Chapter 11

Grieving in Silence: Repercussions of the Family Ideal on Women with Pregnancy Loss

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As soon as my husband and I discovered I was pregnant, we went to our local Barnes and Noble and purchased *The Mayo Clinic's Guide to a Healthy Pregnancy*. Pregnancy was new territory for us; why wouldn't I want a map of the terrain? And who better to guide me than the famed Mayo Clinic? At the time, the book was helpful—comforting even. The future didn't seem as scary if I knew what to expect. However, in retrospect, the book was not a map but an immense, flashing caution sign. Pregnancy transformed me into a vessel for a future generation. The question was whether it (I) was worthy.

Prior to pregnancy, I did not envision myself as a vessel; however, I was often made aware of my unfulfilled maternal potential. Unsurprisingly, friends and family were the most constant source of procreation pressure once I married, but there was also external pressure from unexpected places. Bottles of wine cautioned me about the risks of drinking while pregnant. Amusement park rides urged me to be certain I was not pregnant before riding. There was even the occasional warning regarding raw fish in restaurants to remind me of my obligations to this potential child of mine. I am certainly not arguing that knowledge is harmful or that women should ride roller coasters while pregnant, but these warnings illustrate an important

change regarding how women were told to think about their bodies. In *The Rhetoric of Pregnancy*, Marika Seigel argues that the early twentieth century saw a shift away from female-driven experiential knowledge about pregnancy and towards a medicalization of the pregnant body (42). According to Seigel, pregnancy guides and prenatal technologies (i.e., ultrasounds) have continued to perpetuate prenatal pieties: rules, often implied, that determine acceptable behaviour. In her book, she analyzes a sampling of pregnancy texts to expose three specific pieties, which she believes present the pregnant women as incapable and risky:

- Pregnant women's bodies are invisible.
- Medical knowledge about pregnancy is expert knowledge.
- Prenatal care can solve political and social problems (Seigel 75).

In other words, the messages pregnant women receive through verbal, textual, and visual mediums convey that a woman's body and concerns are secondary to the fetus's. There is also an implied promise that the prenatal system can fix any harm the woman's body may do to the unborn child. Such rhetoric advances the idea that healthy babies are the answer to current sociological ills. If a woman is unable (or if, God forbid, a woman is unwilling) to reproduce, then she is held culpable for failing herself, her child, and society.

This messaging is problematic in many ways, and I am interested in is the amount of pressure it places on women who cannot carry a pregnancy to term. Approximately 15 percent of known pregnancies end in miscarriage.[1] This statistic means about one in seven women will lose at least one pregnancy. This figure is shocking but not because of its truth; it is shocking because it goes unspoken. There are also women like me who do not have the language to describe our losses. A miscarriage occurs early in a pregnancy. In a stillbirth, the baby is born dead. And perinatal loss, which is the most applicable description I have found for my own experience, simply refers to fetal loss near the third trimester or after birth. I have since learned that medical institutions tend to classify all of these losses as fetal demise, which is both gut wrenching in its insensitivity and frustrating in its ambiguity. And a lack of clear nomenclature makes it even more challenging for women to talk about their experiences, thus encouraging more silence. This silence means that many women experience their child's death in isolation and steeped in guilt. They feel at fault for their baby's death

and, therefore, withdraw from others, which is counterproductive for the woman's psychological recovery. In their study, C.E. Scheidt et al. followed thirty-three women after perinatal loss for nine months, with reassessments at four weeks, four months, and nine months to determine if stronger social support systems decreased the bereavement period and/or intensity. They determined that "social support and the quality of current partnership can be considered as potentially protective factors of coping with bereavement after perinatal loss" (Scheidt et al. 379). In addition, Nikčević et al. concluded their study with a correlation between an extended search for meaning and an increased grieving time after perinatal loss (59). While beyond the scope of their project, I believe isolation contributes to this prolonged search for meaning. When I lost my pregnancy, I felt alone. I could not believe that anyone else understood the way I felt, and I knew some people would blame me and my body for our riskiness. It was not until I began to blog and speak about my loss that other women came forwards and spoke of their own. Those conversations have helped me process my grief, which raises the question: why do so few women speak of miscarriages and stillbirths when they are so common? I believe the reason lies in how narratives about pregnancy idealize both the process and result: a healthy child. Childbearing and happiness are conceptually linked in our society (Ahmed 57-59; Warner 7), and I suggest that understanding this linkage can help people learn to both grieve and change the culture of silence currently surrounding involuntary pregnancy termination.[2]

In this essay, I use autoethnography to explore and consider possible reasons for the silence around grief and loss. Using my own experience with stillbirth, I focus on two photographs of my children that illustrate a tension between what I argue is natural grief and a kind of heightened grief, which results from increased pressure to procreate to achieve happiness and fulfillment. While I by no means attempt to lessen the impact of pregnancy loss, I seek to use Seigel's *The Rhetoric of Pregnancy* and Sara Ahmed's *The Promise of Happiness* to make sense of my experience for myself and to begin a larger conversation about involuntary pregnancy termination. I do not attempt to speak for all women who have lost pregnancies. If scholarship and personal experience have taught me anything, it is that all grief is different (Brier 461; Harris 1; Scheidt et al. 381). However, I hope that my

experience will resonate with some and open up fruitful conversations about how to better facilitate care and support when a pregnancy terminates.

Methodology: Why Autoethnography?

Personal narratives are powerful rhetorical tools that can be used to empower and inform, or manipulate. Ashley Shelby and Karen Ernst examine how advocates for and against the antivaccine movement have used narratives to support their perspectives. They argue against simply demonizing the other side of the debate and to instead use narratives along with evidence-based information to engage their audiences and inform them of important information, thus developing the ethos necessary for a successful campaign (1798). In addition, narratives are accessible outside of academic readership (Sparkes 211). Autoethnography works in a similar way. Often dismissed as limited memoir-esque writing, autoethnography is really a "personal narrative and ethnographic analysis [used] to illuminate the relationship between lived experience and culture" (Foster 447).

When done well autoethnography promotes the reflexive research methods embraced by feminist researchers. Instead of self-indulgent writing founded on an "N of 1," Foster argues "that analytical autoethnography is rigorous when it employs personal narrative to synthesize, to illustrate, to interrogate, and even to critique current research" (447). The reflection necessary to critically examine one's experiences looks far beyond the original experience and into the larger societal implications. For example, Katrina Powell and Pamela Takayoshi use the act and scene structure of a stage play to present and analyze narratives about decolonizing practices, thus building upon and adding to Tuhiwai Smith's work. In *Decolonizing Methodologies*, Smith asserts, "The past, our stories local and global, the present, our communities, cultures, languages and social practices—all may be spaces of marginalization, but they have also become spaces of resistance and hope" (4). Storytelling is more than sharing tales. When couched within an analytical and reflexive framework, stories can empower the marginalized and disrupt systems based on faulty or biased assumptions:

> In many ways, true reflection cannot occur without storytelling. According to Oliver, Dialogue with others makes dialogue with oneself possible ... Having a sense of oneself as a subject and an agent requires that the structure of witnessing as the possibility of address and response has been set up in dialogic relations with others. (Oliver, Witnessing 87)

In other words, people truly understand the implications of their experiences when they become part of a larger conversation. Witnessing makes history complex and dynamic, which reveals societal issues to both the witness and her audience. Storytelling also facilitates resilience (Buzzanell 4) and when used as "an act of retrospective sense making" (Gingrich-Philbrook 299), autoethnography reveals and allows for reflexivity on systemic practices. Even deeply personal writing is important—arguably necessary—because it "can inform, awaken, and disturb readers by illustrating their involvement in social processes about which they might not have been consciously aware" (Sparkes 221). My goal through telling my story is twofold: to encourage empathy and to build awareness of how a heteronormative family narrative affects others, specifically women who have not been able to carry a successful pregnancy to term. I want to make my reader uncomfortably aware of the currently invisible issue of pregnancy loss.

Pregnancy = Happiness

After almost a decade of what Kristin Park termed "voluntary childlessness," my husband and I decided to get pregnant. Unfortunately, our bodies did not comply with our wills, and in August of 2011, we decided to undergo in vitro fertilization (IVF). Many people were surprised by this choice because I had, up until this point, expressed no intention of becoming a mother. As a child, I did not own a doll. In fact, I did not hold a baby until my best friend had her first child. I was twenty-two. But when my eight-week ultrasound showed twins, I felt conflicted. When the ten-week ultrasound revealed triplets, I was beside myself. After a decade of intentionally not conceiving and a year of failed conception attempts, I held three developing human beings in my body. Once the shock subsided, we headed back to Barnes and Noble.

I heard that many women cry at their first ultrasound. The sight of

their fetus resonates with them on a deep maternal level, and they are filled with joy. I did not cry at any of my dozens of ultrasounds. I did not glow with anticipation. I simply did not feel the way a pregnant woman should feel (according to every pregnancy book, television show, and baby formula commercial), especially one who spent a small fortune to get pregnant. I became obsessed with pregnancy information. Surely, the more I knew, the more I would feel; and I have to admit that it helped, but why? At the time, I would have replied that the books, apps, and documentaries were making the pregnancy real. They were helping me to become emotionally invested in something so intangible, so unfathomable that I simply could not wrap my head around it. I did not realize they were doing even more. According to Seigel, pregnancy rhetoric moves beyond the necessary emotional rhetoric of parent-child love to an unhealthy idealization of family. This idealization began in the beginning of the twentieth century when J.W. Ballantyne, a botanist turned obstetrician, initiated prenatal care. His goal was admirable: to counter the sharp population decline by increasing successful pregnancies. However, positioning babies as the solution to social and political issues turned procreation into a panacea and the family unit into the ultimate goal (Seigel 39-40). An entire century later, these associations remain. Immersing myself in this rhetoric helped me to feel a sense of purpose, but that was because I was already "in the family way"; however, the same rhetoric also enforces an ideal that may be impossible or undesirable for some.

Many queer studies scholars question the underlying idealization of (traditional heterosexual) childrearing and the politics it entails (Berlant and Warner; Butler; Cohen; Park). The argument is not that children are bad, but that the expectation of childbearing— and the expectation it will bring happiness and fulfillment to all—is not just fallacious but damaging because it enforces particular assumptions about kinship (Butler 21) and family (Cohen 455-457). When the nuclear family is considered normal, then anything outside of normal is marginalized: the single mother, the same-sex couple, the voluntarily childless, the career woman, (Park 25) and the woman who miscarries. Policies, practices, and even tacit behaviours form in support of these assumptions, all of which penalize those who live outside the norm. But queer scholars are not all against reproduction, and my argument is certainly not that it is wrong to have children or to want children.

What is problematic is the overt and covert messaging that children are required for happiness and normalcy. Ahmed explains, "Certain objects are attributed as the cause of happiness, which means they already circulate as social goods before we 'happen' upon them, which is why we might happen up on them in the first place" (28). In our current society, children are social goods that are imbued with happiness and those who cannot or choose not to have children are denied that happiness. Queer studies scholars have problematized this correlation, but I believe the academic community has overlooked an important demographic of those affected by this narrative: women whose pregnancies have terminated.

Significant research has been done on the female body and its reproductive potential, as well as the physical and psychological effects of involuntary pregnancy termination (Carp; Geyser and Seibert; Koerber; Martin; Seigel). However, there is (to my knowledge) no significant research on the rhetoric of miscarriage or stillbirth. Even Elaine Tuttle Hansen's important work *Mother without Child* spends only a few pages on involuntary pregnancy loss. Understandably, scholars who have tried to understand perinatal grief have used assessment standards developed for "normal" grief—including A Stage Theory of Grief (Hutti 453), the Adult Attachment Interview (Scheidt et al. 377), and the Hospital Anxiety and Depression Scale (Nikčević et al. 54). Marianne Hopkins Hutti et al. used assessments like these to develop a specific grief measurement for miscarriage, titled the Perinatal Grief Intensity Scale (Brier 454), but these attempts to quantitatively measure perinatal grief consistently return to a singular problem raised by Norman Brier's definition of grief as "the affective, physiological, and psychological reactions to the loss of an emotionally important figure" (452): what constitutes an emotionally important figure?

Many of these same scholars turn to attachment theory in attempts to answer this question and understand their research results. Scheidt et al. were the first to postulate the connection between attachment and grief in their 2012 cohort study, which followed thirty-three women after perinatal loss. They concluded that the stronger the degree of attachment between parental figure and unborn child, the longer the bereavement process (376). Janice Harris noted that the depth of grief may "vary for each couple depending primarily on the level of perception by the parents of the baby assuming 'personhood' (para. 3).

Though articulated differently, Scheidt et al. and Harris argue that the more parents identify the fetus as a person, the more attached they become and the more prolonged the grief becomes.

Many who have not experienced involuntary pregnancy loss struggle to understand how deeply a parent can grieve a child who never truly lived. This is where attachment theory and Ahmed's theories on happiness prove useful. Brier argues the following:

> Grief following miscarriage seems somewhat distinct from grief that typically occurs following other losses in the preponderant emphasis on time ahead rather than remembered times. Thus, after a miscarriage, the individual seems to dwell on images of an anticipated future and the hopes and dreams about what was to be rather than on past experiences. Yearning after a miscarriage also seems somewhat different in that it is primarily centered on the individual's mental construction of a relationship and future rather than actual, past, directly shared experiences. (Brier 460)

The attachment between mother and child is not simply a biological one fostered in utero; it is created through a lifetime of association between childbearing and happiness. For some, attachment towards their child began long before pregnancy, as the idea of the child and parenthood became "happy objects" (Ahmed 27). In these cases, the "happy object" reached beyond the child itself and into the woman's identity as mother. But when a child is lost in utero or within hours after birth, as Hansen asks, is the woman without her child really a mother? What about a woman who has conceived a child but never comforted her, heard her laugh, or felt his chest rise with breath? Does the act of mothering make a mother? If so, what are women who give birth but never take on the role?

Questions about what it means to be a mother are incredibly complicated, and parsing them is not within this chapter's scope, but the questions illuminate the complexity of perinatal grief. They also begin to explain why some people are more thoroughly devastated by involuntary pregnancy loss than others. For those who, like me, had a difficult time buying into the heterosexual family ideal, the grief should be less intense. People who spend their whole lives envisioning themselves as parents may more readily attach to their unborn child and, quite understandably, mourn its loss more fully. This is not to say

that the loss of a child apart from this narrative is not devastating. However, child loss within it represents more than the loss of a child—it represents the loss of an ideal.

Two Pictures of My Children[3]

I lost three babies over the course of three days. Despite our best efforts, neither a skilled medical team nor I could prevent my body from delivering them early. Although it may seem strange to refer to my body as a separate entity, I have come to realize that there was no connection between my will and my body's actions. It is far too common for the woman to blame herself for her baby's death (Kohner and Henley) especially when the female body is perceived as the linchpin of a heteronormative family ideal. Within this logic, if her body is unable to reproduce, then she is at fault for the lost ideal. In some ways, losing triplets made it easier to avoid feeling guilty. From my ten-week ultrasound onwards, every doctor told me my odds of birthing three healthy babies were not high. My body was risky. Unlike other women who have the odds in their favour, my loss was somewhat expected. In fact when my perinatologist visited me in recovery he said, "It's just a triplet thing." It was the wrong thing to say to someone in my position. It was callous, and it represented the tension between the medical community, the patient[4], and the pregnant body. I was something my doctors could not predict, which meant my pregnancy (and my children) were, in many ways, unmanageable. At the time, my perinatologist's words brought me no comfort; but over time, his ideology did. My doctor's words echoed Ballantyne's early rhetoric. It was my body that was risky, not me. Medical science has yet to solve the so-called triplet problem, so we were all pardoned of fault. If my pregnancy had been "normal"—a singleton versus multiples—then it would have been harder to evade guilt and blame. But as it was, as biased and harmful as the narrative may have been, my riskiness helped me avoid the self-blame many other women who lose their children cannot.

Let me be clear. Avoiding self-blame does not mean avoiding grief. It is natural and necessary to grieve. After the loss of my children, I grieved deeply for about six months before the pain began to lessen and I began to see the world around me again. As time passed, I was even

able to look at my grief more critically. It was at this time that I returned to the heartbreaking photographs that were taken of our children while I was in the hospital. One set always appealed to me more than the other, but I could not articulate why. I began to understand that they represented very different kinds of grief. Here, I want to explore two photographs, one from each set, to articulate the differences and why they are significant. The first photograph captures my husband and me with our firstborn, Ewan, during the few hours of his life. The second was taken of all three babies after Ewan's twin Sebastian and their sister Amelia were born, which was two days after Ewan's birth and death. To me, the first illustrates an authentic moment of grief, complex and raw. The second, on the other hand, represents the loss of an ideal—the happiness associated with our children—not the shock and sorrow itself. Together, the photographs present a bizarre juxtaposition of the grief we felt and the ideal we were expected to grieve.

Photo One: Ewan

The loss of our firstborn was traumatic in many ways. I was admitted to the hospital at twenty-three week's gestation after what I thought would be a routine check at the perinatologist. It turned out that I was in labour. Although babies can be viable as early as twenty-five weeks, the goal is to prevent birthing for as long as possible. The problem was that my body was ready to deliver. My doctors placed me on a high dosage of magnesium sulfate, a common drug administered to women in preterm labour to slow contractions and delay birth. We were hopeful. After four days in the hospital, they deemed me stable and moved me upstairs in anticipation of an extended stay. They were wrong. Moments after my transfer, my water broke, and Ewan was on his way. At only twenty-three-and-a-half-weeks gestation, our hope began to wane. We were then faced with a terrible decision: birth all three babies and almost certainly lose them all or sew up the embryonic sack and hope to buy the other babies more time in utero. We chose hope.

There was no crying when Ewan was born. They did not rush for neonatal intensive care unit (NICU) support. The nurses wrapped his little body, and a nurse asked, "Would you like to hold him?" She expected a "yes," but I almost declined. No one had prepared me for this. I had never even felt my babies kick, and now one was wrapped in a gauzy blanket being placed in my arms. Did it even matter if I held

him? I had no idea at the time that other women had grappled with this same decision. In their remarkable book, *When a Baby Dies*, Nancy Kohner and Alix Henley give voice to parents who experienced late stage pregnancy loss. One woman, Anne (a pseudonym), was not as lucky to have the supportive medical staff we did:

> The young doctor asked if we would like to see Philip, but we declined the offer—a decision I will regret to my dying day. If only someone could have talked to me, could have explained how important it was to say goodbye to our baby, could have told me how it would help with the grieving process, could have just gently taken me by the hand and supported me. (47)

Not only did we hold our son, we were encouraged to take pictures. It felt unnatural—unreal—but the nurses insisted. They were right.

The picture of my firstborn is one of love and grief. In it, my husband, still dressed for work, leans tenderly over me as I hold our son. Ewan's skin is dark from transparency, and his delicate arm is nestled by his face. Our eyes are on him, but his eyes are still fused shut. My hand hovers over his body. It is not a beautiful picture by traditional standards, but it illustrates a beautifully tragic moment—one we would not be able to revisit without the nurses' interventions.

Not long after Ewan drew his final breath, my husband sent a simple tweet: "We've lost the moon." It was, and still is, poignant in many ways. It was the beginning of the end of my pregnancy and our three children. Like the famed Apollo 13 astronauts, we were losing our orientation, and we felt adrift. We had just started to attach ourselves to a new future—one where we were the parents of three children. These children had become our "happy objects" (Ahmed 27). I had a few pregnancy "belly pics" to track my changing body, and we had ordered the cribs. Family friends had even gifted us an incredibly expensive stroller for three, which my husband had already assembled. We had started to literally and figuratively buy into the pregnancy. However, it was not until we lost Ewan that we discovered how much he, and this idea of happiness, meant to us. Ahmed explains that the complexity of happiness lies not just in our possession of it but also in its absence. John Locke terms that absence "uneasiness." As Ahmed further discusses Locke, "His argument is not simply that happiness makes us uneasy. He suggests that something does not become good for

us "until our desire ...makes us uneasy in the want of it" (Locke qtd. in Ahmed 31). In other words, we are pushed forwards to obtain the happy object because of its absence, even if we did not originally fully desire it. In this moment, we truly mourned our child, but we also began to feel the "uneasiness" of his removed potential existence.

I know that even for those who have not experienced pregnancy loss, the term "uneasiness" used in this context is probably unsettling, even angering. Please do not misunderstand me. I am by no means implying that neither I nor any other parent in this situation only felt grief because of unfulfilled potential. Ahmed and Locke have simply provided me with a way to articulate my grief and understand how it began to affect me after Ewan's death. Attachment theory is also helpful. As Scheidt et al. explain, "During pregnancy the growing relationship to the unborn child is accompanied by an increasing readiness and capacity to form an intimate attachment relationship ... Bereavement due to pre- and perinatal death is taking place during a period of a specifically heightened vulnerability" (376). Put in a more personal context, our grieving began because our son died. However, his death came at a time in my pregnancy when we were actively nurturing attachment to our unborn children. This attachment made our grief more extreme, and since we could not actually know our child, he represented more than our relationship actually was at the moment of his death. His death made us realize how deeply we wanted not just the child himself but what that child represented. As difficult as it is to admit, the hope we preserved by sewing up the embryonic sack partially illustrated this uneasiness. Although losing Ewan was tragic, my husband and I still hoped we could preserve happiness through the other two children, and we were not alone. On countless occasions in the following years, well-intentioned people would ask without thinking if we lost all three children. Even if only one had survived, the loss would have been less tragic. My pregnancy would have been a success, albeit not as successful as it could (or should) have been. We would have been a family.

Photo Two: The Triplets

My body held out for two days before it became clear that the other babies were coming. At some ungodly hour of the morning, my amazing OBGYN was paged and after finishing a Caesarean section one town over, sped downtown to deliver our second son, Sebastian. As

Ewan's identical twin, he was the most at risk because he shared the same ruptured embryonic sack. Our attempt to prolong the inevitable had failed. Despite the odds, I still hoped to not deliver Amelia. Unfortunately, the uterus is prone to infection after a woman's water breaks, and mine was no longer an inhabitable space. However, there was a brief glimmer of hope when she was born. Unlike her brothers, she managed a tiny cry. The NICU was called, but it was a false alarm. We held them both for the duration of their short lives, and I was wheeled into another room.

Later that day, a nurse approached me after I awoke from my first real sleep in the hospital. I had been heavily drugged for six days, and I was grieving deeply. To say I was not entirely coherent would be an understatement. She asked if I would like pictures of the babies. Some of the nurses had begun offering the service years ago for grieving parents. She offered to dress the babies and photograph them for me. I had no answer. I did not protest, but I did not fully consent. Instead, my mom spoke on my behalf. In a well-intentioned gesture, she asked if Ewan could be retrieved and photographed so that we could have pictures of the triplets together. Although an unusual request, they consented.

It is impossible to predict how anyone might feel in this situation. I was there, and I did not know how to feel. Some parents wish to continue holding their child after her final breath, in some ways to prolong the inevitable, but also to spend as much time as possible with their little one. Good hospital staff will give grieving parents time and space, but Kohner and Henley report horror stories of parents, like Anne, who were not able to grieve in their own ways (47). The authors strongly encourage parents to request whatever they need in that moment. In this instance, the hospital complied, and I appreciate their accommodations. However, had I been more coherent, I would have refused the photographs. Undoubtedly, some parents find comfort in these final photographs, but I did not.

The picture of my triplets, for me, does not represent grief but the uncanny. The uncanny can be invoked when it is difficult to tell if an object is a living or inanimate thing (Freud 233). Though briefly animate, my children were no longer. In this photograph, all three babies rest shoulder to shoulder with their tiny hands folded on their chests, like so many deceased who have come before them. They have

been clothed in miniature hospital gowns and are wearing colour-coded hand-knit beanies: Amelia in pink, Sebastian in mottled blue and green, and Ewan in blue. They are resting on a baby blue crocheted blanket and a yellow silk sunflower is centred above them—a small gold cross has been embedded in its dark centre. What cannot be seen from the picture is that they are positioned in a small alcove in a hospital room. Although the room is dimly lit, the alcove has bright lights positioned on their bodies like a photographer's studio in a grotesque dollhouse. At a glance, they look almost alive, but a longer look reveals a waxy sheen to their skin and their eyelids still fused shut. With mouths slightly askew, they could almost be drawing breath, but their chests would not move beneath their folded hands. What unsettles me about this image (and this service) is that the babies are posed like living newborns on soft blankets with little hats and props. Instead of mourning the tragedy of their deaths, it mourns the loss of their potentials. Since they would never have an artistic newborn photo shoot, they received this hollow imitation of one.

In a traditional funeral, people share stories about the deceased and reminisce over old photographs. Family, friends, and loved ones will not simply miss the idea of the deceased; they will miss her presence, smile, or laugh. I have few memories of my children, and discussing those memories brings more sorrow than fondness. I still struggle with Hansen's questions about the mother without her child because, as she postulates, "the position of the mother without child is not only a traumatic present reality but also a logical impossibility, a taboo, and therefore a site of instability that facilitates thinking about motherhood and women beyond official logic and conventional possibility" (26). I remember feeling at odds with the label "mother" after losing the triplets, especially on Mother's Day. People wanted to honour my experience and the memory of my children, but it felt artificial to don the title. I had never fulfilled the role; I never had the chance. Also, accepting the label of "mother" opened me up for questions—innocent questions—about my children and how we would celebrate the day. These were questions I was not ready to answer. "Mother" was neither a term I had earned nor an identity I was comfortable adopting. My maternal role lasted only a few hours and was best preserved in the first picture. The same unease I felt about the second picture applied to my identity as "mother." It held some elements of truth, but it was forced

and falsified. It represented more than I could honestly claim, and the pressure to embrace the title only heightened the tension.

A failed pregnancy is, for many, a paradox. When pregnancy rhetoric shows positive outcomes and a myriad of ways the medical system can "troubleshoot" the pregnant body, women expect a healthy baby at the end of their pregnancies (Layne; Seigel). It seems a modest and realistic expectation, but for many women it is not. When the only narratives we are shown are of fruitful pregnancies and happy families, it is no wonder that women who fail in these areas keep quiet. But, at the same time, women who experience pregnancy loss often desperately look for meaning (Nikčević and Nicolaides). How could they not? And how much more difficult is a quest for meaning when it is undertaken in isolation? When viewed in this light, it is easy to see why the nurses at my local hospital began photographing preterm babies postmortem. The narrative was in place; the expectations were set. What else can be done when parents are faced with this terrible twist of fate?

Conclusion

If I have learned anything, it is that all grief is different. We want to understand it. We want to predict it. We want to quantify it in some way to give it meaning, to make it more manageable, but we cannot. As someone who has experienced deep grief and who has spoken to many others who have also experienced it, I am not surprised by grief's slipperiness. And as much as I respect the variability of grief, I cannot escape the idea that we are missing a vital piece of the analysis.

My own grieving process has not been easy. Even after over four years, the reflection necessary for this chapter has been difficult. Grief is sneaky. It digs into the soft recesses of your being only to emerge when you feel certain it has gone. But that is to be expected. One never fully recovers from great loss: it leaves a permanent mark. However, despite losing three babies right on the cusp of viability, I was somehow able to move forwards more steadily than many others. Why? I wish I could provide a proven formula for grief recovery, but I believe that everyone's story is different. Also, I believe the strong association between family and happiness is damaging to many women. Although there is no shame in desiring a child, the pressure created by idealizing heteronormative childrearing compounds the pain of not being able to

successfully carry a pregnancy to term (Berlant and Warner; Butler; Cohen; Park). Placing future happiness in this often unattainable ideal can throw women into despair when, after conception, their bodies betray them and their unborn child. For Ahmed, this imagined ideal is problematic:

> To think of happiness as involving an end-oriented intentionality is to suggest that happiness is already associated with some things more than others. We arrive at some things because they point us toward happiness, as a means to this end. How do we know what points happily? The very possibility of being pointed toward happiness suggests that objects are associated with affects before they are even encountered. An object can point toward happiness without necessarily having affected us in a good way. (Ahmed 27)

Even before many women know that a baby will make them happy, they set it as their happiness goal. Setting an expectation like this one can lead to many ends. Some women find it to be true: they delight in their families. Others struggle with the pressure to reproduce for other reasons, like sexual orientation or nontraditional goals. Equally tragic are those who felt pressured to marry and conceive only to wonder why they are still unhappy. And then there are the women who repeatedly try and fail. They are perpetually mothers without their children.

Systemic change is never easy, but there are always ways to disrupt problematic discourses. I believe the first step is to embrace a polyphony of narratives. When up to a quarter of pregnant women lose their pregnancies and no one talks about it, there is a problem. Here I risk sounding like someone who seeks to perpetuate risky pregnancy rhetoric, but I am not. Seigel argues for new system-disrupting documents that use empowering narratives to show the pregnant body and woman as capable, not risky. Although I wholeheartedly endorse this shift, I fear that we may shy away from authentic stories of loss in the attempt to seem less risky. I do not advocate perpetuating the current troubleshooting style of pregnancy books, but focusing only on success stories can make women who experience involuntary pregnancy loss feel even more at fault. Narratives of strength during successful labours strengthen female agency, and stories of healthy grief and recovery can facilitate resilience.

Endnotes

1 Miscarriage statistics vary by site, age, and known versus unknown pregnancy. The averages appear to be 12 to 20 percent with lows of 10 percent and highs of 25 percent for known pregnancies. Unknown pregnancies (i.e., very early miscarriages) reportedly occur in up to 50 percent of pregnancies (Hurt et al.).

2 I will use the terms "involuntary pregnancy termination" and "pregnancy loss" interchangeably to represent any loss of a child during gestation, which includes preterm labour with infant mortality, miscarriage, and stillbirth. Although I believe abortion raises many of the same issues I discuss in this chapter, it includes other factors of grief, guilt, and social pressures outside the scope of this project.

3 This subheading is inspired by Dorianne Laux's poem "Two Pictures of My Sister" from Laux's What We Carry.

4 Medical rhetoric, psychology, and biomedicine have begun producing research on patient-centred medicine. This conversation informed my position and analysis for this chapter. For more information about this conversation, see Barton; Ellingson; Buzzanell; Roter and Hall; Segal; Sharf and Street; Tong.

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