

Beyond Choice: Infertility and/as Disability

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Abstract: This essay reconceives infertility beyond rhetorics of choice and blame by recognizing that infertility is prevalent in those younger than 35, that infertility rhetorics are eugenic, and that infertility is not only a clinical diagnosis. The essay begins by putting feminist scholarship on infertility in conversation with “choice feminism” through a brief reading of the Netflix film *Private Life*. Next, the essay considers the eugenic implications of educating people about biological fertility timelines. Finally, infertility is positioned as a disability justice issue, which values infertility as a feminist-disability intervention into normative decision-making processes about (not) having children.

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My primary physician washed her hands and smiled over her shoulder as she said, “There’s no rush, I had my children at 41 and 43.” This was an upbeat follow-up to her claim that I probably didn’t want to get pregnant “this depressed.” Pregnancy during major depression is risky, and my doctor’s suggestion that I could choose to have children later seemed reasonable (even feminist). I delayed a year, and at age 34, learned that I was profoundly infertile. I had blithely assumed, along with my doctor, that I would be fertile-enough until at least 35 if not 40, as I’d so often heard. I did not understand how I could be so infertile without anybody noticing, given my privilege in having consistent healthcare and regular OBGYN check-ups. A few years later, after four failed intrauterine inseminations (IUIs), a privately-funded infertility specialist would tell me I was reacting to in-vitro fertilization (IVF) treatment like someone who was 43 years old. By which she meant, unlike my primary physician, like someone at the end of their fertility.

Fertility and infertility are simultaneously silenced and subject to constant rhetorical negotiation. While it may seem that one is silenced (infertility) while the other is not (fertility), I am instead suggesting that we are always talking, or not talking, about the two together. The silence speaks to fears of infertility, the intolerable state of the “barren woman,” and ignorance about the prevalence of infertility when people are in their twenties and early thirties. These silences operated in my conversation with my doctor, who did not discuss infertility with me, inquire about my pregnancy history, or ask about any biological family members who struggled to get pregnant and/or went into early menopause. At the same time, it is routine to rhetorically engage fertility and infertility by asking friends and strangers if and when they will have any or more children (Bute, “Nobody”). When infertile people respond to probing questions by revealing their struggles to get pregnant, family, friends, and bystanders say “‘your time will come,’ ‘you’re meant to be a

mom,' or 'don't try so hard'" (Jarvis, "Invitational" 19; also see Johnson and Quinlan). Very rarely did anyone, except fellow infertile people, respond to my infertility with anything other than chipper advice.

Fertility is treated as the "natural" or "default" status until a certain age, while infertility is an inevitable deficit. Instead of accepting this normative, predictable, and ultimately false continuum, I embrace a fluid notion of infertility that waxes and wanes in specific individuals and populations. My notion of infertility encompasses the broader medical, social, and rhetorical histories and contexts in which fertility and infertility are imbricated, which include rhetorics of abortion and birth control, forced sterilization and population control, adoption, and other assisted reproductive technology (ART). Infertility rhetorics must make room for those who identify as LGBTQIA+ and/or disabled, for those denied adoptions, and/or for single parents, thereby challenging biological and genetic bases as the sole connections to parenthood (Brakman and Scholz). Those who experience infertility may be clinically infertile or may not; I suggest that infertility is not always a clinical diagnosis and is defined by wanting to have children, or the option to have children, and being unable and/or prevented from doing so. To mark my revisions to typical notions of infertility, I could use a new term - maybe "in/fertility" (Marafiote) or, drawing on disability perspectives, "disfertility." I haven't done so here because my primary goal is to shift the way broader publics think of infertility (rather than create a neologism broader publics won't adopt), and to reclaim the term from its currently limited reference to the clinical/physical inability to have children in cisgender women.

While I've sketched infertility broadly, I cannot consider all types of infertility in this essay. I am limiting my examination of assistive reproductive technology (ART), particularly in-vitro fertilization (IVF).¹ Focusing on IVF means focusing on white, cisgender women of means, because we are the ones who are able and encouraged to seek IVF (Britt; Johnson, B.). I am this over-represented woman: white, cisgender, and middle-class (and at the time of treatment, married to a man). In analyzing infertility rhetorics, this over-represented white, cisgender woman threatens to erase the experiences of those who are not like her. I am simultaneously tackling two problems in this essay: that infertility is misrepresented to everyone, causing much pain and limiting the effectiveness of treatment, and that certain people, particularly those who are not white or straight or able-bodied, are not regarded as worthy of infertility treatment and have been actively harmed through sterilization. I analyze these two issues together not to equate their impacts, but because they are connected at the root. That is, cisgender white women of means don't have access to infertility treatment in significantly higher numbers simply because they have money (though that helps), but because this is how the system is designed to work: cisgender white women are encouraged to procreate while disabled people, queer people, and people of color are not, in a system that blames infertile people for their infertility.

1 1. Note that male infertility (Barnes; Culley et al.) and secondary infertility are common causes of infertility.

Partly because of these complications, and partly because I've worked on this essay on and off for nine years, this essay moves in several directions while swirling around issues of choice. I begin by situating infertility in the context of "choice feminism," noting how infertility is positioned as the result of "bad choices." To do this, I examine the 2018 Netflix film *Private Life* in the context of feminist scholarship that dismantles the idea of people simply "choosing" when to have children. In the second section, I trace the eugenic implications of educating people about biological fertility timelines, which simultaneously push white people toward pregnancy and people of color toward sterilization, as represented in "fertility campaigns." In response, I consider incorporating evaluations of infertility into routine medical care (which would have revealed my infertility to me earlier in my life, for better and worse). Finally, I suggest that locating infertility within the frames of progressive disability studies invites infertile people to resist shame and blame discourses, reconceptualizes infertility outside of deficit models, and values infertility as a feminist-disability intervention into normative decision-making processes about when and why to have, or not have, children.

In Jennell Johnson's introduction to *Graphic Reproduction*, she notes: "So this is the point where I must note that I do not have any children." Conversely, this is the point where I must note that I have one child. After four failed IUIs, I was told I had about a 15% chance of having a child through IVF. I produced four eggs and three embryos, all of which were implanted in my uterus and one of which became my son. My privilege facilitated the birth of my child, as my mother paid for me to go to a top-rated infertility clinic and supported various supplementary treatments (such as acupuncture and months of pre-hormonal treatment). While my treatment is over, I remain impacted by my experience and the continuing consequences of my infertility, particularly navigating the risks of early menopause. And, though it would be wrong for me to claim that I understand the experience of infertility treatment that does not produce a child, I do claim that the identity and experience of infertility is not erased through the birth of a child, nor does it always persist when children do not result from treatment.

Infertility, Choice Feminism, Reproductive Justice

Feminist scholarship engages infertility as a "rhetorical vehicle" for discussions of risk, objectification, capitalism, genetics, and Western culture (Sandelowski and de Lacey 33). Christine St. Peter argues that we should group ART with other technologies, such as contraception and abortion, prenatal technologies, and birth-related technology so we can critique the "coercive medical environment in which women are being conditioned to trust, or forced against our will to accept, high-tech interventions in our reproductive lives" (354). In her analysis of choice in relation to abortion, ultrasound, and sterilization, Jennifer Denbow suggests that rhetorics of choice are attached to "autonomy as proper or rational self-governance," which allows for "the appearance of respecting women's rights and self-determination while justifying increased surveillance

and management of women's bodies and reproductive decisions" (3).²

Feminist scholarship on infertility is particularly helpful in challenging the idea that people simply "choose" when to have children. In *Contemplating Maternity in an Era of Choice: Explorations into Discourses of Reproduction*, Hayden and Hallstein argue: "Choice suggests rational deliberation – as if women consider all the options in informed ways, choose the option they prefer, take appropriate action, and achieve their goals." Instead, "women's reproductive desires are often ambivalent, vague, and subject to change" (xvii). Palczewski suggests an emphasis on "reproductive freedom" instead of choice, highlighting "the right to have children as equally important as the right not to have them" (73).³ Jennifer Bute et al. trace reactions to Sylvia Hewlett's very popular *Creating a Life: Professional Women and the Quest for Children*, and they ask: "[H]ow are women to be strategic when their choices are limited by lack of access to paid time off, inadequate child care, or fear of losing their jobs?" (63). Tracy Marafiote echoes this claim, and Elissa Foster places the "choice" of getting pregnant against her non-choice of a miscarriage (150).⁴ Feminist scholarship has also considered infertility in a global context, noting that while infertility is not without stigma in richer countries, infertile people in these places usually "live in a society that does not force them out of their own houses, curse at them in the streets, or condemn them to a life of poverty and destitution due to their infertility" (Shah and Baxter 109-110; also see Inhorn and Balen; Inhorn).

Despite this rich scholarship, much of mainstream feminism adopts a fairly simple notion of infertility informed by "choice feminism," which as Shelley Budgeon explains, "coheres around a set of key principles including a privileging of individual women as best positioned to make choices about how to live; a belief that women are able to unproblematically exercise autonomy because of the achievements of feminism; a claim that traditional feminine norms are no longer connected to gender inequality; and that the role of feminism is to withhold judgment of the choices women make" (12; also see Ferguson; Thwaites). Mainstream, choice feminism confirms dangerous myths surrounding infertility: that it is rare; that cisgender women younger than 35 (even 40) are rarely if ever infertile; that infertility is not an issue for people of color, queer people, trans people, gender non-conforming people, and/or disabled people; that infertility isn't related to, or embedded in, eugenic histories of procreation and sterilization; and that medical advice about fertility and infertility can be issued without medical testing, examination of family history, and discussion of pregnancy histories.

2 Similarly, Anne Burns suggests that choice functions "as a tool for discipline, rather than a means for liberation," noting that viewer comments on involuntary porn sites overwhelmingly shame people for "choosing" to take naked/sexualized photos (102).

3 On being childfree, see Gillespie, Hintz, Kelly; on the blurring of childfree and involuntary childlessness through the concept of non-motherhood, see Letherby and Williams; on managing stigma and the limitation of choice rhetorics for those who are childfree, see Morison et al.

4 The "choice" to end IVF is also complicated (Haas; Harwood; Jarvis, "Expanding"; Thorsby). For a critique of choice rhetorics in infertility clinic marketing, see Takhar and Pembrton.

The 2018 Netflix film *Private Life* is worth analyzing because it challenges mainstream choice feminism but leaves misconceptions of infertility intact. It's important to understand this common rhetorical move, which suggests that people need better choices to prevent infertility, rather than challenging the idea that "better choices" can consistently avoid infertility. Written and directed by Tamara Jenkins (who had IVF treatments in her 40s), the film examines the infertility journey of Rachel and Richard (who are both white and hyper-educated), a married couple played by Kathryn Hahn and Paul Giamatti. As noted in a *Guardian* interview with the filmmaker and Hahn, the film indicts second-wave feminism for "lulling women into a false sense of fertility" (Shoard). This is evident in a scene where Rachel and Richard are in their New York apartment getting ready to go to the fertility clinic:

RACHEL: It totally misrepresents the book. And then it's like, oh, you know, I don't understand the business side of things, which I don't. But I do know if a guy wrote it it wouldn't be packaged like a cupcake.

[RICHARD laughs]

RACHEL: I'm sick of this shit. Same thing with this whole fertility nightmare. I just feel so betrayed.

RICHARD: By what?

[RACHEL is brushing her teeth and talking]

RACHEL: The bullshit I was fed in college. Feminist ideology. [spits in sink] The lie that I could have a career and then kids. Well obviously that hasn't panned out. I should send them the bills for our IUIs and IVFs.

RICHARD: You can't blame second-wave feminism for our ambivalence about having a kid.

RACHEL: I'm not ambivalent.

RICHARD: No now you're not, because you realize that the boat is leaving the dock. But before you kept changing the deadline, remember? You know, we'll start as soon as I finish the play. Right after I get this story published. Once I finish the book.

RACHEL: Are you blaming me?

RICHARD: No I'm not blaming you. I'm just saying that we need to take some responsibility for the situation.

RACHEL: A lot of women have babies at 41. I thought I could too.

RICHARD: Okay. I just don't think it's Gloria Steinem's fault that we can't get pregnant.

RACHEL: Whose fault is it then? I guess it is mine. Because I was too busy writing my stupid book.

The scene ends with Rachel noting that they need to move on and just “repress it, or suppress it, or whichever one is more appropriate.” Like feminist scholarship, the scene suggests that people do not simply “choose” when to get pregnant, though blaming second-wave feminism is a new twist. But rather than blaming “Gloria Steinem,” I would argue that it’s rhetorics of choice, popularized in second-wave feminism’s abortion battles, filtered through choice feminism’s emphasis on personal “freedoms” and “choices,” that misrepresent the realities of when and how pregnancy occurs. Accurate representations of infertility do not align with choice rhetorics that suggest all who can bear children are fertile until 35 or 40.

A feature of *Private Life* that’s received little to no attention is the young woman Rachel and Richard recruit as their egg donor - their young niece Sadie (who is not a blood relative). In a film review, Sadie is referred to as “a fecund 20-something who is exploding with fertility but is completely in no way prepared to have a child” (Almendrala). In actuality, Sadie does not perform as expected as an egg donor - she isn’t fertile enough. In the film, she tearfully reports her conversation with the fertility doctor to Rachel and Richard: “He said I didn’t have enough follicles, that I’m a low responder. That someone my age should have way more and my eggs aren’t growing at the right rate or something. He said he has 41-year-old patients who produce more eggs than me.” I cheered when I first saw this scene, but rather than a needed representation of a young infertile woman, Sadie only serves as a foil for understanding mid-life infertility and as a narrative respite from what is, in this film’s set of relationships, a bad decision to use a family member as an egg donor.⁵ In reality, Sadie’s experience is common if uncommonly represented: As reported by the CDC, 12% of women aged 25-29 use infertility services. In another study of 782 couples (involving women aged 18-40), the rates of infertility (determined by failure to conceive in 12 cycles, or about a year), were 8% for those aged 19-26, 13-14% for those aged 27-34, and 18% for those aged 35-39 (Dunson and Baird). Finally, while based on a dated study, the American Society for Reproductive Medicine (ASRM) prominently positions claims that 7% of women aged 20-24 are infertile, 9% of women aged 25-29, and 15% of women aged 30-34 (“Waiting”).⁶

While the infertility numbers are expectedly higher in the 35+ category, one in ten women being infertile and/or seeking infertility services prior to 35 is significant. But in *Private Life*, the 20-something’s infertility is a brief plot point and the focus stays on Rachel, who is on the older end of normative childbearing age (over 40). Thus, while the film troubles assumptions that people should just “choose” to have children earlier, it keeps intact the idea that Rachel would have been fine if she’d (just) had children earlier. Maintaining this choice, and choice rhetoric, is necessary to hold mainstream feminism together, because if we decide that infertility only happens when we make bad choices, then we just need to make better choices, so let’s fight to keep those choices in the hands of women. While this echoes common pro-choice slogans (“my body my choice”), it

5 Rounding out the film’s representation of maternity is Sadie’s mother, Cynthia (played by Molly Shannon), who complains to her kids about how they ruined her life.

6 Correspondingly, people lament the lack of resources for those who are infertile in their twenties (Pearson; Tigar), and there is debate regarding whether infertile women and girls in their teens should be treated (Derouin; Haimov).

also keeps the systemic factors that prevent and delay (and demand) childbearing, and the reality of pre-35 infertility, obscured.

A reproductive justice (RJ) framework provides an alternative to choice feminism. As described by Kimbala Price, the reproductive justice movement's "three core values are: the right to have an abortion, the right to have children, and the right to parent those children" (341). In "Radical Reproductive Justice," Loretta Ross et al. argue that RJ must "go beyond affirming the right not to have children and pivot to emphasize the right to have children under the conditions we choose" (184). Rhetorically, Shui-yin Sharon Yam argues that reproductive justice must reshape rhetorical work, and Melissa Stone and Zachary Beare offer an infographic on the relationship of RJ, reproductive rights, and reproductive health.⁷ Clearly, RJ frameworks are important to reframing infertility, though much of the scholarship does not address infertility (including the sources I just mentioned). Further, as I suggest in the final section of this essay, the connections between reproductive justice and disability justice are also underdeveloped, and a disability perspective on infertility is necessary to truly challenge rhetorics of choice around infertility.

Age Education and Infertility Testing

Perhaps the answer, then, is to educate people about the actual likelihood of infertility so they can make informed decisions. Upon request, I've tried educating people I love about infertility, noting that it regularly happens to people in their twenties. Each time, I've felt like a pesky great aunt who wiggles her finger and says "tick tock,"⁸ and each time, I've been rebuffed by these folks, who assure me they are "fine," adhering to what Ruhl calls "the willed pregnancy." Education about fertility and infertility is fraught not only because it can feel "unfeminist," but because these conversations are imbricated in eugenic and racist beliefs about who should (not) have children. To move forward with effective education and discussion of infertility issues, we must understand its eugenic underpinnings, and to this end, I examine three sites of fertility education: an ASRM campaign and two "fertility campaigns" (in Italy and Britain). I then consider the complicated benefits of including fertility evaluations as part of routine reproductive care.

Eugenics and "Fertility Campaigns"

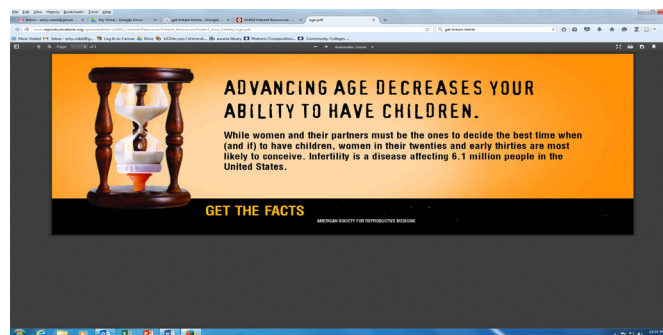
There is a need for education about age-related *and* non-age-related infertility. In a sys-

7 Yam also suggested that rhetoricians rethink using "women-centered" language, as while such language "helps articulate and reclaim the specific history of misogyny and cis-sexism, it inadvertently excludes trans and gender nonbinary people" (22). To this end, in this essay, I have worked to use more inclusive terminology, such as "infertile people." However, my use of such inclusive terminology is overshadowed by the consistent use of "women" in the scholarship I reference (in quotations and article/journal titles).

8 On clock metaphors, see Robbins; on biological clocks and tenure clocks, see Ceraso and VanHaitsma.

tematic literature review of 71 studies of fertility awareness, such awareness is described as “low to moderate among people of reproductive age,” with subjects assuming that “age-related fertility decline starts later than the actual turning point” and overestimating what fertility treatment can do (Pedro et al. 75; also see Bretherick). More shockingly, in a study of 599 childless men aged 20 to 50, the researchers conclude that their subjects “had no coherent body of knowledge regarding age-related fertility and ART treatment and family building options” (Daniluk and Koert 839; also see Benyamini et al.; Bunting and Bovin; Lee; Maheshwari). Geeta Nargund suggests increased attention to age education, sperm-related infertility, impacts of STIs and abortion, IVF treatment, and implications of “low population growth,” though again, pre-age-35 infertility is ignored.

As Lynn Harter et al. claim, existing campaigns to educate about biological timelines “discipline women through rhetoric about time, technology and middle-class values,” ultimately blaming women for not acting “in time” (87). These attempts range from urging people to have children earlier (while ignoring why they wait) to campaigns that less subtly draw on racist and ableist eugenic rhetorics about who should and should not be having children. The former is evident in an ASRM campaign, which while over a decade old, is still prominent online. A series of four posters feature repurposed milk bottles, and one of the posters (below) features an hourglass made of a baby bottle with the sand/milk almost out. All caps against an orange background reads: “Advancing age decreases your ability to have children.” In smaller print, it says: “While women and their partners must be the ones to decide the best time when (and if) to have children, women in their twenties and early thirties are most likely to conceive. Infertility is a disease affecting 6.1 million people in the United States.” (The other three fertility posters focus on STIs, smoking, and weight. All use the phrase “your decisions.”)



As Tracy Marafiote describes, the National Organization for Women (NOW) has had “vehement responses against campaigns to educate women about age constraints with the idea that such campaigns would bully and scare women into having children earlier or at all” (188). Such responses are understandable, as education campaigns like ASRM’s fail to recognize why people have children later in their lives. ASRM’s poster also contradicts its own educational booklet entitled “Age and Fertility,” which more accurately notes: “A woman’s best reproductive years are in her 20s. Fertility gradually declines in the 30s, particularly after age 35.” That people are often rather fertile in their teenage years is ignored; I assume this is to avoid identifying these as rele-

vant childbearing years.⁹

Judith Daar's *The New Eugenics: Selective Breeding in an Era of Reproductive Technologies* claims that a new eugenics perpetuates "decades of restrictive immigration policies, years of discriminatory marriage laws, and a half-century of forced sterilization" (192; also see K. Price).¹⁰ Naively though, Daar suggests that "few worry that modern-day Americans would respond favorably to scientific assertions about improving the human condition by organizing a web of state-sponsored programs that assess, suppress, deprive, and encourage reproduction according to one's expressed and inherited characteristics" (28). Such programs and attitudes are explored by Dorothy Roberts' *Killing the Black Body*, where she claims that "reproductive literacy" centers on the concerns of white, middle-class women and the right to abortion (6), rather than "the devaluation of *Black* reproduction" by new reproductive technologies (246) and the parallel development of state-sponsored sterilization of Black women alongside a "booming" fertility industry to help white, middle-class couples (4; also see Greil).

Another campaign is Italy's government-sponsored "fertility day" in 2016, which released promotional materials but was ultimately canceled.¹¹ The main poster/image features a white woman in a red sweater holding an hourglass toward the camera, with the caption, "La bellezza non ha età. La fertilità sì" ("Beauty has no age, fertility does"). The woman, who has pale white skin and long brown hair, holds her hand over her belly and gives a knowing look, and negative response was swift given the condescending tone and Italy's childcare inequities (Pianigiani).



This campaign, and others like it, are concerned about diminishing numbers of young-

⁹ On the over-focus on preventing teen pregnancy in defining reproductive justice, see Vinson and Daniel.

¹⁰ She adds that Robert G. Edwards, the Nobel-Prize winning doctor who co-created IVF, was an ardent eugenicist (see Johnson, M.; Obasogie).

¹¹ For analyses of infertility on social media, see Blakemore, et al.; Johnson & Quilan; Perone et al.; Rome

er workers, not with preventing difficult and expensive infertility procedures for those who want to have children.¹² In her work on infertility's racial and economic disparities, Ann Bell notes that women of color “must grapple with the stigma of being childless while simultaneously rejecting the negative stereotype that they should not be mothers in the first place” (690). Conversely, in my infertility journey, I was told more than once that “people like me” should have children, because I am “smart” (and white and middle class and cisgender, and at the time, married).

Finally, a similar campaign called “Get Britain Fertile,” sponsored by First Response, adds an ageist twist. In a widely-reported photo from the campaign, 46-year-old Kate Garraway is costumed with gray hair, liver spots, and wrinkles. She’s pregnant and covers her breasts with a shawl (which is fuchsia, the color of First Response boxes), while revealing her pregnant belly.

She’s supposed to seem ridiculous and remind us of fertility timelines. Think Progress responded: “First Response has decided the solution to the trend of women waiting longer to have children is to criticize them, prey on their fears of aging, and exploit social disgust for even moderately sexual old women.” While these concerns are apt, critiques failed to note the eugenic legacy of encouraging white Brits to procreate (Soloway), while people of color are featured in campaigns to prevent teen pregnancy (DasGupta). As Robin Jensen argues, the rhetorical history of infertility “complicates the idea that the discursive past is made up of a diachronic success of strategies, each superseding the other” (5). Instead, rhetorical themes repeat and recur, including eugenic themes



Such fertility “education” depoliticizes infertility and reproductive technology, ignoring how the “toxic by-products of industrialized culture” significantly impact infertility (Gaard 108). In their work on mandatory insurance for infertility, Mary Shanley and Adriene Asch argue that such insurance “obscures the fact that a significant share of infertility stems from quite varied (and oppressive) social contexts that affect different populations: delayed childbearing, untreated pelvic

¹² Russia once gave a national “conception” holiday, with rewards for those who had babies nine months later on what was roughly Russia Day (Gietel-Basten). In another example, a Danish travel agency encouraged folks to “Do it for Mom” and “Screw for Denmark” while on vacation, with possible prizes if you could prove you conceived while on holiday (Sims).

inflammatory disease (PID), and workplace and environmental toxins” (852).¹³ More encouragingly, infertility awareness campaigns driven by non-profit organizations like RESOLVE (an infertility organization) have featured abstract representations of diverse people with emphasis on being “one in eight,” as one in eight people will experience infertility. There is not, however, any emphasis on infertility before age 35, and the impact of such campaigns may be limited (Patel). That only 1% of the articles in major health journals geared toward women have focused on infertility in the last 15 years isn’t helping (Place et al.).

Infertility Evaluation

Another approach to education is to include fertility evaluation as part of routine reproductive care (as such care exists in the United States). At present, heteronormative (and mysterious) “guidelines” in the United States specify that infertility should be suspected after one year of unprotected sex with no pregnancy if you are under 35, six months if over 35. There are also simple blood tests that are infrequently offered, and those tests would have very likely revealed my infertility issue (low ovarian reserve) in my twenties. Instead, by the time my AMH and FSH levels - which roughly correlate to the quantity (AMH level) and quality (FSH level) of eggs - were tested in my early thirties, my AMH number was “scant” and I had no ability to get pregnant without intervention. Such blood tests do not indicate all fertility problems, but they do provide important hormonal information for all people, including current and pending infertility, hormonal imbalance, and/or menopausal status.¹⁴

I wonder what I would have done if a routine fertility evaluation had revealed my quickly diminishing ovarian reserve in my twenties. Bavan et al. explore this issue by reporting the results of a 73-question survey focused on access to testing ovarian reserve, which was administered to 328 women (mean age 22). Most respondents were interested in ovarian reserve testing (79%), and “29% said they agreed or strongly agreed that they would consider stopping their education or work immediately if they became aware that their ovarian reserve was clinically low,” which assumes that one cannot pursue education and work while trying to get, or while being, pregnant. Had I been one of the survey respondents, I believe I would have been among the 62% who “agreed or strongly agreed that they would take no action regarding their education or work despite such news,” and perhaps also the 80% who “indicated that if they received unfavorable results revealing abnormally low ovarian reserve, they would consider having children earlier”

13 Another study reveals that expanding insurance coverage for infertility only results in increased usage by middle class, educated, cis-gender white women (Bitler and Schmidt).

14 For example, clinical testing and tracking of hormones in the “menopause transition” has been shown to help prevent bone loss (Karlamangla et al.; Shieh et al.; Podfigurna et al.), and research indicates a need for testosterone screenings for certain populations (Johnson et al.). At present, over-the-counter hormonal testing is limited to ovulation tests and pregnancy tests (for a feminist critique of such tests, see Layne). A newer market is OTC perimenopause/menopause testing, and while the value of such testing is “unsubstantiated” (Rushing and Santoro), as a non-expert, I’m interested in OTC options given inattention to infertility in reproductive care.

(1196). There is no option in Bavan et al.'s survey to decide not to have children as a consequence of the testing information; "repro-normativity" (Franke) remains intact.

While the right to fertility information feels unquestionable, implementing such testing without a concomitant shift in attitudes and behaviors may further oppressive pressures and systems: As Robin Jensen notes, medicalization and moralizing/shaming often work together. Ovarian reserve testing may scare people into having children before they are ready. Testing may only be offered to some and identify problems that those without insurance cannot attempt to address. Testing won't change the fact that certain people – people of color, LGBTQIA+ people, disabled people, poor people – are often discouraged from having children in the first place. Testing may further stigmatize those who seek infertility treatment, under the guise that they "should have known" they were infertile. Similarly, such testing may reify a healthcare system that already refuses to cover infertility. Finally, increased stigmatization of IVF might impact people who use infertility treatment with no other option.

Tracing familial lineages of infertility, despite the seeming irony of that phrase, is also needed. Well into my infertility process, an infertility specialist asked when my mother had gone into menopause. No medical history had ever asked me this, and when I asked my mother, she felt bad that she'd never thought to tell me she went into menopause in her early forties. At the same time, relying on familial lineages of infertility privileges certain kinds of infertile people, as gathering family history can be challenging.

While useful in some ways, ovarian reserve testing and tracing family lineages of fertility are ultimately problematic because they still rely on choice rhetorics: they assume that people can make better choices with better information, when this often isn't the case. Instead, to radically reconceive and reclaim infertility, we must more overtly (and finally) disconnect infertility from choice and volition. Disability helps us do this.

Crippling Infertility

Early Disability Studies sought to shift disability away from "problem" bodies and position it as a consequence of inaccessible environments (Linton). This body/environment binary has been rightly criticized (Owens), but a kernel remains that helps articulate infertility in environments (rhetorical, historical, cultural, political), rather than solely in individuals' bodies and "choices." For me, a disability perspective was key to resisting the shame-and-blame discourses of infertility while respecting my sense of loss.¹⁵ Further, a disability approach to infertility honors the pain and grief

15 Part of a disability approach to infertility can include considering infertility as a legal disability. Legal scholars have sought protection of infertility under the Americans with Disabilities Act (Dallman; King and Meyer; Sternke), and David Orentlicher notes that reproduction was considered a major life activity in *Bragdon v. Abbott*, which considered whether an asymptomatic HIV+ woman seeking dental care was in fact disabled, and she was considered so because AIDS can impact fertility and reproduction. Orentlicher argues that we often identify age-re-

of infertility and reframes it using *crip time*. Crippling infertility “decenter[s] normative relationships between bodies and institutions” (Simpkins) and emphasizes community, not cure.¹⁶ We must shift from occasionally considering disability as a “topic” to adopting disability as a theoretical and activist lens through which we consider infertility.

Existing work on disability and fertility largely focuses on selective abortion. As Michelle Jarman claims, “[W]e must infuse our politics with a more *crip lens*...that pays careful attention to the dangers of figuring disability as a central defense of either life or abortion “ (63). Alison Piepmeier explores how choice rhetorics of reproduction inform prenatal testing and selective abortion, and in her interviews with mothers who have children with Down Syndrome, Piepmeier highlights the “inadequacy of the narrative of ‘choice,’” as decisions to mostly knowingly have children with Down syndrome were often community decisions, results of indecision, or conflicted choices (166). At the same time, as Bagentos notes, we must pay attention to how disabled people are “frequently denied their own rights to conceive, bear, and parent children, whether through forced sterilization or abortion, the denial of assisted reproduction, or the denial of parental rights once their children are born” (276).

The connections between disability justice and reproductive justice frameworks are underdeveloped and primarily focus on prenatal testing and screening. Dorothy Roberts and Sujathe Jesudeson note that “reproductive justice, women’s rights, and disability rights activists share a common interest in challenging unjust reproductives policies and in forging an alternative vision of social welfare” (318). They discuss developing a shared set of values around reproductive autonomy, parenting, and policy advocacy, though they largely settle on “reproductive genetic technologies” (314), particularly prenatal screening, as the main takeaway of their piece. Similarly, in an exploration of rhetorics of reproductive justice, Novotny et al. touch on disability and infertility, but only to question “what lives are worth living” (“Amplifying” 383). While prenatal testing and screening are important, “any consideration of disability and reproductive rights must consider people with disabilities as parents, not just as fetuses” (287; also see Powell, “Disability”).

As articulated by Crystal Benedicks’ review of two infertility memoirs, a disability perspective on infertility emphasizes that we can’t control our bodies and that self-care won’t prevent or heal infertility.¹⁷ Benedicks reviews Pamela Mahoney Tsigdinos’ *Silent Sorority* and Phoebe Potts’ *Good Eggs*, noting that each features a moment of “outraged entitlement,” where these women claim they “should be fertile” due to healthy lifestyles (also see McLeod and Ponesse). But as Benedicks claims, as each story develops, so does “the realization that there is no moral basis

lated conditions as disabilities (osteoporosis, hearing loss) and that infertility should be no different. Such legal reframings leave “disability as deficit” intact

16 Crippling infertility overlaps with Maria Novotny’s concept of queering rhetorics of infertility, as well as work on queer reproduction (Smietana et al.) and queering reproductive access (Tam).

17 I edited this review while serving as one of two book reviews editors at *DSQ*.

for health, nor is biological function subject to the will.” While neither Tsigdinos nor Potts uses the language of disability, Benedicks notes that “their crises can be read as moments of recognition of one of the ableist myths that undergirds normative understandings of disability: disabled bodies metaphorically signify moral failure; people ‘deserve’ the bodies they have.” Benedicks suggests that disability perspectives can help navigate infertility, and for me, the grief that came with infertility was tempered by my view of it as a disability. While I was sad that I would not be able to have, or easily have, the biological child I wanted, only in my lowest moments did I somehow think it was my fault or that I was “less of a woman,” as infertility memoirs relentlessly relate. I have other disabilities and have discarded the idea that I somehow “deserve” the emotional and physical pain my disabilities cause, and my infertility provides perspectives on reproduction that are valuable.

A disability approach to infertility is also needed because disabled people struggle to access infertility services (Francis et al.) and are more likely to be infertile than nondisabled people. As noted by Ha and Martinez, “[C]ompared to those without disability, WWD [women with disabilities] had 78% increased odds of having self-reported infertility,” and among those, women with cognitive and sensory disabilities have the highest infertility odds (7). There is also weight discrimination surrounding infertility, as access to infertility services is often tied to BMI requirements (Parker and Grice; Slocum et al.). Finally, infertile people prefer the language of disability. A study of preferred terms for infertility among 1,226 U.S. adults reveals “condition” as the preferred term (78.4%), then “disability” (11.5%), then “disease” (9.7%) (Mancuso et al. 2111). Notably though, “Those choosing ‘condition’ were less likely to have a personal history of infertility and more likely to have a family or friend with infertility, and those choosing ‘disability’ were more likely to have a personal infertility diagnosis” (2114). I embrace the language of disability for infertility, in the context of disability and reproductive rights (Kallianes and Rubenfeld) and disabled mothering (Lewiecki-Wilson and Cellio-Miller).

Much as the meaning of disability is slippery in ways that challenge simple binaries, so could “infertility” expand to include all those for whom heterosexual conception is challenging or impossible. In doing this, my goal is not to make the definition of infertility so vast as to be meaningless or include everyone (as happens with “we’re all disabled in some way” arguments, see Murray and Carlson). Instead, broadening and complicating infertility decenters the idea of “choosing” your way out and emphasizes contextual barriers. A disability approach also makes space for the pain and suffering that many with infertility experience. Cara Jones argues that feminist disability scholars “must add to their analytical toolkit a model of disability that centralizes pain” (556), and her work centers on menstruation and sexual pain related to endometriosis. The emphasis on pain where “fun” sexual experiences are expected maps to infertility, and both invite attention to disabilities strongly implicated by hormones. Margaret Price also encourages attention to pain, and I was struck by Price’s description of how she hopes people will react to her pain: by “witnessing” and expressing a “desire to help alleviate pain (rather than denial and eradication of the pain)” (13). This is what I wanted on my infertility journey but did not receive.

A disability approach also invites a needed re-reading of time and aging in relation to infertility. Robin Jensen asserts that given the over-attention to having children “in time,” there is little space left “for the consideration of diverse evidence, historical perspectives, and long-established scientific and cultural refutations” (155). Jensen seeks to center “structural inequalities, lived material experiences, and a variety of relational encounters” (167), and a disability approach extends this work to more squarely question normative fertility/infertility time frames, rather than saying people lack choices within these frames.

In “Six Ways of Looking at Crip Time,” Ellen Samuels notes that she doesn’t exactly wish for a cure; she wants “for time to split and allow two paths for [her] life” that she could move between. I live these two paths, alongside other infertile people who grieve what they may have lost while embracing the path they are on. Samuels’ articulation of crip time can challenge normative fertility-to-infertility timelines and recognize that infertility happens across the life course, as crip time can “extract us from linear, progressive time with its normative life stages and cast us into a wormhole of backward and forward acceleration, jerky stops and starts, tedious intervals and abrupt endings.” As Alison Kafer writes in “After Crip, Crip Afters,” crip time is not only about slowness or doing things “in time,” which again maps to infertility. Instead, she asks: “What are the temporalities that unfold beyond, away from, askance of productivity, capacity, self-sufficiency, independence, achievement?” (421). A disability approach makes space for infertility successes and failures while complicating what those terms mean. A disability approach to infertility makes room for community; infertility is part of disability justice.

Resistance is Infertile

I’ve been writing this essay for a long time, and my motivations and connections to infertility have shifted over the years. At first, I was motivated by a conversation with my therapist about whether I wanted a second child, and in that session, I realized that I was grieving the loss of the choice I thought I would have, not an actual second child. I believe that if I hadn’t felt promised the choice to have a child - if infertility had been typical and expected - I wouldn’t have had so much to grieve, either in thinking about another child or in navigating the privileged and painful gauntlet that led to my son. At the same time, my infertility was a VIP invitation to important conversations I would not otherwise have had, as my infertility required me to think long and hard about whether I really wanted children and what it means to want biological children. Infertility requires us to think deeply about what we want and why, to consider the privilege and exclusion that informs why some of us get what we want and some don’t, and to imagine diverse futures that embrace multiple forms of parenting. For these reasons, I am grateful for my infertility.

Around the time I finished a first draft of this essay, I marched at the second annual Women’s March (in 2018), and I saw a protest sign that said, “Resistance is Fertile” in all caps on a white board, with some hastily-drawn flowers at the bottom. (The rest of the photo features the

backs of marchers dressed for cold, some in pink cat ears and some holding protest signs, against a backdrop of traffic lights, buildings, and a lightly-clouded blue sky.)



The sign assumedly draws off the phrase “resistance is futile” from the Borg in Star Trek, which made me chuckle. But the sign bothered me because it equates resistance, feminism, and fertility in a movement and march significantly composed of infertile and/or menopausal people. Resistance grows in barren wombs and adoption denials; feminist rights extend to infertile people and those who are childfree; fertility is neither natural nor neutral.

In the Covid era, I worried about those who had their infertility treatments put off, in some cases for fear of the virus (Muhaidat et al.). Predictive modeling suggests significant Covid impacts on the success of infertility treatment (Bhattacharya), particularly for those with lower income (Morris), as well as notable impacts on mental health related to infertility (Barra et al.; Marom et al.). I had to move quickly when I learned I was infertile, and had I delayed treatments for a year or two, I would not have been successful. But clinics stayed open for some during Covid (de Souza et al.), and my prestigious clinic probably would have done so for me.

As I submitted this essay for publication, Roe fell. As the federal right to abortion was removed, I found myself less comfortable critiquing the idea of choice, while also feeling galvanized to more loudly declare that not everyone had choice - about abortion and other matters of reproductive justice - even with Roe. The Dobbs decision has also changed how IVF works, “making IVF less efficient, more costly and unsafe, and inevitably limiting access to care” (Ulker et al. 306; also see Crockin; Letterie & Fox).

As I finally finish this essay, I know my family is complete with my son. He won’t inherit my complicated fertility, though it has characterized, and will characterize, our discussions of what it means to have children. My niece will need to know her infertility lineage in a different way and, if she wants children, possibly navigate the testing and timelines I’ve considered in this essay. As I imagine talking to her about it, concerns about her feeling pressured to have children young wash over me anew, despite everything I’ve written here. Rhetorics of choice aren’t only normative and

omnipresent - they're simplistically seductive.

But it won't be one hard conversation or painful realization with my son or my niece, as it was when I learned about my infertility. Conversations with these people I love will be the constant, gradual, and recursive dismantling of myths of fertility and reproduction. Telling the story and lessons of my infertile body and bodies like mine is my choice. There's still time.

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