

# Policing the Maternal Mind: Maternal Health, Psychological Government, and Swiss Pregnancy Politics

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The psychological experience of pregnancy is an issue of increasing concern to policymakers in Europe and North America. However, there are very few accounts of how the emphasis on the “psychological government of pregnancy” informs gender politics. My research approaches the politics of pregnancy as the convergence of several fields: the regulation of the pregnant body, the medicalization of pregnancy, the publicization of the fetus, and the definitions of “good mothering.” Based on fieldwork in a perinatal unit in Switzerland, this article aims to uncover how these psychologically informed discourses contribute to the reproduction of gender stereotypes and naturalize sex differences.

## Introduction

Public and medical interest in the psychological state of pregnant women has been increasing in the past decades in both Europe and North America. In 2003, for example, British psychologists suggested that mentally ill pregnant women could be detained and forced to receive psychiatric care (Beveridge, Ananth, and Scurlock 2003). In 2005, France adopted a nation-wide public health plan aimed at screening pregnant women for psychological and social risk factors (Bréart, Puech, and Rozé 2004). In the summer of 2014, a series of articles in the *New York Times* described the possible fatal outcomes of women with postpartum depression and called for more screening for signs of psychological distress in pregnant women, a proposition that received many supportive comments.<sup>1</sup> In a similar vein, the 2014 edition of *Williams Obstetrics*, the principal reference book in American obstetrics, asserts that “pregnancy and the puerperium are at times sufficiently stressful to provoke mental illness” (Cunningham et al. 2014, 1175).

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Very few studies explore these contemporary psychological discourses on pregnancy, however. Some medical historians, including [Hanson \(2004\)](#) and [Eisenberg \(2010\)](#), have demonstrated that practitioners of Western medicine have long been concerned about the relationship between the maternal psychological state and fetal development. In fact, the theory of “maternal impressions” suggested that a pregnant woman’s experiences could be inscribed onto the fetal body and mind, and this theoretical framework dominated European (and later American) medical discourses from the sixteenth century through much of the nineteenth century. Medical experts believed that bodily traits (such as malformations or birthmarks) and certain mental characteristics were the result of maternal cravings, experiences, or emotions during pregnancy. The Swiss historian [Arni \(2016\)](#) argues that although the physical aspect of maternal impressions was abandoned by the medical community in the nineteenth century, the mental dimension persisted and is being reconfigured in contemporary research trends. Prenatal psychology, endocrinology, and epigenetics, for example, are academic fields concerned with the ways emotions or stress affect fetal development. This interest translates directly into contemporary pregnancy advice encouraging women to “monitor their mental states, because the hormones associated with stress may affect their fetuses adversely” ([Lupton 2012b](#)). Borrowing from Foucault’s theory of a “government of life” ([2004](#)), I describe this process as the “psychological government of pregnancy,” the practices and discourses aimed at producing knowledge and exerting power over the event of pregnancy (see also [Weir 1996](#)).

Pregnancy care is thus an element of reproductive politics, where sex differences and gender regimes are produced and reproduced ([Ginsburg and Rapp 1991](#); [Mottier 2013](#); [Woliver 2002](#)). This article aims to understand how the discourse of the psychological government of pregnancy impacts prenatal care and contributes to the formation of gendered identity, with a focus on Switzerland. Prenatal care in Switzerland is largely influenced by global trends such as the medicalization of childbirth and risk discourses ([Burton-Jeangros, Hammer, and Maffi 2014](#); [Manai, Burton-Jeangros, and Elger 2010](#)). At the same time, the Swiss government’s long history of coercive reproductive politics—from forced sterilizations to punitive custody interventions ([Furrer et al. 2014](#); [Heller, Jeanmonod, and Gasser 2002](#); [Mottier 2000](#))—paired with the Swiss state’s relatively weak support for families has resulted in a particularly complex culture of reproductive politics ([Burton-Jeangros, Hammer, and Maffi 2014](#)).<sup>2</sup> This article relies on a case study of the Perinatal Unit,<sup>3</sup> a publicly funded program dedicated to promoting child health by providing information and support to pregnant women on the “psychosocial” level and offering free appointments with midwives and social workers but no physical examination or tests. The Perinatal Unit can thus both help understand larger issues in prenatal care as well as illustrate the specificity of the Swiss case (see [Ballif 2017](#)).

Borrowing interpretive tools from Foucauldian discourse and policy analysis (Bacchi 2009, 2012), this study focuses on the discourses and practices of professionals (as opposed to pregnant women's subjective experiences) produced in interaction with other professionals, with pregnant women, or with myself, to analyze the subject positions made available in professionals' discourses and their discursive effects—a focus which echoes previous research on the government of pregnancy and birth through professional practice (Apple 1987; Lee 2014; Oakley 1984). I argue that my interlocutors problematized pregnancy both as a period of psychological vulnerability for women and as a state requiring active management and emotional self-discipline in the name of fetal health. These two frames draw from different psychological subfields—psychoanalysis and child development—and have very different “subjectification” effects (Bacchi 2009, 16–17). On the one hand, pregnant women are presented as passively subjected to their unconscious. This representation of pregnancy as a psychological crisis has its genealogy in psychoanalytical theories developed in the post-World War II period in the United States. On the other hand, employees of the Perinatal Unit considered pregnant women to be responsible and expected them to protect their future child—a management of pregnant women's emotions I call “psychopolitics” in reference to Foucault's biopolitics. The psychological government of pregnancy can thus be understood as a way of policing pregnant women and naturalizing their role in reproduction. This process represents a de-politicizing trend in public health policies that has been largely ignored by scholars.

## Psychosocial Government of Pregnancy

In Europe and North America, during the twentieth century, the experience of pregnancy became increasingly medicalized (Davis-Floyd 1992; Hanson 2004; Oakley 1984). Gynecology and obstetrics claimed the authority to supervise pregnant women by marginalizing midwives, although the degree and speed of this medicalization varied from country to country (De Vries 2004; Katz Rothman 1982; Walzer Leavitt 1986; Wertz and Wertz 1977). The surveillance of pregnant women has become more sophisticated over time, with technological innovations enabling obstetricians and gynecologists to claim an increasingly detailed knowledge of fetal health and development (Arney 1982; Barker 1998; Burton-Jeangros, Hammer, and Maffi 2014; Fox, Heffernan, and Nicolson 2009). Today, an elaborate “discourse of risk” shapes the regulation of pregnant bodies and legitimates a host of “pregnancy rules” intended to help women avoid pregnancy complications and damage to the fetus (Lupton 1999; Ruhl 1999).

Scholars have also addressed how, once the children were born, medical professionals were not the only experts surrounding parents. The psychology of parenting—specifically mothering—and its effects on parenting roles has been well

documented (Ladd-Taylor and Umansky 1998; Lee 2014; Urwin and Sharland 1992). According to the latter, mental health experts inform the social regulation of child-rearing, contribute to the construction of motherhood as a subject of scientific research (Apple 1987), and position mothers as the sole responsible agent for their child's mental health (Eyer 1996; Jones 1998).

Less attention has been paid to the emergence of another trend: the increasing focus on the mental health of pregnant women. Several, sometimes opposing, professional groups suggest that an emphasis on mental *as well as* physical health of pregnant women would best aid maternal and child health. In some contexts, advocating for better mental health care of pregnant women emerges as a critique of medical care of pregnancy but the demand also appears in medical discourse. In the 1960s, midwives began to articulate their professional identity as encompassing the concept of "holistic," "women-centered," or "biopsychosocial" support for pregnant women (Davis-Floyd 1992; De Vries 2004; Katz Rothman 1982). As part of a critique of the "medical model of pregnancy" (Katz Rothman 1982), modern midwives developed a holistic approach to maternal health. As practitioners, they promote a "natural" and non-technological approach to pregnancy and childbirth. Some traditional medical practices have also recently adopted a holistic perspective on pregnancy and childbirth. Despite the partial alignment of both medicine and midwifery on this topic, holistic care remains a rallying concept for midwives internationally and demonstrates an alternative mode of conceptualizing pregnancy that advocates for better attention to the psychological aspects of pregnancy and childbirth.

Practitioners in the fields of psychology and psychiatry also claim jurisdiction over pregnant women, and the mental health of pregnant woman is often the subject of public health policies. In 2008, the WHO began a global campaign for better mental health care for pregnant women (World Health Organization 2008, 2015). In anticipation or in response to this demand the United States and Australia, among others, implemented screening programs to detect depression during and after pregnancy (Buist et al. 2002, 2008; Committee on Obstetric Practice 2015; Siu and US Preventive Services Task Force 2016).

Taken together, these policies and expanded oversight formed a new psychological government of pregnancy. However, despite this fundamental shift in the role of pregnancy-related mental health, social scientists have paid very little attention to the topic, in contrast to the widely researched issue of the medicalization of pregnancy. This trend, especially in Switzerland, merits further consideration because it raises many questions about women's rights and social agency as they relate to national and health care policies.

## The Perinatal Unit

My analysis is based on two years of fieldwork in a perinatal counseling unit in French-speaking Switzerland. Founded in 1986, the Perinatal Unit

developed in response to a federal law requiring every Swiss canton to provide free information to pregnant women.<sup>4</sup> It is operated by a private institution but publicly financed—as is common for Swiss health and social policies.<sup>5</sup> The unit comprises nine regional centers and employed about twenty midwives and social workers (including a chief midwife and a chief social worker) and a chief of unit at the time of my fieldwork. The staff was entirely female. The goal of the unit, according to its website, is to offer “information, support, and orientation” during pregnancy in regard to “psychosocial” aspects—the unit does not offer medical care and positions itself as a (necessary) complement to medical supervision. During a typical appointment, pregnant women are asked about their general well-being, emotional state, financial, and professional situation, and provided with information about health care access, social services, or support groups.

Between 2011 and 2013, I attended about sixty meetings (continuing education, administrative organization, team building, or case discussions), thirty-one appointments with pregnant women and couples, and conducted semi-structured or free interviews with every member of the staff, in order to understand how they provided pregnant women with “a specific *technic* of pregnancy” (Kukla 2005, 128, emphasis in original). In this article, I focus primarily on the Unit’s midwives, since they addressed the psychological dimension of pregnancy more explicitly than their social work counterparts. In Switzerland, hospital-based and independent midwives attend most child-births. They also provide care during pregnancy, although most of the pregnant women will continue to consult their obstetrician-gynecologists during pregnancy. Some of the counseling midwives of the Perinatal Unit still practice as independent midwives alongside their counseling activity.

The PU proves an interesting case study for several reasons. First, it appears to be one of very few examples in Europe or North America of a social service targeting solely the *psychosocial* dimension of pregnancy. Since the PU aims to reach the whole population and not specific “at risk” groups, pregnancy in this context is framed as a psychosocial “problem” for any pregnant woman. This implicitly echoes Switzerland’s long history of eugenicist politics aiming at promoting the quality of future generations through “positive” measures such as sexual education and marriage advice (Mottier 2005). Second, even though prenatal care in Switzerland is very medicalized (Burton-Jeangros, Hammer, and Maffi 2014), psychoanalysis has had a direct influence on the Swiss medical curriculum and on the country’s educational policies since the 1950s (Despland and Berney 2012; Fussinger 2008; Odier Da Cruz 2013). Switzerland is often considered one of the cradles of psychoanalysis. Swiss psychologists and psychiatrists adopted a Freudian approach to the field in the early decades of the twentieth century, even before their German and French counterparts (De Mijolla 1992; Haynal 2009). Although it is important to bear in mind that this dialectic might prove very different in other contexts, this case illustrates how psychological discourse can be used as a critique of

dominant (medicalized) prenatal care and a way to advertize for a certain type of prenatal care.

## Pregnancy as a Psychological Problem

In the unit's only extensive booklet, the former (now retired) chief midwife and chief social worker of the PU explained the importance of their intervention during pregnancy by referring to psychological concepts.

Today maternity is considered as a particular phase of a woman's development: the *maternity*. This period, beginning at conception, only ends several months after childbirth. "Like adolescence, it is an identity crisis with large-scale hormonal movements, a questioning of traditional positions, of concrete and socially relevant achievements, a complex game of identifications that undergo a new adjustment. It is a natural and maturational crisis but, essentially, a zone of fragility" (Dr. Antoinette Corboz, psychotherapist . . .). Within a few months, the woman undergoes considerable physical, physiological and psychic modifications. Her position in the family changes as does her social status in the eyes of her relational circle. (Perinatal Unit, my translation, emphasis in the original)

Here, the authors compare pregnancy to adolescence and frame it as a crisis in a woman's life. The same discourse surfaced in several of the interviews with the members of the unit. Caroline was the first to introduce this topic. While explaining that her consultations are useful for every future parent regardless of their social or economic background, she shared her vision of her role.

For everybody, [pregnancy] is going to be a time where we must listen to them because they are in a time of their life where they are a little fragile and destabilized. So it will be a time for settling down, figuring things out, and exchanging, a time for listening. . . . We try to give them words to express what they are experiencing. They know that a big change is going to happen, especially within their partnership, so they feel insecure: "How is this going to impact my relationship? How can I—." We can work to make sure the couple sustains their relationship in this trial. Statistics show that one out of every two couples breaks up in the region, that's huge! And it happens mostly during the first years of the children's lives. So it's true that it's really the birth of children that destabilizes couples. So that's why it is such a time of vulnerability. (Interview with Caroline, April 2, 2012, my translation)

Using a psychological vocabulary, Caroline described pregnant women and expecting couples as experiencing an overwhelming and threatening process.

She frames pregnancy as the cause of various troubles, from forcing women to change their relationship with their own mother to putting the (assumed and heteronormative) marital balance into jeopardy to creating an urge for introspection. Cécile, another midwife, mentioned this last point in an interview with me.

It's true that during pregnancy a woman is totally open in her entire being. She wants everything to go well for her baby so it's the right time to reexamine things—They have that kind of openness. (Interview with Cécile, July 10, 2012, my translation)

This psychological representation of pregnancy forms the core argument by which the members of the PU define their work. Providing psychosocial counseling to pregnant women is useful, necessary, and legitimate *because pregnancy is intrinsically problematic*, providing either an opportunity for development, or posing a risk to one's psychological balance.

This “problematization” of pregnancy constitutes it as a psychological “object for thought” (Foucault 1988, 257). How did pregnancy become a psychological problem? In his description of the contemporary rise of a “therapy culture” in the United Kingdom and in the United States, sociologist Furedi (2004) argues that a therapeutic ethos tends to redefine daily experiences as potentially damaging for the individual. “The variety of encounters and experiences which are said to overwhelm the individual has increased enormously in recent decades. Even some of the most elementary adult roles such as parenting have been redefined as skills requiring professional support” (2004, 122). The self is portrayed as ontologically vulnerable and requiring counseling. The vulnerability of the self takes place in a Western “culture of emotionalism,” where one's internal emotional world needs daily attention and where the authority of “psy” experts is asserted (Castel and Le Cerf 1980; Rose 1985).

Mothering practices represent a striking example of this process. Beginning in the nineteenth century, mothering was increasingly considered as an activity for which both European and North-American women needed to seek professional advice and support (Apple 1987; Lee 2014). In a case study of a Swiss “School for parents” (an institution offering activities to help parents in the childrearing practices), Odier Da Cruz (2013) shows how psychological experts define “good parenting.” Both medical and psychological expert discourses are translated into the vast amount of childrearing advice literature that European and North-American parents are exposed to (Marshall 1991; Urwin and Sharland 1992).

One might argue that it was an extension of the growing psychological interest in children's development that gave birth to prenatal psychology. Developments in attachment theory suggest such a shift. This highly influential field of psychological theory framed maternal attachment in early infancy

as a condition for future mental and emotional balance. Primarily interested in disorders in children's behaviors, attachment theory gradually moved to the description and promotion of normal mother-child relations (Kanieski 2010). Eventually, maternal-fetal attachment scales were created (Lupton 2012a), making the prenatal period an object of psychological interest for children's development. Although this hypothesis proves fruitful, the problematization of pregnancy is more than a mere extension of the preoccupation for a child's development. I argue that the psychology of pregnancy has a distinctive genealogy in psychosomatic and psychoanalytical thought. The "crisis" model of pregnancy has a distinctly woman-centered, rather than child-centered, form.

## Genealogy: The "Crisis" Model of Pregnancy

Drawing on my interlocutors' own references and suggestions, I developed a genealogy of the psychology of pregnancy. Because my research process moved from my fieldwork to early scholarship in the field of maternal psychology, my genealogy moves in a reverse chronological order. I follow the trajectory of the "crisis" model of pregnancy to Switzerland, via French psychiatry, from the psychoanalytical theories developed mid-century in the United States.

When I asked my interlocutors to describe how they problematized pregnancy, they pointed me to the work of two French psychoanalysts and psychiatrists: Monique Bydlowski and Françoise Molénat. Both were hired by maternity hospitals in France in the 1970s and 1980s to offer care and conduct research on the mental health of pregnant women and mothers. Molénat (1992, 2009) describes the special "vulnerability" of pregnant women while Bydlowski defines pregnancy as a state of "psychic transparency" where "fragments of the unconscious become conscious" (1991, 136, my translation) and compares the "crisis" of pregnancy to the experience of adolescence. Both are fervent advocates of the systematic incorporation of a psychiatric approach into prenatal care. Molénat acquired national fame thanks to her instrumental role in the implementation of the Perinatal Plan 2005–2007, the most recent of three nation-wide French programs aimed at reforming childbirth practices in hospitals (Bréart, Puech, and Rozé 2004).

Bydlowski's and Molénat's writings are not based on empirical research but draw their authority from references to earlier theorizations of pregnancy by prominent psychiatrists. The "crisis" model of pregnancy was first formalized as a psychoanalytical theory in the United States after World War II. Specifically, the work of psychoanalysts and psychiatrists Helene Deutsch (1884–1982), Therese Benedek (1890–1977), and Grete Bibring (1899–1977) led to the formulation of a coherent psychoanalytical theory of pregnancy. While some of their fellow psychiatrists had already researched the psychopathology of pregnancy (Eisenberg 2010), Deutsch, Benedek, and Bibring



focused on *normal* (non-pathological) pregnancy. All three women had studied medicine and psychoanalysis in Europe before emigrating to the United States between 1935 and 1941, along with forty other European psychoanalysts fleeing the Nazi regime (Coser 1984; Zaretsky 2004, 288–89).

Deutsch, Bibring, and Benedek shared a psychosomatic approach to pregnancy, framed as a tremendous upheaval on the somatic as well as the unconscious level, a process that brought past unconscious contents to the fore. Deutsch was the first to publish this definition of pregnancy in her two-volume study *The Psychology of Women: A Psychoanalytical Interpretation* (1944, 1945). A close student of Freud, Deutsch was the first psychoanalyst ever to specialize in women's psychology. In the late 1930s, she was already the most famous psychoanalyst in the United States (Buhle 1998, 180) and later trained numerous psychiatrists (Coser 1984, 50–54). She approached motherhood as inherent to a feminine personality and a biological imperative, a deterministic, and essentialist vision shared by Benedek and Bibring. She also insisted that pregnancy “may disturb the psychic balance” (1945, 144). In particular, the relationship of a pregnant woman with her mother are considered “at the center of the psychological problems of pregnancy” (1945, 141). Deutsch went so far as to claim she had observed several miscarriages provoked by tensions in the mother–daughter relationship (1945, 143).

Benedek (1952, 1959), Bibring (1959), and Bibring et al. (1961a, 1961b) drew from Deutsch's work while framing their definition of pregnancy in developmental terms. They claimed that pregnancy is a critical phase in a woman's psychic development. While Benedek soberly described pregnancy as a “maturational step,” Bibring called it a crisis.

Pregnancy, like puberty or menopause, is a period of crisis involving profound psychological as well as somatic changes. These crises represent important developmental steps and have in common a series of characteristic phenomena. In pregnancy, as in puberty and menopause, new and increased libidinal and adjustive tasks confront the individual, leading to revival and simultaneous emergence of unsettled conflicts from earlier developmental phases and to the loosening of partial or inadequate solutions of the past. (Bibring 1959, 116)

The crisis of pregnancy is what enables girls to transform into women, according to this deterministic view of women's development. Bibring was the first psychoanalyst to explicitly advocate for a “better preventive psychiatric management of pregnancy” (1959, 120), and she believed that a psychoanalytical approach should be integrated into medical prenatal care. She expected pregnant women to welcome the advice of experts and willingly submit themselves to therapeutic work.

The work of Deutsch, Benedek, and Bibring forms the basis of what I call the psychology of pregnancy. They form a relatively coherent discourse and

have often been cited together. Despite some resistance, the psychology of pregnancy has flourished in the United States since the 1950s. Prominent psychiatrists and obstetricians followed Bibring's recommendation to include psychiatrists into prenatal care, eventually leading to the inclusion of psychoanalytical theories into medical pregnancy care starting in the 1950s (Eisenberg 2010, 123–27). As the examples cited in the introduction demonstrate, today the idea that a woman's psyche can cause serious problems for a pregnancy is considered mainstream gynecological knowledge. In recent decades, the psychoanalytical jargon of this discourse has shifted into more general calls for greater awareness about stress and early signs of what might develop into postpartum depression (Godderis 2010). In francophone psychiatry, the concept of "perinatality," which usually designates the period between the twenty-eighth week of amenorrhea and the seventh day of the child's life, has become a domain in its own right (Dayan, Andro, and Dugnat 1999; Missonnier 2005).

This success of psychoanalytic models within prenatal medicine might be partly explained by the resonance of the "crisis" model of pregnancy with the cultural representations of pregnant women as mentally unsound and emotionally unstable, an "insanity of pregnancy" that historian Hanson (2004) traces back to nineteenth-century British medical textbooks. The reformulation of the insanity of pregnancy into psychoanalytical theory awarded a new legitimacy to this older discourse. Eisenberg (2013), a medical historian, argues that the impact of the psychology of pregnancy can also be identified in the American "natural childbirth" movement that developed from the 1950s, drawing from British obstetrician Dick-Read's conviction that well-prepared expectant women only need minimal medical intervention for childbirth. Natural childbirth and parenting advocates claim that a proper psychological preparation is necessary for "good mothering" practices (see also Blum 1999).

More surprisingly, the "crisis" model of pregnancy made its way into the United States women's health movement alongside feminist sociology and anthropology.<sup>6</sup> In 1970, the very first version of *Our Bodies, Ourselves*—the popular women's health book whose subsequent editions remain best-sellers in the United States—seems to echo psychoanalytical hypotheses. In the chapter on pregnancy, reminiscence of old unconscious contents is mentioned.

Throughout the pregnancy there will be negative feelings and thoughts, during general depressions and especially if a woman feels threatened, angered, and upset by it. The depressions are perhaps related to all the underground anxieties we have in relation to our own mothers and our childhoods. (Pincus and Bell 1970, 113)

Two decades later, birth sociologist Katz Rothman praised the midwifery model of birth (as opposed to the medical model) for considering pregnancy

as “a period of *psychological* as well as physical growth and development” (Katz Rothman 1982). Leading birth anthropologist Davis-Floyd described pregnant women as experiencing “rapid psychological growth and change” and “a continuous state of upheaval as old ways of thinking change to include a new life” (1992, 24). She argued that during pregnancy a woman is “in much closer touch with her own childhood experiences, allowing old, deeply buried thoughts and emotions to surface” and in a “psychological state of openness and receptivity” (1992, 24–25). When I described my research to feminist scholars, I was often met with a very positive view of the psychology of pregnancy and regularly encountered statements asserting that pregnant women were indeed psychologically vulnerable.

The psychology of pregnancy and the way it travelled in the United States and Europe has attracted surprisingly few critical comments. Some of Deutsch’s biographers go so far as to celebrate her as a feminist, lauding her pioneering and progressive vision of women (Appignanesi and Forrester 1992; Roazen 1985; Sayers 1991; Webster 1985). Benedek is celebrated as a precursor of female psychosexual development theories (Schmidt 2004; Weiss Cooper 2007). We should, however, look more critically at the “subjectification” effects of these discourses (Bacchi 2009, 16–17; Foucault 1982). Which subject positions does the “crisis” model of pregnancy make available?

The “crisis” model frames pregnant women as passive and driven by powerful processes they cannot master. Deutsch goes so far as to assert that pregnant women are “hardly ever intellectually aware of [their] deepest psychic experiences” (1945, 137). This representation resonates with the cultural representation of the feminine body as less controllable than the masculine one. As Lupton puts it, “particularly in states such as menstruation, pregnancy, and menopause, the female body is culturally portrayed as chaotic, subject to hormonal and emotional fluctuations and instabilities” (2012b, 333). Psychoanalytical theories of pregnancy blend the “unruly” biological character of the female body (Kukla 2005) with the rule of the unconscious. In turn, this representation of women as unable to control their psyche renders them dependent on experts. Psychoanalysis is a prime example of the “deskilling” effects of expertise, to borrow from Giddens’s (1991) analysis of modern expert systems. Because of the very essence of their object—the unconscious—women are positioned as needing the mediation of “psy” professionals to grasp the full extent of their transformation.

The assimilation of psychic processes to physiological changes—and their supposed uncontrollable nature—gives a universal and natural character to the psychic processes of pregnancy, constructing the pregnant woman as a generic figure. The crisis is supposed to affect every pregnant woman regardless of her psychological state, or the social and economic contexts of her life. Even the difference between *primi-* and *multigravidae* (i.e., woman going through their first or subsequent pregnancy) is ignored, leaving the reader to wonder if a woman is bound to reenact her past conflicts through each of her

pregnancies. Bibring and Benedek do not mention childless women in their developmental model, and one can only deduce that they cannot have acquired the same maturity as mothers and forever linger in a previous developmental stage.

The influence of the psychology of pregnancy is obvious in the PU, as demonstrated by my interlocutors' use of Deutsch's, Benedek's, and Bibring's tropes. Every midwife and social worker at the PU is strongly encouraged to follow a continuous education with Molénat in person. Bydlowski's and Molénat's work was frequently cited to me as a reference. How can we account for the use of the "crisis" model of pregnancy in the PU, as well as in certain feminist literature? I think the woman-centeredness of the psychology of pregnancy has played a role in the diffusion of these ideas. The fetus is practically absent from these discourses that focus on women. When I asked the members of the PU if they understood their work as a feminist engagement, they almost all replied that they wanted to promote "women's well-being," their "right to health," to "autonomy," and to "solidarity," a vocabulary that echoes feminist health movements of the 1970s and beyond. In addition, they all shared a differentialist vision of gender, arguing that women were essentially different from men. Their engagement as women for women was not exclusive, though, as the priority given to the fetus in the regulation of emotions shows.

## A "Psychopolitics" of Emotions

Biopolitics has been used as a theoretical framework to analyze the way pregnant bodies are governed in Western societies. Pregnant women in Europe and North America are surrounded by "pregnancy rules" (Oaks 2001). They are expected to carefully choose their diet, eliminate alcohol, tobacco and select drugs, and submit their body to regular medical checks (Duden 1993; Lupton 1999). The overall objective of this regulation is the "production of a normal infant" (Lupton 1999, 64). But what about the regulation of pregnant *psyches*? I suggest that the case of pregnancy invites us to inquire into the ways the governance of daily life entails forms of "psychopolitics" (Orr 2006): apparatuses and discourses that aim at ensuring the psychological and mental health of citizens.<sup>7</sup> In what follows, I concentrate on two instances where I observed midwives explicitly encourage their clients to manage their emotions.

The first incident took place in December 2012, when I attended a meeting in one of the regional centers of the unit where the professionals discussed Mrs. C.<sup>8</sup> Introduced by the midwife Julia, Mrs. C. was described as a twenty-seven-year-old pregnant woman who had just broken up with her partner and had come to the PU for various appointments. During one appointment, Mrs. C.'s partner had asked that a paternity test be performed. Mrs. C. reacted

very angrily to what she understood to be a challenge to her fidelity. In the following appointments, Julia sought to encourage her to take the test so as “not to have any doubts” and to secure her rights to child support.

I met Mrs. C. again on October 9, she came alone. It allowed me to talk about paternity testing, to explain its meaning, and to say it’s not against her, the usual blah blah. And then she was so angry, she said very aggressive things like “I’ll beat him up!” I tried to calm her down, I came back to her pregnancy, I showed her some pictures. And she calmed down. Then I said I was struck to see how violent she was. I said “The words you said, the things you say. . . . You are pregnant, you know!” I didn’t want to make her feel guilty, but to tell her “Not only will your child not be able to live in an environment where people are threatening each other and are being violent, but right now, when you are talking, when you are screaming, your child hears things! You will have to work on that anger in order to cool down.” We did a few relaxation exercises. I encouraged her to learn how to manage her emotions. I am worried. (Field notes, December 4, 2012, my translation)

In this, Julia engaged in a “pedagogy of affects” (Ameeriar 2015) by encouraging Mrs. C. to manage her anger instead of investigating, and possibly alleviating, the conditions that cause her distress. Julia’s discourse suggests that Mrs. C. is responsible for the proper management of her emotions. Ruhl (1999) has argued that contemporary American prenatal care relies on a model of pregnancy as “individualized risk.” American care providers expect the “responsible pregnant woman” (1999, 95) to individually and rationally ensure the protection of her fetus. Ruhl argues that the “didactic rhetoric of responsible pregnancy” (1999, 112) is pervasive in pregnancy advice literature. In Switzerland too, risk discourses are an intrinsic feature of prenatal care (Hammer and Burton-Jeangros 2013; Manai, Burton-Jeangros, and Elger 2010). Here, Julia assumes the role of an authoritative expert and frames Mrs. C.’s emotions as a risk that requires active (self-)management.

A second example illustrates the way psychopolitics operate in the PU. In July 2013, I was observing an appointment between Alexandra, another midwife, and Mrs. L, a thirty-five-year-old primigravida whose partner had left her when he learned about the pregnancy.

Alexandra: Do you feel less well at times?

Mrs. L.: Yes, when I come back from work alone, I have a hard time cooking only for myself. Sometimes I cry alone, I let steam out. But I am afraid it could affect the baby. So I talk to him,<sup>9</sup> I tell him it’s not his fault, that it’s because of his father, that he chose not to be here, and I have to accept that but that it’s not against him. I try to reassure him.

Alexandra: Why do you think he feels that?

Mrs. L.: Because people say that hormones are very much linked, psychologically, with the fetus and all, and that he receives everything.  
Alexandra: You can forget that. It's not true at all. What the child feels is stress, because when not enough blood arrives in the placenta, it leads to a rigidity of the arteries, and this can cause growth retardation. But as long as you simply have emotions, which are natural in your case—We are humans after all! Tell yourself that it's even good for the child that you cry, you are a mother, a natural woman, alive, that's what he needs. It wouldn't be good to stop yourself. Guilt is very bad for the child. You are doing very well, you tell him things, you tell him it's hard. The child will be able to put that into a drawer, tell himself it's not his fault, he won't carry that. (Field notes, July 8, 2013, my translation)

Here, as in the previous example, body and emotions are intertwined in Mrs. L.'s interpretation of her own experience of the pregnancy and in Alexandra's answers. Both articulate their views in psychosomatic terms but whereas in the previous incident anger was unilaterally framed as a negative emotion to be suppressed, here Alexandra introduces Mrs. L. into a moral economy of emotions where "natural" grief is harmless while stress and guilt are harmful. My fieldwork suggests that midwives modulate their interpretation of emotions according to their client's situation. In every context, they framed emotions perceived as harmless as "natural."

Another common characteristic of the emotional management discourses I witnessed at the PU is the central place given to the figure of the fetus. Both Julia and Alexandra used the word "child" to designate the fetus, as is common in the PU. This figure, what I refer to as the fetus-as-future-child, is ambiguous. It is both a fetus rendered present in the conversation (through allusions to what the fetus presently hears and feels) and a child projected into the future. Feminist discussions of fetal representations often argue that the surveillance of pregnant women coincides with the growing tendency to represent the fetus as an individual, a person, a human being (Kukla 2005; Oaks 2000). Here, the expectations of maternal emotional responsibility rely on the dual temporality in which the fetus is discursively placed. As a fetus in the present, it is represented with the capacity of hearing and feeling; as a child in the future, it will have to cope with the consequences of its experiences. In her analysis of medico-scientific discourses on fetuses, Franklin describes "fetal teleology" as the representation of fetuses as potentials: "there is . . . not only a focus upon the fact that it is constitutionally (ontologically) an individual person, but on the fact that it is developmentally a potential human adult" (1991, 197).

In terms of subject positions, the fetus is vulnerable. This image resonates with other contexts in Europe and North America where the fetus is represented as vulnerable and in need of protection: in anti-abortion politics,

anti-smoking campaigns, contemporary pregnancy advice, or fetal medicine (Bitouzé 2001; Hartouni 1992; Kukla 2005; Lupton 2012b; Oaks 2000). This fetus is denied agency and caught in a model of “parental determinism” (Furedi 2002): its future is defined by its parents’—its mother’s—actions.

The fetus-as-future-child is the ultimate reason given for Mrs. C. and Mrs. L.’s necessary self-discipline. Psychopolitics in the PU operate here in preserving the emotional state of the fetus-as-future-child. The “quest for the perfect child” (Lupton 1999, 67) is typical of biopolitical apparatuses. The PU can be understood as a typical “regime of anticipation,” reaching before birth to “allow tactical interventions to prevent and/or enable imagined futures” (Adams, Murphy, and Clarke 2009, 251). Anticipatory politics govern the present accordingly to possible futures. Based on her study of maternity care in Germany, the sociologist Eva Sängler interpreted pregnancy as an exemplary site of anticipation, highlighting “discursive strategies in which the foetus and the pregnant woman are addressed as if the foetus were already born and the pregnant woman already a mother, as opposed to *becoming* an infant or *becoming* a parent” (Sängler 2015, 106, emphasis in original).

Whereas the psychoanalytical approach to pregnancy as a crisis has a distinct woman-centered tone, the frame of pregnancy as a preparation for the fetus-as-future-child’s life is definitely child-centered. This resonates with another aspect of the mission of the PU: to promote children’s health and prevent child abuse. Particularly in cases of parental conflicts or domestic violence, members of the PU explained that they tried to place the (future) child at the center of their intervention. Even though Swiss laws do not grant any legal status to fetuses, PU employees frequently told their pregnant clients that their fetus, as a future child, had a “right” to know both parents and to live in a safe environment.

## Conclusion: Silences of the Psychological Approach to Pregnancy

The two approaches of pregnancy in the PU—woman-centered and child-centered—could be interpreted as operating in blunt contradiction. As Lealle Ruhl has observed, the pregnant woman is simultaneously “her foetus’ most ardent protector or its most dangerous threat” (1999, 97). My fieldwork suggests that these two discourses coexist within the same context. Rather than being in conflict, they reflect the double engagement of perinatal counselors for woman and fetuses. Other aspects of the experience of pregnancy, however, are left aside. Locating the problem in the individual obscures the social conditions in which pregnancy happens. In other words, the psychologization of social problems means their desocialization (Armstrong 2003, 11–12) and displacement beyond the reach of social action. This has important implications for the rights of women, precisely because the expanding psychological government of pregnancy rarely addresses the social or environmental issues



that impact women's health. In the case of the PU, the presence of social workers in the unit mitigates this obfuscation of contextual issues.

More research is needed to understand the effects of psychopolitics in prenatal care in other contexts. However, the case study presented here highlights some larger consequences of the de-politicizing effects of psychopolitics. First, as the philosopher Rebecca Kukla notes, the emphasis on the pregnant person happens "at the direct and tragic cost of sufficient attention to the many other crucial determinants of maternal and child health . . . such as domestic violence, environmental damage, and the ravages of poverty" (2005, 136). Second, the psychological lens reinforces the representation of pregnant women alone being responsible of their future child's physical and mental health. Ladd-Taylor and Umansky (1998) argue that psychological discourses were instrumental in positioning mothers as solely responsible for the provision of a healthy environment for their children. As in the case of anti-smoking advice (Oaks 2000) and fetal abuse (Schroedel and Peretz 1994), paternal influences on fetal health are largely silenced. In the PU, pregnant women are routinely encouraged to invite the future father or their partner to the appointments. Midwives and social workers often told me how important it was for them to acknowledge the transformation men also experienced during pregnancy but my observations lead me to conclude that men were primarily encouraged to support, surround, and "be there" for pregnant women—their subjectivity was never the focus of discussions. This observation can be extended to the role of the pregnant woman's entourage of partner(s), grandparent(s), and friends.

Third, when observed from a "psy" point of view, "pregnanthood" seems to be closely intertwined with femininity and with motherhood. Pregnancy happens to a *woman* who is becoming a *mother*. Thus, analyzing psychological discourses of pregnancy should prompt further interrogation of the very concept of "pregnant woman" and its seemingly natural definition. As Walks' analysis of the pregnancy experiences of butch lesbians, transmen, and genderqueer illustrates (2013), identifying as a woman is neither inherent nor necessary to the experience of pregnancy—an observation that easily extends to all pregnant persons. The overwhelming cultural association of pregnancy with normative femininity contributes to the further marginalization of non-heteronormative experiences of gestation. Furthermore, pregnancy does not always lead to motherhood (or parenthood, for that matter). Abortion, miscarriage, adoption, or death (of the pregnant person or the newborn) can disrupt this seemingly natural process and the ideology of the "willed pregnancy," as Ruhl (2002) puts it. The social script requiring pregnant persons to anticipate the birth of their child acts to silence these possibilities in favor of a singular, normative future: motherhood. Analyzing the seemingly natural characteristics of "pregnanthood" reveals the marginalizing effects of psychological discourses—and thus calls for further feminist attention.



## Notes

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1. See Pam Belluck's articles on June 15 ("Thinking of Ways to Harm Her': New Findings on Timing and Range of Maternal Mental Illness") and June 16 ("After Baby, an Unraveling: A Case Study in Maternal Mental Illness"), and the many letters to the editor on June 21 ("Postpartum Depression") and June 23, 2014 ("Support for New Mothers"). Accessed June 28, 2018, [www.nytimes.com](http://www.nytimes.com).
2. While explicitly eugenicist policies no longer exist, some reproductive rights have until recently, or are still, restricted in Switzerland: abortion has been legalized only in 2002 at the federal level; paid maternity leave was established in 2004 on the federal level; access to medically assisted procreation remains restricted and not funded through (compulsory) medical insurance; egg donation and surrogacy are not allowed.
3. This is a pseudonym, as are the names of all the interviewees.
4. This law was a by-product of ongoing political debates around abortion legislation in Switzerland. At that time, abortion was officially only available upon medical indication—even though some urban cantons had a more liberal understanding of the law and provided easier and cheaper access to abortion (Engeli 2010). As every attempt to soften the federal legislation was failing, a consensus was nevertheless reached about the necessity of providing information to pregnant women who were considering abortion. When the "law on consultation centers for pregnancy" was passed in 1981, most cantons entrusted pre-existing family planning centers with the task. The case of the PU is unique, since a specific unit was created in response to the law, and because the PU did not seek to address abortion cases but pregnancy more broadly. Eventually, the PU would entirely depart from abortion to be recognized as part of the cantonal prevention program for child's health.
5. It is common in Switzerland for cantons to mandate and fund private organizations to outsource social or health policy-related tasks. The Perinatal Unit is hosted by a private foundation providing public services in the domains of health and reproduction. Their services include perinatal counseling, sex education in public schools, family planning, couple therapy, and counseling to victims of infractions.
6. I qualify researchers as feminists insofar themselves claim this label for their work. Consequently, various subfields of feminist studies are cited in this article.
7. I do not want to suggest that psychopolitics operate in contradiction with but rather along with governmentality of the body. As following examples make clear, body and mind are regulated jointly in the PU.

8. In the PU, women are always called “Mrs.,” regardless of their marital status, as is increasingly usual in Swiss administrations. I follow this use in subsequent transcriptions.
9. In French, “bébé” is a masculine noun and is thus referred to as “he,” which does not necessarily imply that it is thought of as a boy.

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