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Chapter 6

‘Silent’ Miscarriage and Deafening Heteronormativity: A British Experiential and Critical Feminist Account

Elizabeth Peel and Ruth Cain

In this chapter we provide a critical feminist analysis of sonographically-diagnosed miscarriage, otherwise known as ‘silent’, ‘missed’ or delayed miscarriage, using our experiential accounts as a catalyst to explore both academic and lay literatures surrounding pregnancy loss. We delineate the similarities and differences in our own experiences (one of us part of a lesbian married couple; the other part of a heterosexual married couple) before focusing on relational context as a prime site of difference. Through an examination of scholarly and ‘self-help’ writing on miscarriage we argue that pervasive heteronormativity doubly marginalises the experiences of lesbians – and women otherwise located outside the realm of heterosexual relationships. In conclusion, we suggest a more thorough engagement with ‘non-normative’ experiences of pregnancy loss will substantially enhance our understandings of miscarriage. Placing marginalised experience and non-normative groups of women more firmly within pregnancy loss scholarship promises to significantly augment critical, feminist and social scientific theorising. This more expansive consideration of the diversity of women’s lives and experiences is also likely to help pregnancy loss become included in reproductive health agendas.

Pregnancy loss is an example of the cultural silence around reproductive ‘malfunction’: statistically common, it remains shrouded in secrecy (Renner et al. 2000). Early loss (before 20 weeks gestation) occurs in between 15 to 31 per cent of confirmed pregnancies (Cosgrove 2004). Yet the normative western narrative of pregnancy is continually reproduced: a missed period, a positive home pregnancy test, and a medically managed pregnancy prominently featuring visits to view the developing ‘baby’ via ultrasound (Davis-Floyd and Dumit 1998). Pregnancy loss at any stage of gestation ‘does not conform to the norm’ of joyful maternity, and represents ‘an incomplete rite of passage’ for women in the normative route to motherhood (Layne 2003: 27, 39). It also contradicts medical norms of correct reproductive embodiment, since it exposes and disrupts the myth of linear ‘biomedical progress’ implicit in western ‘technobirthing’ discourses, which make pregnancy and child-rearing the object of rationalizing medical interventions and management (Layne 2003: 176).

Silent miscarriage occurs when the foetus dies in utero and is discovered by ultrasound scan before the foetus is expelled. In other words, as far as women are concerned, until the loss is diagnosed by sonogram the pregnancy appears to be progressing. This was the type of loss experienced by both authors. Although the term missed miscarriage is more commonly used to describe this experience in, for instance, widely accessed internet resources such as babycentre.co.uk (Hammonds 2009), we prefer silent miscarriage as this term conveys the cultural silence around miscarriage as well as the lack of clear physiological symptoms of loss and the comparative rarity of this type of miscarriage. Of course, this particular form of pregnancy loss is dependent upon the availability, frequency, and point of use of sonograms within any given pregnancy trajectory. We have not been able to locate published statistics on the frequency of silent miscarriage – a fact that partly reflects the lack of attention paid to the subjective and bodily experience of pregnancy loss, which clearly alters when the miscarriage is discovered in this way. It also reflects national differences in the prevalence and use of ultrasound. In Britain the first routine ultrasound is offered to National Health Service (NHS) patients at around 12 weeks into pregnancy unless there have been previous antenatal problems, in which case an aptly named ‘viability scan’ is offered at around eight weeks. Women with the resources to do so also have the choice of paying for an earlier private scan. In the USA, the frequency of silent miscarriage will be higher as a routine first scan is at 8 weeks (Swain and Layne 2005). Indeed in cultures where ultrasound technologies aren’t available this specific form of pregnancy loss, shaped as it is by medical technologies, doesn’t exist. But as Layne (1992) highlights there is always dis-synchronicity in pregnancy loss – a lag between demise and expulsion from the body. In Peel’s (2010) online survey of British, American, Canadian and Australian lesbian and bisexual women’s experience of pregnancy loss 36 per cent of participants found out about their loss through ultrasound, but as this was a convenience sample no conclusions about prevalence can be drawn. We can speculate, however, that the fairly high number of losses revealed in this way partly reflects the relatively high usage of assisted reproduction technologies (ARTs) including ultrasound in this sample (Peel 2010).

Moreover, the narrative of normal pregnancy begins with ‘natural’ conception within a heterosexual relationship, usually marriage. Lesbian motherhood is less common than heterosexual motherhood, and lesbian routes to conception are by definition non-(hetero) normative. Furthermore, since most lesbians use ARTs (insemination with known or anonymous donor sperm) or adopt children, their family-forming practices are also likely to be considered non-normative. Even in cases where no medical assistance is used for conception, lesbian pregnancies are prone to classification as ‘artificial’ (Ferrara, Ballet and Grudzinkas 2000, Mamo 2007).

Statistics on the number of lesbian mothers are vague. About one third of British lesbians are mothers (Golombok et al. 2003). And even less is known about the incidence of pregnancy loss among lesbian women. A study of intrauterine insemination with frozen donor sperm (122 single heterosexual women and 35

lesbian couples attending a fertility clinic in London) found that in 63 pregnancies the miscarriage rate was 15 per cent for lesbian couples and 35 per cent for single heterosexual women (Ferrara, Balet and Grudzinkas 2000). The authors suggest that the difference in miscarriage rates between the two groups may be due to the heterosexual single women in their study being older than the lesbians; having failed to conceive for some time prior to clinic referral. Examining sonographically-diagnosed early pregnancy loss is important for a number of reasons. First, research suggests women's feelings about miscarriage are not influenced by gestational age at loss (Swanson et al. 2007, Cosgrove 2004), and so first trimester miscarriage can be just as distressing as later pregnancy loss or stillbirth. Second, there are particular nuances of silent miscarriage that increase the prospective parents' sense of 'fetal personhood' (Layne 2003: 101, Petchesky 1987), since the death of the foetus is experienced later than it physiologically occurred; an unintended consequence of a new reproductive technology. While sonography has been well studied by interdisciplinary feminist scholars of the new reproductive technologies (for example see Harpel 2008), this unintended consequence has been almost entirely neglected. The medical benefits of routine sonography in pregnancy and the great pleasure that many women and their families take in 'seeing the baby' and sharing the baby with others that this affords outweigh any consideration for the many women who will learn they have lost their pregnancy this way. As one British lesbian in Peel's (2010: 725) study vividly expresses: 'I get very angry that people see this [ultrasound] as an opportunity to put the first photo in the album not as a serious medical procedure with potentially disastrous news'.

Furthermore, as Peel (2010: 725) reports 'numbness, shock, distress and devastation were the overriding emotions conveyed by those respondents who had their loss revealed to them in this way'. As one of her survey respondents – a self-labelled butch dyke from the USA – elucidated:

We were very excited going for an ultrasound at our obstetrician's office – so far the pregnancy seemed to be going well – I was having symptoms but none of them were too extreme. My wife Emma was a medical student so she was a little more cautious than me knowing that many things can go wrong this early in a pregnancy – I really expected any kind of pregnancy loss to be symptomatic and since I hadn't had any cramping or bleeding at all I didn't expect there to be any problems ... Emma started crying and I just felt really numb. (Peel 2010: 725)

Another respondent, a British bisexual woman, was 'absolutely devastated' and found it 'enormously, terribly distressing' (725) to have first one and then subsequently a second pregnancy loss revealed through sonogram.

With reference to social science and 'self-help' literature, including our own experiences, this chapter explores the non-normative experience and consequences of silent miscarriage. While not an autoethnographic analysis per se (c.f., Sheach Leith 2009, Ellis 2004), our argument is embedded in experiential

perspectives. We focus particularly on how lesbians' experiences of pregnancy loss are marginalised within an overarching context of heteronormative, 'natural' pregnancy (Peel 2010). Attention to pregnancy loss in such marginal contexts could help to refocus medical and psychological practice on the varying needs of each woman in this traumatic situation. Also, it could broaden feminist concepts of the embodied 'standpoint' of the reproducing woman, whether she is a socially, legally and clinically recognized 'mother', 'mother-without-child', 'non-mother', or 'would-have-been mother' (Hansen 1997).

Experiential Accounts of Silent Miscarriage

Both Liz and Ruth had the shared experience of shock and dissociation in finding out, in the coldly technical setting of an ultrasound room during their first sonogram, that, to quote the health professionals involved, their pregnancies were not 'viable'. Liz's pregnancy loss occurred within the context of a planned lesbian parent family. Ruth was heterosexually married and her pregnancy was unplanned. Below we recount our experiences of pregnancy and loss.

Liz's Story, 2008

We started the conception process in the autumn of 2007. Five months later Rosie (my wife) and I were becoming disillusioned and less believing that a minute amount of liquid in a syringe could enable us to have a baby. I did everything as the books suggested – even slowly rotating myself so the sperm would coat my entire cervix. Each month we waited, hoped, tested, waited a while longer, tested again and then my period arrived and we'd go through the process of checking, negotiating, coordinating and collecting sperm from our friend again. After I'd convinced myself getting pregnant wasn't going to work for me I conceived in March 2008.

Rosie and I were thrilled I was pregnant and told family and friends immediately. We bought a new family home with room for a nursery, and the baby clothes and shoes that couldn't be resisted; evaluated different cots and buggies and agreed on a name. The fact that I wasn't sick didn't trouble me. I could compare notes with my also pregnant (and very sick) sister and feel secretly self-congratulatory – all the organic vegetables, herbal teas and vitamins were elevating me above the realms of morning sickness. We were very excited about the routine 12 week scan – it meant being able to tell people at work – and we needn't be concerned with the possibility of miscarriage any more, the books said. I'd noticed some dark blood the week before and anxiously called the midwife (no answer) so I phoned the hospital where we were due to have the scan and spoke to a receptionist who said someone would call me back. But they never did. Surely they would have returned my call if there was anything to worry about? And in

any case, I'd heard that women can 'spot' throughout their pregnancy and the blood I'd seen wasn't fresh so it couldn't be problematic.

We attended the scan appointment at the maternity department of the local hospital. As instructed, I made sure I had a full bladder for the ultrasound and we organized the five pound coins we needed in order to get a ticket which would be exchanged for the scan picture of our baby. There was this cataclysmic disjuncture between our excited expectation and the unfolding experience. The sonographer looked concerned and from the looming chasm of disbelief I was slipping into came the words: *'there doesn't appear to be a heartbeat'*; *'there's a foetal pole and sac'*; *'this is the worst part of my job'* and *'failed pregnancy'*. But there must have been some uncertainty because another sonographer was brought in and I was vaginally probed.

Ruth's Story, 2002

My husband and I looked forward to the 12 week scan, when we would see 'our baby'. We told everyone well before the scan date; congratulations were ours in abundance. The fact that I felt no sickness confirmed my belief that I could breeze through pregnancy. After all, I had become pregnant so easily.

I had begun to bleed slightly the day before; no cramps. Bleeding, I read on the internet, was a sign of miscarriage in 50 per cent of cases. Something could well be wrong; but I felt the bleeding was too light to mean anything.

At the scan, my husband focused on the screen before us. The scan technician grinned at his eager face. A poster in the waiting room showed a cartoon foetus complete with wiggly umbilical cord, shouting to 'mum': *'if you want a photo of me, tell the technician before you leave!'* The technician stopped smiling and turned the screen away. I felt a dull recognition of defeat settle upon me: *'I'm sorry, I can't see a heartbeat.'* It had seemed to slump to the bottom of the womb. It had a shrimplike shape, with something like arms seeming to emerge from its tiny torso.

The trajectory of the 'baby's' existence did not end at its predicted birth date. On the day the pregnancy calendars gave for its birth, I found I was pregnant with my now eight year old son. The anxiety attached to the miscarried foetus fastened itself firmly upon its successor.

There are similarities in both stories: the medicalized experience, treatment by the NHS, emotional reactions and subsequent grief, and joy at our subsequent children. There are also axes of difference. Liz experienced her loss in 2008 and Ruth in 2002. Liz was treated in a regional town, Ruth in London. Another difference, which we now go onto explore more broadly, is how our relational

contexts shaped these experiences. In other words, we offer a critical evaluation of how being in same-sex versus different-sex relationships affects the experience of pregnancy loss. We begin by outlining the invisibility of lesbians in the pregnancy (and pregnancy loss) literature before discussing the management of miscarriage.

Lesbians and Pregnancy Loss: Doubly Invisible

Lesbians and bisexual women are all but invisible in the generic literatures on pregnancy and pregnancy loss. The 'heterosexist monopoly' of reproduction' (Wojnar and Swanson 2006: 5) is invidiously pervasive (Mamo 2007). Popular pregnancy and childbirth books (and the literature presented to women by general practitioners (GPs) and midwives after confirmation of pregnancy) in the UK are similarly heteronormative. (See for example 'Emma's Diary', the pregnancy guidance booklet written in fictional diary form and distributed by GPs to pregnant women who have contact with antenatal services [Royal College of General Practitioners 1997].) British anthropologist Sheila Kitzinger devotes four of her 448 pages in *The New Pregnancy and Childbirth* to miscarriage, to a chapter entitled (insensitively in this context) 'You and your newborn'. Lesbians do not receive a mention, even in passing. The very popular 421-page British book *Rough Guide to Pregnancy and Birth* (Cooke 2001) dedicates just over two pages to miscarriage in the chapter focused on 'Week 6'. Again, there is no mention of lesbians in the book. A best-selling American manual, *What to Expect When You're Expecting* (Eisenberg, Murkow and Hathaway 1991) makes no mention of same sex parenting and mentions miscarriage very briefly. The absence of lesbian parents in this very normative popular literature parallels that of lone parents (female or male) and non-normative conception methods.

In the dedicated lesbian pregnancy self-help literature, discussion of pregnancy loss is similarly lacking. However, in a book entitled *The Essential Guide to Lesbian Conception, Pregnancy, and Birth* written by American midwives (Toevs and Brill 2002) just six of 487 pages discuss miscarriage.

Toevs and Brill (2002: 395) acknowledge that 'because of the lack of openness surrounding its normalcy, miscarriage has become unnecessarily medicalized' and recognize that 'pregnancy loss is a big marker in women's lives'. They note two ways that miscarriage poses special challenges for lesbians' writing: 'While in the crisis, you may also need to decide how to represent your family structure, and you may have to filter through the possible homophobia or judgments about single mothers, which, more than likely, will only add to your stress' (396). They also mention how the difficulty of becoming pregnant for lesbians affects grief. Whereas, heterosexually married women bridle when told, 'oh you can always have another one'. Such a suggestion is more thoughtless to women (regardless of their sexuality) who have gone through the process of sperm acquisition and artificial insemination: 'Grieving takes on an additional dimension when you realize you're basically starting all over when you inseminate again' (398). Lisa Saffron (2001),

the British lesbian mother, writer and activist provides one page on miscarriage in her 331 page book *It's a Family Affair: The Complete Lesbian Parenting Book*, in a chapter entitled 'when it doesn't go as planned'. She also provides the story of a would-be lesbian mother entitled 'A lost dream – Casey's story' (109-113). Casey describes her multiple miscarriages including one that she learned of during her scan: 'Before the scan with the first miscarriage she [her partner Lesley] had been concerned, while I had not seriously considered that pregnancy loss could be a possibility' (112). This is the only mention of a lesbian's miscarriages discovered by a scan we have been able to find in the 'self-help' literature.

Feminist scholarship is little better on the subject of pregnancy loss in non-heteronormative contexts. For example, in Layne's (2003) feminist anthropology of pregnancy loss in America, she never addresses lesbians. Indeed, Celia Kitzinger's (1996) idiom of 'the token lesbian chapter' coined in the context of feminist psychology over fifteen years ago seems utopian when applied to the pregnancy loss literature. The 'tokenism' of feminism in relation to lesbian parenting disturbingly mirrors the exclusionary tendencies of mainstream pregnancy literature which occludes 'abnormal' narratives of pregnancy or parenthood. As Lisa Cosgrove (2004: 113) highlights in her feminist critique of the academic pregnancy loss literature:

Despite awareness that technological advances have allowed many women to get pregnant who previously would not have been able to, the voices of single or lesbian mothers and non-traditional couples are nowhere to be found in the research literature. By failing to consider the ways in which implicit assumptions about compulsory heterosexuality determine the focus of their work, researchers have actively silenced the experiences of many women and their partners ... [this] must be addressed so that 'women's responses' to pregnancy loss are not conflated with 'married heterosexual women's responses to pregnancy loss.

Empirical research about lesbians' experiences of pregnancy loss is scant. Only two studies to date have focused on non-heterosexual women's experiences (Peel 2010, Wojnar 2007). Wojnar (2007) conducted a phenomenological study based on 10 interviews with white US lesbian couples. She found that the participants who were growing the baby (which she describes as birth mothers) typically bonded with the unborn child very early in pregnancy and that they grieved their loss openly, whilst the non-pregnant participants, social mothers, kept their sadness more private, feeling that they needed to be strong for their partners, much as men in heterosexual couples are reported to do (Puddifoot and Johnson 1997). Wojnar (2007: 483) concluded that: 'in contrast with heterosexuals whose unintended pregnancy rates linger at about 50 per cent, lesbian pregnancies are generally planned and wanted ... regardless of how long it took couples to conceive, the 'typical' stressful process of becoming pregnant for lesbians was similar to the 'atypical' experience of the subset of heterosexual women who experience infertility'. Similarly, Peel's more recent research based on online

survey responses from 60 non-heterosexual women from the UK, USA, Canada and Australia found that the experience of loss was amplified due to participants' relational situations, and the financial and emotional investment respondents had made in order to achieve conception (Peel 2010).

Miscarriage (Mis)Management

Regardless of our sexual orientations, we both received horrible 'care'. Our emotional losses and physical pain were minimised and ignored.

Liz: Three weeks after the scan that revealed the 'failed pregnancy' I was given The Miscarriage Association's 'We're sorry that you have had a miscarriage' leaflet by a hospital midwife. I said they really should provide information earlier as I didn't have a clue what to expect, and was told it would be like a 'heavy period'. She replied platonically 'we'll take that on board'. During the worst of the bleeding and clots I experienced horrific pain. That was my experience of 'expectantly managed' miscarriage (see also Cote-Arsenault, Scare and Layne, 2006; Layne, 2006, 2007, Maclean and Layne 2006).

Ruth: We sat in Accident and Emergency (A&E or Emergency Room) for three hours. I then remember the blank face of the doctor who examined me in a windowless room; she stood back and looked at the wall as I burst into tears of shock. She concluded her examination with the news that to avoid infection, I must return for an operation: 'the products of conception must be removed'. The phrase was the ugliest I had ever heard.

The female body, particularly in 'abnormal' reproductive contexts, is a disciplinary site. Medicalisation, pathologising and legal control of 'unruly' bodies all play their parts in the production and maintenance of femininity (Ussher 1991, Foucault 1990). The 'power' exercised here is not unipolar and totalitarian, but patchy and variable (Foucault 1980). Our stories provide anecdotal examples of such variability, over a relatively brief time period (2002-2008) and in different areas of the UK. Ruth was given no option but to undergo an Evacuation of Retained Products of Conception (ERPC) procedure involving a general anaesthetic in 2002. In 2008 Liz was told to 'wait and see' (otherwise referred to as 'expectant management', see also Layne, 2006). Medical management of miscarriage changed during the last decade of the twentieth century and the six-year gap between our experiences reflects this: there is now a tendency to allow 'expectant management' rather than opting automatically for a surgical solution (Nanda et al. 2006, Griebel et al. 2005). 'Expectant management' allows the body to miscarry in its own time, although it should be noted that this will not always happen and that there are risks attached to both forms of management (Jauniaux, Johns and Burton 2005, Sotiriadis et al. 2005, Wieringa-de Waard et al. 2003). ERPC is associated with a higher risk of infection (Nanda et al. 2006) and while the anxiety associated

with surgery is avoided in 'expectant management', the latter involves much pain, bleeding and knowingly carrying a dead foetus for days or weeks.

Perhaps more importantly, the risks and benefits of each kind of management appear to be inadequately represented to women. The research literature emphasizes 'the woman's preference' (for example, Nanda et al. 2006, Smith et al. 2006), but in both cases we were given no options at all, and scant information from which to make any independent choice or judgment (see further Smith et al. 2006).

An important aspect of the silencing of miscarriage experience is that of emotional suppression, the unacceptability of grief for the loss. Medical care for women in Britain is routinely criticised for being perfunctory, insensitive, and unsupportive, and aftercare barely exists (Nikcevic 2003). Society (including both heterosexuals and lesbians) fails to recognise grief, particularly for losses in early pregnancy (women are routinely told to 'just try again' for a baby); and in Britain there is also too little professional support, women and their partners tend to suffer alone. Professional awareness of, and training in, the psychological issues surrounding early pregnancy loss and its aftermath appears to be minimal despite the fact 'the qualities that characterize midwifery care, including providing complete information, encouraging self-determination and being sensitive to the emotional state, are particularly important at this time' (Thorstensen 2000).

Undoubtedly funding issues are at play here, particularly in the cash-starved British NHS. Economic pressures combined with the cultural taboos on pregnancy loss, the non-normative mother or 'mother-without-child' (Hansen 1997) is an important 'lost' object. As a focal point of social exclusion and/or intervention, she epitomizes maternal marginality. When she can be judged to be 'deviant' in a sexual as well as reproductive/physical sense, the mother or mothers are additionally excluded.

As we have noticed in our examination of the pregnancy loss literature, silencing and exclusion of the uncomfortable subject of loss is not restricted to the medico-legal 'mainstream'. It is hard to locate pregnancy loss in the lexicon of feminism: Feminists have been well taught to mistrust the concept of the 'pre-born' child, the now-ubiquitous foetal image which threatens to take over the mother's subjectivity and agency (Petchesky 1987). The dangers of 'burying' women's experience is far reaching and damage is done to women's emotional lives, confidence, and sense of self. Because there is so little social and cultural recognition of lost pregnancies, they retain an astonishing power to haunt the potential parents who are enjoined to publicly gloss over the loss of their almost-babies, as Mantel (2003: 228) has described:

Children are never simply themselves ... Their lives start long before birth, long before conception, and if they are aborted or miscarried or simply fail to materialise at all, they become ghosts within our lives. Women who have miscarried know this, of course, but so does any woman who has ever suspected she is pregnant when she wasn't. It's impossible not to calculate, if I had been,

it would have been born, let's see, in November, ice on the roads, early dark; it would have been the offspring of late March, a child of uncertain sun and squalls.

Pregnancy loss adds another dimension of 'ghostliness' to the abject construction of reproduction and maternity in western societies. (See Layne, this volume.) If the mother remains an 'absent presence' (Kaplan 1992: 3), in the case of loss she conceives another. The lesbian/queer woman is another abiding 'absent presence' in medico-legal regulation and discourse. Just as she is often presumed (wrongly) to be excluded from reproductive life, her experience of loss fails to 'fit' even within the limited cultural outlets for the expression of grief and support, such as web-based support boards. (Though we do not mean to imply that such virtual support communities as www.babyloss.org and www.sands.org are deliberately exclusionary of non-normative sexualities and reproductive contexts, membership and postings are nonetheless dominated by heterosexual couples who have experienced loss.) And the context in which the lesbian woman must 'just try again' is a far more complex and socially fraught than for many heterosexual women.

Concluding Remarks

In concluding, we offer practical suggestions for improving women's experience of early sonographically-detected miscarriage aimed at mitigating some of the negative implications of pregnancy loss. First, health professionals should ensure that: information that ultrasound could reveal pregnancy loss be provided in preparatory materials given to women; and information about what to expect (physically and emotionally) from miscarriage could be provided shortly after the expected loss is identified. Second, health professionals should demonstrate awareness and sensitivity to women's relational contexts and ensure, in the case of lesbian couples, that partners are acknowledged and actively included in consultations. And that for single mothers by choice whether gay or straight, and other women who have used ARTS that awareness of the special difficulty it took to achieve a pregnancy be acknowledged. There is a clear need for improved and broadened practitioner education, but truly sensitive, flexible treatment of pregnancy loss will require wider and less easily achievable cultural shifts in assumptions and expectations about pregnancy, loss and motherhood, and subsequent policy changes.

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