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When Research Bleeds into Real Life: Studying Reproductive Ageing while Ageing Reproductively

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In a book chapter addressing feminist research methods and women's health and healing, Rayna Rapp (1999) wrote about the complicated ways in which everyday life is embroiled in feminist research methods. She was speaking about how her own experience with amniocentesis was situated in her now canonical, multi-sited ethnography of this technology, and the corresponding challenges that arise when doing research 'at home.' But in recently re-reading this chapter, I have been wondering what happens when feminist research bleeds into everyday life? In this entry for *Somatosphere*, I want to discuss the complicated ways in which personal experience, combined with time and corresponding social changes, can extend, reshape, and further nuance findings from a research project long considered complete. This extends questions about doing research regarding biomedicine at home, when 'everything is data' in a feminist research project that turns out to be everywhere.

While doing my PhD at UCSF, I was a research assistant from 2001-2005 on an NIH funded project that explored couple's experiences using donor egg and donor sperm. The research was focused on heterosexual couple's thoughts about and experiences with disclosing this information to their resulting child(ren). Using ethnographic interviews, this disclosure decision was situated in people's experiences with infertility more generally. Most of the couples I interviewed had used donor egg to conceive their child(ren) in the context of age-related infertility. I went on to write two articles about women's experiences with reproductive ageing (Friese, Becker, & Nachtigall, 2006, 2008).

What struck me about women's narratives at that time was the way in which 'lack of knowledge' and 'lack of culpability' were intertwined in women's discussions of their infertility, and their subsequent use of donor egg. Specifically, almost all of the women I spoke with had believed that menopause marked the end of their fertile years. The idea that eggs age was surprising to the women in this study, and indeed was experienced as alarming given that 'old eggs' shortened their reproductive capacity. In addition, many women I spoke with perceived blame from others for their

infertility. The women I interviewed would often use their lack of knowledge as a means to justify their decision to postpone having children, and thereby ward off the idea that they were somehow culpable and thereby less deserving (Friese, et al., 2006).

In this context, I have not been surprised to watch the ways in which reproductive scientists have responded to women's experiences with reproductive ageing. First, the focus has been to educate women about the 'fact' of 'diminished ovarian reserve' in the hope that this would change women's behavior. While working on this research project, the American Society for Reproductive Medicine was rolling out its first campaign educating women about age-related infertility. When I moved to the UK, I was invited to respond to a talk given by two clinicians, who were similarly focused on educating young women about the biological problems that arise in the context of delayed parenthood. Here I have sought to emphasize that the women I interviewed did not *only* point to lack of knowledge as a problem. Many would intertwine this narrative with another, one that also emphasized the personal, social, and structural factors that caused them to delay childbearing in the first place, including not meeting a partner until they were older and not wanting to be a single parent, not being financially secure, being focused on other things such as their career, being in a career that made having a child difficult, and/or not feeling ready to parent until reaching an older age (Friese, et al., 2008).

In contrast to the women I interviewed in the early 2000s, today many people are well aware that eggs age, and that female reproductive capacity in general declines after 35. In stark contrast to the narratives I heard from women who had used donor egg in the 1990s, Sarah Franklin (2013: 223-224) writes that for "the post-IVF generation of young women born in the 1980s, and now entering their thirties, both ART and fertility anxiety are now facts of life — as familiar as YouTube or Facebook. It is as if their biological clock is not so much ticking toward offspring as toward a newly-routinized technological encounter." Indeed, because knowledge does not change the social and structural reasons for delayed parenthood, egg freezing has become a much-discussed technological solution. And while I would personally prefer to see adequate parental leave as well as high-quality, low-cost child care as social solutions, I appreciate that some women with sufficient financial resources would like the opportunity to freeze their eggs so that they can increase the *chance* of reproducing at a later age.

But while I have continued to give occasional talks or interviews on the topic of diminished ovarian reserve and donor egg, and have looked on with interest to the current discussions surrounding egg freezing, I have nonetheless viewed my research on age-related infertility as complete, a topic that I had started and finished exploring in my twenties. I have

moved on to other topics, including the use of reproductive technologies in zoos (Friese, 2013a) and more recently to the reproductive work involved in providing care to animals in laboratory science (Friese, 2013b). However, the idea that I was 'finished' with reproductive ageing began to change as I was labelled with diminished ovarian reserve myself. However, I have not entirely experienced this label as either my study informants had or as Sarah Franklin describes the post-IVF generation of young women. And as my research has bled into real life, I have found my real life bleeding back into research.

In my mid-thirties, my partner and I decided to start the process of having a child as a lesbian couple. My previous research became a resource for us in this context, something that we could draw on as consumers of biomedicine. My partner and I were well aware of our relatively privileged position within the processes of biomedicalization (Clarke, Mamo, Fosket, Fishman, & Shim, 2007; Clarke, Shim, Mamo, Fosket, & Fishman, 2003), in that we were well-educated, relatively financially secure and able to navigate the privatization of the NHS. On the other hand, we also encountered homophobia in the NHS, in that we had to privately pay for assisted conception through a NHS clinic because the council within which we lived did not pay for lesbians to use reproductive technologies (Priddle, 2015 early online). We did question if we should go through biomedicine in order to have a child at all in this context. We knew full well that we were engaging in our own medicalization (Mamo, 2007), and this meant having our bodies treated in ways that we absolutely did not want in certain instances. [\[1\]](#) But living in the UK as US citizens, we ultimately decided that it was pragmatic (Lock & Kaufert, 1998) to have the law built into our conception story (Nordqvist, 2011). Social science scholarship provided a way to make informed decisions; the literature provided footnotes to the broader social, political, economic, and structural processes that were shaping our lives. But our experience did not make me rethink my research on assisted conception; I remained a knowledge consumer.

After my partner and I had, between the two of us, gone through six failed cycles of intrauterine inseminations (IUIs), our doctor told us that there was a clinical trial of in vitro fertilization (IVF) and, if we wanted, they could enroll me. The study was comparing how women aged 35-38 respond to two different drug protocols. I said yes, and was frankly thrilled to have a free round of IVF. We started on the next round of tests, according to the needs of the clinical trial. My follicle stimulating hormone (FSH) had to be tested again, and this time was very high — so high that I ultimately could not be enrolled in the clinical trial. More tests followed, and I was finally diagnosed with diminished ovarian reserve.

I have to admit that it was strange to be diagnosed with diminished ovarian reserve after having spent my twenties studying this label. At first my

research continued to be a resource for me. I felt a sense of comradeship with the women I had interviewed a decade ago, as some people blamed me for having diminished ovarian reserve and questioned my 'true' desire to parent. But there were also moments when I felt my own experience with age-related infertility was leading me to think in new ways about the topic itself, extending rather than consuming my previous research. For example, despite *knowing* everything that I knew about diminished ovarian reserve, I still could say that I honestly would not have done anything differently. My partner and I started to try to have a child when we felt ready in our lives to do so, and when we felt financially secure. Like some of the people I had interviewed, you could say that we are 'late bloomers' and so were just ready to parent a bit later than others. I did not need 'lack of knowledge' to ward off the comments of those who might blame me for delaying parenthood. There are a number of very good reasons for deciding to wait to have a child. All the knowledge in the world regarding diminished ovarian reserve did not change my behavior.

What also became clear to me, in being both a student and user of IVF, is the extent to which IVF has become a model of female reproductive ageing. It is not only that menopause has been displaced by eggs as an indicator of female reproductive ageing (Friese, et al., 2006). In the process, likely and actual 'response' to IVF is itself a key indicator of female reproductive ageing. FSH and now anti-müllerian hormone (AMH) are used to not only assess ovarian reserve, but possibly more importantly to estimate how likely a person is to respond well to the IVF process (e.g., are they likely produce a large number of eggs that can be collected).

Reproductive ageing is thus an instance in what Sarah Franklin has theorized as 'biological relatives,' a theoretical platform that denotes the normalization of IVF, the kinds of biological relatives IVF makes, and the ways in which biology becomes relative in the process. Being after IVF is about a state of being that is modelled upon artifice according to Franklin, wherein there are 'evolving' biological and technological relativities as the two become increasingly isomorphic. Female reproductive ageing exemplifies these biological relativities, as the biology of reproductive ageing is modelled upon the procedures of IVF. It is only within this context that I, for example, could be diagnosed as having diminished ovarian reserve after having only 'tried to conceive' for two months (e.g. having had two IUIs).

I foresee this expanding, such that hormonal counts could ultimately displace age as an indicator of female reproductive capacity. There are problems with using age as a proxy for female reproductive ageing because of that fact that a) this correlation has largely been produced with IVF patients who are a select sub-group and b) reproductive ageing as a

process differs significantly across women. These problems are resulting in a backlash against all the information that is now available about age-related infertility. Just today, for example, I read a newspaper article in which a woman, recounting her road to parenthood, stated that she felt pressured to start trying to have a child as she neared 35. However, she goes on to state that all the information about women's reproductive ageing is simply 'not true.'

My own experience exemplifies these dilemmas. On the one hand, I demonstrate the truth of the idea of diminished ovarian reserve, as my FSH went up significantly during my 36th year. However, my partner — who is older than me — had a lower FSH and so, in the end, we used her eggs to create embryos with donor sperm using IVF. The embryos were then transferred to me, and I gave birth to our daughter in 2014. In general, it seems that ovarian reserve declines after 35, but this differs significantly across women. As Sarah Franklin (2013:224) notes "fertility has always been biologically relative."

But while I have worries about the conflation of age and infertility, I also have worries about its complete rejection, as seen in the newspaper article mentioned above. While I was interviewing women about their experiences with donor egg, some discussed their disclosure decision as in part motivated by their own lack of knowledge regarding age-related infertility. Specifically, they felt the need to disclose their use of donor egg not only to their child(ren) but also to other women. They did not want to reinforce the idea that one could wait until their 40s and expect to have a child easily.

Possibly because of my research background, and possibly because I have recently had a child, I find many younger women in academia asking me when is the best time to have a child. It is an impossible question to answer because there is never a 'right time.' So I tell these women that I had my child at a great time in my life and my career, but entirely by luck. My book came out and I was promoted from lecturer to associate professor during my third trimester. The article based on the pilot study for my subsequent research project was published at about the same time, and I found out that I had received the research bid to continue this research four weeks after my daughter was born. I was extremely lucky to be able to enjoy a generous maternity leave, and return to work with funding for my next research project. But while this timing couldn't have been more ideal, it was also to some degree dumb luck. My partner and I had been 'trying' for over two years before I had gotten pregnant. I had been diagnosed with diminished ovarian reserve, and so I was lucky that — being a lesbian — my partner could, technically speaking, also be my 'egg donor.' And because of my and my partner's age, it is very likely that we will not be able to have a second child. Like the women I had interviewed,

I have had to narrate my identity as an academic mother as a “technological achievement” (Franklin, 2013: 229).

Rayna Rapp noted that as she began to engage in a multi-sited ethnography of amniocentesis, she had to move beyond what she had identified as her experience with it. In my case, personal experience with age-related infertility has made me revisit and rethink the topic of diminished ovarian reserve, a topic that I thought I had finished studying years ago. In this context, it is worth pointing out that Rapp’s chapter appeared in a book edited by Adele Clarke and Virginia Olesen (1999), which sought to ‘revision’ women, health and healing in the context of biomedicalization.

Fourteen years later, Sarah Franklin’s book *Biological Relatives* (2013) addressed many of the challenges that Clarke and Olesen articulated, particularly the richness of feminist theory and the problems of viewing nature and culture in a bifurcated manner in the context of biomedicine. But where Clarke and Olesen emphasized vision, Franklin emphasizes practice specifically through the trope of ‘tool cultures.’ It seems to me critical to start looking at how IVF is retooling reproductive ageing. I would like to see social studies of reproduction explore this retooling across clinics, women’s lives, families, popular media representations, and workplaces, but also back into the laboratory, where animal reproductive lives are also very likely being retooled as well.

Note

[i] It is true that the women’s health movement has improved some women’s experiences within medicine. But it is also true that ‘inappropriate objectifications’ (Thompson [Cussins], 1996) of women in the ontological choreographies of biomedicine persist. The trauma of these objectifications is currently being articulated with [American Childbirth: Exposing the Silence](#).

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