**The invisible work involved in early gestational loss in Spain**

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**Long Abstract**

Friedrich Engels posited in 1876 that work is a basic and fundamental condition of human life, a primal activity that sets us apart from other beings, through which the world -or nature, in the author’s words-, is transformed. It is through work that human beings are created and shaped across generations, and solely through it that we become who we are. This conception urges us to consider work from a broad perspective, as a prerequisite for the creation and transformation of life. Thus, work is a way of acting upon the world in multiple ways, some of which have a visible material expression while others remain invisible.

This paper aims to contribute to the Panel’s discussion on the concept of work, focusing particularly on that which is considered “invisible” or “invisibilized”. We will explore the work(s) undertaken by women who experience an early gestational loss. Drawing upon Arlene Kaplan Daniel’s concept of “invisible work”, our discussion will delve into the social, affective, moral, and physical dimension involved in the work of dealing with that loss, additionally to the work of planning and achieving a pregnancy, based on the research results on early pregnancy losses in Spain, specifically those occurring in the first gestational trimester.

We argue that navigating a gestational loss falls within the work of making a set of decisions that predominantly burden women, leading to increased mental and emotional strain (Hochschild, 1983; Dean et al., 2021). Research revealed that women of ‘reproductive age’ or those who are pregnant, as they project or practice motherhood, carry out a diverse and complex set of cognitive, emotional, and material efforts (Hochschild, 2003; Offer, 2014; Dean et al., 2021) during these processes, impacting their health, relationships, and future aspirations in multiple ways.

In contemporary European countries, perinatal losses are both a common public health concern and a demographic issue. In the Spanish case, since the late 1990s, Spain has experienced drastic demographic changes, moving from a baby boom to “structural infertility” (Marre, 2012). Until 1976, Spain’s Total Fertility Rate (TFR) was one of the highest in Europe, at 2.8 children per woman. By 1996, it had reached 1.16, one of the lowest in the world (Kohler, Billari, and Ortega, 2002) and it remains today at similar levels. Social, political, and economical reasons such as job precarity, income inequalities, unaffordable housing, lack of maternity public, and men’s low participation in family care rather than biological ones, are the main reasons to motherhood postponement (Alvarez and Marre, 2022). Often, when women decide to have a child, they need to resort to some form of assisted reproductive technologies, such as adoption, medically assisted reproduction with or without gamete or embryo donation, or surrogacy (Marre et al., 2018).

According to recent estimations, first-trimester losses occur in approximately 25% of all diagnosed pregnancies (Schummers et al. 2021; Tommys, 2021). Consequently, significant numbers of people today are experiencing or have experienced a perinatal loss themselves or in their family or friends. Despite its high prevalence, early pregnancy loss remains a hidden and unknown phenomenon in Spain. When it occurs, social science research demonstrates that families, relatives, and health professionals lack information and are often unable or even reluctant to address it.

Women who undergo an early pregnancy loss are thus placed in a situation of having to carry out a complex work that is often invisible and invisibilized, that is, unknown and unrecognized, which increases their burden. Making this work visible, that is, accounting for it both qualitatively and quantitatively, is the aim of a research project carried out by the AFIN Barcelona Research Group at the Universitat Autònoma de Barcelona.

This paper presents the results of a mixed-methods investigation on the experiences of women, their partners, and relatives, as well as healthcare providers, after the diagnosis of an early pregnancy loss (<12 weeks’ gestation), exploring the challenges it entails. We engaged in three months of naturalistic observations of prenatal appointments, the obstetric emergency room, and fertility consultations, carried out in one primary care service and in a third level public hospital in Catalonia. We also conducted interviews with 32 women, 10 family members, and 23 health professionals from different Spanish autonomous communities.

Analyzing narratives coming from a selection of these interviews with women who underwent early gestational losses, we discuss the potential of viewing their experience through the lens of invisible work. We think that we can offer a deeper understanding of the invisible work attached to the different stages of the gestational journey ending in a reproductive loss.

First, the work of “creating a family”: we refer to all the efforts involved in deciding to have a child considering the conditions to become a mother in Spain, achieving a pregnancy, including health care, lifestyle adjustments, and increasingly often, medically assisted reproductive treatments. Indeed, 80% of the women who participated in our study, who experienced one or multiple early pregnancy losses, were attempting to achieve a pregnancy between the ages of 35 and 41, and more than 70% had undergone several reproductive treatments, adding a significant additional workload to their journeys -time and resources management, anticipating possible scenarios, reconciling work with treatment obligations, among others-.

Secondly, once pregnancy is achieved, the process introduces a realm of uncertainty and unpredictability, especially for those who already underwent a gestational loss previously. Women learn about this new stage and, often, the potential risks it entails, managing a set of variables to carry out a healthy pregnancy. It is relevant here to focus on the fact that the decision-making and emotional work involved is often shouldered in solitude, as many women decide to “keep the secret” of the pregnancy until the first-trimester ultrasound takes place, because it is during this period that a series of screenings are performed to detect potential fetal pathologies and that most gestational losses occur. The custom of not making the pregnancy public until this threshold is crossed, a true rite of passage in the gestational journeys, brings with it great solitude at this stage of decision-making and when loss occurs. As they face the difficulty of sharing the news, informing about their health status, or requesting a leave from work, women often describe this entire period in terms of an intense effort and uncertainty, while simultaneously taking care of themselves and continuing a life that does not deviate from “normality” to avoid questions, giving explanations, or generating expectations in the social environment.

Thirdly, when a gestational loss occurs, women face a series of situations that require efforts and decision-making concerning the end of the pregnancy. The “expulsion” -or delivery, as many interviewees referred to it- is experienced in different and multiple ways, and medical, familial and social support during this period appears to be crucial albeit often reported as insufficient or lacking. The work of thinking about how to face “what comes next” after the gestational loss diagnosis is implicitly and explicitly stated -both by health professionals and by male partners- as something that must be assumed by the woman: it is “her decision” since it is “her body”. Few people witness the multiple evaluations, anticipations, and planning that are entailed in initiating any of the proposed therapeutic options, while managing complex emotions such as insecurity, fear, sadness, loneliness, along with physical pain and possible medical complications that are often underestimated. In these circumstances, the effort to pay attention and be aware of how this situation affects or could affect others also manifests, especially when women evaluate how to talk about it to other children and close relatives, empathizing with the feelings this may generate, alluding to the responsibility for managing their own feelings and those of others.

Fourthly, the most demanding cognitive and emotional labor involves assuming a shift in identity, from being the mother of a developing embryo to a grieving mother due to the loss of that embryo. This turning point in the anticipated journey has varied consequences on women’s lives and futures. Faced with the lack of response from healthcare professionals to their request for explanations -other than that it is a common occurrence -, many women examine their past and immediate events surrounding the loss, seek explanations, formulate hypotheses, compare, and assess possibilities, and based on this, evaluate available and feasible options for trying for a new pregnancy. This workload can be composed of multiple medical appointments and studies, time, and resources management, aimed at gathering information and making new decisions. It also requires a set of actions that women must take for their loss to be recognized, legitimized, and validated, which often does not happen for various medical, legal, and social reasons in the cases of early losses. Furthermore, when gestational loss occurs more than once, which is statistically less common, it triggers a set of significant and additional challenges.

Our findings suggest that various women’s behaviors, attitudes, and dispositions described by the interviewees could be framed as what Hochschild (2003) calls “emotional work” -the work of managing one’s emotions and those of others- and, at the same time, what Daminger (2019) and Offer (2014) coined as “cognitive labor” -the work of organizing, thinking, and planning. According to Dean et al. (2021), tasks of this nature, when combined and as they fall exclusively on women, become a “burden” which affects their health and emotional well-being.

The different experiences shared by the women who participated in this study reflect these aspects to varying degrees, depending on their personal and family situations, or their experiences with the healthcare system, among others. However, what is common to all the experiences of early gestational losses observed and narrated by those who underwent them is that this work remains “invisible”, in its condition of internal and personal work. As Kaplan Davies (1987) argues, it occurs out of sight of an audience, which recognition would validate it, hence it is not accounted for, except perhaps by other women who have gone through the same experiences. As she notes: “[…] the fabric of life requires this effort -or it is poorer if that work is absent. Most of the people expected to do it -or assumed to do it most easily- are women” (Kaplan Davies, 1987:408). That is even more significant in the case of early gestational losses, that is, the least visible of all reproductive losses.