MEDICAL ANTHROPOLOGY
Health, Inequality, and Social Justice

Reproductive Boundaries

Psychosocial Care and Pregnancy in Switzerland

Edmée Ballif

REPRODUCTIVE BOUNDARIES

MEDICAL ANTHROPOLOGY: HEALTH, INEQUALITY, AND SOCIAL JUSTICE

Series editor: Lenore Manderson

Books in the Medical Anthropology series are concerned with social patterns of and social responses to ill health, disease, and suffering and how social exclusion and social justice shape health and healing outcomes. The series is designed to reflect the diversity of contemporary medical anthropological research and writing and will offer scholars a forum to publish work that showcases the theoretical sophistication, methodological soundness, and ethnographic richness of the field.

Books in the series may include studies on the organization and movement of peoples, technologies, and treatments; how inequalities pattern access to these; and how individuals, communities, and states respond to various assaults on well-being, including from illness, disaster, and violence.

For a complete list of titles in the series, please see the last page of the book.

REPRODUCTIVE BOUNDARIES

Psychosocial Care and Pregnancy in Switzerland

EDMÉE BALLIF

RUTGERS UNIVERSITY PRESS
New Brunswick, Camden, and Newark, New Jersey
London

Rutgers University Press is a department of Rutgers, The State University of New Jersey, one of the leading public research universities in the nation. By publishing worldwide, it furthers the University's mission of dedication to excellence in teaching, scholarship, research, and clinical care.

ISBN 978-1-9788-4052-2 (cloth)
ISBN 978-1-9788-4053-9 (paper)
ISBN 978-1-9788-4054-6 (epub)

Cataloging-in-publication data is available from the Library of Congress.
LCCN 2025031230

A British Cataloging-in-Publication record for this book is available from the British Library.

The prepress stage of this publication was published with the support of the Swiss National Science Foundation

♾ The paper used in this publication meets the requirements of the American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1992.

rutgersuniversitypress.org

To Abel and Victor

CONTENTS

FOREWORD

LENORE MANDERSON

The Medical Anthropology: Health, Inequality, and Social Justice series is concerned with the diversity of contemporary medical anthropological research and writing. The beauty of ethnography is its capacity through storytelling to make sense of suffering as a social experience and to set it in context. Central to our focus in this series, therefore, is how social structures, political and economic systems, and ideologies shape the likelihood and impact of infections, injuries, bodily ruptures and disease, chronic conditions and disability, treatment and care, and social repair and death.

Health and illness are social facts: the circumstances of maintaining and losing health are always and everywhere shaped by structural, local, and global relations. Social formations and relations, cultures, economies, ecologies and political organizations all shape experiences of illness, disability, and disadvantage. The authors of the monographs in this series are concerned centrally with health and illness, healing practices, and access to care, but in the different volumes, they highlight the importance of such differences in context as expressed and experienced at individual, household, and wider levels. Health risks and the outcomes of social structures and household economies (for example, health systems factors), as well as national and global politics and economics shape people's lives. In their accounts of health, inequality, and social justice, the authors move across social circumstances, health conditions, geography, and their intersections and interactions to demonstrate how individuals, communities, and states manage assaults on people's health and well-being.

As medical anthropologists have long illustrated, the relationships between social context and health status are complex. In addressing these questions, the authors in this series showcase the theoretical sophistication, methodological rigor, and empirical richness of the field while expanding a map of illness, social interaction, and institutional life to illustrate the effects of material conditions and social meanings in troubling and surprising ways. The books reflect medical anthropology as a constantly changing field of scholarship, drawing on research in such diverse contexts as residential and virtual communities, clinics, laboratories, and emergency care and public health settings; with service providers, individual healers, and households; and with social bodies, human bodies, biologies, and biographies. While medical anthropology once concentrated on systems of healing, particular diseases, and embodied experiences, today the field has expanded to include environmental disasters, war, science, technology, faith,

gender-based violence, and forced migration. Curiosity about the body and its vicissitudes remains a pivot of our work, but our concerns are with the location of bodies in social life and with how social structures, temporal imperatives, and shifting exigencies shape life courses. This dynamic field reflects the ethics of the discipline to address these pressing issues of our time.

As the subtitle of the series indicates, the books center on social exclusion and inclusion, social justice, and repair. The volumes in this series illustrate multiple ways that globalization and national and local inequalities shape health experiences and outcomes across space, how economic, political, and social inequalities influence the likelihood of poor health and its outcomes in different settings. At the same time, social and economic relations enable the institutionalization of poverty: they produce the unequal conditions of everyday life and work and hence powerfully influence who gets sick and who is most likely to survive. The books challenge readers to reflect on suffering, deficit, and despair within families and communities while they also encourage readers to remain alert to resistance and restitution—to consider how people respond to injustices and evade the fissures that might seem to predetermine their lives.

Edmée Ballif's volume, *Reproductive Boundaries: Psychosocial Care and Pregnancy in Switzerland*, brings us to an unlikely setting to consider questions of inequality and justice. Switzerland is one of the wealthiest countries of the world, with an exceptionally high standard of living, low rate of unemployment, and a strong social security system. Reproductive health care, although largely medicalized there as elsewhere, offers women various options with state sanction and support: They typically deliver with midwife assistance and can deliver at home. Birth is therefore framed as an event that extends beyond medicalized dimensions and hospital settings. In support of this wider view of reproduction, the confederation and canton governments in Switzerland define pregnancy, birth, and the postpartum period as family and personal events and so as psychosocial; services appropriate to this construction are consequently provided. Informed by twentieth-century developments in psychology and psychoanalysis, as understood by French and Swiss therapists and clinicians, economic, interpersonal, social, and personal factors are all delineated as critical to people's experiences of reproduction. No longer only a medical event analogous to illness, pregnancy is now also framed as a psychological ordeal.

The medicalization of pregnancy dates from early twentieth-century shifts in the locus of power over reproduction from midwifery to obstetrics, when women's surveillance was designed to prevent or urgently intervene in the case of preeclampsia, obstructed labor, septicemia, or hemorrhage. Although such measures were driven by a commitment to reduce maternal mortality, the primacy focus even then was fetal health and infant survival. Subsequent interventions have centered fetal health, most recently in the twenty-first century, to

prevent health conditions associated with the fetal environment and disruptions to fetal development (hence, maternal obesity and alcohol consumption, for example).

To preclude possible negative outcomes, in the Swiss canton in which this study is set mothers are referred to the Pregnancy Support Center, where Ballif's ethnography is set. If mothers' responses to a first interview with a midwife at the Center cause no concern—most likely if they are middle-class, heterosexual women in a lasting union—then they may never be asked to return. But others, socially, fall outside normative understandings of family-making—they may embrace an alternative sexual or gender identity; they may fall into an age range (young, under nineteen, or old, over forty) construed medically, psychologically and socially as "risky"; they may be single, with low education or unemployed. In establishing this risk profile, center staff also explore risks to the fetus and to the newborn and child, such as parental smoking, and they pursue mothers' vigilance to reduce risk factors. But the risk factors that mark pregnancy as requiring surveillance extend even beyond this: People who have failed to register for childcare early in their pregnancy and those who plan to continue working a few months after they deliver are judged to be unrealistic about or in denial of their pregnancy or the impact of an infant on their future life. The boundaries of normative pregnancy and parenthood, it transpires, are surprisingly tight.

As Edmée Ballif describes it, the Pregnancy Support Center and the ideological shifts that informed its establishment aimed to loosen the constraints on women, as imposed by medicalized reproduction, and to provide a measure of individual support—as warranted and requested by those who were pregnant. But the conceptualization of pregnancy, birth, and postpartum as psychosocial brings to the fore a notion of the "pregnant mind" and extends, rather than reduces, the exercise of power. The services offered by the Pregnancy Support Center, Ballif illustrates, expand rather than shrink the surveillance of pregnant body-minds. Demographic status; affectional, emotional, and household ties; kinship relations; diet, alcohol, and smoking; employment, finances, and personal safety; questions of citizenship, security, and entitlement: All become factors that potentially protect or introduce risks to pregnancy, delivery, and the postpartum. In this context, rather than enjoying privacy, freedom, and the anticipation of a newborn, people who are pregnant are subject to a high level of supervision and potential intrusion. This includes ongoing obstetric care to monitor physical maternal and fetal health as well as, with these added services, the monitoring of psychological, social, and economic factors. And any of these factors might interfere with fetal growth, affect maternal health and well-being, or potentially place the future infant and growing child at risk of disease either through epigenetics or exposure (through parental drinking or smoking, for example) or as a consequence of household precarity, violence, or maternal depression.

Once identified as at risk by staff at the Pregnancy Support Center, expectant mothers who resist continued surveillance by attending further appointments are followed up by staff since their refusal to continue their psychosocial care is further evidence to center staff of risks to their own well-being and that of their future children. This, in turn, provokes extended debate among staff. How do midwives and social workers continue to provide care for an expectant mother who cancels appointments and refuses to answer follow-up phone calls? And from this, we might ask: To what extent is psychosocial care not simply a means to provide support but an extended system of vigilance over those who fall outside of a relatively narrow definition of normative pregnancy and normative bodies, personal relationships, and family desires?

In this compelling, troubling, and thoughtful account of the management of reproduction, Edmée Ballif introduces us to new ways of understanding its governance. She offers a provocative analysis of the work of those at its fore, professionals who would see their work as challenging medicalization and championing women's well-being. In exploring how their own conservative understandings of mothering shape the contours of their care and inform their ethical tussles around the limits of their engagement, we are brought back to a critical issue. Because human society's existence depends on biological reproduction, reproduction is inevitably subject to the exercise of power and power plays. In this context, desires, hopes, imagined futures, and reproducing bodies are sometimes surprisingly decentered. And further, because understandings of human society draw on social structures and their ideologies, such as gender, class, sexuality, and ethnicity, then the institutions that are designed to support reproducing bodies are often the least forgiving, and most controlling, of those who are marginalized and made even more vulnerable and marginal.

PREFACE

This book is the culmination of over a decade of research, writing, and intellectual growth, made possible by generous research participants and supportive colleagues and family members.

The book began as my doctoral dissertation in social sciences at the University of Lausanne, Switzerland. My ethnographic research at the Pregnancy Support Center was made possible by the willingness of its director to open the doors of her unit and its archives and most of all by the generosity of the pregnancy advisers who gave their time and shared their experiences with me. I remain deeply humbled and grateful for their invitations to let me sit through counseling sessions with them, opening up the intimacy of their encounters with their pregnant patients to my gaze. My work owes an equal debt of gratitude to the pregnant patients and their partners who gave their consent for me to attend their counseling sessions, thus letting me hear about their reproductive and psychosocial journeys. I cannot thank them enough.

I was lucky enough to benefit from Véronique Mottier's support and advice from the very beginning to the last version of this book manuscript. First as a PhD supervisor, then as a colleague and a friend, Véronique has been the most exceptional mentor, generous in her advice giving, relentless in her support, always encouraging me to find my own voice. Véronique, thank you for being such a fountain of knowledge and a steadfast cheerleader along my academic journey.

As a doctoral student, I also benefited from the guidance of Heather Paxson and Bruno Perreau, who welcomed me as a visiting scholar at the Massachusetts Institute of Technology, and of Laura Frader, Claudine Burton-Jeangros, and Irene Maffi. They were all excellent and caring guides who taught me how to navigate academia, be bold, and claim my identity as a scholar at the crossroads of various fields and disciplines. The Institute of Social Sciences at the University of Lausanne was—and still feels like—my academic home as a doctoral student and beyond; I am especially thankful to Dina Bader, Glòria Casas Vila, Caroline Chautems, Farinaz Fassa, Eléonore Lépinard, Laura Morend, Marta Roca i Escoda, and Isabelle Zinn for years of friendship, peer support, and scholarly advice.

I was a postdoctoral researcher at the University of Cambridge's ReproSoc (Reproductive Sociology Research Group) when I started revising and translating my doctoral work into a book manuscript. My fellow ReproSocs helped me by sharing their experiences and reviewing my book proposals. I am thinking especially of Sarah Franklin and her relentless enthusiasm and generosity but also Julieta Chaparro-Buitrago, Natalie Fixmer-Oraiz, Anika König, Doris Leibetseder,

Sonja Mackenzie, Aideen O'Shaughnessy, Rachell Sánchez-Rivera, Veronika Siegl, Marcin Smietana, and Lucy van de Wiel. The exceptionally supportive environment that I found at ReproSoc provided the necessary impetus to start writing the manuscript. I was fortunate enough to be able to continue working on this book in parallel with my other postdoctoral research projects. My special thanks go to Charlotte Faircloth and Rebecca O'Connell (Thomas Coram Research Unit, University College London), and Ellie Lee (Center for Parenting Culture Studies, University of Kent) for their support, guidance and understanding. Norah MacKendrick not only welcomed me to the Department of Sociology at Rutgers University but also provided invaluable support in navigating the publication process. Thanks for never letting me drop the ball, Norah. Annuska Derks generously welcomed me into her team at the Department of Social Anthropology and Cultural Studies of the University of Zurich. I feel very lucky to have found there a group of passionate, engaged and supportive colleagues with whom to brainstorm new projects while also finishing this book—and tasting the finest East Asian cuisine. I was also fortunate to benefit from the cutting-edge, rich intellectual environment of the University of Zurich's Human Reproduction Reloaded research program.

At Rutgers University Press, I am grateful to series editor Lenore Manderson, who claimed my manuscript for the Medical Anthropology series, for her thorough and generous reviews, and to Kimberly Guinta and Elizabeth Graber for their editorial advice and support. I am grateful to the two anonymous reviewers for their advice. One read the entire manuscript—please find here my heartfelt thanks for your thoughtful insights and constructive review. Lena Moore proofread various versions of the manuscript with patience and care.

The Swiss National Science Foundation supported my research activities through four doctoral and postdoctoral grants, allowing me to write this book while developing other research projects in medical anthropology and sociology.

My parents and grandparents supported and encouraged me in what must have seemed like an outlandish project—publishing a book with an American academic publisher. It is through their unfailing support of my education and career that I got there. To my partner and our little reproductees Abel and Victor: You gave me the strength every day to keep going. You have kept me grounded and balanced through the years, which is no small feat, and afforded me the time I needed to write. I love you endlessly.

REPRODUCTIVE BOUNDARIES

INTRODUCTION

October 2011. I am sitting in a conference room at the Pregnancy Support Center,[1] a state-sponsored unit delivering free psychosocial advice to pregnant people in the francophone Canton Romand of Switzerland.[2] Sitting around the table with me are two dozen psychosocial advisers (midwives or social workers) and the center's director. They are discussing modalities of the psychosocial appointments they offer, which consist of a review of pregnant people's financial, personal, relational, and work situations. That day, I am starting my ethnographic fieldwork at the center, and this is the first meeting I get to observe. I would go on to sit through many more meetings and appointments at the center, carefully recording the talk about pregnancy that took place between advisers, their patients, and occasionally with me.

In this book I explore how psychosocial pregnancy care shifts reproductive boundaries. The Pregnancy Support Center was founded on boundary-shifting promises: Its goal is to offer a new form of pregnancy care, one that complements medical prenatal care and addresses some of its shortcomings, thus remapping which territories of people's lives prenatal care should oversee and which professional boundaries define the surveillance of pregnancy. In the context of Switzerland, marked by deep social inequalities, rampant xenophobia, and persistent gender inequalities, the center also promises to extend its support to both expectant women and men and to people of all socioeconomic backgrounds. Thus, the starting point of my ethnography of prenatal care was to explore the resetting of the conceptual, professional, and epistemic boundaries that underlaid the work of the Pregnancy Support Center and allowed its advisers to expand prenatal care to the psychosocial, redefining the borders of reproduction.

What I realized over time was that this remapping of the landscape of prenatal care also involved setting moral and power boundaries. In spring 2015, I am four months pregnant with my first child. Two years after the end of my fieldwork, and after an eighteen-month research stay in the United States, I am coming back to the Pregnancy Support Center for follow-up conversations with senior staff. Congratulating me on my pregnancy, one social worker exclaims, "Oh! So now you are going to make an appointment for yourself at the center!" I mutter that I will

think about it—and never follow up. I feel very uncomfortable with the idea. This is partly because I know the center's psychosocial advisers in a professional capacity and find the idea of revealing intimate details about my personal life awkward. But also, my reluctance has to do with the fact that I find the idea intrusive, an overbearing incursion of professionals into my reproductive journey. Observing daily activities at the Pregnancy Support Center and listening and talking with its staff, I had become increasingly aware that pushing the boundaries of prenatal care to include the psychosocial was not only a conceptual remapping of pregnancy but also a contribution to the expanding scrutiny of reproductive lives.

Reproductive boundary-drawing and boundary-shifting shape everyday reproductive experiences. Reproductive scholars have revealed, for example, that an ever-increasing portion of women's lives are brought under the purview of reproductive medicine and the fertility industry. Women in the United States and Europe are increasingly encouraged to prepare their bodies to ensure healthy reproduction by acting, before conception, "as if" they were pregnant, avoiding harmful substances, and eating healthily. "Pre-pregnancy care," Miranda Waggoner (2017, 3) argues, emerged in the United States in the twenty-first century and expanded "the task of perfecting pregnancies" to the months and years before conception. The temporal boundaries of reproductive medicine are not only pushed backward to preconception but also forward, as assisted reproductive technologies and, more recently, egg freezing promise to extend women's reproductive age (Bühler 2021; Inhorn 2023; Van de Wiel 2020). What counts as "reproductive" is shifting, at the same time as reproduction is pushed to the center of ever more political debates. In the United States, Laura Briggs argues, all major political discussions of the past half century—immigration, welfare, race—have reproductive politics at their core, "even though that fact is sometimes obscured" (2017, 4): "All politics have become reproductive politics." What I call the reproductivization of life—the conceptualization, organization, and regulation of an ever-increasing array of activities in people's lives through the prism of reproduction—is not new, as it builds on the long-standing connection between women's social status and their reproductive roles. These shifting reproductive boundaries deeply affect reproductive experiences and reproductive rights.

Recent developments in reproductive care such as egg freezing and prepregnancy care raise questions about consequences for reproductive subjects: Are they empowering reproductive subjects to reduce risks and achieve their desired reproductive outcomes, or are they increasing control and surveillance over reproductive bodies, placing the responsibility on individuals to achieve pregnancy? Thus, accounting for the shifting of reproductive boundaries matters because it is not only our understanding of what reproduction is, when it starts, and when it ends but also our knowledge of who has authority over reproductive decisions and which moral definitions of "good" reproductive subjects are at stake.

In this book, I ask what the expansion of prenatal care to the psychosocial dimension of people's lives means. My concern with the reproductivization of life is grounded in a concern for social justice and equality. Switzerland has a long history of deeply stratifying state interventions into reproductive lives, including through eugenic policies, sterilization laws, and child removal targeting poor women, ethnic others, and single mothers (Comité de direction du PNR 76 "Assistance et coercition" 2024; Delessert, Boraschi, and Valsangiacomo 2024b; Mottier 2006). With restrictive naturalization laws and the fairly recent acquisition of voting rights for women at the federal level (1971), Swiss national identity and society are marked by hierarchies along gender, race, and migration lines. As Véronique Mottier argues, women's bodies have been "a central site in this Swiss struggle against 'difference'" (2006, 254), with state-sanctioned interventions to limit women's reproductive choices reflecting classed and racialized imaginaries of good citizenship. Against this backdrop of deeply stratified control over reproductive subjects, is psychosocial prenatal care a welcome innovation that provides more holistic care for pregnant patients or yet another form of reproductive surveillance?

REPRODUCTIVE BOUNDARIES

To explore how prenatal care expands to encompass a larger portion of reproductive subjects' lives, I focus on the definition, the maintenance, and the shifting of reproductive boundaries. Borders and boundaries have long been a topic of interest for reproductive scholars. The language of borders, boundaries, and limits has been used to discuss how reproduction is affected by geopolitical, legal, ethical, and conceptual boundary drawing. Pregnancy is a fertile site for discussions of identity boundaries. The different ways in which pregnant and fetal subjects are conceptualized—Are they one? Are they two?—underlie legal, political, ethical, and cultural discussions of pregnancy, abortion, assisted reproduction, and contraception. Feminist philosophers have described pregnancy as a unique state of both unity and differentiation between self and other, a state where bodily and identity boundaries are redrawn (Irigaray 1977; Kristeva 1983; Young 1984). Cross-culturally and historically, that which is growing in the womb has not necessarily or immediately been considered a person or a distinct individual (Duden 1999; Hanson 2004; Kukla 2005; Morgan 1997). New evidence from epigenetics underlines how past and present experiences (such as exposure to toxic environments) determine our own and our children's future, renewing discussions of the boundaries of fetal individuality. Julienne Rutherford reconceptualizes the fetus as "borderless," as bound to past and future generations, to environment, and society "rather than completely constrained by the borders of an individual uterus in an individual woman's body" (2017, 27).

Geopolitical borders have been identified as sites of reproductive injustice (Franklin 2011; Inhorn and Gürtin 2011; Nahman 2013; Vertommen 2017; Vertommen, Parry, and Nahman 2022). Analyzing how Palestinian women cross borders to undergo fertility treatment in Israel, Gala Rexer (2021) shows that the management of borders inescapably produces a stratification of reproduction since access to reproductive technologies is state regulated. People gain or lose reproductive and parental rights when crossing borders (Courduriès 2018; Guerzoni 2020). In Julieta Chaparro-Buitrago's analysis of contemporary forced sterilization of migrant women in the United States and Uighur women in China, reproductive coercion appears as "a tool for fortifying borders and consolidating territorial dominance, a means of social control and containment, and a practice of deterrence and punishment" (2024, 11).

With these works in mind, I wondered what we might learn from looking at psychosocial prenatal care as a (professional and conceptual) *territory* and at prenatal care providers as engaged in defining and managing *borders*. As anthropologists have long discussed, boundary drawing is a dynamic process defining the attributes of a group (Benedict Anderson 1983; Barth 1969; Douglas 1966) or, in this case, of a type of reproductive care. Attending to the remapping of psychosocial prenatal care, I ask: What are the borders of psychosocial care, and how are they negotiated and contested? Over which territories—which dimensions of people's lives—does psychosocial care extend its purview? How is the work of surveilling this territory distributed and implemented? The psychosocial remapping of prenatal care shifts different types of reproductive boundaries: moral, professional, epistemic, and temporal, as well as power boundaries. By doing so, psychosocial counselors participate in the reproductivization of life: They shift and expand the borders of prenatal care to include a larger portion of people's lives, and more professional and epistemic perspectives, in the domain of prenatal care. These shifting reproductive boundaries are closely linked to geopolitical, linguistic, and social borders. Switzerland is a country of many borders, divided into twenty-six cantons that form its federal state; it has four linguistic regions and is socially divided and hierarchized along gender, racial/ethnic, migration, and class lines. Exploring reproductive boundaries provides a lens through which to understand this deeply fragmented society.

Psychosocial prenatal care in Switzerland is based on boundary-shifting promises, claiming to redefine prenatal care, pregnancy as a reproductive stage, and the subjects of prenatal care. These claims are explored in the following subsections in dialogue with reproductive scholarship.

PRENATAL CARE

When the center was created in 1986, it was a local response to three converging trends, as we will see in chapter 1: the global rise of the midwifery, natural child-

birth, and feminist movements, which advocated for alternative models to what was considered the excessive medicalization of pregnancy and birth care; the increasing involvement of psychiatrists in pregnancy and postpartum care in France; and a shift away from coercive measures to the support and empowerment of families in Swiss reproductive governance. In this context, what the Pregnancy Support Center did was implement another way to do prenatal care—to shift the borders of the then-conventional biomedical approach to prenatal care to include social and psychological circumstances. The term "psychosocial" itself, commonly used at the Pregnancy Support Center to name its domain, directly refers to a critique of biomedicine and its narrow focus on the body. In the 1970s, American psychiatrist Georg Engel introduced the "biopsychosocial" perspective as an alternative model of care, one that would take into account "the social, psychological, and behavioral dimensions of illness" (1977, 135) that biomedicine tended to neglect. The biopsychosocial model thus proposes a holistic approach to health and illness that has resonated widely in health research (Pilgrim 2015). Claiming the "psychosocial" as its domain positions the Pregnancy Support Center as complementary to biomedical pregnancy care.

Switzerland offers a good opportunity to explore the complex boundaries between medical and psychosocial prenatal care. Pregnancy is a heavily medicalized experience in Switzerland (Burton-Jeangros, Hammer, and Maffi 2014b; Fournier 2013; Fuschetto 2017; Luisier 2006; Rieder 2007). Most pregnant patients are monitored by a private gynecologist during pregnancy, and pregnancy care usually comprises a minimum of seven checkups and two ultrasounds, the costs of which are entirely covered by compulsory Swiss health insurance.[3] Even though pregnancy surveillance by independent midwives is also covered by health insurance, a minority of pregnant people choose that option (Borner and Grylka 2023). Birth is also a heavily medicalized experience, with 96.2 percent of all births happening in a hospital setting in 2022 (Borner and Grylka 2023).[4] C-section rates reached 32.3 percent in 2017, one of the highest rates among Organization for Economic Co-Operation and Development (OECD) countries (Federal Statistical Office 2019). The delineation of professional territories between obstetrician-gynecologists and midwives is not as clear-cut as elsewhere (Cavalli and Gouilhers-Hertig 2014; Chautems 2022a). In the United States, the medicalization of pregnancy and birth that unfolded over the twentieth century resulted in medical doctors gaining authority over the reproductive process, and midwives were largely marginalized. Katz Rothman (1982) has described this polarized landscape as an opposition between the "technocratic" model of birth and the "midwifery" model. Such a distinction has deeply influenced (mostly U.S.-based) anthropologists of pregnancy and birth. In contrast, in Switzerland midwives have largely been incorporated into hospital settings and supervise most deliveries. Health insurance covers midwife-led pregnancy, birth, and postpartum care (even if very few pregnant patients choose

this option). The development of psychosocial care has thus occurred in a landscape where professional boundaries are overlapping and often contested.

Exploring prenatal care is also a way to critically explore the boundaries of the anthropology and sociology of reproduction. Pregnancy as a reproductive stage is often studied in relation to technology and exceptional reproductive events. "When feminist and anthropological studies of reproduction have discussed pregnancy over the past four decades," Teman and Ivry (2022, 383) write, "it has most often been with a focus on the effects of the transformative technologies that are involved in pregnancy." Historical studies of prenatal care such as Oakley's (1984) and Hanson's (2004) have traced the development and institutionalization of prenatal care, from the early development of obstetrics in the eighteenth century to its present forms, as the implementation of an increasing number of tests and checks. Many classic and more recent explorations of prenatal care have focused on the effects of technologies such as ultrasounds, prenatal diagnosis, or surgery on the experience of pregnancy or on surrogacy,[5] with "reproductive drama" given more attention than "ordinary," mundane experiences of pregnancy, as Sallie Han (2013) argues. Ethnographies of prenatal care have often focused on medical settings, documenting how pregnancy is medicalized and how the pregnant body is scrutinized and the impact of this on the experience of pregnancy (Andaya 2021; Bridges 2011; Browner and Press 1996; Ivry 2010). Studies of pregnancy in Switzerland have likewise focused on the medical surveillance of pregnancy and the impact of medical risk discourses (Burton-Jeangros 2011; Burton-Jeangros et al. 2013; Hammer and Burton-Jeangros 2013; Hammer et al. 2022; Hammer and Inglin 2014).

Such analyses of pregnancy have been instrumental in laying bare how biomedicine has redefined pregnancy as a medical event and thus gained direct access to the bodily processes of pregnancy (through testing and imaging), bypassing women's embodied knowledge and experience. Feminist scholars have pointed to the fetus-centered nature of medical pregnancy care, which focuses overwhelmingly on monitoring fetal health and ensuring its optimal development to the detriment of pregnant people's needs and wishes—especially in contexts like the United States, where pro-life movements have pushed for the defense of fetal rights (Han 2017; Morgan and Michaels 1999). But focusing on the use of technologies may have the unintended effect of reproducing the framing of pregnancy as an event in which the pregnant body occupies center stage, and medicine constitutes the main source of authoritative knowledge.

This ethnography of psychosocial prenatal care thus contributes to the exploration of prenatal care beyond medical settings and beyond the body. It draws inspiration from classic as well as more recent scholarship on alternative forms of birth and postpartum care (Davis-Floyd and Davis 1996; Davis-Floyd and Sargent 1997; Jordan 1978; Kline 2019). In Switzerland, while birth is highly med-

icalized, independent midwives, doulas, and alternative medicine therapists increasingly offer to complement or circumvent medical care during birth and postpartum (Chautems 2022a, 2022b, 2024). Bringing these insights back to the case of pregnancy, studying an alternative form of prenatal care similarly means critically exploring competing claims to the territory of pregnancy and challenges to medical authority.

PREGNANCY

The Pregnancy Support Center's model of psychosocial care is an opportunity to interrogate how the boundaries of pregnancy as a reproductive stage are being redefined. Psychosocial pregnancy care in Switzerland is offered during pregnancy through up to six months after birth. It is part of a public health strategy aimed at promoting children's health. Its creation in the 1980s happened in a context in which state intervention into families was increasingly conceived as an opportunity for preventive measures aimed at protecting children's health and well-being. This reflects a trend in the governance of pregnancy that U.S. and UK scholars have also identified: Social expectations of good parenting are increasingly extended "backward" during pregnancy (Lee et al. 2014; Lee, Macvarish, and Bristow 2010). Expectant parents are urged to adopt a cautious approach and avoid all risks to their future children's health during pregnancy.[6] In recent years, conceptualizing pregnancy as important to the health of future generations has been fueled by the growing incorporation of epigenetics into public health programs in some countries (Fournier and Jarty 2019; Landecker 2011; Lappé and Jeffries Hein 2021; Manderson 2016; Manderson and Ross 2020; Pentecost 2024; Pentecost and Ross 2019; Richardson 2015). Swiss psychosocial care is thus a lens onto wider, global transformations in how pregnancy is conceptualized within public health discourses. Exploring the shifting boundaries between reproductive stages—here, how pregnancy becomes treated as a stage of parenthood—is an important step to defragment the study of reproduction. In 2015, Renée Almeling called on reproscholars to conceptualize reproduction as a process rather than a series of successive steps, a call that Faircloth and Gürtin (2018) strengthened by underlining the parallels between the study of assisted reproductive technologies and parenting. This approach allows for tracing continuities between different areas of reproductive governance and broader mechanisms of social inclusion and exclusion.

INEQUALITIES

Switzerland is known as one of the wealthiest countries in the world, but fractures and inequalities within Swiss society run deep. Switzerland has a very high standard of living, political stability, and quality of life in international comparison,

but these privileges are not equally distributed. It ranks among the countries with the highest wealth inequality, with the top 10 percent of the population holding 77.6 percent of the total wealth in 2018 (Federal Council 2022). In contrast to other immigration countries like the United States, Canada, or Australia, Switzerland has restrictive integration and naturalization policies, which translate into a large share of residents who do not have Swiss citizenship (including descendants of first-generation immigrants; Lavenex 2023; Manatschal 2023). The share of foreigners among residents is the second highest in Europe after Luxembourg. More than a third of Swiss residents were born abroad. The largest migrant groups are from Italy, Germany, Portugal, and France; however, taken together, migrants from Southeastern Europe (especially Kosovo, Turkey, Macedonia, Serbia, Bosnia and Herzegovina, and Croatia) form by far the largest group of foreign residents. Anti-immigrant rhetoric is widespread, and migrants face discrimination in many areas of life. Not all foreigners are treated equally, though, with the perceived proximity of some nationalities that supposedly share Swiss cultural "values" facilitating integration (dos Santos Pinto et al. 2022; Ossipow, Counilh, and Chimienti 2019).

This backdrop of both privilege and inequality is reflected in the scholarship on Swiss prenatal care. Some scholars underline that the medical surveillance of pregnancies in Switzerland, which involves many technical examinations and tests, generates anxieties—the flip side of access to highly medicalized, quality health care (Burton-Jeangros 2010, 2011; Hammer et al. 2022). Others denounce the difficulties that migrant women face in accessing care (Cai et al. 2024; Desseauve et al. 2022; Perrenoud, Kaech, and Chautems 2023; Sami et al. 2019). This tension is not only raised in scholarship about Switzerland. Lenore Manderson (2016) argues that there are two contradictory trends in feminist scholarship on pregnancy and childbirth: While many anthropologists of reproduction developed critiques of the (over)medicalization of pregnancy, others focused on the fact that many pregnant people around the world, often racialized and poorer people, including in wealthy countries, do not have sufficient access to prenatal care.

To address the question of (in)justice in prenatal care, I lean on the framework of reproductive justice. Black feminists and feminists of color in the United States introduced reproductive justice in the 1990s precisely to overcome tensions between different viewpoints on (in)justice in relation to reproductive rights (Roberts 2015; Ross and Solinger 2017). Reproductive justice sought to go beyond the then-prevailing approach to reproductive rights that focused almost exclusively on advocating for access to abortion. Collectives such as SisterSong (SisterSong, n.d.) underlined that this overlooked the reproductive harm faced by women of color and other marginalized groups, such as poor access to reproductive care or sterilization. The reproductive justice framework introduced a new, broader approach to reproductive rights that comprises the right to have

children, the right not to have children, and the right to raise children in safe and dignified conditions. A growing number of reproductive scholars have explored the analytic and political potential of this framework to reveal different, situated needs and challenges to reproductive lives (Chaparro-Buitrago and Freeman 2023; Davis 2019b). Dána Ain Davis (2019a, 2019b) introduced the term "obstetric racism" to capture the specific violence that Black women face in their medical encounters during pregnancy, labor, and birth, which results in higher rates of negative reproductive outcomes. Elise Andaya (2018, 2019) details how racial and class inequalities shape the temporal dimension of prenatal care, with racialized and poor patients exposed to longer waiting times, for instance.

Inequalities and discrimination can have different, sometimes contradictory effects on how prenatal care is delivered, however. In the United States, where the legacies of slavery and segregation still run deep in health care, Khiara Bridges (2011) has documented the encounters of poor women of color with prenatal care providers in a public hospital as a site of racialization. Poor Black women, Bridges argues, are subjected to oversurveillance and invasions of their privacy while also being generally medically underserved. I agree with Rachel Chadwick when she underlines that "resolidifying binary thinking by arguing that medicalization is only a problem for privileged women in the Global North and that marginalized women have no problem with being 'medicalized' during birth (see C. Johnson 2016) is not a helpful position" (2018, 27). Race and class inequalities can translate both into poor quality of care and increased surveillance. Thus, especially in a Swiss context, where medicalization is widespread and inequalities high, how social inequalities intersect with prenatal care requires fine analysis.

In my research on psychosocial prenatal care in Switzerland, the reproductive justice framework led me to question whose pregnancies were supported and whose were not, who came through the door and who did not, who was considered to be vulnerable and who was not—and how this affected the care they received. I did not immediately assume that people who are generally considered socially disadvantaged in Switzerland would be framed as such by psychosocial advisers, but, rather, I focused my attention on the delineation and hierarchization of reproductive subjects and their corollary of the under- or overinvolvement of experts. I explore how psychosocial pregnancy care, while free and claiming to be nondiscriminatory, is delivered in a stratified manner at the Pregnancy Support Center.

SEX AND GENDER

Scholars working within a reproductive justice framework or on queer reproduction have underlined that some pregnancies are more socially valued than others. Using the framework of reproductive justice or the related concept of "stratified

reproduction" (Colen 1995), reproductive studies largely share a concern about unequal access to reproductive technologies, rights, and care (Andaya and El Kotni 2022; Smietana, Thompson, and Twine 2018). Laws governing access to assisted reproductive technologies are excellent examples of such stratification, with some subjects (often white, heterosexual, married couples in the Global North) having easier access to technologies than others (often racialized, poor, or queer people; Inhorn 2015; Leibetseder 2018; Russell 2015). In Switzerland, significant barriers exist for LGBTIQ+ persons accessing reproductive technologies: Egg donation and surrogacy are illegal, and access to assisted reproduction has been possible for lesbian couples only since 2022. Heteronormativity intersects with class inequalities: Swiss health insurance companies currently deny coverage of assisted reproductive technologies for lesbian couples, making fertility treatment more difficult to afford.

Heteronormativity in Swiss reproductive governance is inherent to a traditional gender regime. The traditional family model with a male breadwinner and a female caretaker is still widespread (Madörin, Schnegg, and Baghdadi 2012; Rossier, Bernardi, and Sauvain-Dugerdil 2023). Mothers tend to work part-time and assume a significant part of the domestic and childcare labor. The persistence of this conservative gender order is linked to the fact that family policies are underdeveloped in comparison to other European countries, which translates into scarce and expensive childcare provision (Häusermann and Bürgisser 2023).

Barriers to nonnormative experiences of reproduction and the gendered distribution of reproductive labor both reveal how deeply pregnancy is associated with an essentialization of gender and sex (Ballif 2019). The "repronormative" (Franke 2001) imaginaries of pregnancy that dominate in Switzerland and Europe in general link pregnancy to a female body and a female identity (Karaian 2013; Walks 2018; Weissman 2017). Trans men's or queer individuals' pregnancies have been described as socially "unthinkable" because they contradict the fundamental belief that it is the ability to get pregnant that distinguishes women from men (Karaian 2013; Toze 2018; Walks 2015; Weissman 2017). Even among reproductive scholars, the "fact" that pregnancy is a woman's experience has long seemed so obvious that many studies of pregnancy or prenatal care do not discuss it.

This reproductive imaginary is increasingly questioned in Switzerland, however, not only in public discussions of trans pregnancies but also because pregnancy is becoming a less and less common experience, even among cisgender women. Switzerland has one of the highest rates of childlessness in Europe, and the fertility rate continues to drop: In 2022, 8.5 percent fewer babies were born than the year before (Federal Statistical Office 2023). Thus, it has become less socially obvious that pregnancy is the hallmark of womanhood.

Against this backdrop, I examine the Pregnancy Support Center's argument that psychosocial prenatal care should be offered to both women and men and

the reality that few men come to appointments at the center. This leads me to approach psychosocial care as a site of essentialization, where dominant ideas about sex and gender, and the boundaries that mark their differences, are both contested and reproduced.

Some of my own language choices reflect my positionality regarding sex and gender. I use gender-neutral terms such as "pregnant people" and "pregnant clients" in this book, even though psychosocial advisers at the center consistently talked about "pregnant women." Staff at the Pregnancy Support Center always assumed pregnant people were cisgender women, and I never witnessed a client contradict this. Gender identity, and the fact that someone could be pregnant and not identify as a woman, was not a topic of discussion during most of my fieldwork and currently remains marginal. My choice to veer away from the cis-sexist language used in the field reflects my critical stance toward cis-sexist assumptions in prenatal care and the critical distance that separates my analysis from the perspective of research participants. I do use the term "pregnant women," though, when it is how people self-identified and when paraphrasing scholarship, reports, or laws that are phrased in a binary way.

AN ETHNOGRAPHY OF DISCURSIVE PRACTICES

Having had a part-time student job (processing statistical data) at the Pregnancy Support Center a couple of years before I commenced the study on which this book is based, I was already familiar with the day-to-day organization of the unit. I intended to conduct an ethnographic study at the center using participant observation and to be attuned to what people did, how they moved, their nonverbal cues and physical interactions, and the spatial arrangements of prenatal care, as I had been trained while studying anthropology and sociology in Switzerland. Early on, however, I became increasingly frustrated at my inability to do so. My fieldwork largely consisted of sitting in a chair and listening to people talk.

A typical fieldwork day for me was to take the train to one of the center's regional offices to attend a staff meeting, to witness an appointment with pregnant clients, or to conduct a one-on-one interview with one of the staff members and then return to my own office at the University of Lausanne. I spent most of my fieldwork sitting at a table with psychosocial advisers, listening to them talking as I took notes and asking them questions about their work. I also spent time listening to formal and informal conversations between staff members during their meetings, their coffee breaks, and in between appointments. I started with a twenty-two-month intensive phase between 2011 and 2013, during which I conducted observations and interviews. The data collected formed the basis of my doctoral dissertation (Ballif 2017) and associated publications (Ballif 2014, 2019, 2020, 2023a). Since the end of my fieldwork and to this day, I have conducted

regular follow-up interviews with some psychosocial advisers and continue collecting new policy documents. The center's policies, internal organization, and approach to psychosocial care have seen little change over this period. The COVID-19 pandemic forced the center to move a quarter of its consultations online in 2020. While the mental health of pregnant women in Switzerland and the quality of prenatal care deteriorated during the pandemic (de Labrusse et al. 2022; Favre et al. 2022; Lambelet et al. 2021), the center soon went back to working like before. What I describe are thus long-lasting practices of psychosocial care, as well as their evolution.

Observing consultations with clients proved more difficult than I initially expected. I gained access to consultations only after one year of negotiations, first to observe ten consultations and then a further round of two dozen. Although most psychosocial advisers were willing to let me observe their appointments, internal conflicts were brewing at the time, and the center's management team framed authorizing my observations as a possible source of new tensions. Meanwhile, I easily obtained access to staff meetings and observed about thirty of these. Different types of meetings involve either the entire staff ("general meetings," three per year) or different subgroups of the staff: advisers working at one or two of the regional offices ("regional meetings," six per year, and "intervisions," four per year); they include meetings involving all midwives or all social workers ("midwives' meetings" and "social workers' meetings," three per year). Each of these internal meetings focuses on topics that are relevant to the specific subgroup of staff they target: Strategic decisions are discussed with the entire staff while relationships with local public hospitals are discussed with the staff active in that region. In addition, ad hoc meetings for the entire staff are organized several times a year as part of their continuous training. External experts such as public health specialists, nurses, lawyers, or social workers are frequently invited to update psychosocial advisers' knowledge of a particular topic related to prenatal care and pregnancy—for example, to present the latest public health campaign to prevent smoking during pregnancy in the region, current knowledge on intimate partner violence, or legal changes regarding patients' rights in Switzerland.

During the intensive phase of my fieldwork, I scheduled one-on-one qualitative interviews with each of the seventeen psychosocial advisers and the center's director to explore their understanding of their work and role.[7] I sat down more than once with each of the founding members to hear about the history of the center. In addition, each of my visits to the Pregnancy Support Center was an opportunity to chat with psychosocial advisers. Especially after some months, when my presence had become so normal that they were wondering why I was not there some days—I was teaching and writing up my field notes—I gathered precious insights into psychosocial care through informal discussions, those between advisers and those in which I was involved. These were conversations in

which staff did not necessarily repeat the official discourse of the center's policies and guidelines. They talked about their clients through categories and notions that were presumably more meaningful and spontaneous than when I asked them to describe their work during an interview with me. I also conducted a dozen interviews with members of key institutions involved in prenatal care or reproductive governance, such as midwives, gynecologists, pediatric nurses, family planning advisers, and child protection agents.

In addition, I gathered different types of internal documents at the center: policy documents that describe the center's approach to psychosocial care, including internal guidelines; strategic plans; web pages; and flyers that advertise the center. I had access to the center's modest archives: These included reports prepared by the founding members and past employees to present the psychosocial model of prenatal care and advocate for support from the local canton government.

My time in the field and the ethnographic data I produced reflect daily life as it is for a midwife or social worker at the Pregnancy Support Center, composed overwhelmingly of talk and fragmented. A typical day for a psychosocial adviser is a succession of discussions with clients, colleagues, other professionals, and, occasionally, me. Similarly, my ethnographic experience is a collection of discussions, some longer than others, fragmented across locations and interlocutors. This is how I realized that talk is the stuff that psychosocial pregnancy care is made of. Precisely because the center does not offer medical care or tend to the pregnant body, what midwives and social workers do is talk to pregnant people to care for the social dimensions of their experience of pregnancy.

While still a marginal topic in the anthropology and sociology of reproduction, language has been used as an entry point to understand reproductive care and governance. As Sallie Han argues, "Language is a practice of reproduction" (2018, 1). For example, Rayna Rapp (1999) centered her ethnography of genetic counseling on the way counselors communicate biomedical concepts and risks to their pregnant patients considering amniocentesis. The language of genetic counseling, Rapp argues, "communicates and miscommunicates not only medical information but also structural power arrangements, social knowledge, and popular meanings" (1988, 143) about health, disability, and reproduction. Ethnographies of reproductive caregiving in Switzerland also show how interactions between midwives or parental counselors and (future) parents convey biomedical conceptualizations of the body and moral expectations (Chautems 2022a; Maffi 2014; Preissler 2022a). Thus, the experience of reproduction is shaped by and enacted through talk.

I therefore conducted an ethnography of discursive practices. The notion of "discursive practices" draws from Foucault's work and poststructuralist discourse analyses (Arribas-Ayllon and Walkerdine 2008; Bacchi and Goodwin 2016) that approach discourse not just as what people say but as a practice. Discursive

practices are the site where reproductive boundaries are established and enacted in the context of psychosocial care. To borrow from Sallie Han's (2018) typology of reproductive talks, "talk about" psychosocial care and "talk between" counselors and patients are where boundaries are drawn between ideas, concepts, and categories. While discourse analysis is generally applied to written documents, I used it to analyze the various ethnographic data that I produced. I sought to uncover the discursive boundary-drawing practices that shape the daily activities at the Pregnancy Support Center.

I chose to anonymize the center, its location, and all the names of my interviewees. The center's director was keen to have the name of the unit made public, as a way to advertise the unique and pioneering work it is doing. However, anonymity protects individual advisers, many of whom are still working at the center. Anonymizing the unit also means that I had to refrain from citing local policies, laws, or other elements of context that would have made the location of the unit immediately recognizable. Furthermore, the relatively small number of pregnancy advisers meant that many personal or professional details needed to be removed to avoid making them easily recognizable. Readers may find themselves wanting for more details while reading about psychosocial advisers—this is the reason why I could not add more.

CHAPTER OUTLINES

The book takes readers through various aspects of the psychosocial remapping of prenatal care. I begin with a chapter presenting the Pregnancy Support Center within the entire landscape of Swiss reproductive culture. The Pregnancy Support Center is unique in that it represents the innovative implementation of an alternative form of prenatal care in what is otherwise a very medicalized Swiss culture of pregnancy. It is not singular, however, because it reflects global transformations of reproductive politics, gender regimes, medical care, and social policies.

The subsequent five chapters focus on different types of boundaries—moral, professional, epistemic, temporal, and power boundaries—that psychosocial care claims to shift. In chapter 2, I describe an appointment at the Pregnancy Support Center to map out the territory of psychosocial pregnancy care. Exploring the topics that are discussed during appointments lays bare the moral boundary-drawing work that underlays psychosocial care. Canvassing pregnant people's psychosocial lives, psychosocial advisers perform an evaluation that relies on stratified assumptions about which parents will be more apt than others. Chapter 3 focuses on professional and epistemic boundary-shifting that is at work in the psychologization of pregnancy. I reflect on narratives that frame pregnancy as a period of psychological crisis, a discourse that traveled from psychology to midwifery and prenatal care as a way to counteract medicalization

and offer care to pregnant patients in a more holistic way. I show how at the Pregnancy Support Center, psychologization extends the fetus-centered culture of prenatal care to mental health, as pregnant women are advised against the potential threat that their emotions represent to their fetus.

Psychosocial pregnancy care redefines the temporal boundaries of reproduction, which is explored in chapter 4. I examine how psychosocial advisors urge their clients to anticipate their futures, and even actively intervene in future parents' plans. Psychosocial pregnancy care relies on an "anticipatory" regime, in which future parents are expected to act as parents before the birth of their children. Anticipation works as a measure of "good" mothering and fosters the reproduction of traditional gender roles.

Chapter 5 explores the shifting power boundaries that define who has authority over pregnancies. Pregnancy care in Switzerland is conceptualized as a journey from expert to expert, following a pre-established curriculum of encounters with professionals for appointments, checks, and tests. Psychosocial pregnancy care, despite its anti-medicalization stance, seeks to form an almost seamless grid of surveillance with biomedical experts over the territory of pregnancy. From the point of view of experts, interprofessional collaboration among members of the pregnancy network is a hallmark of good and efficient care. But pregnant patients sometimes contest and resist this surveillance, seeking to regain power and autonomy over their reproductive journeys.

Last, chapter 6 focuses on a contested portion of the territory of psychosocial pregnancy care. I describe the doubts and struggles of the center's staff as they tried to implement a new screening policy for intimate partner violence. Their concerns about the relevance and potential drawbacks of such screening reveals how the conceptual and moral boundaries of psychosocial care are constantly re-negotiated.

In the conclusion, I offer some thoughts on reproductive boundaries, reproductive talk, and the potential they hold for the social study of reproduction. This book is not intended as a criticism of psychosocial pregnancy care as a whole, nor a criticism of the Pregnancy Support Center. I felt and still feel very supportive of the center's work, which I see as an important complement to medical care and a welcome source of free support for future parents. I do not want to downplay the decency or the sincerity of the intentions of those who work in this field. Beyond this particular center, what I critically explore are the tensions and challenges of the reproductive governance of families in Switzerland.

1 • THE LANDSCAPE OF SWISS PRENATAL CARE

The Pregnancy Support Center is both unique and representative of larger trends in the governance of reproduction. In this chapter, I describe psychosocial care within the landscape of Swiss prenatal care, reproductive governance, gender regimes, and social policies, highlighting how the Pregnancy Support Center aligns or differs from other modes of prenatal care. As a state-funded center providing psychosocial prenatal care, it does not have many equivalents in Europe or more globally; rather, the lack of psychosocial or holistic care for pregnant people is widespread. It is, however, far from singular. The global midwifery and natural childbirth movements, with their critique of medicalization, deeply influenced the creation of the center. Its model of psychosocial prenatal care also illustrates larger transformations of reproductive politics, the gender regime, medical care, and social policies in Switzerland. I present the creation and organization of the Pregnancy Support Center while attending to how it draws boundaries, in the sense of inclusion and exclusion of concepts, knowledge systems, domains of care, or categories of clients.

A UNIQUE CENTER

The birth of a unique center for psychosocial pregnancy care in one of Switzerland's cantons is linked to internal Swiss geopolitical borders. As a confederation, Switzerland has three political levels: the federal state (*confédération/Bund*); 26 cantons; and over 2,000 municipalities (*communes/Gemeinden*). This federal structure was created with the first Swiss Constitution of 1848 and was heavily inspired by the 1789 United States Constitution. Before that date, Swiss cantons were bound by treaties, and there was no federal government. Today, each political level has its own executive government and legislative assembly, while legislative powers are distributed across the three levels. Cantons have great autonomy in all areas of government (including education, health care, welfare, and taxation) except for those that are managed by the federal government, such

as the armed forces, immigration, foreign relations, and civil and criminal law. This federalist structure means that health care and public health strategies can differ across the 26 cantons, which makes possible the development of various and distinctive policies.

The creation of the Pregnancy Support Center came from a federal law: the 1981 Act on Pregnancy Support Centers.[1] Since 1942, the Swiss penal code had explicitly made abortion unlawful except in a limited number of medically accepted cases. In the 1960s, urban, liberal-leaning cantons such as Geneva often did not apply the penal code or prosecute women and doctors for abortions, which created discrepancies in the criminalization of abortion between cantons (Commission fédérale pour les questions féminines 2011). Several legal changes aimed at decriminalizing abortion during the first trimester were discussed at the federal level during the 1970s, at the same time as neighboring France and Germany were successfully legalizing abortion (Engeli 2010; Schulz and Schmitter 2022). Contrary to neighboring countries, though, abortion laws were submitted to popular vote in Switzerland, and profound divisions among the population prevented legal changes.[2] In 1977, a federal initiative (i.e., a change in the constitution proposed by citizens) to make elective abortion legal during the first twelve weeks of pregnancy was rejected by 51.7 percent of voting citizens. The following year, a proposed federal act that would have decriminalized abortion during the first twelve weeks under strict medical or social conditions was rejected by 68.8 percent of voters. Another popular vote rejected a complete ban of abortion in 1985, and it was only in 2002 that a revision of the penal code to decriminalize elective abortion up to twelve weeks was accepted by 72.2 percent of voters. No changes have been made since.

The 1981 Act on Pregnancy Support Centers is a by-product of the failed attempts to revise abortion legislation in the 1970s. The federal act that was rejected by popular vote in 1978 contained an article requesting cantons to provide "pregnancy consultations" (*consultations en matière de grossesse/Schwangerschaftsberatungsstellen*) to the population. In the context of the 1978 act, which sought to authorize abortions only for very strict medical or social reasons, these consultations were thought of as a way to dissuade pregnant people from pursuing abortion. After the act was rejected, the Federal Council nevertheless decided to recycle the idea of pregnancy consultation, this time formulated in a neutral way. The act gained the support of both chambers of the Federal Assembly, and since no political party rejected it, it came into force in 1981 without submission to a popular vote. The first article of the Act on Pregnancy Support Centers reads:

> (1) In the event of pregnancy, directly concerned individuals are entitled to free consultations and assistance. (2) They will be informed about the private and public support available to help them carry the pregnancy to term, the medical

> consequences of an interruption, and pregnancy prevention. (3) The cantons establish consultation centers for all issues related to pregnancy. They may create them jointly, recognize existing ones, and call upon private organizations to set them up and operate them. (4) The consultation centers must have staff and financial resources that enable them to provide free consultations and necessary assistance to individuals without delay.

In almost all Swiss cantons, this federal act did not trigger the creation of new centers but provided an incentive to fund and reinforce existing family planning centers, which were already providing information on contraception and abortion to the population. In one canton, though, the federal act served as an incentive to create a new center, distinct from the family planning centers and specifically dedicated to pregnancy support.

What was different in the Canton Romand? In that canton, family planning centers were attached and managed by a private foundation, the Intimacy Foundation, which received public funds to offer health and social services. Such public-private partnerships, whereby private foundations receive public mandates to provide health care services, are common in Switzerland (Trein, Rüefli, and Vatter 2023). The Intimacy Foundation was founded in the 1960s and fulfills missions in the domain of sexual and reproductive health (family planning, prevention and detection of sexually transmissible diseases), couples' therapy, sex education, and support for victims of violent crimes. Almost all of its services are subsidized by the canton and thus free to their clients.

In the 1980s, after two decades of massively dropping birth rates, the Intimacy Foundation was accused by a member of the cantonal executive from a center-right Christian party of contributing to the decline in the canton by providing access to contraceptives. According to witnesses—the midwife and social worker who founded the center as well as a former family planning adviser with whom I conducted interviews—creating a new center for pregnancy support, separate from the family planning centers, was a way for the Intimacy Foundation to regain support in the midst of such political attacks. The canton announced that it would no longer subsidize the foundation as a whole but would allocate funds to specific programs and requested that the foundation diversify its activities. Faced with the threat of shrinking public subsidies, the foundation sought to demonstrate its commitment to supporting pregnancies and births, as a former employee said: "We always had the idea that, in exchange for all this talk about abortion and everything, we should offer counseling in cases of infertility or things like that. So, as a way to promote motherhood and fertility in the public's eyes, compared to family planning, which was often seen as negative, as preventing births. There was also that need to restore the reputation of all those working in this field [of intimacy]." Although the federal act

that prompted the creation of the Pregnancy Support Center originated in debates about abortion, the center was never meant to provide abortion counseling. Instead, it served as the breeding ground for a new form of pregnancy support.

The history of the Pregnancy Support Center started in 1986 when a midwife was hired by the Intimacy Foundation to offer pregnancy consultations in the largest urban area of the Canton Romand. She was replaced after a few months by another midwife, Charlotte. In a context in which not all women had the same rights to maternity leave, in 1989 the midwife was then joined by a social worker, Nadine, to cover questions related to work and finances. During the 1990s and early 2000s, the Pregnancy Support Center grew steadily with the opening of new offices across the Canton Romand. Charlotte and Nadine worked "in tandem" as a midwife and a social worker and saw the complementarity between both professions as a cornerstone of psychosocial care. They were promoted to lead midwife and lead social worker, positions that they kept until they retired around 2010. They left a deep imprint on the model of psychosocial care that the center currently implements. The general goal of the pregnancy consultations was then and has remained over time to offer psychosocial support to all future parents in the Canton Romand. Each regional antenna of the Pregnancy Support Center to this day offers consultations both with midwives and social workers to cover all psychosocial aspects of pregnancy.

In 2006, the Pregnancy Support Center received further public recognition (and financial support) when it was incorporated into the Canton Romand's public health strategy. The Pregnancy Support Center was identified as a key actor in the Early Childhood Plan aimed at promoting young children's health, along with free infant health clinics run by pediatric nurses and drop-in centers for parents and children.[3] The objective of the Pregnancy Support Center in the program is to "act in terms of prevention in the domains of maternal and infant health (tobacco, alcohol, other addictions, stress, work conditions, precarity), of prematurity and low birth weight, and of pre- and postnatal depression."[4] The Early Childhood Plan thus consolidated the center's profile as a major public health actor in the canton, which came with financial support to expand the center's reach. This translated into increased staffing and a surge in consultations.

When I started my fieldwork in 2011, the Pregnancy Support Center had offices in nine cities across the Canton Romand and employed eleven midwives and seven social workers, a director, and a secretary. Offices were located in the vicinity of each of the seven public maternity hospitals spread across the canton. One regional office covered a region where a maternity hospital used to be located prior to its closure in 2005. In 2019, two maternity hospitals—and, consequently, two regional antennae of the center—merged into a newly built public hospital. The center has employed about thirty advisers in recent years, some working at a very low rate of 20 percent. When I was conducting observations, appointments

with midwives were more frequent, which explained (and was sustained by) more midwives than social workers employed at the center. Since 2017, however, the center has hired more social workers, bringing their consultations almost on par with midwives.'

Since the early 1990s, the Pregnancy Support Center has received clients in two types of locations: "in town" and "in hospitals." For "town" consultations, clients are received in the Intimacy Foundation's offices, which—depending on the city—may also host a local antenna of other foundation centers, such as family planning or couples' therapy. The Intimacy Foundation's offices are meant to create a warm and welcoming atmosphere and are decorated with bright colors, modern furniture, and plants. Walls are adorned with posters from previous or current public health campaigns such as "Stop smoking" or "Where to get help if you are a victim of violence." In the waiting room, flyers and brochures are placed on coffee tables or shelves for clients to help themselves and cover a wide range of topics related to health, sexuality, and parenting. Individual offices where appointments take place include office desks and a round table where midwives and social workers sit with their clients, as well as a comfortable chair or gym ball for pregnant women.

"Hospital" consultations, in contrast, are organized in a conference room, small office, or lunchroom of the maternity department of local public hospitals. These multifunctional hospital rooms are relatively anonymous, furnished simply with chairs and tables. Most of the time, the Pregnancy Support Center's staff only have a stack of printed files with them as well as blank forms they fill in with their clients. Rarely, some have a laptop ready on the table to fill in clients' electronic files directly, but most dislike using a computer during appointments, as they feel it is a barrier to interactions. The majority of midwives' appointments are organized in hospitals, especially initial appointments for which midwives often offer to tour the maternity ward with clients to introduce the delivery rooms, postpartum ward, and cafeteria. Psychosocial advisers usually have dedicated days of the week during which they work from their office "in town" or "in hospital." The center's secretary, who answers clients' calls to make appointments, thus indicates to callers where the appointment will take place.

The incorporation of the Pregnancy Support Center into the canton's Early Childhood Plan in 2006 translated into greater visibility of the center among prenatal care specialists and hospitals, which translated into a rise in number of yearly consultations and clients (see figures 1 and 2).[5] The busiest year so far was 2009, with 5,600 consultations and 2,742 clients. Compared to the number of pregnancies in the Canton Romand, this means that 33 percent of pregnant people visited the center that year. This effect seemed to taper off over time, though, with attendance dropping after 2009 and stabilizing from 2013. In the last decade, the Pregnancy Support Center has offered about 4,500 consultations every year to 2,100 clients, which represents approximately 1 out of every

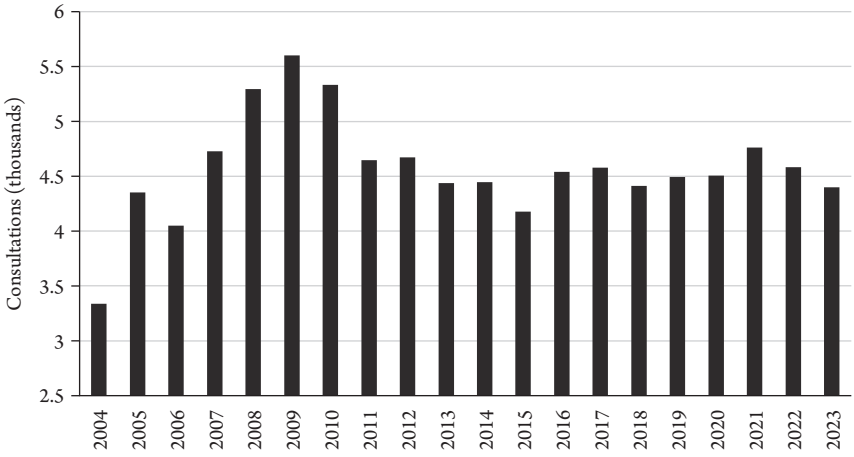

FIGURE 1. Number of yearly consultations at the Pregnancy Support Center from 2004 to 2023. (*Source:* Pregnancy Support Center database at time of analysis.)

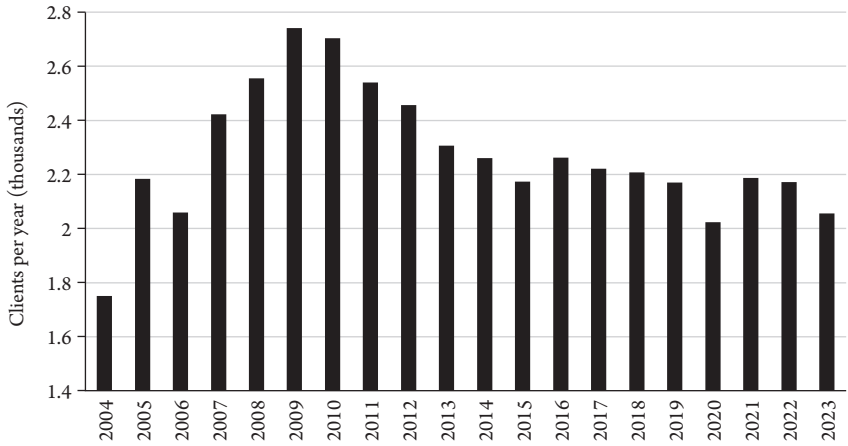

FIGURE 2. Number of clients per year visiting the Pregnancy Support Center from 2004 to 2023. (*Source:* Pregnancy Support Center database at time of analysis.)

4 pregnant people in the canton. Overall, while the number of clients shows a slight decline since 2009, the number of consultations per client has been slowly rising in the same period, illustrating a trend toward more follow-up appointments (see figure 3).

The COVID-19 pandemic caused the number of consultations and clients to rise temporarily in 2020 and 2021. Most consultations were conducted on the phone or via videoconference during the first and second waves of the pandemic (March to May and November to December 2020). While the Swiss government strongly recommended social distancing throughout the pandemic, a (semi-)lockdown was only imposed from mid-March to mid-May 2020, during

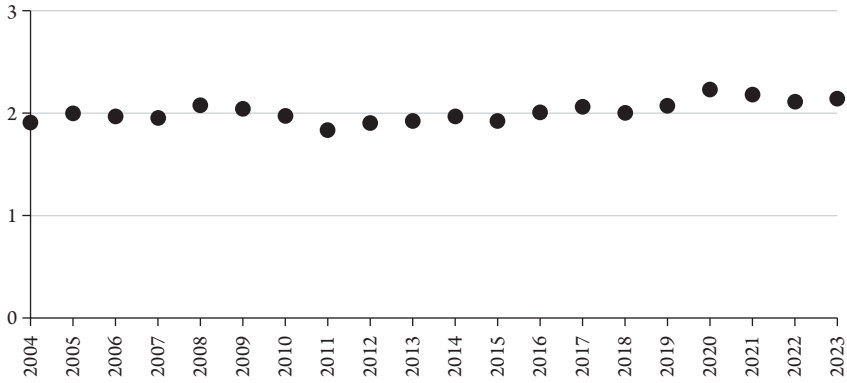

FIGURE 3. Average number of consultations per client at the Pregnancy Support Center from 2004 to 2023. (*Source:* Pregnancy Support Center database at time of analysis.)

which time all nonessential medical practices and stores were closed to in-person visits, which included the Pregnancy Support Center. From mid-May, the center resumed in-person consultations, including in hospitals, but continued offering phone and video consultations to protect their staff from infection. The pandemic thus did not impede the center's work—quite the contrary. Psychosocial advisers recall a surge in anxiety among pregnant people who feared for their health and that of their fetus and who asked for support to obtain medical leave from their jobs out of fear of being infected.

Clients at the Pregnancy Support Center are mostly identified as (cisgender) women. Apart from very rare occasions when a man visits the center without his pregnant partner, clients' files are opened under the name of the pregnant client exclusively, and couples' appointments are registered under the woman's name. While the number of men attending appointments at the center is not recorded, several indicators help estimate the number of men who attend consultations. First, roughly a quarter of appointments are recorded as "couple consultation," indicating that the pregnant client's partner was present (see figure 4). This could in theory include female partners, but according to the center's staff, lesbian couples very rarely visited the center (see chapter 2 for a discussion of heteronormativity). The rate of couple consultations dropped sharply in 2020 when most consultations were moved online due to social distancing rules. Second, about 1.5 percent of consultations are recorded as "partner only"; these are follow-up consultations in which the pregnant person is not present, which happens, for example, when a partner comes to discuss their employment issues with a social worker.

Clients of the center are a mix of persons with relative social and economic privilege (highly educated Swiss citizens with stable employment) and persons with a lower socioeconomic status. In comparison to the average profile of the Canton Romand's population, pregnant people under nineteen, those

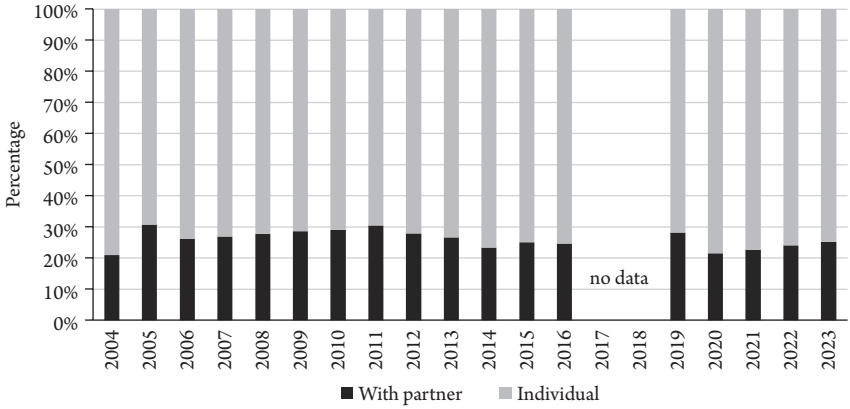

FIGURE 4. Share of consultations with a partner from 2004 to 2016 and 2019 to 2023. (*Source:* Pregnancy Support Center database at time of analysis.)

with a migration background, with a low education level, and those unemployed were overrepresented at the center. What follows are estimates based on available data.[6]

Clients registered as "younger than nineteen years old" formed about 2 percent of the clientele, which is twice their proportion in the Canton Romand. The Pregnancy Support Center and the Canton Romand's family planning centers are all part of the same Intimacy Foundation and therefore often operate from shared offices. Since family planning centers are especially popular among adolescents, many adolescents whose pregnancy was determined at a family planning center were directed to the Pregnancy Support Center. The other clients were equally divided among twenty to twenty-nine years old and thirty to thirty-nine years old. While the age at first birth has slowly risen from thirty to thirty-two years in the past two decades, the large share of clients younger than thirty at the center further illustrates that younger parents are more likely to be referred to the center.

In terms of nationality, the center attracts a large number of noncitizen clients, and increasingly so (see figure 5). While Swiss citizens have formed roughly 70 percent of the Canton Romand's population over the last two decades, they account for approximately half of the center's clients. Until 2012, the center attracted a growing number of clients with Swiss citizenship, reaching a high of 58.1 percent. Over the same period, the proportion of Swiss citizens in the Canton Romand was decreasing (from 72% in 2004 to 68% in 2012), which suggests that the center was increasingly popular among pregnant people with Swiss citizenship. After 2012, the trend reversed, however, and the proportion of foreigners among the center's clients grew, while among the Canton Romand population that proportion remained stable. At the time of my study, the center was increasingly supporting non-Swiss citizens. Among those, the center attracted

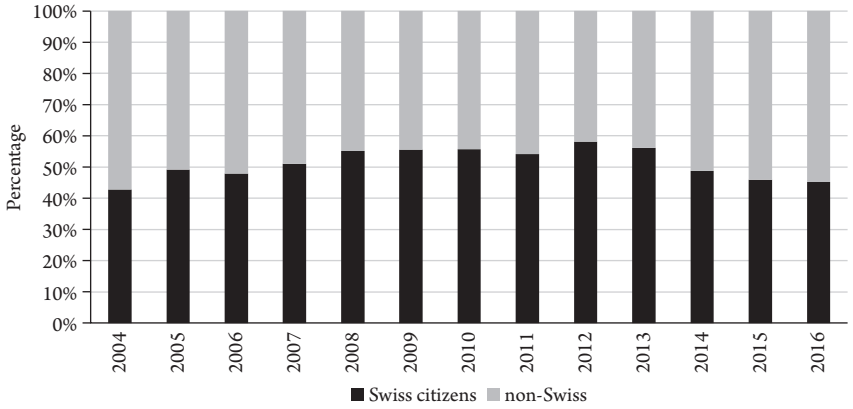

FIGURE 5. Share of Swiss citizens among clients at the Pregnancy Support Center from 2004 to 2016. (*Source:* Pregnancy Support Center database at time of analysis.)

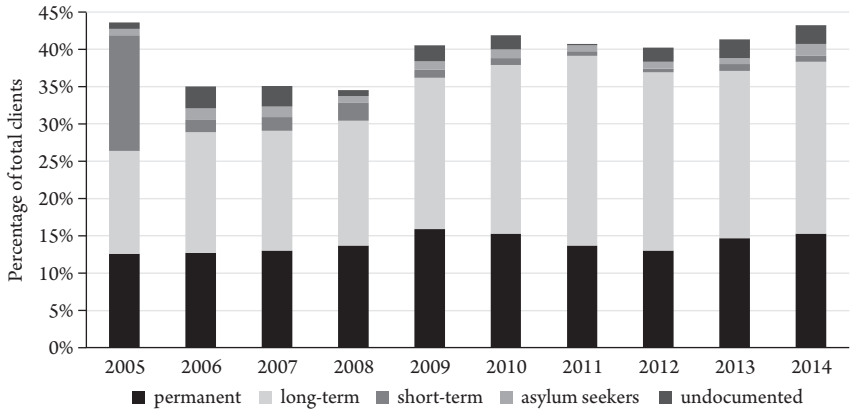

FIGURE 6. Noncitizen clients per immigration status at the Pregnancy Support Center from 2005 to 2014 The share of short-term permits in 2005 probably reflects an error in the database. (*Source:* Pregnancy Support Center database at time of analysis.)

a larger proportion of migrants with a temporary residence permit: The share of clients with a long-term resident permit (five-year "B permit") or a short-term residence permit (twelve-month "L permit") or of asylum seekers and undocumented migrants were all twice as high as in the canton's population (see figure 6).

Persons either with a very high or a very low level of education were more likely to make an appointment at the Pregnancy Support Center. The number of clients with a university diploma rose steadily from around 14 percent in 2004 to almost 30 percent in 2014, which suggests that the center is particularly attractive to highly educated persons whose proportion, in the same period, also rose in the canton but remained under 20 percent. The share of persons who had not

completed obligatory school was twice as high among the center's clients as among the general population; this figure shows a decline over time, though, in keeping with its decline in the population.

In terms of employment, the center seemed to attract a particularly large share of unemployed people. While the rate of unemployment remained around 4 percent to 7 percent in the Canton Romand between 2006 and 2016, the proportion of unemployed clients at the center reached 8 percent to 13 percent in the same period.

A RESPONSE TO MEDICALIZATION

Psychosocial pregnancy care at the Pregnancy Support Center builds on a critique of the medicalization of pregnancy and of the shortcomings of medical prenatal care. In a forty-page report presenting psychosocial pregnancy care in 2000—to date the longest written description of the center's mission by its own staff—Charlotte and Nadine, both founding members and lead midwife and social worker of the center, positioned psychosocial care as a complement to medical care. They first underlined the quality of prenatal care in Switzerland:

> If we compare Switzerland with other countries in the world, women here are fortunate to benefit from particularly efficient medical care. Not only is cutting-edge medicine available to them, but the quality of hospital care and hospitality is often incomparable to other less privileged countries. Women express how important it is for them to entrust their health and that of their unborn child to the competent and reassuring hands of doctors and midwives who will be there throughout the pregnancy and during childbirth.

Nadine and Charlotte then argue that parents need more than the existing medical care:

> However, future parents very soon realize that the questions that arise are not all within the realm of medicine. Many things in their emotional, relational, and social lives are changing and will continue to change. . . . It is very difficult for them to have a comprehensive view of the event they are experiencing. It is with these numerous questions that pregnant women and couples turn to [the Pregnancy Support Center].

Psychosocial care is thus conceptualized as different in kind from medical care.

Although unique in Switzerland, the Pregnancy Support Center is not alone in its critique of medical prenatal care. The creation of the center in the 1980s reflected advocacy for alternatives to biomedical care that circulated in Switzerland and globally. The Pregnancy Support Center is one local expression of

diverse reactions to the medicalization of pregnancy. During the nineteenth century, pregnancy and birth were progressively medicalized in Switzerland, as in most European countries and in North America (Burton-Jeangros, Hammer, and Maffi 2014b; Fournier 2013; Fuschetto 2017; Luisier 2006; Rieder 2007).[7] Before then, deliveries usually happened at home under the supervision of a traditional midwife. The rise of professional medicine and the development of obstetrics transformed reproductive experiences. Surgeons gained increasing legitimacy over pregnancy and childbirth, a larger proportion of deliveries happened in newly founded hospital maternity wards, and midwives were progressively marginalized. However, in contrast to other countries like the United States where obstetricians led almost all births by the 1970s (Arney 1982; Kline 2019; Wertz and Wertz 1977), midwives in Switzerland were largely integrated into hospitals (Luisier 2006). Thus, as Swiss anthropologist Caroline Chautems (2022a) argues, the stark dualism between the medical management of birth and the midwifery model that U.S. scholars described (Davis-Floyd 1992; Katz Rothman 1982) must be nuanced, as hospital midwives in Switzerland are active participants in the medicalization and technicization of hospital birth. Today, public maternity wards are largely run by midwives, who perform the vast majority of deliveries considered low risk ("physiological") in Switzerland. While they are trained to oversee the entire birth process from pregnancy to postpartum care, in hospitals midwives almost always work under the medical supervision of obstetricians and focus on monitoring deliveries and the first days postpartum. Midwives who work as independent health care professionals, in contrast, can provide holistic care including prenatal, birth, and postpartum care.

Despite the participation of Swiss midwifery in the medicalization of pregnancy and childbirth—or maybe because of it—the natural childbirth movements that grew in Europe and North America from the 1960s also had an impact in Switzerland (Chautems 2022a, 2022b; Rieder 2007; Vuille 2009). The biomedical approach to pregnancy and birth was increasingly criticized by some midwives' and feminist movements that sought to allow women to reclaim their bodies and play a more active role in pregnancy and birth (Kline 2019; Wertz and Wertz 1977). Natural childbirth advocates also sought to include partners and fathers more directly in pregnancy and birth. In Switzerland, the most vocal critiques of medicalization came from independent midwives, while hospital midwives (i.e., midwives employed in a hospital maternity ward) remained constrained by hospital policies and procedures (Chautems 2022a; Gouilhers 2010).

Inspired by the global natural birth movement, independent midwives opened the first midwife-led birthing center in Switzerland in 1983. In the decade that preceded, similar centers had opened in the United States and in several European countries to offer an alternative to hospital birth (Kline 2019; Quagliarello 2017). Currently, more than twenty birth centers operate in Switzerland

for a population of eight million; with four birthing homes, the Canton Romand presents their largest concentration. However, out-of-hospital births remained a small minority, amounting to only 1.7 percent of deliveries in 2017 and 3.8 percent in 2022 (Borner and Grylka 2023; Federal Statistical Office 2019). With cesarean section rates among the highest in Europe, birth remains highly medicalized in Switzerland (Chautems, Maffi, and Farin 2023; Maffi 2013).

Prenatal care is also highly medicalized in Switzerland. Pregnancy supervision was established by and remains mostly carried out by gynecologists. The basic prenatal care in Switzerland, entirely covered by health insurance, includes seven routine checkups and two ultrasounds (for more details, see chapter 5). Prenatal care is provided to most pregnant patients by a gynecologist in private practice (who, apart from prenatal care, also delivers contraception and pap smears). A minority of patients receive their prenatal care from midwives in maternity hospitals (mostly poorer, marginalized, or undocumented patients). Over the past fifteen years, an increasing proportion of pregnant people (mostly middle to upper class) have chosen independent midwives for part or all of their prenatal care. At the start of my research in 2011, about 10 percent of pregnant patients in Switzerland had one or more consultations with an independent midwife, but this rate rose steadily to reach 44 percent in 2022, according to the latest available statistics (Borner and Grylka 2023). Among those, first trimester consultations are rising (15.5% of independent midwives' pregnancy consultations in 2011, 42% in 2022), which indicates that independent midwives become involved at the very beginning of pregnancies more often. While the increasing popularity of midwife-led prenatal care is a long-term trend that reflects increasing skepticism of the medicalization of birth among middle-class parents in Switzerland (Chautems 2022a), the COVID-19 pandemic in 2020–2021 accelerated this trend. Restrictions imposed on hospital stays (COVID testing, masks, limitations on visitors) led more parents to turn to midwives and plan to give birth at home or in a midwife-led birthing home.

Although exact figures are not known, most pregnant people in Switzerland attend prenatal classes (*cours de préparation à la naissance/Geburtsvorbereitungskurse*) during their pregnancy. Prenatal classes originally emerged in the 1950s in Switzerland, at the same time French obstetrician Fernand Lamaze was popularizing his methods for "painless childbirth" as part of the natural childbirth movement (Knibiehler 2007; Rieder 2007; Vuille 2005). With the increasing technicization of childbirth and its relocation to hospitals, prenatal classes since the 1980s have been increasingly organized within maternity wards. Hospital midwives focus on introducing hospital routines and spaces to pregnant patients who plan to deliver their babies there (Avignon et al. 2023; Maffi 2014). Health care insurance partially covers the costs of the classes, which can include one to four sessions and cover childbirth, pain management, hospital stay, and infant

care. Additionally, hospitals and independent midwives offer a large variety of classes on specific topics such as baby massage, hypnosis, prenatal yoga, and water aerobics.

The Pregnancy Support Center thus opened in 1986 in a context in which the medicalization of pregnancy was being criticized, and independent midwives were implementing alternative care. The founding midwife, Charlotte, and social worker, Nadine, were both strong supporters of the natural childbirth movement. Their commitment to include fathers in their psychosocial consultation—who were at the time still rarely invited to attend prenatal care classes or admitted to delivery rooms—aligned with globally circulating ideals in the natural childbirth movement.

FRANCE'S PRENATAL INTERVIEWS

During the 1970s, other voices were being raised in France to challenge the shortcomings of the medicalization of prenatal care. Psychiatrists were advocating for better mental health care during pregnancy and the early postpartum. Some, inspired by psychoanalytical theories that framed pregnancy as a period of mental crisis (see chapter 3), were hired to work within maternity wards and offer psychological support to patients. Psychiatrists Monique Bydlowski (1991, 1997, 2000; Bydlowski and Camus 1988), Françoise Molénat (1992, 2001, 2004), and Sylvain Missonnier (2001, 2005) were among the first to join maternity hospitals, and they became vocal advocates for the development of perinatal psychiatry in France.

In the 2000s, psychiatrists succeeded in putting psychosocial prenatal care on the French government's agenda. The 2005–2007 Perinatality Plan (Plan périnatalité) aimed at reducing maternal and perinatal deaths (i.e., deaths of fetuses or infants before, during, or right after birth). It followed the 1994 Perinatality Plan, which pursued similar objectives by way of making medical care better and safer (Haut Comité de la Santé Publique 1994). With the 2005–2007 plan, the government vowed to further reduce mortality, which was still higher than in other European countries (Bréart, Puech, and Rozé 2004). But in contrast to the 1994 plan, in the 2000s the pathway to safer pregnancies and birth was considered to be not only making medical care safer but also developing "a more humane and closer" provision of care (*une offre plus humaine et plus proche*). A report by Françoise Molénat (2004) on "medical-psychological collaborations in perinatality" played a major role in steering France's public health policy toward the incorporation of psychiatric care alongside other medical measures.

The plan's first part, "More Humaneness" (Plus d'humanité), announced the implementation of a "fourth-month interview" (*entretien du quatrième mois*), a consultation with a midwife that would be offered to all "pregnant women

and future parents" during their fourth month of pregnancy in France. The interview's aim was "to promote the expression of [pregnant women's and future parents'] expectations, their needs, their project, to provide them with useful information about local resources they can utilize to achieve it, and to create secure relationships, including with the most appropriate partners in the perinatal network" (Bréart, Puech, and Rozé 2004, 2). France has a much more centralized form of governance than Switzerland, which allowed the government to implement the fourth-month interview over the whole national territory. In 2022, fifteen years after its creation, the fourth-month interview was offered to 62 percent of pregnant people in France (Ministère du travail 2024), with critiques pointing out that more human resources needed to be dedicated to psychosocial care and calling for a new Perinatality Plan (Villé 2023).

France's fourth-month interview seems to have inspired other (partly) francophone regions in Europe. In Belgium, a "prenatal interview" was implemented following the French model in 2005 (Absil, Vandoorne, and Prato 2008). The main public hospital in Geneva has offered prenatal interviews since 2008 to all pregnant patients planning their delivery there. The psychologist and psychiatrist who created the Geneva prenatal interview claim to have followed the model of both the Pregnancy Support Center and the French fourth-month interview (Sancho Rossignol and Nanzer 2010). Since the mid-2000s, the Pregnancy Support Center has also drawn inspiration from the French fourth-month interview and refers to French psychiatrists' conceptual framework (see chapter 3 for a description of Geneva's and France's psychosocial interviews).

These different forms of psychosocial pregnancy care were developed in the 2000s, two decades after the creation of the Pregnancy Support Center, but reflect the same turn toward psychosocial care during pregnancy. They share core principles with the Pregnancy Support Center: that psychosocial care should fill a void that medical care is considered to have left; that it should be offered ideally to all pregnant people, or at least to most of them; and that pregnant people's partners should also attend such consultations. But the Pregnancy Support Center differs from the French, Belgian, and Genevan models in that it was not initiated directly by psychiatrists. At the Pregnancy Support Center, psychosocial care is not only about incorporating a concern for mental health into prenatal care, as it is in France, for example, where the fourth-month interview is conducted by hospital midwives as part of regular prenatal care. Its form of prenatal care is distinct from and complementary to medical pregnancy supervision and can span the whole duration of pregnancy and the postpartum and—crucially—it involves social workers. In that sense, the Pregnancy Support Center's model is more explicitly "psychosocial" and separate from existing medical care.

REPRODUCTIVE GOVERNANCE AND THE SWISS GARDENING STATE

The Pregnancy Support Center was founded on the premise that all parents need psychosocial support. This is different, for example, from prenatal psychosocial support in the United States. In her ethnography of a prenatal clinic in New York City, Khiara Bridges (2011) revealed that publicly insured pregnant patients (which, in the U.S. health care system, signifies low-income women) are automatically considered "at social risk" and referred to a social worker. In Switzerland (like in France), psychosocial support is meant to be for all. This ideal has never been attained, however, since, as we have seen, the center tends to attract an increasingly large share of persons in lower socioeconomic situations. The intention to support and monitor every pregnancy can be understood against the backdrop of Switzerland's long history of reproductive governance, which has framed the reproduction of all members of the population as subjects of state intervention.

From the late nineteenth century, Switzerland was a pioneer of eugenics, both in the development of its scientific discourses and in the implementation of eugenicist policies and practices (Heller, Jeanmonod, and Gasser 2002; Jeanmonod and Heller 2001; Mottier 2000, 2005, 2008; Wecker 1998b, 2003). The country was a breeding ground for eugenics theorists of international renown like psychiatrists Auguste Forel, Eugen Bleuler, and Ernst Rüdin. The science of eugenics builds on the premise that both physical and moral traits such as mental illness, alcoholism, and more generally "immoral behavior" are hereditary. Eugenics is also a social project and aims to support government efforts to improve the "quality" of the population by discouraging the reproduction of citizens deemed "inferior" and encouraging the reproduction of "superior" persons. In Switzerland, those whose reproduction was deemed less desirable and who were targeted by eugenic policies included "Jews, 'vagrants' such as Yenish ('Gypsies') and other 'travelers,'[8] the mentally ill, the physically disabled, unmarried mothers, or homosexuals" (Mottier 2008, 265).

Until the 1980s, eugenic policies in Switzerland took a shape that eugenicists called "negative," indicating they were aimed at preventing the reproduction of certain individuals. This involved the use of coercive measures such as marriage bans, sterilization, and forced abortions (Heller, Jeanmonod, and Gasser 2002; Huonker 2002, 2003). In 1912, Switzerland was the first country in Europe to introduce a law banning the marriage of mentally ill persons on eugenic grounds (Wecker 1998a). The Canton Romand passed the first European law to legalize the coerced sterilization of "mentally ill and disabled" persons in 1928. In 1931, the same canton allowed eugenic abortions (Heller, Jeanmonod, and Gasser 2002; Jeanmonod and Heller 2000). This law was used to sterilize 187 persons

(mostly women) in the Canton Romand alone and was abrogated only in 1985 (Mottier 2005).

Coercive measures also entailed child removal. Between 1800 and the early 1980s, Swiss authorities removed hundreds of thousands of children from their parents and placed them in foster families or in institutions, where they were frequently mistreated and subjected to forced labor (Furrer et al. 2014; Galle 2016; Häfeli, Lengwiler, and Vogel Campanello 2024; Hauss, Gabriel, and Lengwiler 2018; Ziegler, Hauss, and Lengwiler 2018). Children placed in care mostly came from poorer families or from single or divorced mothers—parents deemed incapable of providing sufficiently good education and living conditions for their children. Between 1926 and 1973, the Swiss government sponsored a program, run by a private foundation, that separated about 600 Yenish children from their families as a means of sedentarization (Galle 2016; Galle and Meier 2009; Huonker 1987; Leimgruber, Meier, and Sablonier 1998).

Aside from efforts to prevent the reproduction of people deemed morally or physically inferior, reproductive governance also took the form of what eugenicists called "positive" eugenic measures, including education to encourage the reproduction of "good" individuals (Gerodetti 2006). With support from prominent eugenicists, marriage advice bureaus opened in several Swiss cities in the first half of the twentieth century to inform young people about the importance of choosing a "good" spouse from a eugenic perspective and to gather information about their heredity before marriage (Mottier 2000). Eugenicist rhetoric became increasingly sidelined only after the genocidal crimes committed by the Nazis in the name of racial hygiene during the Second World War became well-known (Gerodetti 2006).

To capture the nature of reproductive governance in Switzerland, sociologist Véronique Mottier (2000, 2005, 2006, 2008) coined the term "gardening state," a state concerned with removing the "weeds" from its national community. The heyday of eugenics in Switzerland, from the late nineteenth century to the mid-twentieth century, coincided with the construction of the modern nation-state and national identity as well as the development of the welfare state. In striking contrast to other modern nation-states in Europe, Switzerland comprises four national languages (German, French, Italian, and Romansh) and a mosaic of both Catholic and Protestant cantons. Eugenics, according to Mottier, contributed to the construction of a shared national identity by drawing boundaries between acceptable internal differences within the national community (language and Christian denominations) and differences that were a threat to the national order. Social policies inspired by eugenics applied these ideas to "eradicate the weeds from the Swiss garden" (Mottier 2008, 268). "In a nation state founded on linguistic and religious differences, some differences were less acceptable than others. Eugenically 'inferior' categories of the population were

held up as the unacceptable 'other' to the 'good citizens,' whose stock would form the building blocks of the future nation" (Mottier 2008, 268). The gardening metaphor suggests that at the same time Switzerland was cultivating some of its internal differences, it was excluding others. With regard to the dynamics of exclusion from the national community, eugenic discourses in Switzerland are interesting for their focus on *internal* others. Unlike colonial countries like the United Kingdom and France, Switzerland had no colonies,[9] which meant that eugenic policies focused not on colonized populations but on racialized internal others such as the Yenish and Jews and on other differences along gender, class, sexuality, or ability lines.

Historians have underlined that eugenic measures were applied in a very gendered way in Switzerland. The vast majority of sterilizations and abortions on eugenic grounds were practiced on single women (Huonker 2002, 2003). Until 1981, single mothers also faced potential administrative detention (i.e., being detained in prisons or institutions without a right to appeal), and their children were much more likely to be forcibly removed and placed in care by authorities (Delessert, Boraschi, and Valsangiacomo 2024b; Droux and Praz 2021; Independent Expert Commission on Administrative Detention 2019; Valsangiacomo et al. 2024). Importantly, gender intersected with class, with women from poorer backgrounds especially targeted.

GOVERNING PARENTS

The 1980s, when the Pregnancy Support Center was created, marked a major shift in Swiss reproductive governance, "from coercing to empowering" (Preissler 2022b, 101) reproductive subjects. All over Europe, governments at the time were moving away from coercive measures and were implementing new "supportive" measures to empower parents and protect child welfare through advice rather than direct intervention (Vandenbroeck, Roose, and De Bie 2011). In 1981, the Swiss law allowing administrative detention, which disproportionately targeted single mothers, was abrogated. Four years later, the Canton Romand abrogated its law on eugenic sterilizations.

A growing focus on supporting parents accompanied this shift. From the 1970s, the idea that "parenting" was an activity that required a certain skill set that could be learned and taught gained traction all over Europe and North America (Furedi 2008; Hays 1996; Lee et al. 2014; Macvarish and Martin 2022). The term "parenting" became increasingly popular in social policies and popular literature, along with the idea that what parents do is "both the source of, and solution to, a whole host of social problems" (Faircloth, Hoffman, and Layne 2013a, 1–2). Sociologist Sharon Hays (1996) argued that the dominant mode of parenting in the United States at the end of the twentieth century centered on an expectation of intensive maternal dedication. She coined the term "intensive

mothering" to capture this "child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive" (1996, 8) model of child-rearing. Intensive mothering profoundly shaped expectations of good parenting in Europe, as parenting culture scholars have shown (Faircloth, Hoffman, and Layne 2013b; Hamilton 2022; Lee et al. 2014). In the Swiss context, the ideology of intensive mothering gained prominence in the childcare advice literature that circulated during the twentieth century (Preissler 2022b) and remains influential among contemporary parents (Ballif 2024; Baumgarten and Maihofer 2021a).

Today, parenting support is the main form of reproductive governance in Switzerland. Across all Swiss cantons, state-sponsored units and programs offer free advice and guidance to support parents in their tasks. These experts—whose number and profiles vary depending on each canton's policies—include pediatric nurses, lactation consultants, "mothers' and fathers' advisers" (nurses trained in parenting support), and independent midwives providing postpartum care. These experts all provide advice and support for newborn care, infant feeding, child development, education, or children's health. This includes public health advice on how to feed infants and children, which reproduces normative ideas of good parenting (Ballif 2023b, 2024). Such parenting experts play a key role in the diffusion of an ideology of good parenting as intensive (Chautems 2022a; Preissler 2022a). Contemporary reproductive governance thus takes the form of parenting support from a distance rather than direct intervention into reproductive capabilities.

When describing the rise of intensive mothering in the United States, Sharon Hays (1996) underlined that this ideology was in tension with the concomitant entry of women into the workforce following the Second World War, which made expectations of intensive parental commitment almost impossible to meet. In Switzerland, Giraud and Lucas (2009) characterized the gender regime as "neomaternalistic." Despite women's significant integration into the workforce in the twentieth century, the family model of "man as breadwinner" and "woman as caretaker" remains very common (Madörin, Schnegg, and Baghdadi 2012; Rossier, Bernardi, and Sauvain-Dugerdil 2023). In 68.8 percent of families, women perform the majority of housework and childcare duties, according to the latest statistics report on Swiss families (Federal Statistical Office 2021). This translates into a lower participation of mothers in the workforce. While Switzerland has the second-highest rate of women in paid employment in Europe, it also ranks second in the highest share of women working part-time (Federal Statistical Office 2020b). Women with children in particular work substantially reduced hours in comparison to fathers. Only about 15 percent of women with children work full-time, compared to approximately 80 percent of men with children (Federal Statistical Office 2021). Four out of every twenty mothers do not work at all in comparison to fewer than one out of twenty fathers. In other words, the most common type of family is one in which the father works

full-time and the mother part-time or not at all. Becoming parents is a key driver of gender inequality. Becoming a father pushes men to work outside the home more than ever over their life course (average employment rate of 97.6%; Federal Statistical Office 2021). Becoming a mother leads to a 20 percent drop in women's employment rate, with mothers of children under twenty-five working less than other categories of women. Mothers' employment rates tend to rise with the age of their youngest child, but statistics show that full-time employment remains low (20.1%) among mothers even when their youngest child is eighteen to twenty-four years old (Federal Statistical Office 2021).

The persistence of traditional gender roles in Switzerland is linked to the fact that family policies in Switzerland are notably underdeveloped, and government spending remains low in comparison to most European states (Häusermann and Bürgisser 2023; Rossier, Bernardi, and Sauvain-Dugerdil 2023). Public spending on childcare provision is well below that of other OECD countries, resulting both in a shortage of childcare facilities in urban areas and in extremely high costs for parents. The parental share of childcare costs is "at least twice as high as in the rest of the OECD" (Häusermann and Bürgisser 2023, 741). It was only in 2004 that legally guaranteed maternity leave was introduced at the federal level. Before that, the situation differed from canton to canton and from employer to employer. With a duration of only fourteen weeks with 80 percent of one's salary, the Swiss maternity leave is well below the forty-week average of OECD countries (Häusermann and Bürgisser 2023, 738), although some employers, especially in the public sector, offer more generous maternity leave, generally five to six months. Since 2021, fathers have received two weeks' paternity leave—also much shorter than in other European countries. Moreover, with rare exceptions, state schools close for a two-hour lunch break, during which children traditionally go back home. Especially in urban areas, lunch clubs can welcome children during the lunch break, but places are limited, and parents are charged a fee. As a result, combining paid work and parental duties is notably more difficult in Switzerland than in neighboring countries. Switzerland also does not have pronatalist policies, which may be because despite decreasing birth rates, immigration keeps population levels stable (Federal Statistical Office 2022).

Contemporary reproductive governance in Switzerland is thus based on the view that raising children is a private affair, with the financial costs of children largely left to parents. Even so, it must be accomplished under expert guidance. At the same time, nonnormative family models are still subjected to more direct restrictions on their reproductive lives. Echoing earlier eugenic policies aimed at preventing the reproduction of undesirable "others," significant barriers still exist for nonnormative family forms to access reproductive technologies in Switzerland. The Federal Act on Medically Assisted Reproduction, which came into force in 2001, restricts access to married couples only, which at the time excluded

same-sex couples and single persons.[10] Same-sex marriage was legalized, and access to assisted reproduction for same-sex couples therefore granted, only in 2022. However, egg donation and surrogacy are still forbidden, and significant legal and financial barriers to same-sex couples' reproductive journeys remain. Consequently, many LGBTIQ+ and single prospective parents choose to travel abroad to access technologies that are forbidden in Switzerland (Siegl et al. 2021). These barriers to reproduction for individuals who fall outside heteronormativity can be seen as forms of "social sterilization," as Marcin Smietana (2024) argues: While it is not the body that is made infertile through direct state intervention, legal regulations still significantly impede the reproduction of some.

CARING FOR WOMEN, CARING FOR CHILDREN

While the natural birth movement advocated for more woman-centered care, reproductive governance in Switzerland is marked by a long-standing concern with the fitness of future generations. At the confluence of these two histories, the Pregnancy Support Center's model of psychosocial care is built on a tension, dedicated both to supporting women and to protecting children.

As discussed above, the center was created by a midwife and a social worker who described themselves as supporters of woman-centered care. As part of their critique of the medicalization of pregnancy, they were critical of the almost exclusive focus on fetal health in medical prenatal care and saw psychosocial care as a counterbalance. Charlotte and Nadine explicitly linked their support for woman-centered care to feminism. Both identified as feminists, and Nadine had been active in feminist movements most of her life. By the time I started my research, feminism was no longer held as a foundation of psychosocial care. Few psychosocial advisers identified with feminism, which they considered to blur differences between men and women. While they all defended equality, most regarded differences between women's and men's reproductive roles as natural and valuable, as Beatrice explained to me:

> [I support] education for everyone, studies for everyone, work for everyone, equality in tasks and everything, but I also think that equality is not possible, it is complementarity that is possible. . . . A man is not a woman. Biologically, we are already different, so inevitably we are different. . . . No, we are not the same, no, we are not really equal. We can be equal in certain areas. We need to value the differences precisely because that is what allows us to be together, to appreciate each other.

Some psychosocial advisers criticized feminism for having blurred traditional gender roles, like Cecile:

> Before, if you will, [fathers] had their well-defined role, which was a role of supporting the family financially, professionally, etc., whereas now they take more part in caring for the baby, etc., so that is great, but sometimes there is confusion of roles. So the mothers want the fathers to do everything like them, you know, and then sometimes the father takes the place, he ends up taking the mother's place, well there you go. But the roles are different.

It is thus according to an essentialist view of gender roles that psychosocial advisers advocated for centering women in their consultations. This concurs with the conceptualization of pregnancy and birth as a source of power for women that is widespread among midwives in Switzerland and within the natural birth movement more generally (Bobel 2002; Chautems 2022a; Faircloth 2013; Guignard 2020). This approach limits fathers to a secondary role, as I discuss further in chapter 2.

On the other hand, psychosocial pregnancy care was also established in Switzerland as a form of early intervention for infants and children. At the same time as the Pregnancy Support Center was developing, child welfare services and social workers in the Canton Romand were campaigning for more comprehensive policies to prevent child abuse. Pregnancy was repeatedly identified as a period during which early signs of child abuse and of child neglect could be identified. In one pilot project in the early 1990s, the child protection services in a midsize city of the canton hired a midwife to meet expecting couples (the position was later incorporated into the Pregnancy Support Center). In 2006, these efforts resulted in Canton Romand's first Early Childhood Plan, which included the Pregnancy Support Center as a key actor promoting children's health and well-being.

The double genealogy of the center as woman- and child-centered is evident in the first policy documents that I found in the center's archives. The then-director of the Intimacy Foundation presented the importance of the Pregnancy Support Center on the dual grounds of protecting children and supporting women:

> Precarious material and psychosocial conditions and loneliness play major roles in the incidence of child development disorders, maltreatment, and early psychological disturbances. Distraught by their multiple difficulties, some young parents do not have the resources to establish a positive bond with their child. Hence the importance of a prevention policy that does not limit itself to taking into account the needs of the individual only from birth onwards.
>
> Our concern is to offer a service that addresses maternity in its entirety. Pregnancy and the arrival of a child require each person to readjust their practical, emotional, and relational life. While most future parents don't necessarily have "problems," they all have questions. To help them build a new life plan that takes into account their needs and those of the child, they must be able to find answers to these questions as they arise. (Internal document, 1993)

Since the mid-2000s, however, the center has tended to move away from explicit mentions of preventing child abuse or neglect. While still integrated into the canton's Early Childhood Plan, its website, brochures, and flyers define the center's mission as supporting future parents and not protecting children. This may reflect controversies that arose in France that raised concerns that psychosocial prenatal care (the French fourth-month interview) could be misused as a form of social control over parents. Psychiatrists argued that fourth-month interviews should focus on supporting parents rather than detecting risk factors for psychological disorders in children, as a research report suggested at the time (Dugnat and Douzon 2007; Missonnier 2007b; Neyrand 2007). They warned of the difficulty of predicting future outcomes in children's development as early as pregnancy and underlined the importance of offering support rather than surveillance of future parents. The vocabulary used at the Pregnancy Support Center over the past two decades reflects this commitment to supporting parents rather than early risk detection.

The Pregnancy Support Center is at the crossroads of different, sometimes contradictory transformations of reproductive governance. Its model of care seeks to open up a new space of reproductive care, which aligns with the global midwifery movement's advocacy for psychosocial care as well as some psychiatry-inspired transformations of prenatal care in francophone Europe and with the development of parental support in Switzerland. At the same time, the influence of public health, the development of programs to promote children's health, and a gender-conservative context also mark the organization of the center. As a result of this complex background, the very definition of psychosocial care in Switzerland is marked by tension. This tension is most obvious in the delineation of the center's clientele. Clients ought to be from all socioeconomic backgrounds, and they are to a certain extent but not entirely, reflecting the structural inequalities of Swiss society. They ought to be women and men but are mostly women, reflecting the gendered distribution of reproductive responsibilities. The appointments ought to focus on parents, but local public health policies favor a focus on future children's health. The creation of the unit illustrates yet another tension, having redirected a law targeting women seeking abortions to provide a service to all pregnant women. Drawing boundaries around categories of reproductive subjects that should constitute the clientele of psychosocial care is thus a dynamic process, one that includes unsolved contradictions. Those tensions will remain salient, as evident in the day-to-day practices of psychosocial advisers.

2 • THE BOUNDARIES OF PSYCHOSOCIAL CARE

I briefly encountered Valerie in 2012 when I attended her appointment with the midwife Colette at the Pregnancy Support Center. Valerie was a thirty-three-year-old cisgender woman in the seventh month of her first pregnancy. Employed full-time as an office clerk, she was soon to be married to her thirty-six-year-old partner, a lumberjack who had fathered her unborn child and who had two young daughters from a previous union. Her pregnancy was medically unremarkable, and she received standard prenatal care through regular consultations with her private gynecologist, as is usual in Switzerland. She intended to deliver at the public hospital maternity ward nearest her residence—it was there that we met. Although I only exchanged a few words with Valerie, by observing her appointment I learned quite a lot about her life circumstances. This window into people's lives that the center's appointments provide delineates the territory of the Pregnancy Support Center: the psychosocial dimensions of pregnancy.

Valerie's gynecologist had recommended she schedule a consultation at the Pregnancy Support Center to receive guidance on the legal documentation required, as Valerie might not be married at the time of birth. According to the Swiss Civil Code, if a child is born to an unmarried mother, legal paternity is established through "paternal recognition"—a declaration of paternity submitted to the Civil Records office before or after the birth. At the time of my fieldwork, if unmarried parents wished to share parental authority, they had to file an additional declaration, but since 2014, parental authority has been shared by default. However, Valerie's queries about these administrative and legal steps went unaddressed during her appointment with Colette. As is customary at the Pregnancy Support Center, her first appointment was automatically scheduled with a midwife. Early on in the meeting, Colette explained that administrative questions would be better answered by a social worker and suggested that Valerie make a separate appointment with her colleague. Valerie ultimately did not

pursue this option. Instead, Valerie was offered a comprehensive "initial appointment" by Colette, which entailed a review of all psychosocial aspects of her pregnancy.

How is the psychosocial territory of pregnancy defined at the Pregnancy Support Center? On what presumptions does it rely? I approach the center's appointments as a "dispositive" (*dispositif*) in the Foucauldian sense, an institutional apparatus that produces knowledge as well as power relations (Foucault 2004). Examples of dispositives in Foucault's writings are prisons, schools, hospitals, or factories—apparatuses that capture, control, and orient individual behaviors. Drawing from Donzelot's (1977) classic work *The Policing of Families* (*La police des familles*), francophone sociologists have analyzed how reproductive governance is enforced through dispositives such as prenatal care, abortion care, child welfare, and early education (Boulet 2021; Cardi 2004, 2007; Garcia 2011; Memmi 2003). Building on Foucault's idea of a knowledge/power nexus at the heart of dispositives, in this chapter I describe on the one hand the conceptual boundaries (or knowledge systems) that define "the psychosocial" as a domain of prenatal care and on the other the moral boundaries that distinguish some categories of clients as more in need of professional support than others.

VALERIE'S PSYCHOSOCIAL APPOINTMENT

During my time at the Pregnancy Support Center, I grappled at length to understand precisely what constituted the psychosocial domain beyond the basic definition of being "distinct from and complementary to" the prenatal care provided by gynecologists, as no clear definition existed. One way to get a sense of the conceptual contours of psychosocial care is the list of topics covered during consultations at the center, as found in the unit's policy documents and archives. A list of topics appeared in a 1997 internal policy document and was then frequently reused in the center's policy documents.

Consultations at [the Pregnancy Support Center] offer information, listening, and orientation about the following:

- Pregnancy and its progression: the baby's development, bodily changes, physical activities, postures, relaxation, dietary behaviors, sexuality, and couple dynamics
- Psychological changes inherent to maternity and the transition to parenthood
- Challenges in life or personal and couple organization related to the child's arrival
- Childbirth, various approaches to childbirth preparation, and childcare classes
- Postpartum: welcoming the newborn, postpartum care, breastfeeding, contraception, sexuality

- Legal matters: labor rights, maternity leave, child recognition, paternity testing, disavowal of paternity, etc.
- Social issues: public and private benefits, allowances, insurance, home assistance, daycare, nurseries, childminders, community resources, etc.
- Challenges related to residency permits and insurance coverage
- Multiple pregnancies: organization, support, specific benefits.

According to policy documents, the topics covered in the center's appointments encompass the physical experience of pregnancy, birth, and the postpartum period; psychological and relational aspects; practical organization; and legal and administrative matters. Such lists do not entirely reflect daily practices, however. My immersion in psychosocial advisers' daily activities revealed that some topics including multiple pregnancies and sexuality were rarely discussed. Although the list suggested that physical health and the body were to be discussed, in practice these topics were given limited attention and usually were restricted to general information on the timing of labor or the stages of pregnancy (e.g., suggesting that prolonged standing may become difficult in the last trimester due to the baby's weight). In line with the psychosocial orientation of the unit, these aspects of pregnancy were mostly considered the territory of medical care unless a physical issue was relevant from a psychosocial perspective.

I realized over time that initial appointments provide the clearest sense of how psychosocial advisers delineated the conceptual boundaries of their professional territory. This is because during an initial consultation, midwives and social workers aim to assess the multidimensional situation of the pregnant person along the dimensions they deem most relevant. What they inquire about, advise on, and evaluate demarcate the boundaries of psychosocial prenatal care. What they omit is a clue to what they leave to other professionals or for pregnant individuals to navigate independently. A second reason why initial consultations are of particular interest is that this is the most frequent type of consultation provided at the center. At the time of my observations, for two out of three clients, it was their sole consultation. Exploring the proceedings of an initial appointment thus gives us a tour of the center's approach to psychosocial pregnancy care.

On a crisp November morning, I made my way to a regional public hospital in a small Swiss town to join midwife Colette and observe two initial consultations with pregnant clients. I made my way directly to the hospital maternity ward, one of six in the Canton Romand. I had known Colette for many years, having held an administrative position at the center long before returning as a researcher. This long-standing and trusting relationship prompted Colette to immediately volunteer when I inquired about which staff members would permit me to observe their consultations. Colette ushered me into the lunchroom of the maternity ward, empty at that time, where she would receive her clients.

She asked me to stay there while she went to the waiting room to greet her first client of the day, Valerie, and obtained her consent for me to observe the consultation. As Valerie agreed, midwife Colette escorted her into the lunchroom, where I greeted her. We all took seats around a round table.

Initial consultations are guided by a threefold objective: to assess the client's situation, determine whether further appointments or referrals should be recommended, and complete the "transmission document,"[1] a form that summarizes the case for the maternity ward staff (doctors, midwives, and nurses). Valerie's sixty-minute appointment unfolded to the cadence of Colette's questions. From biographical details to lifestyle habits, Colette canvassed a vast panorama of Valerie's life and pregnancy experience, documenting key responses on the transmission form while offering guidance and advice when deemed necessary. After a brief introduction to the Pregnancy Support Center, the initial segment of the appointment focused on the client's biographical and administrative information.

COLETTE: So your full name is Valerie [last name]?
VALERIE: Yes.
COLETTE: What is your date of birth?
VALERIE: [*States her date of birth*].
COLETTE: So you are thirty-three?
VALERIE: Yes.
COLETTE: Your nationality?
VALERIE: I am Swiss.
COLETTE: And do you work?
VALERIE: Yes, I am an office clerk.
COLETTE: At which percentage?
VALERIE: 100 percent.

Maintaining this staccato line of questioning, Colette then inquired about Valerie's partner:

COLETTE: And what about the future father? What's his name and date of birth?
VALERIE: [*Names the father and his date of birth*].
COLETTE: And you are in a relationship, yes?
VALERIE: Yes.
COLETTE: Are you married?
VALERIE: No, but we plan to get married soon.

Colette then turned to the topic of children:

COLETTE: What is your due date?
VALERIE: [*States due date*]. I am in my seventh month.

COLETTE: Is this your first pregnancy?
VALERIE: Yes, but my partner has two girls from a previous relationship.
COLETTE: Okay. So as far as you are concerned, no previous miscarriage or abortion?
VALERIE: No.

Colette also requested the name of Valerie's health insurance provider, general practitioner, and gynecologist. She manually filled out the transmission form as she proceeded. After this initial volley of short questions, the consultation delved deeper into the following topics: father/partner, work, psychological aspects, relational aspects, practical organization, health, and preparation for the hospital stay.

Father/partner. Having already ascertained that Valerie's current partner was the baby's father, Colette proceeded to inquire about his name, date of birth, occupation, employment status, and nationality. When a pregnant client explained that her partner was not the biological father, midwives collected contact information from the current partner while only documenting details about the biological father's anticipated involvement (e.g., whether he would visit the newborn at the hospital and custody arrangements).

Work. Colette inquired about the duration of Valerie's intended maternity leave, which in Switzerland can range from the legal minimum of fourteen weeks to five or six months in the public sector—with some mothers supplementing this with a portion of their annual paid leave allotment or unpaid leave. Midwives provide their clients with basic information on state financial support and allowances available to parents in the region (including a birth allowance of CHF 1,500 [US$1,650] per child) but offer to schedule an appointment with their social worker colleagues if clients have further questions on this aspect.

Inquiries about employment serve as an indirect means of assessing families' financial circumstances. When a client is unemployed, especially if they work in a low-wage sector such as the service sector, midwives dedicate additional time for further assessment and support because of the presumed financial precarity associated with unemployment. For instance, when Clara, a thirty-two-year-old woman pregnant with her second child, met with midwife Beatrice for her initial appointment and disclosed being unemployed ("*au chômage*," implying she was receiving unemployment benefits), Beatrice immediately posed additional questions: "Until when are you entitled to unemployment benefits?"; "Have you heard about the birth allowance you will receive from the canton?"; "When your first child was born, did you receive any financial assistance?"; "Do you still have essential baby items from your first child?"; "Do you know where to purchase inexpensive baby necessities?"; "Do you have friends who could pass along some baby items?" This approach allows midwives to tailor their questions and support to their assessment of each family's needs. In Clara's case, midwife Beatrice initiated a discussion about financial resources because she assumed

this family to be in a precarious financial situation, without ever directly inquiring about their disposable income.

Discussions about employment also afford midwives an opportunity to offer counseling on balancing work and maternity. When Valerie informed Colette that she was employed full-time as an office clerk, Colette lifted her gaze from the transmission form to ask her whether she would be able to reduce her work hours toward the end of her pregnancy—to which Valerie responded uncertainly. Colette urged her to reduce her work time as soon as possible to avoid insomnia, exhaustion, or depression. In Switzerland, contrary to other European countries, pregnant women are not automatically granted medical leave from work in the final stages of pregnancy. Decisions to reduce work hours are made by private gynecologists on a case-by-case basis. The center's midwives were critical of the expectation that pregnant women should work until the very end of their pregnancy and routinely encouraged their clients to request being placed on leave by their gynecologist, warning them of potentially severe consequences for their health if they exhausted themselves.

Psychological aspects. Colette inquired how Valerie had been feeling during her pregnancy and whether she had long desired to become pregnant. Valerie responded that she had wanted this pregnancy, that it had taken only five months to conceive, and that she felt "great, no nausea, only tired." Colette summarized this as a "harmonious, fulfilling pregnancy" (grossesse harmonieuse, épanouissante) and did not probe further. In contrast, Lana's appointment with midwife Barbara entailed an extensive discussion of her mental state. Lana, a thirty-five-year-old nurse pregnant with her first child, informed the midwife that she had been frequently crying because her partner had recently left her. After reassuring her that her emotions would not affect her baby, as I describe further in chapter 3, midwife Alexandra asked Lana to elaborate on the reasons behind her partner's decision to leave her. Lana replied that her ex-partner was "not ready" to become a father. Alexandra sought to rationalize the absent partner's behavior:

ALEXANDRA: What happens is that he doesn't trust himself to play the role of a father.

LANA: And he had an absent father himself.

ALEXANDRA: Ha! He didn't have a role model.

LANA: No. And he thinks he is behaving just like his father. He is considering seeing a therapist.

ALEXANDRA: I think becoming a father touches upon something very deeply buried within him. Do you write to each other?

LANA: No, but I am thinking about it.

ALEXANDRA: I think it would be a good idea. I think you should still nurture this relationship as a couple.

The conversation about Lana's mental health concluded with her declining therapy for the time being, after which the discussion transitioned to other topics. As in Lana's case, inquiries about psychological well-being can open avenues for midwives to explain, advise, and guide their clients.

Relational aspects. Colette probed into Valerie's relationships with her partner and family: "Is your future husband happy about the pregnancy? Is he supportive? Is he helping you with household chores?" Valerie affirmed that yes, her partner was very happy and that this was his third time expecting a child, as he had two daughters from a previous marriage. This prompted further questions from Colette: "What are the girls' reaction to the arrival of a new sibling?," and "Are they not jealous?" Valerie responded that no, her two stepdaughters were merely impatient. What Colette was eager to ascertain was whether conflicts and tensions were present in Valerie's immediate environment.

The topic of family relationships was particularly emphasized with clients with a migration background. Jane, a twenty-nine-year-old Swiss citizen, explained to midwife Beatrice during her initial appointment that her family resided in Kosovo. Beatrice then posed a series of questions to map out Jane's support system: "Where were you born?"; "When did you migrate to Switzerland?"; "Will your mother come to Switzerland when the baby is born?"; "Is your future husband Swiss?"; "Where does his family live?"; "Does he have siblings?"; "Where do they live?"; "Have you met them?" The goal of this detailed mapping was to assess Jane's risk of being isolated and lonely—a risk that the center's advisers associate with migration. Midwives and social workers consider having family members living nearby or visiting in the weeks following birth an important factor in reducing the risks of postpartum depression because they assume relatives will be supportive, even though some pregnant people said they dreaded the intrusion of such family visits.

Although Colette omitted the question, many initial appointments also entail an inquiry about intimate partner violence, such as "Have you experienced domestic violence?" (the center's screening strategy for intimate partner violence is discussed in chapter 6). If Valerie had hinted at conflicts, as I witnessed in other appointments, Colette would have offered advice—like carving out quality time with one's partner before the birth—and would have referred Valerie to couples' therapy or a women's shelter, depending on the apparent severity of the situation. Only once did I hear a pregnant client answer that she was a survivor of intimate partner violence, but since the abuse had occurred with an ex-partner, the midwife swiftly moved on to other topics.

Practical Organization. While midwife-led prenatal classes in Switzerland typically cover the labor process itself, its timing, and unfolding (Avignon et al. 2023; Maffi 2014), some midwives at the Pregnancy Support Center incorporated basic

information during appointments, such as how to time contractions and discern when to proceed to the maternity ward. Practical questions also extended to the postpartum period, encompassing intentions regarding breastfeeding, contraceptive choices after birth, and the name of the future child's pediatrician. Colette informed Valerie about the two types of (complimentary) home visits she would receive after delivery, by an independent midwife and by a pediatric nurse. She also inquired about childcare arrangements: Had Valerie registered her unborn child for a place in local nurseries? With nurseries and accredited childminders in dire shortage in Switzerland, even early registration during pregnancy does not guarantee a spot at the conclusion of one's maternity leave. Colette's question served as a means to ensure her client was planning ahead.

Health. The territory covered by the Pregnancy Support Center deliberately excludes the biomedical aspects of pregnancy. Yet biomedical health is not entirely omitted. As part of her exploration of Valerie's pregnancy experience, Colette inquired whether she was generally in good health, had undergone major surgeries in the past, or had any allergies. However, these questions were not posed with a medical intent—Colette's primary concern was potential psychosocial implications. Valerie disclosed having previously undergone bypass surgery to treat morbid obesity. Colette, again lifting her gaze from her paperwork, asked: "And how is it going with your pregnancy in relation to your body image?" Valerie's mention of past obesity prompted Colette to consider whether she might be uncomfortable about weight gain during pregnancy. Since Valerie indicated she was not, the subject was dropped. Concerns rooted in the body serve as an entry point for exploring psychosocial matters.

Another impetus for the center to address biomedical concerns was to fulfill its public health mission. The Pregnancy Support Center receives government funding because it was integrated into the cantonal early childhood health promotion policy in 2006. In accordance with this public health mandate, psychosocial advisers addressed two public health topics during each initial consultation: alcohol and tobacco consumption. When Colette asked Valerie if she was a smoker, Valerie affirmed she was but that she had reduced her smoking from twenty to ten cigarettes per day since becoming pregnant. After commending her efforts, Colette inquired whether Valerie could consider further reduction, to reach two to three cigarettes daily. Valerie responded that she had discussed this with her gynecologist, who advised against attempting further cutbacks if it would heighten her stress levels. Colette then inquired about Valerie's partner's smoking habits. Since he, too, was a smoker, she immediately asked how the couple would protect their future newborn from secondhand smoke exposure: "Have you thought about which rooms will be smoke-free?" Valerie stated he would smoke on the balcony. Colette, apparently assessing the situation as presenting health risks for the future baby, advised:

> It's true that compared to ten, fifteen, or twenty years ago, we're much stricter now, right? A newborn should never be in a smoke-filled environment. . . . They even say that a dad who smokes, like you mentioned, a pack—it might seem extreme that we suggest this, but I've heard that now they even recommend smoking dads and moms change clothes before holding the baby because there are many particles deposited on us that the baby would inhale, and then—Yeah, in any case, never smoke next to the baby or in the car. . . . And then, regarding breastfeeding, they always say "breastfeed and then smoke afterward." So there's no nicotine [in your milk]. And I think that if from ten [cigarettes per day], you could manage to bring it down to four to five in the coming weeks . . . maybe by working less?

The center's midwives are not specialists in addiction and do not offer mid- or long-term support. However, they do deliver health promotion messages and guidelines to their clients, indicating the direction they should take for a healthy pregnancy and infancy. The same approach is taken regarding alcohol consumption. Colette inquired whether Valerie consumed any alcohol. Since Valerie stated she did not, demonstrating adherence to the Swiss recommendation of abstinence during pregnancy, Colette briefly confirmed this was the appropriate approach according to medical and public health authorities:

> The guidance now is "zero, zero alcohol," and that the baby is truly in a context, in a closed environment, so everything they receive, they receive at the same dosage as us. If we have a glass of wine, the baby, with their size, will receive the same dosage. And they can't eliminate it like us through the skin, through—So they really say absolutely zero alcohol.

Preparation for Hospital Stay. Since Valerie's initial appointment took place inside the maternity ward, Colette offered her the opportunity to tour the maternity ward before leaving. When I joined Colette, I was surprised to see her donning the white coat typically worn by hospital health care staff (doctors, nurses, and midwives alike) in Switzerland, despite not being a hospital employee. Colette explained that she wore the white coat when receiving clients at the hospital, primarily to be identified by hospital staff as "one of them" and so to facilitate interprofessional communication. After inquiring if Valerie had any remaining questions, Colette assumed another role, that of a guide introducing hospital facilities to Valerie. Most expecting parents attend birthing classes at their local public hospital, which includes visiting the labor and delivery rooms—an opportunity Valerie had missed by attending classes with an independent midwife. Colette, Valerie, and I thus exited the lunchroom and proceeded down a corridor to one of the labor and delivery rooms. There, Colette briefly pointed out various equipment Valerie might utilize during labor, such as exercise balls

and a bathtub. Valerie expressed happiness at having previewed the facility before her due date. Colette and I then escorted her back to the entrance of the maternity ward and Valerie took her leave.

A HARMONIOUS PREGNANCY

Psychosocial advisers draw a distinction between two categories of clients: those for whom "everything goes well"—the "simple cases"—and the other, "complex" cases. Midwife Julia was among those who volunteered to permit me to attend some of her psychosocial consultations. When attempting to schedule my visit late in 2012, she looked at her diary, saying "I am trying to see when I have a case that would be interesting for you. You know, not a simple situation where everything goes well, but someone with a somewhat more complex situation. It will be more interesting for you!" I immediately reassured her that there was no need for such a selection on my account (at that point in my fieldwork, having been granted only very limited access to appointments, I was eager to observe any consultation). Julia's concern revealed an understanding that clients belong to two different categories. As Caroline, another midwife, articulated during an interview with me, midwives are "not always doing the same job." On one hand, they encounter "Mr. and Mrs. Anybody, who are overall doing well, who have questions but are overall in a harmonious psychosocial context" (*context psychosocial harmonieux*). These persons, the "simple" cases, typically have a single appointment. Then, according to Caroline, there are "women whom we will support for a more extended period, who are in a more fragile context." At the time I was conducting observations at the center, two-thirds of clients came for a single appointment. There is a tendency clearly showing over time, however, toward multiple appointments per client. Between 2004 and 2022 (the earliest and latest years for which I have been able to access data on the number of appointments per client), the proportion of clients who came for a single consultation fell from 83 percent to 51 percent, which may reveal a rise in "complex cases" but potentially also psychosocial advisers' advocacy that "everyone" needs support at different stages of their parenting journey.

Crucially, the distinction between a "simple" and "complex" case does not merely refer to the number of appointments but also to moral boundaries. The distinction is qualitative, indicating a distance from what the psychosocial advisers commonly term a "harmonious pregnancy." Valerie exemplified a "simple" case and a "harmonious pregnancy." Clues to this designation included the fact that she visited the center only once, that she was not referred to other health care professionals, and that most of her responses to Colette's inquiries did not elicit commentary or advice. Her age, citizenship, employment situation, degree of preparedness for her baby's birth, and relationships—none of these aspects appeared to raise concerns. In Valerie's file, Colette wrote "harmonious pregnancy."

There is no official definition of what constitutes a harmonious pregnancy. During my interview with her, however, Agnes, a full-time, long-tenured social worker, stated that "ideally," the pregnancy should be "well-accepted" and planned, the pregnant person's partner should be supportive, "both partners have employment and legal status," and the pregnant person should be surrounded by family and friends. In recent decades, medical professionals and researchers have increasingly underscored the social determinants of health—namely, the impact of economic and social circumstances on health outcomes. A 2016 nursing review of predictive factors of health practices among pregnant women identified demographic factors (age, education, employment, income), as well as psychological (maternal-fetal attachment, depression, stress), social (marital status, social support), and obstetric (parity, gestational age) factors (Cannella, Yarcheski, and Mahon 2018). Others have highlighted the role of social factors such as race, religion, or caste (Crear-Perry et al. 2021; Hamal et al. 2020). A healthy pregnancy is thus largely understood as correlated with psychological and social factors among medical professionals. For Agnes, all these conditions ensure that "the pregnant woman will have no worries" and will be able to "focus on her pregnancy." Key to a harmonious pregnancy, therefore, is having no distractions from what is understood as the primary event: the child's arrival. This moral expectation marks the boundary between simple and complex cases.

Distinguishing between simple and complex cases in the context of psychosocial pregnancy care mirrors the classification of pregnancies as "low" or "high" risk in biomedicine. With the rise of obstetrics from the nineteenth century, pregnancy was pathologized. As Barbara Katz Rothman argues, in the United States the medical model of pregnancy defines every pregnancy as risky: "In fact, even if a [pregnant] woman does have all the healthy characteristics medicine can ask for, she still won't be called healthy, or even normal. She will be classified 'low risk'. . . . [Contemporary medicine] has distinguished between 'low risk' and 'high risk' pregnancy, with the emphasis always on risk, and then goes on to define an ever-increasing proportion of pregnancies as 'high risk'" (1982, 132).

In Switzerland, as in most European countries, such a classification operates differently. Pregnancy risks demarcate professional territories. While midwives are responsible for "physiological" (low-risk) pregnancies and births, doctors care for "pathological" (high-risk) cases (Akrich and Pasveer 1996; Cavalli and Gouilhers-Hertig 2014). At the Pregnancy Support Center, while advisers offer support for all pregnancies regardless of medical complexity, a risk-based logic also hierarchizes pregnancies. During an interview, midwife Cecile explained that she believed babies' opportunities varied according to their parents' socioeconomic situation: "I think, babies, they don't all have equal opportunities at the start. Frankly. Because when you see that sometimes they are born to a

couple who are both on social assistance, they are not motivated, they watch TV all day, they smoke cigarette after cigarette, etc., and then maybe you see people who are a little better off and who are interested in a lot of things, you think that, well, their lives will be different." Within a psychosocial approach to pregnancy, parents' psychosocial circumstances operate as risk factors, with occupation, income, and lifestyle risk indicators.

While an appointment largely consists of the collection of patient information and the completion of a form and is presented as such to clients, a significant yet invisible evaluation unfolds. During Valerie's initial appointment, Colette was weighing each of Valerie's responses to identify risk factors and determine whether to suggest further support. Psychosocial pregnancy care constitutes an assessment of people's psychosocial situation—an "examination" (*examen*), as Foucault would term it. Behind each answer to each question lies a potential risk factor. When Valerie discloses her date of birth to Colette, she is unknowingly situating herself on an age spectrum in which extremes (under eighteen or over forty) are associated in Colette's mind with potential psychosocial risks. Through my conversations with Colette and her colleagues, I learned that teenage mothers (referred to as "adolescents" or "minors") would be offered much more intensive supervision by social workers based on the assumption that they would require financial support and would not be autonomous in their administrative tasks, such as paying bills, or registering for health insurance or for childcare places. Becoming a mother after forty was associated, in Colette's perspective, with a higher probability of having difficulty carving out time for one's baby outside of work—an assumption grounded in a stereotypical association of late motherhood with selfishness and career pursuits (Budds, Locke, and Burr 2013; Shaw and Giles 2009). When Valerie responds to Colette's questions about her medical history, she confirms she is not at higher risk of a mental health crisis at birth (as a history of depression, for example, would suggest). Each of Valerie's responses is considered either as protective or as a risk factor for her pregnancy experience and her future child.

HARMONIOUS PREGNANCY STRATIFIED

Who are the "complex" cases? Digging through policy documents and the archives of the center, I uncovered several lists of situations considered to warrant additional support. One such typical list reads: "Adolescence; loneliness; couple conflict; violence; sexual abuse; migration-related difficulties; mental health issues; addictions; gynecological and obstetrical history; medically assisted reproduction; surrender for adoption planned" (Internal document, 2004). A wide array of health-related issues and life course events are regarded as psychosocial risk factors. This list is strikingly similar to the criteria for psychosocial screening utilized in a New York

City prenatal clinic as documented by Khiara Bridges (2011). The U.S. clinic screens for the same risk factors as well as others that the Pregnancy Support Center's staff would certainly concur with: unwanted pregnancy, HIV status, intimate partner violence, concerns regarding capacity to care for a newborn, lack of entitlements or benefits, and homelessness (2011, 49). At the center, however, some situations are much less prevalent than others: adolescence, sexual abuse, addictions, medically assisted reproduction, or adoption were hardly ever broached during my fieldwork, presumably because those circumstances are either exceedingly rare or are not disclosed during appointments at the center.

In their discussions, psychosocial advisers depicted the pregnant people with whom they were most concerned as isolated mothers with scant social support, facing work- or immigration-related adversities, and grappling with poor mental health. For example, Ana, a twenty-seven-year-old migrant from Portugal, was considered a "complex" case. I attended her second consultation at the Pregnancy Support Center, and she ultimately met with the social worker fourteen times over a year, during her pregnancy and postpartum. Upon her arrival at the center, she exhibited numerous psychosocial risk factors: She was a migrant with minimal family support in Switzerland; her pregnancy was unplanned and initially unwanted (although she had just decided to continue with it); she struggled financially because she supported her family in Portugal; and she had to relocate to another town because the company she worked for was moving. The center's social worker initially focused on her financial situation, negotiating with her creditors to restructure her debt and securing new housing. Since her partner physically assaulted her during her pregnancy and after the birth of her son, the social worker also advised Ana about her legal options while facilitating contact with social services, the civil registry, a pediatrician, and her employer following the baby's birth. Ana's contact with the Pregnancy Support Center ceased after a year when she stopped responding to the center's phone calls.

Lina and Isaac, whose third appointment I attended, were another example of a "complex" case, with eight appointments over a ten-month period. Lina and Isaac, both Swiss and in their twenties, had been in a relationship for several years when Lina unexpectedly became pregnant. Both had just completed their professional training and were seeking employment, which proved challenging for Lina due to her pregnancy. Isaac held only a temporary, low-wage job as a cook and was apprehensive about their long-term financial situation as well as his ability to repay his debts. The social worker referred them to a colleague specializing in debt management, discussed the possibility of soliciting financial support from relatives, and informed them about available subsidies and how to apply for them. Over the ensuing months, the social worker supported Lina and Isaac as additional issues arose: Isaac endured illegal working conditions and decided to quit his job; he did not receive wages; then had to leave another posi-

tion when his boss failed to extend a formal contract. After the birth of a healthy baby, conflicts erupted between Lina and Isaac, who at the time was unemployed and addicted to alcohol and video games. During her final visit to the center, Lina disclosed to the social worker that she had left home with her baby after Isaac had physically assaulted her. She did not schedule another appointment.

There are compelling reasons for Swiss medical practitioners to be concerned about migrant, single, or unemployed expectant mothers. The social groups most affected by poverty in Switzerland are single-parent households, foreigners (especially from outside Europe), individuals with low education levels, and unemployed persons (Ferro Luzzi, Flückiger, and Weber 2006; Hobi 2023; Humbelin, Hobi, and Fluder 2022; Leu and Burri 1999). As already noted, although Switzerland is one of the wealthiest countries globally, income and wealth inequalities are also among the highest in the world. According to the latest published data, in 2022, 8.2 percent of the population lived below the national poverty line (Federal Statistical Office 2024). This rate was lower in the 2010s (around 6%) but it has risen steadily since 2014. During the same period, Switzerland was among the few European countries in which child poverty increased by more than 10 percent (child poverty is defined here as relative income poverty—i.e., below the average income in the population; UNICEF 2023).

Immigration and nationality play a pivotal role in stratifying individuals' socioeconomic trajectories in Switzerland. Foreigners encounter discrimination in the job market and when obtaining housing, especially if they hold citizenship from outside Europe, rendering them much more susceptible to falling into poverty (Zschirnt 2020). Swiss citizenship is based on the jus sanguinis (lit., "right of blood") principle and is most often acquired through birth (being born to a Swiss citizen), contrary to the United States where citizenship is granted to children born within the country based on the jus soli ("right of soil") principle. Swiss citizenship is also conferred through naturalization, provided the applicant meets a stringent list of conditions set by the Swiss Citizenship Act of 2014,[2] including at least ten years of lawful residence, workforce participation, mastery of a national language (German, French, Italian, or Romansh), and otherwise displaying (subjectively defined) "good" citizenship (being "well integrated," showing "respect for public order" and "respect for the federal constitution"). Naturalization applications are handled by municipal councils (the third and lowest political level in Switzerland), which are regularly criticized for their arbitrariness and origin-based discrimination. A person's country of origin strongly influences their chances of being granted citizenship, and applicants from Turkey and the former Yugoslavia are far less likely to succeed (Hainmueller and Hangartner 2013).[3] Due to this restrictive citizenship regime, 25 percent of Swiss residents do not hold citizenship. This rate is by far the highest of all "developed" OECD countries except for Luxembourg (Federal Statistical Office 2020a; Hainmueller and Hangartner 2013). Xenophobia has been on the rise since the

1990s with the growing political success of the far-right, anti-immigration Swiss People's Party, which has held the largest number of seats in the Swiss federal legislative assembly since 2003 (between 25% and 29%; dos Santos Pinto et al. 2022).

Discrimination based on nationality and presumed "origins" translates into "obstetric racism" (Davis 2019a, 2019b) and discrimination in migrants' encounters with health care professionals. Migrants in Switzerland report difficulties communicating with health care workers and being discriminated against (Bollini, Stotzer, and Wanner 2007; Drewniak et al. 2016), including during pregnancy and childbirth (Cai et al. 2024; Desseauve et al. 2022; Sami et al. 2019). Children born to migrants have a higher mortality rate (Wanner 2020; Wanner and Bollini 2017).

The center's midwives and social workers shared a conviction that they were present to assist individuals regardless of their circumstances and that migrants were generally treated unfairly and faced systemic discrimination in Switzerland. So, while advisers readily acknowledged that most of their clients had a "harmonious pregnancy" and would not require extensive support beyond a single appointment, they considered supporting the ones they called "complex cases" a crucial component of their mission. They shared a profound sense of commitment to aiding the most vulnerable members of society.

Yet as much as midwives' and social workers' conceptualization of vulnerable pregnant clients reflects existing inequalities in Switzerland, it is also shaped by moral expectations, stereotypes, and a stratified conceptualization of good parenting. Historically, expert guidance for parents in Switzerland has developed along two partly contradictory lines. On the one hand, child-rearing advice literature emerged in the eighteenth century and gradually focused on educated middle-class mothers from the early nineteenth century onward. These books, magazines, and pamphlets played a major role in disseminating an ideal of middle-class motherhood in Switzerland as intensive and expert guided (Odier 2018; Preissler 2022b), which reflected trends in parenting culture in the United Kingdom and the United States (Bloch and Taylor 2014; Cooper 2021; Gillies 2005; Hardyment 2007; Hays 1996; Hulbert 2003; Lareau 2003; Lee et al. 2014). On the other hand, so-called mothers' schools and advice centers were developed in the early twentieth century and targeted primarily working-class mothers, in a context in which infant mortality was particularly high among poor families (Desiderato, Lengwiler, and Rothenbühler 2008). Today's childcare advice centers are a legacy of this dual history and operate under the assumption that all parents, including middle-class parents, need support, and that poorer or migrant parents are especially vulnerable (Preissler 2022b). Preissler (2022a, 2022b) has described how pediatric nurses working as parental advisers in Switzerland, conducting free home visits and consultations with parents, considered migrant and poorer parents to need more support: "Some

parents—certainly those who belong to a middle-class background and adhere to 'intensive methods,' such as informing themselves about child development, were encouraged by advisors to use practices of the self, such as introspection, in order to find the 'right' approach to a certain issue. In contrast, other parents, often migrants with many children and little financial means, were believed to need more instructive and regular guidance" (Preissler 2022b, 30). In France, the United Kingdom, and the United States, classic and more recent studies have similarly described encounters between social workers and parents as stratified along class and race/ethnicity or migration lines (Boulet 2021; Cardi 2007; Cooper 2021; Gillies 2007; Henderson, Harmon, and Houser 2010; Lareau 2003; Vozari 2012). As sociologists Ladd-Taylor and Umansky (1998b) noted in their now classic volume *Bad Mothers*: "Everyone except middle-class whites . . . fall[s] outside the narrow good-mother ideal" (3).

Which practices are considered "good" parenting is largely influenced by class-based values and expectations. A crucial factor influencing what counts as good parenting is the social and cultural proximity between (some) parents and parenting experts. Professionals who author parenting books and assess parental behaviors, such as doctors, psychologists, midwives, or social workers, are likely to be middle-class themselves in Switzerland (Odier 2018; Preissler 2022b) and tend to steer their clients toward sociocentric and ethnocentric expectations of "good" parenting and citizenship. Símonardóttir, Rúdólfsdóttir, and Gottfreðsdóttir (2021) argue that prenatal care providers in Iceland tend to consider pregnant patients with a migration background as failing to "do pregnancy" the Icelandic way and believe that they should adopt culturally specific norms, such as midwife-led prenatal care and paternal involvement. An "us and them" dichotomy, in this case based on national origin, thus influences how health care providers deem patients' behaviors adequate or inadequate. Similarly, in Switzerland, Saugy and Aeby (2021) studied child protection proceedings and found that child protection officers and judges tend to expect parents to conform to parenting norms that are typical of Swiss middle-class parents. For example, professionals underline the importance of sharing parental tasks and housework among parents—a norm that, while far from being achieved in Swiss families, is part of a dominant understanding of middle-class good parenting. At the Pregnancy Support Center, a proximity between the socioeconomic background of staff members and those they assume would be unproblematic parents is evident. Almost all psychosocial advisers were married with children, held Swiss citizenship, and worked part-time to care for their children. Only one was a first-generation immigrant and worked full-time. The poor, isolated, pregnant migrant women about whom they were most concerned had, at least in their minds, lives vastly different from their own.

How pregnancy support professionals associated individuals' socioeconomic backgrounds with parenting skills is best illustrated by the way clients' occupations

factored into midwives' and social workers' evaluations. When differentiating "simple" from "complex" cases, conversations among staff members placed a strikingly significant emphasis on the education levels and occupations of expectant parents. A person's educational attainment served as an indicator of their autonomy, capacity to handle paperwork and administrative tasks independently, and the possible need for professional support.

"She is a press secretary, he is a doctor; we can treat them as adults and let them figure things out," said midwife Colette, who was discussing whether to offer further support to her pregnant client. The conversation occurred during a regional staff meeting at the center called an "intervision" (peer supervision), in which the three to four local midwives and social workers convene with the lead midwife and lead social worker to seek advice about courses of action and clients' situations. Psychosocial advisers would summarize a client's circumstances and solicit their colleagues' guidance on how to proceed. Clients' occupations were such a pivotal indicator that staff would never fail to mention them during these meetings. That day, Colette presented Barbara's case to midwife Sabrina, social worker Agnes, lead midwife Mireille, and lead social worker Nadine, offering the following description: "She is German and works as a press secretary. She was hospitalized at twenty-one weeks of pregnancy and was very worried about her pregnancy. I met her at thirty-two weeks, and she was much more relaxed. Her psychiatrist contacted me because she would like me to organize a network meeting. I said no: I am not worried for Barbara. But a little voice in my head is telling me: What if she has a mental breakdown at birth? Did I do my job?"

A "network meeting" is an interprofessional meeting to discuss a patient's situation and treatment between health care professionals and social workers, with or without the patient present. It is a form of interprofessional collaboration routinely employed in health care and social work in Switzerland to facilitate information sharing among various practitioners—for example, to plan for a patient's care upon discharge after surgery. In Barbara's case, beyond her psychiatrist and midwife Colette it would presumably include a midwife working at the maternity ward where Barbara planned to deliver and a postpartum midwife or nurse. In other situations, social workers could also be invited to join the network meeting. Colette refused to organize such a meeting because she was not concerned about Barbara. Her colleagues' immediate reaction was to support her decision. Colette then further justified her stance by referring to Barbara and her partner's nationality and occupation: as a press secretary and a doctor from another high-income European country, they should be capable of managing independently without the involvement of additional professionals. Stereotypes attached to individuals' ages or socioeconomic backgrounds steered advisers' evaluation of their clients' capacities.

While a high socioeconomic status was explicitly linked to good parental skills, on the contrary, I never heard psychosocial advisers associate a lower-

education level, working-class occupation, or foreign nationality with less adequate parental skills. Migrant or poor parents are considered to need more psychosocial support, but they are not explicitly characterized as (potentially) bad parents. Such explicit ethnocentric and sociocentric bias would have contradicted the advisers' outward commitment to supporting vulnerable social groups. It was more indirectly that the stratification of reproductive subjects was expressed. Another reason for psychosocial advisers' reluctance to draw an explicit negative causal link between class, migration, and parenting skills is the influence of psychological understandings of pregnancy, which I present in more detail in chapter 3. Among child welfare officers in Switzerland, Saugy and Aeby note a similar tendency to not explicitly mention, and even to minimize, sociocultural differences in their assessment of parental competencies. They argue that this "disappearance of social realities" in child welfare proceedings may be due to the psychologization of social work: "The behaviors or conduct of family members, perceived as socially 'inappropriate,' are mainly attributed to psychological factors, even though these may originate from socioeconomic difficulties" (2021, 199). The psychologization of pregnancy and parenting leads to an individualization of life trajectories that obscures social determinants.

Besides this, the stratification of good parenting at the Pregnancy Support Center along class lines was not straightforward. If occupations that require a university degree were generally associated with an expectation of good parental skills, precarity among highly educated parents was considered a mitigating factor. Catherine, an experienced social worker working in the largest city of the Canton Romand, told me during an interview that she was also concerned for a well-educated but financially precarious portion of the urban population, such as artists and academics:

> I wanted to come back to the people in difficulty. Because for me, there are two categories of people in difficulty. Uh . . . you have people, I don't know, migrants, undocumented individuals, those with psychological issues, those with addiction stories, and so on. But those who are also struggling, for example—and I think this is specific to an urban context—are . . . well, even if there are not many of them, I see them very regularly. These are all the people involved in artistic professions . . . actors, costume designers, graphic designers, those who are semi-independent, half in Berlin, half here, living in Paris, living here, and who are in great difficulty. Their difficulties are not related to education or lack of information, but are truly complicated issues financially and organizationally, because now, well, they no longer have the right to unemployment benefits as they used to, for various reasons. So there is also—you also have this whole category of people, the academics, those in social sciences and others, part on a contract, part "Oh, I'm waiting for this project," "Oh no, but I no longer have a job, I'm going to . . . ," all those people.

While stereotypes attached to individuals' ages or socioeconomic backgrounds steered advisers' evaluation of their clients' capacities, those stereotypes did not necessarily associate socioeconomic status with parental skills in a straightforward way. Rather intersectionality, with factors such as nationality, occupation, education, presumed income, or job stability, modulated social workers' assessment.

A WOMEN'S AFFAIR

In contrast to medical prenatal care, the Pregnancy Support Center purports to be open to both women and men. "At every point during pregnancy, women, men, or couples can be seen free of charge," the center's website announces. In the 1980s, the two founding members of the center explained that inviting fathers to attend such prenatal appointments was a progressive stance. Fathers at the time rarely attended birthing classes or births. In a 2000 brochure where they described the center's history and mission, both founding members explained how their father-friendly approach was a reaction to a culture of prenatal care they found overly matricentric: "In medical prenatal care, men are most often considered merely as partners to the pregnant woman, and their own trajectories as fathers-to-be are not addressed. At [the center], our choice is to allow men to be received as subjects, as actors, with the possibility for them to make their own voices heard." The center was always framed as a space for both future fathers and mothers, as the founding members were persuaded that fathers may have questions of their own.

When Valerie attended her appointment with midwife Colette at the center, however, she came unaccompanied. As in her case, three-quarters of appointments were attended by women alone (see figure 4 in chapter 1). By the time I became involved with the Pregnancy Support Center, the share of couple appointments was declining, a trend that puzzled the center's staff. There were practical reasons for men's scarcity at the Pregnancy Support Center. Consultations were only offered during office hours at the time—roughly between 9 A.M. and 5 P.M.—contributing to this gender imbalance. Since Valerie's appointment was scheduled for midmorning, her partner was likely at work. A full-time job in Switzerland equates to forty-two hours per week, and 87 percent of Swiss fathers work full-time (Federal Statistical Office 2021). In this context, the Pregnancy Support Center's office hours inadvertently posed a barrier to men's attendance.

While presenting my findings to the center's staff between 2013 and 2015, I mentioned the opening hours and the unit's color scheme as potential factors impeding men's visits. I also underscored the fact that the Pregnancy Support Center's logo was pink, which may contribute to its association with (normative) femininity. Within the following year, the center's director implemented a

change of visual identity (from pink to orange) and introduced after-work opening hours. A partnership with a regional fathers' association was implemented in the form of workshops for fathers within the center. These changes reflected an increasing awareness of gender biases and a shift toward a more men-inclusive positioning. Those efforts apparently paid off, since the rate of couple consultations rose again to reach 28.2 percent in 2019. However, the pandemic made the presence of fathers much scarcer (21.5% of couple interviews in 2020), probably because of social distancing rules that discouraged (but did not prohibit, in the Swiss context) partners from attending medical or psychosocial appointments. While the rate of couple consultations is rising steadily since the pandemic, it has not yet reached pre-pandemic levels.

Several other factors contributed to the Pregnancy Support Center being a deeply gendered institution, potentially explaining the scarcity of male clients. The center's staff was and had always been entirely composed of cisgender women. The center's director informed me that she would gladly hire a man, but very few are trained in midwifery and a minority in social work, and the (rare) male applicants did not possess the necessary experience or qualifications. She also underscored that most positions at the center were part-time, making the center an unattractive employer to men, who typically seek full-time employment. Even the software used at the center to store clients' files was gendered: When a heterosexual couple attended an initial appointment, the file was created under the woman's name. These gendered biases within the organizational structure of the center revealed assumptions about the primary client base, contradicting the center's avowed gender-neutral stance.

Beyond the gendered nature of the center as an institution, how psychosocial advisers conducted their appointments was also inherently gendered (Ballif 2019). In the psychosocial terrain that midwives and social workers investigate and evaluate, indicators pertaining to women matter more than those pertaining to men. Most of Colette's questions to Valerie referred to her situation, not her partner's. During that appointment, like the others I observed, men's or partners' mental health, family support, and alcohol and tobacco consumption were only discussed if the women's responses to these same questions revealed a risk factor. In Valerie's case, Colette inquired about her partner's smoking habits only because Valerie had first indicated she was a smoker herself. In all consultations I witnessed, when a woman stated she was not a smoker, no question was asked about her partner's habits. This bias was particularly striking in the case of smoking given that, as Colette acknowledged, a partner's smoking may directly affect a child's health through secondhand smoke exposure.

In their introduction to their edited volume on men and reproduction, Marcia Inhorn and colleagues (2009) posit that men tend to be viewed as "the second sex of reproduction." In medical, social scientific, and lay spheres, they argue, men's reproductive lives are far less frequently described and investigated

than women's. Examining discussions of fetal harm in U.S. science, media, and public policy, Daniels (1997, 2008) has demonstrated that men's contributions to fetal health are rarely broached. After conception ("the 'fleeting' contribution of the father," Daniels contends), "women are assumed to be the primary sources of both fetal health and fetal harm" (1997, 608). This partly reflects the long-standing belief in medical literature that only undamaged, healthy sperm could fertilize an egg. Thus, if conception occurred, men's contribution could not be held accountable for fetal health issues.

The corollary of rendering men's contributions invisible is, of course, the overresponsibilization of women in relation to fetal outcomes. The criminalization of pregnant behaviors in the United States has led some women to face trial for having consumed drugs or alcohol during their pregnancies, while no such accountability thus far has been expected of fathers (Gallagher 1987; Goodwin 2020; Paltrow and Flavin 2013). Parenting scholars have also laid bare how, once children are born, numerous aspects of children's health and development are attributed to maternal behaviors (Bell, McNaughton, and Salmon 2009; Blum 2007; Caplan and Hall-McCorquodale 1985; Eyer 1996; Ladd-Taylor and Umansky 1998a). Obesity, criminal conduct, academic achievement, autism—the list of children's and adolescents' health or social "problems" that have been linked to maternal failures is striking and extensive. More recently, the rise of epigenetics as a field of research and its translation into public health strategies in several countries reframes the pregnant body as the "environment" in which fetuses grow and frames pregnancy as a crucial window during which lifelong health outcomes can be determined (Fournier and Jarty 2019; Landecker 2011; Lappé and Jeffries Hein 2021; Manderson 2016; Manderson and Ross 2020; Pentecost 2024; Pentecost and Ross 2019; Richardson 2015).

Despite recent significant advances in the study of men's reproductive experiences (Almeling 2020; Almeling and Waggoner 2013; Inhorn 2020; Mohr and Almeling 2020), reproduction and childcare remain largely understood as a woman's affair. Midwife Colette does not inquire about Valerie's partner's mental health history or alcohol consumption, and in this, she is reproducing a gendered hierarchization of reproductive responsibilities. The Pregnancy Support Center's mission to welcome both future mothers and fathers, although signaling a consideration of paternal influences, does not disrupt the essentialist and differentialist view of gendered roles that has traditionally structured Swiss society. Fathers are welcome, but as secondary reproductive subjects.

Likewise, while I was conducting direct observations at the center in the 2010s, silence surrounded same-sex couples and queer, nonbinary, or transgender individuals' experiences of pregnancy. Reproductive options for same-sex couples remain restricted in Switzerland in comparison to other European countries. The regulation of assisted reproductive technologies in Switzerland is fairly strict and requires a couple to be married, which has only been possible for

same-sex couples since 2022. Egg donation and surrogacy are forbidden. Many same-sex couples travel abroad to access technologies forbidden in Switzerland (Siegl et al. 2021). While the numbers and profiles of LGBTIQ+ families remain largely understudied, the Federal Statistical Office suggested in 2021 that 0.1 percent of children under twenty-five years old are living with same-sex parents; however, the survey only included parents living in the same household (Federal Statistical Office 2021). At the Pregnancy Support Center, while the words "couple" or "future parents" used in the center's texts appear to be fairly inclusive, heterosexuality is the unspoken norm. Pregnant people were assumed to be cisgender women, and their partners were assumed to be cisgender men. Several advisers told me that they would be pleased to support lesbian couples during their pregnancies but that they had only encountered lesbian clients two or three times throughout their careers. Gay couples and transgender individuals never came up in my conversations with psychosocial advisers. This noninclusivity was not rooted in overt hostility toward the LGBTIQ+ community or their parenting rights; rather, it stemmed from a default focus on heterosexist family forms. The center's website, at the time, featured a picture of a heterosexual couple on its front page. In written documents and archives, the word "partner," which in French could grammatically be either masculine or feminine (*partenaire*), was always treated as masculine. Same-sex parenting was not referenced in the center's policy documents.

In 2018, the Pregnancy Support Center took a turn toward more inclusiveness and organized a cycle of conferences to train the staff to use more inclusive language and learn about and offer support for the specific challenges that same-sex parents may face. This happened in a context in which LGBTIQ+ families were being increasingly discussed in Swiss health care and society. Since around 2010, LGBTIQ+ parents' associations have been created in Switzerland; these have increasingly sought to promote inclusive care in Switzerland by training health professionals (Fussinger and von Känel 2020). The Swiss Midwives' Association has also been promoting inclusiveness in midwifery through conferences and guidelines for its members since 2019 (Rey 2019, 2022). However, according to current and former employees, such parents remain rare at the center; they attribute this trend to persisting heterosexist biases among some of their colleagues. It is possible that these parents either do not feel comfortable attending appointments at the Pregnancy Support Center or do not disclose their family situation or sexual orientation.

Psychosocial appointments are grounded in a conceptualization of pregnancy as an event of psychosocial significance. Discursive practices—talk between advisers and clients—delineate what aspects of people's lives are relevant to prenatal care and thus draw the conceptual borders of psychosocial care. This pushes a much larger portion of people's lives into the domain of reproductive care: Beyond what medical prenatal care usually covers, the Pregnancy Support

Center brings work, relationships, or financial situation firmly into the realm of what matters in a reproductive experience. Parallel to canvassing clients' psychosocial experiences, an evaluation unfolds. Psychosocial advisers' assessment of a client's situation relies on moral expectations of good parenting. Migration status and socioeconomic background intersect with normative parenting expectations, leading the center's staff to assume that some profiles necessitate more professional support than others. Behind an apparently inclusive stance, the Pregnancy Support Center operates on stratified assumptions about the social profiles of "good" and "bad" reproductive subjects. Such moral boundaries are not necessarily fixed, as recent attempts to enhance inclusivity illustrate.

3 • THE PREGNANT MIND

"Pregnancy brings about significant changes for every woman. So, it's normal that sometimes you won't sleep well, it's normal to have nightmares, it's normal to experience all of this—it's an intense psychological transformation!" This is how Agnes, a social worker, advised her colleagues to present pregnancy to their clients during a regional meeting. The discussion that day was led by midwife Zoe, who asked her colleagues for advice about how to open a discussion with a pregnant client whose gynecologist had described as "probably depressive." Zoe had only joined the center a few weeks before, and Agnes, an experienced social worker, was eager to teach her what she thought was the appropriate message to transmit. In Agnes's opinion, the main message to share was that it was normal to experience pregnancy as a psychologically trying time. She went on: "We need to normalize that during this period there are these fluctuations, and it's possible that it will happen to her. Because otherwise, what is shown to us is that it's normal for all women to be happy. Society portrays that it's normal for a pregnancy to be joyful. And that's not always the case!"

Agnes was echoing an understanding of pregnancy as a "normal crisis" that I encountered over and over again in my conversations at the Pregnancy Support Center.[1] In Switzerland, advocates for psychosocial prenatal care rely heavily on psychological concepts to frame pregnant people as psychologically vulnerable. Attention to the pregnant mind supports and justifies the extension of prenatal care to the psychosocial. Medical prenatal care, in their eyes, has not paid enough attention to the pregnant mind—a lacuna the center was meant to fill by offering a more holistic, woman-centered care. This psychologization of pregnancy is part of a global trend that shifts the epistemic boundaries of pregnancy as well as the professional territories of prenatal care.

Feminist scholarship has described the increasing attention to postpartum depression in maternal care in the Global North over the past two decades (Godderis 2010; Santino and Monaghan 2023; Tseris 2022). Detecting and preventing postpartum depression was the motivation behind the creation of local psychosocial prenatal care efforts and the incorporation of mental health screening tools into prenatal care, including in Switzerland (Nanzer and Epiney 2013,

2015; Sancho Rossignol and Nanzer 2010). The Pregnancy Support Center, which was created two decades before postpartum depression became a widely discussed topic in Swiss health care, engaged with two different concerns with the pregnant mind: first, that pregnancy was a period of psychological crisis and, second, that emotions during pregnancy may present a risk to fetal health. Exploring these two approaches to the pregnant mind that coexist at the Pregnancy Support Center gives insights into different facets of the psychologization of pregnancy and their relation to different theories of the maternal mind.

PREGNANCY AS A "NORMAL CRISIS"

In the 1940s and 1950s, a novel theory of pregnancy was developed by U.S.-based psychoanalysts. This theory posited that pregnancy creates a very particular psychological state, a "crisis" that is a normal, common occurrence in all "pregnant women" (following the gendered vocabulary used in psychoanalytical literature). The "normal crisis" theory builds on earlier theorizations of mental health in relation to reproductive events. Physicians had long observed psychological disorders affecting women *after* childbirth, such as "puerperal madness" (Arena 2008, 2012). In the eighteenth and nineteenth centuries, pregnancy itself was thought to cause "insanity" by irritating the uterus (Hanson 2004). This discourse was based on the ancient Greek theory of hysteria, which attributed several female ailments to the uterus wandering in the body. Between the 1930s and 1950s, leading psychiatrists and OB-GYNs in the United States, influenced by emerging Freudianism, attributed certain negative events in pregnancy to the women's psychological state (Eisenberg 2010, 2013). In particular, nausea, miscarriage, and infertility were related to neuroses or the unconscious rejection of the fetus or of femininity. The association of pregnancy with ill mental health thus has a long history, within which the psychoanalysis of pregnancy as a normal crisis forms a distinct, yet less well-known, trend.

Three U.S.-based psychiatrists and psychoanalysts—Helene Deutsch, Therese Benedek, and Grete Bibring—opened up a new field of study in the 1940s and 1950s: that of "normal" psychological processes during pregnancy. While earlier theorizations of pregnancy focused on acute disorders, these three psychoanalysts were interested in the psychologically disturbing aspects of *any* pregnancy, thus shifting the epistemic borders of psychoanalytical theories. Deutsch, Benedek, and Bibring had strikingly similar biographies. They were born fifteen years apart respectively in Poland (Deutsch, 1884), Hungary (Benedek, 1890), and Austria (Bibring, 1899) into Jewish families, and all had studied medicine before specializing in psychoanalysis. Helene Deutsch was one of Freud's students and the first psychoanalyst ever to specialize in female psychology. With their physician husbands (Felix Deutsch and Edward Bibring were psychiatrists and psychoanalysts, Tibor Benedek a dermatologist), they emigrated to the United

States between 1935 and 1941 following the National Socialist Party's takeover in Germany and the start of the Second World War. All three had successful careers in the United States, with Deutsch and Bibring at Boston hospitals and Benedek in Chicago.

Deutsch, Benedek, and Bibring's works share a psychosomatic approach, focusing on the interplay between psychological processes and physical symptoms. Their central thesis was that pregnant women's psyches undergo profound transformations while their bodies go through the various stages of pregnancy. Deutsch was a pioneer when she published the two volumes of her main work, *The Psychology of Women: A Psychoanalytic Interpretation*, in 1944 and 1945. The second volume is entirely devoted to motherhood, "the central problem of femininity" (1944, xiii–xiv), with a particularly long chapter on pregnancy. Deutsch saw pregnancy as representing a "tremendous upheaval" (1945, 126) that "may disturb the psychic balance because it brings to the fore earlier, unresolved conflicts that have hitherto remained relatively dormant" (144). In particular, the relational history and identification of the pregnant person with their own mother are considered to be central to the "psychologic [*sic*] problems of pregnancy" (141). Deutsch claimed to have observed several miscarriages occurring due to such conflict.

A few years after the publication of Deutsch's *Psychology of Women*, in Chicago, Therese Benedek published the first of several texts on the "psychology of pregnancy" as part of her larger interest in "women's psychosexual functions" (Benedek 1952, 1959, 1970). Benedek stated that pregnant women saw memories of the oral phase of their development resurface. She theorized pregnancy as a distinct, "critical" phase in women's psychological development, driven by biological changes: "Pregnancy, like puberty, is a biologically motivated step in the maturation of the individual which requires physiologic adjustments and psychologic adaptations to lead to a new level of integration that, normally, represents development" (Benedek 1970, 137). Pregnant women should "normally" negotiate this step to reach a subsequent developmental stage. In 1955, building on the ongoing work of her two predecessors, psychiatrist and psychoanalyst Grete Bibring undertook a series of research studies on pregnancy at the Beth Israel Hospital in Boston (Bibring 1959; Bibring et al. 1961a, 1961b; Bibring and Valenstein 1976). Bibring (1959) described pregnancy as a "crisis" and an opportunity for psychological "maturation": "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" (116).

The parallel introduced between puberty, menopause, and pregnancy supports the idea of pregnancy as part of a developmental cycle, a natural and biological sequence of events leading to maturity. Bibring uses the terms "normal crisis," "psychobiologic crisis," or "maturational crisis" and insists that the crisis

affects every pregnant person, regardless of her psychological health (1961b, 25). She adds that this "crisis" might look severe: "This disturbance in the equilibrium of the personality is responsible for temporarily creating the picture of a more severe disintegration" (1959, 116). Observing severe psychological disturbances during consultations with pregnant patients led Bibring to develop her theory: "The content of these interviews was remarkably similar to that which we usually find in severely disturbed patients. Magical thinking, premonitions, depressive reactions, primitive anxieties, introjective and paranoid mechanisms, frequently associated with the patient's relation to her own mother, seemed to prevail" (Bibring 1959, 115). Bibring reports that her research team even diagnosed cases of borderline or psychotic disorders before realizing that the observed behaviors were caused by the pregnancy (Bibring and Valenstein 1976).

Underlying the "normal crisis" model of pregnancy are normative ideas about motherhood that fit the 1940s and 1950s heteronormative and biologizing view of women's role in society. For Deutsch, motherhood was a woman's "destiny" inherent to a "feminine nature" (1945, 153). Benedek, too, saw motherhood as a woman's "biologic destiny" (1970, 141). Within the idea that pregnancy represents a developmental step lies the presumption that nonmothers are necessarily less mature than mothers. "Very often, until she realized her pregnancy, the mother-to-be had thought of herself predominantly as a girl rather than as a woman" (Bibring and Valenstein 1976, 357–358). Childless women (by choice or otherwise) are strikingly absent from psychoanalytic texts, leaving one to wonder if, without pregnancy, a woman is forever stuck in an earlier stage of psychological development.

Despite their modest number of publications, Deutsch, Benedek, and Bibring had a long-lasting impact on psychiatry and psychology worldwide. Deutsch achieved significant fame as a pioneer of female psychoanalysis; she was the most famous American psychoanalyst in the 1930s and a prolific training analyst (Buhle 1998; Coser 1984). To this day, pregnancy psychologists still draw on Deutsch, Bibring, and Benedek's theories.[2] Their work made pregnancy a lasting object of psychological interest.

FRENCH RECEPTIONS

French psychiatry was fertile soil for the new theory, given the influence of psychoanalysis in French medicine, psychology, and society (Botbol and Gourbil 2018; De Mijolla 1992). Building on the pioneering work of nineteenth-century alienist Louis Victor Marcé (1858) on "insanity in pregnant, postpartum and lactating women," French psychiatry had developed a distinct interest in the postpartum period and its pathologies, a tradition continuing to this day through the work of the influential Société Marcé Francophone (Arena 2008, 2020; Dayan, Andro, and Dugnat 1999).

The notion that pregnancy is normally a psychological crisis soon crossed French borders and made its way into francophone psychiatry, with renowned

French psychiatrist Paul-Claude Racamier publishing an article in 1961 (in French) drawing heavily on Deutsch's, Benedek's, and Bibring's work (Racamier, Sens, and Carretier 1961). The article translated and introduced the "normal crisis" theory to francophone specialists. With the adoption of the normal crisis theory of pregnancy, French psychiatry started to focus on prevention and ordinary parenting experiences, away from its earlier focus on psychotic, depressive, or anxiety disorders in the tradition of Marcé's work (Missonnier 2023).

In the decades after Racamier, the "normal crisis" approach to pregnancy continued to be diffused through the works of famous psychoanalysts and clinical psychiatrists such as Monique Bydlowski (1991, 1997, 2000; Bydlowski and Camus 1988), Sylvain Missonnier (2001, 2005, 2007a, 2013, 2023), and Françoise Molénat (1992, 2001). From the 1980s, this widening of the gaze to include "milder" dysfunctions translated into an ever-greater involvement of psychoanalysts in maternity and neonatal wards of French public hospitals and, eventually, into the creation of the "fourth-month interview" in the 1990s. Monique Bydlowski, Sylvain Missonnier, and Françoise Molénat were among the psychoanalysts hired to implement preventive psychoanalytical care in maternity hospitals, along with Yvon Gauthier. Gauthier wrote that his clinical experiences confirmed "the hypothesis that Greta [*sic*] Bibring . . . had advanced in the 1950s" (2009, 66; my translation), thus drawing a direct connection between American psychoanalysis and contemporary French psychiatry. According to Missonnier (2023), the work of Deutsch, Benedek, and Bibring forms one of the two theoretical foundations of contemporary perinatal psychology in France—the other being developmental psychoanalysis with its focus on infant skills and attachment theory.

Monique Bydlowski's publications illustrate the deep influence of American psychoanalysis in French psychiatry. Drawing from her clinical work, Bydlowski introduced the concept of "psychological transparency":

> Pregnancy is the moment of a particular psychological state, a state of susceptibility or psychological transparency where fragments of the unconscious come to consciousness. This phenomenon, which clinically often characterizes serious psychiatric conditions, especially psychosis, presents itself in the pregnant woman as an ordinary event. (Bydlowski 1991, 136)

Drawing on the parallel between adolescence and pregnancy, Bydlowski emphasized the vulnerability of pregnant subjects and their need for psychoanalytic support:

> A particular relational state manifests itself, a latent, ambivalent, and almost permanent call for help, just like in adolescence. . . . These new dispositions, this call for help from a solid and benevolent referent, are keenly felt by the practitioners

> consulted. They are also favorable conditions for building a therapeutic alliance. (Bydlowski 2001, 43)

Bydlowski's texts had a significant impact in the French-speaking world. "Psychological transparency" is widely cited by psychiatrists and psychoanalysts, becoming "the consecrated formula to qualify [the] transient psychological functioning" of pregnant women (Missonnier 2011, 128).

PSYCHOLOGIZING PRENATAL CARE

It was during an interview with Caroline, one of the midwives of the Pregnancy Support Center, that my attention was first drawn to the psychologization of pregnancy. Only a few months into my fieldwork at the time, I was unaware of psychoanalytic theories of pregnancy. When I asked Caroline to define her role as a counseling midwife, she explained to me that pregnancy was "a period of [future parents'] life where they are a little bit fragile, destabilized." I then asked her again:

EDMÉE: You were saying, pregnancy is a time when people are fragile, destabilized. What's at stake at that time?

CAROLINE: So . . . well, first, for women, at the psychological level, they have their unconscious working a lot, which is really there on the surface, which will perhaps sometimes cause them moments of anxiety, which will force them to take stock of who they are, their relationship with their mother, to leave the little girl, to project themselves as mothers. So they can suddenly feel anxious, stressed, impulsive, and not understand why. So we try to put words to what they are experiencing. They know that . . . there is going to be a big change that awaits them, especially at the level of the couple, so there is an insecurity: "What is this going to do to my relationship? How can I—?" We can also work on putting things in place so that the couple can survive this ordeal. Statistics show that one couple out of two separates in the Canton [Romand], so it's huge! And it's a lot in the first period, in the first years of children. So it's true that it's really the arrival of children that destabilizes couples a lot. So . . . that's why it's a period like that, a little bit of fragility.

As I came to realize later, the core elements of the "normal crisis" model of pregnancy are found in Caroline's words: Pregnancy is a psychologically trying time during which the unconscious resurfaces and one's relationship with one's own mother is reevaluated. The picture painted here is of pregnant subjects undergoing a process that is out of their control. Following my interview with Caroline, I listened more carefully to these psychologizing discourses on pregnancy coming from the staff. Cecile, another midwife, also described pregnancy

as a time of profound psychological changes and qualified it as a "crisis": "It's a whole adaptation for, well—physical modification, but psychological, mental, for, uh—since nature does things well, to be ready, in quotes, to become a mother at birth . . . It's a moment in the pregnancy when it's extraordinary what happens. Uh, because the woman is—there is already her baby, eh, which in fact puts her in connection with her interiority. Much more than—And then that, well, it's a crisis situation. And a situation of stress for the couple."

The "normal crisis" theory of pregnancy became a major source of inspiration for the Pregnancy Support Center in two ways. First, while the center's psychosocial advisers were neither psychologists nor psychiatrists, they nevertheless came into contact with psychological theories. Midwives and social workers consistently mentioned Molénat as their author of reference when it came to the theoretical "basis" for psychosocial prenatal care. At the time of the intensive phase of my fieldwork, about half of the staff had taken what they called the "Molénat course" (named after the French psychiatrist), an eight-day course in perinatal health held at a Swiss university leading to a Certificate of Advanced Study. Molénat was sometimes invited as a guest lecturer during the course. Language plays an important role here: Like most of the Swiss francophone population, midwives and social workers at the Pregnancy Support Center only read French fluently, which greatly facilitated their familiarity with French authors and experts. The circulation of French psychoanalysis also reflects the popularity of psychoanalytical theories in general in Switzerland (Hafner, Germann, and Janett 2023; Haynal 2009; Haynal and Falzeder 2014; Nobs and de Coulon 2014). Switzerland is considered one of the historical cradles of psychoanalysis, with this current having penetrated psychology and psychiatry more rapidly than in France or Germany (De Mijolla 1992; Haynal 2009). Psychoanalytical theories have deeply influenced not only Swiss medicine but also child protection policies (Despland and Berney 2012; Fussinger and Ohayon 2010; Hafner, Germann, and Janett 2023; Odier 2018).

Psychoanalytic theories of pregnancy also left a deep imprint on the natural birth movement and midwifery globally. According to the American historian Eisenberg (2010, 2013), the American natural birth movement was the main catalyst behind the diffusion and acceptance of pregnancy psychoanalysis among professionals and the general public. Deutsch had a profound influence on British obstetrician Grant Dick-Read, whose relaxation techniques were disseminated in the United States in the 1940s. The natural birth movement was based on the idea that a woman's mental state was a determining factor in her experience of pregnancy and birth: "Natural childbirth enthusiasts believed that women needed psychological help to change their attitudes toward maternity, overcome unwarranted fear of pregnancy and childbirth, and enjoy motherhood" (Eisenberg 2013, 361–362).

In the very first edition of *Our Bodies, Ourselves* (Boston Women's Health Collective 1970), the iconic book of the women's health movement in the United

States, we find echoes of psychoanalytic theses. *Our Bodies, Ourselves* was written by a feminist collective and was a huge popular success. In its first edition in 1970, the authors borrowed from psychoanalysis the idea that pregnancy is disturbing at the psychological level and brings up buried anxieties: "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).

The idea that pregnancy is psychologically upsetting thus became a fundamental argument in the critique of the medicalization of pregnancy and childbirth. Consequently, pregnancy is also presented as a normal psychological crisis in some of the most iconic texts of U.S. feminist sociology and anthropology. In *In Labor*, Barbara Katz Rothman praised the "midwifery model" of birth (as opposed to the medical model) because "the midwifery model approaches pregnancy as essentially normal and healthy, a period of psychological as well as physical growth and development" (1982, 160). Similarly, Robbie Davis-Floyd, one of the pioneers of the anthropology of birth, described "pregnant women" as being in a "psychological state of openness and receptivity" (1992, 24–25): "Rapid psychological growth and change are possible in pregnancy as they are not in usual structural life. . . . The near-constant inner and outer flux of pregnancy keeps the category systems of pregnant women in a continuous state of upheaval as old ways of thinking change to include new life. For example, growing a baby inside, as well as mothering a newborn, puts a woman in much closer touch with her own childhood experiences, allowing old, deeply buried thoughts and emotions to surface." The "normal crisis" model has thus become a core element of globally circulating discourses that point to the limits of medicalization and advocate for better attention to emotional aspects of pregnancy and childbirth—arguments that found local resonance in Switzerland.

The "normal crisis" model of pregnancy is at the core of the Pregnancy Support Center's *raison d'être*. In a foundational text of the unit, the founders reported the "surprise" of future parents confronted with the intensity of their psychological upheavals, in a passage that, uncommonly, extends the crisis to men as well as women: "Between stress and wonder, the twists and turns and questions follow one another, they are not the same and are in constant evolution . . . But it is the emotional stages, the questioning of one's partner or the sudden imperative need to settle old family affairs, to 'put one's life in order,' that represent the greatest surprise for those who are confronted with them. 'It's like an earthquake, a volcano, a tidal wave.'" Psychosocial advisers told me that they wanted to break the image of a happy pregnancy: They consider it their duty to inform people that pregnancy is not necessarily pleasant and can cause fragility and anxiety. Alexandra told me that she felt it was important to "break the image that a young mother is necessarily happy. You have to tell them that it

can happen that things go wrong, that you hate your baby." Psychoanalytical ideas are thus strategically used to carve out a new territory for psychosocial care, shifting professional boundaries. Since pregnant people are fragile and destabilized, and since gynecologists lack the time and skills to delve into pregnant patients' emotional states, they must be offered psychosocial support by the midwives and social workers. Bringing the pregnant mind into the purview of prenatal care at the same time promotes a new understanding of pregnancy as a psychological ordeal.

The influence of the "normal crisis" theory of pregnancy sets the Pregnancy Support Center apart from other forms of psychosocial prenatal care in Switzerland. In Geneva, since 2008, the main public hospital offers a psychosocial prenatal appointment to all pregnant people who plan their delivery there. The Geneva prenatal interview was created with the explicit goal of preventing and detecting postpartum depression (Nanzer and Epiney 2013, 2015; Sancho Rossignol and Nanzer 2010). Recently, influenced by Chantal Razurel's (midwife and psychologist) work on stress in the pre- and postpartum, this model is slowly extending to the wider Geneva region (Razurel et al. 2017; Razurel et al. 2016; Razurel et al. 2010; Razurel, Kaiser, Dupuis, Antonietti, Citherlet, et al. 2014; Razurel, Kaiser, Dupuis, Antonietti, Sellenet, et al. 2014). The Geneva model was created by psychiatrists and psychologists and is thus more distinctly psychological in its form than the Pregnancy Support Center model. It relies on the use of psychometric questionnaires and standardized interviews (Razurel 2015; Razurel, Kaiser, Dupuis, Antonietti, Citherlet, et al. 2014; Razurel, Kaiser, Dupuis, Antonietti, Sellenet, et al. 2014). At the Pregnancy Support Center, such tools are not used. The center's model represents the original integration of psychoanalytical ideas into a unique psychosocial model of care.

DISCIPLINING EMOTIONS

When faced with pregnant clients expressing violent emotions, I witnessed midwives recommend that they engage in emotional regulation so that their fetus would not suffer. During an "intervision," when staff discuss complex cases, I observed, Julia, a midwife, present the case of Carla, twenty-seven years old and pregnant with her first child. Carla had recently separated from her partner and had had several consultations with Julia and a social worker. Julia described Carla as slightly "mentally handicapped," unemployed, "a bit of an outsider," "partying a lot," and having had a "messed up life." Her partner was reportedly violent and alcoholic. While her description served the purpose of communicating what she saw as psychosocial risk factors to her colleagues, her choice of words also betrayed sociocentric judgment of Carla's "marginal" lifestyle. The reason that Julia was concerned, however, was not related to these social and health-related risks—it was Carla's emotions. During a consultation with Carla

and her partner, the latter allegedly asked for a paternity test to be performed once the child was born, which made Carla very angry. Midwife Julia told her colleagues how Carla's anger worried her and how she encouraged Carla to control her emotions:

> I saw the woman alone again. That allowed me to take up the story of the paternity test, to explain to her the meaning of it, that it was not against her. And now she is very angry, she has very aggressive words, like "I'm going to beat him up." I try to calm her down a bit, finally I come back to the pregnancy, I show her pictures, I explain things to her. Then she calms down and then I try to resume with her, to tell her that it strikes me to see how violent she is. "The words you said to me, the things you're saying," I say. "You know, you're pregnant!" The goal is not to make her feel guilty, but to tell her "Not only will your child not be able to live in an environment where there is always a threat, where there is violence, but also when you speak, when you rant like that, your child will also hear a certain number of things! You will have to work with this anger so that you can find calm again." I did relaxation exercises with her, conscious presence, being able to breathe. I encouraged her to learn to deal with her emotions. For me it's really important to get her to pay attention to that. I'm concerned.

In this excerpt, Julia recounts how she applied a "pedagogy of affect" (Ameeriar 2015) by encouraging Carla to manage her anger. She coached Carla in body exercises aimed at altering her emotions. What Julia did not do, however, is investigate and possibly alleviate the causes of Carla's emotions, including being exposed to a violent and alcoholic partner and living in a financially precarious situation. Anger is seen as unwelcome because of the pregnancy, and Carla is positioned as responsible for managing her emotions through relaxation practices.

I soon realized that when psychosocial advisers engaged with pregnant clients, it was not psychoanalytical theories and their understanding of pregnancy as a crisis that they foregrounded. The "normal crisis" model usually directs attention to the pregnant person and the psychological processes they are experiencing while being pregnant. In contrast, I found that concerns for the future child were at the forefront during encounters with clients. Pregnant clients' emotions were addressed because of fears they would affect the fetus and the mental health of the unborn child.

Julia considered Carla to be in a moment of "emotional deviance" (Hochschild 1983, 57), a discrepancy between what a person feels and what they should feel. Arlie Hochschild (1983) coined the term "feeling rules" to refer to "what guide emotion work by establishing the sense of entitlement or obligation that governs emotional exchanges" (56). Emotions, Hochschild argues, are something we manage according to social scripts. Pregnancy literature such as books

and magazines are repositories of "pregnancy rules" (Oaks 2001, 4), which increasingly include emotional management. In parallel to the disciplining of pregnant bodies, pregnancy manuals also encourage pregnant people to regulate their emotions for fear that their stress will affect their fetus (e.g., Lupton 1999; Marshall and Woollett 2000). In magazines for pregnant women in the United States, Gardner (1994a) noted a constant injunction to manage emotions and avoid anxiety: "During pregnancy, women are often told to avoid 'thinking too much,' 'being anxious,' 'worrying,' or 'introspecting' for a variety of reasons" (79). In Switzerland, the management of one's own emotions forms a central part of the advice given to parents through parenting literature and encounters with parenting experts (Preissler 2022b). Parenting advice "call[s] on parents to 'work' on themselves, to reflect on their state of mind and to regulate their feelings" (Preissler 2022b, 238), cultivating "docile emotions" (239) as an ideal of good parenting.

Moments of emotional deviance not only make feeling rules visible; they also reveal that rules are not straightforward. In July 2013, I observed a consultation between Alexandra and thirty-five-year-old Lana. Lana's partner had left her when he learned of her pregnancy. Because Lana's profession is in the field of psychiatric care, a certain collusion of vocabulary quickly developed between her and Alexandra.

ALEXANDRA: Are there times when it's not going so well?

LANA: Yes, when I come home from work alone, I have a hard time making my own food. Sometimes I cry by myself, so I release some of the pressure. But I'm afraid it will affect the baby. So I talk to him/her,[3] I tell him/her that it's not about him/her, I tell him/her that it's his/her daddy, that he chose not to be here and that I have to accept it but that it's not against him/her. I try to reassure him/her.

ALEXANDRA: Why do you think s/he feels that?

LANA: Because they say that hormones are very psychologically linked with the fetus and all that and it gets all—

ALEXANDRA: You can forget about it.

LANA: Is that right?

ALEXANDRA: That's not true at all. The child, what s/he feels is the stress, if for example s/he doesn't have enough blood arriving in the placenta there is a rigidification of the blood vessels, which can cause growth restriction—physical, mental stress, workplace bullying, things like that. If your state of sadness leads to that, it could have consequences like that, if it really puts you in a state of prostration. But as long as you just have emotions, which are natural in your case—we are human beings, never 100 percent—100 percent does not exist, it is not human. Tell yourself that it is even good that you cry for the child, you are a mother, a natural, living woman, that is what s/he needs. It would not be good to stop you. It would be out of guilt. It is very bad for the child, guilt. It's especially bad when

> you want to force yourself not to feel. It's very good the way you do it, you tell him/her things, you tell him/her it's hard—the child will be able to put it in a drawer, to tell him/herself that it's not because of him/her that mommy is crying, s/he won't carry it with him. Go ahead, live what you have to live, it's even good for him/her. But I know we're steeped in this idea, all the emotions we don't like—Anger is really good too.

Whereas midwife Julia framed anger as a negative emotion to be suppressed, here Alexandra has introduced a hierarchy of emotions according to which sadness is "natural" and harmless while stress and guilt are harmful to the unborn child. Midwives modulated their interpretation of emotions according to the situation of their interlocutor and according to the social and cultural distance between professional and patient. Julia disapproves of Carla's behavior and clearly advises her to change it, whereas Alexandra, who sees Lana as a competent parent, comforts her and gives her interpretive tools to manage her emotions. Midwives thus behave as "experts of subjectivity" (Rose 1990) who instruct parents in "technologies of the self" (Foucault 1984) that typically characterize good citizenship in modernity. In both examples, such detailed attention to emotional management sidesteps practical, social, health, or other problems that pregnant patients are experiencing.

Fears that emotions during pregnancy may have an impact on fetuses derive from long-standing anxieties about the pregnant body and mind. The idea that the emotions of the pregnant woman can affect the health of the child in utero was particularly popular between the sixteenth and eighteenth centuries in the form of the doctrine of "maternal impressions" (Hanson 2004; Kukla 2005). The theory held that experiences, emotions, and sensations during pregnancy could be inscribed directly on the body of the fetus, creating marks or visible deformations on the child's body. Medical textbooks described the following phenomena, for example: "Cravings for strawberries and other fruits caused birthmarks resembling those fruits; cravings for shellfish caused particularly grotesque facial deformities; fright by a bear would cause a hairy child; being startled by a hare would cause a harelip or cleft palate; and lascivious thoughts could produce hermaphroditism and other obscene monstrosities" (Kukla 2005, 14). In another example, the birth of an "Ethiopian" child is explained by a painting of a dark-skinned man that the woman viewed at the time of conception (2005, 15). The features observed on the children's bodies were thus linked to the pregnant mind—her positive or negative feelings and the mental images associated with them.

The corporeal version of the doctrine of maternal impressions (in which viewing an object could mark the body of the fetus) was progressively marginalized in medical writings during the nineteenth century (Gardner 1994b; Oakley 1984). However, the general idea of the influence of the female mind persisted.

At the turn of the eighteenth and nineteenth centuries, medical research began to focus on physiological influences on fetal health (Arni 2012; Richardson 2021). Embryo-fetal physiology focuses on the close relationship between maternal and fetal bodies and how strong sensations could disrupt the nutrition of the fetus and thereby its nervous system (Arni 2012). In the 1940s, this hypothesis was explored within the framework of endocrinology: Women's emotions were transmitted to the fetus through hormones.

In contemporary Switzerland, the Pregnancy Support Center operates in a context in which at least three theoretical frameworks fuel anxieties over the impact of pregnant people's emotions. Attachment theory, initially developed by psychoanalysts René Spitz (1945, 1951) in the United States and John Bowlby (1951, 1969) in the United Kingdom, underlines the importance of maternal attachment to the health and well-being of infants and children. Attachment theory became a core component of the social and scholarly construction of "good" motherhood in Europe and North America through the promotion of "proximal parenting," or attachment parenting (Bobel 2002; Faircloth 2013; Kanieski 2010), and is part of the daily vocabulary of parenting advisers in Switzerland (Preissler 2022b). Growing attention to postpartum depression and the implementation of various types of screening strategies in Switzerland over the past two decades has also been fueled by the risks such episodes may pose to the mother-child relationship and hence to children's mental health (Razurel 2015; Razurel et al. 2013; Sancho Rossignol and Nanzer 2010). The development of neuroscience has also greatly increased the focus on the fetal and infant brain and has informed warnings to be wary of anything during pregnancy that might damage fetal brain function (Lowe, Lee, and Macvarish 2015; Macvarish 2014, 2016). More recently, the development of epigenetics and research on the "developmental origins of disease" is also renewing attention to the detrimental effects of maternal stress on offspring (Lappé and Jeffries Hein 2021; Richardson 2021). Epigenetics has fueled new public health strategies around the world based on the idea that the "first thousand days" of life—which include pregnancy and the first two years—are a time of increased sensitivity to epigenetic processes and, as such, a window of opportunity to prevent health problems across future generations (Pentecost 2018, 2024; Pentecost and Ross 2019; Yates-Doerr 2011). Epigenetics has not had the same massive influence on maternity and early childhood care in Switzerland as it has in France (Fournier and Jarty 2019) or South Africa (Manderson 2016), for instance. Nevertheless, the idea that pregnancy is a crucial stage of development that determines future children's health is still culturally prominent and reinforces "gendered imaginaries" (Chiapperino and Panese 2018) of maternal responsibility for fetal health.

At the Pregnancy Support Center, one of the main concerns regarding the pregnant mind is that a depressed mother will not be a "good" mother. During an informal conversation at coffee time, one midwife told me that maternity

health care providers at the local public hospital had decided to hospitalize a patient in a psychiatric ward against her will just after delivery.[4] This woman, according to the hospital, was displaying signs of mental illness. This midwife had supported this decision by the hospital's health care team: It seemed important to her that the professionals had time to "evaluate her maternal skills." A mother deemed too mentally ill is suspected of being an abusive mother in the making, to the point that hospitalization may be ordered in the name of the child's welfare even before birth.

REMAPPING REPRODUCTIVE BOUNDARIES?

The psychologization of pregnancy shifts epistemic boundaries, redefining what pregnancy is through a psychological lens. Psychoanalytical theories were particularly influential in reframing pregnancy as a period of crisis within the reproductive process. Accompanying this redefinition, professional boundaries were remapped, with mental health professionals entering the field of prenatal care. Claiming psychological expertise allows psychosocial counselors to position themselves as complementary to medical doctors.

Incorporating psychological sensitivity into prenatal care potentially allows for more holistic care and extended support for persons who need it while they are going through an important life transition. However, expanding prenatal care to the pregnant mind also contributes to the psychologization of everyday life (Castel and Le Cerf 1980; Donzelot 1977; Rose 1990). The rise of "therapeutic culture" fosters self-examination, self-improvement, and reflexivity as hallmarks of good citizenship (Furedi 2004; Madsen 2014). The Pregnancy Support Center instructs clients that "good" parenting involves the management of emotions and the involvement of psychosocial experts. Good pregnant subjects are to be mindful of their emotions. Thus, what pregnancy is as a reproductive stage and what pregnancy care providers should attend to has shifted.

As shown by the way Carla and Lana's cases were handled, feeling rules at the Pregnancy Support Center are contradictory. On the one hand, it seems impossible for pregnant people to remain serene during pregnancy since pregnancy is alleged to disturb their psychological balance and their relationship with their partner and with their mother. As Italian feminist Patrizia Romito summarized, according to psychological theories, "pregnant women are mentally disturbed and this is normal" (1990, 36). But at the same time, pregnant subjects are enjoined not to allow themselves emotional excesses and to actively discipline their emotions. This forces pregnant people to engage in careful "calibration" (Cairns, Johnston, and Oleschuk 2019; MacKendrick and Pristavec 2019) of their maternal identity to avoid being identified as either unnaturally serene or excessively emotional.

While this process has been framed overall as reclaiming pregnancy not only as a medical event but also a psychological one, biomedical and psychological definitions of pregnancy are not necessarily two territories with clear-cut borders. Psychosocial prenatal care also reproduces the fetus-centered culture that dominates the medical approach to pregnancy (Lupton 2012; Manderson 2016; Manderson and Ross 2020). In practice, the midwives and social workers that I encountered during my fieldwork were more concerned with preventing bad outcomes for fetuses and children than caring for pregnant clients' mental health.

While shifting the borders of prenatal care, psychosocial care at the Pregnancy Support Center does little to rethink the boundaries of the environments of reproduction. When describing the Japanese "theory of gestation," Tsipy Ivry (2010) underlined that mothers are understood as the physical and mental "environment" for their fetus. Mothers and babies form "holistic entities," and the unborn baby is "totally dependent on every single aspect of the maternal environment" (2010, 95). The attention that doctors pay to a pregnant patient's mental state, Ivry writes, "adds to her portrait as an all-powerful motherly environment, in the physical and mental sense" (2010, 99). At the Pregnancy Support Center, neither focusing on women's emotions nor on their impact on future children disrupts the positioning of mothers as primarily responsible for children's health, the dynamic that Ivry describes in the Japanese "environmentalist theory of gestation" and that is also typical in Swiss prenatal care. The mental health of fathers was largely ignored at the Pregnancy Support Center. At most, pregnant clients were asked how their partners were "experiencing" the pregnancy. If men were present, they were encouraged to support and look after their pregnant partner. Psychosocial advisers often leave unexplored the larger social and physical environment in which pregnancies unfold. Feminists have underlined how gender norms and ideologies of good motherhood may influence postnatal mental health (Santino and Monaghan 2023; Tseris 2022). In Switzerland, relatively short maternity leaves (fourteen weeks) in comparison to the rest of Europe, as well as a shortage of day care facilities, are major stress factors in the postpartum. The influence of psychology on prenatal care, however, revives the framing of pregnant women as "fetal containers" (Annas 1986) and curtails consideration of structural factors that may influence their mental health.

4 • A GOOD FUTURE

Normalizing Lives

During Valerie's appointment with midwife Colette (described in chapter 2), a large number of Colette's questions for her client concerned the future: "Will you have help and support from family members when you come back from the hospital?"; "Do you plan to work full-time or part-time after your maternity leave?"; "Which childcare options have you considered for your baby?" Preparing future parents for birth, the postpartum, and beyond forms a significant part of the Pregnancy Support Center's activities. Midwives and social workers seek not only to know how future parents plan for the arrival of their child but also to intervene to change these plans if they are considered inadequate. When Valerie told Colette that she was a smoker, Colette promptly advised her to cut down on cigarettes and change her clothes after smoking. Appointments entail evaluating and disciplining pregnant clients' behavior according to predefined understandings of what a "good" future involves.

Anticipation is a temporal regime in which the present is thought of and acted on in reference to possible futures (Adams, Murphy, and Clarke 2009; Ben Anderson 2010; Tavory and Eliasoph 2013). Experiences of health, illness, and medical care are often marked by hopes and fears regarding possible futures, and these imagined relations guide present actions (Harrison, Smith, and Adams 2024). Anticipation is particularly enmeshed in reproductive imaginaries: Reproductive and parenting decisions often involve ideas about potential futures (Adams, Murphy, and Clarke 2009; Ballif 2023a; Barnes 2014; Broer, Pickersgill, and Cunningham-Burley 2022; Sänger 2015; Svendsen 2015, 2021). Anticipation in psychosocial prenatal care creates a "time displacement" (van der Ploeg 2002, 62) that reconfigures events and the subject: Potential futures become the ultimate standard against which the present is evaluated, "good" maternal behavior is expected from pregnant clients even before their child is born, and fetuses are considered to bear children's rights.[1]

At the Pregnancy Support Center, such integration of the future into prenatal care is intended to be different from the way medical care handles anticipation.

Psychosocial advisers are critical of medical care for its "risk logic" that centers on avoiding bad future outcomes for the fetus and neglecting parents' psychological and practical "preparedness" for the birth and postpartum. But like risk-based medical pregnancy care, psychosocial anticipation relies on normative definitions of what constitutes a good future (Ballif 2014). Psychosocial care thus creates new expectations of preparedness and anticipatory parenting. In this chapter, I interrogate the different meanings of anticipation at the Pregnancy Support Center and explore the role of psychosocial advisers in shaping ideas of pregnancy and fetal subjects, of good citizenship, and of a good life in Switzerland.

ANTICIPATION, RISK, AND PRENATAL CARE

Evaluating future parents' level of preparedness for the arrival of their child is a core element of psychosocial care at the Pregnancy Support Center. When discussing her work with me, midwife Julia underlined the importance of checking her clients' plans: "For me, what is essential in what I do is how . . . Madame and Monsieur project themselves,[2] how they are going to organize themselves around this child. On the practical level as well, how they prepare for the birth, what their questions are—but also talking about their return from the hospital." As Julia puts it, pregnancy involves a process of preparation both for the immediate and long-term future. The Pregnancy Support Center offers a designated space for anticipation. The center's staff anticipate health, administrative, financial, relational, or work-related matters and mobilize future parents to organize themselves in anticipation of these issues.

Anticipation in psychosocial care builds on a critique of medical prenatal care: Midwives and social workers believe that gynecologists both ignore psychosocial problems and fail to anticipate their consequences. Discussing her work with me, midwife Caroline blamed medical care providers for failing to identify psychosocial difficulties: "You see, sometimes gynecologists don't necessarily ask women questions, or women don't dare to talk about their difficulties. So, in the end, they have a lonely and stressful pregnancy, and suddenly they come to the hospital for a prenatal checkup, and they are asked, 'But actually, where is the father?' for example. And then we see them at thirty-six, thirty-eight weeks of pregnancy and we realize that this whole pregnancy happened and [the woman] did not have any support. It is a shame, really." Psychosocial care thus extends anticipation to areas that medical care does not cover, bringing it beyond bodily risks to the psychosocial.

Risk-focused anticipation is a core element of medical prenatal care in Switzerland and motivates medical surveillance of pregnancies (Burton-Jeangros et al. 2013; Burton-Jeangros, Hammer, and Maffi 2014a; Hammer and Burton-Jeangros 2013). Risk discourse is pervasive in prenatal care in Switzerland (Ballif

2014, 2019; Burton-Jeangros 2010, 2011; Burton-Jeangros et al. 2013; Gouilhers et al. 2019; Hammer and Burton-Jeangros 2013; Hammer and Inglin 2014). Like other highly medicalized contexts, gynecologists delivering pregnancy care consider a "duty to inform" (Hammer 2010, 245) their patients about risks inherent to pregnancy (such as miscarriage or fetal malformation) and about medical procedures (like amniocentesis or C-sections) to be a central part of their work. This sense of duty is fueled by increasing fears of the legal repercussions of failing to inform, even though Swiss gynecologists stress that legal proceedings against medical doctors remain very rare in Switzerland in comparison to the United States, to their relief (Hammer 2010). Routine prenatal care involves information about risks associated with alcohol, tobacco use, and certain foods in pregnancy. Prenatal screening for genetic abnormalities is offered to all pregnant patients, which combines measuring nuchal translucency by ultrasound and serum testing via a blood test. When the probability of genetic malformation is considered high, patients are offered amniocentesis, a more risky and invasive procedure. As in other contexts where prenatal care is highly medicalized, risk discourse focuses on fetal health and positions pregnant people as responsible for those outcomes (Hallgrimsdottir and Benner 2014; Lupton 1999, 2011, 2012; Ruhl 1999).[3] Pregnant patients in Switzerland develop contrasting attitudes toward the culture of medical risk, ranging from skepticism toward risk logic and health advice to aspiration for control and risk avoidance (Burton-Jeangros et al. 2013; Hammer and Burton-Jeangros 2013). Faced with advice to abstain from drinking alcohol for fear that it could cause fetal malformation, some pregnant patients relativize risk, while others strictly adhere to expert advice (Hammer et al. 2022; Hammer and Inglin 2014). All, however, report feelings of anxiety and guilt associated with the "pervading discourses of risk" (Gouilhers et al. 2019, 762) in prenatal care.

To differentiate their approach from the biomedical model, staff at the Pregnancy Support Center hardly ever used the vocabulary of "risks," "risk factors," or "risk avoidance," which they strongly associated with the medical world, to explain their approach to anticipation (Ballif 2014). A "risk" approach to pregnancy care was, for them, synonymous with a focus on fetal health, rushed appointments, and anxiety—a criticism shared by classic feminist analyses of the medicalization of pregnancy (Gardner 1994a; Katz Rothman 1982; Lupton 1999; Ruhl 1999). In contrast, the anticipatory approach to prenatal care at the Pregnancy Support Center emphasizes *preparedness*, not only to manage and avoid pregnancy risks (specifically, bad fetal outcomes) but to maximize readiness for other aspects of future (parental) life. Compared with the biomedical model and its focus on "risk," the center's anticipatory model is understood as a less anxiety-inducing approach to birth and the postpartum period, one that emphasizes the importance of thinking about the future and acting in the present in a more pragmatic way. Underlying anticipation is the idea that the birth

of a child generates practical and administrative work that needs attending to in a timely manner but that should not necessarily become laden with the sense of fear and danger. It also intends to shift the focus away from fetal health to encompass the need for future parents to prepare themselves for their impending role.

Being prepared and well organized are aspects of what is considered good citizenship in Switzerland. Liberalism and individual responsibility are characteristic features of Swiss society and politics. In comparison to other European countries, the federal government is "much more reluctant to implement restrictive public health policies" (Trein, Rüefli, and Vatter 2023, 715). Instead, health policies have historically been dominated by the principles of free choice and individual responsibility. The national health insurance system, while creating an obligation for all residents to have insurance, leaves individuals free to choose their insurance provider and yearly deductible. Despite rising costs that put many Swiss households in financial difficulty, premiums are not adjusted to income (cantons offer subsidies with varying criteria). The federal state is likewise reluctant to implement family policies that would facilitate work-life balance and day-care options. Moreover, an "obligation to self-organize the reconciliation of work and the family" (Fux 2002, 10) has characterized the scarce Swiss family policies that do exist (Häusermann and Bürgisser 2023; Levy, Widmer, and Kellerhals 2002). Liberalism goes hand in hand with the expectation that individuals will make rational choices and plan and manage their lives responsibly. At the Pregnancy Support Center, despite staff's general political sympathies for welfare measures and social solidarity, midwives' and social workers' expectations about how future parents should prepare are deeply informed by this liberal political culture.

TIMELY INTERVENTION

Each appointment at the Pregnancy Support Center is categorized to correspond to the stage of the client's pregnancy and is so coded in the unit's electronic files: "pre-conception," "first trimester," "second trimester," "third trimester," or "postpartum." For each stage, a slightly different interview structure is used. Stages of pregnancy are thought to differ from each other both physically and psychologically. This representation of pregnancy as a succession of different stages parallels the use of time standards in obstetrics. Medical management of both pregnancy and birth became organized along a standardized temporal logic over the twentieth century: Milestones, stages, and rhythms orient health professionals' actions during pregnancy and labor (Downe and Dykes 2009; Simonds 2002). Pregnancy checks, ultrasounds, and tests are organized along a standard pregnancy calendar divided into trimesters, months, and weeks. At the Pregnancy Support Center, this temporal logic is extended to the psychological sphere. In a brochure, the two founders described pregnancy as divided into

three psychosocial stages. The first trimester of pregnancy is associated with mixed feelings about pregnancy:

> In early pregnancy: . . . During a first appointment, our role is of course to provide accurate information to the questions they ask but also to allow the woman, and the man if he is accompanying her, to situate this pregnancy in her context and to share her first feelings, which can sometimes be unsettling. . . . Quite often, early pregnancy is characterized by what we call a time of ambivalence. The desire for a child mixes with the fear of pregnancy, the fear of becoming a parent.

The second trimester is associated with a more positive state of mind:

> Pregnant women generally describe the second trimester of pregnancy as the most fulfilling. . . . More often than not, [the pregnant woman] has regained all of her energy, she feels active and creative towards the future. But it is also during this period that women share with us possible tensions with their employer or their family.

The third trimester is a time of physical discomfort and preparation for birth:

> From the start of the third trimester, pregnancy becomes more "cumbersome." Along with backaches and other physical symptoms, contractions can be a sign of extreme tiredness and unease. . . . The closer the arrival of the child, the more the pregnant woman needs everything to be ready to welcome him/her.[4] It is the last moment to make sure all the steps being taken are in order.

Midwives and social workers believe that their intervention should be stage-appropriate: providing the right information at the right stage of pregnancy. Anticipation—both as a professional and parental skill—is indexed according to the psychosocial stages of pregnancy. Future parents should prepare for specific things during specific periods of the pregnancy. In this vein, according to Nadine, a social worker, it does not make sense to talk about birth or the postpartum period in early pregnancy: "If I meet a person or a couple for the first time, well I won't talk about the next stages [of pregnancy] with them, I will tell them, 'Let's make another appointment another day where we will talk about the postpartum, later.' Because it is quite useless to bury them under new information that they will remember only in pieces."

Stage-appropriate intervention is a shared ideal among midwives and social workers. Conceiving of pregnancy as a succession of psychological and physical stages, each with their own specificities, aligns with and contributes to the belief that pregnancy should be a supervised experience (see chapter 5). If pregnant people experience different states of mind and encounter different challenges

each trimester, repeated consultations at the center are necessary. In reality, however, midwives and social workers are often unable to offer regular appointments to their clients. Most appointments occur in the last trimester of pregnancy, which professionals consider at odds with the need to anticipate and prepare appropriately. "Meeting people very late allows us to think about birth, but it doesn't allow for anticipating difficulties, or you anticipate very late. We would really like to see people from the twenty-fifth week of pregnancy, and even earlier when they have difficulties" (Charlotte, sixty-three, midwife). Many staff members expressed their frustration, explaining that since the center is chronically understaffed due to underfunding, clients often had to wait weeks, sometimes months, for an appointment. Moreover, many clients contact the center late, having not been previously aware of the center's existence. The center's management team made proactive efforts to advocate for early psychosocial consultations among health care professionals and the wider public, which led third-trimester consultations to decrease from 70 percent to 58 percent during the last decade. But midwives did not want to see clients too early in pregnancy either. Between one and twelve weeks of pregnancy, midwives consider the risk of miscarriage to still be high, making prenatal appointments during this period inappropriate. Julia (a midwife) expressed her sense of unease about such early appointments: "I have seen some women at six, seven, eight weeks of pregnancy and I felt like they were not really in the thing. You are still in the period where you can have a miscarriage. . . . A part of me was thinking: 'Does it make sense to talk about all of that? Maybe in a week the girl will have a miscarriage.' And I was thinking 'Would it not make more sense to see them at ten or twelve weeks?' It is very different. Because women are more into it, they are out of the risk of miscarriage."

Anticipation as a model of psychosocial care relies on normative conceptualizations of pregnancy as entailing specific states of mind and sets of behavior. Midwives and social workers organize their work according to what is considered the "normal" attitude for pregnant people in each trimester. It is in that sense that anticipation as a temporal logic is intrinsically psychosocial and differs from a risk logic that professionals associate more specifically with physical health and medical care.

FAILED ANTICIPATION

As a skill that future parents are expected to develop and deploy, anticipation acts as a measure of "good" mothering in psychosocial pregnancy care. In the United States—a context also marked by the influence of individual responsibility—Han (2013) describes how preparing the baby's room while expecting is a typical feature of middle-class experiences of pregnancy. "Remodeling the house," Han (2013, 125) writes, is one of the processes through which "families become remade" with the arrival of a new child and is expected in an "ordinary pregnancy"

in America. During the appointments I observed, health care providers sometimes openly criticized pregnant clients for failing to anticipate properly because decisions were not made at the right moment. Sometimes practical concerns were involved: Some administrative steps like applying for parental leave or subsidies are time-sensitive, and a failure to act in a timely manner can be detrimental to future parents. During an appointment, Agnes (a social worker) criticized her client for not having registered her future baby in a nursery yet. In Switzerland, a long-standing shortage of day-care provision translates into monthslong, and even yearslong, waiting lists. Registering as early as possible ensures the best possible chance of securing a place.

Typical examples of failed anticipation occurred when clients' attitudes did not conform, as prescribed, to the relevant psychosocial stages of normative pregnancy. Midwife Alexandra rebuked Lana, a thirty-five-year-old nurse pregnant with her first child, who was eager to discuss the birthing experience although she was only four months pregnant:

ALEXANDRA: I think it's a bit early to talk about birth, what do you think?

LANA: I think a lot about birth. I am looking forward to it!

ALEXANDRA: Are you not worried? Didn't you hear alarmist things?

LANA: No. I've always wanted to be a midwife. My mum always told me about her deliveries as something wonderful.

ALEXANDRA: It is a bit early because you are not the same at eighteen, twenty, or twenty-five weeks of pregnancy. It is a psychological process. We can feel worried at thirty weeks when you feel your belly grow big. When the body deforms, sometimes the mind—you have to digest and allow yourself to have apprehensions. You shouldn't idealize delivery. It can be heavy and hard. You shouldn't feel guilty if you have fears.

Alexandra clearly disapproved of Lana's attempts to think about birth at a stage in pregnancy she considered too early. She considered planning for birth appropriate during the third trimester—not at the start of the second. The midwife made her client aware that she should postpone these thoughts until later. Alexandra further reprimanded Lana for her lack of apprehension with regard to delivery. Thinking about birth as a "wonderful" event, or as something to look forward to, is not contingent with a "normal" pregnant state of mind, the midwife explained. Clarifying what she considers to be the proper mode of anticipation, Alexandra warned that her client "shouldn't idealize delivery," setting rules for how to feel while pregnant.

Through such examples of failed anticipation, psychosocial advisers reveal their understandings of what a "normal" future as a mother should look like. In a conversation, Catherine, a social worker, told me about a recent client whom she thought was "not being realistic" about her future motherhood plans: "The other

day, I received a twenty-six-year-old woman who wants to start studying midwifery in September although she will give birth in December, and on top of that she will take care of her partner's two children. She is in denial!" For Catherine, this client's plan to be a student, a mother, and a stepmother is not realistic. The social worker establishes her conceptualization of a normal future as the only one grounded in "reality," and accordingly, she expects her clients to anticipate "realistically." This means along the lines of her normative representation of motherhood.

Another example of failed anticipation arose in a consultation between Agnes, a social worker, and Libby, a thirty-four-year-old married client who was due to give birth to her first child two weeks later. In this case, the social worker admonished her client for wanting to make decisions she considered inappropriate. During their appointment, Agnes explained the existing options to extend one's maternity leave beyond the Swiss legal minimum of fourteen weeks. These options include using one's (paid) holiday entitlement or taking (unpaid) leave, for which local authorities offer meager financial compensation. Libby asked if her husband could take parental leave and stay home with the baby because she wanted to go back to work immediately at the end of her fourteen-week maternity leave. Visibly surprised at this plan, Agnes did not answer Libby's precise question but laughed and continued the conversation as such:

AGNES: Have you already taken care of other babies?
LIBBY: A little. Not really. I don't have a lot of experience, but I know a lot of things.
AGNES: Yes, but when I hear you, I think, "She is not in Baby's reality!" [*laughs*].[5]
LIBBY: Oh, yes?
AGNES: Because you are already thinking about going back to work, I thought, "Oh gosh, when Baby's here, I would be curious to see what you think!"
LIBBY: No, I know it will be difficult; I hear mothers talk—
AGNES: It's hard to leave them to go to work! Because sometimes you have plans and when the baby is here, you think, "Can I really do this, what are my priorities?" It changes. This is why I think it's good to know your options but leave decisions for after the birth.
LIBBY: I think so too. Maybe I will change my mind.

Agnes barely hid her disapproval of Libby's plans, as her anticipated future was considered not to be in line with the "reality" of having a baby. This reality entails, in Agnes's view, a shift of priorities from work to mothering. Since this shift appears not to have happened in Libby's case, Agnes explains in a rather patronizing tone that she should wait for this transformation to occur before she makes any decisions. In her electronic file (inaccessible to Libby), Agnes wrote: "Libby does not seem aware of the baby's arrival." The vocabulary of "reality" and "awareness" bluntly reveals the uncritical normative conceptualization of the

pregnant person's future as prioritizing maternity over career. The "haunting images" (Gammeltoft 2013, 93) that psychosocial advisers push against and try to prevent from becoming reality are not those of children with disabilities, as Tine Gammeltoft described in her ethnography of prenatal screening in Vietnam, but those of the "detached parent" (Faircloth 2014) who is not sufficiently physically and emotionally available for their child.

A GOOD FUTURE

Anticipation draws upon images of the future that one seeks to avoid or to bring about. In official policy documents, the Pregnancy Support Center's mission is to "accompany" future parents and answer their questions. In practice, I noticed on several occasions how midwives and professionals tried to change their clients' decisions and orient their actions in specific ways. In these instances, acting upon the present in relation to anticipated futures often took the form of promoting traditional gender roles.

Psychosocial advisers implicitly regarded full-time work as incompatible with pregnancy and early infancy. They regularly encouraged their clients to lower their working hours during pregnancy. In Switzerland, pregnant people normally work until their due date, unless their gynecologist puts them on medical leave earlier (which does not affect one's salary). For example, Colette (a midwife) praised seven-months-pregnant Valerie's choice to lower her occupation as an office clerk from full-time to half-time (see chapter 2): "Yes, at some point you need to make a choice. We see a lot of women who are very invested professionally. Often around twenty-eight, thirty weeks [of pregnancy], it's like there is a choice to be made. They have operated around their job a lot and suddenly the baby is more present, the pregnancy has requirements. The ones that can't let go of work, they end up with insomnia, exhaustion, depression. If one can slowly diminish [one's percentage], that's better." Colette warned Valerie of the risks associated with being too invested in her career. She presented the third trimester as a time in which clients have to choose between their job and their health.

In another example, Sabrina (a midwife) conveyed the same notion of late pregnancy as incompatible with work and made her client doubt her own assessment of the situation. Doris was six months pregnant and worked a full-time office job. During the appointment, Sabrina asked her several times how she felt and if working full-time was not too much—to which Doris continually responded that she felt great. Accordingly, Sabrina explained that this was not going to be the case for very long:

SABRINA: You will need to see how it goes with your job, how you will manage, if sitting is making you tired. When Baby grows up, she/he comes into the pelvis and sometimes presses down, it hurts in your legs, and you can have edema. With

the [summer] heat, the next two months are going to be tough. You will need to see how you feel with working, if it suits you. If you feel it's too much, don't hesitate to talk about it with your gynecologist to change your percentage a little bit or even stop.

DORIS: I have already talked about that with him. I feel so good that I wonder if I am not aware of my limits.

Even if Doris feels perfectly fine, Sabrina's speech makes her doubt her own sensations.

If psychosocial advisers encourage clients to work less during pregnancy, especially at a late stage, it is with the goal of protecting maternal and fetal health. Since gynecologists do not routinely put pregnant patients on leave (and are under pressure from employers and health insurance companies not to do so too generously), psychosocial advisers view their role as empowering clients to ask for medical leave and not strain themselves. As the center's first midwife and social worker expressed in a brochure, it is for them a matter of women's rights:

> When work overload is too severe, a leave from work is sometimes necessary to stop the vicious cycle of tension/fatigue. . . . We must often insist, remind them of their rights, so that women realize that it is also by resting that they can take care of their future child and that they should not feel guilty about their transitory "frailty." Who can work 80% or 100% of the time at a job, "work" 100% of the time in their body to grow a child, and work more at housekeeping, cooking, doing laundry, and cleaning, and this for nine months? Women understand quickly that it is in this full-time pregnancy "work" that they are indispensable and irreplaceable.

The center's founding members adopted a feminist vocabulary, pointing to the accumulation of productive, reproductive, and domestic work that many pregnant people assume. Contrary to a feminist discourse that might call for pregnant people to be relieved of domestic work, however, psychosocial advisers encourage their clients to pull out of paid work instead.

Moreover, advisers present engagement in paid work as incompatible with taking care of an infant. In some cases, they suggested that mothers—not fathers—diminish their working hours after their baby was born. Returning to work after maternity leave is a frequent topic of discussion during appointments. Given the shortness of maternity leaves (fourteen weeks), many parents try to negotiate with their employers to extend their leave by using their annual paid leave allotment (generally four to five weeks a year) or taking unpaid leave from work (which must be negotiated with their employer and during which time they are not protected against dismissal). Statistically, the birth of a child has a heavy and direct impact on women's careers. Welcoming a child led one out of

seven women to step back from paid employment altogether in 2020, while the remaining cohort reduced their working hours by 20 percent on average (Federal Statistical Office 2021). No such impact is observed on men's careers.

The "good future" that midwives and social workers prepare for is a future in which mothers—and mothers only—take time off work to take care of their baby. No such expectation is placed on fathers. Social workers at the center routinely encourage pregnant clients to take unpaid parental leave after their maternity leave, without warning them about the risk of early dismissal. Clients are made aware of the possibility of arranging additional unpaid leave and even helped with completing the necessary paperwork. Advisers do not take any similar actions in terms of helping fathers access unpaid leave, however. Social worker Agnes laughed at the idea of her client going back to work while her husband stayed home with the baby. Instead, she explained that Libby could receive a meager subsidy from local authorities if she took unpaid leave from her job after her legal maternity leave (fourteen weeks) up until her child was six months old. Libby inquired about the possibility of her husband receiving this subsidy:

LIBBY: This extension, the father cannot receive it?
AGNES: No [*laughs*]. They have not thought about that. For now, the father doesn't get any paternity leave, no.
LIBBY: What a shame.
AGNES: Is it true? You would rather go back to work?
LIBBY: What I would like is to do the ninety-eight days [fourteen weeks of maternal leave], and then I'll leave her/him with the father.
AGNES: Yes, you say that because the baby is not here yet! [*laughs*] I'd like to see if you say the same thing in a month!

Agnes adopts a paternalistic tone to inform her client that she does not yet realize what her priorities will be once her child is born. In doing so, she reproduces a gendered order wherein mothers take care of infants and fathers continue in paid employment.

The desire to get back to work immediately after maternity leave is sometimes anxiously interpreted as a potential indicator of depression. In one case, I observed an appointment between Nadine, a social worker, and Natalie, who had given birth to a child three weeks prior. Natalie was a recent college graduate and had been looking for a job in earth sciences while pregnant. She said to Nadine that she would go back to work "as soon as [she] found a suitable job." After Natalie left, Nadine shared with me that this desire to find job might be a symptom of mental distress:

> When she says, "If I find a job in my field as soon as possible I will take it," it worries me in relation to her baby. When I hear a mother who just gave birth say she

> wants to find a job immediately, generally it's not a good sign. [The first weeks] are the most difficult period of the postpartum stage, where we often see women who say they want to go back to work even before the end of their maternity leave. Actually, it's about getting back to being themselves, they don't know who they are anymore once they have given birth.

In another interview with me, Nadine clearly expressed that wanting to get back to work early after the birth of a child was, in her view, "a sign of depression." For Nadine, wanting to get back to work early in the postpartum period was often for the "wrong" reasons: to escape a difficult daily reality of taking care of a newborn and to get back to a familiar professional environment. It is not so much the fact that Natalie wants to work that bothers Nadine but the timing of her desire that is the problem. Thinking about a return to work during the early postpartum period is considered inappropriate and problematic.

The "good" future that anticipation must bring about is one in which care work is an unquestioned maternal priority. Deviation from this norm is met with sarcasm, skepticism, or a pathologizing gaze.

FETUSES AS FUTURE CHILDREN

The first time I attended a "midwives' meeting" at the Pregnancy Support Center—a meeting for all the center's midwives to discuss topics relevant to midwifery—the topic of discussion was alcohol and tobacco. In Switzerland, since the late 1990s public health messages have advocated no smoking and no drinking during pregnancy for fear of harmful consequences for fetal development and children's health. The prevalence of alcohol and tobacco use during pregnancy remains higher than in other European countries, however, for reasons ranging from skepticism toward risk discourses to social norms and peer pressure (Gouilhers et al. 2019; Hammer 2019; Hammer et al. 2022; Hammer and Inglin 2014). After a brief reminder from one of the midwives of the dangers of alcohol and tobacco for fetal and children's health, the conversation among midwives then drifted to an exchange of tips and tricks to best convey prevention messages to pregnant clients. Alexandra advocated for a direct approach to tobacco prevention, using the image of a "stressed newborn" suffering from withdrawal syndrome:

> This, for me, is a way to make them aware, because often women who smoke are very tense, nervous, and need a cigarette. They think, "My job isn't going well, my relationship is difficult, I'm pregnant, I need my smoke." I noticed that it can help them become aware by saying "It's good that you mention [that you smoke during your pregnancy], so we can understand why the baby cries so much. The midwives at the maternity ward can take this into account; they'll know it's because

> of that that the baby cries so much." "Oh, it will do that?" I say, "Yes, the baby will be stressed; it will be a stressed newborn." And I felt that this has touched them a little. It's really about raising awareness!

Anticipation in psychosocial care means that fetuses are talked about mainly in their capacity as future children. In the name of the future child's well-being, midwives and social workers seek to orient future parents' actions or redirect their plans, including around their alcohol, tobacco, or food intake during pregnancy.

The highly medicalized prenatal care culture of Switzerland has contributed to positioning fetuses as individual beings, as has been the case elsewhere in North America and Europe. Technological innovations incorporated into prenatal care over previous decades, such as ultrasounds, fetal surgery, and prenatal genetic testing, have increased the visibility of fetuses, transforming them into patients in their own right (Casper 1998; Löwy 2014; Oakley 1984; van der Ploeg 2002). Images of fetuses, particularly from sonograms, played a central role in the construction of fetal personhood in North America and Europe (Hopwood 2015; Morgan 2009), and feminists questioned the consequences of the "irresistible rise of the visible fetus" (Löwy 2014) for reproductive rights (Hartouni 1992; Morgan and Michaels 1999; Petchesky 1987; Taylor 1992). "Fetalhood" has emerged as a phase of childhood, "an extension of childhood as a social and biological state . . . backward into the womb" (Armstrong 2003, 21).

The fact that the Pregnancy Support Center has been integrated since 2006 into a children's health program illustrates this "infantilising of the unborn" (Lupton 2013, 3) well beyond medicine. The pregnancy support offered at the center is part of a canton-wide public health program dedicated to health promotion and primary prevention for "children between 0 and 6 and their parents." The program allocates funding to several institutions both in the public health and child protection services sectors, such as to pediatric nurses (who offer free visits at home or in a clinic to check on infants' health) and parent-child day centers (playgroups for children under school age accompanied by a parent or carer). Strikingly, with the Pregnancy Support Center, pregnancy appears as the time in which prevention starts—in other words, it is the first stage of children's lives. In other countries such as France or South Africa, public health strategies informed by epigenetics are also increasingly solidifying this continuity between "fetalhood" and childhood (Fournier and Jarty 2019; Manderson and Ross 2020; Pentecost 2018; Pentecost and Ross 2019). Epigenetics and in particular DOHaD—the research field focused on the developmental origins of health and disease—have identified the period from conception to the age of two years as a crucial period for lifelong health. These "first thousand days" of life, as this period was termed in 2008, are presented as a critical widow of development during which epigenetic modifications are particularly likely to occur and

influence the health and disease of several generations. The "first thousand days" became a central framework in public health strategies of the United Nations and numerous countries around the world aiming in particular to improve nutrition from conception to the second birthday. As Lenore Manderson (Manderson 2016; Manderson and Ross 2020) has argued, such a reframing of pregnancy and early childhood as a prevention window for long-term health problems carries "the assumption of the female body as an incubator of population health, both in the immediate present and, according to current understandings of epigenetics, for two generations (at least) into the future" (Manderson and Ross 2020, 6) and neglects "women's health needs" in favor of "infant well-being" (7). Although the "first thousand days" has only had a marginal influence on Swiss public health to date, the role of the Pregnancy Support Center in promoting children's health participates in the same merging of fetalhood into childhood in the name of anticipation and prevention.

Staff almost always refer to fetuses as "babies" and not as "embryos" or "fetuses." This choice of words marks the territory of psychosocial care as distinctly nonmedical: While medical pregnancy care focuses on fetal development, psychosocial care focuses on future babies. The biological fetus developing in the womb and what are commonly considered its "proofs of life" (Howes-Mischel 2017, 255)—for instance, ultrasound images, genetic testing results, or movements—were very rarely discussed during appointments. Nevertheless, fetuses were never discussed as full "persons." While in the United States anti-abortion movements have advocated for an understanding of fetuses as persons, in Switzerland the social, political, and medical importance of fetuses is not as closely linked to abortion wars. In the U.S. context, proponents of "fetal rights" position the fetus as equivalent to a child in the eyes of the law (Daniels 1993; Goodwin 2020). Fetuses have come to be largely considered "biological facts of life" (Han 2017, 63) in the United States, embodying the very beginnings of life: This status is the product of both their politicization and medicalization (Hartouni 1992; Petchesky 1987; Taylor 1992). Anti-abortion movements exist in Switzerland and regularly seek to restrict access to abortion care (Heinen 2022), but political debates about fetal life are nowhere near as heated as in the United States. The Pregnancy Support Center and the canton's Family Planning Center are both part of the Intimacy Foundation and psychosocial advisers share a pro-choice stance. Consequently, they do not argue that fetuses have moral or legal personhood. When fetuses are treated as children, it is because midwives and social workers understand that these fetuses *will be* children in a near future. This is a fine but arguably significant distinction. Fetuses in psychosocial prenatal care are not regarded as full persons but as *future children* whose rights can and should be anticipated.

Discussions of paternity and child recognition at the Pregnancy Support Center typically involve anticipating children's rights during pregnancy. Marie was

twenty-two when she discovered that she had become pregnant unexpectedly by her boyfriend. Her pregnancy was determined at the Family Planning Center, which provides free consultations in case of unplanned pregnancies. There it was recommended that she meet with a social worker from the Pregnancy Support Center. Marie's age framed her as a "young" pregnant person (the average age at the birth of one's first child is around thirty-one in Switzerland), along with the fact that she lived with her parents and had not yet completed her vocational degree as a nursery worker. This was probably why Catherine, the experienced social worker who conducted Marie's initial appointment, conducted a particularly thorough examination of Marie's professional and financial plans, which involved Marie dropping out of her vocational education and moving to France and becoming financially dependent on her boyfriend. When Marie said she was not sure they were going to get married, Catherine warned her that the father would then have to officially recognize the child: "If you don't get married [to the father] he has to recognize the baby. It is obligatory. The law is that each child has a right to have the name of a father on her/his documents. It is obligatory. It can shock some men. But you can understand and accept this thing if you understand that laws center on the child."

The law that Catherine referred to was Article 309 of the Swiss Civil Code, in force until July 1, 2014: "As soon as an unwed pregnant woman requests it from child protection authorities or as soon as the latter have been informed of the birth, they name a legal guardian tasked with establishing paternal filiation, counseling, and assisting the mother in an appropriate way" (my translation). According to this law, a child born in Switzerland to an unwed mother and who was not officially recognized by a man was automatically placed under the state's protection through so-called paternal guardianship (Delessert, Boraschi, and Valsangiacomo 2024b). The legal guardian gains legal authority over the child along with the mother and opens an inquiry to identify the child's father. Since 2014, paternal guardianship is no longer automatic but can still be decided by child protection authorities on a case-by-case basis (article 308 of the Swiss Civil Code). In practice, a variety of circumstances can lead to the absence of paternal recognition: A mother could be unable or unwilling to contact the father (in cases of conflict, violence, sexual assault, or where there are multiple or unidentified sexual partners, for example). Equally, a presumed father could be reluctant to proceed with official recognition (to avoid paying child support or in the case of doubts over paternity, for example).

Social workers at the Pregnancy Support Center framed paternal guardianship and fathers' obligation to recognize their children as a matter of children's rights—the right to know the name of one's father. In addition, paternal guardianship is a way for the state to ensure that biological fathers are identified and can be obliged to assume their financial duties toward their child by paying child support. When I learned about paternal guardianship from the center's staff, however, it struck me as a form of "patriarchal and paternalist coercion" (Deles-

sert, Boraschi, and Valsangiacomo 2024a, 14) of single mothers. The compulsory nature of this system meant that single mothers did not have a choice in the matter, even if they did not want any form of relationship, financial or otherwise, with the biological father of their child. Moreover, under this system, social services remained involved with unwed mothers for an average of three to four years, usually well beyond the time needed to establish paternity, which suggests that the paternal guardianship system was deployed as a tool to instigate wider forms of (maternal) surveillance (Delessert, Boraschi, and Valsangiacomo 2024b). Single-mother families were framed as a deficient family form that needed to be supported by a legal guardian until a point at which a father could assume his role. Paternal guardianship was also a striking illustration of heteronormativity in Swiss family and reproductive laws at the time. Paternal guardianship consolidated the biogenetic model of kinship dominant in Europe and North America, which defines children as the biogenetic product of a man and a woman. Until 2018, a child could not officially have same-sex parents, and until a national vote in 2021, same-sex couples could not access assisted reproduction services. In this model, marriage is the foundation of the family; in Switzerland, three-quarters of families are formed of married heterosexual couples and their common children (Federal Statistical Office 2017). Legally, a woman's husband is presumed to be the father of any child she bears. When a child born out of wedlock threatens this traditional model, the state steps forward to establish paternity and consolidate biological heteronormative kinship.

Enforcing such surveillance of single mothers seemed, to me, to be at odds with the openly feminist stance of most psychosocial advisers at the Pregnancy Support Center. Toward the end of my fieldwork, I decided to confront the head social worker, one of the most vocal feminists in the unit, and ask her how she felt about paternal guardianship:

EDMÉE: What is your position toward paternal guardianship? How do you see your role? The law instates a guardianship automatically when the mother is not married. Is it a legacy of the state's control over young single mothers?

NADINE: No, because paternal guardianship is not about mothers; it's about children's rights. A child comes from a couple. However complex adult relationships can be, children's rights must be guaranteed.

Nadine did not view paternal guardianship as problematic because she focused on future children's rights. In other words, promoting children's rights in advance, before birth, resulted in obscuring the potentially problematic effects of paternal guardianship for mothers.

The Pregnancy Support Center frequently collaborated with child protection services, another example of anticipating children's rights during preg-

nancy. In the Canton Romand, every professional working with minors has a legal obligation to report any child "who seems to need help" to child protection services. By virtue of this law, staff regularly reported unborn children to child protection services, who sometimes summoned future parents before birth. Technically though, child protection laws do not apply to unborn children. In 2012, the center's director invited a lawyer to inform the center's staff about confidentiality and data protection. Experts from fields connected to psychosocial care (such as social work, medical care, or public health) were regularly invited, and this was considered part of the staff's continuing education. The lawyer confirmed that there was no legal basis for reporting an unborn child to child protection services:

> Child protection is implemented for children who are born, otherwise children don't have a legal personality. . . . If you report a child before birth, there is no legal basis for that. The law is to protect children in danger, not fetuses.

The center's staff who attended that meeting were stupefied, with one of them exclaiming that this was questioning a well-established practice at the center. The underlying issue was future parents' rights and data protection. If there was no legal basis for it, health care professionals were not allowed to communicate their personal details to child protection services. Staff members were unsettled, realizing for the first time during this meeting that their actions could be illegal and could consequently get them into trouble. The lawyer immediately sought to reassure the staff by explaining that nobody would hold it against them if they kept on reporting unborn children:

> Nobody is here to check if you respect data protection. Of course, you won't get caught, because parents don't know [that it is illegal to do so]. . . . If you report a child before its birth, you do it for the child's prevailing interest and nobody will do anything to you. You are in such an asymmetrical power relation anyway; nobody will do anything to you. You do this for people's welfare, even if it is not in the law.

During this meeting, the lawyer thus advised the center's staff to continue bending the legal framework in the name of child welfare. Parents' lack of power to prevent such a violation of their privacy and rights was explicitly mentioned as proof that the center's staff did not need to fear legal repercussions.

Anticipating children's rights in psychosocial pregnancy care means that birth does not mark a clear transition in which the fetus becomes a child and the expectant persons become parents. This is also the case in Canada, where child welfare authorities began to draw on the notion of perinatality in the 1980s in an attempt to extend their mandate to include fetuses, as sociologist Lorna Weir

(1996) has traced. The "birth threshold"—the idea that the living subject enters social life at birth—lost prominence with the medical invention of the "perinatal threshold" in the first part of the twentieth century, Weir argues. Medical historian Caroline Arni (2015) argues that the idea of "trans-natal continuity" emerged even earlier, as physiological research in the nineteenth century took the development of the embryo/fetus/baby, before and after birth, as an object of inquiry. Within Swiss psychosocial care, as in Canadian child welfare, transnatal continuity is not used to advocate for fetal rights and attack access to abortion; rather, pregnancy is reframed as a phase of infancy and so is brought into the professional territory of child protection services. In this context, fetuses are "protosocial beings," to borrow from Sonja Luehrmann's (2017) analysis of Russian Orthodox anti-abortion activism: "expected to take on a place" (237) in society in the near future and therefore endowed with anticipated rights.

SHIFTING TEMPORAL BOUNDARIES, NORMALIZING LIVES

Temporal boundaries are crucial to the social definition of pregnancy. When pregnancy is considered to start and to end provides the foundation for the endowment of legal rights to the fetus and the expectant subject, for access to care, and for moral obligations. Temporal standards define what a "normal" pregnancy is. As Eva Sänger (2015) described in her study of pregnancy care in Germany, prenatal checks include comparing measures of the fetal body against "time standards and normality standards" (109) that define "normal" fetal development. Temporal thresholds also demarcate access to abortion and contribute, for example, to the delineation of "late" abortions as morally problematic (Beynon-Jones 2012, 2017). The temporal definitions of pregnancy, and of the fetal subject, are not universal, though, and vary across time and space (Han, Betsinger, and Scott 2017).

Psychosocial care blurs the temporal boundaries of pregnancy through an anticipatory approach to care. The fetal subject is treated as a future child and pregnancy as the first stage of life. This conceptualization permeates medical prenatal care. Psychosocial care does not necessarily lead to the "disappearance" (Nash 2008) of pregnant women and the neglect of their own health needs that Lenore Manderson (Manderson 2016; Manderson and Ross 2020) identified as resulting from public health strategies targeting pregnancy as crucial for lifelong health. Instead, psychosocial care also transforms the temporal definition of pregnant subjects, who are approached as "future parents." Expectations of good parenting—including intensive parenting and the expectation that people will focus on parenting rather than work—are extended "backward" into pregnancy (Lee, Macvarish, and Bristow 2010). Protecting children before birth implies parenting before children.

Blurring the birth threshold introduces a clearer distinction between the "mother" and the fetus during pregnancy (van der Ploeg 2002; Weir 2006).

Transnatal continuity means that during pregnancy, the fetus is already regarded as a singular entity. Increasingly, the maternal body is being reconceived as the site of a "maternal-fetal conflict" in which the interests of women and fetuses are considered to be at odds. This paradigm is particularly salient in anti-abortion discourses and medical discourses (Armstrong 1998; Markens, Browner, and Press 1997). At the Pregnancy Support Center, while women's and fetuses' interests were not explicitly construed as in "conflict," anticipation translated into an expectation that future children's interests were a priority. Despite a pro-choice and nonmedical stance, through its anticipatory regime of care, psychosocial pregnancy care incorporates the child-centered ideology that characterizes intensive parenting in Switzerland (Baumgarten and Maihofer 2021b; Zimmermann and LeGoff 2020).

The anticipation work that psychosocial advisers undertake, and which they expect prospective parents to undertake, is *normalizing*. In Foucault's (1974) terms, disciplinary power operates through norms rather than through the law to codify and regulate behavior. Disciplinary power relies on a distinction between the "normal" and the "abnormal" and seeks to "normalize" behaviors regarded as *outside* the norm. Midwives and social workers work to bring the behaviors of expectant parents in line with a normative model of pregnancy and family life: Pregnant subjects should behave as parents; they should engage in timely and active preparation for their child's life; future mothers should prioritize their role as caretakers over their career. Like other parental advisers in Switzerland, they practice a form of "pastoral work" by guiding clients to their ideal of family life (Preissler 2022a). Reproducing traditional gender roles and the bourgeois, middle-class, heteronormative family model that is predominant in Switzerland's traditional gender regime (Madörin, Schnegg, and Baghdadi 2012) is never an explicit goal at the Pregnancy Support Center—quite the contrary. Through ideas related to the psychosocial stages of pregnancy and the pragmatics of work-life balance, pregnant clients are steered toward intensive mothering.

5 • THE PREGNANCY NETWORK

Weaving a Thread Before and After Birth

During a staff meeting at the Pregnancy Support Center, midwife Zoe sought advice from her colleagues regarding Karina, one of her pregnant clients who had ceased communication after an initial consultation. Zoe was particularly concerned because she suspected Karina was experiencing depression, a concern shared by Karina's gynecologist. Zoe posed several questions to her colleagues: "Should I persist and call her back? Should I discuss this with her gynecologist? Should I alert the hospital?"

The medicalization of pregnancy has shifted power boundaries, transforming pregnancy into an expert-led experience (Hanson 2004; Johnson and Quinlan 2019; Kukla 2005; Oakley 1984). In Switzerland, pregnancies involve multiple contacts with prenatal care providers: midwives, nurses, and doctors, who perform an increasingly intense series of medical appointments, checks, and tests. Following childbirth, parents are encouraged to educate themselves and access expert advice through childcare magazines, brochures, and contacts with parenting advisers (Odier 2018; Preissler 2022a, 2022b). The rise of such an expert-led culture has been well-documented across Europe and North America, where, despite local differences, parenting has been increasingly reframed as requiring expert guidance since the early twentieth century (Apple 2006; Faircloth, Hoffman, and Layne 2013b; Grant 1998; Hays 1996; Hulbert 2003; Lee 2014a; Lee et al. 2023). Parenting culture studies have identified several factors that may have contributed to the rise of this expert-led reproductive culture: the general rise of expertise as a central feature of modern societies; increasing concerns about social change in the wake of industrialization and urbanization; a shift away from implicit trust in a "maternal instinct"; and the long-standing cultural fear and desire to control femininity and women's reproductive bodies.[1]

Networks of experts form an inescapable dimension of contemporary reproductive experiences. Recent work in reproductive studies has, for example, illuminated the intricate connections that form the global fertility industry: prospective patients, substances, technology, knowledge, and institutions are

linked through malleable relations, forming "reprohubs" (Inhorn 2015) and "reprowebs" (König and Jacobson 2023). Reproductive governance—the power mechanisms through which people's reproductive behaviors are monitored and oriented—thus largely relies not on single actors but often on constellations of collaborating institutions and individuals (Andaya 2021; Browner and Sargent 2021; Morgan and Roberts 2012).

In Switzerland, despite a very fragmented health care landscape (with each of the twenty-six cantons regulating health care providers and hospitals in their territory), providers have been increasingly encouraged to form networks and collaborate to enhance and standardize the quality of care and mitigate rising health care costs in the last two decades (Filliettaz et al. 2021; Rey 2021). At the cantonal level, such a push for "integrated care" often gave birth to regional "health care networks," which has created a partnership between public hospitals, private clinics, care homes, and private doctors, with the goal of enhancing interprofessional communication and cost-efficient health care provision. Every regional office of the Pregnancy Support Center is therefore a member of the health care network of its region. A central feature of a health care network is communication: Sharing patient data is usually made simple within a network. The development of health care networks is connected to the worldwide promotion of interprofessional collaboration in health, which relies on increased communication and cooperation as a path toward better health care (D'Amour et al. 2005; World Health Organization 2010; Zwarenstein, Goldman, and Reeves 2009).

To explore the effects of these developments, I turn the lens to the inner workings of a network of reproductive experts. What I call the "pregnancy network" is an assemblage of health and social care providers (doctors, midwives, nurses, psychologists, social workers), institutions (hospitals, child welfare agencies, social work agencies, shelters, etc.), and policies that support and monitor any given pregnancy in Switzerland or any other highly medicalized context. Around any public maternity ward, a local pregnancy network operates, a loose assemblage of actors who provide some form of prenatal care, who are aware of each other's work, and who often share information about their patients.

In this chapter, starting from the perspective of pregnant patients, I describe how pregnancy in Switzerland is conceptualized as a journey from expert to expert, following a preestablished curriculum of encounters with professionals (appointments, checks, and tests). From the point of view of experts, interprofessional collaboration with members of the pregnancy network is a hallmark of good and efficient care. Midwives and social workers at the Pregnancy Support Center see themselves as part of a network of professionals—a term that is part of their daily vocabulary—who provide prenatal care or can be called to intervene if needed. They often personally know a significant part of the local pregnancy network and can thus recommend an independent midwife or a secondhand shop, depending on their client's needs. But the pregnancy network is also a site of

power relations and tensions, as we will see from Karina's story, with patients trying to regain power over the reproductive journey by escaping the intense gaze of experts.

Looking at the pregnancy network and its web of relations shows that psychosocial pregnancy care in Switzerland, despite its antimedicalization stance, forms an almost seamless grid with other experts over the territory of pregnancy. Having shifted the borders of pregnancy care to include psychological and social dimensions, power boundaries have also moved. The standard of what constitutes good prenatal care includes collaborations between various providers of pregnancy supervision. While interprofessional collaboration has much to offer quality care, it also raises questions about patients' autonomy and agency.

THE PREGNANCY CURRICULUM

Karina's pregnancy was supervised by a gynecologist in a private practice, as is customary in Switzerland. She likely attended regular consultations throughout her pregnancy, undergoing physical examinations, urine and blood tests, and ultrasounds. Prenatal care in Switzerland follows a predetermined schedule of appointments and tests, which I refer to as the "pregnancy curriculum"—a series of interactions with a network of experts.

Federal laws on health insurance establish a standard for basic prenatal and postnatal care in Switzerland. Prenatal, birth, and postnatal care is the only type of medical care where no out-of-pocket expense is required from patients. The 1994 Federal Health Insurance Act specifies which prenatal care services are included under compulsory health insurance, termed "basic" insurance. For a "normal" pregnancy, this includes seven appointments with a gynecologist, two ultrasounds, birthing classes, delivery (whether at a hospital, midwife-led birthing home, or home birth), a gynecological exam six weeks postpartum, ten postpartum home visits by a midwife within the first fifty-six days after birth, and three consultations with a lactation consultant.[2] "Risky" pregnancies may receive additional appointments, tests, and exams as prescribed by a gynecologist. Patients have the option to choose a midwife for prenatal appointments and delivery, although few opt for this.

Maternity care under the Health Insurance Act concludes fifty-six days after a birth, yet the involvement of health care experts continues. Following the birth, Karina would have received a call from a specialized pediatric nurse to arrange a home visit. Most Swiss cantons offer free pediatric nurse home visits and clinics from birth until the child is four years old. The primary role of these nurses is to monitor the child's development and advise parents on sleep and feeding patterns. Regional nurses' clinics also provide free parenting classes. Additionally, regular pediatrician visits are recommended, although vaccinations and checkups are not mandatory in Switzerland. The Swiss Society of Pediatrics advises

eleven appointments to monitor a child's health and development from birth to age four (Société Suisse de Pédiatrie 2011).

Throughout pregnancy and postpartum, pregnant people thus undergo extensive examinations and assessments by a diverse group of experts. Only significant medical events or chronic conditions necessitate similar intense medical supervision. Elise Boulet's (2021) research on French women's experiences of pregnancy describes the demanding nature of attending prenatal appointments (which unfold at a similar rhythm as in Switzerland) as a "third shift," a type of labor that pregnant individuals must manage alongside paid work and domestic responsibilities. Similarly, Elise Andaya's (2024) study of low-wage workers in New York City highlights the challenges of balancing work in the service sector with prenatal care appointments. For most, pregnancy and the postpartum are the periods in people's lives subject to the most intense medical scrutiny.

WEAVING A THREAD

The first expert to monitor pregnancy in Switzerland is typically a gynecologist. It was Karina's gynecologist who contacted midwife Zoe at the Pregnancy Support Center, suggesting that Zoe should meet Karina promptly because she suspected depression. As Zoe explained to her colleagues, she immediately called Karina and set up an appointment for the same day (having presumably received Karina's contact details from her gynecologist). Midwife Zoe reported having "mixed feelings" about Karina's mental state following their initial appointment: She felt Karina was "at the same time showing signs of depression, with sleep trouble and a lack of appetite, at the same time as she had lots of resources." Zoe was "wondering about possible depression but was not a specialist," so she suggested she would contact the hospital psychiatry unit—which Karina agreed to, along with a second appointment with Zoe. Right after this appointment, midwife Zoe made two phone calls. She first called Karina's gynecologist: "I told her it was hard for me to tell whether Karina was depressive but that I would see her again." She then called the psychiatrist on call to describe Karina's situation: "The psychiatrist said, based on my description, that it felt like she was overwhelmed and burned out but not necessarily depressive, and that she would gladly see Karina to assess her."

There is an active effort by health experts in Switzerland to not let the supervision of pregnancy and the postpartum be a succession of disconnected medical interventions but rather, to ensure a coherent form of care. Private gynecologists, midwives, and social workers do not work for the same institutions and do not automatically share patients' medical files. Yet multiple forms of communication occur between experts to weave a thread of expert intervention around pregnant people. At that stage, midwife Zoe was actively crafting a network of professionals around Karina, liaising with the gynecologist and the psy-

chiatrist. The Pregnancy Support Center acts as a platform to coordinate care and circulate information between health care providers. While Karina's gynecologist could presumably have contacted the psychiatry unit herself, gynecologists may be relieved to save time and delegate these tasks to the center. Acting as a hub or a coordinating platform for a pregnant person's network of care is a central mission of the Pregnancy Support Center.

To capture this aspect of her work, the midwife who founded the center used a textile metaphor in an interview with me: "The network is a thread that goes from prenatal to postnatal, in a continuum. [We build a network around each client] rather than addressing certain things before birth, and then in the maternity ward they approach things differently, and in the postpartum we involve yet other professionals. Whereas here [at the center], we weave a thread between the professionals before and after the birth." Psychosocial advisers weave a thread between those professionals who were already involved in their patient's care and those who will be in the future. Such thread-weaving takes several forms. First, every initial appointment involves mapping out pregnant patients' health care providers: their general practitioner and gynecologist, as well as possibly their psychiatrist, social worker, and others. Second, midwives and social workers at the center inform and refer their pregnant clients to other care providers, like birthing instructors, independent midwives, or, in Karina's case, a psychiatrist. Third, they communicate information about their clients to members of the network, via the transmission document that they send to maternity wards or via phone calls or network meetings. In Karina's case, midwife Zoe ended up making at least five phone calls with three different professionals to discuss her situation.

INTERPROFESSIONAL COLLABORATION

Interprofessional collaboration has been central to the very idea of psychosocial prenatal care from its inception in France and Switzerland. When France implemented its first "Perinatal Plans" in the 1990s, interprofessional collaboration was a cornerstone of the proposed measures (Bréart, Puech, and Rozé 2004; Haut Comité de la Santé Publique 1994). One of the key aspects of the Perinatal Plans was the creation of "perinatal networks" involving medical, mental health, and social actors.

The work of French psychiatrist Françoise Molénat had a huge influence on the development of such networks, and she was tasked with putting together courses in interprofessional collaboration. Molénat expresses the importance of interprofessional collaboration in psychological terms: Networks of professionals are expected to "contain" and guide parents: "The structuring role of a reliable professional network, centered on each family, based on the expression of its own needs, acting with sufficient coherence from ante- to postnatal, is now intellectually obvious" (Molénat 2004, 2).

The network offers, for Molénat, a reassuring structure to stabilize future parents who may otherwise feel lost. In the description of a Molénat-inspired curriculum on interprofessional collaboration, the network is portrayed as a model for parent-child relationships: "[The network allows parents to] experience, in their meetings with all the perinatal actors, what they will have to feel and support in their child: adjustment to its needs, construction of its internal security, experience of the reliability of the link, access to a good autonomy. Thanks to the confidence acquired and the security experienced during the pregnancy follow-up, they will be able to trust their own emotions and help their child in turn" (Association de Formation et de Recherché sur l'Enfant et son Environnement 2007, 19). The network of professionals must therefore serve as a model for parents so that they themselves can be a safe and secure role model to their children. This paternalistic conceptualization of interprofessional collaboration had a large influence on the Swiss model of psychosocial care, as evidenced by how frequently the Pregnancy Support Center's psychosocial advisers mention Molénat's work. Françoise Molénat herself was a keynote speaker in a continuing education course on "perinatal care" that almost all the center's staff had attended after being hired as psychosocial advisers. From the creation of the center in 1986 to the present, the terms "orientation" and "network" have featured prominently in descriptions of its central missions, as evidenced in its archives and communication material (website, brochures). Collaboration and communication between professionals are generally seen among health care providers and at the center as constituting the best care for pregnant patients. Weaving a tight thread around each pregnant client is a pathway to safe, happy, and fulfilling pregnancies.

Interprofessional collaboration is also what fills the Pregnancy Support Center's waiting room. The center depends on the collaboration of other health care providers to send clients their way. At each initial appointment, psychosocial advisers ask their client who has sent them to the center and make a note of their answer in the internal database. Having been allowed to consult this database for a limited period of time while conducting observations at the center (2011–2013), I was able to identify that at the time, 54 percent of clients said they were sent to the center by their doctor (generally, their gynecologist) and 18 percent by other health care providers (for example, an independent midwife). Other clients came at the suggestion of social workers (5%) or family planning centers (3%) or after a previous appointment at the center (5%). Thus, more than four out of five clients made an appointment at the center after having been encouraged to do so by a member of the local pregnancy network, with only 10 percent saying this had been prompted by a relative's or friend's advice or a media article (the remaining 5% were missing data). In a conversation with me, the center's director stressed the vital importance of the pregnancy network for the continuing existence of the center: "Talking about psychosocial pregnancy care without

talking about the network makes no sense. The network is indispensable. Without the collaboration of gynecologists who refer women to the [center], women would not come; they would not know we exist. If the doctors and the health network in general (independent midwives, pediatric nurses) do not collaborate, then women will not have access to our services. So we pay a lot of attention to all the medical-psycho-social and early childhood partners." Each time the center opened a regional office, it did so in collaboration with local partners. At first, the center only offered consultations in the main city of the Canton Romand. Over time, offices were opened in the town where a regional hospital was located, with the goal of being closely connected to every maternity ward of the canton. Each of these openings was carefully coordinated by committees and in communication with local medical and social actors. Close collaboration with local actors seems to be correlated with a higher number of clients received at each regional office. One regional office was opened without such careful preparation. When I visited the midwife employed there, who had invited me to attend one of her appointments, she shared her frustration at the low numbers of pregnant people who had contacted her for an appointment. She directly linked this low attendance to what she believed to be a case of local gynecologists being totally unaware of what the center could offer or remaining doubtful of its usefulness for their patients.

RESISTING THE NETWORK

After a first round of encounters with midwife Zoe, Karina started resisting the expanding supervision of her pregnancy. As Zoe reported, Karina called the center's office to cancel her second appointment. Zoe decided to call her back to ask why she had canceled. According to Zoe, at the time, Karina was "so tired that she was almost bed-bound, it was hard for her to move around, and she did not see the need to meet [Zoe] again." Because Karina complained of physical pains, Zoe suggested arranging for an independent midwife to visit her at home, which Karina agreed to—thus bringing one more expert into the network. After this conversation, midwife Zoe called an independent midwife to arrange a home visit and reported this new development to Karina's gynecologist. A couple of days later, the independent midwife called Zoe at the center to reassure her that Karina was doing fine. Zoe waited a few weeks and called Karina back "just to have some news and set up a follow-up appointment." Again, Karina ended up canceling her appointment at the center. At that stage, Zoe, confused, asked her colleagues for advice: Should she keep insisting and trying to meet Karina? Or should she report directly to her gynecologist?

Zoe's confusion at Karina's reluctance to meet her again illustrates how much compliance with a supervised pregnancy experience is expected as a norm of good pregnant behavior. Accepting and even actively seeking the involvement

of health care experts during pregnancy is, in midwives' and social workers' eyes, part of a normal pregnancy experience. During appointments with their clients, follow-up appointments at the center were often announced rather than offered as a suggestion. I frequently found in my fieldnotes sentences such as "I will see you again in a month," or "We won't talk about this now; I prefer scheduling another appointment." Likewise, the involvement of other professionals after birth was often announced as a fact rather than an option: "A midwife will come to your place for a home visit"; "A pediatric nurse will call you to schedule an appointment"; "You have to schedule an appointment with your child's pediatrician one month after you give birth." Pregnant people are thus directed to follow a curriculum rather than informed about available support. The pregnancy curriculum is a normative model of health care implemented for the good of the patient. It leaves little space for individual needs and preferences.

When midwife Zoe called Karina back after she had canceled her appointment, she was following an unspoken rule at the center. When a client cancels, they should be tracked down to understand their reasons. Canceling an appointment altogether, as opposed to postponing it, caused psychosocial advisers to worry. It was interpreted as a sign that something was wrong. As midwife Sabrina explained in an interview with me, "If a lady refuses to set a follow-up appointment with me, I have to try and understand why. Often, ladies who refuse further appointments break down later on at the maternity ward." Or as Catherine, a social worker, put it, "When folks don't come, it's not by chance." People may have very pragmatic reasons for canceling an appointment at the center, such as not having found their initial appointment useful, having found answers they sought elsewhere, or not having the time. However, in my conversations with the center's staff, cancellations were always worrisome and prompted attempts to try and get clients to come back to the center.

When Karina canceled her second appointment, midwife Zoe called her and managed to continue weaving the thread of professional intervention by organizing for a midwife to visit Karina—and report back to Karina's gynecologist. However, after this round of interventions Karina canceled an appointment again and stopped returning Zoe's calls. Zoe was now asking her colleagues what to do. While she expressed not wanting to "harass" a client who clearly expressed that she did not want to meet again, she was too worried to back down. Around the table, Zoe's colleagues expressed that there was not much she could do if Karina was not answering the phone. Nadine, lead social worker, had another suggestion: "You take the other phone line to call her again, so she can't see it's you who is calling!"

What Nadine was suggesting was tricking Karina into answering the phone by using another phone number, to force her into a conversation. The lead midwife immediately said she was not comfortable with "backing people into a corner" like that, but Nadine confirmed it was "not a problem" in her eyes. Nadine

made another suggestion: "In such a situation, when I see she has come to the maternity ward for delivery, I would go and talk to her."

On some days, Zoe conducted her appointments in the maternity ward of the regional hospital. Nadine suggested using this opportunity to locate Karina's room and pay her an unannounced visit while she rested after giving birth. Again, her suggestion was rejected by her colleagues, with Agnes (social worker) underlining the need to respect Karina's privacy.

In her study of the work of parenting advisers in Switzerland (pediatric nurses working for a state-sponsored program offering counseling to parents of children under school age), Preissler (2022a, 2022b) described how counselors are torn between "pushiness" and restraint in their relationship with their clients. Convinced that their assistance was beneficial and constructive, counselors sometimes used their authority to tell parents to come for a follow-up appointment, purposefully omitting to mention that such appointments were entirely voluntary, or showed up unannounced at parents' homes when they failed to answer their phone calls (Preissler 2022b, 145–153). However, aware that some parents might resist their visits and cease soliciting their advice, counselors were also wary of acting in ways that could be seen as too authoritarian, for fear of losing access to parents. This, as Preissler notes, draws a parallel between parenting counselors and the Foucauldian figure of the pastor: "The pastor's stand is somewhat volatile, so getting involved with families and accompanying them must be exercised with deliberation" (2022a, 78). Parents, as well as the Pregnancy Support Center's pregnant clients, can sometimes escape surveillance, as, to some extent, it is they who "give the 'pastor' the power to guide, by allowing her insights into their conscience and conduct" (2022a, 78).

THE LIMITS OF INTERPROFESSIONAL COLLABORATION

As well-intentioned as interprofessional collaboration is, communication between health care professionals raises questions of privacy and data protection. In theory, in Switzerland patients' data can only be transmitted between institutions and medical professionals if the patient knows what information is being shared and gives their consent. Thus, unable to reach Karina anymore, midwife Zoe could not obtain her consent to forward her observations to the hospital where Karina planned to give birth to her child. Normally, the center's midwives send a report to the maternity ward to summarize the psychosocial situation of each client (see chapter 2, note 1). Unable to share information, Zoe felt she was failing her partners: Hospital staff would presumably not be aware of Karina's fragile mental state, which was the initial reason why she was sent to the center.

Zoe's anguish at being unable to transmit important information reveals the overwhelming expectation from her hospital-based partners that she would do

so. Midwives and social workers were frequently critical of the culture of communication they encountered in hospitals. Hospital staff, they complained, would often ask them for information on a patient in an informal and impromptu way, without giving them the chance to ask their clients for their consent. These concerns were particularly voiced during a staff meeting at the center in which the center's director had invited a lawyer to refresh psychosocial advisers' knowledge of the legal framework for patient confidentiality. Several midwives and social workers asked the lawyer for her opinion about interactions they frequently had with hospital staff asking them for patient information. Midwife Colette, for example, said that when she was conducting pregnancy support appointments in the maternity wards, maternity ward staff would perceive her as a colleague and "frequently ask [her] for information on a patient in the corridor or at the cafeteria," which made her "uncomfortable." Discussing a patient's situation in a corridor would be problematic not only because the conversation could be overheard but also because patient consent may not have been obtained. Others felt hospital staff expected them to share too much information with too many professionals. Julia (midwife) described hospitals as environments of transparency: "The medical field is a field where we tell everything to everyone."

Midwife Zoe felt at odds with her hospital partners when she found herself unable to share information about Karina without her consent. She shared with her colleagues that she "would not feel like she has completed her job if [she had] met that client but not transmitted anything to the hospital." She was worried that maternity staff might be frustrated or disappointed with her: "If I do something only halfway, it's going to put me in a difficult position with the maternity ward. I need to do something that does not compromise my position with the maternity ward."

Torn between the network's expectation that they would share all information, a desire to maintain good relations with their hospital partners, and the limit to data sharing imposed by the legal framework, psychosocial advisers had to walk a fine line between sharing enough information and not too much. A couple of weeks before Zoe exposed her dilemma to her colleagues, I had sat down with Agnes, one of the center's social workers, for an individual interview and had a lengthy exchange on information sharing with hospitals. It was Agnes who had brought the topic to the table, by explaining that her rule was to share only "necessary" information with hospitals—information that was strictly necessary for the two or three days a person usually spent in a maternity ward after giving birth: "If the information helps the maternity team do their job well, it's justified. If it's just to feed gossip, 'Monsieur doesn't have a job, Madame doesn't know who the father is,' no."

Oversharing, for Agnes, risked fueling hospital staff's inappropriate remarks about a patient's situation. She had all too often heard hospital staff laugh or sigh at the presentation of a patient's social situation, reactions that she found deeply

inappropriate. I asked Agnes how she chose which information to transmit, and she gave the example of a pregnant client whose partner was undocumented:

> [To the hospital, I can pass on the fact] that the lady has a problem—well, she's anxious because she's still waiting for her friend to get his residence permit; he might be deported. But we shouldn't delve into the fact that he could be expelled. That, my goodness, fuels a discussion that has nothing to do with hospital care. At the hospital, they need to know if, when this lady is discharged, her partner will be present. If he is not there, who will support her. That's more like it, I think. Not to put everything.

Agnes' strategy was to select information that she thought was strictly necessary for her client's hospital stay. She was also wary of mentioning a client's history of depression:

> If the woman had depression fifteen years ago and she is no longer depressed, and she is being treated, she is radiant, she is surrounded, she has no medication, she has her doctor, we will put the names of doctors, the address, as we always do. But why should we point out that she had depression fifteen years ago? Because otherwise she'll bear the stigma.

As members of the pregnancy network, psychosocial advisers must navigate relations of dependency and resistance to their partners. Their ambivalent attitude toward sharing information was fueled by their awareness that the Pregnancy Support Center has not gained recognition by all members of the pregnancy network. Tensions were a constant feature of the staff's relationships with partner institutions. Those tensions arose from the fact that some health professionals saw the center's work as redundant with their own. Midwife Julia explained to me that gynecologists felt threatened by the center's work. "Curiously, if you want, it's always very complicated to make gynecologists understand that we do something else than them, and that this other thing we do is not—We don't do it by saying: 'Ah, they were not able to do it.' You see, there is a whole thing that is extremely threatening, that is experienced as a threat. They say: 'Yes, but I do all that.' And then we say: 'But no, because you have fifteen minutes of consultation, and you do a lot of things . . . that we don't do. And then we do other things because we have an hour, and we approach things differently.'"

Whereas most client referrals to the center come from gynecologists, according to staff, many gynecologists never refer their patients or only do so when they have very specific concerns that fall outside of gynecological expertise or when they consider their patient vulnerable—like Karina. One reason for this partial recognition of the importance of the center's work among gynecologists

is that a biopsychosocial or holistic approach has also influenced medical prenatal care. Obstetrician-gynecologists in Switzerland themselves do not wish to be reduced to a technical role and claim the entirety of pregnancy follow-up (Cavalli and Gouilhers-Hertig 2014). Even though prenatal care appointments are short (fifteen minutes) and mostly focused on physical examinations, many gynecologists conceive their role in a holistic way rather than as a merely technical intervention. Psychosocial care thus remains a contested domain in the Canton Romand, and psychosocial advisers' efforts to foster interprofessional relationships are a means to gain legitimacy.

REPRODUCTIVE POWER SHIFTS AND THE AMBIVALENCE OF CARE

Medical literature has advocated—with good reason—for interprofessional collaboration as a standard of quality of care. The pregnancy network is a form of benevolent care work, meant to optimize the quality of care for each pregnant patient across medical, psychological, and social domains. As midwife Julia explained during an interview, what psychosocial advisers wish to convey to future parents is "You are not alone, you have people here to support you." Such a dense pregnancy network, with its communication channels, reflects the very high standard of health care in Switzerland; in most countries maternity care is much more fragmented and limited in time and scope.

The potential pitfalls of health care networks for patients have been less discussed. Networks cannot be presumed to be good or bad for patient care in and of themselves; it largely depends on the way collaboration is practiced. Fox and Reeves (2015) warn against the "feel-good" effect that comes with implementing better communication and collaboration in health care while "mask[ing] and perhaps even enhanc[ing] inequitable relations of power that exist among health providers" (116) and between health providers and patients. The pregnancy network can jeopardize patients' autonomy, privacy, and agency. In the name of efficient interprofessional collaboration, as I witnessed, patients' details are sometimes shared without their consent, and professionals may burst into patients' lives unannounced (for example, through unsolicited phone calls) and use their authority to pressure patients to accept further surveillance. Interprofessional collaboration may become a route to extend medical reach over patients' care choices and reinforce patients' compliance with medical directives.

The medicalization of pregnancy has often shifted reproductive powers from pregnant subjects to medical professionals. Feminist theorists and scholars have long been concerned with the power shifts that have accompanied new reproductive technologies, increasing professional and social monitoring of reproductive lives. In *The Political Geographies of Pregnancy,* Laura Woliver describes how "the

maps and boundaries of women's reproductive powers are being redrawn" with the introduction and implementation of genome editing, abortion, adoption, or surrogacy policies: "Decision making concerning reproduction [is] moving toward professionals, policymakers, genetic counselors, and others and away from women as agents of their bodies, themselves" (2002, 26).

Panopticism is a powerful metaphor for the surveillance of reproductive subjects, exerted partly without their consent or knowledge. Panopticism refers to the work of eighteenth-century philosopher Jeremy Bentham, who designed a new model of prisons as a circular building with cells open to the constant gaze of jailers, the Panopticon. Foucault (1973, 1974, 1975) used the Panopticon as a metaphor for how power and surveillance over individual behavior operate in modern societies. The end of the eighteenth century saw a shift, Foucault theorizes, toward "disciplinary societies," in which individuals' behaviors are constantly surveilled by institutions: schools, hospitals, the army, or prisons. Panopticism represents "an extremity of discipline: generalized surveillance" (1975, 243; all translations are mine).

> We live in a panoptic society. You have absolutely generalized structures of surveillance, of which the criminal justice system, the judiciary system are part and of which prison is another part, and of which psychology, psychiatry, criminology, sociology, and social psychology are effects. (Foucault 1973, 1305–1306)

Through "examinations" (*examens*), institutions monitor and evaluate individuals' behaviors constantly.

> Constant surveillance of individuals by someone who exerts power over them—a teacher, foreman, doctor, psychiatrist, prison director—and who, as long as he [*sic*] exerts power, may extend surveillance as well as produce knowledge about those he surveils. This knowledge [aims at] determining if an individual behaves properly or not, in conformity with the rule, if he progresses or not. (Foucault 1974, 1463)

While Foucault largely failed to comment on the gendered nature of surveillance, panopticism applies particularly well to the surveillance of the pregnant body in highly medicalized contexts. The ever-refining imaging, monitoring, and controlling of the pregnant body in prenatal care has rendered the pregnant body panoptic, an object of all-around surveillance (Cummins 2014; Kukla 2005; Symonds LeBlanc 2020).[3] Such "surveillance medicine" is salient in Swiss women's experiences of pregnancy, even for those considered medically "low risk" (Hammer and Burton-Jeangros 2013; Hammer et al. 2022). Thus, controls, surveillance, and monitoring technologies tend to place more power over reproductive experiences in the hands of biomedical experts.

Psychosocial prenatal care represents the expansion of panopticism beyond the pregnant body, subjecting the minds, social lives, and personal circumstances of pregnant people to scrutiny and examination by experts. While medicalization opened up pregnant *bodies* for surveillance and discipline, psychosocial care now extends this gaze into many aspects of life, shifting the "geography of reproductive power" (Woliver 2002, 26) yet again. Pregnant clients are expected to report unfavorable life events such as job loss or relationship changes, which are then evaluated by a network of experts as potential "symptoms" requiring intervention. Through the involvement of interprofessional networks, psychosocial care forms a seamless net of "reproductive governance" (Morgan and Roberts 2012) in conjunction with the medical surveillance of pregnant bodies.

The surveillance of reproductive subjects also extends beyond professional experts in Switzerland. Swiss mothers report being called out by friends or given disapproving looks for smoking or drinking during pregnancy, leading some of them to try and hide their consumption (Burton-Jeangros 2010; Hammer and Inglin 2014). In the United States, the social surveillance of pregnancy is particularly intense, as illustrated by the increasingly restrictive legal regulation of abortion, the criminalization of pregnant women for adverse fetal outcomes in some states, and even the frantic media coverage of celebrities' baby bumps that Renee Cramer (2016) analyzes as a form of surveillance (Gallagher 1987; Goodwin 2020; Paltrow and Flavin 2013). While social surveillance has not reached such heights in Switzerland owing partially to the fact that reproductive choices are largely considered private choices, sociologist Raphaël Hammer (2019) nevertheless argues that risk management in pregnancy among Swiss couples is a matter of "co-surveillance," with some monitoring their pregnant partner's behavior.

Clients do not come to the Pregnancy Support Center to seek surveillance. Nor did I start my fieldwork at the center with the impression that I was entering a place where evaluation and control were taking place. This is because, outwardly, the center is offering support, information, and advice—not surveillance. And yet surveillance does happen. It is only after a thorough evaluation and after bringing much of her personal life under the professional gaze that woman's pregnancy can be declared "harmonious." In that sense, no pregnancy is surveillance-free.

Psychosocial care thus underlines the ambivalence of care. While care has usually been thought of as inherently good and benevolent in feminist and disability studies, this perspective risks losing sight of frictions or violence in care relations (Cook and Trundle 2020; Thelen 2015). In *The Violence of Care,* Sameena Mulla (2014) shows how care for survivors of sexual assault in the United States sometimes results in further violence against survivors. In that context, forensic care is focused on collecting biological evidence that can be used in the courtroom while immediate patient care, paradoxically, comes second. In another

context, Lisa Stevenson's (2014) study shows how policies aimed at preventing suicides among Inuit communities in Canada neglected what life, death, or care meant in those very communities. Preventing deaths may not do much to improve lives. Such paradoxes are also visible in the workings of the pregnancy network. A focus on interprofessional collaboration and communication, despite the well-meaning intention to increase support for pregnant patients, results in some patients' needs and rights being sidelined. My focus on professionals' perspectives highlights that care providers themselves may be aware of the ambivalence of caregiving. When pregnancy support providers at the center hesitate about the scope of the information they are willing to share, when they purposefully withhold information from their network partners to protect their clients, they lay bare their own critical distance from prescribed forms of interprofessional collaboration. Pregnancy advisers add to the complexity and ambivalence of care, demonstrating that pregnant patients may need to be protected from health care institutions by members of those very institutions.

6 • CONTESTED BORDERLANDS

The Problem of Intimate Partner Violence

Toward the end of my observations at the Pregnancy Support Center, its management team presented their newly implemented intimate partner violence screening policy at a local social work conference on violence. It was a proud moment for the center's staff since they were only the third institution in the canton to implement such a policy. Thanks to this screening tool, they had identified that 3.7 percent of their clients had experienced intimate partner violence and were able to refer them for further support. Yet their approach was immediately questioned by their audience, a panel of health and social workers working in the field of intimate partner violence: Why was the prevalence of intimate partner violence survivors among the center's pregnant clients much lower than what epidemiological studies would suggest (3.7%, versus an estimated 7% of pregnant women in Switzerland)? Were they sure pregnancy was the right moment for such screening? Slightly dismayed, the center's lead midwife confirmed they shared these doubts: "We asked ourselves if pregnancy was the right time to talk about violence. It's a special time, a happy time, where women hope Monsieur will be less violent. Maybe it's hard to talk during pregnancy," she told the audience.

Should intimate partner violence screening be included within the boundaries of psychosocial pregnancy care? Or is it best left to other professionals in other settings? The start of my research in 2011 coincided with a cycle of conferences and workshops within the center to learn about intimate partner violence and discuss the implementation of a screening policy. Two years later, guidelines had been set. Over that period, the center's psychosocial advisers grappled with doubts, torn between the motivation to help survivors of violence, difficulties getting their clients to talk, and fear of losing rapport with them. Following the process that brought the staff from discussing systematic screening to acknowledging publicly that it might never work as hoped sheds light on the way they struggled with the limits of psychosocial care.

A PSYCHOLOGICAL APPROACH TO VIOLENCE

Understanding how the Pregnancy Support Center tackled intimate partner violence requires clarifying how violence is understood in its local context. While violence within couples and families is largely understood as an urgent problem in Europe, how acts of violence are termed, explained, and addressed varies significantly across contexts. At the Pregnancy Support Center and in French-speaking Switzerland in general, the terms "domestic violence" and "victims" have largely been used in policy, law, and research since the 1990s. These terms replaced "conjugal violence" (*violence conjugale*), which was commonly used before. Such a language change reveals a shift in the understanding of the problem.

Sociologist Carol Bacchi's (1999b, 2009, 2016; Bacchi and Goodwin 2016) policy analysis approach is particularly useful for understanding what is at stake in how a particular problem is represented. She approaches policies not as solutions to self-evident "problems that exist"; rather, the goal of policy analysis is to tease out how the problem is represented in a particular policy and to what effect. Policies "*produce* 'problems' as particular sorts of problems" and "the manner in which these 'problems' are constituted shape lives and worlds" (Bacchi and Goodwin 2016, 16). The language used to frame the problem of intimate partner violence (e.g., "conjugal violence," "domestic violence," "violence against women") refers to different problem representations, which in turn have different effects on survivors, as illustrated in Bacchi's (1999a) and more recent analyses of intimate partner violence policies (Delage and Roca i Escoda 2023; Gerrits 2024; Goicolea et al. 2023; Murray and Powell 2009).

Switzerland, as a federal state, is an interesting case to study framings of violence because violence policies are the purview of cantons, which translates into twenty-six potentially different approaches to violence in a small country (Delage, Roca i Escoda, and Lieber 2020). Applying Bacchi's approach, sociologists Pauline Delage and Marta Roca i Escoda argue that the shift from "conjugal violence" to "domestic violence" in French-speaking Switzerland in the late 1990s reveals a move away from a feminist perspective that the earlier notion of "conjugal violence" encapsulated. While a feminist perspective frames intimate partner violence as arising from male domination and gender inequalities, "domestic violence" is a broader category that includes all forms of violence perpetrated between family members. In French-speaking Switzerland, the development of public health policies using the framework of domestic violence "thus consecrates the failure of feminist thought on violence by men" (Delage and Roca i Escoda 2023, 228). The Canton Romand exemplifies this tendency, with policies mostly formulated according to a public health approach and carefully using gender-neutral language to describe survivors and perpetrators. Delage, Roca i Escoda, and Lieber (2020) attribute this absence of a

gendered perspective to the absence of feminist mobilization around the topic in the canton. In comparison to other cantons and other countries like Spain (Casas Vila 2017), the local feminist movement was not strongly organized and was hardly involved in the development of violence policies (Delage, Roca i Escoda, and Lieber 2020, 43).

Training offered to the Pregnancy Support Center's staff about violence was deeply influenced by psychology, specifically the systemic approach. Inspired by systems theory, systemic psychology frames families or couples as a system and focuses on interactions within this system (Perrone and Nannini 1995; Rondeau, Brodeur, and Carrier 2001). Systemic psychology has had a deep influence in Switzerland, as well as in the broader francophone context, and largely dominates approaches to family therapy and intimate partner violence (Delage and Roca i Escoda 2018, 2023; Despland and Berney 2012; Rietmann 2023). It considers parties responsible for maintaining any relationship, including one in which violence is inflicted. Both training sessions organized for the center's advisers demonstrated a systemic understanding of violence. The first session was run by two social workers: One (a woman) was the director of the local women's shelter—which was not connected to feminist associations—and the other (a man) managed a local state-sponsored program for violent men. The second training session was organized by another associate from the same program for abusers; he would later become the director of the local women's shelter. All three were major actors involved in the development of public policies against violence in the Canton Romand, and all were trained in systemic therapy.

Systemic approaches to violence have been considered deeply problematic from a feminist standpoint (Greene and Bogo 2002). As early as the 1980s, the U.S. psychologist Michele Bograd underlined "biases against women" found in family systems approaches. Systemic psychology, Bograd argued, essentially blames the survivor by arguing that women "collaborate" in maintaining violent relationships. Such formulations "imply that the battered woman could and should control her husband's feelings and actions; [and] attenuate the man's responsibility for his violence" (Bograd 1984, 561). Hansen (1989) further underlines that this conceptualization of intimate partner violence within family therapy tends to assign responsibility for violence either to the survivor, to both the survivor and the perpetrator (co-responsibility), or to no one and fails to hold perpetrators accountable for their actions. Feminist family therapy approaches were developed in the United States in response to these critiques (Leslie and Southard 2009; Silverstein and Goodrich 2003; Walters 1990) but have found little resonance so far in Switzerland. The experts leading the Pregnancy Support Center's training sessions seemed to be wary of feminist critiques, as they carefully spoke of women as "engaged" but not "responsible" in maintaining violent relationships. They nevertheless explicitly distanced themselves from feminist

theories, insisting on the importance of considering both abusers' and survivors' roles in maintaining their violent interactions.

The center's psychosocial advisers clearly framed violence in a gendered way. In contrast to the dominance of a public health approach in local policies, at the center the problem of intimate partner violence was always thought of as men abusing their female partners. Violence was linked to assumed psychological traits of male abusers. During the general discussion following one of the internal conferences on violence, midwife Colette said it was her position that abusers should be prevented from attending the birth of their child if the pregnant person did not want them in the delivery room. Her colleagues agreed but added that as a father, that man would have a right to see the baby immediately after birth. Midwife Alexandra interjected that an abuser may not accept this policy so easily: "Often, in cases of violence, don't you agree? He wants to dominate her, he wants to control her, so it's very hard to make him understand that he does not have every right." At the center, violence is considered the result of a controlling relationship that some men have with their partners. This framing did not, however, lead the center's staff to adopt a feminist analysis of violence as linked to structural sexism and patriarchy.

INTIMATE PARTNER VIOLENCE AND PREGNANCY

Screening for intimate partner violence at the Pregnancy Support Center was based on the idea that pregnancy is a period in which women are at higher risk of violence. Pregnancy is regularly mentioned as a risk factor in national and canton-level policy documents on intimate partner violence (Bureau fédéral de l'égalité entre hommes et femmes 2020; Federal Council 2009; Hofner and Sigen 2001). In 2008, the Federal Office for Gender Equality underlined in its main report on intimate partner violence in Switzerland "that pregnancy and the birth of a child form a risky situation when the man is behaving in a domineering way and experiences the arrival of a child as threatening his hold and the full attention he gets from his partner" (Egger and Schär Moser 2008, 26). At the Pregnancy Support Center, it was also commonly assumed that there was a causal relation between pregnancy and violence: that the period of pregnancy was often the moment when violence started or worsened, as the center's director, lead midwife, and lead social worker described in a coauthored article published in a Swiss health care journal:

> The increased risk of domestic violence against women when they are expecting a child is well-known. The prevalence of violence against women is high. In Switzerland, it affects one woman in five during her lifetime and 7% of women during pregnancy. For many women who are victims of violence in their relationship, the violence began or worsened during their first pregnancy. . . . The consequences for

> pregnant women are significant. For example: attachment disorders, pre- and post-partum depression, major physical and psychological trauma, difficulties in protecting the child, neglect, death. During pregnancy and for the child: intra-uterine growth retardation, premature birth, psycho-motor development difficulties, attachment disorders, functional disorders, depression and withdrawal, eating and sleeping disorders, learning and adjustment disorders, aggressive behavior, increased risk of accidents, etc.[1]

The center's senior staff put forward three arguments to support their screening policy: that the rate of intimate partner violence is high during pregnancy (correlation), violence may start or worsen during pregnancy (causality), and that its consequences could be severe for both pregnant partner and fetus.

Researchers disagree on whether violence is more, equally, or less frequent during pregnancy compared to other periods.[2] In Switzerland, two small-scale studies conducted in the 2000s suggested that between 1 percent and 7 percent of women experience physical, sexual, or psychological violence during pregnancy, with undocumented women (11%) more exposed than the general population (Irion et al. 2000; Wolff et al. 2008). Internationally, rates of intimate partner violence during pregnancy are estimated to be 9.2 percent for physical violence, 18.7 percent for psychological violence, and 5.5 percent for sexual violence (Román-Gálvez et al. 2021). Rates vary significantly depending on which country is studied, the population studied, the moment questionnaires were administered (during or after pregnancy), and the definition of violence. Generally, rates of intimate partner violence during pregnancy appear to be higher among poorer, racialized, and younger women. Prevalence in Europe was consistently found to be lower than elsewhere in the world (Campbell, García-Moreno, and Sharps 2016; Román-Gálvez et al. 2021). Nevertheless, and despite the challenges of determining the prevalence of violence during pregnancy, the fact that such violence occurs is a very serious public health concern (Guo et al. 2023; World Health Organization 2011).

The second argument for the center's screening policy was that pregnancy causes intimate partner violence to start or worsen. In line with the psychological definition of pregnancy as a crisis, which psychosocial advisers widely share (see chapter 3), marital relationships were thought to be destabilized during pregnancy, as the center's director, lead midwife, and lead social worker explained in their 2013 article:

> Pregnancy and the arrival of a child disturb couples. It unbalances established conjugal roles and male-female roles to make way for new modes of interaction. Everyone may be surprised by the questions and feelings that come up. For both of them, the individual family history resurfaces and imposes itself with force. What couple will they be afterward? What parents will they be? This parenthood

> under construction raises great common satisfactions but also provokes astonishment and misunderstandings.[3]

This narrative draws from the psychoanalytical framing of pregnancy as a crisis to imply a causal link between pregnancy and violence. Framing pregnancy as a challenge for male and female roles relies on several normative assumptions: that pregnancy happens within a heterosexual relationship, that this couple had a stable and balanced relationship before pregnancy, and that pregnancy is unsettling. A year later, the center's management team finalized their internal guidelines on intimate partner violence, including an explanation for their staff of the reasons pregnancy could cause violence:

> Pregnancy is a period of repositioning of relationships and roles in the couple and the family, with multiple questions, but also tensions and necessary negotiations.
>
> Sexuality and desire can change for both women and men, and this can be misinterpreted by the partner.
>
> During pregnancy, old wounds can be reactivated.
>
> The woman is particularly weakened; we speak about "psychic transparency."[4] First focused on her pregnancy and her sensations, then on her baby, she is less available to her partner, and her emotional reactions change.

The same page includes a citation attributed to a father:

> Before, my wife was very present and attentive to me, but as soon as she got pregnant, she changed! She spent a lot of time preparing the room. She only talked about the baby, and we couldn't plan any projects. I didn't exist anymore, it was unbearable!

The possible causes of violence are thus essentially linked to changes in pregnant women's behavior. Focused on their own psychological turmoil and on their "baby" (as psychosocial advisers commonly refer to fetuses), women in this text are portrayed as neglecting their partner sexually and affectively. This not only reflects an expectation that women should be constantly emotionally and sexually available for their partner but also that pregnancy alters their behavior and that men resent these (presumed) changes, an interpretation rooted in deeply misogynistic and patriarchal norms of marital relations.

The third argument that supported the screening policy was the severity of damage caused to pregnant people and fetuses. The seriousness, scale, and cost of a problem are ubiquitous features of public health campaigns and policies

(e.g., Guo et al. 2023; World Health Organization 2011). At the center, the risks that psychosocial advisers associate with intimate partner violence mostly refer to the future child (attachment, neglect, and a wide range of somatic and psychological disorders) and secondarily to the pregnant person's health (depression, trauma, death). As Maher et al. (2021) argue, discussions of intimate partner violence tend to focus disproportionately on the negative impact on children and on the (in)adequacy of mothers' protection of their children. This is particularly true of the Swiss context, where child protection services played a major role in the development of public policies against intimate partner violence in the 1990s (Delage and Roca i Escoda 2018). While the Pregnancy Support Center was developing its screening program between 2011 and 2013, a local pediatrician was alerting Swiss health care professionals to the detrimental effects of intimate partner violence on children (Cheseaux, Duc Marwood and Romain Glassey 2013), and child protection services was publishing a report on the same topic (Alvarez 2014). The figure of the child—yet unborn, in the context of prenatal care—as a potential victim of violence is foregrounded, and the multiple consequences of violence for pregnant people remain secondary.

The existence of a causal relation between pregnancy and violence is contested not only because epidemiologists are not unanimous on the prevalence of violence during pregnancy. The idea that pregnant people may be at higher risk for violence was first introduced by an American sociologist in 1975. Within a study of physical violence, Gelles (1975) reported that in a quarter of the families in the study, women had been abused by their partners for the first time during their pregnancy. Gelles identified five factors that may contribute to violence during pregnancy: "sexual frustration," "family transition, stress and strain," "biochemical change in the wife," "pre-natal child abuse," and "defenselessness of the wife" (1975, 82). Gelles thus framed pregnancy, and mostly changes in women's attitudes and roles, as the cause of abuse. This article sparked widespread concern and scientific interest in the question, resulting in an ever-growing number of publications on the prevalence of violence during pregnancy in many countries. However, Gelles himself, thirteen years after his pioneering article, critically reexamined his hypothesis and concluded that "the previously reported association between pregnancy and husband-to-wife violence is spurious and is an artifact of the effect of another variable, age" (Gelles 1988, 846). Indeed, the overall rate of violence is higher among younger women, precisely at the age when most pregnancies happen. Gelles regrets that most studies did not control for age in their statistical analysis by including a control group of nonpregnant women. He concludes that pregnant women are not a special high-risk group. This led sociologists Bergen and Logue (2009) to advance the idea that there may be different patterns: For some women, violence during pregnancy continues as before; for some, pregnancy causes an increase in violence; and for others, pregnancy is a period marked by a decrease in violence. At the Pregnancy Sup-

port Center, however, the shared assumption was that pregnancy was a time of increased danger for all pregnant people.

SCREENING FOR INTIMATE PARTNER VIOLENCE

The decision to implement a screening policy at the center was made by its director. Screening took the form of a requirement for every midwife and social worker to ask their clients during initial appointments if they were experiencing intimate partner violence and to refer them to specialized support services if needed. This strategy was abbreviated as DOTIP:

D—detect (*dépister*) possible violence
O—offer (*offrir*) a clear message of support
T—treat (*traiter*) and organize follow-up
I—inform (*informer*) about one's rights and resources in the [health care and social care] network
P—protect (*protéger*) by ensuring the safety of the pregnant woman/mother and of the children (internal guidelines)

The DOTIP approach had been developed a decade earlier as a guideline for caring for survivors of intimate partner violence within the emergency department of the largest public hospital of the Canton Romand and then was adapted for its maternity department. The Pregnancy Support Center adapted the DOTIP protocol to its own needs and limitations. Specifically, while the hospital translated the "T—treatment" of DOTIP into the provision of medical care, the center transformed that action into "organizing follow-up treatment"—that is, referring survivors to other services. The center's psychosocial advisers had neither the time nor the psychological, legal, or social competencies to offer mid- or long-term support to survivors of intimate partner violence. Since other services that specialized in supporting survivors of violence already existed in the canton, the Pregnancy Support Center acted as a referral platform in accordance with the interprofessional collaboration logic that framed prenatal care as performed by a network of health care and social workers (see chapter 5). Center staff were already using the same procedure—asking, informing, and referring—to screen for alcohol and tobacco consumption, exemplifying their approach to prevention.

Despite this limitation, the center's director framed screening for violence as an important responsibility: "We have clearly understood that it's only if different actors like doctors, hospital staff, and midwives, ask the question that one day a victim will dare to talk about it and say 'Yes, I am experiencing violence.' If she says no, we are not responsible for that. . . . As professionals, we are not responsible for the answers the victims give us. But we are responsible, in terms

of prevention, if we fail to ask the question." Taking the prevention mission of the center seriously, according to the center's director, meant that professionals should at least try to identify survivors when they came to the center, even if they then had to pass on the responsibility for care to other professionals.

Identifying survivors of intimate partner violence through talk, via a direct question, was introduced as a shift away from another way of identifying survivors: through "feeling," or intuition. Intuition plays an important role in guiding diagnosis and decision-making in nursing and midwifery (Davis-Floyd and Davis 1996; McCutcheon and Pincombe 2001; Perrenoud 2014; Shepherd 2011). Australian midwives, for instance, rely on "gut feelings" in their assessment of intimate partner violence despite the implementation of a formal screening tool, as Baird et al. (2021) report. Moving away from this approach to care was an important underlying impetus for the center's screening policy and was particularly supported by social workers at the center. While midwives and social workers mostly shared the same approach to psychosocial pregnancy care—a common culture that they acquired through continuous education when they joined the center—discussions of the violence screening policy revealed that the social workers generally criticized their midwife counterparts for relying on intuition. Anne, one of the most senior social workers at the center, was particularly vocal because she had realized the limits of assessing situations based on nonverbal cues. During our one-on-one interview, I asked her to explain how she came to advocate for verbal screening for violence. She explained that a few months prior, during building renovations, she had had to briefly share offices with the crime survivors' support unit hosted in the same building. She had been shocked to realize that clients she had met during their pregnancies—whom she thought were fine—were later seeking support and legal counsel because they were survivors of intimate partner abuse. Anne had started doubting herself: Why had she not sensed that these clients were experiencing violence when they were sitting in her office during their pregnancies? Had she missed a clue? She vowed to convince her colleagues to drop the intuition approach: "Some among us say, 'But you can feel whether they are a victim,' and 'It's enough to count on your intuition.' I'm convinced this is not the case. No, it's not true; I have seen it."

Anne's realization that intuition was not enough pushed her to advocate for a shift to verbal screening within the Pregnancy Support Center, and she welcomed the implementation of the DOTIP approach to violence. In the last decade, a similar turn toward identifying survivors of intimate partner violence by asking directly has been observed in Europe, North America, and Australia (Goicolea et al. 2023).

GOVERNING THROUGH TALK

Introducing intimate partner violence screening into psychosocial prenatal care is an extension of professionals' panoptic surveillance of pregnancy. But this form of

surveillance does not happen through *vision*, as the panopticism metaphor suggests, but through *talk*. By talking to pregnant clients, psychosocial advisers get to know about their lives, and by talking again, they seek to change their behaviors when deemed necessary. While the panopticon analogy highlights the scope of the surveillance exerted over pregnant people, another of Foucault's concepts captures this tremendous power of speech in surveillance: the use of "confession" (*aveu*) to produce truth and knowledge.

Confession is a core ritual in the Catholic Church, in which a person confesses their sins to a priest and obtains forgiveness. As a technique, confession both produces truths about the confessant and is a power relation since the confessor offers advice or reminders about the permissibility of the confessed behaviors and suggests actions to be taken in reparation. Confession implies the "presence of a partner who is not simply the interlocutor but the authority who requests the confession, imposes it, evaluates it, and intervenes to judge, punish, forgive, console, reconcile" (Foucault 1976, 82–83; my translation). According to Foucault (1977), while Catholicism relies on confession to access people's thoughts and behaviors, following the Reformation, confession spread as a technique to produce truths in the legal, medical, or psychiatric systems.

The concept of confession illuminates certain power relations in health care and social work (Fassin 2006; Holmes and O'Byrne 2006; Roberts 2005). At the Pregnancy Support Center, psychosocial advisers ask questions of their clients to know the truth of their lives and behaviors: Do they smoke regularly? Have they had a drink since they knew they were pregnant? Did they experience violence? As Foucault puts it, the confessor needs to "know from the inside what is happening within the soul, the heart, in the deepest secrets of the individual" to be able to "teach the truth, teach the Scriptures, teach morality, teach God's commandments and the Church's commandments" (1978, 564; my translation). The client/confessant is expected to talk but also to listen while midwives and social workers deliver public health messages such as "Alcohol is bad for your baby." As in the religious context, confession is a necessary step to allow the expert—the midwife or social worker—to act upon people's lives to steer them in a direction they consider more desirable. Depending on the client's answers, psychosocial advisers give absolution ("That's fine, you only had one drink; this is nothing to worry about") or admonishment to change ("It would be better for your baby if you cut down on smoking").

The Pregnancy Support Center's appointments differ from religious confession in a significant way, however. Pregnant clients do not come to the center to be granted access to medical intervention. They do not come explicitly to be evaluated or tested to determine whether they will be granted help, support, or pardon. Most come with either only a vague idea about what to expect or with very specific, practical questions—like Valerie in chapter 2, who wanted to know about paternity recognition. From my brief conversations, it seems clients

mostly had no idea the consultation would cover so many topics. However, I never witnessed a client openly resist the surveillance and confession nature of their appointment at the center either by refusing to answer a question, contesting the advice they received, or leaving the appointment early. Such open rebellions, according to the center's staff, were extremely rare. People tended to be quite compliant with experts, especially when asked to disclose personal information in medical settings. Of course, this does not mean that they did not resist surveillance altogether. Some may have chosen to disclose partial truths or lie, especially if they were aware that certain confessions would be frowned upon (like alcohol use). Some, like Karina in chapter 5, might have tried to escape the surveillance gaze of experts after their initial appointments by not showing up to their follow-up appointments.

The speech-based approach to psychosocial care is both what enables the deployment of psychosocial care and limits it. Talk is what allows psychosocial care to reach well beyond the event of pregnancy to deploy a more generalized surveillance of reproductive subjects. In medical care, prenatal care providers rely on what they can assess either directly or indirectly through their measuring instruments (for instance imaging, blood tests, and urine tests). Talk allows experts to reach people's thoughts and emotions, to know about people's past and what they plan for the future, and to communicate the knowledge they acquire to other experts. But psychosocial care is also limited by the basic fact that it relies on speech: If clients avoid or stop talking, psychosocial pregnancy support becomes impossible.

TO ASK OR NOT TO ASK, THAT IS THE QUESTION . . .

Despite the clear direction dictated by the center's management, the implementation of the systematic screening approach immediately raised concerns and doubts among the staff. This was not, as one might anticipate, because of the emotional load that supporting survivors of violence might place on psychosocial advisers' shoulders, nor because of midwives' possible reluctance to disavow their intuition-based approach to screening. What caused turmoil was the fear that introducing the topic of violence in initial consultations might damage advisers' rapport with their clients.

In September 2012, a year after implementation of the screening policy began at the center, one midwife explained that she was backing down from the systematic screening. This was at a "midwives' meeting," a thrice-yearly meeting in which all midwives working at the center met with the lead midwife to discuss topics related to midwifery (e.g., the latest professional guidelines on breastfeeding or ways to tackle sensitive topics such as mental health or violence with clients). During this meeting, midwife Colette explained why she did not want to ask her pregnant clients directly about intimate partner violence. Despite the

center's new guidelines, she found the systematic questioning difficult to implement: "I find it harder and harder to systematically ask about violence during appointments. Six to eight months ago, I was very well-intentioned, I systematically asked the question, and it did not always go well. So now I'm more sensitive to the experience of pregnancy for the couple, to the relational aspect, to symptoms of violence. I ask certain questions, but I don't ask the question head-on anymore." She continued explaining what it was that made her change her approach: She felt that asking about intimate partner violence "blocked something in the interview," and that some people became defensive and closed off after hearing the question. She recalled an appointment with a pregnant client: "The interview was going well; trust had been established. Asking about violence created a rift in the interview. I couldn't get her back [i.e., reestablish rapport]." Two months later, I had the opportunity to observe two of Colette's appointments. During those, she opted for an indirect approach to violence, asking about the couple's relationship: "And about your husband—do you feel supported? Because sometimes some things change in a relationship during pregnancy. Can you rely on him enough?"

Colette's colleague, midwife Alexandra, on the contrary, defended a direct approach to violence that was more in line with the center's policy. Expressing her "surprise" at Colette's indirect approach, she said she had had good experiences asking about violence directly. However, she did not ask head-on about intimate partner violence but about violence in a more general way: "Generally, I start with 'Have you been a victim of violence or witnessed violence around you? It could be abusing a dog, kicking an animal . . .' And then [the woman may answer], 'Ah yes, it was tough at home, my father was beating me.' And then I say, 'How about now?' 'Now I am all right.' You see immediately if she is okay."

Over the following years, psychosocial advisers still disagreed about their approach to violence. These disagreements did not derail the implementation of the DOTIP protocol, however. The Pregnancy Support Center continued to profile itself as a regional leader in intimate partner violence screening, and its DOTIP guidelines served as a model for other social or medical units in French-speaking Switzerland. Since 2020, the center has offered training to interested health care professionals and social workers in French-speaking Switzerland to educate them on intimate partner violence and how to use the DOTIP protocol.

THE LIMITS OF PREGNANCY SUPPORT

Witnessing the development of intimate partner violence screening policy at the Pregnancy Support Center revealed ambiguities and struggles at the border of prenatal care. The intent seemed straightforward: Ask clients about their experiences, identify clients who presented this risk factor, and allow them to get

support from specialized professionals, much in the same manner that other issues were tackled at the Pregnancy Support Center. Yet psychosocial advisers did not all agree whether they were well-positioned to screen for intimate partner violence and whether it was a good idea for them to do so. The topic of violence did not seamlessly integrate into the psychosocial model of prenatal care.

Psychosocial advisers feared that bringing the topic of violence into the conversation would jeopardize their relationship with their clients. Mostly, they feared—and some experienced—that their clients would find the topic intrusive and inappropriate and would not go along with this extension of surveillance. Such worries can be understood against the backdrop of the still-fragile position of psychosocial care in Switzerland. The Pregnancy Support Center is still struggling to find legitimacy among health care providers and the public. Psychosocial care providers may thus be especially wary of alienating their clients with questions that might be perceived as intrusive, the probability being high that such clients will never come back to the center. As a unit dependent on public funds, a disgruntled or crumbling clientele could jeopardize financial and political support from the local government.

Another reason why psychosocial advisers saw screening for violence as a challenge was their fear that it would not be an effective way to detect survivors. The center's statistics indeed showed a lower rate of violence than reported in the medical literature. Studies suggest that many do not disclose violence while pregnant, even if they are asked by health care providers. Reasons for nondisclosure include the hope that the violence will cease, fear of retribution from the abuser, having had bad experiences after disclosing violence to other professionals in the past, or fear of judgmental attitudes (Branjerdporn et al. 2023; Creedy, Baird, and Gillespie 2020; Salmon, Baird, and White 2015). Building trust appears to be a very important factor in encouraging disclosure, a process that is made difficult by the fact that most clients only visit the center once. Survivors might be even less likely to disclose violence during pregnancy in comparison to other moments in their lives. Edin et al. (2010) found that some survivors of violence during pregnancy in Sweden "would do almost anything to reduce stressful situations or to avoid violence so as to protect and care for the expected baby" and waited until after the pregnancy to seek help. As a result, the adequacy of screening measures to address intimate partner violence during pregnancy has been regularly questioned in other countries (O'Doherty et al. 2015; Taft 2002; Thurston, Cory, and Scot 1998). A specific concern is that screening methods may be harmful to survivors. If the health provider responds in a manner considered judgmental or inadequate by the survivor or fails to provide adequate support, the survivor not only does not get the help they hoped for but may be discouraged from seeking further help. Additionally, disclosing violence may trigger the involvement of child protection services, which can result in losing guardianship. Yet, despite these many reasons why survivors would not want to talk about vio-

lence during prenatal care appointments, the center's psychosocial advisers assumed that speaking up was emancipatory and the pathway to getting support.

What was not identified as a challenge to violence screening at the Pregnancy Support Center was the staff's limited options for supporting survivors. Qualitative interviews with midwives in the United Kingdom and Australia revealed that many were unsure how they would support their patients adequately after they had disclosed their experience of violence (Baird et al. 2021; Eustace et al. 2016; Price, Baird, and Salmon 2005). According to the DOTIP screening model of the center, the primary goal was not so much to support survivors directly but to detect and refer them. *Disclosure* was the measure of good care provision at the center, more than mid- or long-term support, as illustrated by the staff's worry about nondisclosure. What may seem like a shortcoming of their prevention strategy is in fact typical of their model of psychosocial care based on talk.

A further limitation of the center's strategy for intimate partner violence relates to the psychologization of violence and of life events more generally. Violence at the center was mostly understood in psychological terms as the result of the perpetrator's frame of mind, in line with the discourse delivered by violence experts within the center and the overall influence of psychology among psychosocial advisers (see chapter 3). Such a psychological framing of violence, as feminist scholars have pointed out (Delage and Roca i Escoda 2023; Romito 2006), tends to obscure structural causes of violence. Furthermore, there was no discussion at the center of the fact that marginalized, poorer, or racialized clients could have more barriers to accessing social or professional support. The psychological lens thus obscures the multiple and complex social factors that may influence experiences of violence and their (non)disclosure.

CONCLUSION

Reproductive Boundaries

The Pregnancy Support Center was founded to push the boundaries of prenatal care. Through the concept of "psychosocial" care, it promises to offer more comprehensive care than the medical monitoring of the pregnant body. In that sense, the invention of this model of psychosocial prenatal care illustrates the shift from coercive to supportive measures in the governance of families. At the same time, though, psychosocial care extends surveillance to the minds of pregnant clients as well as to their lives as professionals, partners, and relatives. Psychosocial care extends the reach of pregnancy surveillance not only to other dimensions of people's lives but also across time to their past, present, and future. Weaving a thread of care across people's lives coincides with weaving a thread of expert surveillance around reproductive subjects. And the threat of the state's sovereign power to discipline and punish parents—to use Foucault's vocabulary (1975)—is still present in the possibility that psychosocial advisers will have to denounce inadequate parents-to-be to child protection services. The territory of psychosocial care is a terrain of shifting conceptual, moral, professional, and power boundaries.

This expansion of prenatal care is an invitation for reproductive scholars and medical practitioners to think about how aspects of people's lives are reframed as reproductive, or at least as highly relevant, to their reproductive journeys—what I call the reproductivization of life. The reproductivization of everyday life is not a new phenomenon: Women's place in society has long been defined by their reproductive roles and in many ways still is. The historical exclusion of women from the workplace is tied to the expectation that they should fulfill child-rearing duties at home. In Switzerland, women still face considerable hurdles reconciling work and family lives. Against this backdrop, the notion of reproductivization draws attention to the dynamic processes whereby institutions and social actors such as the Pregnancy Support Center shift the boundaries of what is commonly considered reproductive in a certain context. What the center does is problematize *more* of pregnant people's lives as relevant to their pregnancy experience.

Talk is an essential vehicle for the reproductivization of life and is of central interest for reproductive scholars. With the multiplication of reproductive care providers—fertility, genetic, parental, or psychosocial advisers, to name just a few—reproduction is being talked about and talked between reproductive subjects in an ever-increasing variety of encounters. Furthermore, as Sallie Han (2018) underlines, the everyday experience of reproduction is also shaped by language, such as the way people talk about and to their imagined children, as well as the role of texts, from pregnancy advice literature to medical records. At the Pregnancy Support Center, discursive practices are where reproductive boundaries are established and enacted. The conceptual boundaries of psychosocial care are traced through the questions asked (and those not asked) of pregnant clients; the moral boundaries of what a "good" and "normal" pregnancy is are traced through the advice given by psychosocial advisers; power boundaries are enacted through the refusal of psychosocial advisers to divulge some aspects of their clients' lives to the maternity ward staff. Talk matters also to reproductive journeys because it is for reproductive subjects a potential site of resistance to surveillance, through the (active or passive) refusal to unveil some details of their intimate life to the panoptic gaze of reproductive care providers.

The field of reproductive studies has been undergoing exciting developments driven by reproductive justice in recent years (Andaya and El Kotni 2022). The reproductive justice framework draws attention to the *different* viewpoints, needs, and claims that people may have over reproduction—for example, the fact that some groups of people may want facilitated access to abortion care, while others may need freedom from coercion to end pregnancies. This means recognizing that justice is necessarily contextual and that claims for justice should take a form that is socially situated. In that spirit, while it is important that reproductive scholars highlight the harmful consequences that some people face for lack of comprehensive reproductive care, it is also important that we examine the potential harm caused by the expansion of reproduction. What does it mean when almost everything in a person's life, from their emotions to their working conditions to their relationship with their siblings, is read as a potential risk to their future baby? What my study suggests is that this can translate into an extension of expert surveillance of reproductive subjects. This book thus extends an invitation: to think about, with, and—whenever necessary—against the reproductivization of life.

The expansion of prenatal care to the pregnant mind exemplifies how a new dimension of pregnant people's lives is reframed as tied to their reproductive experience. Considering the psychological state of a pregnant person to be essentially different from that of a nonpregnant person means that the reproductive journey of pregnancy extends to the psyche. This essentialization and blurring of the mind/body distinction could theoretically translate into calls for better protection and care for pregnant people. But it can also, as we have seen,

imply that pregnant individuals are all undergoing a crisis, as an inevitable aspect of being pregnant, and this understanding undermines their agency, autonomy, and resilience. Psychosocial advisers' difficulties in implementing their screening tool for intimate partner violence also illustrated that expanding prenatal care did not necessarily result in better care for survivors.

Thinking about reproductive borders also means thinking about what lies beyond the borders, what is left unproblematized, unmonitored, and undiscussed. Despite being founded on a critique of medicalization, psychosocial care does not necessarily succeed in challenging the existing gendered boundaries of pregnancy. Inspired by the natural childbirth movement, the founders advocated for a novel approach to pregnancy that would treat all pregnant people as equally deserving of support. that would include fathers. and that would be less fetus-centric. Today these are still core values according to which the center operates, and yet this project to reform prenatal care has only partially succeeded. By and large, psychosocial care revolves around the idea that pregnancy is a woman's affair. The questions that form the basis of psychosocial interviews, the practical organization of the center, and the gendered makeup of the staff are based on and uncritically reproduce the assumption that the person who is pregnant is the main subject of counseling. The psychosocial conditions in which a pregnancy occurs are almost entirely equated to the pregnant person's psychosocial conditions. This reproduces the long-standing presumption that reproductive outcomes are women's responsibility and overlooks men's roles. Uncovering the persistence of these gendered assumptions at the Pregnancy Support Center shows how deeply they still permeate Swiss society, a country in which the regulation of female reproduction and sexuality has been central to the construction of good and respectable citizenship (Bader and Mottier 2020; Mottier 2006).

Psychosocial care's focus on pregnant individuals also leaves the larger social, cultural, and material environment in which pregnancies take place in the background. Pregnant clients are counseled and advised as if they control their destiny and their choices. While psychosocial advisers are very aware of social inequalities and xenophobia in Switzerland, the center does not engage in advocacy or political activity, and its action is limited to supporting individuals navigating a very unequal society. This reflects the entrenched expectation of individual responsibility as a sign of good citizenship in Switzerland, particularly in relation to health and families: It is usually considered the responsibility of individuals and parents to know about, and figure out how to pay for, health care and childcare services. Psychosocial care, like health care and family counseling in Switzerland, also remains permeated with stereotypes that attach lower socioeconomic status to less adequate parenting skills. The social forces that constrain parents' choices and prevent some from having "harmonious" pregnancy experiences remain largely beyond the boundaries of prenatal care.

The psychosocial model of care, as well as the Swiss model of reproductive governance underlying it, has been slow to address the changing reproductive landscape. Psychosocial advisers at the Pregnancy Support Center more or less explicitly considered the traditional heterosexual family model the norm. Focusing on heteronormative models of families implies that nonnormative families, especially LGBTIQ+ parents, remain largely outside the boundaries of care. Pregnancies that do not happen within "repronormative" (Franke 2001) boundaries are largely unthought of. Even if a trend toward more inclusiveness has been legible in recent attempts to promote awareness of diversity in Swiss prenatal care (Fussinger and von Känel 2020; Rey 2022), LGBTIQ+ prospective parents still face significant barriers and discrimination when embarking on a reproductive journey (Gouilhers, Albospeyre-Thibeau, and Gardey 2023; Gouilhers, Gardey, and Albospeyre-Thibeau 2023). Studies conducted in other European countries and North America describe the far-reaching practical, material, and personal consequences of the "unthinkability" (Toze 2018) or "inconceivability" (Ferrara 2024) of trans pregnancies, such as inadequate care and the administrative barriers facing pregnant persons with a masculine legal identity (Falck et al. 2020; Kirczenow MacDonald et al. 2005). The increasing political discussion and visibility of so-called rainbow families in Switzerland remain marked by homonormative expectations that these families will mimic the heteronormative model (Nay 2017, 2019).

Drawing and maintaining boundaries are core mechanisms of reproductive governance and of the stratification of reproduction and are central issues for reproductive studies. In this book I have underlined ongoing challenges to reproductive justice in Switzerland by shedding light on distinctions between categories of reproductive subjects and on the definition of what counts as reproduction. Experts—psychosocial advisers—have emerged in this analysis as the tracers and guardians of the borders of prenatal care. Following Véronique Mottier's (2008) metaphor, experts are the gardeners who identify the good plants in the Swiss garden and help them grow, leaving the weeds beyond the boundaries of their care. Thus, exploring boundary drawing in reproductive imaginaries and its consequences in terms of exclusion and access to care is central to rethinking reproductive care on more inclusive grounds. Disentangling pregnancy and other reproductive events from their association with normative womanhood, femininity, and motherhood roles contributes to challenging what Sarah Franklin (2023, 6) calls the "normative, familiar and naturalized grammar of reproductive common sense." What is at stake is not only the provision of better care but also the undoing of fundamental social structures of inequalities.

NOTES

INTRODUCTION

1. The Pregnancy Support Center is a pseudonym, as are all names of pregnancy advisers cited in the book.

2. The Swiss federal state is divided into twenty-six cantons, the equivalent of U.S. states, among which four are entirely francophone and three are bilingual French German. "Canton Romand" is a pseudonym. Romand is the term used for French-speaking Swiss persons, while Romandie designates the French-speaking part of Switzerland. Romand derives from Roman, the term used to designate the languages that are descended from Latin, such as French.

3. In Switzerland, all residents are legally required to purchase health insurance from private health insurance companies. Although residents can freely choose their insurance provider, the basic insurance package is defined by the Swiss Health Insurance Act of March 18, 1994 and provides the same standard coverage across all insurers. Although Switzerland offers universal health care, health services are not free. Out-of-pocket health care expenses are comparatively high (Trein, Rüefli, and Vatter 2023). Patients pay for monthly insurance premiums, a yearly deductible (i.e., the amount of money that the insured person must pay before their insurance starts covering costs), 10 percent of all costs after meeting the deductible, room and board during hospitalization, and any costs not explicitly covered by the basic insurance plan. Patients can choose their yearly deductible ranging from 300 to 2,500 CHF (about USD 340 to 2,800), with a lower deductible translating into a higher monthly insurance premium. In 2024, the average monthly insurance premium was CHF 426 (about USD 480) for an adult, with variations depending on the individual's age, canton of residence, and selected yearly deductible. Premiums generally increase annually, following the rising health care costs in the country, significantly burdening household finances. "Complementary" insurance policies can offset some of these additional costs, but they can be prohibitively expensive and do not cover preexisting health conditions. Prenatal, birth, and postpartum care is the only type of health care for which no deductible applies, which means that it is entirely covered by health insurance without out-of-pocket expenses (see chapter 5 for more details).

4. Hospital policy is the responsibility of cantons in Switzerland, which implies different practices across Switzerland. Generally, each canton finances several public hospitals spread across their territory, which provide health care for the whole population. Private clinics delivering specialized care (such as rehabilitation) can be partially subsidized. Only about 10 percent of patients choose a private hospital for delivery, as this requires costly private health insurance (Federal Office of Public Health 2024).

5. Key references on prenatal screening and diagnosis include Gammeltoft (2013); Katz Rothman (1986); Löwy (2017); Rapp (1999); Schwennesen and Gammeltoft (2022). On fetal surgery, Casper (1998); on surrogacy, König (2023); König et al. (2022); Siegl (2023); Whittaker (2018).

6. On risk discourses in pregnancy, key references include Kukla (2010); Lupton (1999, 2012); Lyerly et al. (2009); Ruhl (1999). In relation to alcohol, tobacco, and drug use, see Armstrong (2003); Lee, Sutton, and Hartley (2016); Lowe and Lee (2010); Oaks (2001). In relation to food and obesity, see Keenan and Stapleton (2010); Parker and Pausé (2018).

For Switzerland, see Burton-Jeangros et al. (2013); Gouilhers et al. (2019); Hammer (2019); Hammer and Burton-Jeangros (2013); Hammer et al. (2022); Hammer and Inglin (2014).
7. I conducted interviews with the center's ten midwives (including the lead midwife), seven social workers (including the lead social worker), and the center's director.

CHAPTER 1 THE LANDSCAPE OF SWISS PRENATAL CARE

1. "Federal Act on Pregnancy Support Centers of 9 October 1981," accessed September 3, 2025, https://www.fedlex.admin.ch/eli/cc/1983/2003_2003_2003/fr.
2. Along with federalism, direct democracy has been another feature of Swiss politics since 1848. In a direct democracy, a large share of the legislative power lies with voters instead of elected representatives. At all three political levels (municipality, canton, and federal state), citizens can propose changes to the constitution (popular initiative) or request a legal change be submitted to popular vote (referendum). Some decisions of the Parliament are automatically submitted to popular vote (mandatory referendum). As a result, Swiss citizens usually vote four times a year on various issues. Voting rights are reserved for Swiss citizens, with foreign permanent residents given voting rights at the municipal or canton level in some regions. Women were only granted voting rights at the federal level in 1971.
3. The Canton Romand offers nine drop-in centers for parents and children (*lieux d'accueil parents-enfants*, literally "parents-children welcome spaces"). These are facilities where parents can come and spend time with their children; they do not require registration or a fee. They are inspired by the Maison Verte model from French psychoanalyst Françoise Dolto, who opened the first *maison verte* in Paris in 1979. Staff in the *lieux d'accueil* are usually trained in psychoanalysis, observe parent-child interactions, and offer counseling and support.
4. All French to English translations of documents or interviews are mine.
5. In the Pregnancy Support Center's statistical database, data started being recorded in 2004, and not all years were on record for all criteria. The graphs presented in this chapter present all available data at the time of my research.
6. I had limited access to the Pregnancy Support Center's internal database during the intensive phase of my fieldwork. The database contained aggregated data on clients (such as age range, legal permit, employment status, level of education) and consultations (number of consultations, duration, led by midwife or social workers) per year and per city, for the years 2004 to 2016. Earlier data were not available because the center did not have electronic client files before 2004. I complement this with evidence from my follow-up interviews with employees as well as the Intimacy Foundation's annual reports. Data from the Federal Statistical Office concerning the Canton Romand were used to compare the profile of the center's clients with the general population.
7. For the history of the medicalization of pregnancy in Europe and North America, key references include Al-Gailani and Davis (2014); Barker (1998); Berthiaud (2013); Gélis (1984); Hanson (2004); Jacques (2007); Kukla (2005); Oakley (1984).
8. The Yenish are a group of traveling persons who live mostly in Germany, Austria, Switzerland, and France.
9. Switzerland never had colonies but was closely involved with colonial powers and profited from colonialism—a situation that Swiss historians called "colonialism without colonies" (Purtschert and Fischer-Tiné 2015; Purtschert, Lüthi, and Falk 2012).
10. "Federal Act on Medically Assisted Reproduction of 18 December 1998," accessed September 3, 2025, https://www.fedlex.admin.ch/eli/cc/2000/554/en.

CHAPTER 2 THE BOUNDARIES OF PSYCHOSOCIAL CARE

1. The so-called transmission document is a two-page form that psychosocial advisers fill during their first appointment with each client. On the document, advisers indicate a client's contact information and personal data (nationality, civil status, languages spoken, occupation), information about the client's partner (name, date of birth, occupation, nationality), and health (number of previous pregnancies and deliveries, last menstruation date, estimated date of delivery, name of gynecologist, allergies, name of maternity hospital chosen for delivery). The rest of the form contains boxes where advisers can write down comments, divided into the following topics: Mother (socio-professional situation, health, addictions); Father; Family situation; Experience of previous pregnancies, births, and breastfeeding; Experience of current pregnancy; Birth (including desires, fears, birthing classes); Hospital stay (including mode of infant feeding, contraception); Organization of return home (including name of midwife for postpartum care, pediatric nurse, and child's pediatrician); and Other professionals involved. The form is then sent, in paper or electronically, to the maternity ward where the client plans to give birth and can then be consulted by the doctors, midwives, and nurses of the maternity ward.
2. "Swiss Citizenship Act (Law on Swiss Nationality) of 20 June 2014," accessed September 3, 2025, https://www.fedlex.admin.ch/eli/oc/2016/404/fr.
3. Significant waves of workers migrated from Turkey in the 1960s and, following the Yugoslav wars, the 1990s and 2000s saw waves of refugees from former Yugoslavian countries and Albania. Taken together, immigrants from these countries form by far the largest migrant group in Switzerland. Other large migrant groups in Switzerland are from Germany, Italy, France, and Portugal, and they are generally considered less "culturally distant" from Switzerland and as such are less discriminated against (dos Santos Pinto et al. 2022).

CHAPTER 3 THE PREGNANT MIND

1. I published a previous and shorter version of this discussion in Ballif (2020).
2. Classic works include Leifer (1977, 1980); Ballou (1978); and Valentine (1982). More recent examples include Trombetta et al. (2021); Della Vedova et al. (2023); and Missonnier (2023).
3. In French, all nouns are either masculine or feminine. "Baby" and "child" are masculine, so Carla and Alexandra used the pronouns "he/his" when talking about Carla's baby, which does not necessarily indicate she was expecting a baby boy. In the English translation, I use "s/he" and "his/her" to reflect this indeterminate gender.
4. The Swiss Civil Code allows involuntary hospitalization of patients up to three days in case of "mental disorder," "mental disability," or "serious neglect" (article 426). The decision-making process for involuntary hospitalization varies from canton to canton but usually involves doctors and legal guardianship authorities.

CHAPTER 4 A GOOD FUTURE

1. I published a previous and shorter version of this discussion in Ballif (2023a).
2. In conversations among psychosocial advisers, clients were frequently referred to as "Madame" (Mrs.) and "Monsieur" (Mr.), a common practice in health care and social work settings. This allows professionals to discuss cases anonymously and maintain client confidentiality.

3. Rich scholarship in sociology and anthropology has explored risk discourses and pregnancy. Key studies have in particular focused on risk discourses in relation to alcohol (Armstrong 2003; Golden 2005; Lee 2014b; Lee et al. 2021; Lee, Sutton, and Hartley 2016; Lowe and Lee 2010), smoking (Oaks 2000, 2001), prenatal genetic testing (Gammeltoft 2013; Ginsburg and Rapp 2020; Katz Rothman 1986; Rapp 1999; Valdez 2018), feeding infants and children (Keenan and Stapleton 2010; Knaak 2010; Lee 2007, 2008; Murphy 2000), and, more recently, epigenetics (Manderson and Ross 2020; Mansfield 2012; Pentecost 2024; Richardson 2021).
4. In French, "child" is a masculine noun and is grammatically treated as "he," which does not indicate that the child is necessarily considered a boy.
5. It was common for midwives to use "Baby" as a proper noun in French as an affectionate way to personify the future child. This is not very common in French or in medical settings, where the use of qualifying words such as "the" or "your" baby is usually preferred.

CHAPTER 5 THE PREGNANCY NETWORK

1. To read more about expertise and modernity, readers may refer to the classic works of Ehrenreich and English (1989); Giddens (1991); Rose (1990); Ussher (2006).
2. "Article 29 of the Swiss Health Insurance Act of March 18, 1994," accessed September 3, 2025, https://www.fedlex.admin.ch/eli/cc/1995/1328_1328_1328/fr, and articles 13 to 16 of the "Ordinance on Health Insurance Benefits of September 29, 1995," accessed September 3, 2025, https://www.fedlex.admin.ch/eli/cc/1995/4964_4964_4964/fr.
3. Classic and more recent works on the medical surveillance of pregnancies and motherhood more generally in Europe and North America include Arney (1982); Barker (1998); Berthiaud (2013); Bessett (2010); Boulet (2021); Fixmer-Oraiz (2019); Fox, Heffernan, and Nicolson (2009); Henderson, Harmon, and Houser (2010); Jacques (2007); Katz Rothman (1982); Lupton (1999); Murphy (2003); Oakley (1984); Oaks (2001).

CHAPTER 6 CONTESTED BORDERLANDS

1. Reference withheld for confidentiality purposes.
2. Key references on the prevalence of intimate partner violence during pregnancy include Agarwal et al. (2023); Bailey (2010); Ballard et al. (1998); Chen et al. (2024); Gazmararian et al. (1996); Jasinski (2004).
3. Reference withheld for confidentiality purposes.
4. The notion of "psychic transparency" was developed by the French psychiatrist Monique Bydlowski, as discussed in chapter 3.

BIBLIOGRAPHY

Absil, Gaëtan, Chantal Vandoorne, and Elisabette Prato. 2008. *Projet de soutien à la parentalité en consultation prénatale: De l'expérience des professionnels au référentiel.* Accessed September 3, 2025. https://orbi.uliege.be/bitstream/2268/12972/1/ELE%20THE-MAT%20R-9631.pdf.

Adams, Vincanne, Michelle Murphy, and Adele E. Clarke. 2009. "Anticipation: Technoscience, Life, Affect, Temporality." *Subjectivity* 28 (1): 246–265.

Agarwal, Sristy, Roshan Prasad, Saket Mantri, Rashi Chandrakar, Shalvi Gupta, Vaishnavi Babhulkar, Samriddhi Srivastav, Arpita Jaiswal, and Mayur B. Wanjari. 2023. "A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health." *Cureus* 15 (5): e39262.

Akrich, Madeleine, and Bernike Pasveer. 1996. *Comment la naissance vient aux femmes. Les techniques de l'accouchement en France et aux Pays-Bas*. Les Empêcheurs de penser en rond.

Al-Gailani, Salim, and Angela Davis. 2014. "Introduction to 'Transforming Pregnancy Since 1900.'" *Studies in History and Philosophy of Biological and Biomedical Sciences* 47 (pt. B): 229–232.

Almeling, Renee. 2020. *GUYnecology: The Missing Science of Men's Reproductive Health*. University of California Press.

Almeling, Renee, and Miranda R. Waggoner. 2013. "More and Less than Equal: How Men Factor in the Reproductive Equation." *Gender & Society* 27 (6): 821–842.

Alvarez, Caroline. 2014. *Enfants exposés aux violences conjugales. Rapport: État des lieux, interventions institutionnelles et propositions*. Accessed September 3, 2025. https://www.vd.ch/fileadmin/user_upload/themes/vie_privee/jeunesse/UPP_-_Rapport_SPJ_-_Enfants_expos%C3%A9s_aux_violences_conjugales.pdf.

Ameeriar, Lalaie. 2015. "Pedagogies of Affect: Docility and Deference in the Making of Immigrant Women Subjects." *Signs: Journal of Women in Culture and Society* 40 (2): 467–486.

Andaya, Elise. 2018. "Stratification Through Medicaid: Public Prenatal Care in New York City." In *Unequal Coverage: The Experience of Health Care Reform in the United States*, edited by Jessica M. Mulligan and Heide Castañeda, 102–125. New York University Press.

———. 2019. "Race-ing Time: Clinical Temporalities and Inequality in Public Prenatal Care." *Medical Anthropology* 38 (8): 651–663.

———. 2021. "Reproductive Governance in Practice." In *The Routledge Handbook of Anthropology and Reproduction*, edited by Sallie Han and Cecilia Tomori, 123–136. Routledge.

———. 2024. *Pregnant at Work: Low-Wage Workers, Power, and Temporal Injustice*. New York University Press.

Andaya, Elise, and Mounia El Kotni. 2022. "The Anthropology of Reproduction." In *A Companion to Medical Anthropology*, edited by Merrill Singer, Pamela I. Erickson, and César E. Abadía-Barrero, 213–229. John Wiley & Sons.

Anderson, Ben. 2010. "Preemption, Precaution, Preparedness: Anticipatory Action and Future Geographies." *Progress in Human Geography* 34 (6): 777–798.

Anderson, Benedict. 1983. *Imagined Communities: Reflections on the Origin and Spread of Nationalism*. Verso.

Annas, George J. 1986. "Pregnant Women as Fetal Containers." *Hastings Center Report* 16 (6): 13–14.

Apple, Rima D. 2006. *Perfect Motherhood: Science and Child Rearing in America*. Rutgers University Press.

Arena, Francesca. 2008. "La folie des mères: Théories et pratiques autour du diagnostic de la folie puerpérale, XVIIe–XXe siècles, France-Italie." *Rives Méditerranéennes* 30:143–154.

———. 2012. "La maternité: Entre santé et pathologie. L'histoire des délires puerpéraux à l'époque moderne et contemporaine." *Histoire, médecine et santé* 3 (6): 101–113.

———. 2020. *Trouble dans la maternité: Pour une histoire des folies puerpérales, XVIIIe–XXe siècles*. Presses Universitaires de Provence.

Armstrong, Elizabeth M. 1998. "Diagnosing Moral Disorder: The Discovery and Evolution of Fetal Alcohol Syndrome." *Social Science & Medicine* 47 (12): 2025–2042.

———. 2003. *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder*. Johns Hopkins University Press.

Arney, William Ray. 1982. *Power and the Profession of Obstetrics*. University of Chicago Press.

Arni, Caroline. 2012. "Vom Unglück des müttlerlichen 'Versehens' zur Biopolitik des 'Pränatalen': Aspekte einer Wissensgeschichte des maternal-fötalen Beziehung." In *Biopolitik und Geschlecht: Zur Regulierung des Lebendigen*, edited by Eva Sänger and Malaika Rödel, 44–65. Westfälisches Dampfboot.

———. 2015. "Traversing Birth: Continuity and Contingency in Research on Development in Nineteenth-Century Life and Human Sciences." *History and Philosophy of the Life Sciences* 37:50–67.

Arribas-Ayllon, Michael, and Valerie Walkerdine. 2008. "Foucauldian Discourse Analysis." In *The Sage Handbook of Qualitative Research in Psychology*, edited by Carla Willig and Wendy Stainton-Rogers, 91–108. Sage.

Association de Formation et de Recherché sur l'Enfant et son Environnement. 2007. *Référentiel pour la mise en place et l'animation de formations "au travail en réseau personnalisé de soins."* Accessed September 3, 2025. https://afree.asso.fr/wp-content/uploads/2023/02/Referentiel-pour-la-mise-en-place-et-lanimation-de-formations-au-travail-en-reseau-personnalise-de-soins.pdf.

Avignon, Valérie, Laurent Gaucher, David Baud, Hélène Legardeur, Corinne Dupont, and Antje Horsch. 2023. "What Do Mothers Think About Their Antenatal Classes? A Mixed-Method Study in Switzerland." *BMC Pregnancy and Childbirth* 23 (1): 741.

Bacchi, Carol. 1999a. "Domestic Violence: Battered Women or Violent Men?" In *Women, Policy and Politics: The Construction of Policy Problems*, 164–180. Sage.

———. 1999b. *Women, Policy and Politics: The Construction of Policy Problems*. Sage.

———. 2009. *Analysing Policy: What's the Problem Represented to Be?* Pearson.

———. 2016. "Problematizations in Health Policy: Questioning How 'Problems' Are Constituted in Policies." *Sage Open* 6 (2): 215824401665398.

Bacchi, Carol, and Susan Goodwin. 2016. *Poststructural Policy Analysis: A Guide to Practice*. Palgrave Macmillan.

Bader, Dina, and Véronique Mottier. 2020. "Femonationalism and Populist Politics: The Case of the Swiss Ban on Female Genital Mutilation." *Nations and Nationalism* 26 (3): 644–659.

Bailey, Beth A. 2010. "Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management." *International Journal of Women's Health* 2:183–197.

Baird, Kathleen, Debra K. Creedy, Grace Branjerdporn, and Kerri Gillespie. 2021. "Red Flags and Gut Feelings: Midwives' Perceptions of Domestic and Family Violence Screening and

Detection in a Maternity Department." *Women and Birth: Journal of the Australian College of Midwives* 34 (5): e468–e474.

Ballard, Terri J., Linda E. Saltzman, Julie A. Gazmararian, Alison M. Spitz, Suzanne Lazorick, and James S. Marks. 1998. "Violence During Pregnancy: Measurement Issues." *American Journal of Public Health* 88 (2): 274–276.

Ballif, Edmée. 2014. "Des grossesses entre 'trouille folle' et 'bulle de bonheur': Le discours du risque de professionnelles de l'accompagnement des grossesses." In *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*, edited by Claudine Burton-Jeangros, Raphaël Hammer, and Irene Maffi, 115–132. Giuseppe Merrone.

———. 2017. "Mettre en mots avant de mettre au monde: Modalités temporelles de l'accompagnement psychosocial des femmes enceintes." PhD diss., University of Lausanne.

———. 2019. "La grossesse, une affaire de femmes? Enjeux de genre dans la prévention de la consommation de tabac et d'alcool auprès des futurs parents." In *Sexuer le corps: Huit études sur des pratiques médicales d'hier et d'aujourd'hui*, edited by Hélène Martin and Marta Roca i Escoda, 119–136. Editions HETSL.

———. 2020. "Policing the Maternal Mind: Maternal Health, Psychological Government, and Swiss Pregnancy Politics." *Social Politics: International Studies in Gender, State and Society* 27 (1): 74–96.

———. 2023a. "Anticipatory Regimes in Pregnancy: Cross-Fertilising Reproduction and Parenting Culture Studies." *Sociology* 57 (3): 476–492.

———. 2023b. "Multispecies Childcare: Child Veganism and the Reimagining of Health, Reproduction and Gender in Switzerland." *Medical Anthropology* 42 (6): 565–578.

———. 2024. "Vegan Labor: The Intensification of Family Foodwork at the Intersection of Dietary and Gender Norms." *Food, Culture & Society* 27 (2): 458–478.

Ballou, Judith W. 1978. *The Psychology of Pregnancy: Reconciliation and Resolution*. Lexington Books.

Barker, Kristin K. 1998. "A Ship upon a Stormy Sea: The Medicalization of Pregnancy." *Social Science & Medicine* 47 (8): 1067–1076.

Barnes, Medora W. 2014. "Anticipatory Socialization of Pregnant Women." *Sociological Perspectives* 58 (2): 187–203.

Barth, Fredrik. 1969. *Ethnic Groups and Boundaries*. Waveland.

Baumgarten, Diana, and Andrea Maihofer. 2021a. "Elternschaft, Erwerbsarbeit und der Faktor Geschlecht—einige Thesen insbesondere zu weiblicher Erwerbsarbeit." In *Geschlecht, Bildung, Profession: Ungleichheiten im pädagogischen Berufsfeld*, edited by Susanne Burren and Sabina Larcher, 128–152. Barbara Budrich.

———. 2021b. "Ideas of Family and Work—Their Impact on the Careers of Young Men* and Women*." In *Transitioning to Sustainability Series 5*, edited by Christa Binswanger and Andrea Zimmermann, 197–212. MDPI.

Bell, Kirsten, Darlene McNaughton, and Amy Salmon. 2009. "Medicine, Morality and Mothering: Public Health Discourses on Foetal Alcohol Exposure, Smoking Around Children and Childhood Overnutrition." *Critical Public Health* 19 (2): 155–170.

Benedek, Therese. 1952. "Some Psychophysiological Problems of Motherhood." In *Psychosexual Functions in Women*, 407–418. Ronald Press.

———. 1959. "Parenthood as a Developmental Phase: A Contribution to the Libido Theory." *Journal of the American Psychoanalytical Association* 7 (3): 389–417.

———. 1970. "The Psychobiology of Pregnancy." In *Parenthood, Its Psychology and Psychopathology*, edited by E. James Anthony and Therese Benedek, 137–151. Little, Brown.

Bergen, Raquel Kennedy, and Melissa A. Logue. 2009. "Intimate Partner Violence During Pregnancy: What Does the Research Tell Us?" *Sociology Compass* 3 (2): 196–216.

Berthiaud, Emmanuelle. 2013. *Enceinte: Une histoire de la grossesse entre art et société*. Editions de La Martinière.

Bessett, Danielle. 2010. "Negotiating Normalization: The Perils of Producing Pregnancy Symptoms in Prenatal Care." *Social Science & Medicine* 71 (2): 370–377.

Beynon-Jones, Siân M. 2012. "Timing Is Everything: The Demarcation of 'Later' Abortions in Scotland." *Social Studies of Science* 42 (1): 53–74.

———. 2017. "Gestating Times: Women's Accounts of the Temporalities of Pregnancies That End in Abortion in England." *Sociology of Health and Illness* 39 (6): 832–846.

Bibring, Grete L. 1959. "Some Considerations of the Psychological Processes in Pregnancy." *Psychoanalytic Study of the Child* 14 (1): 113–121.

Bibring, Grete L., Thomas F. Dwyer, Dorothy S. Huntington, and Arthur F. Valenstein. 1961a. "A Study of the Psychological Processes in Pregnancy and of the Earliest Mother-Child Relationship: I. Some Propositions and Comments." *Psychoanalytic Study of the Child* 16 (1): 9–24.

———. 1961b. "A Study of the Psychological Processes in Pregnancy and of the Earliest Mother-Child Relationship: II. Methodological Considerations." *Psychoanalytic Study of the Child* 16 (1): 25–72.

Bibring, Grete L., and Arthur F. Valenstein. 1976. "Psychological Aspects of Pregnancy." *Clinical Obstetrics and Gynecology* 19 (2): 357–371.

Bloch, Katrina, and Tiffany Taylor. 2014. "Welfare Queens and Anchor Babies: A Comparative Study of Stigmatized Mothers in the United States." In *Mothering in the Age of Neoliberalism*, edited by Melinda Vandenbeld Giles, 199–210. Demeter Press.

Blum, Linda M. 2007. "Mother-Blame in the Prozac Nation: Raising Kids with Invisible Disabilities." *Gender & Society* 21 (2): 202–226.

Bobel, Chris. 2002. *The Paradox of Natural Mothering*. Temple University Press.

Bograd, Michele. 1984. "Family Systems Approaches to Wife Battering: A Feminist Critique." *American Journal of Orthopsychiatry* 54 (4): 558–568.

Bollini, Paola, Urszula Stotzer, and Philippe Wanner. 2007. "Pregnancy Outcomes and Migration in Switzerland: Results from a Focus Group Study." *International Journal of Public Health* 52 (2): 78–86.

Borner, Barbara, and Susanne Grylka. 2023. *Ausführlicher Statistikbericht der frei praktizierenden Hebammen der Schweiz: Rapport statistique détaillé des sages-femmes indépendantes en Suisse.* Accessed September 3, 2025. https://www.hebamme.ch/wp-content/uploads/2023/09/Ausfuehrlicher-Statistikbericht-SHV-2022.pdf.

Boston Women's Health Collective, ed. 1970. *Women and Their Bodies: A Course*. New England Free Press.

Botbol, Michel, and Adeline Gourbil. 2018. "The Place of Psychoanalysis in French Psychiatry." *British Journal of Psychiatry International* 15 (1): 3–5.

Boulet, Elsa. 2021. "La triple journée des femmes enceintes: L'encadrement des grossesses en France, entre droits des femmes et devoirs des mères." *Enfances familles générations* 38 (10): 1–23.

Bowlby, John. 1951. *Maternal Care and Mental Health*. Schocken Books.

———. 1969. *Attachment and Loss.* Vol. 1, *Attachment*. Basic Books.

Branjerdporn, Grace, Tanya Clonan, Jennifer Boddy, Kerri Gillespie, Rosemary O'Malley, and Kathleen Baird. 2023. "Australian Women's Perspectives of Routine Enquiry into Domestic Violence Before and After birth." *BMC Pregnancy and Childbirth* 23 (1): 44.

Bréart, Gérard, Francis Puech, and Jean-Christophe Rozé. 2004. *Plan "périnatalité" 2005–2007: Humanité, proximité, sécurité, qualité*. Accessed September 3, 2025. https://sante.gouv.fr/IMG/pdf/Plan_perinatalite_2005-2007.pdf.

Bridges, Khiara. 2011. *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*. University of California Press.

Briggs, Laura. 2017. *How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump*. University of California Press.

Broer, Tineke, Martyn Pickersgill, and Sarah Cunningham-Burley. 2022. "Temporal Imaginaries in Accounts of Parenting Practices: Negotiations of Time, Advice, and Expertise." *Catalyst: Feminism, Theory, Technoscience* 8 (1): 1–24.

Browner, Carole H., and Nancy Press. 1996. "The Production of Authoritative Knowledge in American Prenatal Care." *Medical Anthropology Quarterly* 10 (2): 141–156.

Browner, Carole H., and Carolyn F. Sargent. 2021. "Reproduction and the State." In *The Routledge Handbook of Anthropology and Reproduction*, edited by Sallie Han and Cecilia Tomori, 87–105. Routledge.

Budds, Kirsty, Abigail Locke, and Vivien Burr. 2013. "'Risky Business': Constructing the 'Choice' to 'Delay' Motherhood in the British Press." *Feminist Media Studies* 13 (1): 132–147.

Buhle, Mari Jo. 1998. *Feminism and Its Discontents: A Century of Struggle with Psychoanalysis*. Harvard University Press.

Bühler, Nolwenn. 2021. *When Reproduction Meets Ageing: The Science and Medicine of the Fertility Decline*. Emerald.

Bureau fédéral de l'égalité entre hommes et femmes. 2020. *La violence dans les relations de couple: Causes, facteurs de risque et de protection*. Accessed September 3, 2025. https://backend.ebg.admin.ch/fileservice/sdweb-docs-prod-ebgch-files/files/2024/04/25/8dd95a3b-e669-4a5f-bdaf-510fb1a96418.pdf.

Burton-Jeangros, Claudine. 2010. "Les femmes enceintes confrontées à l'information et aux risques." In *Risques et informations dans le suivi des grossesses: Droit, éthique et pratiques sociales*, edited by Dominique Manaï, Claudine Burton-Jeangros, and Bernice Elger, 177–212. Stämpfli et Bruylant.

———. 2011. "Surveillance of Risks in Everyday Life: The Agency of Pregnant Women and Its Limitations." *Social Theory & Health* 9 (4): 419–436.

Burton-Jeangros, Claudine, Samuele Cavalli, Solène Gouilhers, and Raphaël Hammer. 2013. "Between Tolerable Uncertainty and Unacceptable Risks: How Health Professionals and Pregnant Women Think About the Probabilities Generated by Prenatal Screening." *Health, Risk & Society* 15 (2): 144–161.

Burton-Jeangros, Claudine, Raphaël Hammer, and Irene Maffi, eds. 2014a. *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*. Giuseppe Merrone.

———. 2014b. "Pratiques professionnelles et contextes institutionnels autour de la naissance." In *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*, edited by Claudine Burton-Jeangros, Raphaël Hammer, and Irene Maffi, 5–24. Giuseppe Merrone.

Bydlowski, Monique. 1991. "La transparence psychique de la grossesse." *Etudes freudiennes* 32:135–142.

———. 1997. *La dette de vie: Itinéraire psychanalytique de la maternité*. Presses universitaires de France.

———. 2000. *Je rêve un enfant: L'expérience intérieure de la maternité*. Odile Jacob.

———. 2001. "Le regard intérieur de la femme enceinte, transparence psychique et représentation de l'objet interne." *Devenir* 13 (2): 41–52.

Bydlowski, Monique, and Claude-Henri Camus. 1988. "Recherche psychanalytique dans une maternité hospitalière." *Revue de médecine psychosomatique* 14 (29): 19–30.

Cai, Dingcui, Paulina Villanueva, Hong Lu, Basile Zimmermann, and Antje Horsch. 2024. "What Matters to Migrant Women During Labor and Birth: Chinese Mothers' Experiences in Switzerland." *BMC Pregnancy and Childbirth* 24 (1): 69.

Cairns, Kate, Josée Johnston, and Merin Oleschuk. 2019. "Calibrating Motherhood." In *Feeding Children Inside and Outside the House: Critical Perspectives*, edited by Vicky Harman, Benedetta Cappellini, and Charlotte Faircloth, 174–190. Routledge.

Campbell, Jacquelyn, Claudia García-Moreno, and Phyllis Sharps. 2016. "Abuse During Pregnancy in Industrialized and Developing Countries." *Violence Against Women* 10 (7): 770–789.

Cannella, Barbara L., Adela Yarcheski, and Noreen E. Mahon. 2018. "Meta-Analyses of Predictors of Health Practices in Pregnant Women." *Western Journal of Nursing Research* 40 (3): 425–446.

Caplan, Paula J., and Ian Hall-McCorquodale. 1985. "Mother-Blaming in Major Clinical Journals." *American Journal of Orthopsychiatry* 55 (3): 345–353.

Cardi, Coline. 2004. "La figure de la 'mauvaise mère' dans la justice des mineurs. La représentation de la déviance maternelle dans les dossiers de mineurs ayant fait l'objet d'une mesure de placement." In *Maternité et parentalité*, edited by Yvonne Knibiehler and Gérard Neyrand, 69–82. Editions ENSP.

———. 2007. "Le contrôle social réservé aux femmes: Entre prison, justice et travail social." *Déviance et société* 31 (1): 3–23.

Casas Vila, Gloria. 2017. "D'une loi d'avant-garde contre la violence de genre à l'expérience pénale des femmes: Le paradoxe espagnol?" *Champ Pénal / Penal Field* 14 (2).

Casper, Monica. 1998. *The Making of the Unborn Patient: A Social Anatomy of Fetal Surgery*. Rutgers University Press.

Castel, Robert, and Jean-François Le Cerf. 1980. "Le phénomène 'psy' et la société française: Vers une nouvelle culture psychologique." *Le débat* 1 (1): 32–45.

Cavalli, Samuele, and Solène Gouilhers-Hertig. 2014. "Gynécologues-obstétriciens et sages-femmes dans le suivi de la grossesse: Une complémentarité sous contrôle médical?" In *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*, edited by Claudine Burton-Jeangros, Raphaël Hammer, and Irene Maffi, 85–106. Giuseppe Merrone.

Chadwick, Rachelle. 2018. *Bodies That Birth: Vitalizing Birth Politics*. Routledge.

Chaparro-Buitrago, Julieta. 2024. "Sterilizing Body-Territories: Understanding Contemporary Cases of Forced Sterilization in the United States and China." *Feminist Anthropology*. Online ahead of print.

Chaparro-Buitrago, Julieta, and Cordelia Freeman. 2023. "Reproductive Justice and the Figure of the Child: The Multiple Harms of Forced Sterilization and Abortion in Peru." *Feminist Anthropology* 4 (2): 171–177.

Chautems, Caroline. 2022a. *Negotiated Breastfeeding: Holistic Postpartum Care and Embodied Parenting*. Routledge.

———. 2022b. "Restoring the Sacred Part of Birth: Doula Care and Cesarean Birth in Switzerland." *Medical Anthropology* 41 (5): 560–573.

———. 2024. "'I Felt like I Was Cut in Two': Postcesarean Bodies and Complementary and Alternative Medicine in Switzerland." *Culture, Medicine, and Psychiatry* 48 (2): 329–349.

Chautems, Caroline, Irene Maffi, and Alexandre Farin. 2023. "The Introduction of 'Natural Cesareans' in Swiss Hospitals: A Conversation with One of Its Pioneers." In *Cognition, Risk, and Responsibility in Obstetrics*, edited by Robbie Davis-Floyd and Ashish Premkumar, 125–143. Berghahn Books.

Chen, Xiao-Yan, Camilla Kin Ming Lo, Qiqi Chen, Shuling Gao, Frederick K. Ho, Douglas Austin Brownridge, Wing Cheong Leung, Patrick Ip, and Ko Ling Chan. 2024. "Intimate Partner Violence Against Women Before, During, and After Pregnancy: A Meta-Analysis." *Trauma, Violence & Abuse* 25 (4): 2768–2780.

Cheseaux, Jean-Jacques, Alessandra Duc Marwood, and Nathalie Romain Glassey. 2013. "Exposition de l'enfant à des violences domestiques." *Revue Médicale Suisse* 374: 398–401.

Chiapperino, Luca, and Francesco Panese. 2018. "Gendered Imaginaries: Situating Knowledge of Epigenetic Programming of Health." *Sociology of Health and Illness* 40 (7): 1233–1249.

Colen, Shellee. 1995. "Like a Mother to Them: Stratified Reproduction and West Indian Childcare Workers and Employers in New York." In *Conceiving the New World Order: The Global Politics of Reproduction*, edited by Faye Ginsburg and Rayna Rapp, 78–102. University of California Press.

Comité de direction du PNR 76 "Assistance et coercition." 2024. *Synthèse: Ingérences dans les parcours de vie. Résultats et impulsions du Programme national de recherche « Assistance et coercition » (PNR 76)*. Fonds national Suisse (Bern). Accessed September 3, 2025. https://www.nfp76.ch/media/fr/BUe4hrFjJhBKmWkL/Synthe%CC%80se_PNR76_FR.pdf.

Commission fédérale pour les questions féminines. 2011. *Interruption de grossesse*. Accessed September 3, 2025. https://www.ekf.admin.ch/ekf/fr/home/documentation/geschichte-der-gleichstellung--frauen-macht-geschichte/frauen-macht-geschichte-18482000.html.

Cook, Joanna, and Catherine Trundle. 2020. "Unsettled Care: Temporality, Subjectivity, and the Uneasy Ethics of Care." *Anthropology and Humanism* 45 (2): 178–183.

Cooper, Kerris. 2021. "Are Poor Parents Poor Parents? The Relationship Between Poverty and Parenting Among Mothers in the UK." *Sociology* 55 (2): 349–383.

Coser, Lewis A. 1984. "European Psychoanalysts in America: The Promised Land." In *Refugee Scholars in America*, 42–54. Yale University Press.

Courduriès, Jérôme. 2018. "At the Nation's Doorstep: The Fate of Children in France Born via Surrogacy." *Reproductive BioMedicine and Society Online* 7 (11): 47–54.

Cramer, Renée Ann. 2016. *Pregnant with the Stars: Watching and Wanting the Celebrity Baby Bump*. Stanford University Press.

Crear-Perry, Joia, Rosaly Correa-de-Araujo, Tamara Lewis Johnson, Monica R. McLemore, Elizabeth Neilson, and Maeve Wallace. 2021. "Social and Structural Determinants of Health Inequities in Maternal Health." *Journal of Women's Health* 30 (2): 230–235.

Creedy, Debra K., Kathleen Baird, and Kerri Gillespie. 2020. "A Cross-Sectional Survey of Pregnant Women's Perceptions of Routine Domestic and Family Violence Screening and Responses by Midwives: Testing of Three New Tools." *Women and Birth: Journal of the Australian College of Midwives* 33 (4): 393–400.

Cummins, Molly Wiant. 2014. "Reproductive Surveillance: The Making of Pregnant Docile Bodies." *Kaleidoscope: A Graduate Journal of Qualitative Communication Research* 14 (4): 33–51.

D'Amour, Danielle, Marcela Ferrada-Videla, Leticia San Martin Rodriguez, and Marie-Dominique Beaulieu. 2005. "The Conceptual Basis for Interprofessional Collaboration: Core Concepts and Theoretical Frameworks." *Journal of Interprofessional Care* 19 (suppl. 1): 116–131.

Daniels, Cynthia R. 1993. *At Women's Expense: State Power and the Politics of Fetal Rights*. Harvard University Press.

———. 1997. "Between Fathers and Fetuses: The Social Construction of Male Reproduction and the Politics of Fetal Harm." *Signs: Journal of Women in Culture and Society* 22 (3): 579–616.

———. 2008. *Exposing Men: The Science and Politics of Male Reproduction*. Oxford University Press.

Davis, Dána-Ain. 2019a. "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing." *Medical Anthropology* 38 (7): 560–573.

———. 2019b. *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*. New York University Press.

Davis-Floyd, Robbie. 1992. *Birth as an American Rite of Passage*. University of California Press.

Davis-Floyd, Robbie, and Elizabeth Davis. 1996. "Intuition as Authoritative Knowledge in Midwifery and Homebirth." *Medical Anthropology Quarterly* 10 (2): 237–269.

Davis-Floyd, Robbie, and Carolyn F. Sargent, eds. 1997. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. University of California Press.

Dayan, Jacques, Gwenaëlle Andro, and Michel Dugnat. 1999. *Psychopathologie de la périnatalité*. Masson.

de Labrusse, Claire, Alessia Abderhalden-Zellweger, Ilaria Mariani, Anouck Pfund, Michael Gemperle, Susanne Grylka-Baeschlin, Antonia N. Mueller, Emanuelle Pessa Valente, Benedetta Covi, and Marzia Lazzerini. 2022. "Quality of Maternal and Newborn Care in Switzerland During the COVID-19 Pandemic: A Cross-Sectional Study Based on WHO Quality Standards." *International Journal of Gynecology & Obstetrics* 159 (S1): 70–84.

Delage, Pauline, and Marta Roca i Escoda. 2018. "Deux processus de sanitarisation: L'action publique contre les violences dans le couple dans deux cantons de Suisse romande." *Sciences sociales et santé* 36 (3): 37–62.

———. 2023. "Intimate Partner Violence and the Complexity Turn: The Multiple Conceptions of Gender in IPV Policy in Switzerland." *Swiss Journal of Sociology* 49 (1): 215–231.

Delage, Pauline, Marta Roca i Escoda, and Marylène Lieber. 2020. *Contrer les violences dans le couple: Emergence et reconfigurations d'un problème public*. Antipodes.

Delessert, Thierry, Chiara Boraschi, and Nelly Valsangiacomo. 2024a. "Introduction." In *Pauvres, immorales et contraintes: Les adversités des mères célibataires en Suisse*, edited by Thierry Delessert, Chiara Boraschi, and Nelly Valsangiacomo, 9–20. Seismo.

———, eds. 2024b. *Pauvres, immorales et contraintes: Les adversités des mères célibataires en Suisse*. Seismo.

Della Vedova, Anna Maria, Fabrizio Santoniccolo, Cristina Sechi, and Tommaso Trombetta. 2023. "Perinatal Depression and Anxiety Symptoms, Parental Bonding and Dyadic Sensitivity in Mother-Baby Interactions at Three Months Post-Partum." *International Journal of Environmental Research and Public Health* 20 (5): 4253.

De Mijolla, Alain. 1992. "France (1893–1965)." In *Psychoanalysis International: A Guide to Psychoanalysis Throughout the World*. Vol. 1, *Europe*, edited by Peter Kutter, 66–113. Frommann-Holzboog.

Desiderato, Simone, Urs Lengwiler, and Verena Rothenbühler. 2008. *Zwischen Professionalität und politischem Kräftemessen: Jugendhilfe Kanton Zürich, 1918–2008*. Lehrmittelverlag des Kantons Zürich.

Despland, Jean-Nicolas, and Sylvie Berney. 2012. "Psychiatre et psychothérapeute? Petite histoire suisse." *L'information psychiatrique* 88 (7): 535–542.

Desseauve, David, Stephanie Meyer, Eva Cignacco, Settimio Monteverde, Manuel Trachsel, Luigi Raio, and Stephan Oelhafen. 2022. "'We Felt like Part of a Production System': A Qualitative Study on Women's Experiences of Mistreatment During Childbirth in Switzerland." *PLOS One* 17 (2): e0264119.

Deutsch, Helene. 1944. *The Psychology of Women: A Psychoanalytic Interpretation*. Vol. 1. Grune & Stratton.

———. 1945. *The Psychology of Women: A Psychoanalytic Interpretation*. Vol. 2, *Motherhood*. Grune & Stratton.

Donzelot, Jacques. 1977. *La police des familles*. Editions de Minuit.

dos Santos Pinto, Jovita, Pamela Ohene-Nyako, Mélanie-Evely Pétrémont, Anne Lavanchy, Barbara Lüthi, Patricia Purtschert, and Damir Skenderovic, eds. 2022. *Un/doing Race: La racialisation en Suisse*. Seismo.

Douglas, Mary. 1966. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. Routledge.

Downe, Soo, and Fiona Dykes. 2009. "Counting Time in Pregnancy and Labour." In *Childbirth, Midwifery and Concepts of Time*, edited by Christine McCourt, 61–83. Bergahn Books.

Drewniak, Daniel, Tanja Krones, Carsten Sauer, and Verina Wild. 2016. "The Influence of Patients' Immigration Background and Residence Permit Status on Treatment Decisions in Health Care: Results of a Factorial Survey Among General Practitioners in Switzerland." *Social Science & Medicine* 161:64–73.

Droux, Joëlle, and Anne-Françoise Praz. 2021. *Placés, déplacés, protégés? L'histoire du placement d'enfants en Suisse, XIXe–XXe siècles*. Alphil.

Duden, Barbara. 1999. "The Fetus on the 'Farther Shore': Toward a History of the Unborn." In *Fetal Subjects, Feminist Positions*, edited by Lynn M. Morgan and Meredith W. Michaels, 13–25. University of Pennsylvania Press.

Dugnat, Michel, and Marina Douzon. 2007. "Pas de 0 de conduite pour les femmes enceintes et les fœtus de 3 mois: Pour un entretien prénatal précoce 'prévenant.'" *Spirale* 41 (1): 43–60.

Edin, Kerstin E., Lars Dahlgren, Ann Lalos, and Ulf Hogberg. 2010. "'Keeping Up a Front': Narratives About Intimate Partner Violence, Pregnancy, and Antenatal Care." *Violence Against Women* 16 (2): 189–206.

Egger, Theres, and Marianne Schär Moser. 2008. *La violence dans les relations de couple. Ses causes et les mesures prises en Suisse.* Accessed September 3, 2025. https://backend.ebg.admin.ch/fileservice/sdweb-docs-prod-ebgch-files/files/2023/08/28/afa0b8c0-d598-4bd9-9157-4c46bdcec7fd.pdf.

Ehrenreich, Barbara, and Deirdre English. 1989. *For Her Own Good. Two Centuries of the Experts' Advice to Women*. Anchor.

Eisenberg, Ziv. 2010. "Clear and Pregnant Danger: The Making of Prenatal Psychology in Mid-Twentieth-Century America." *Journal of Women's History* 22 (3): 112–135.

———. 2013. "The Whole Nine Months: Women, Men, and the Making of Modern Pregnancy in America." PhD diss., Yale University.

Engel, George L. 1977. "The Need for a New Medical Model: A Challenge for Biomedicine." *Science* 196 (4286): 129–136.

Engeli, Isabelle. 2010. *Les politiques de la reproduction: Les politiques d'avortement et de procréation médicalement assistée en France et en Suisse*. L'Harmattan.

Eustace, Jennifer, Kathleen Baird, Amornrat S. Saito, and Debra K. Creedy. 2016. "Midwives' Experiences of Routine Enquiry for Intimate Partner Violence in Pregnancy." *Women and Birth: Journal of the Australian College of Midwives* 29 (6): 503–510.

Eyer, Diane. 1996. *Motherguilt: How Our Culture Blames Mothers for What's Wrong with Society*. Times Books.

Faircloth, Charlotte. 2013. *Militant Lactivism? Infant Feeding and Maternal Accountability in the UK and France*. Berghahn Books.

———. 2014. "The Problem of 'Attachment': The 'Detached' Parent." In *Parenting Culture Studies*, edited by Ellie Lee, Jennie Bristow, Charlotte Faircloth, and Jan Macvarish, 147–164. Palgrave Macmillan.

Faircloth, Charlotte, and Zeynep B. Gürtin. 2018. "Fertile Connections: Thinking Across Assisted Reproductive Technologies and Parenting Culture Studies." *Sociology* 52 (5): 983–1000.

Faircloth, Charlotte, Diane M. Hoffman, and Linda Layne. 2013a. "Introduction." In *Parenting in Global Perspective: Negotiating Ideologies of Kinship, Self and Politics*, edited by Charlotte Faircloth, Diane M. Hoffman, and Linda Layne, 1–17. Routledge.

Faircloth, Charlotte, Diane M. Hoffman, and Linda L. Layne, eds. 2013b. *Parenting in Global Perspective: Negotiating Ideologies of Kinship, Self and Politics*. Routledge.

Falck, Felicitas, Louise Frisén, Cecilia Dhejne, and Gabriela Armuand. 2020. "Undergoing Pregnancy and Childbirth as Trans Masculine in Sweden: Experiencing and Dealing with Structural Discrimination, Gender Norms and Microaggressions in Antenatal Care, Delivery and Gender Clinics." *International Journal of Transgender Health* 22 (1–2): 42–53.

Fassin, Didier. 2006. "Souffrir par le social, gouverner par l'écoute: Une configuration sémantique." *Politix* 73 (1): 137–157.

Favre, Guillaume, Cléa Kunz, Simone Schwank, Ho-Fung Chung, Anda Petronela Radan, Luigi Raio, Mihaela Fluri, Ursula Winterfeld, David Baud, and Léo Pomar. 2022. "Mental Health in Pregnant Individuals During the COVID-19 Pandemic Based on a Swiss Online Survey." *Scientific Reports* 12 (1): 18448.

Federal Council. 2009. *Rapport sur la violence dans les relations de couple*. Accessed September 3, 2025. https://backend.ebg.admin.ch/fileservice/sdweb-docs-prod-ebgch-files/files/2023/08/28/3f6a01b9-a036-49a1-9d27-81bd2bf65fbc.pdf.

———. 2022. *Verteilung des Wohlstands in der Schweiz: Bericht in Erfüllung des Postulats 15.3381 Kommission für Wirtschaft und Abgaben des Nationalrates vom 14.04.2015*. Accessed September 3, 2025. https://www.estv.admin.ch/dam/estv/de/dokumente/estv/steuerpolitik/berichte/stp-berichte-2022-verteilung-wohlstand-de.pdf.download.pdf/stp-berichte-2022-verteilung-wohlstand-de.pdf.

Federal Office of Public Health. 2024. "Quality Indicators for Swiss Acute Hospitals." Accessed September 3, 2022. https://www.bag.admin.ch/de/qualitaetsindikatoren-der-schweizer-akutspitaeler.

Federal Statistical Office. 2017. *Les familles en Suisse*. Accessed September 3, 2025. https://dam-api.bfs.admin.ch/hub/api/dam/assets/2347881/master.

———. 2019. *Accouchements et santé maternelle en 2017*. Accessed September 3, 2025. https://www.bfs.admin.ch/bfsstatic/dam/assets/8369419/master.

———. 2020a. *Acquisitions de la nationalité Suisse*. Accessed September 3, 2025. https://dam-api.bfs.admin.ch/hub/api/dam/assets/15022042/master.

———. 2020b. *Participation des femmes au marché du travail de 2010 à 2019*. Accessed September 3, 2025. https://dam-api.bfs.admin.ch/hub/api/dam/assets/14941827/master.

———. 2021. *Les familles en Suisse*. Accessed September 3, 2025. https://dam-api.bfs.admin.ch/hub/api/dam/assets/17084547/master.

———. 2022. *Portrait démographique de la Suisse: Etat, structure et évolution de la population en 2020*. Accessed September 3, 2025. https://dam-api.bfs.admin.ch/hub/api/dam/assets/21764559/master.

———. 2023. *Indicateurs de fécondité en Suisse, de 1950 à 2022*. Accessed September 3, 2025. https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/naissances-deces/fecondite.assetdetail.27225532.html.

———. 2024. "Poverty." Accessed September 3, 2025. https://www.bfs.admin.ch/bfs/en/home/statistics/economic-social-situation-population/economic-and-social-situation-of-the-population/poverty-deprivation/poverty.html.

Ferrara, Mellynwood. 2024. "Inconceivable: Cisnormativity and the Management of Trans and Intersex Reproduction." In *A Companion to the Anthropology of Reproductive Medicine and Technology*, edited by Cecilia Coale Van Hollen and Nayantara Appleton, 234–249. John Wiley & Sons.

Ferro Luzzi, Giovanni, Yves Flückiger, and Sylvain Weber. 2006. "A Cluster Analysis of Multidimensional Poverty in Switzerland." In *Quantitative Approaches to Multidimensional Pov-*

erty Measurement, edited by Nanak Kakwani and Jacques Silber, 63–79. Palgrave Macmillan.

Filliettaz, Séverine Schusselé, Peter Berchtold, Ursula Koch, and Isabelle Peytremann-Bridevaux. 2021. "Integrated Care in Switzerland: Strengths and Weaknesses of a Federal System." *International Journal of Integrated Care* 21 (4): 1–8.

Fixmer-Oraiz, Natalie. 2019. *Homeland Maternity: US Security Culture and the New Reproductive Regime*. University of Illinois Press.

Foucault, Michel. 1973. "A propos de l'enfermement pénitentiaire." In *Dits et Ecrits I. 1954–1975*, 1303–1313. Gallimard.

———. 1974. "La vérité et les formes juridiques." In *Dits et Ecrits I. 1954–1975*, 1406–1514. Gallimard.

———. 1975. *Surveiller et punir: Naissance de la prison*. Gallimard.

———. 1976. *Histoire de la sexualité I. La volonté de savoir*. Gallimard.

———. 1977. "Pouvoir et savoir." In *Dits et Ecrits II. 1976–1988*, 399–414. Gallimard.

———. 1978. "Sexualité et pouvoir." In *Dits et Ecrits II. 1976–1988*, 552–570. Gallimard.

———. 1984. *Histoire de la sexualité III. Le souci de soi*. Gallimard.

———. 2004. *Sécurité, territoire, population: Cours au Collège de France. 1977–1978*. Gallimard.

Fournier, Claude-Alexandre. 2013. *Odette Fournier, sage-femme: Attitudes religieuses face à la naissance en Valais entre 1930 et 1970*. Labor et Fides.

Fournier, Tristan, and Julie Jarty. 2019. "Gouverner les 'mille premiers jours de vie': Quelles résistances possibles face à la biolégitimité du 'care alimentaire'?" *Revue des sciences sociales* 61 (1): 46–55.

Fox, Ann, and Scott Reeves. 2015. "Interprofessional Collaborative Patient-Centred Care: A Critical Exploration of Two Related Discourses." *Journal of Interprofessional Care* 29 (2): 113–118.

Fox, Rebekah, Kristin Heffernan, and Paula Nicolson. 2009. "'I Don't Think It Was Such an Issue Back Then': Changing Experiences of Pregnancy Across Two Generations of Women in South-East England." *Gender, Place & Culture* 16 (5): 553–568.

Franke, Katherine M. 2001. "Theorizing Yes: An Essay on Feminism, Law, and Desire." *Columbia Law Review* 101 (1): 181–208.

Franklin, Sarah. 2011. "Not a Flat World: The Future of Cross-Border Reproductive Care." *Reproductive BioMedicine Online* 23 (7): 814–816.

———. 2023. *Embodied Progress: A Cultural Account of Assisted Reproduction*. 2nd ed. Routledge.

Furedi, Frank. 2004. *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. Routledge.

———. 2008. *Paranoid Parenting: Why Ignoring the Experts May Be Best for Your Child*. Continuum.

Furrer, Markus, Kevin Heiniger, Thomas Huonker, Sabine Jenzer, and Anne-Françoise Praz, eds. 2014. *Fürsorge und Zwang: Fremdplatzierung von Kindern und Jugendlichen in der Schweiz, 1850–1980. Entre assistance et contrainte: Le placement des enfants et des jeunes en Suisse 1850–1980*. Schwabe.

Fuschetto, Roxane. 2017. *La maternité de Lausanne: Un patrimoine pour la vie*. Editions BHMS.

Fussinger, Catherine, and Annick Ohayon. 2010. "Psychotherapy in Switzerland and France in the 1950s: Similar Controversy, Different Solutions." In *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800–2000*, edited by Waltraud Ernst and Thomas Mueller, 272–296. Cambridge Scholars.

Fussinger, Catherine, and Maria von Känel. 2020. "L'Association faîtière familles arc-en-ciel en Suisse: Une décennie d'engagements singuliers pluriels." *Nouvelles Questions Féministes* 39 (2): 140–155.

Fux, Beat. 2002. "Which Models of the Family Are Encouraged or Discouraged by Different Family Policies?" In *Family Life and Family Policies in Europe*. Vol. 2, *Problems and Issues in Comparative Perspective*, edited by Franz-Xaver Kaufmann, Anton Kuijsten, Hans-Joachim Schulze, and Klaus Peter Strohmeier, 363–418. Clarendon Press.

Gallagher, Janet. 1987. "Prenatal Invasions and Interventions: What's Wrong with Fetal Rights." *Harvard Women's Law Journal* 10:9–58.

Galle, Sara. 2016. *Kindswegnahmen: Das "Hilfswerk für die Kinder der Landstrasse" der Stiftung Pro Juventute im Kontext der schweizerischen Jugendfürsorge*. Chronos.

Galle, Sara, and Thomas Meier. 2009. *Von Menschen und Akten: Die Aktion "Kinder der Landstrasse" der Stiftung Pro Juventute*. Chronos Verlag.

Gammeltoft, Tine M. 2013. "Potentiality and Human Temporality: Haunting Futures in Vietnamese Pregnancy Care." *Current Anthropology* 54 (S7): S159–S171.

Garcia, Sandrine. 2011. *Mères sous influence: De la cause des femmes à la cause des enfants*. La Découverte.

Gardner, Carol Brooks. 1994a. "Little Strangers: Pregnancy Conduct and the Twentieth-Century Rhetoric of Endangerment." In *Troubling Children: Studies of Children and Social Problems*, edited by Joel Best, 69–92. Aldine de Gruyter.

———. 1994b. "The Social Construction of Pregnancy and Fetal Development: Notes on a Nineteenth-Century Rhetoric of Endangerment." In *Constructing the Social*, edited by Theodore R. Sarbin and John I. Kitsuse, 45–64. Sage.

Gauthier, Yvon. 2009. *L'avenir de la psychiatrie de l'enfant*. Erès.

Gazmararian, Julie A., Suzanne Lazorick, Alison M. Spitz, Terri J. Ballard, Linda E. Saltzman, and James S. Marks. 1996. "Prevalence of Violence Against Pregnant Women." *JAMA* 275 (24): 1915–1920.

Gélis, Jacques. 1984. *L'arbre et le fruit: La naissance dans l'Occident moderne (XVIe–XIXe siècles)*. Fayard.

Gelles, Richard J. 1975. "Violence and Pregnancy: A Note on the Extent of the Problem and Needed Services." *Family Coordinator* 24 (1): 81–86.

———. 1988. "Violence and Pregnancy: Are Pregnant Women at Greater Risk of Abuse?" *Journal of Marriage and the Family* 50:841–847.

Gerodetti, Natalia. 2006. "Eugenic Family Politics and Social Democrats: 'Positive' Eugenics and Marriage Advice Bureaus." *Journal of Historical Sociology* 19 (3): 217–244.

Gerrits, Bailey. 2024. "When a 'Feminist' Government Tackles Gender-Based Violence: A WPR Approach to the Speeches of Canadian Cabinet Ministers (2015–2019)." *Canadian Journal of Political Science* 57 (1): 119–138.

Giddens, Anthony. 1991. *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford University Press.

Gillies, Val. 2005. "Raising the 'Meritocracy': Parenting and the Individualization of Social Class." *Sociology* 39 (5): 835–853.

———. 2007. *Marginalised Mothers: Exploring Working-Class Experiences of Parenting*. Routledge.

Ginsburg, Faye, and Rayna Rapp. 2020. "'We Are All in the Image of God': Reproductive Imaginaries and Prenatal Genetic Testing in American Jewish Communities." *Reproductive Biomedicine and Society Online* 11:1–8.

Giraud, Olivier, and Barbara Lucas. 2009. "Le renouveau des régimes de genre en Allemagne et en Suisse: Bonjour 'néo maternalisme'?" *Cahiers du genre* 46 (1): 17–46.

Godderis, Rebecca. 2010. "Precarious Beginnings: Gendered Risk Discourses in Psychiatric Research Literature About Postpartum Depression." *Health* 14 (5): 451–466.

Goicolea, Isabel, Hanna Bäckström, Marcus Lauri, Maria Carbin, and Ida Linander. 2023. "Daring to Ask About Violence? A Critical Examination of Social Services' Policies on Asking About Gender-Based Violence." *Journal of Gender-Based Violence* 7 (3): 467–482.

Golden, Janet. 2005. *Message in a Bottle: The Making of Fetal Alcohol Syndrome*. Harvard University Press.

Goodwin, Michele. 2020. *Policing the Womb: Invisible Women and the Criminalization of Motherhood*. Cambridge University Press.

Gouilhers, Solène. 2010. "Le suivi de la grossesse par les sages-femmes: Vers une 'autonomie raisonnée' des femmes enceintes." In *Risques et informations dans le suivi des grossesses: Droit, éthique et pratiques sociales*, edited by Dominique Manaï, Claudine Burton-Jeangros, and Bernice Elger, 213–243. Stämpfli et Bruylant.

Gouilhers, Solène, Raphaël Albospeyre-Thibeau, and Delphine Gardey. 2023. "Vers l'inclusion des personnes trans dans les protocoles de préservation de la fertilité en Suisse romande." *Revue médicale suisse* 18 (833): 1262–1265.

Gouilhers, Solène, Delphine Gardey, and Raphaël Albospeyre-Thibeau. 2023. "De la stérilisation imposée à la préservation de la fertilité des personnes trans: Les médecins au travail." *Travail, genre et sociétés* 50 (2): 61–78.

Gouilhers, Solène, Yvonne Meyer, Sophie Inglin, Stéphanie Pfister Boulenaz, Céline Schnegg, and Raphaël Hammer. 2019. "Pregnancy as a Transition: First-Time Expectant Couples' Experience with Alcohol Consumption." *Drug and Alcohol Review* 38 (7): 758–765.

Grant, Julia. 1998. *Raising Baby by the Book: The Education of American Mothers*. Yale University Press.

Greene, Kelly, and Marion Bogo. 2002. "The Different Faces of Intimate Violence: Implications for Assessment and Treatment." *Journal of Marital and Family Therapy* 28 (4): 455–466.

Guerzoni, Corinna. 2020. *Sistemi procreativi: Etnografia dell'omogenitorialità in Italia*. FrancoAngeli.

Guignard, Florence Pasche. 2020. "Back Home and Back to Nature? Natural Parenting and Religion in Francophone Contexts." *Open Theology* 6 (1): 175–201.

Guo, Cancan, Mengtong Wan, Yue Wang, Peijie Wang, Marissa Tousey-Pfarrer, Haoyang Liu, Liangming Yu, Lingqi Jian, Mengting Zhang, Ziqi Yang, Fenfen Ge, and Jun Zhang. 2023. "Associations Between Intimate Partner Violence and Adverse Birth Outcomes During Pregnancy: A Systematic Review and Meta-Analysis." *Frontiers in Medicine* 10:1140787.

Häfeli, Christoph, Martin Lengwiler, and Margot Vogel Campanello, eds. 2024. *Entre protection et coercition: Normes et pratiques au fil du temps*. Schwabe Verlag.

Hafner, Urs, Urs Germann, and Mirjam Janett. 2023. *Das Problem Kind—Zur Geschichte der Kinder- und Jugendpsychiatrie der Schweiz im 20. Jahrhundert*. Schwabe.

Hainmueller, Jens, and Dominik Hangartner. 2013. "Who Gets a Swiss Passport? A Natural Experiment in Immigrant Discrimination." *American Political Science Review* 107 (1): 159–187.

Hallgrimsdottir, Helga Kristin, and Bryan Eric Benner. 2014. "'Knowledge Is Power': Risk and the Moral Responsibilities of the Expectant Mother at the Turn of the Twentieth Century." *Health, Risk & Society* 16 (1): 7–21.

Hamal, Mukesh, Marjolein Dieleman, Vincent De Brouwere, and Tjard de Cock Buning. 2020. "Social Determinants of Maternal Health: A Scoping Review of Factors Influencing Maternal Mortality and Maternal Health Service Use in India." *Public Health Reviews* 41 (1): 13.

Hamilton, Patricia. 2022. *Black Mothers and Attachment Parenting: A Black Feminist Analysis of Intensive Mothering in Britain and Canada*. Bristol University Press.

Hammer, Raphaël. 2010. "Le devoir d'information des gynécologues-obstétriciens et le risque médico-légal." In *Risques et informations dans le suivi des grossesses: Droit, éthique et pratiques sociales*, edited by Dominique Manaï, Claudine Burton-Jeangros, and Bernice Elger, 245–280. Stämpfli et Bruylant.

———. 2019. "'I Can Tell When You're Staring at My Glass . . .': Self- or Co-Surveillance? Couples' Management of Risks Related to Alcohol Use During Pregnancy." *Health, Risk & Society* 21 (7–8): 335–351.

Hammer, Raphaël, and Claudine Burton-Jeangros. 2013. "Tensions Around Risks in Pregnancy: A Typology of Women's Experiences of Surveillance Medicine." *Social Science & Medicine* 93:55–63.

Hammer, Raphaël, Solène Gouilhers, Irina Radu, Jessica Pehlke-Milde, and Yvonne Meyer. 2022. "Uncertainty, Manageability and Individuation: A Longitudinal Qualitative Study of Women's Conceptualisations of Risk from Pregnancy to Breastfeeding—the Case of Alcohol Consumption." *SSM—Qualitative Research in Health* 2 (12): 100152.

Hammer, Raphaël, and Sophie Inglin. 2014. "'I Don't Think It's Risky, but . . .': Pregnant Women's Risk Perceptions of Maternal Drinking and Smoking." *Health, Risk & Society* 16 (1): 22–35.

Han, Sallie. 2013. *Pregnancy in Practice: Expectation and Experience in the Contemporary US*. Berghahn Books.

———. 2017. "Pregnant with Ideas: Concepts of the Fetus in the Twenty-First-Century United States." In *The Anthropology of the Fetus: Biology, Culture, and Society*, edited by Sallie Han, Tracy K. Betsinger, and Amy B. Scott, 59–80. Berghahn Books.

———. 2018. "Reproduction and Language." In *The Oxford Handbook of Language and Sexuality*, edited by Kira Hall and Rusty Barrett. Oxford University Presss.

Han, Sallie, Tracy K. Betsinger, and Amy B. Scott. 2017. "Introduction: Conceiving the Anthropology of the Fetus." In *The Anthropology of the Fetus: Biology, Culture, and Society*, edited by Sallie Han, Tracy K. Betsinger, and Amy B. Scott, 1–12. Berghahn Books.

Hansen, Marsali. 1989. "Feminism and Family Therapy: A Review of Feminist Critiques of Approaches to Family Violence." In *Battering and Family Therapy: A Feminist Perspective*, edited by Marsali Hansen and Michèle Harway, 69–81. Sage.

Hanson, Clare. 2004. *A Cultural History of Pregnancy: Pregnancy, Medicine and Culture*. Palgrave Macmillan.

Hardyment, Christina. 2007. *Dream Babies: Childcare Advice from John Locke to Gina Ford*. Francis Lincoln.

Harrison, Mia, Anthony K. J. Smith, and Sophie Adams. 2024. "Matters of Time in Health and Illness." *Health Sociology Review* 33 (1): 1–9.

Hartouni, Valerie. 1992. "Fetal Exposures: Abortion Politics and the Optics of Allusion." *Camera Obscura* 29 (2): 131–150.

Häusermann, Silja, and Reto Bürgisser. 2023. "Family Policy." In *The Oxford Handbook of Swiss Politics*, edited by Patrick Emmenegger, Flavia Fossati, Silja Häusermann, Yannis Papadopoulos, Pascal Sciarini, and Adrian Vatter, 733–752. Oxford University Press.

Hauss, Gisela, Thomas Gabriel, and Martin Lengwiler, eds. 2018. *Fremdplatziert: Heimerziehung in der Schweiz, 1940–1990*. Chronos Verlag.

Haut Comité de la Santé Publique. 1994. *La sécurité et la qualité de la grossesse et de la naissance: Pour un nouveau plan périnatalité*. Editions ENSP.

Haynal, André. 2009. "L'originalité de la pensée psychanalytique helvétique." *Le Coq-héron* 197 (2): 63–69.

Haynal, André, and Ernst Falzeder. 2014. "Les Suisses." *Le Coq-héron* 218 (3): 11–19.

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood*. Yale University Press.

Heinen, Jacqueline. 2022. "Offensives tous azimuts contre le droit d'avorter aux Etats-Unis et en Europe." *Cahiers du genre* 72 (1): 233–250.

Heller, Geneviève, Gilles Jeanmonod, and Jacques Gasser. 2002. *Rejetées, rebelles, mal adaptées: Débats sur l'eugénisme, pratiques de la stérilisation non volontaire en Suisse romande au XXe siècle*. Georg.

Henderson, Angela C., Sandra M. Harmon, and Jeffrey Houser. 2010. "A New State of Surveillance? An Application of Michel Foucault to Modern Motherhood." *Surveillance & Society* 7 (3–4): 231–247.

Hobi, Lukas. 2023. *Caught in the Slough: Poverty Persistence in Switzerland*. Working paper. Bern University of Applied Sciences. Accessed September 3, 2025. http://dx.doi.org/10.24451/arbor.21266.

Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. University of California Press.

Hofner, Marie-Claude, and Stéphanie Sigen. 2001. *Violence conjugale dans le canton de Vaud: Recherche préparatoire réalisée sur mandat du Bureau de l'égalité entre les femmes et les hommes du canton de Vaud.* Accessed September 3, 2025. https://www.vd.ch/fileadmin/user_upload/themes/vie_privee/ViolenceDomestique/pdf/Violence_conjugale_canton_Vaud_2001_Siggen_Hofner.pdf.

Holmes, Dave, and Patrick O'Byrne. 2006. "The Art of Public Health Nursing: Using Confession Technè in the Sexual Health Domain." *Journal of Advanced Nursing* 56 (4): 430–437.

Hopwood, Nick. 2015. *Haeckel's Embryos: Images, Evolution, and Fraud*. University of Chicago Press.

Howes-Mischel, Rebecca. 2017. "The 'Sound' of Life: Or, How Should We Hear a Fetal 'Voice'?" In *The Anthropology of the Fetus: Biology, Culture, and Society*, edited by Sallie Han, Tracy K. Betsinger, and Amy B. Scott, 252–275. Berghahn Books.

Hulbert, Ann. 2003. *Raising America: Experts, Parents, and a Century of Advice About Children*. Knopf.

Humbelin, Oliver, Lukas Hobi, and Robert Fluder. 2022. "Rich Cities, Poor Countryside? Social Structure of the Poor and Poverty Risks in Urban and Rural Places in an Affluent Country." *Local Economy* 37 (3): 169–193.

Huonker, Thomas. 1987. *Fahrendes Volk—verfolgt und verfemt: Jenische Lebensläufe*. Limmat Verlag.

———. 2002. *Anstaltseinweisungen, Kindswegnahmen, Eheverbote, Sterilisationen, Kastrationen: Fürsorge, Zwangsmassnahmen, "Eugenik" und Psychiatrie in Zürich zwischen 1890 und 1970*. Sozialdepartment der Stadt Zürich.

———. 2003. *Diagnose: "Moralisch defect." Kastration, Sterilisation und Rassenhygiene im Dienst der Schweizer Sozialpolitik, 1890–1970*. Orell Füssli Verlag.

Independent Expert Commission on Administrative Detention. 2019. *Mechanics of Arbitrariness: Administrative Detention in Switzerland. Final report*. Chronos Verlag, Editions Alphil, Edizioni Casagrande.

Inhorn, Marcia C. 2015. *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*. Duke University Press.

———. 2020. "Reproducing Men in the Twenty-First Century: Emergent Masculinities, Subjectivities, Biosocialities, and Technologies." *Norma* 15 (3–4): 299–305.

———. 2023. *Motherhood on Ice: The Mating Gap and Why Women Freeze Their Eggs*. New York University Press.

Inhorn, Marcia C., and Zeynep B. Gürtin. 2011. "Cross-Border Reproductive Care: A Future Research Agenda." *Reproductive Biomedicine Online* 23 (5): 665–676.

Inhorn, Marcia C., Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard. 2009. "The Second Sex in Reproduction? Men, Sexuality, and Masculinity." In *Reconceiving the Second Sex: Men, Masculinity, and Reproduction*, edited by Marcia C. Inhorn, Tine Tjørnhøj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard, 1–17. Berghahn Books.

Irigaray, Luce. 1977. *Ce sexe qui n'en est pas un*. Minuit.

Irion, Olivier, Michel Boulvain, Anne-Thérèse Straccia, and Jocelyne Bonnet. 2000. "Emotional, Physical and Sexual Violence Against Women Before or During Pregnancy." *British Journal of Obstetrics and Gynaecology* 107 (10): 1306–1308.

Ivry, Tsipy. 2010. *Embodying Culture: Pregnancy in Japan and Israel*. Rutgers University Press.

Jacques, Béatrice. 2007. *Sociologie de l'accouchement*. Presses universitaires de France.

Jasinski, Jana L. 2004. "Pregnancy and Domestic Violence: A Review of the Literature." *Trauma, Violence & Abuse* 5 (1): 47–64.

Jeanmonod, Gilles, and Geneviève Heller. 2000. "Eugénisme et contexte socio-politique: L'exemple de l'adoption d'une loi sur la stérilisation des handicapés et malades mentaux dans le canton de Vaud en 1928." *Revue suisse d'histoire* 50:20–44.

———. 2001. *Eugénisme et stérilisation non volontaire en Suisse romande durant le 20e siècle: Rapport final complet*. Institut romand d'histoire de la médecine.

Johnson, Bethany L., and Margaret M. Quinlan. 2019. *You're Doing It Wrong! Mothering, Media, and Medical Expertise*. Rutgers University Press.

Johnson, Candace. 2016. *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. Routledge.

Jordan, Brigitte. 1978. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. Eden Press.

Kanieski, Mary Ann. 2010. "Securing Attachment: The Shifting Medicalisation of Attachment and Attachment Disorders." *Health, Risk & Society* 12 (4): 335–344.

Karaian, Lara. 2013. "Pregnant Men: Repronormativity, Critical Trans Theory and the Re(conceive)ing of Sex and Pregnancy in Law." *Social and Legal Studies* 22 (2): 211–230.

Katz Rothman, Barbara. 1982. *In Labor: Women and Power in the Birthplace*. Norton.

———. 1986. *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*. Viking.

Keenan, Julia, and Helen Stapleton. 2010. "Bonny Babies? Motherhood and Nurturing in the Age of Obesity." *Health, Risk & Society* 12 (4): 369–383.

Kirczenow MacDonald, Trevor, Michelle Walks, MaryLynne Biener, and Alanna Kibbe. 2005. "Disrupting the Norms: Reproduction, Gender Identity, Gender Dysphoria, and Intersectionality." *International Journal of Transgender Health* 22 (1–2): 18–29.

Kline, Wendy. 2019. *Coming Home: How Midwives Changed Birth*. Oxford University Press.

Knaak, Stephanie J. 2010. "Contextualising Risk, Constructing Choice: Breastfeeding and Good Mothering in Risk Society." *Health, Risk & Society* 12 (4): 345–355.

Knibiehler, Yvonne. 2007. *Accoucher: Femmes, sages-femmes et médecins depuis le milieu du XXe siècle*. Editions ENSP.

König, Anika. 2023. "Reproductive Entanglements in Times of War: Transnational Gestational Surrogacy in Ukraine and Beyond." *Medical Anthropology* 42 (5): 479–492.

König, Anika, and Heather Jacobson. 2023. "Reprowebs: A Conceptual Approach to Elasticity and Change in the Global Assisted Reproduction Industry." *BioSocieties* 18 (1): 174–196.

König, Anika, Andrea Whittaker, Trudie Gerrits, and Virginie Rozée. 2022. "Shifting Surrogacies: Comparative Ethnographies." *International Journal of Comparative Sociology* 63 (5–6): 235–246.

Kristeva, Julia. 1983. "Stabat Mater." In *Histoires d'amour*, 225–247. Denoël.

Kukla, Rebecca. 2005. *Mass Hysteria: Medicine, Culture, and Mothers' Bodies*. Rowman & Littlefield.

———. 2010. "The Ethics and Cultural Politics of Reproductive Risk Warnings: A Case Study of California's Proposition 65." *Health, Risk & Society* 12 (4): 323–334.

Ladd-Taylor, Molly, and Lauri Umansky, eds. 1998a. *"Bad" Mothers: The Politics of Blame in Twentieth-Century America*. New York University Press.

———. 1998b. "Introduction." In *"Bad" Mothers: The Politics of Blame in Twentieth-Century America*, edited by Molly Ladd-Taylor and Lauri Umansky, 1–28. New York University Press.

Lambelet, Valentine, Michael Ceulemans, Hedvig Nordeng, Guillaume Favre, Antje Horsch, Milos Stojanov, Ursula Winterfeld, David Baud, Alice Panchaud, and Léo Pomar. 2021. "Impact of the COVID-19 Pandemic on Swiss Pregnant and Breastfeeding Women—a Cross-Sectional Study Covering the First Pandemic Wave." *Swiss Medical Weekly* 151 (3738): w30009.

Landecker, Hannah. 2011. "Food as Exposure: Nutritional Epigenetics and the New Metabolism." *BioSocieties* 6 (2): 167–194.

Lappé, Martine, and Robbin Jeffries Hein. 2021. "You Are What Your Mother Endured: Intergenerational Epigenetics, Early Caregiving, and the Temporal Embedding of Adversity." *Medical Anthropology Quarterly* 35 (4): 458–475.

Lareau, Annette. 2003. *Unequal Childhoods: Class, Race, and Family Life*. University of California Press.

Lavenex, Sandra. 2023. "Migration Policy." In *The Oxford Handbook of Swiss Politics*, edited by Patrick Emmenegger, Flavia Fossati, Silja Häusermann, Yannis Papadopoulos, Pascal Sciarini, and Adrian Vatter, 658–676. Oxford University Press.

Lee, Ellie. 2007. "Infant Feeding in Risk Society." *Health, Risk & Society* 9 (3): 295–309.

———. 2008. "Living with Risk in the Age of 'Intensive Motherhood': Maternal Identity and Infant Feeding." *Health, Risk & Society* 10 (5): 467–477.

———. 2014a. "Experts and Parenting Culture." In *Parenting Culture Studies*, edited by Ellie Lee, Jennie Bristow, Charlotte Faircloth, and Jan Macvarish, 51–75. Palgrave Macmillan.

———. 2014b. "Policing Pregnancy: The Pregnant Woman who Drinks." In *Parenting Culture Studies*, edited by Ellie Lee, Jennie Bristow, Charlotte Faircloth, and Jan Macvarish, 129–146. Palgrave Macmillan.

Lee, Ellie, Jennie Bristow, Rachel Arkell, and Clare Murphy. 2021. "Beyond 'the Choice to Drink' in a UK Guideline on FASD: The Precautionary Principle, Pregnancy Surveillance, and the Managed Woman." *Health, Risk & Society* 24 (1–2): 17–35.

Lee, Ellie, Jennie Bristow, Charlotte Faircloth, and Jan Macvarish, eds. 2014. *Parenting Culture Studies*. Palgrave Macmillan.

———. 2023. *Parenting Culture Studies*. 2nd ed. Palgrave Macmillan.

Lee, Ellie, Jan Macvarish, and Jennie Bristow. 2010. "Risk, Health and Parenting Culture." *Health, Risk & Society* 12 (4): 293–300.

Lee, Ellie, Robbie M. Sutton, and Bonny L. Hartley. 2016. "From Scientific Article to Press Release to Media Coverage: Advocating Alcohol Abstinence and Democratising Risk in a Story About Alcohol and Pregnancy." *Health, Risk & Society* 18 (5–6): 247–269.

Leibetseder, Doris. 2018. "Queer and Trans Access to Assisted Reproductive Technologies: A Comparison of Three EU-States, Poland, Spain and Sweden." *Journal of International Women's Studies* 20 (1): 10–26.

Leifer, Myra. 1977. "Psychological Changes Accompanying Pregnancy and Motherhood." *Genetic Psychology Monographs* 95 (1): 55–96.

———. 1980. "Pregnancy." *Signs: Journal of Women in Culture and Society* 5 (4): 754–765.

Leimgruber, Walter, Thomas Meier, and Roger Sablonier. 1998. *Das Hilfswerk für die Kinder der Landstrasse*. Schweizerisches Bundesarchiv.

Leslie, Leigh A., and Ashley L. Southard. 2009. "Thirty Years of Feminist Family Therapy: Moving into the Mainstream." In *Handbook of Feminist Family Studies*, edited by Sally A. Lloyd, April L. Few, and Katherine R. Allen, 328–339. Sage.

Leu, Robert E., and Stefan Burri. 1999. "Poverty in Switzerland." *Schweizerische Zeitschrift für Volkswirtschaft und Statistik* 135 (3): 303–328.

Levy, René, Eric Widmer, and Jean Kellerhals. 2002. "Modern Family or Modernized Family Traditionalism? Master Status and the Gender Order in Switzerland." *Electronic Journal of Sociology* 6 (4): 1–42.

Lowe, Pam, and Ellie Lee. 2010. "Advocating Alcohol Abstinence to Pregnant Women: Some Observations About British Policy." *Health, Risk & Society* 12 (4): 301–311.

Lowe, Pam, Ellie Lee, and Jan Macvarish. 2015. "Growing Better Brains? Pregnancy and Neuroscience Discourses in English Social and Welfare Policies." *Health, Risk & Society* 17 (1): 15–29.

Löwy, Ilana. 2014. "Prenatal Diagnosis: The Irresistible Rise of the 'Visible Fetus.'" *Studies in History and Philosophy of Biological and Biomedical Sciences* 47 (pt. B): 290–299.

———. 2017. *Imperfect Pregnancies: A History of Birth Defects and Prenatal Diagnosis*. Johns Hopkins University Press.

Luehrmann, Sonja. 2017. "Beyond Life Itself: The Embedded Fetuses of Russian Orthodox Anti-Abortion Activism." In *The Anthropology of the Fetus: Biology, Culture, and Society*, edited by Sallie Han, Tracy K. Betsinger, and Amy B. Scott, 227–251. Berghahn Books.

Luisier, Viviane, ed. 2006. *Sages-femmes: La cornette sous le paillasson? Évolution de la profession entre 1960 et 2000 à Genève: Contribution au débat sur la naissance*. Médecine & Hygiène.

Lupton, Deborah. 1999. "Risk and the Ontology of Pregnant Embodiment." In *Risk and Sociocultural Theory: New Directions and Perspectives*, edited by Deborah Lupton, 59–85. Cambridge University Press.

———. 2011. "'The Best Thing for the Baby': Mothers' Concepts and Experiences Related to Promoting Their Infants' Health and Development." *Health, Risk & Society* 13 (7–8): 637–651.

———. 2012. "'Precious Cargo': Foetal Subjects, Risk and Reproductive Citizenship." *Critical Public Health* 22 (3): 329–340.

———. 2013. *The Social Worlds of the Unborn*. Palgrave Macmillan.

Lyerly, Anne Drapkin, Lisa M. Mitchell, Elizabeth Mitchell Armstrong, Lisa H. Harris, Rebecca Kukla, Miriam Kuppermann, and Margaret Olivia Little. 2009. "Risk and the Pregnant Body." *Hastings Center Report* 39 (6): 34–42.

MacKendrick, Norah, and Teja Pristavec. 2019. "Between Careful and Crazy: The Emotion Work of Feeding the Family in an Industrialized Food System." *Food, Culture & Society* 22 (4): 446–463.

Macvarish, Jan. 2014. "Babies' Brains and Parenting Policy: The Insensitive Mother." In *Parenting Culture Studies*, edited by Ellie Lee, Jennie Bristow, Charlotte Faircloth, and Jan Macvarish, 165–183. Palgrave Macmillan.

———. 2016. *Neuroparenting: The Expert Invasion of Family Life*. Palgrave Macmillan.

Macvarish, Jan, and Claude Martin. 2022. "Towards a 'Parenting Regime': Globalising Tendencies and Localised Variation." In *The Palgrave Handbook of Family Sociology in Europe*, edited by Anna-Maija Castrén, Vida Česnuitytė, Isabella Crespi, Jacques-Antoine Gauthier, Rita Gouveia, Claude Martin, Almudena Morena Mínguez, and Katarzyna Suwada, 435–451. Palgrave Macmillan.

Madörin, Mascha, Brigitte Schnegg, and Nadia Baghdadi. 2012. "Advanced Economy, Modern Welfare State and Traditional Care Regimes: The Case of Switzerland." In *Global Variations in the Political and Social Economy of Care*, edited by Shahra Razavi and Silke Staab, 43–60. Routledge.

Madsen, Ole, J. 2014. *The Therapeutic Turn: How Psychology Altered Western Culture*. Routledge.

Maffi, Irene. 2013. "Can Caesarean Section Be 'Natural'? The Hybrid Nature of the Nature-Culture Dichotomy in Mainstream Obstetric Culture." *Tidsskrift for Forskning I Sygdom Og Samfund* 19:5–26.

———. 2014. "Les cours de préparation à la naissance dans une maternité suisse: Entre logiques institutionnelles, postures des sages-femmes et autonomie des couples." In *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*, edited by Claudine Burton-Jeangros, Raphaël Hammer, and Irene Maffi, 175–197. Giuseppe Merrone.

Maher, Jane Maree, Kate Fitz-Gibbon, Silke Meyer, Steven Roberts, and Naomi Pfitzner. 2021. "Mothering Through and in Violence: Discourses of the 'Good Mother.'" *Sociology* 55 (4): 659–676.

Manatschal, Anita. 2023. "Integration Policy." In *The Oxford Handbook of Swiss Politics*, edited by Patrick Emmenegger, Flavia Fossati, Silja Häusermann, Yannis Papadopoulos, Pascal Sciarini, and Adrian Vatter, 677–694. Oxford University Press.

Manderson, Lenore. 2016. "Foetal Politics and the Prevention of Chronic Disease." *Australian Feminist Studies* 31 (88): 154–171.

Manderson, Lenore, and Fiona C. Ross. 2020. "Publics, Technologies and Interventions in Reproduction and Early Life in South Africa." *Humanities and Social Sciences Communications* 7 (1): 1–9.

Mansfield, Becky. 2012. "Race and the New Epigenetic Biopolitics of Environmental Health." *BioSocieties* 7 (4): 352–372.

Marcé, Louis V. 1858. *Traité de la folie des femmes enceintes des nouvelles accouchées et des nourrices*. L'Harmattan.

Markens, Susan, C. H. Browner, and Nancy Press. 1997. "Feeding the Fetus: On Interrogating the Notion of Maternal-Fetal Conflict." *Feminist Studies* 23 (2): 351–372.

Marshall, Harriette, and Anne Woollett. 2000. "Fit to Reproduce? The Regulative Role of Pregnancy Texts." *Feminism & Psychology* 10 (3): 351–366.

McCutcheon, Helen H. I., and Jan Pincombe. 2001. "Intuition: An Important Tool in the Practice of Nursing." *Journal of Advanced Nursing* 35 (3): 342–348.

Memmi, Dominique. 2003. *Faire vivre et laisser mourir: Le gouvernement contemporain de la naissance et de la mort*. La Découverte.

Ministère du travail, de la santé, des solidarités et des familles. 2024. "L'entretien prénatal précoce." Accessed September 3. https://sante.gouv.fr/prevention-en-sante/sante-des-populations/1000jours/EPP.

Missonnier, Sylvain. 2001. "Le bébé, la maternité et la prévention." In *Le bébé et ses institutions*, edited by Pierre Delion, 53–66. Erès.

———. 2005. *La consultation thérapeutique périnatale: Un psychologue à la maternité*. Erès.

———. 2007a. "La parentalité prénatale, la préparation à la naissance et l'entretien précoce." *Contraste* 26 (1): 55.

———. 2007b. "La prévention, l'anticipation et la prédiction." *Spirale* 41 (1): 85–96.

———. 2011. "Stress, grossesse et psychanalyse: Spinoza avait raison!" In *Stress et grossesse: Quelle prévention pour quel risque?*, edited by Luc Roegiers and Françoise Molénat, 115–132. Erès.

———. 2013. "Grossesse, stress et psychanalyse: Un débat primordial." *La psychiatrie de l'enfant* 56 (1): 37–66.

———. 2023. "The Genesis of Perinatal Clinical Psychology and Its Contemporary Issues." *Frontiers in Psychiatry* 14 (7): 1090365.

Mohr, Sebastian, and Rene Almeling. 2020. "Men, Masculinities, and Reproduction—Conceptual Reflections and Empirical Explorations." *Norma* 15 (3–4): 163–171.

Molénat, Françoise. 1992. *Mères vulnérables: Les maternités s'interrogent*. Stock-Laurence Pernoud.

———. 2001. *Naissances: Pour une éthique de la prévention*. Erès.

———. 2004. "Périnatalité et prévention en santé mentale: Collaboration médico-psychologique en périnatalité." Accessed September 3, 2025. https://pia.ac-paris.fr/portail/jcms/p1_517108/rapport-perinatalite-et-prevention-en-sante-mentale-collaboration-medico-psychologique-en-perinatalite?details=true.

Morgan, Lynn M. 1997. "Imagining the Unborn in the Ecuadoran Andes." *Feminist Studies* 23 (2): 322–350.

———. 2009. *Icons of Life: A Cultural History of Human Embryos*. University of California Press.

Morgan, Lynn M., and Meredith W. Michaels, eds. 1999. *Fetal Subjects, Feminist Positions*. University of Pennsylvania Press.

Morgan, Lynn M., and Elizabeth F. S. Roberts. 2012. "Reproductive Governance in Latin America." *Anthropology & Medicine* 19 (2): 241–254.

Mottier, Véronique. 2000. "Narratives of National Identity: Sexuality, Race, and the Swiss 'Dream of Order.'" *Revue suisse de sociologie* 26 (3): 533–558.

———. 2005. "From Welfare to Social Exclusion: Eugenic Policies and the Swiss National Order." In *Discourse Theory in European Politics: Identity, Policy, Governance*, edited by David Howarth and Jacob Torfing, 255–274. Palgrave Macmillan.

———. 2006. "Eugenics and the Swiss Gender Regime: Women's Bodies and the Struggle Against Difference." *Revue suisse de sociologie* 32 (2): 253–267.

———. 2008. "Eugenics, Politics and the State: Social Democracy and the Swiss 'Gardening State.'" *Studies in History and Philosophy of Biological and Biomedical Sciences* 39 (2): 263–269.

Mulla, Sameena. 2014. *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*. New York University Press.

Murphy, Elizabeth. 2000. "Risk, Responsibility, and Rhetoric in Infant Feeding." *Journal of Contemporary Ethnography* 29 (3): 291–325.

———. 2003. "Expertise and Forms of Knowledge in the Government of Families." *Sociological Review* 51 (4): 433–462.

Murray, Suellen, and Anastasia Powell. 2009. "'What's the Problem?' Australian Public Policy Constructions of Domestic and Family Violence." *Violence Against Women* 15 (5): 532–552.

Nahman, Michal. 2013. *Extractions: An Ethnography of Reproductive Tourism*. Palgrave Macmillan.

Nanzer, Nathalie, and Manuella Epiney. 2013. "Entretien prénatal genevois: Préparer à la parentalité et dépister les troubles émotionnels." *Revue médicale suisse* 9:1841–1845.

———. 2015. "L'entretien prénatal genevois: Etude de faisabilité et de satisfaction pour les femmes enceintes." *Revue de médecine périnatale* 7 (1): 55–62.

Nash, Meredith. 2008. "3D Fetuses and Disappearing Mothers: Rethinking the Politics of Ultrasonography." In *Mother Knows Best: Talking Back to the "Experts,"* edited by Jessica Nathanson and Laura Camille Tuley, 46–57. Demeter Press.

Nay, Yv E. 2017. *Feeling Family: Affektive Paradoxien der Normalisierung von "Regenbogenfamilien."* Zaglossus.

———. 2019. "Homonormative und nationalistische Politiken des Fortschritts in Debatten um nicht-hegemoniale Familien und Verwandtschaft." *Gender: Zeitschrift für Geschlecht, Kultur und Gesellschaft* 11 (2): 41–55.

Neyrand, Gérard. 2007. "Conflit des modèles de prévention psychique précoce: A propos de la publication du rapport de l'INSERM." *Informations sociales* 140:64–73.

Nobs, Lucette, and Nicolas de Coulon. 2014. "La psychanalyse à Lausanne, entre crise de filiation et construction groupale." *Le Coq-héron* 218 (3): 90–103.

Oakley, Ann. 1984. *The Captured Womb: A History of the Medical Care of Pregnant Women*. Blackwell.

Oaks, Laury. 2000. "Smoke-Filled Wombs and Fragile Fetuses: The Social Politics of Fetal Representation." *Signs: Journal of Women in Culture and Society* 26 (1): 63–108.

———. 2001. *Smoking and Pregnancy: The Politics of Fetal Protection*. Rutgers University Press.

Odier, Lorraine. 2018. *Métamorphoses de la figure parentale: Analyse des discours de l'Ecole des parents de Genève (1950 à 2010)*. Antipodes.

O'Doherty, Lorna, Kelsey Hegarty, Jean Ramsay, Leslie L. Davidson, Gene Feder, and Angela Taft. 2015. "Screening Women for Intimate Partner Violence in Healthcare Settings." *Cochrane Database of Systematic Reviews* 2015 (7): CD007007.

Ossipow, Laurence, Anne Laure Counilh, and Milena Chimienti. 2019. "Racialization in Switzerland: Experiences of Children of Refugees from Kurdish, Tamil and Vietnamese Backgrounds." *Comparative Migration Studies* 7 (1): 19.

Paltrow, Lynn M., and Jeanne Flavin. 2013. "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health." *Journal of Health Politics, Policy and Law* 38 (2): 299–343.

Parker, George, and Cat Pausé. 2018. "Pregnant with Possibility: Negotiating Fat Maternal Subjectivity in the 'War on Obesity.'" *Fat Studies* 7 (2): 124–134.

Pentecost, Michelle. 2018. "The First Thousand Days: Epigenetics in the Age of Global Health." In *The Palgrave Handbook of Biology and Society*, edited by Maurizio Meloni, John Cromby, Fitzgerald Des, and Stephanie Lloyd, 269–294. Palgrave Macmillan.

———. 2024. *The Politics of Potential: Global Health and Gendered Futures in South Africa*. Rutgers University Press.

Pentecost, Michelle, and Fiona Ross. 2019. "The First Thousand Days: Motherhood, Scientific Knowledge, and Local Histories." *Medical Anthropology* 38 (8): 747–761.

Perrenoud, Patricia. 2014. "Naissance et évolution des pratiques: Entre Evidence-Based Medicine, expérience et intuition." In *Accompagner la naissance: Terrains socio-anthropologiques en Suisse romande*, edited by Claudine Burton-Jeangros, Raphaël Hammer, and Irene Maffi, 133–153. Giuseppe Merrone.

Perrenoud, Patricia, Christelle Kaech, and Caroline Chautems. 2023. "Immigrant Women Looking for Information About the Perinatal Period on Digital Media: A Qualitative Study." *Women and Birth* 36 (3): e341–e352.

Perrone, Reynaldo, and Martine Nannini. 1995. *Violence et abus sexuels dans la famille: Une approche systémique et communicationnelle*. ESF.

Petchesky, Rosalind Pollack. 1987. "Fetal Images: The Power of Visual Culture in the Politics of Reproduction." In *Reproductive Technologies: Gender, Motherhood and Medicine*, edited by Michelle Stanworth, 57–80. Polity Press.

Pilgrim, David. 2015. "The Biopsychosocial Model in Health Research: Its Strengths and Limitations for Critical Realists." *Journal of Critical Realism* 14 (2): 164–180.

Pincus, Jane, and Ruth Bell. 1970. "Pregnancy." In *Women and Their Bodies: A Course*, edited by Boston Women's Health Collective. New England Free Press.

Preissler, Laura. 2022a. "Accompanying Parents Through Early Childhood: the Pastoral Work of Mothers' and Fathers' Advisors." *Intersections* 8 (3): 66–82.

———. 2022b. "Governing Parents: Early Childhood, Intensive Mothering and Disciplinary Power in Switzerland." PhD diss., University of Lucerne.

Price, Sally, Kathleen Baird, and Debra Salmon. 2005. "Asking the Question: Antenatal Domestic Violence." *The Practicing Midwife* 8 (3): 21–25.

Purtschert, Patricia, Barbara Lüthi, and Francesca Falk, eds. 2012. *Postkoloniale Schweiz: Formen und Folgen eines Kolonialismus ohne Kolonien*. Transcript.

Purtschert, Patricia, and Harald Fischer-Tiné, eds. 2015. *Colonial Switzerland: Rethinking Colonialism from the Margins*. Palgrave Macmillan.

Quagliarello, Chiara. 2017. "L'accouchement naturel contre l'hôpital moderne? Une étude de cas en Italie." *Anthropologie & santé* 15:1–21.

Racamier, Paul-Claude, Charles Sens, and Louis Carretier. 1961. "La mère et l'enfant dans les psychoses du post-partum." *Evolution psychiatrique* 26 (4): 525–570.

Rapp, Rayna. 1988. "Chromosomes and Communication: The Discourse of Genetic Counseling." *Medical Anthropology Quarterly* 2 (2): 143–157.

———. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. Routledge.

Razurel, Chantal. 2015. *Se révéler et se construire comme mère: L'entretien psycho-éducatif périnatal*. Editions Médecine et Hygiène.

Razurel, Chantal, Jean-Philippe Antonietti, Françoise Rulfi, Nadia Pasquier, Sophie Dominguez-Montanari, and Joëlle Darwiche. 2017. "The Impact of Pre- and Post-Natal Psycho-Educational Intervention on the Construction of Parenthood." *Archives of Women's Mental Health* 20 (3): 469–472.

Razurel, Chantal, Valérie Avignon, Pascale Gerdy, and Jocelyne Bouton. 2016. "Postpartum Psycho-Educational Interviews to Promote Adaptation in New Mothers: A Preliminary Study." *Journal of Nursing Education and Practice* 7 (2): 1–9.

Razurel, Chantal, Maryse Benchouk, Jocelyne Bonnet, Susanna El Alama, Graziella Jarabo, and Bérangère Pierret. 2010. "Comment les mères primipares font-elles face aux événements de la naissance dans le post-partum? Une démarche qualitative." *La Revue Sage-Femme* 9 (5): 240–249.

Razurel, Chantal, Barbara Kaiser, Marc Dupuis, Jean-Philippe Antonietti, Catherine Citherlet, Manuella Epiney, and Catherine Sellenet. 2014. "Validation of the Antenatal Perceived Stress Inventory." *Journal of Health Psychology* 19 (4): 471–481.

Razurel, Chantal, Barbara Kaiser, Marc Dupuis, Jean-Philippe Antonietti, Catherine Sellenet, and Manuela Epiney. 2014. "Validation of the Post-Delivery Perceived Stress Inventory." *Psychology, Health & Medicine* 19 (1): 70–82.

Razurel, Chantal, Barbara Kaiser, Catherine Sellenet, and Manuela Epiney. 2013. "Relation Between Perceived Stress, Social Support, and Coping Strategies and Maternal Well-Being: A Review of the Literature." *Women & Health* 53 (1): 74–99.

Rexer, Gala. 2021. "Borderlands of Reproduction: Bodies, Borders, and Assisted Reproductive Technologies in Israel/Palestine." *Ethnic and Racial Studies* 44 (9): 1549–1568.

Rey, Jeanne. 2019. "Grossesse chez un homme trans: Suivi et accompagnement." *Obstetrica* 10:58–61.

———. 2021. "Travaille-t-on mieux ensemble aujourd'hui?" *Obstetrica* 10:52–57.

———. 2022. "La diversité façonne notre activité de sages-femmes." *Obstetrica* 7:42–48.

Richardson, Sarah S. 2015. "Maternal Bodies in the Postgenomic Order: Gender and the Explanatory Landscape of Epigenetics." In *Postgenomics: Perspectives on Biology After the Genome*, edited by Sarah Richardson and Hallam Stevens, 210–231. Duke University Press.

———. 2021. *The Maternal Imprint: The Contested Science of Maternal-Fetal Effects*. University of Chicago Press.

Rieder, Philip, ed. 2007. *A l'orée de la vie: Cent ans de gynécologie et d'obstétrique à la Maternité de Genève (1907–2007)*. Médecine & Hygiène.

Rietmann, Felix E. 2023. "Von der Systemanalyse zum Familiennarrativ: Die Anfänge der Kleinkindpsychiatrie in Lausanne." In *Das Problem Kind—Zur Geschichte der Kinder- und Jugendpsychiatrie der Schweiz im 20. Jahrhundert*, edited by Mirjam Janett, Urs Hafner, and Urs Germann, 79–93. Schwabe Verlag.

Roberts, Dorothy. 2015. "Reproductive Justice, Not Just Rights." *Dissent* 62 (4): 79–82.

Roberts, Marc. 2005. "The Production of the Psychiatric Subject: Power, Knowledge and Michel Foucault." *Nursing Philosophy* 6 (1): 33–42.

Román-Gálvez, Rosario M., Sandra Martín-Peláez, Borja M. Fernández-Félix, Javier Zamora, Khalid S. Khan, and Aurora Bueno-Cavanillas. 2021. "Worldwide Prevalence of Intimate Partner Violence in Pregnancy: A Systematic Review and Meta-Analysis." *Frontiers in Public Health* 9:738459.

Romito, Patrizia. 1990. *La naissance du premier enfant: Etude psycho-sociale de l'expérience de la maternité et de la dépression post-partum*. Delachaux et Niestlé.

———. 2006. *Un silence de mortes: La violence masculine occultée*. Syllepse.

Rondeau, Gilles, Normand Brodeur, and Nicolas Carrier. 2001. *L'intervention systémique et familiale en violence conjugale: Fondements, modalités, efficacité et controverses*. Centre de recherché interdisciplinaire sur la violence familiale et la violence faite aux femmes.

Rose, Nikolas. 1990. *Governing the Soul: The Shaping of the Private Self*. Routledge.

Ross, Loretta J., and Rickie Solinger. 2017. *Reproductive Justice: An Introduction*. University of California Press.

Rossier, Clémentine, Laura Bernardi, and Claudine Sauvain-Dugerdil, eds. 2023. *Diversité des familles et bien-être en Suisse: Enquêtes sur les familles et les générations 2013 et 2018*. Seismo.

Ruhl, Lealle. 1999. "Liberal Governance and Prenatal Care: Risk and Regulation in Pregnancy." *Economy and Society* 28 (1): 95–117.

Russell, Camisha. 2015. "The Race Idea in Reproductive Technologies: Beyond Epistemic Scientism and Technological Mastery." *Journal of Bioethical Inquiry* 12 (4): 601–612.

Rutherford, Julienne. 2017. "The Borderless Fetus: Temporal Complexity of the Lived Fetal Experience." In *The Anthropology of the Fetus: Biology, Culture, and Society*, edited by Sallie Han, Tracy K. Betsinger, and Amy B. Scott, 15–33. Berghahn Books.

Salmon, Debra, Kathleen M. Baird, and Paul White. 2015. "Women's Views and Experiences of Antenatal Enquiry for Domestic Abuse During Pregnancy." *Health Expectations* 18 (5): 867–878.

Sami, Janesh, Katharina C. Quack Lotscher, Isabelle Eperon, Lea Gonik, Begoña Martinez de Tejada, Manuella Epiney, and Nicole C. Schmidt. 2019. "Giving Birth in Switzerland: a Qualitative Study Exploring Migrant Women's Experiences During Pregnancy and Childbirth in Geneva and Zurich Using Focus Groups." *Reproductive Health* 16 (1): 112.

Sancho Rossignol, Ana, and Nathalie Nanzer. 2010. "L'entretien prénatal: Un outil de prévention de la dépression périnatale et de soutien à la parentalité." Unpublished report.

Sänger, Eva. 2015. "Obstetrical Care as a Matter of Time: Ultrasound Screening, Temporality and Prevention." *History and Philosophy of the Life Sciences* 37 (1): 105–120.

Santino, Hannah, and Lee F. Monaghan. 2023. "(F)ailing Mothers and the Quest for Redemption: A Sociological Study of Postnatal Depression Recovery Blogs." *Social Theory & Health* 22 (1): 18–35.

Saugy, Aude, and Gaëlle Aeby. 2021. "Les familles issues de la migration dans les audiences de protection de l'enfant en Suisse." *TSANTSA—Journal of the Swiss Anthropological Association* 26:195–202.

Schulz, Kristina, and Leena Schmitter. 2022. "Women's Liberation and the 'Right to Choose': Struggling for Abortion in the United Kingdom and Switzerland." In *A Fragmented Landscape: Abortion Governance and Protest Logics in Europe*, edited by Silvia De Zordo, Joanna Mishtal, and Lorena Anton, 66–82. Berghahn Books.

Schwennesen, Nete, and Tine M. Gammeltoft. 2022. "Prenatal Screening and Diagnosis." In *The Routledge Handbook of Anthropology and Reproduction*, edited by Sallie Han and Cecilia Tomori, 339–350. Routledge.

Shaw, Rachel L., and David C. Giles. 2009. "Motherhood on Ice? A Media Framing Analysis of Older Mothers in the UK News." *Psychology and Health* 24 (2): 221–236.

Shepherd, Marie Louise. 2011. "Behind the Scales: Child and Family Health Nurses Taking Care of Women's Emotional Wellbeing." *Contemporary Nurse: A Journal for the Australian Nursing Profession* 37 (2): 137–148.

Siegl, Veronika. 2023. *Intimate Strangers: Commercial Surrogacy in Russia and Ukraine and the Making of Truth*. Cornell University Press.

Siegl, Veronika, Christine Bigler, Tina Büchler, Laura Perler, and Carolin Schurr. 2021. *Transnationale Reproduktive Mobilität aus der Schweiz*. Accessed September 3, 2025. https://backend.bag.admin.ch/fileservice/sdweb-docs-prod-bagadminch-files/files/2025/03/18/2e813864-2525-436a-b138-cc85ea44133e.pdf.

Silverstein, Louise B., and Thelma Jean Goodrich. 2003. *Feminist Family Therapy: Empowerment in Social Context*. American Psychological Association.

Símonardóttir, Sunna, Annadís Greta Rúdólfsdóttir, and Helga Gottfreðsdóttir. 2021. "'We At Least Say We Are Equal': Gender Equality and Class in Healthcare Professionals' Discursive Framing of Migrant Mothers." *Social Science & Medicine* 281 (7): 114089.

Simonds, Wendy. 2002. "Watching the Clock: Keeping Time During Pregnancy, Birth, and Postpartum Experiences." *Social Science & Medicine* 55 (4): 559–570.

SisterSong. n.d. "What Is Reproductive Justice?" Accessed September 3, 2025. https://www.sistersong.net/reproductive-justice.

Smietana, Marcin. 2024. "Unreproductive Citizenship: Social Sterilisation of Queer and Trans People in Poland." *Women's Studies International Forum* 105:102948.

Smietana, Marcin, Charis Thompson, and France Winddance Twine. 2018. "Making and Breaking Families: Reading Queer Reproductions, Stratified Reproduction and Reproductive Justice Together." *Reproductive Biomedicine and Society Online* 7 (11): 112–130.

Société Suisse de Pédiatrie. 2011. *Checklists pour les examens de prévention.* Accessed September 3, 2025. https://cdn.paediatrieschweiz.ch/production/uploads/2024/02/Checkliste_mit-Zusatzuntersuchung_fr_Formular.pdf.

Spitz, René A. 1945. "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood." *Psychoanalytic Study of the Child* 1 (1): 53–74.

———. 1951. "The Psychogenic Diseases in Infancy: An Attempt at Their Etiologic Classification." *Psychoanalytic Study of the Child* 6 (1): 255–275.

Stevenson, Lisa. 2014. *Life Beside Itself: Imagining Care in the Canadian Arctic*. University of California Press.

Svendsen, Mette N. 2015. "Selective Reproduction: Social and Temporal Imaginaries for Negotiating the Value of Life in Human and Animal Neonates." *Medical Anthropology Quarterly* 29 (2): 178–195.

———. 2021. *Near Human: Border Zones of Species, Life, and Belonging*. Rutgers University Press.

Symonds LeBlanc, Sarah. 2020. "'Surveilling the Maternal Body': A Critical Examination Through Foucault's Panopticon." *Qualitative Report* 25 (11): 3885–3901.

Taft, Angela. 2002. "Violence Against Women in Pregnancy and After Childbirth: Current Knowledge and Issues in Health Care Responses." *Australian Domestic & Family Violence Clearinghouse* 6:1–23.

Tavory, Iddo, and Nina Eliasoph. 2013. "Coordinating Futures: Toward a Theory of Anticipation." *American Journal of Sociology* 118 (4): 908–942.

Taylor, Janelle S. 1992. "The Public Fetus and the Family Car: From Abortion Politics to a Volvo Advertisement." *Public Culture* 4 (2): 67–80.

Teman, Elly, and Tsipy Ivry. 2022. "Pregnancy and the Anthropology of Reproduction." In *The Routledge Handbook of Anthropology and Reproduction*, edited by Sallie Han and Cecília Tomori, 383–395. Routledge.

Thelen, Tatjana. 2015. "Care as Social Organization: Creating, Maintaining and Dissolving Significant Relations." *Anthropological Theory* 15 (4): 497–515.

Thurston, Wilfreda E., Jill Cory, and Cathie M. Scot. 1998. "Building a Feminist Theoretical Framework for Screening of Wife-Battering: Key Issues to Be Addressed." *Patient Education and Counseling* 33 (3): 299–304.

Toze, Michael. 2018. "The Risky Womb and the Unthinkability of the Pregnant Man: Addressing Trans Masculine Hysterectomy." *Feminism & Psychology* 28 (2): 194–211.

Trein, Philipp, Christian Rüefli, and Adrian Vatter. 2023. "Health Policy." In *The Oxford Handbook of Swiss Politics*, edited by Patrick Emmenegger, Flavia Fossati, Silja Häusermann, Yannis Papadopoulos, Pascal Sciarini, and Adrian Vatter, 714–732. Oxford University Press.

Trombetta, Tommaso, Maura Giordano, Fabrizio Santoniccolo, Laura Vismara, Anna Maria Della Vedova, and Luca Rollè. 2021. "Pre-Natal Attachment and Parent-to-Infant Attachment: A Systematic Review." *Frontiers in Psychology* 12 (3): 620942–620942.

Tseris, Emma. 2022. "The Psychiatric Surveillance of Pregnancy and Early Parenting." In *Troubled Persons Industries: The Expansion of Psychiatric Categories Beyond Psychiatry*, edited by Martin Harbush, 171–191. Springer.

UNICEF. 2023. *Innocenti Report Card 18: Child Poverty in the Midst of Wealth*. Accessed September 3, 2025. https://www.unicef.org/innocenti/media/3296/file/UNICEF-Innocenti-Report-Card-18-Child-Poverty-Amidst-Wealth-2023.pdf.

Ussher, Jane M. 2006. *Managing the Monstrous Feminine: Regulating the Reproductive Body*. Routledge.

Valdez, Natali. 2018. "The Redistribution of Reproductive Responsibility: On the Epigenetics of 'Environment' in Prenatal Interventions." *Medical Anthropology Quarterly* 32 (3): 425–442.

Valentine, Deborah P. 1982. "The Experience of Pregnancy: A Developmental Process." *Family Relations* 31 (2): 243–248.

Valsangiacomo, Nelly, Thierry Delessert, Laura Bertini-Soldà, Spartaco Greppi, Jean-Michel Bonvin, Chiara Boraschi, and Gwenaëlle Bhasin. 2024. "Mériter l'assistance par le travail: Les mères seules et les héroïnomanes au travers du prisme des médias audiovisuels (1960–aujourd'hui)." In *Entre protection et coercition: Normes et pratiques au fil du temps*, edited by Christoph Häfeli, Martin Lengwiler, and Margot Vogel Campanello, 85–98. Schwabe Verlag.

Vandenbroeck, Michel, Rudi Roose, and Maria De Bie. 2011. "Governing Families in the Social Investment State." *International Critical Childhood Policy Studies* 4 (1): 69–85.

van der Ploeg, Irma. 2002. *Prosthetic Bodies: The Construction of the Fetus and the Couple as Patients in Reproductive Technologies*. Kluwer Academic.

Van de Wiel, Lucy. 2020. *Freezing Fertility: Oocyte Cryopreservation and the Gender Politics of Aging*. New York University Press.

Vertommen, Sigrid. 2017. "From the Pergonal Project to Kadimastem: A Genealogy of Israel's Reproductive-Industrial Complex." *BioSocieties* 12 (2): 282–306.

Vertommen, Sigrid, Bronwyn Parry, and Michal Nahman. 2022. "Introduction: Global Fertility Chains and the Colonial Present of Assisted Reproductive Technologies." *Catalyst: Feminism, Theory, Technoscience* 8 (1): 1–17.

Villé, Yves. 2023. "Planification d'une nouvelle politique de périnatalité en France." *La revue du praticien* 73 (4): 367–369.

Vozari, Anne-Sophie. 2012. "Surveiller pour veiller sur en Protection Maternelle et Infantile." In *La maternité à l'épreuve du genre: Métamorphoses et permanences de la maternité dans l'aire Méditerranéenne*, edited by Yvonne Knibielher, Francesca Arena, and Rosa Maria Cid Lopez, 109–116. Presses de l'EHESP.

Vuille, Marilène. 2005. "Le militantisme en faveur de l'Accouchement sans douleur." *Nouvelles questions féministes* 24 (3): 50–67.

———. 2009. *Les sages-femmes vaudoises face à l'accouchement sans douleur (ASD) (1950–1989): Rapport de recherche remis au Réseau d'Etudes Appliquées des Pratiques de Santé, de Réadaptation et de Ré/insertion (RéSaR), Haute Ecole de la Santé, Genève*. Accessed September 3, 2025. https://www.ecolelasource.ch/wp-content/uploads/stories/articles_attachement/recherche_prestations/RapportMV.pdf.

Waggoner, Miranda R. 2017. *The Zero Trimester: Pre-Pregnancy Care and the Politics of Reproductive Risk*. University of California Press.

Walks, Michelle. 2015. "Masculine Pregnancy: Butch Lesbians', Trans Men's and Genderqueer Individuals' Experiences." In *Natal Signs: Cultural Representations of Pregnancy, Birth and Parenting*, edited by Nadia Burton, 41–57. Demeter Press.

———. 2018. "The Gender of Pregnancy." In *Global Currents in Gender and Feminisms: Canadian and International Perspectives*, edited by Glenda Tibe Bonifacio, 181–194. Emerald.

Walters, Marianne. 1990. "A Feminist Perspective in Family Therapy." In *Gender and Power in Families*, edited by Ann C. Miller and Rosine Jozef Perelberg, 13–33. Routledge.

Wanner, Philippe. 2020. "Adverse Perinatal Outcomes Among Children in Switzerland: The Impact of National Origin and Socio-Economic Group." *International Journal of Public Health* 65 (9): 1613–1621.

Wanner, Philippe, and Paola Bollini. 2017. "The Contribution of the Foreign Population to the High Level of Infant Mortality in Switzerland: A Demographic Analysis." *BMC Pregnancy and Childbirth* 17 (1).

Wecker, Regina. 1998a. "Eugenik: Individueller Ausschluss und nationaler Konsens." In *Krisen und Stabilisierung: Die Schweiz in der Zwischenkriegszeit*, edited by Sébastien Guex, Brigitte Studer, Bernard Degen, Markus Kübler, Edzard Schade, and Béatrice Ziegler, 165–179. Chronos.

———. 1998b. "Frauenkörper, Volkskörper, Staatskörper: Zu Eugenik und Politik in der Schweiz." In *Frauen und Staat: Bericht des schweizerischen Historikertages in Bern, Oktober 1996*, edited by Brigitte Studer, Regina Wecker, and Béatrice Ziegler, 209–226. Schwabe.

———. 2003. "Vom Verbot, Kinder zu haben, und dem Recht, keine Kinder zu haben: Zu Geschichte und Gegenwart der Sterilisation in Schweden, Deutschland und der Schweiz." *Figurationen* 4 (2): 101–119.

Weir, Lorna. 1996. "Recent Developments in the Government of Pregnancy." *Economy and Society* 25 (3): 373–392.

———. 2006. *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject*. Routledge.

Weissman, Anna L. 2017. "Repronormativity and the Reproduction of the Nation-State: The State and Sexuality Collide." *Journal of GLBT Family Studies* 13 (3): 277–305.

Wertz, Richard W., and Dorothy C. Wertz. 1977. *Lying-In: A History of Childbirth in America*. Free Press.

Whittaker, Andrea. 2018. *International Surrogacy as Disruptive Industry in Southeast Asia*. Rutgers University Press.

Wolff, Hans, Manuella Epiney, Ana P. Lourenco, Michael C. Costanza, Jacqueline Delieutraz-Marchand, Nicole Andreoli, Jean-Bernard Dubuisson, Jean-Michel Gaspoz, and Olivier Irion. 2008. "Undocumented Migrants Lack Access to Pregnancy Care and Prevention." *BMC Public Health* 8 (1): 93.

Woliver, Laura R. 2002. *The Political Geographies of Pregnancy*. University of Illinois Press.

World Health Organization. 2010. *Framework for Action on Interprofessional Education and Collaborative Practice*. Accessed September 3, 2025. https://iris.who.int/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1.

———. 2011. *Intimate Partner Violence During Pregnancy*. Accessed September 3, 2025. https://iris.who.int/bitstream/handle/10665/70764/WHO_RHR_11.35_eng.pdf?sequence=1.

Yates-Doerr, Emily. 2011. "Kinship. Bodily Betrayal: Love and Anger in the Time of Epigenetics." In *A Companion to the Anthropology of the Body and Embodiment*, edited by Frances E. Mascia-Lees, 292–306. John Wiley & Sons.

Young, Iris Marion. 1984. "Pregnant Embodiment: Subjectivity and Alienation." *Journal of Medicine and Philosophy* 9 (1): 45–62.

Ziegler, Béatrice, Gisela Hauss, and Martin Lengwiler, eds. 2018. *Zwischen Erinnerung und Aufarbeitung: Fürsorgerische Zwangsmassnahmen an Minderjährigen in der Schweiz im 20. Jahrhundert*. Chronos.

Zimmermann, Regula, and Jean-Marie LeGoff. 2020. "The Transition to Parenthood in the French and German Speaking Parts of Switzerland." *Social Inclusion* 8 (4): 35–45.

Zschirnt, Eva. 2020. "Evidence of Hiring Discrimination Against the Second Generation: Results from a Correspondence Test in the Swiss Labour Market." *Journal of International Migration and Integration* 21 (2): 563–585.

Zwarenstein, Merrick, Joanne Goldman, and Scott Reeves. 2009. "Interprofessional Collaboration: Effects of Practice-Based Interventions on Professional Practice and Healthcare Outcomes." *Cochrane Database of Systematic Reviews* 7 (3): CD000072.

INDEX

ABOUT THE AUTHOR

EDMÉE BALLIF is a research affiliate at the Department of social anthropology and cultural studies of the University of Zurich as well as the coordinator of the gender studies platform of the University of Lausanne. She is the cofounder of SwissRepro, the Swiss research network in reproductive studies.

Available titles in the Medical Anthropology:
Health, Inequality, and Social Justice series:

Carina Heckert, *Fault Lines of Care: Gender, HIV, and Global Health in Bolivia*

Joel Christian Reed, *Landscapes of Activism: Civil Society and HIV and AIDS Care in Northern Mozambique*

Alison Heller, *Fistula Politics: Birthing Injuries and the Quest for Continence in Niger*

Jessica Hardin, *Faith and the Pursuit of Health: Cardiometabolic Disorders in Samoa*

Beatriz M. Reyes-Foster, *Psychiatric Encounters: Madness and Modernity in Yucatan, Mexico*

Sonja van Wichelen, *Legitimating Life: Adoption in the Age of Globalization and Biotechnology*

Andrea Whittaker, *International Surrogacy as Disruptive Industry in Southeast Asia*

Lesley Jo Weaver, *Sugar and Tension: Diabetes and Gender in Modern India*

Ellen Block and Will McGrath, *Infected Kin: Orphan Care and AIDS in Lesotho*

Nolan Kline, *Pathogenic Policing: Immigration Enforcement and Health in the U.S. South*

Ciara Kierans, *Chronic Failures: Kidneys, Regimes of Care, and the Mexican State*

Stéphanie Larchanché, *Cultural Anxieties: Managing Migrant Suffering in France*

Dvera I. Saxton, *The Devil's Fruit: Farmworkers, Health, and Environmental Justice*

Siri Suh, *Dying to Count: Post-Abortion Care and Global Reproductive Health Politics in Senegal*

Vania Smith-Oka, *Becoming Gods: Medical Training in Mexican Hospitals*

Daria Trentini, *At Ansha's: Life in the Spirit Mosque of a Healer in Mozambique*

Mette N. Svendsen, *Near Human: Border Zones of Species, Life, and Belonging*

Cristina A. Pop, *The Cancer Within: Reproduction, Cultural Transformation, and Health Care in Romania*

Elizabeth J. Pfeiffer, *Viral Frictions: Global Health and the Persistence of HIV Stigma in Kenya*

Anna Versfeld, *Making Uncertainty: Tuberculosis, Substance Use, and Pathways to Health in South Africa*

Tanja Ahlin, *Calling Family: Digital Technologies and the Making of Transnational Care Collectives*

Sarah A. Smith, *Forgotten Bodies: Imperialism, Chuukese Migration, and Stratified Reproduction in Guam*

Danya Fast, *The Best Place: Addiction, Intervention, and Living and Dying Young in Vancouver*

Michelle Pentecost, *The Politics of Potential: Global Health and Gendered Futures in South Africa*

Mirko Pasquini, *The Negotiation of Urgency: Economies of Attention in an Italian Emergency Room*

Lily N. Shapiro, *Connective Tissue: Factory Accidents and Reconstructive Plastic Surgery in South India*

Christine Sargent, *Making Down Syndrome: Motherhood and Kinship Futures in Urban Jordan*

Edmée Ballif, *Reproductive Boundaries: Psychosocial Care and Pregnancy in Switzerland*