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Reproductive Failure and Information Work: An Autoethnography

GINA SCHLESSELMAN-TARANGO

ABSTRACT

In providing an autoethnography of the author's own reproductive failures while working as a librarian, this paper considers the ways in which neoliberalism maps disability onto non-(re)productive bodies thought to be outside the realm of individual control. The author calls upon feminist disability theory to surface themes of embodiment and relationality and to unearth the unrecognized labor of reproductive failure. Suggesting that library and information studies would do well to take seriously all sorts of "failures," the author recommends that we turn to archives of failure; doing so would allow for a richer and more nuanced exploration of how neoliberalism casts some bodies and minds as "normal" and others as not, and makes the necessary space to, rather than celebrate the triumphant, recognize the failed.

*After a miscarriage, the body still seems pregnant—may still look pregnant—
and yet the question is still asked: Where's the baby?*

—Jennifer Scuro

A STORY

In 2015, my partner and I decided it would be a good time for us to have a child. I had just turned thirty, and he forty. Having never experienced any uterine, ovulatory, or menstrual problems in the past and knowing my partner didn't have any previous testicular incidents (the fact that he had never been kicked in the groin was all the reassurance we needed), I figured it would take us a few months, perhaps six at the longest, to conceive. So many stories like ours start this way, with an unfounded faith in one's fertility. *We know our bodies*, was what we told ourselves.

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But we didn't. Instead, this is what happened:

We conceived after nine months, which felt like an eternity, an earlier impatience I now find highly insulting. In early January 2016, I miscarried at eight weeks, likely due to a subchorionic hemorrhage (a growing clot of blood that can eventually tear the embryo from the uterus). A few days after "the main event" (this is how one ER doctor described the onslaught of contractions that expels the majority of the thing you thought was going to be your baby from your body, usually followed by milder cramps and bleeding in the days and weeks that follow), I was in the shower and my partner was kind enough to play Freddie Mercury's "We are the Champions," vocals only. It is one of the few things I remember from that fuzzy time awash in grief, and the song was devastating, but it was also beautiful, and I do think it's the reason we were, not long after, ready to try again. *No time for losers.*

We weren't able to conceive "naturally" again within six months, so we sought treatment starting in June 2016. A hysterosalpingogram (where they shoot dye into your uterus to help determine its shape and whether or not the fallopian tubes are blocked) followed by an MRI confirmed that I had a bicornuate uterus, not unlike a horse or a kangaroo or a rabbit or a rat. In humans, a bicornuate uterus is a congenital abnormality characterized by a uterus that has not fully fused. In Latin, *bicornuate* means two horns, and if you encounter someone particularly cutesy, they might refer to it as a "heart-shaped uterus." While this sort of deformity doesn't normally affect your ability to conceive, it does correspond to a higher risk of second-term miscarriage, preterm labor, and birth defects.

We were referred to a reproductive endocrinologist, the doctor whose job it is to get you pregnant. Since they couldn't find anything "wrong" with my partner's semen analysis (save a few tiny and wayward swimmers here and there), my body—the one with the uterus and the ovaries, the one that menstruates—became the site of experimentation, which I've since learned is not uncommon. I began what is a typical regimen: a few months of Clomid, an estrogen modulator meant to stimulate ovulation but also often given to those who do ovulate, like me, as a first line of treatment. After failing to conceive via timed intercourse, I underwent three intrauterine inseminations, which involved two months of superovulation due to an overly enthusiastic physical response to an abdominal human chorionic gonadotropin (HCG) trigger shot. Superovulation, as amazing as it sounds, is not super. Not only did my ovaries swell to the size of softballs so much so that they were touching one another, my abdomen distended, and I appeared to be five months pregnant. Everything hurt. Urinating was incredibly painful, as was standing, sitting, and even breathing. I traveled to Los Angeles to give a keynote address at the height of one of these superovulation dramas, being careful not to lean my belly into the podium. I wondered whether people in the audience were silently asking

themselves if I was expecting, and whether that would be the only time my body would prompt such a question.

My partner and I were eventually told that our only option would be to pursue in vitro fertilization. This is expensive, and my kangaroo uterus meant that even a successful conception by these means did not guarantee a baby. So we stopped treatment. We were diagnosed with what they call unexplained infertility. We were infertile.

This is a sad story.

About a year later, I found myself unexpectedly pregnant. It happened! To us! All was fine—we saw the heartbeat three times—but then suddenly, just like that, it wasn't fine. Another rush of blood, another trip to the emergency room, another miscarriage. A fuzzy empty space that punctuated the beginning of 2018, almost three years since we had so confidently decided we were going to make a baby. Just like that.

This is a sad story indeed.

A METHOD

While the details are mine, experiences like mine are not uncommon. The Centers for Disease Control and Prevention (2016) tell us that in the United States, 7.3 million women, aged 15–44, have used infertility services and that 24,000 babies are stillborn every year. Additionally, studies show that anywhere from 10 to 25 percent of pregnancies end in miscarriage (American Pregnancy Association 2017). Reproductive failure is ubiquitous, even though the silence surrounding it makes it seem otherwise. No one wants to hear a sad story. However, the story I want to tell is not just an account of my particular experiences with infertility and pregnancy loss, or even the particulars that affect so many of us (meaning that they're not particularly particular). The story I want to tell is one that accounts for the context that framed what I and so many others experience, one that attempts to explain and understand why we find ourselves confronting failure and loss in certain ways.

This is an autoethnography, which is a way of saying that I'll be recounting some of my individual experiences in an effort to better understand society and culture (May 2011). Another way of putting this is to say that I'm engaging in storytelling, a practice offered up by a radical reproductive-justice framework, created and championed by women of color, that insists on recognizing context and that rejects "commercialized storytelling practice," or self-help approaches that ignore, for example, "corporate practices, endless wars, environmental degradation, gender and racial inequality, and the alienation of individuals" (Ross et al. 2017, 11, 22). This is a qualitative and subjective study of myself, but, more importantly, it is a study of norms and practices and politics.¹

As a librarian, I'm fascinated with texts, sites of analysis. Many autoethnographers use texts and other sorts of data to assist with their analy-



Figure 1: Trashcan stuffed with doctor's appointment reminders, medical receipts, and prescriptions. Source: Archive of Reproductive Failure, 2015–.

ses, and these could be personal accounts and records, journal entries, or other forms of writing, along with lived experiences and observations. In addition to my experiences and observations, stored in my body and in my memory, my field notes (both digital and physical) are as numerous as they are sundry: a trashcan stuffed with old appointment reminders, medical receipts, and prescriptions (see figure 1); the months of cycles charted and stored in a fertility application on my phone; empty bottles of progesterone and Clomid and B6 and prenatal vitamins; the wrappers

of pregnancy tests taken (*again a single line, always a single line*); even the stack of books I've turned to that have helped me understand and have given me language for these experiences. All this is the stuff of an Archive of Reproductive Failure, an archive that allows me to track not only time, but also emotion—*each month the excitement, each month the grief*—and the work that attends each failure.

I want to note that I use terms like “failure” and “loser” not because I consider myself—or other in/sub-fertile individuals or dyads—as such but as a way to highlight the ways in which ableism, sexism, heterocentrism, pronatalism, bionormativity, racism, classism, and neoliberalism work in concert to shape how the world thinks and talks about those who have trouble biologically reproducing, those who are stubbornly unable to control their bodies or succeed in healthcare systems never meant for them in the first place.

This is an autoethnography, an act of storytelling, but perhaps this is better understood as a coming-out story. Garland-Thomson (2002, 21–22) tells us that “coming-out stories . . . expose what previously was hidden, privatized, and medicalized in order to enter into a political community.” Could this be a coming-out story? Do I have something to come out about? What would a political community of reproductive losers look like? *Is there time for losers, after all?*

A FAILED (NEOLIBERAL) BODY

This is the infertility story I choose to tell. As we know, the personal stuff—our bodies, our desires and aspirations—are never not political. The contours of my story, like that of all stories, are shaped largely by neoliberalism, the current governing zeitgeist that, in its worship of “the market,” demands that healthcare is something that must be bought and sold rather than treated as a human right. Neoliberalism turns on the Great American Dream Myth that hard work (*Produce! Produce! Produce!*) will equal success, though the truth is that where there is capitalism, there is competition; and where there is competition, there will always be those who succeed, which is to mean there will also always be those who will fail. Halberstam, in *The Queer Art of Failure* (2011, 88), reminds us that capitalism and failure go hand in hand.

This being the case, reproductive failure is more inevitable for some than others, simply because the costs of treatment are prohibitive. There's that Great American Dream Myth again: you can do anything you put your mind to, when in reality, at least with infertility, you *might* be able to do the thing you want *if* you have enough money and time and emotional wherewithal to throw at it.

Of course, it's never just about the money—it's also about race and sexuality and age and ability and a host of other things. Indeed, our society is built around and cheerleading for the reproductive success of particular

bodies, ones like mine (white, educated, in an opposite-sex relationship, of traditional child-bearing age, infertile but otherwise able-bodied), ones whose reproduction is not assumed to produce an economic “burden” for others, ones who have in turn become the ideal patients for a fertility industry that trades in not only hard cold cash but also in the overconfidence of middle-class white women who have up until this point been convinced that the future is in our control, baby. A little hard work and some grit is all it will take.

There’s even a script for women like me, one that Britt outlines in *Conceiving Normalcy: Rhetoric, Law, and the Double Binds of Infertility* (2001). It starts with a view that infertility or reproductive failure is a disruption of one’s life “plan” that simply can be overcome. The script, so familiar it somehow seems divine, demands that this disruption first be addressed by seeking, then exhausting medical treatment (in states like Massachusetts where insurance coverage for fertility treatment is mandated, it has become nothing short of compulsory, in turn underscoring the widely held belief that other routes of family building will always be last resort, second best). If this obligatory engagement with the fertility industry fails, the expected path is some neat mourning for one’s not-quite-but-could-have-been biological child(ren), then the process of deciding whether to live childfree or pursue adoption, foster care, etc. So tidy you could almost put a bow on it.

As if neoliberalism’s demand to produce—goods, services, feelings, a personal brand, an appropriately sized and “normal” family—and individually overcome any impediment to this (re)production weren’t insidious enough, it is emboldened by our current political moment in which the right to choose if and when one wants to engage in reproductive work continues to be under attack. Those of us who want to protect and expand that choice and who also choose to “produce” a family in nontraditional ways (adoption or foster care) find ourselves the talking points of politicians aligning adoption with the pro-life movement (Papisova 2017), or on the receiving end of well-intended strangers who applaud our choice because it amounts to “saving” a baby from, well . . . *that*. Both of these examples are twisted reminders that others will tell your story if you don’t.

We live in a world that, in general, valorizes heteronormative reproduction but is rather indifferent to nonreproductive and queer labor. Halberstam (2011, 41) provides an incisive critique of the celebrated 2005 documentary *March of the Penguins*, arguing that the necessary labor of what they call the “homo or nonrepro queer penguins” is flatly ignored: “The indifference in the film to all nonreproductive behaviors obscures the more complex narrative of penguin life . . . [for example], we see with our own eyes that only a few of the penguins continue to carry eggs through the winter, but the film provides no narrative at all for the birds who don’t carry eggs . . . while the visual narrative reveals a wild world of

non-human kinship and affiliation, the voice-over relegates this world to the realm of the unimaginable and unnatural” (41–42).

As with the anthropomorphic rendering of the film, the nonreproductive human body is viewed as a nonproductive body, for which there is no place in a neoliberal, pronatalist society. Scuro (2017, 223), in *The Pregnancy ≠ Childbearing Project: A Phenomenology of Miscarriage* (part autobiographical graphic novel, part philosophical treatise on pregnancy loss), tells us that the unproductive body “signals only the body as empty, bloated, active only in its leakage and expulsion.” For those of us who have experienced pregnancy loss, her observation rings true. Once a miscarriage is confirmed, you are expelled from the medical establishment, and your body is no longer relevant (Hardy and Kukla 2015, 106). Never mind the weeks of bleeding, the months of spotting, the uterine twinges, the wondering when it might be okay to have sex again or when you might finally lose those five or ten or thirty pounds, the praying that you hope you will stop feeling pregnant because, *goddamn*, you’re not pregnant anymore, the process of deciding what to do next; *no*, all of this labor ceases to be of interest.² When my doctor called to confirm that yes, you’ve miscarried, the fetal sac is gone, he said he was sorry. He said, “Next time you’re pregnant, we’ll get you in early.” That’s the same thing he said the first time. Then radio silence.

A DISABILITY

Given neoliberalism’s fetishization of bodies producing and bodies under control, there is no body more failed than the disabled body. According to the Americans with Disabilities Act (US Department of Justice, Civil Rights Division 2009, 7; Fertility Within Reach 2018), infertility is a disability. It is a unique disability in that it is largely invisible, is often unknown until reproduction is sought, affects some (usually those with uteruses and/or ovaries) in what are considered their “child-bearing years” and might therefore be considered a temporary disability, while others (usually those who are assumed to produce sperm) are often considered infertile throughout their adult lives. In some cases, infertility can be treated or corrected or cured, and in some cases it cannot. Greil, in *Not Yet Pregnant: Infertile Couples in Contemporary America* (1991), reminds us that infertility is also unique in that it is often experienced in relation to another person—though the cis female body is often on the receiving end of both treatment and blame, the body providing sperm can certainly be a culprit, and it’s not uncommon for both bodies to contribute to the “problem” (ASRM 2017). Greil also reminds us that infertility, unlike many disabilities, is not a condition or state but instead is marked by the *absence* of a desired condition or state: successful conception and pregnancy (1991, 46–47). And unlike many disabilities that cannot be “solved” or “cured,” Greil contends that infertility

can be taken care of by simply no longer desiring to have a child (48), or moving from *childlessness* to being *childfree*. I largely disagree with this last claim (the childfree still experience a great amount of stigma—the social experience of infertility is sustained, shifted rather than erased), and his text is grossly heterocentric, but Greil’s observation of the intersections of infertility and illness—and by extension disability—remains useful, as is his insight that “the meaning of children, and therefore the meaning of infertility, varies both crossculturally and historically” (67).³

Though infertility is generally considered a disability in the United States, some question this classification and whether it is worthy of treatment. These are rather boring questions, and instead of belaboring them, I am interested in what a critical approach to disability can tell us about the lived experience of reproductive failure. To say that a body is a failed body is to recognize that failure and loss are not simply psychological but also corporeal experiences, ones hemmed to the body as much as to the heart.

An eye on embodiment allows us to, as Garland-Thomson (2002, abstract) writes, turn our attention to “the social formations that interpret bodily difference.” Advocating for what she terms a feminist disability theory, she insists on exploring the body and (dis)ability as social and historical constructs that “pervade all aspects of culture: its structuring institutions, social identities, cultural practices, political positions, historical communities, and the shared human experience of embodiment” (4). She goes on to contend that “the informing premise of feminist disability theory is that disability, like femaleness, is not a natural state of corporeal inferiority, inadequacy, excess, or a stroke of misfortune. Rather, disability is a culturally fabricated narrative of the body, similar to what we understand as the fictions of race and gender” (6). Feminist disability theory therefore provides the critical room to look beyond reproductive failure as an individual or biological phenomenon, instead understanding it as always situated and always produced.

There are two key insights proffered by feminist disability theory that we might apply to the experience of reproductive failure, one of which brings into sharp relief the ways in which neoliberalism maps disability onto certain bodies that are thought to be outside of the realm of individual control. To call someone disabled, Garland-Thomson (2002, 6) writes, is to “call into question our cultural fantasy of the body as a neutral, compliant instrument of some transcendent will.” But we try, how we try to control and “fix” the unruly body. In the past, it was through prayer, a profound faith that divine intervention could lead to reproductive success. Now, it’s through a change in attitude (“once you relax it’ll happen”) or more commonly, through medicalization (vitamins, hormones, X number of inseminations followed by X rounds of IVF). The stubbornly infertile body, the body that continues to fail, that refuses to succeed through such inter-

ventions, at once signals “corporeal insufficiency and deviance . . . [and] becomes a repository for social anxieties about such troubling concerns as vulnerability, control, and identity” (Garland-Thomson 1997, 6).

Identity is a tricky thing in that it is less about who you are and more about who you aren’t. The second insight that feminist disability theory offers points to the relationality of bodies, the fact that the disabled body is necessary to sustain the myth of the able one. The able body, what Garland-Thomson (1997, 8) calls the “normate,” is comprised of an “array of deviant others whose marked bodies shore up [its] boundaries.” Translated to reproductive failure, we see that failed bodies, like the failed family, or the failed state and failed economies, serve to validate the alleged normality of reproductively successful bodies, successful families, successful nations, and successful economies. To be a winner, there has to be a loser. To be #blessed with happy and healthy children, there must be those who are #unblessed.

INFORMATION WORK: AN ACCOUNT

I am a librarian, meaning that much of my compensated labor is information work. I select books to purchase, update and build online resources, teach college students how to do research, answer questions at a reference desk, and supervise an employee who handles assessment data. I get paid for this because my work contributes to the smooth operation of neoliberal society (higher education specifically), and this labor is recognized in that it is visible, measurable, and I am remunerated. However, there are other sorts of labor that are often (made) invisible and not compensated. The labor that is affective or emotional (e.g., caretaking, or dealing with bullshit to ensure another’s comfort) and the labor that is reproductive (e.g., conceiving, birthing, raising, and socializing children) are two areas that feminists, who have long recognized that such work is feminized and therefore undervalued, demand be seen as the labor that it is.

Reproductive labor and the affective or emotional labor that goes along with it is hard work, even when that labor fails to yield a desired result (or any result). That labor might entail choosing abortion or abstinence or birth control or surrogacy or adoption or deciding that this will be the last IVF cycle, or whatever it may be. Here, I want to make space to think about both affective or emotional and reproductive labor as integral aspects of the experience of reproductive failure. I specifically want to suggest that we take into account the strategic *working toward* reproduction as labor that is repeated with every menstrual cycle, along with the accompanying emotional and physical consequences. I want to explore the reproductive labor of bodies that do not “work,” and in order to tell my story, I need to consider my work, or position this labor within my experiences as an information worker. Not only can I not divorce the two experiences, as

they have so shaped one another, but thinking about reproductive failure alongside and within a traditional work environment provides the necessary contrast to critically examine valued and recognized versus nonvalued and nonrecognized labor. Further, it allows us to see how themes raised by feminist disability studies—in particular, embodiment and the desire to control the unruly body—intersect with the workplace in particular ways. Finally, I suspect that information work has shaped how my body is put in relationship with reproductively successful bodies, which surfaces a host of questions about identity and perception.

Emotional labor, which has been explored in library and information studies literature (see Emmelhainz, Pappas, and Seale 2017) can be defined as labor that “requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others” (Hochschild 1983, 6–7). Like many (women) librarians, I engage in emotional labor when I must provide *service with a smile*, even while being harassed by patrons. When it comes to reproductive labor in the library, I too engage in emotional work, certain sorts of suppression of feeling so I *don't cause a stir*. I have received so much unsolicited advice: *Just relax. Have you considered acupuncture? Eat pineapple during your luteal phase. Take a vacation. Give your body time. Yams for implantation. Adopt, then you'll get pregnant*. Upon returning to work after my first miscarriage had started but was by no means complete, a comment: *My, you look haggard!* At home among friends, I would have *caused a stir*, but professionalism demands otherwise, demands emotional labor: don't scream, don't cry, focus on the jelly between your legs and getting through your day. Smile and nod so you *don't cause a stir*. And the worst, from those (no doubt well-meaning) who knew my partner and I were struggling to conceive and who later knew we had stopped trying: *When you have a baby. . .* They looked right through me, and rather than understanding me as infertile, they insisted on the normate. They could not conceive of a body that was unlike their own. I wasn't even on the scene.

Librarianship is a female-majority profession, and my workplaces have reflected that. There are some really nice aspects about having so many women colleagues—for example, most libraries have a robust whisper network⁴ (what pink-collar profession doesn't?) (Meza 2017) about which patrons to hurry along and which to avoid, and I've been fortunate enough to work at places that generally make space for certain forms of feminized labor, the kind that's more visible than that which typically accompanies reproductive failure (childrearing and caretaking, for instance). There are also some aspects of being surrounded by women—many of whom have birthed biological children of their own—that, as an infertile cis woman, are uncomfortable. Again, I am often assumed to be fertile and *in control*. Instead of crying, I laugh (I've learned this will cause *less of a stir*)

when mentors and colleagues have suggested that I plan to start a family after receiving tenure. They don't realize or are unwilling to accept that infertility, lack of access to reproductive control, and an unruly body are possibilities. Interactions with pregnant others in the workplace are unavoidable sites of comparison, as are certain celebrations and events. How can you refuse to attend a colleague's baby shower? How can you explain that it would be too emotionally difficult to do so? How can you explain that you can't "get over what you cannot get over?" (Scuro 2017, 223). Any answer to these questions involves coming out, and while I hate being assumed fertile, outwardly acknowledging or embracing infertility throws into stark relief the relationality between the fertile and the infertile body, the successful and the failed.

One of the most overlooked and embodied aspects of emotional labor is grief. Scuro (2017, 238) points to the work involved with what she terms *griefwork*, that which, she argues, "has become the labor of women as it serves the patriarchal ends of a neoliberal economy." As we see time and time again, women are burdened with the task of emotional labor, labor "read as nonproductive—that is, *infertile*" (236). Here, Scuro reveals that neoliberalism, and, more specifically, the devaluation of that which does not produce, turns on the logics of both sexism and ableism.

So much of my griefwork was experienced not only at work but also alongside of, with, and because of my body. My griefwork, like most reproductive labor, was embodied. When my second miscarriage began, I was just starting a shift at the reference desk. Feeling the warming in my crotch and cursing myself for not bringing enough pads (*you should have known this would happen!*), I visited the restroom every ten minutes or so, hoping patrons wouldn't notice. I tried to hold myself together, my heart pounding and sinking, and then I only had thirty minutes left, and how could I possibly give a shit about correctly formatting an MLA citation, and maybe by the time I leave the bleeding will stop and I won't have to go to the emergency room. And how can I tell my partner about what's happening, how can I possibly break this news to him yet again? There is grief and there is blood.

I've made countless commutes to work after reading a negative pregnancy test or discovering that I had started my period. I would leave home hoping that the drive would offer enough time for a quick sob followed by quiet sniffing with a few minutes to spare to fix my running mascara and confirm that I'd have enough Midol to handle the impending cramps. I spent one morning in front of my computer, unable to do much but stare at the screen because the night before an increased dose of Clomid skewed my vision, and I was confident that the subject line of an e-mail was still hazy. On more than one occasion, I've missed important meetings because I discovered blood a day or two after I had seen a very faint positive pregnancy test. This is the drill: get up super early, sign in at the doc-

tor's office, wait, wait some more, and finally be called to get your blood drawn to measure your Human Chorionic Gonadotropin (HCG) levels (anything below five generally confirms that you're not *actually* pregnant, at least not anymore). And then the follow-up: Yes ma'am, it must've been another chemical pregnancy, there's no way to tell now, thank you, dial tone. There is blood and there is grief.

In an effort "to narrate how to resist the devaluing of griefwork, in that its devaluation is fundamentally ableist," Scuro ultimately invites an expanded circle of grievers (not just women) to engage in an outward-facing griefwork: "I want to treat it as an undergoing and not merely an overcoming—as a resource and a reserve of invisible labor" (2017, 237). While this vision for griefwork as testimony is a noble one, it's tricky. Those who are engaging in griefwork—those whose bodies are expelling or contracting or bloating or deflating, or those who are struggling with how to comfort their partner or frantically searching for someone to whom they can whisper—may not want to testify, may not want to come out. I know who I can tell about my grief, about my reproductive labor and loss and failure, and who I can't. I've learned who I should not have told. This knowing-who-to-tell, too, is a constant negotiation; it is constant work.

In addition to the myriad ways that race and class and ability and other axes of identity shape who is considered deserving of infertility treatment, who is encouraged to succeed and who might be better off failing (see *Misconception: Social Class and Infertility in America* [Bell 2014] and *Radical Reproductive Justice: Foundations, Theory, Practice, Critique* [Ross et al. 2017]), workplace policy (the extent to which infertility treatment is covered—if at all) and workplace status affect one's ability to access treatment (if they so desire). While most information workers, regardless of rank, aren't making a ton of money, library hierarchies do dictate pay, which can dictate access. For example, at my current workplace, I am considered faculty and therefore make more money than most staff members, which meant I was likely more able to afford to pay out of pocket for certain costs of treatment. As a faculty member, too, I have a more flexible schedule that is less controlled and scrutinized by a supervisor or my colleagues. I did not have to "out" myself in order to receive the treatment I wanted—I could simply share that I could not make a meeting, and that was that. Not all information workers are afforded this same flexibility and therefore likely find themselves in the awkward position of having to out themselves, making griefwork all the more public, the failed body all the more visible.

At its core, information work involves various forms of information seeking and sharing. Being a librarian, then, adds an additional layer to all of the seeking and sharing that's part of the labor of reproductive failure, specifically the seeking and sharing involved in the *working toward*. My position as someone who was an information worker and an infertility patient no doubt shaped the dynamics that marked my experience of seeking

and receiving medical treatment. Having information—and being able to find it in “reputable” scientific journals—allowed me to feel like I had some sort of control over what I knew about my body and therefore my ability to manipulate it. I became very skilled at locating and interpreting meta-analyses about fertility outcomes for those with congenital uterine abnormalities, for example. When I first met my OBGYN, and later my reproductive endocrinologist, I found a way to slip into the conversation that I was an “academic librarian,” signaling that I had access to the same sorts of information the professionals did, so watch out and don’t try to pull a fast one over on me! I was probably—like other middle-class white women—a monster patient because I always came to my appointments prepared (or so I thought), armed with information that would allow me to suggest different approaches, potential problems, etc. If I was going to have to tell you about the consistency of my cervical mucus, I expected to be heard. I became very savvy at advocating for myself and navigating the labyrinthine health-care industry—this is one of the many survival skills I’ve picked up, one of the many ways we reproductive losers retain some element of dignity and control.

Most librarians would agree that anything you learn or experience makes you a better librarian because you’re better able to answer questions patrons may have, better able to put materials in context and make sound decisions about them. I cannot wait for the day a reproductive loser stops by the reference desk or sends me an e-mail asking for information. *What is involved in a typical infertility workup? Here’s a source*, but also: bloodwork, pap smear, vaginal ultrasound, ovulation predictor kits (these are expensive from the grocery store, so order these and pregnancy tests online), semen analysis (if you give a sample there, they’ll have all sorts of pornographic material on hand to facilitate the process, but you’ll also likely hear the nurse blowing her nose the next room over, so it can be weird). *Where’s the best place to order a trigger shot? Find a discount pharmacy that specializes in fertility meds*, but also: here’s the number for the one I used. It was still expensive, but at least they were fast and will ship directly to the clinic. *How long does a home study take before you are adopt-ready? It varies by agency and the type of adoption*, but also: for us it was about a month and a half. They ask a lot of questions, inspect your home, and you’ll need to get a physical exam and have proof of your pet’s vaccinations.

Of course, those experiencing reproductive failure also seek and share information outside of libraries, and certainly outside of other institutionalized settings like the fertility clinic, usually because they feel the medical establishment has failed them or because they’ve been cast out, no longer productive or paying and therefore no longer of interest (Hardy and Kukla 2015, 110). In the digital age, online communities of reproductive losers have formed and flourished, resulting in rich sites of information sharing and seeking. Hardy and Kukla point out that such communities

provide users not only alternative spaces but also language that reproductive losers, and also some parents, need but cannot find elsewhere (110). Following is an incomplete but illustrative thesaurus of common acronyms one would encounter in such a community:

AF=aunt flo
 AI=artificial insemination
 Angel baby=miscarried fetus/baby
 BBT=basal body temperature
 BD = baby dance (sex for the purpose of conception) or baby dust
 (good wishes for conception/pregnancy)
 D&C = dilation & curettage
 DD=dear daughter
 DS=dear son
 ENDO=endometriosis
 FTM=first time mom
 HTH=hope this helps
 HPT=home pregnancy test
 LO=little one
 MC=miscarriage
 MS=morning sickness
 OPK=ovulation predictor kit
 Rainbow baby=baby born after previous pregnancy ended in
 miscarriage
 SAHM=stay at home mom
 STTN=slept through the night
 TTC=trying to conceive

During my brief and frightening first pregnancy, I found an online community and was able to participate in a discussion board where my concerns were validated and questions answered. Once my miscarriage was confirmed, this digital space was one where griefwork could be done in the way I needed—at that time, anonymously. When I miscarried, I couldn't say the words out loud, but I could type them. I was in my office at work, and within minutes another online user responded with a simple "I'm so sorry." Perhaps this digital space provided access to what Scuro (2017, 237) is referring to when she imagines thinking about griefwork as a "resource and reserve of invisible labor"; indeed, recognizing and responding to another's griefwork is a kind of griefwork of its own. My body reacted, the digital breathed flesh, and I shut my door so no one would hear the sobs.

As I was working on this autoethnography, I wanted to see if I could locate this user who had so kindly validated my grief and trace their words back to my original post. I logged back on, assuming I would access only this small piece of my archive, as it really is the only thing I recall from my

time there. I found the user's kind response, but I also saw that I had registered my due date (*Why had I done that? Such hubris.*), and I was informed that my baby is now 19 months old. I was presented with a breakdown of toddler milestones, and according to the site, I should be preparing for potty training and an adjusted bedtime. Galvan (2017, 4) reminds us that in the digital age, "physical death may be removed from our everyday experience, but we carry graveyards in our phones."

FAILURE'S OFFERINGS

Death, loss, grief, fruitless attempts—these are macabre things, this is the stuff of graveyards. Reproductive failure roams there too. How can we navigate these experiences in a way that gives us something in return? What might we recuperate from failure? What could losing give us?

Refusal or inability to participate in a gender- and hetero-normative teleology perhaps creates space for us to critique the idea that "the bearing of children is an 'accomplishment' because it is attached to the master narrative of neoliberal ideology" (Scuro 2017, xiii), but also to live lives that aren't tethered to what Edelman (2004) calls a compulsory allegiance to a "reproductive futurism" (4) that insists that "the cradle must endlessly rock" (116). This being untethered can provide room to problematize the many facets of the pronatalist imperative, all while revealing alternative and more liberatory possibilities, perhaps moving us closer to Garland-Thomson's (2002, 22) political community.

This is the type of possibility Clare (2015, 107) points to in describing disability pride: "not an unessential thing. Without pride, disabled people are much more likely to accept unquestioningly the daily material conditions of ableism. . . . Without pride, individual and collective resistance to oppression becomes nearly impossible." For those who are childfree by circumstance rather than choice, turning failure into resistance—even pride!—might seem an uncomfortable embrace, as it flies in the face of the social script of what one ought to do when they are confronted with failure. Garland-Thomson's (2002, 19) exploration of the possibility for disabled women is illustrative: she writes of the ways in which these women are often defeminized, not unlike the ways trans women, queer women, infertile women, and women of color—a woman can, of course, carry one, some, or all of these identities—too are often "purged from the feminine economy." While this being cast out and aside underscores the ways that gender, sexuality, physical difference, and race shape how failure is written on and through the body, such purging might also provide a way out of "oppressive and debilitating scripts" that dictate what it means to be a woman (19). For infertile women, this could mean exploring possibilities beyond the confines of the "motherhood mandate" (Russo 1979).

For those like me who are in an opposite-sex relationship, failing to

reproduce is also an obvious failure to properly perform heterosexuality. Halberstam (2011, 3) tells us that “success in heteronormative, capitalist society equates too easily to specific forms of reproductive maturity combined with wealth accumulation.” In this way, the critique of pronatalism and what Warner (1991) calls “repro-narrativity: the notion that our lives are somehow made more meaningful by being embedded in a narrative of generational succession” (7) and “repro-sexuality—the interweaving of heterosexuality, biological reproduction, cultural reproduction, and personal identity” (9) is instructive, forcing one to think seriously about and carve out space for a nonreproductive future (or perhaps, as Edelman (2004) suggests, *no future*).

As Warner (1991, 16) reminds us, “normal sexuality and the machinery of enforcing it do not bear down equally on everyone,” and the application of a queer politics to the experience of infertility, which is not solely experienced by those who identify as queer, could be considered problematic (see, for example, “Failing Fertility: A Case to Queer the Rhetoric of Infertility,” by Maria Novotny [2017] and “Adoptive Maternal Bodies: A Queer Paradigm for Rethinking Mothering?” by Shelly M. Park [2006]). Yet, the important insight proffered by a queer critique of power is that compulsory heterosexuality does shape everyone, even if, as Warner says, unequally; indeed, heteronormativity marries sexuality with reproduction, claiming “nature” to make its case for moral superiority. Inability or unwillingness to fulfill heterosexuality’s “natural” progression is therefore in some sense to fail, both biologically and morally. Again, the exciting question is what this failure might offer.

I am well aware that the potential for alternative possibilities, new scripts, and nonreproductive imaginations discussed above offers little consolation to those in the throes of infertility, pregnancy loss, or stillbirth. I also think it’s vital to point to failure’s promise, failure’s potential. Without it, how else can we reproductive losers get by?

* * *

I want to return to my Archive of Reproductive Failure. It is dispersed—it is paper stuffed in a trashcan, data stored and quantified on a fertility application, entered and translated code on a website. It is an appointment on a calendar I can’t bring myself to delete, an ultrasound image printed and pressed neatly in a notebook I won’t open. It is part medical record, part Amazon order history, part text-message chain to my sisters, part memory. The parts comprise the whole—this archive is messy.

As an information worker, I wonder about forbidden archives like this one. Necessarily complex, this archive is an answer to the neatly bound baby book, to the curated feed of happy healthy babies featured on any

given social media platform. What if library and information studies took seriously all sorts of failure and the labor involved, even attempted to document and expand existing archives of failure, so as to create not only a necessary record of losing and loss but also a site from which we could problematize the ways in which neoliberalism, pronatalism, ableism, and the like cast some bodies as “normal” and others as not, some lives as “failed” and others as not?

Indeed, collecting and celebrating materials that speak through negativity and loss and grief toward the possibilities of failure would allow us to honor political communities of reproductive losers, to honor bodies that don’t “work,” bodies that are twisted and bent and wheezing, hallucinating and stuttering. An archive like this could pave the way for recognizing failure among our colleagues and with our patrons, making the necessary space for griefwork, and acknowledging the importance of access to affordable healthcare for those who want or need it, regardless of their status within a workplace or institution. Further, as an homage to the kangaroo uterus and the mangled fist, the spastic and the schizophrenic, such an archive can compel us to imagine these bodies “as extraordinary rather than abnormal” (Garland-Thomson 1997, 137) and allow us to capture a broader swath of human experience in all its dismay and all its giving up. We can turn from celebrating the triumphant to recognizing the failed.

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I wrote this because I was unable to find the feminist infertility community I so desperately needed. I dedicate this piece to this invisible community and to those who are childfree, by choice or by circumstance.

NOTES

1. Autoethnography is a fairly new method within library and information science and studies. For more, see Deitering, Schroeder, and Stoddart (2017). Thank you to Bob for so kindly sending me a signed copy.
2. Roxane Gay (2017, 68) recounts a college experience in which her complaints of severe abdominal pain, once determined not to be pregnancy-related, were dismissed. “The medical community,” she concludes, “is not particularly interested in taking the pain of women seriously.”
3. For an excellent analysis and chronology of the infertility experience in the US, see Marsh and Ronner (1996).
4. “A whisper network is an informal chain of conversations among women about men who need to be watched because of rumors, allegations or known incidents of sexual misconduct, harassment or assault. It’s a way for women to protect themselves, and to do so under the radar. In one way or another, in every major industry and institution, there have been whisper networks helping women to watch out for each other” (Meza 2017).

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