feminine: Understanding the Gender Identity of Voluntarily Childfree Women. *Gender & Society*, *17*(1), 122-136.

Goisis, A., Palma, M., Metsä-Simola, N., Klemetti, R., Martikainen, P., Myrskylä, M., & Remes, H. (2023). Medically assisted reproduction and mental health: A 24-year longitudinal analysis using Finnish register data. *American Journal of Obstetrics and Gynecology, 228*(3), 311.e1–311.e10.

Goldscheider, F., Bernhardt, E., & Lappegård, T. (2015). The Gender Revolution: A framework for understanding changing family and demographic behavior. *Population and Development Review*, *41*(2), 207–239.

Goldstein, J. R., Kreyenfeld, M., Jasilioniene, A., & Karaman Örsal, D. D. (2013). Fertility reactions to the Great Recession in Europe: recent evidence from order-specific data. *Demographic Research*, *29*, 85–104.

Gottvall, K., & Waldenström, U. (2002). Does a traumatic birth experience have an impact on future reproduction?. *BJOG: An International Journal of Obstetrics & Gynaecology, 109*(3), 254–260.

Haire, D. (1972). The cultural warping of childbirth. *International Childbirth Education Association News*, *11*(1), 5–35.

Hakim, C. (2000). *Work-lifestyle choices in the 21st century: Preference theory*. Oxford: Oxford University Press.

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum "hotspots". *Psychology & Health*, *27*(10), 1166–1177.

Harrison, D. J., Skop, I., Cirucci, C. A., Craver, C., Tsulukidze, M., & Ras, Z. (2022). The Enduring Association of a First Pregnancy Abortion with Subsequent Pregnancy Outcomes: A Longitudinal Cohort Study. *Health services research and managerial epidemiology*, *9,* 1-9.

Hays, S. (1996). *The cultural contradictions of motherhood.* New Haven: Yale University Press.

Hollander, M. H., van Hastenberg, E., van Dillen, J., van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of Women's Mental Health*, *20*(4), 515–523.

Hynes, K., Clarkberg, M., & Andersson, G. (2004). Parenthood and happiness: Effects of work-family reconciliation policies in 22 OECD countries. *American Journal of Sociology, 110*(2), 16-18.

Johnson, K. M., Greil, A. L., Shreffler, K. M., & McQuillan, J. (2018). Fertility and infertility: Toward an integrative research agenda. *Population Research and Policy Review, 37,* 641–666.

Johnson, K. M., Shreffler, K. M., Greil, A. L. & McQuillan, J. (2023). Bearing the Reproductive Load? Unequal Reproductive Careers Among U.S. Women. *Population Research and Policy Review, 42*(1), 1-12.

Johnson, K. M., & Simon, R. M. (2021). Privilege in the delivery room? Race, class, and the realization of natural birth preferences, 2002–2013. *Social Problems, 68*(3), 552–573.

Jones, J. C. (2012). Idealized and Industrialized Labour: Anatomy of a Feminist Controversy. *Hypatia*, *27*(1), 99–117.

Kahana, M. (2012). *Foundations of human memory*. Oxford: Oxford University Press.

Kahn, J., García-Manglano, J., & Bianchi, S. (2014). The Motherhood Penalty at Midlife: Long-Term Effects of Children on Women's Careers. *Journal of Marriage and the Family*, *76*(1), 56-72.

Kahneman, D., & Tversky, A. (1979). Prospect Theory: An Analysis of Decision under Risk. *Econometrica, 47*(2), 263-291.

Kendall-Tackett, K. (2007). A new paradigm for depression in new mothers: The central role of inflammation and how breastfeeding and anti-inflammatory treatments protect maternal mental health. *International Breastfeeding Journal, 2*(1), 6.

Köksal, S., & Goisis, A. (2023). *Loneliness during the pregnancy-seeking process: Exploring the role of medically assisted reproduction. Journal of Health and Social Behavior, 64*(2), 209–227.

Kristensen, A. P., & Lappegård, T. (2022). Unemployment and fertility: The relationship between individual and aggregated unemployment and fertility during 1994–2014 in Norway. *Demographic Research*, *46*, 1037-1064.

Kukla, R. (2008). Measuring Mothering. *International Journal of Feminist Approaches to Bioethics*, *1*(1), 67–90.

Lazzari, E., Potančoková, M., Sobotka, T., Gray, E., & Chambers, G. M. (2023). Projecting the Contribution of Assisted Reproductive Technology to Completed Cohort Fertility. *Population research and policy review*, *42*(6), 1-22.

Lerner, J., Li, Y., Valdesolo, P., & Kassam, K. (2015). Emotion and decision making. *Annual review of psychology*, *66*, 799-823.

Lévesque, S., & Ferron-Parayre, A. (2021). To Use or Not to Use the Term "Obstetric Violence": Commentary on the Article by Swartz and Lappeman. *Violence Against Women, 27*(8), 1009-1018.

Lesthaeghe, R. (1995). The second demographic transition in Western countries: An interpretation. In K. O. Mason & A-M. Jensen (Eds.), *Gender and family change in industrialized countries* (pp. 17-62). Oxford: Clarendon Press.

Lombardi, L. (2016). Reproductive technology in Italy between gender policy and inequality. Can we speak of "social infertility"?. *About Gender, 5*(9), 1–20.

Maine, D. (1979). Does Abortion Affect Later Pregnancies? *Family Planning Perspectives*, *11*(2), 98–101.

Margolis, R., & Myrskylä, M. (2015). Parental Well-being Surrounding First Birth as a Determinant of Further Parity Progression. *Demography, 52*(4), 1147–1166.

McDonald, P. (2000). Gender equity in theories of fertility transition. *Population and Development Review, 26*(3), 427–439.

McQuillan, J., Greil, A. L., Shreffler, K. M., & Tichenor, V. (2008). The importance of motherhood among women in the contemporary United States. *Gender & Society, 22*(4), 477-496.

Mencarini, L., Vignoli D., Zeydanli, T., & Kim, J. (2018). Life satisfaction favors reproduction. The universal positive effect of life satisfaction on childbearing in contemporary low fertility countries. *PloS One, 13*(12), 1-19.

Merleau-Ponty, M. (2004). The intertwining—The chiasm. From The visible and the invisible. In T. Baldwin (Ed.), *Maurice Merleau-Ponty: Basic writings* (pp. 130-155). London and New York: Routledge.

Mills, M., Mencarini, L., Tanturri, M.L., & Begall, K. (2008). *Gender equity and fertility intentions in Italy and the Netherlands*, *Demographic Research, 18*(1), 1-26.

Muttarak, R. (2021). Demographic perspectives in research on global environmental change. *Population Studies, 75*(sup1), 77-104.

Nilsson, C., Hessman, E., Sjöblom, H., Dencker, A., Jangsten, E., Mollberg, M., Patel, H., Sparud-Lundin, C., Wigert, H., & Begley, C. (2018). Definitions, measurements and prevalence of fear of childbirth: A systematic review. *BMC Pregnancy and Childbirth*, *18*(1), 28.

Nomaguchi, K. M., & Milkie, M. A. (2020). Parenthood and well-being: A decade in review. *Journal of Marriage and Family, 82*(1), 198-223.

Oakley, A. (1984). *The captured womb: A history of the medical care of pregnant women*. Oxford: Blackwell.

O'Brien, E., & Rich, M. (2022). Obstetric violence in historical perspective. *Lancet*, *399*(10342), 2183-2185.

Patel, K., Pirie, D., Heazell, A. E. P., Morgan, B., & Woolner, A. (2024). Subsequent pregnancy outcomes after second trimester miscarriage or termination for medical/fetal reason: A systematic review and meta-analysis of observational studies. *Acta obstetricia et gynecologica Scandinavica*, *103*(3), 413–422.

Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podesek, M., Stephenson, M. D., Fisher, J., Brosens, J. J., Brewin, J., Ramhorst, R., Lucas, E. S., McCoy, R. C., Anderson, R., Daher, S., Regan, L., Al-Memar, M., Bourne, T., MacIntyre, D. A., Rai, R., Christiansen, O. B., Sugiura-Ogasawara, M., Odendaal, J., Devall, A. J., Bennett, P. R., Petrou, S., & Coomarasamy, A. (2021). Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss. *Lancet, 397*(10285), 1658–1667.

Ramsay, R. (1990). Invited review: post-traumatic stress disorder; a new clinical entity?. *Journal of Psychosomatic Research, 34*(4), 355–365.

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, D. R., Downe, S., Kennedy, H. P., Malata, A., McCormick, F., Wick, L., & Declercq, E. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet, 384*(9948), 1129–1145.

Rich, A. (1976). *Of woman born: Motherhood as experience and institution*. New York: Norton and Company.

Rodríguez-Almagro, J., Hernández-Martínez, A., Rodríguez-Almagro, D., Quirós-García, J. M., Martínez-Galiano, J. M., & Gómez-Salgado, J. (2019). Women's Perceptions of Living a Traumatic Childbirth Experience and Factors Related to a Birth Experience. *International Journal of Environmental Research and Public Health, 16*(9), 1654.

Rowland, D. T. (2007). Historical Trends in Childlessness. *Journal of Family Issues, 28*(10), 1311-1337.

Ruggeri, K., Garcia-Garzon, E., Maguire, Á., Matz, S., & Huppert, F. (2020). Well-being is more than happiness and life satisfaction: a multidimensional analysis of 21 countries. *Health and Quality of Life Outcomes*, *18*(1), 192, 1-16.

Shabot, S. C. (2021). We birth with others: Towards a Beauvoirian understanding of obstetric violence. *European Journal of Women's Studies, 28*(2), 213–228.

Sobotka, T. (2004). Is Lowest-Low Fertility in Europe Explained by the Postponement of Childbearing?. *Population and Development Review, 30*, 195-220.

Sobotka, T., Skirbekk, V., & Philipov, D. (2011). Economic recession and fertility in the developed world. *Population and Development Review, 37*, 267–306.

Spitzer, S., di Lego, V., Greulich, A., & Muttarak, R. (2021). A demographic perspective on human well-being: Concepts, measurement and population heterogeneity. *Vienna Yearbook of Population Research, 19*, 1–11.

United Nations (1999). General Recommendation No. 24 (20th session, 1999). https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm

United Nations (2017). Women's autonomy, equality and reproductive health. https://www.ohchr.org/en/special-procedures/wg-women-and-girls/womens-autonomy-equality-and-reproductive-health

van de Kaa, D. J. (1987). Europe's second demographic transition. *Population Bulletin*, *42*(1), 1-57.

van Wijk, D., & Billari, F. C. (2024). Fertility Postponement, Economic Uncertainty, and the Increasing Income Prerequisites of Parenthood. *Population and Development Review*, *50*, 287-322.

Vignoli, D., Bazzani, G., Guetto, R., Minello, A., & Pirani, E. (2020) Uncertainty and Narratives of the Future. A Theoretical Framework for Contemporary Fertility. In: R. Schoen (Ed.). *Analyzing Contemporary Fertility* (pp. 1-20). Cham: Springer.

Walsh, D. (2012). *Evidence and Skills for Normal Labour and Birth: A Guide for Midwives*. London: Routledge.

Watson, K., White, C., Hall, H., & Hewitt, A. (2021). Women's experiences of birth trauma: A scoping review. *Women and birth: journal of the Australian College of Midwives, 34*(5), 417-424.

Weber, M. (1978). *Economy and society: An outline of interpretive sociology*. In: G. Roth and C. Wittich (Eds.). Berkeley: University of California Press. (Original work published 1922).

World Health Organization (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Geneva: World Health Organization. https://www.who.int/publications/i/item/WHO-RHR-14.23

World Health Organization (2016). *Standards for improving quality of maternal and newborn care in health facilities*. Geneva: World Health Organization.

Zemishlany, Z., & Weizman, A. (2008). The impact of sexual illness on sexual dysfunction. *Advances in Psychosomatic Medicine, 29*, 89-106.