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The Toxic Pregnancy: An Ethnography of Reproductive Psychiatry

A dissertation submitted in partial satisfaction of the
requirements for the degree
Doctor of Philosophy
in Sociology

by

Charlotte Magalie Abel

2026

ABSTRACT OF THE DISSERTATION

The Toxic Pregnancy: An Ethnography

of Reproductive Psychiatry

by

Charlotte Magalie Abel

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2026

Professor Stefan Timmermans, Chair

This dissertation examines how clinical uncertainty is managed within reproductive psychiatry, a nascent specialty at the intersection of reproductive health, and pharmaceutical medicine. I draw on over four years of ethnographic fieldwork at a reproductive psychiatric clinic within a Los Angeles teaching hospital, including observations of resident training, case conferences, and clinical appointments, alongside approximately 40 interviews with patients, residents, attendings, and therapists. I trace how toxicity operates as an organizing concept across three empirical sites: the professional socialization of resident psychiatrists, the cultural and biomedical frameworks that patients bring to clinical encounters, and the interactional tactics through which medical authority is maintained by clinicians. I argue that toxicity functions in

this clinic as a boundary object—flexible enough to hold together what is biological and social, while retaining a sense of clinical urgency across contexts. In Chapter One, I trace a reversal in clinical psychiatric guidelines—from cautioning against psychotropic medication during pregnancy to recommending it—and show how resident physicians are socialized to manage the data inadequacy underlying this shift. In Chapter Two, I turn to the patient perspectives, who arrive already shaped by what I call *toxicity imaginations*: durable, culturally assembled understandings of exposure and risk that clinical encounters often compound rather than resolve. I find that this leaves patients to weigh the toxicity of medication against the toxicity of their own untreated symptoms. In Chapter Three, I identify two sets of tactics—outsourcing responsibility and repositioning danger as undertreatment—through which clinicians maintain treatment recommendations amid inadequate evidence. Together, these findings reveal what I call: *biological logics* that position the maternal mind as an environment of consequence for fetal development, and the *eugenic logics* they structurally enable—not reproductive prohibition, but optimization toward a child unburdened by the psychiatric condition of its mother. I argue that reproductive psychiatric patients are best understood as bellwethers of a broader cultural anxiety about chemical exposure, reproduction, and futurity, and that this dissertation contributes to medical sociology, science and technology studies, and feminist health scholarship.

The dissertation of Charlotte Magalie Abel is approved.

Hannah Landecker

Rene Almeling

Ippolytos Kalofonos

Stefan Timmermans, Committee Chair

University of California, Los Angeles

2026

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INTRODUCTION

At 10am on Tuesday morning, Carrie[1], a therapist in training, and Deb a senior therapist welcome the patients in a reproductive psychiatric clinic's hospitalization program to their first group meeting of the day—Skills Group. The seven new moms are tired eyed, and hold their babies on their laps. Some breastfeed, one burps her baby as she sips coffee. I take my seat as an observer, introduce myself to the new members, and greet the other patients. We settle into the program's daily routine—Dr. Dagan, the psychiatrist on staff, asks for each mom to share a 'win' that occurred over the weekend after reminding them of the ground rules for the group, "Remember, this is a space for you to share and receive support. And as a reminder, please don't share any details of your past or current trauma. No details about your diagnoses, and keep any information about your medication regimens, and suicidal ideations to yourself." There are a few minutes of silence as the patients look around. Finally a mother volunteers, "I took a shower." Another mom shares, "My baby slept a three-hour stretch."

They shift to discuss the program's topic of the day—relationships. Tanya, who holds 11-week-old Emily is the newest mother to join the group. She shares that when her symptoms of anxiety are at their worst, in combination with the physical pain from her c-section recovery, she often lashes out at her husband, "Things are not going well," she says. Carrie tries to offer advice, "It's hard because… he's the person you feel most comfortable with—it's not abnormal to take things out on him, and with your symptoms, um…" Deb the senior therapist interrupts, "When one person in the household has mental health issues, it affects everyone around you," she says to the group, "You're experiencing these terrible symptoms, but everyone around you is

[1] All names used are pseudonyms to maintain patient privacy.

too. That's why you're all here right now. You want to get better so that you can be the healthy mom you want to be." Some of the mothers nod.

Deb brings up the use of medication to help manage strained family dynamics. "If you're feeling down or hopeless, remember you're not just doing this for yourself, but everyone around you. The decision to take medication for example, that's a really difficult choice to make. You might not want to take it. It causes side effect. You're afraid it'll make you feel worse. Who knows what will happen. It's really mysterious. But sometimes the choice to say, 'I'm hurting everyone with my symptoms, I don't want to take my meds, but you know what, I'm going to do what the doctor tells me for everyone else right now.' That's a helpful way to think about your treatment- not just for you but for everyone you love."

—

A month later, I shadow a group of psychiatric residents and attendings during their weekly case conference, and Tanya's case comes up. After completing the hospitalization program, she was transferred to the weekly clinic and just completed her intake appointment. Shelley, the resident assigned to her case, brings up Tanya's lingering symptoms of anxiety and depression, and discusses her medication hesitancy related to negative experiences with Zoloft. Dr. Knight, the attending on the case interrupts, "Yeah, she has some… feelings about us. She has some… Cluster B personality stuff." Several of the attendings nod in understanding. While not a formal diagnosis, this ad hoc evaluation orients the conversation to managing patients who push back against the operating norms of the clinic. The group discusses her case at length, including details from her psychiatric intake, and information from her group therapy sessions while hospitalized. Dr Knight elaborates on her evaluation of the patient, "I think of the risk of taking Zoloft during pregnancy as non-existent, but she wanted outcomes data up to 30 years old. Those studies just don't exist. It was very, very complicated with her."

Dr. Vince, a senior attending adds, "This is a very tough patient, isn't it? She's still not taking medication, because there's no guarantee it won't be a problem. Really makes you think about how people perceive risk. You know, we're a science, but we're not exactly *a science here, there's still so much we don't know." Shelley completes her presentation of her intake with Tanya, finishing by recounting her use of psychoeducation to try to get Tanya to comply with her recommendations for medication use and dosage increases. A therapist on staff adds, "We really have to move her away from those values," referring to Tanya's medication hesitancy. Shelley concludes by saying at the end of the hour and a half appointment, Tanya opened up to potentially trying medication if her symptoms didn't improve, "It really helped when I told her that a depressed mother is known to have all these negative impacts on raising a child."*

The management of Tanya's case illustrates more than the complex dynamics of a reproductive psychiatric clinic; it's a microcosm of competing priorities amongst doctors and patients, resident and attending psychiatrists, and interdisciplinary care teams as they navigate a biomedical context riddled with uncertainty.

Tanya's trajectory through the clinic—from the hospitalization program where clinicians framed medication compliance as an act of maternal love, to the case conference where her hesitancy was quietly pathologized as—traces the same arc this dissertation follows. As Tanya's case exemplifies, the location of knowledge, danger and priorities in the caring infrastructure for reproductive psychiatric patients is impacted by patient's maternal identities, and divergent perceptions of risk. This project aims to uncover how mental health becomes relevant during the reproductive experience. At a critical juncture for sociological inquiry, I focus on reproductive psychiatry as an empirical space of undecidability, investigating how people negotiate

uncertainty and compliance in a field with few definitive answers. What do patients, attendings, and psychiatrists *do* when inhabiting a high-stake space of such risk and uncertainty? How do the patient's perceived and experienced states of mind —riddled with suspicion following a history of mental illness— affect and compromise the choices that must be made within this context?

Tanya's case highlights several elements that situate reproductive psychiatry as an ideal entry point into this investigation—her hesitation about medication use, the psychiatrists' acknowledgment of a lack of substantive data on the long-term effects of mediations throughout reproduction, and the invocation of gender and appropriate maternal behavioral norms shape psychiatric care (E.g., *"It really helped when I told her that a depressed mother is known to have all these negative impacts on raising a child.")* .

Each of the elements highlighted here is a thread that this dissertation pulls; how clinicians are taught to navigate minimal data—how they transmit that process to residents through lectures, case conferences and backstage briefings that accompany each appointment—is the subject of the first empirical chapter. How patients like Tanya arrive already steeped in cultural messaging about toxicity, good mothering, and the dangers of their own psychiatric histories is the subject of the second. And in the third, I take up how the tensions between Tanya's hesitancy, and the clinic's recommendations plays out in clinical interactions, including the tactics that clinicians deploy to manage that tension while maintaining the prescription.

As a biomedical discipline, reproductive psychiatry amplifies the increased control of human bodies through both psychiatry and reproduction. Both areas navigate divergent definitions of choice, conflicting conceptions of patienthood, and varying degrees of trust and autonomy pregnant people and those with serious mental illness are afforded under medical supervision. Further, this area of biomedicine exists where undecidability and uncertainty are

common but both action and inaction may have serious consequences for maternal and fetal-infant health. The family as a reproductive unit and the field of medicine have been classical examples of key institutions of social control. The convergence of the two as a subspecialty of medicine aims to treat patients of 'reproductive capacity' with psychiatric diagnoses, psychotropic medication, and hospitalization. The psychiatrists' management of pregnant and postpartum patients like Tanya extends beyond the confines of the psychiatric hospital and our biomedical understandings of fetal versus maternal patienthood into a broader cultural narrative that articulates normative expectations of 'good motherhood,' and appropriate reproductive behavior.

Psychiatry has also long been a site of the control of human bodies. Sociologists have theorized psychiatry as an institution that disciplines human behavior; from the rise of the coercive asylum (Gong 2019) and the management of deviant behavior in particular social contexts (Foucault 1965), to more recent neoliberal theories that illustrate the use of intensive surveillance and self-governance to achieve psychiatric control in lieu of explicit coercion and institutionalization. Following deinstitutionalization in the US, the development of antipsychotic medications as "technologies of management" (Rose 2001) shifted the control of people with serious mental illness toward compliance-reliant self-governance. Patients with serious mental illness under psychiatric care are surveilled and managed through compliance reliant treatments of medication and/or psychotherapies unless they prove to be a "danger to themselves or others," in which coercive care may be legally implemented.

While a novel medical subspecialty, reproductive psychiatry is shaped by decades of biomedical practice. Medical school curricula have long prioritized fetal subjectivity through the making and centralization of the unborn patient. In the context of medication use, concerns of

chemical toxicity for women of reproductive capacity and the effects of medication use on fetal development has generated a framework that prioritized fetal patienthood. At the same time, the exclusion of pregnant people from clinical trials, and the increasing interest around maternal mental health has led to calls for *more intensive* maternal care during the reproductive process. Reproductive psychiatry then exists at an intersection of clashing cultural and biomedical values; amidst the relentless pursuit of new reproductive technologies that reinforce age old patterns of fetal centric medicine, reproductive psychiatry promises to prioritize maternal wellbeing in a biomedical context that has historically excluded women and pregnant people. However, the uncertainty about the teratogenic effects of psychiatric medication in the absence of clinical trials puts the onus of assessing biomedical risk on the patient, particularly in the era of patient-centered care and decision-making. Thus, in the reproductive psychiatric clinic, psychiatrist and patients have to make decisions amidst an absence of evidence. The clinic's response to this absence, specifically its organization of care around a biological logic of maternal-fetal transmission, and it's implicit promise that treating a mother can interrupt the intergenerational transmission of psychiatric difference (and the eugenic logic that underwrites this promise) are among the central analytic features of the chapters that follow. For patients, experiences and sociocultural influences of what constitutes appropriate maternal and 'sane' behavior offers a different type of evidence to bring to the discussion and often manifests in suspicion of psychopharmacology. In this project, I observe how these often incommensurable knowledges are managed in the reproductive psychiatric context.

Encounters between patients and reproductive psychiatrists also take place in a specific sociohistorical context that heavily polices the reproductive process from pre-conception to post-natal care. Reproduction has historically been a site of legislative, biomedical and social control.

Who can and should reproduce has inspired oppressive biopolitics and simultaneous anti-natal and pro-natal policies and practices that support some families and target others. Despite the larger cultural and structural contexts that shape experiences of reproduction, responsibility for reproductive decision-making falls back onto the individual patient/mother. As reproductive technologies and the reach of reproductive biomedicine continue to expand, the surveillance of reproductive bodies and stakes of decision making has expanded too. Extensive biomedical scholarship on the increasingly pervasive methods of anticipatory medicalization, and the socio-legal scholarship on the expansion of the criminalization of pregnancy, eugenics, and motherhood illustrate both the breadth and the severity of this reproductive frontier.

While the increasing control of reproductive bodies as a mechanism of statewide biopower has led to surveillance of reproduction under the purview of US medical and legal institutions, fetal wellbeing has increasingly become the responsibility of the maternal individual. The pervasive Western ideology of "intensive mothering" that is child-centered and expert guided, reiterates that mothers are inherently responsible for fetal and child wellbeing. This care work is institutionalized during the reproductive process, as the surveillance of bodies increases dramatically during the entire perinatal period. Expectations of maternal behavior and decision-making over fetal wellbeing reinscribe both fetal personhood and intensive mothering. Maternal behaviors are closely monitored to ensure ideal fetal outcomes, equating fetal centric biomedical decision-making to 'good mothering.'

Taking the nascent specialty of reproductive psychiatry as my site of investigation and drawing from a critical feminist perspective, this project aims to understand how epistemic uncertainty is managed is biomedicine, how mental health becomes relevant during reproductive periods, and how both gender and maternity norms influence reproductive and psychiatric care.

The chapters that follow draw on over four years of ethnographic fieldwork at a reproductive psychiatric clinic embedded in a large teaching hospital in Los Angeles, tracing these dynamics across three sites: the backstage training of resident psychiatrists, the toxicity imaginations patients bring to clinical encounters, and the interactional tactics through which clinical authority is maintained.

Literature

This doctoral research is motivated by literature on the Western cultural ideologies of 'good mothering', as well as the biomedical and feminist health bodies of literature that have long investigated the fetal-maternal debate. In the next sections, I situate reproductive psychiatry in the historical context of the social construction of psychiatric disease, and contextualize how gender and maternity have been treated within the institution of psychiatry. I review the prevalence of uncertainty and incommensurability in medical sociological scholarship, and the literature on the exclusion of women from pharmaceutical clinical trials. Lastly, I situate the experience of the pregnant psychiatric patient at the intersection of biomedical and cultural hyper-surveillance.

Intensive Mothering & The Fetal Maternal Debate

Pregnant women with psychiatric conditions have historically been put under extreme surveillance at the intersection of both gendered and biomedical mechanisms of social control. The historical tensions between patient autonomy, paternalistic medicine, and the exclusion of pregnant people from clinical trials clashes against the increased national attention on maternal mental illness and calls for more care to improve birth outcomes and maternal morbidity. In

addition, the rise of individualistic and intensive mothering ideologies increasingly point to maternal behaviors as responsible for childhood outcomes. What remains unknown is how the confluence of these factors is played out in the clinical context when psychiatrists treat patients with reproductive concerns.

Amidst the rise of biomedical interventions that treat and prioritize fetal personhood, the maternal responsibility for safeguarding the fetus has become synonymous with ideologies of responsible mothering. Various sociological theories have evaluated parenting behaviors as they relate to class and material resources, and gendered behavior. Intensive mothering for example, the Western ideology that holds mothers responsible for child rearing methods that are expert guided, child-centered and self-sacrificing (Cappellini et al. 2019; Hays 1996; Randles 2021) is implemented during, and in some cases prior to pregnancy. Prenatal care has also expanded to encompass the period prior to conception itself, what Conrad and Waggoner (2017) call anticipatory motherhood. Using maternalism as a biopolitical strategy, the preconception healthcare paradigm treats anyone that can become mothers as mothers-to-be, and heavily surveilles those who do become pregnant. Strict regimens of prenatal care constitute one of the ways in which responsible mothering is cultivated prior to delivery. During prenatal visits, clinicians document maternal behavior to assess its effects on fetal development. How patients eat, move, and think is scrutinized with extreme precision under the pretense that behaviors during pregnancy that prioritize fetal wellbeing, in some instances at the expense of maternal wellbeing, reflect responsible mothering.

The cultural inoculation of responsible mothering takes place across the reproductive trajectory as the prenatal, childbirth and postpartum period are all increasingly characterized by biomedical surveillance and interventions. This is not only enforced upon pregnant patients, but

also accepted and encouraged by cultural scripts of intensive mothering that equate interventions and hyper-biomedical reproductive experiences as responsible maternal behavior**.** Genetic testing for example, that takes place during pregnancy and in the immediate postpartum has become institutionalized, despite its frequent inaccuracy. In this context, the 'individualization of risk' that emerged in the post-genomic era has placed the complex factors that affect fetal outcomes on individual bodies and behaviors, normalizing intensive biomedical practices that measure the wellbeing of future children in relation to women's bodies (Lappé 2016; Stivers and Timmermans 2016).

Pregnancy and motherhood for patients with mental illness often falls under more intensive surveillance, maintaining fetal-centric perspectives. For these patients, biomedicalization does not simply apply the general logics of prenatal risk management outlined above, but compounds it. Harrision (2023) documents how psychiatric risk has been folded into the standardized care of obstetric surveillance; healthcare organizations for example, have formalized routine perinatal depression screening tools like the Edinburgh Postnatal Depression Scale, administered often as a matter of protocol rather than judgement. Once flagged through the screening apparatus, patients are routed toward pharmacological management. Harrison found that obstetric clinicians relied on antidepressants as their primary tool for addressing psychiatric symptoms, referring patients who require more specialized care onward toward psychiatric, or when available, reproductive psychiatric consultation. This screening-to-referral pipeline demonstrates how pre-existing or emergent psychiatric diagnoses does not merely add a data point to prenatal risk assessment, but activates a parallel track of surveillance onto pregnancy itself, governed by pharmacological norms. This too is organized around a fetal-centric calculus, linking untreated maternal symptoms to adverse fetal/infant outcomes.

Beyond the intensely biomedicalized experience of reproduction, the ideology of intensive mothering holds that the mother is responsible for the child even at her own expense. Several sociological studies have investigated how the tension of maternal versus fetal prioritization manifests in biomedicine. Monica Casper's ethnography of fetal surgery for example, was a groundbreaking investigation into how the interests of the mother versus those of the child are weighed and both socially and biomedically constructed. The debut of the 'unborn patient' as a fetal citizen (Casper 1998) recast this debate into the preconception period, which has only further exploded amidst the sharp rise of reproductive technologies that reinforce a biomedical ethic of fetal prioritization. The trend of fetishizing the fetus, as Dubow (2011) and Gentile (2023) have observed, involves a reorientation toward the fetus particularly during periods of cultural crisis, leading to the increased surveillance and control over the gestating, or even potentially gestating body (Gentile 2023).This logic extends beyond the confines of the clinic into the cultural and biopolitical milieu in the form of pro-life arguments cloaked as fetal prioritization laws (Goodwin 2020; Nash 2019; Taylor 2008). Roberts (1997) has pointed out that how women of 'childbearing potential' are perceived and surveilled often varies by race and class, such as the simultaneous pro-natal push for access to reproductive technologies for affluent white women, and the anti-natal policies, practices and stereotypes that target poor women and women of color. Fetal fetishism, therefore, does not apply uniformly. This dissertation draws from this literature to trace how fetal-centric medicine is reproduced and complicated in the reproductive psychiatric context.

Gender and Psychiatry

In addition to the scholarship on intensive mothering and fetal prioritization, I draw upon the medical sociological literature on psychiatry and maternal mental health to build a theoretical

understanding of how these areas converge in the reproductive psychiatric context. For example, the combination of intensive mothering ideologies and biomedical prioritization of fetal personhood requires both an institutional and an interpersonal level of maternal surveillance during reproductive periods, not simply top-down social control. The constant self-surveillance required of both intensive mothering and anticipatory motherhood has been described as a "psychological police-state" affecting those across social identities (Henderson, Harmon, and Houser 2010 in Murray and Tizzoni 2022). As Foucault (2008) argued, while diagnostic classification and the management of psychiatric disease once took place within the asylum, it has since expanded well beyond these borders, requiring intensive self-surveillance and psychotropic medication compliance. This has contributed to unprecedented rates of psychiatric diagnoses worldwide. The reasons for the explosion of psychiatric diagnoses remain contested: could it be because there has always been a high prevalence of psychiatric illness and due to greater disease awareness and more effective diagnoses, and perhaps the particular patterns of stress in the postmodern age, the rates of diagnosis and psychiatric treatment are appropriate in their increasing scope? Or alternatively, as Rose (2006) and others have questioned, could it be that difficulties in life are more commonly treated through processes of medicalization?

Psychiatrists have always been called on to treat social deviation in individuals (Lewis 1953; quoted in Rose 2019), and diagnoses themselves are bound by cultural and gendered norms, and values and background expectations of doctors. For women and mothers, disorder is conceptualized in relation to the normative boundaries of (im)proper maternal behavior. In psychiatry, gender has long operated as a "dividing practice" (Foucault 1965) contributing to the organization of some behaviors and bodies as mad/insane, delinquent, and hysteric and others as normal. In feminist historiographies of psychiatry, scholars have observed that constructions of

hysteric illness reflect male domination (Chodoff and Lyons 1958; Micale 1990; Scott 1986). Adding to this historical context, the modernization of state interest in population regulation including "birth, longevity, eugenics, health," (Deveaux 1994; 229) has expanded both state and medical surveillance of reproduction into what Terry (1988) calls a "natal panopticism." This biopolitical paradigm in conjunction with the many forms of stigma associated with mental illness—internal, external and disclosure stigma (Corrigan, Markowitz, and Watson 2004; Goffman 1986; Moore, Ayers & Drey 2016)—may also inhibit people, especially mothers in the perinatal period (Byatt, Deligiannidis, and Freeman 2013) from seeking treatment.

Public awareness surrounding perinatal mood and anxiety disorders has also increased in the public consciousness, especially following the COVID-19 pandemic in which the unequal household and emotional labor of mothers came under media and policy scrutiny. Racial maternal and infant mortality rates have also increased over the past several years. While the absence of affordable healthcare, lack of postpartum support including paid parental leave, and rising economic and housing insecurity all contribute to these inequities, public health officials have explicitly tied suicidality and drug overdoses in the postpartum period to the high rates of maternal mortality, prompting calls for increased attention on maternal mental health (Chin et al. 2022).

This renewed attention to reproduction in the mental health arena occurs in the context of increased lay awareness and growing demands for formal acknowledgement of psychiatric diagnosis, an expansion of what (Brinkmann 2016) calls 'diagnostic cultures'. In addition, the marketization and commodification of psychiatric diagnoses has created 'fuzzy boundaries' or significant uncertainty within diagnostic encounters (Lane 2020). Public health organizations have decried the lack of parity between physical and mental health: many who deserve or need

psychiatric treatment do not receive it, and that this ever expanding 'burden' of untreated disease has large economic and societal impacts (Rose 2019). Without organized social services to treat conditions related to mental health, this task falls to doctors, specifically pediatricians and OBGYNs who come into most frequent contact with new mothers to screen for mental health conditions. Screening tools to assess mental health- such as the Edinburgh Postnatal Depression Scale are recommended in OB visits, though the frequency of their use, and their efficacy has been contested (Krantz et al. 2008). As Rosenberg (2002)) and others (Pickersgill 2014) have suggested however, diagnostic tools may result in 'diagnostic creep,' (Haslam 2026), eliciting false positives, and are routinely proposed and financially supported by pharmaceutical companies (Lenzer 2004). While the most recent 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders- the DSM-5 drove forward critical discourse about the use and role of diagnosis in mental health, it also attracted notable criticism, particularly about its omissions (Pickersgill 2014). Postpartum mental health conditions, for instance, are not included as distinct disorders within the DSM-5, despite the clinical recognition that 15% of mothers suffer from postpartum depression, and 1 in 1,000 suffer from postpartum psychosis (Stevens 2017). In summary, for those without pre-existing psychiatric diagnoses, there is both an increased awareness on the significance of perinatal mood and anxiety disorders, while the caring infrastructure is inadequate to manage such demands.

Pregnant people with pre-existing psychiatric diagnoses have thus come under immensely more scrutiny during the perinatal period. In the cultural context of intensive mothering, and amidst rising maternal and infant mortality in the US, mental health diagnoses of pregnant people have become recognized as a telling risk factor for clinicians. Mothers in turn, who subscribe to intensive mothering ideologies, may turn toward medicine to treat behaviors

categorized as perinatal mood and anxiety disorders. To answer the growing need, reproductive psychiatry clinics have increasingly been established across the US. Reproductive psychiatrists rely upon psychiatric diagnoses and psychotropic medication as interventions for people of 'reproductive capacity,' and situate themselves as experts in a field of minimal medico-legal recognition, and a lack of substantive data.

Uncertainty, Pharmaceuticals and Biomedical Inclusion

How has uncertainty taken shape in medicine and how might it play out in the reproductive psychiatric context? To contextualize this study, I turn to the literature on medical uncertainty, including the history of biomedical exclusion of people of 'reproductive capacity' from pharmaceutical trials. Medical sociologists have highlighted uncertainty's prevalence in medicine for decades; from Fox's (1980, 2002, 2013) claim that uncertainty was a hallmark of the medical field, to Katz (1984) analysis of doctors' reluctance to disclose uncertainty by way of imposing order and professional authority on complex and inexact situations, to Timmermans and Berg's (2003) challenge of evidence-based medicine (EBM) as a method to counter uncertainty in medical socialization. Both the continued prevalence of uncertainty in medicine and the reliance on EBM in medical socialization are relevant factors in the study of reproductive psychiatry, which takes place in a uniquely understudied context, yet requires evidence-based diagnostic and treatment related decisions to be made during critical periods of care.

In the past, the exclusion of people of 'childbearing potential' in drug Phase I trials echoed the logic of anticipatory motherhood, in which all women were kept in a "perpetual potential pregnancy state," (Epstein 2007) to avoid potential harm of a hypothetical fetus. While organizations that produce biomedical research have emphasized the importance of including

diverse populations in clinical trials, Jain, Cottingham and Fisher (2020) point out that the parallel emphasis on "preconception" and the health of future fetuses has resulted in a paternalistic approach to biomedical knowledge making. Without the inclusion of women of 'reproductive capacity' in clinical trials, the safety of pharmaceuticals is effectively worse for women (Roth 2018).

Some of the prevailing anxieties about giving medication to pregnant people, or those who may become pregnant at any point, are motivated at least in part on previous medical practices that have resulted in detrimental outcomes for babies born to mothers taking dangerous medications—such as the European Thalidomide tragedy in the 1950s and 1960s (Corrigan 2002; Kim and Scialli 2011). Following this, in 1977, the FDA banned the inclusion of all women in pharmaceutical drug trials. It wasn't until 1993 that this exclusion was reversed, yet despite the reversal and the consensus that the inclusion of pregnant women in clinical trials is useful, several studies have found that pregnant women often remain excluded. Some research has found that between 1980-2013, anywhere between only 9-1% of clinical trials are conducted for pregnant women (Van der Graaf et al. 2018). As many scholars have pointed out, men are subject to much less surveillance despite the contribution that sperm might make to adverse birth outcomes (Almeling and Waggoner 2013; Daniels 1997; Inhorn 2009) reaffirming the false notion that women bear more reproductive responsibility over procreation. Thus, normative conceptions of gender roles and maternal responsibility permeate the logics of the institution that produce biomedical knowledge as well. The result is a uniquely understudied population, receiving unprecedented diagnoses and prescriptions of psychotropic medication. Further, in the context of increasingly policed reproductive bodies, patient non-compliance may call into question both patient sanity and legal autonomy (Goodwin 2020).

Pregnant people have historically been treated as a vulnerable population and excluded from clinical trials and biomedical research (Epstein 2007). Consequently, clinicians don't know much about drugs and pregnant women, even if their bodies are hyper surveilled. This in turn affects the decision-making of those receiving care in a psychiatric context that requires intensive self-governance through medication compliance. The emphasis in reproductive psychiatric clinics is on the use and management of psychotropic medication; continuing, paring down, or prescribing new pharmaceuticals. Physicians who turn to EBM in the face of uncertainty find a lack of substantive data on psychotropic medication use during pregnancy. Patients, in turn, bring the social experience of mental illness and lay knowledge influenced by intensive mothering ideologies of appropriate maternal behavior that prioritize fetal wellbeing to clinical interactions. Further, this takes place against the backdrop of dramatic changes to psychiatry—namely deinstitutionalization and the increased use of pharmaceutical medication and self-governance, and biomedicine—including "the rapid expansion of the global pharmaceutical industry constantly searching for new markets and engaging in new ways with consumers," (Epstein 2007;6). I am not the first to examine psychiatry within this paradigm of incommensurability; Kendler (2014) who drew on Kuhn's (1962) work and others (Thomas, Bracken, and Timimi 2012) have noted how biological, social and pharmaceutical models of mental health care remain incommensurable. This dissertation examines how decisions about pharmaceutical treatment are made, negotiated and responded to amidst epistemic uncertainty.

Hyper-surveillance of the pregnant, psychiatric patient under conditions of uncertainty

Within an area of medicine that positions both the pregnant and psychiatric patient as uniquely 'high-risk,' pregnant psychiatric patients fall under hyper-surveillance under conditions

of extreme uncertainty. Sociologists of medicine have illustrated the emergence of risk-management as a central tenant to contemporary methods and practices of psychiatry. By increasing efforts to calculate and quantify risk, psychiatric interventions promise to bring potential future outcomes into the present and make them manageable and preventable. However, this also leads, as Rose (2001) and others (Gong 2017; 2024) have argued into overarching schemas of intervention for anyone who falls under psychiatric purview. Instead of organizing individuals from legal positions—dangerous or not, to be institutionalized or not—contemporary psychiatry operates under different and more far-reaching regimes of control.

When the question of uncertainty emerges in clinical encounters between patients and providers, the knowledge deficit is presented as a 'risk-risk' scenario. Rarely if ever do psychiatrists find a 'no risk" situation. As Rose (2002) explains:

> "All psychiatric patients can, and should be allocated to a level of risk, risk assessed, risk classified, risk managed: high risk, medium risk, low risk — but rarely no risk […] [Risk] is not about binary distinctions but location on a continuum […], does not identify something fixed, stable, inherent and hence predictable to all futures, but implies continuous day-to-day risk management of the potentially risky person (Steadman et al, 1993, c.f. Crichton, 1995: 29)," (Rose in Baker and Simon 2002).

Relatedly, as other sociologists have shown, medicalization and criminalization go hand-in-hand. For example, fetal protection laws (FDLs) and maternal conduct laws (MCLs) have institutionalized fetal-centrism and the punishment of maternal behavior if not in direct beneficence to potential fetal life. Elizabeth Armstrong's (2003) study of the construction of fetal alcohol syndrome as a social problem is one such example. In her analysis, the author illustrates how medical knowledge is socially constructed and situated beyond empirical evidence. She traces the methods by which American medicine individualizes social problems, intertwining morality and women's roles in reproducing the "fitness of future generations" with medical

findings about alcohol and reproduction. Others have applied similar analyses to drug use, both legal and illicit.

Scholarship in this area has shown how during pregnancy patients are encouraged to report all recreational and prescription drug use to their clinicians (Chasnoff, Landress, and Barrett 1990; Mitchell et al. 2011; Stengel 2014). Health professionals, in turn, are encouraged to query about drug use during prenatal and well-baby visits. As Michele Goodwin (2020) has argued, while women across races use illicit drugs at about the same rate, educated white women have the highest use of legal and potentially addicting drugs, at a rate that increases with age. While illicit drug use carries stigma and the potential for criminalization, both legal and illicit drugs may affect the function of the placenta, "which can affect the supply to the baby, or cause preterm labor or birth," (Mitchell 2011; in Godwin 2020). Thus, punitive public policy trends such as FDLs and MCLs disparately police some women and mothers through stereotype and bias, while others are encouraged to pursue prescription medication. Like fetal alcohol syndrome, the data on the effects of psychotropic medication during pregnancy is minimal, and lawmaking that allegedly pursues to reduce fetal harm creates draconian levels of surveillance over some women's *illicit* drug use without prioritizing the reduction of *all* potentially harmful drugs (Goodwin 2020). Risk in the perinatal and postpartum period is calculated, quantified and criminalized to varying degrees and across populations disparately, however the medicalization of diagnosable, psychiatric risk has a singular clinical track toward the increased use of medication**.** The chapters that follow trace how this plays out across the training of resident psychiatrists, the toxicity imaginations that patients bring to clinical encounters, and the interactional tactics through which authority is maintained.

Feminist Toxicity Studies and the Reproductive Body

The literature reviewed above—intensive mothering, the gendered history of psychiatry, pharmaceutical exclusion, and the hyper-surveillance of pregnant psychiatric patients—share an underlying concern with how the maternal body has emerged as a site of management, risk, and responsibility throughout history and biomedicine. Another core pillar of this dissertation's frame is feminist science studies, and specifically the way it has taken up toxicity and the reproductive body. I follow Packer's (2021) critical feminist approach to toxicity, which, as she argues, is necessary if the multiple harms that toxicants generate are to be meaningfully understood. This approach attends not only to who bears the heaviest toxic burdens, but also to whose bodies are considered normal and fully human by the hegemonic onto-episteme (Wehelive 2014; Wynter 2003)[2]. This is particularly relevant in the reproductive psychiatric context, as degrees of toxic exposure, chemical entanglements (Murphy 2008) and fetal development are interwoven with the pathologization of behavior categorized as psychiatric disorders.

This framework is particularly relevant to the reproductive psychiatric clinic's organization around pharmaceutical prescription and treatment. Here I turn to Packer's situating of pharmaceutical infrastructures within Murphy's (2008) broader account of "chemical regimes of living," meaning regimes shaped and molecularly altered by pharmaceuticals consumed at record-profit rates and redispersed back into shared environments (Murphy, 2008, p. 697). In this sense, pharmaceutical drugs are considered as more than simply a clinical tool, but part of a chemical regime, tying bodies and particular populations to transnational markets, and the larger ecosystems that the bodies interact with. My research extends the subject of analysis from the maternal body to the fetal/infant body within the clinical ecology, though a number of studies

[2] Onto-episteme Onto-epistemology" combines ontology—ways of being—with epistemology—ways of knowing, to signify the inseparability of being and knowing.

have taken a more explicitly ecological approach (Dillon 2014; Povinelli 2016; TallBear 2011). Relatedly, many feminist critiques of toxicity have taken "slow violence" (Nixon 2013) as the temporal dimension through which toxic exposure is analyzed, whereas this research takes the reproductive timeline related to exposure, gestation fetal/child development as its temporal frame (see: Agarde-Jones 2013; Kimura 2016; Langston 2010; Petryna 2013 for other examples).

Read through this framework, the asymmetry Goodwin (2020) illustrates, between the punitive surveillance of illicit drug use among poor women and women of color and the clinical encouragement of prescription medication among insured women, is not a contradiction within the same system but two expressions of the same underlying logic: that places and people, marginalized on the basis of racial, sexual, and economic hierarchies bear disproportionately heavier toxic burdens, while the sciences that define and measure toxicity continue to be organized around normative bodies and their protection. To this I add, psychiatric status as an additional axis of that hierarchy.

Packer (2021) notes that the transgenerational effects of toxic exposures threaten to turn hegemonic social categories of race and sex back into the purportedly biological categories that social justice advocates have long argued against (Guthman 2014; Packer 2021). This dissertation takes that framework as an orienting premise. What gets named as toxic, whose bodies are understood as sites of dangerous exposure, and who bears responsibility for managing that exposure are organized by the same hierarchies that structure reproduction more broadly, and the reproductive psychiatric clinic, as the chapters that follow show, is no exception.

Methods

The overarching questions guiding this project are

1) in the context of reproductive psychiatry, how does mental health become socially and clinically relevant across the reproductive experience, from pre-conception through the postpartum period?

And 2) how does the reproductive psychiatric clinic function as a site of medical socialization, and how do doctors and patients come to manage incommensurability that exists within it?

From these questions, three subsidiary tracks organize my dissertation. The first focuses on how *patienthood is conceptualized, and contested within the clinic*—specifically if and how psychiatrists weigh fetal against maternal interests, rather than adopting an orientation toward reproduction as site and temporality of co-embodiment (Simms 2009). The second examines *if and how gendered conceptions of maternity and appropriate mothering behavior are used to compel patients toward treatment*. The third asks *how epistemic uncertainty, or incommensurability shapes psychiatric recommendations and the various forms of knowledge that both patients and providers bring to clinical interactions*. Taken together, these questions demand a methodological approach that attends to process and interactions over time, one that I describe through an account of my field site and its ecology, my ethnographic and interview methods, and analytical approach.

I use ethnographic methods to conduct this research; based primarily on field observations (both clinical and virtual) as well as qualitative interviews. The research questions that guide this work would result a different outcome if conducted by surveys or administrative data; they've require sustained presence and observations, even participation at times, both within and beyond the confines of the clinic with particular attention to the texture of these interactions and processes over time to answer. After several years of observing the daily life of

the reproductive psychiatric clinic, I feel confident that ethnography is uniquely positioned to attend to the moments in which institutional logics are made visible, such as when attendings articulate reasonings that might otherwise be left implicit, or when a patient pushes back against a particular medication in ways that are folded into the clinical record. Observing the clinic from a backstage (Goffman 1956) vantage point, including the lectures, didactic training sessions and clinical 'downtime' in addition to doctor-patient interactions highlights the gaps between what is said in case conferences, and what is said to patients in clinical observations. Additionally, conducting interviews with patients without the presence of their doctors and outside of the clinical setting offers a different vantage point into a patient's decision-making, worldviews and conduct that has helped me answer these questions.

For 4.5 years, I engaged in ethnographic fieldwork at a reproductive psychiatric clinic within a large university teaching hospital in Los Angeles, for which I received IRB approval, HIPAA certification and CITI training. This clinic was established to assess and treat people with psychiatric conditions associated with reproductive life events—pregnancy, postpartum, breastfeeding, pre-pregnancy consultation, miscarriage and pregnancy loss, infertility, assisted reproductive technologies, and perimenopausal mood and anxiety disorders. My observations center on doctor-patient interactions between psychiatry residents and their patients, the didactic training of residents by attending psychiatrists both within and outside of patient encounters, and weekly case conferences and lectures involving the full interdisciplinary clinical team. Between eight and twelve psychiatry residents rotate through the clinic each academic year in their third or fourth year of residency. Over the course of my fieldwork, I observed five cohorts of residents as they treated patients and received training in reproductive psychiatric care. Each week I was assigned a resident by the clinic director, met with that resident over Zoom prior to appointments

to review incoming cases, and remained present, with patient consent, during both 90-minute intake appointments and 30-to-60-minute follow-up visits. Before diagnoses and treatment plans were finalized, I joined the resident in meeting with the supervising attending, where the resident presented the case and the attending offered instruction and clinical direction. These within-the-appointment moments were consistently among the most analytically generative in my fieldwork. They externalized what in a solo-practitioner setting might remain invisible, such as the transmission of clinical norms, the negotiation of diagnostic uncertainty, and the reproduction of professional authority. I also observed weekly case conferences and didactic lectures with residents, attendings, psychologists, and therapists affiliated with the clinic.

I gained access to the clinic in increments—beginning with a phone call with the clinic's director in 2020, where I was invited to attend in-person lectures. I did so until the clinic shut down in-person operations during Covid-19 as it adapted to a virtual and eventually hybrid model. In 2021 I rejoined the clinic after receiving IRB approval, using Zoom to participate in lectures and didactic training sessions. I requested to gain access to doctor-patient interactions then too, for which I presented my case the clinic's administrative board and received approval. For several years, I joined virtually as the clinic integrated online and in-person appointments, joining via Zoom as residents met with patients, and put them in virtual 'waiting rooms' while I observed them make phone calls to their attendings. While the clinic intended to return to an in-person operation, they found that online appointments were preferred for their patient population, so maintained a virtual clinical operation.

In 2023 I gained access to the clinic's affiliated partial hospitalization program, where I conducted observations for one and a half years. The hospitalization program is a 20-hour-per-week intensive outpatient program where patients remain for eight weeks to six months,

receiving group and individual therapy, medication management, and specialized bonding and coping programming. My observations in that setting were confined to group contexts, including emotional regulation groups, support groups, relationship skills groups, and a mothering and infant interaction group, conducted largely over Zoom, with infants present. The majority of cases I observed across both settings involved patients who were pregnant, hoping to become pregnant, or within the first year postpartum, with diagnoses ranging from perinatal mood and anxiety disorders in patients with no prior psychiatric history to longstanding conditions including bipolar disorder, schizophrenia, and borderline personality disorder. Patients arrived through a range of referral pathways: OBGYNs and pediatricians, general psychiatrists unwilling to treat through pregnancy or breastfeeding, self-titration leading to symptom exacerbation, and self-referral. The clinic I observed accepts HMO, and PPO insurance plans as well as Medi-Cal, unusual among specialty reproductive clinics, many of which operate on a private-pay basis only.

Scope of the Field

Reproductive psychiatry is a nascent medical specialty that exists at the intersection of general psychiatry, pharmaceutical medicine, obstetrics, and pediatrics, each with its own epistemological commitments, professional hierarchies and institutional logics. Understanding it as a field, rather than simply a site of data collection, is integral to how this project is designed. As Krause (2021), and Erikson and Occhiuto (2017) argue, field theory offers a relational framework for understanding how social phenomena are produced and reproduced within bounded domains of practice; the field shapes what counts as knowledge, who counts as an expert and how disputes are resolved. Situating reproductive psychiatry this way orients my ethnographic attention toward relational processes, such as how residents are trained into particular ways of knowing, and how patients come to be perceived as more or less credible.

Conceptualizing reproductive psychiatry as a field also alerts me to its boundaries and porosity. This allows me inquire about when the logics of obstetrics or other specialties influence psychiatric recommendations for example, whether fetal protection laws influence how a clinician discusses patient compliance, or how the pharmaceutical industry might affect the framing of a lecture, or medication recommendation. These boundary crossings are central to my analysis and often where the most theoretically generative analyses happen. Put simply, the reproductive psychiatric clinic does not exist in isolation, but is constituted within and by a broader network of institutional fields, and the management of uncertainty within the clinic is never fully separable from the forces that produce this uncertainty from the outside.

As a field, reproductive psychiatry is characterized by incommensurability—competing frameworks of knowledge that fail to be fully reconcile within a single clinical encounter. Separate from the uncertainty that Fox (1980, 2002) has documented as a hallmark of medical practice, incommensurability has a specific structural cause— in this study, the absence of robust clinical trial data on psychotropic medication use during pregnancy, a direct consequence of decades of excluding people of "reproductive capacity" from pharmaceutical trials (Epstein 2007; Cottingham and Fisher 2022). Timmermans and Berg (2003) have argued that evidence-based medicine operates as a method to counter uncertainty in medical practice, however in reproductive psychiatry that evidence base is largely unavailable. Clinicians must therefore navigate between competing frameworks of knowledge that are, as Kendler (2014) and others have argued, genuinely incommensurable. Understanding the field then means uncovering how this condition of incommensurability is managed—through, as I find, professional authority, the invocation of normative maternal ideologies and through training of residents to translate uncertainty into clinical competence.

The Clinical Ecology

The clinic I focus on in my ethnographic observations is held within a major research university hospital in Los Angeles. The clinic operated at two levels, in physical space on the campus of the academic hospital, as well as online, using a variety of methods to mimic classical arrangements of a clinic. When the COVID-19 pandemic transformed clinical and social life, I adapted my methods to include Zoom telepsychiatry sessions and virtual resident training lectures. This methodological flexibility expanded the surface area of observation, as patients' homes became semiotic spaces where doctors interpreted everyday behaviors as signals of maternal and patient credibility. Residents consulted online charts for example, before appointments with patients that were held in exam rooms, or online via Zoom as patients joined from home, work or occasionally their cars. Lectures were held in the clinic's meeting room, and online, offering a hybrid model to attendings and residents. While I first attended lectures in person, I shifted my participation to Zoom or with the use of an 'owl', a videoconferencing device equipped with a full-room camera that tracks and zooms-in on meeting participants, and a microphone and built in speakers.

The hospitalization program operates differently; it runs primarily on Zoom since the COVID-19 pandemic, with one in-person day per week. Group sessions on Zoom bring patients together virtually who are at home with their infants—in living rooms, bedrooms, with their domestic lifeworlds made visible through the screen. The facilitators of the hospitalization program are mostly psychologists and social workers, who patients addressed by first name, a more explicitly relational dynamic than the outpatient setting. Patients participated in the program while often attending to their infants, blurring the boundary between the clinic and the home, and producing a qualitatively different kind of interactional data than the exam room,

particularly around the way maternal identity and capability, and psychiatric patienthood were managed and surveilled simultaneously.

The ecology surrounding both settings includes a range of institutional actors whose presence was felt while not being directly observed; OBGYNs and pediatricians who referred patients and received discharge summaries, the legal apparatus of fetal and child protection laws, family members and employers. I attended carefully to the moments when the logic of an adjacent field intruded upon the psychiatric encounter. These boundary crossings, as I noted above, are the most theoretically generative in the fieldwork, illuminating how the reproductive psychiatric clinic is shaped by forces beyond its walls, and how the management of incommensurability is entangled with the broader institutional fields that produce it.

Case Selection

The many possible sites for this research include institutional settings where psychiatric care of pregnant and postpartum people is organized, which could include general psychiatric practices, maternal-fetal medicine units, OBGYN offices, telehealth psychiatric platforms and specialized reproductive psychiatric clinics. My choice of a dedicated reproductive psychiatric clinic embedded within a larger academic teaching hospital introduced features such as resident-attending dynamics that are specific to this institutional form. Drawing on Pacewicz's (2022) framework for ethnographic case selection, I argue that my site functions as what he and Katz (2019) call a "critical case" or one that represents with special clarity phenomena that exist more widely but in more diluted forms elsewhere. In a teaching clinic, the transmission of clinical norms and reproduction of professional authority are externalized—attendings must articulate in real time what might be left implicit in a solo-practitioner reproductive psychiatric practice.

The two institutional settings I observe, the outpatient clinic and the hospitalization program, are not a formally comparative design, however they do function somewhat comparatively within my research. While they draw from the same patient population and operate under the same institutional umbrella, they're organized around different logics. The outpatient clinic is pharmacologically centered, structured by the resident rotations and academic calendar, while the hospitalization program is psychotherapeutically oriented, run by a different professional staff and with a group-based model of care and different temporal structure. Attending to both allows me to assess which features of clinical care are specific to the pharmaceutical encounter, and which are more broadly characteristic of institutional management of reproductive mental health. This interpretive comparison (Sckocpol 1984) clarifies these characteristics through contrasts rather than to control for variables. Or to let each setting serve as Geertz (1971) says, as a commentary on the other's character.

Ethnographic Method & Analytical Approach

During my field observations, I took notes that I later elaborated into narrative field notes (Emerson, Fretz and Shaw 2011). I took real time notes during case-conferences, group sessions, appointments and conducted open-ended interviews with patients, residents, attendings and therapists. I also recorded audio with permission using a transcription and recording software. I quote statements recorded in real-time from audio, occasionally edited for clarity. I practice what Katz (2019) calls the "modeling" genre of ethnography, depicting how a social world works by showing the interconnection between the macro-historical, meso-institutional structures and micro-level clinical interactions. As my research questions are about how a set of social processes operates within and through this institutional setting, "modeling" with its commitment

to showing how a world works felt like the appropriate genre for this project early on in the fieldwork. I take inspiration from Nicholas Shapiro (2015)'s "chemo-ethnography" and Elizabeth Roberts and Camilo Sanz' (2018) "bio-ethnography", tracing embodied entanglements with ordinary toxicity, and the complex tangles of the biological, ecological, chemical and social co-constitutions.

My approach to comparison within the ethnography follows Tavory and Timmermans' (2020) argument that ethnographers necessarily work comparatively, even within a single site. They distinguish between shadow comparisons—contrasts with prior literature and theoretical expectations that accompany fieldwork, internal comparisons between situations and interactions within the site, and sequential comparisons between field sites chosen to extend emergent theoretical arguments. I utilize all three in my ethnographic approach.

My data analysis follows the precepts of an abductive analytical approach (Timmermans and Tavory 2012), meaning I systematically read my empirical material in dialogue with relevant literature. In practice this has meant that early observations surfaced phenomena that were not anticipated by existing literature, which drove my theoretical development. Emerging conceptualizations were brought back to the field and refined through several rounds of focused coding, and further developed through a series of analytical memos. This iterative process allowed the concepts introduced above to take their current form.

Interview Methods

In addition to ethnographic observation, I conducted open-ended interviews with patients, residents, attendings and therapists affiliated with the clinic. While ethnography offers access to the interactional components of the clinic, interviews gives access to the meaning-making that

accompanies and sometimes diverges from it. The relationship between my own observations and what respondents disclose in interviews is itself analytically productive—particularly when they diverge in ways that illuminate the gap between institutional goals or logics and individual meaning-making.

Martin's (2017) interview methodology is foundational to my own approach—particularly by treating interviews as interactional, mutually constructed events rather than windows into fixed attitudes or stable beliefs. In my interviews with patients, I treat their accounts as processes of sense-making of their psychiatric disorders, reproductive experiences and clinical interactions, specifically attending to how they narrate their relationship to psychiatric authority, frame medication decisions and position themselves as mothers and patients. In my interviews with physicians, I attempt to understand how professional narratives are constructed, illuminating how residents and attendings understand their clinical mission and manage their own uncertainty. I organize interviews based on Lareau (2021)'s tiered structure; starting with broad questions that allow respondents to frame their own narratives before moving into more focused probes. With patients I begin by inviting them to share their psychiatric and reproductive histories before moving toward more specific questions about their clinical experiences. For clinicians, I invite them to narrate their trajectories into reproductive psychiatry before asking about specific practices or viewpoints.

One specific commitment to my interview design is inspired by the feminist health imperative to treat patient testimony as a form of epistemic authority. This is in direct response to the psycho-legal context of anosognosia, a contested but impactful concept meaning one's neurologically based impaired insight into one's psychiatric condition (Gong, 2017). Creating a context in which patients can articulate their perspectives without pathologization, or the

immediate interpretive authority of a clinician does not promise to reverse this dynamic, but it does create different conditions of possibility for the patient experience in the data collection process, as well as for my analytical process. My sampling of patient interviewees sought variation across psychiatric diagnosis, and stage of reproductive experience, as well as degrees of compliance or resistance in clinical trajectories. I paid particular attention to patients who had declined medication, had been hospitalized involuntarily, or referred to the outpatient hospitalization program. These are what Pacewicz (2022) has referred to as "pointy" cases in relation to the theoretical questions I pose. I completed approximately 40 formal interviews across all respondent categories, supplemented by extensive informal conversation accumulated over my time in the field.

Limitations & Reflexivity

The arguments I develop are derived from my observation of one clinic in one city, within particular socio-historical and temporal constraints. My claims can be best understood as contingent generalizations (Bennett 2022), or arguments about mechanisms plausibly operative in other reproductive psychiatric settings, with well-defined structural similarities, rather than empirical claims about the distribution of these phenomena more broadly. That being said, the processes I observe and concepts I offer will ideally be of use to researchers in adjacent or overlapping fields as my own. Additionally, the patient-population, while more socioeconomically varied than many specialty clinics, is shaped by the insurance landscape and referral networks of Los Angeles, a constraint that impacts whose experiences in the clinic are most represented in my data.

There are difficulties central to any clinical ethnography that are relevant to this research; the emotional weight of fieldwork in a setting where patients discuss suicidal ideation, intrusive thoughts about infant harm, and serious psychiatric crises required developing protocols for managing my own responses while maintaining the kind of attentive presence required of ethnographic fieldwork. In addition, my identity as a white female researcher with evident interest in feminist health scholarship influenced with patients and providers shared with me in ways I cannot fully account for. If patients were at times more or less candid with me than their physicians, and that physicians sometimes narrated their clinical reasoning for a sociological audience, are themselves data about the organization of the clinic.

Lastly, there is the difficulty specific to studying a setting in which what I'm analyzing—the institutionalization of maternal norms, translation of pharmaceutical uncertainty and professional management of patient resistance—are consequential for my study participants. Reproductive psychiatry is not a neutral institutional space. The patients I encountered and the clinical decisions made surrounding their care had real effects on their pregnancies, their medical care, their families, and their self-perceptions. Ethnography is uniquely positioned to illuminate these stakes, the way institutional practices and biomedical logics affect individual lives in settings where quantitative research alone is often insufficient to capture the texture of that weight (Hansel, Holmes and Lindemann 2013). As Hansen, Holmes, and Lindemann (2013) put it, clinical ethnography's contribution is not only to describe the 'contact zone' between institutions and patient lives, but to place it in the historical, economic, and political context that makes its stakes legible and, potentially, actionable. My methodological framework of ethnography and interviews cannot resolve the imbalances, tensions and inequalities I uncover. I do believe it's the methodological approach best suited to taking these tensions seriously

however, and to producing the kind of scholarship and knowledge that may eventually be useful in addressing them.

Chapter Organization

This dissertation traces the reproductive psychiatric clinic across three sites of inquiry, moving from the backstage formation of clinical knowledge, through the cultural landscape patients inhabit before they arrive, into the clinical encounter itself. Each chapter builds on the previous; the logics that residents absorb in training for example are the same that the patients encounter in appointments, and the clash chapter draws on the resident socialization and patient perspectives, respectively.

Chapter One: "Medicating: Professional Socialization into Toxicity"

The first chapter examines how toxicity functions as an organizing concept in the professional formation of resident psychiatrists. Drawing on my ethnographic observations in weekly lectures, didactic training sessions and case conferences, I uncover historicize how the reproductive psychiatric clinic underwent a striking reversal, from cautioning against psychotropic medications during pregnancy to actively recommending them. I then uncover how that reversal was absorbed and transmitted through medical training and professional socialization of incoming reproductive psychiatric residents. I find that toxicity functions in this clinic as a boundary object: porous enough to hold together what is biological and what is social, what is quantifiable and what is experienced or felt, while retaining its clinical urgency across contexts. Residents are taught, I find, not only what is toxic, but how to communicate this, how to sequence information in appointments, to manage data inadequacy during patient care, and

how to translate genuine uncertainty into clinical confidence. Ultimately this is a chapter about the professional socialization of reproductive psychiatric residents, how they're made, what is emphasized in their training, and what this reveals about the nascent specialty.

Chapter Two: "Purifying: Being a Good Mom with Mental Illness"

In the second chapter, I turn to the patient perspective. Here I look at how patients arrive at the clinic having already begun the work of what they understand to be 'good mothering'. Drawing on clinical observations and patient interviews, I trace how patients develop toxicity imaginations—lay understandings of the effects of psychiatric medication on fetal and infant development—shaped by decades of public health messaging, intensive mothering ideologies, social media influence and the cultural script that makes purification the default of responsible gestation, while opposing 'good patient' behavior. I follow patients chronologically from pre-conception appointments through their pregnancies and into the postpartum, showing how toxicity imaginations are formed, acted on and brought into clinical contact. I find that patients do not arrive as passive recipients of clinical guidance but as engaged and active participants, that have already located toxicity in their own treatment. This also reveals that the clinic's task is not to inform them as much as to reorient a framework they've already internalized in order to achieve its clinical treatment goals.

Chapter Three: "Enforcing Psychiatric Authority: The Clash between the Voice of Psychiatry and Lifeworld of Patients"

The third chapter examines what happens when patient toxicity imaginations meet the clinic's biological logics in the clinical encounter. In other words, when the patient and physician

perspectives clash, how this is managed, and what it reveals. I argue that clinical authority is maintained through two characteristic tactics deployed by residents in response to patient engagement about medication. The first is outsourcing responsibility, or deferring the evidentiary burden to the limits of the research on psychopharmaceutical use during pregnancy, to external authorities, or adjacent specialties. I also look at how clinicians reposition danger from overtreatment to undertreatment, co-opting patients own frameworks to redirect their concern from medication to the untreated psychiatric symptoms themselves on their fetus' development. Drawing on observations of intake and follow-up appointments across pre-conception, pregnancy and postpartum, along with interview data, I show how these tactics are used individually and in combination, calibrated in real time in clinical appointments to whatever form patient resistant takes. The chapter concludes with the case of Sophie, whose decision to birth outside biomedical surveillance reveals that the uncertainty the clinic had been managing is conditional, with an examination of the eugenic logics that underwrite the clinic's organizing promise that treating the mother can interrupt the transmission of psychiatric difference to the next generation.

Conclusion

I situate my dissertation's contributions around three main topics. The first is that the clinic does not only manage clinical uncertainty, but displaces it. Residents, as I show, are trained to navigate incommensurability with professional confidence, strategically sequencing information, and utilizing the lack of data as a clinical move. The data inadequacy is not resolved, but rerouted from the prescription back onto the patient. I situate this finding within a broader critique about what a psychiatry organized around structural rather than pharmacological

response might look like, particularly one attentive to the sociogenic conditions the clinic names but fails to act on. The second finding is that patients arrive in doctor-patient interactions as already formed maternal subjects, saturated by purification discourse and epigenetic messaging, for many of whom stopping medication was felt as the intuitive default of good parenting, even if in contrast with good patienthood. Rather than dissolving what I call patients' *toxicity imaginations*, clinical encounters added to them, leaving patients to carry both their original concerns and the clinic's redirection. This finding contributes to a broader set of questions in STS and feminist health studies around chemical entanglement and co-embodied life, about what it means to inhabit, rather than merely pass through, a world of chemical exposures, and thinking through more porous conceptions of patient/subject in relation to exposure. Third, is that clinical authority is maintained through the tactical management of patient engagement. I find that outsourcing responsibility and repositioning danger as undertreatment are strategic responses to patient engagement in the reproductive psychiatric clinic, which, I argue, is legible within a longer history of reproductive governance, but names something new within it. The *biological logics* that organize clinical care around the maternal mind as an environment of consequence enable what I call *eugenic logics*: not the prohibition of reproduction among psychiatrically diagnosed women, but its optimization, meaning prioritizing the birth of child unburdened by the mother's condition. Finally, I interpret the patients in this study as bellwethers of more widely distributed cultural anxieties about toxic exposure and reproduction.

CHAPTER ONE

Medicating: Professional Socialization into Toxicity

Introduction

Maternity has been steeped in discourses of toxicity across a long history and in a variety of forms, from chemical exposures and pharmaceutical risks to stress, trauma, and the structural conditions of women's lives. Toxicity has never been peripheral to reproduction; it has been one of its organizing logics. From the earliest biomedical attention to maternal exposure and fetal vulnerability, to contemporary epigenetic frameworks that locate risk in the material and psycho-social environments that surround a pregnant person, maternity has accumulated a long and layered history of toxicity discourse. The maternal body has been considered an 'environment of consequence' (Lappé, Hein & Landecker 2019); based on exposure, biomedical and public health research that has built on tropes of the maternal body as a vessel, the maternal-fetal symbiosis or conflict, and the spatial emphasis of women's bodies as sites for children's wellbeing during and even prior to pregnancy (Armstrong, 2003; Casper, 1998; Kukla 2010 and Waggoner 2015; in Lappé 2016). One enduring quality of this framing is the flexibility of locating the specific site of risk, the 'environment' in the environment of consequence, which shifts across historical periods, fields and clinical contexts while maintaining the underlying logic that the maternal body is the primary site of management.

In this chapter, I examine how toxicity is used as a frame through which the maternal environment of consequence is understood in the field of reproductive psychiatry. I find that toxicity functions as a boundary object in this clinic—pervasive and organizationally useful, while difficult to locate in any single, stable form. The work of this chapter is to showcase the layered conceptions of toxicity as it relates to reproduction from physicians' perspectives. I

illustrate how reproductive psychiatry emerged as a field with close association to toxicity as an organizing concept, how recent changes in the specialty concerning medication use have been navigated in backstage (Goffman 1956) medical training interactions, and as well as how toxicity is recognized and taught to be managed by resident physicians as they become future experts in the field. I begin with the historical conditions that made toxicity central to reproductive health discourse, trace the guideline shift that inverted what counts as toxic in reproductive psychiatry, and then turn to my ethnographic data in weekly lectures and didactic training sessions to show how this framework is actively transmitted to resident physicians as they become the next generation of experts in the field.

Toxicity is a term used frequently in the clinic by both medical professionals, patients, and social workers managing patient care. It has a specific set of associations, even while failing to bring clinic members to a singular consensus about its meaning. For example, biomedical perspectives that have historically taken maternal exposure as the site of toxicity, whether through stress, chemicals, food, alcohol or drugs, influence its location and use by physicians in the clinic. Lay understandings of toxicity on the other hand are informed by public health discourse such as through the environment, stress, relationships and ingestion. While there are overlaps in its use, the incongruencies are revealing; they inform patient and clinician behavior, affect the production of knowledge in the clinic and public discourse on reproduction, exposure and responsibility.

Toxicity subtends this entire research, but it's definition varies throughout the chapters and locations through which I conduct my observations. Definitions from medicine and science define toxicity with varying and changing thresholds that have shifted throughout time and space. What and how much of a particular environment, chemical or material is understood as

toxic is shaped by biomedical research and policy, despite not always being easily quantifiable (Murphy 2006). Similarly to Chen (2023), I engage with toxicity as a boundary object –one with a malleable definition depending on context, but with a few defined characteristics. Boundary objects are abstract or concrete, flexible enough to adapt to local needs and robust enough to maintain a common identity across worlds (Star & Griesemer 1989; Trompette & Vinck 2009). Their use is in allowing different groups to collaborate without consensus, to allow distributed and heterogenous perspectives to coexist. Toxicity as a boundary object in the reproductive psychiatric clinic is both shaped by the environmental—including chemical and material—as well as the social—from the psychological and interpersonal to the institutional—and overarchingly is recognized as something to be avoided. Further, it is harmful and has negative health effects, particularly during pregnancy, with potentially intergenerational impacts, often discussed in this clinic as its 'biological' effects.

Toxicity as a boundary object in this clinic is useful precisely because it need not resolve into a single meaning to do clinical work. Despite incongruencies in specific definitions and locations, it remains a powerful signal—something to be avoided, managed and understood as carrying significant and potentially life threatening intergenerational consequences.

In the sections that follow, I trace toxicity across the registers in which it appears in this clinic; first situating it within the broader history of toxicity in reproductive health discourse, then examining the U-turn in clinical guidelines that repositioned the untreated mother as the field's primary site of risk, and finally turning to my ethnographic data to show how this framework is transmitted to resident physicians—through the management of data inadequacy, the technical threshold of medication toxicity, and the psychosocial and environmental forms of toxicity that are named in the clinic and routed, nonetheless, toward pharmacological solutions.

Historical background

The application of toxicity as a boundary object in the reproductive psychiatric clinic becomes legible through its history. The intersections of toxicity and reproduction have a past in the environmental and reproductive health movements. What material and environmental factors influence fetal development have long been centralized in biomedical, political and public health discourse. As Lappé, Hein and Landecker (2019) have traced,

> "The toxic landscape of World War II and postwar chemical and pharmaceutical production made environments of conception, pregnancy and child development uniquely visible as sites of biological vulnerability."

Further, the focus on children's environmental health in the wake of thalidomide, diethylstibestrol (DES) and lead public health crisis turned attention toward chemicals and endocrine disruptors in addition to the postwar toxic landscapes. Food has also been seen as a biologically meaningful exposure among others (Landecker 2011), but today the shift in focus from nutritional to environmental factors encompasses a diversity of psychosocial, environmental, and microbial toxicants. Overwhelmingly, toxins are something to be avoided, locationally, they have expanded rather than contracted over time, as they continue to permeate across different social and material contexts.

The nucleated focus on children's environmental health (Lappé 2016) is also informed by the exclusion of pregnant people from clinical trials, a practice that reified the developmental biologies of fetuses as having critical or sensitive windows of development (Natl. Res. Counc. 1993). This exclusion had its own internal logic: without data on how medications affected fetal development, the cautionary move was to remove them from the equation altogether. If the effects of a substance were unknown, avoidance was reasonable, even responsible. The absence

of evidence became, in effect, evidence for caution. The consequence, however, of pregnant people being treated as a vulnerable population and excluded from clinical trials and biomedical research (Epstein 2007) is that clinicians accumulated very little knowledge about drugs and pregnant women, despite the hyper-surveillance of reproductive bodies. This data gap would prove consequential; it is the condition of possibility for the guideline reversal that follows.

Recently, the framework of fetal protectionism that drives the conceptions of toxicity as consequential to fetal wellbeing has further exploded amidst the emergence and proliferation of the field of epigenetics. This area of research that studies how exposures and experiences can turn genes on and off heightens the stakes of toxicity exposure, and has the capacity to create a dangerously deterministic framework as it further individualizes the responsibility of toxic exposure to something women must actively negotiate. Under the epigenetic framework, toxic environments can be both within and beyond the body. Instead of focusing exclusively on ingestion during pregnancy, a mother becomes "more and less than an individual, interconnected to and instantiated through the many potentially toxic environments that surround her and her fetus," (Lamoreaux 2016).

The epigenetic turn did not create the figure of the toxic mother, but extended her reach, making the consequences of her exposures—chemical, psychological, relational, structural—potentially heritable. The information about environmental exposures from pollution to diet, to stress and trauma permeates public health interventions, and has created messages of "responsible", "safe" and "good" parenting practices extending as early as the preconception period, informing patients' perspectives on appropriate maternal behavior in order to avoid embodying toxicity during gestation. This, as Sasser (2018) and Ford (2020) have argued, creates a simultaneously vulnerable and empowered subject, but one that nonetheless is centrally

responsible for one's body and choices for children and future generations (MacKendrick 2014). Precautionary consumption (avoiding the toxic) and anticipative medicalization (medicalizing the pre-conception reproductive body) have both been theorized as ways to enact good mothering despite potentially toxic contexts. The influence of toxicity for patient/mothers in the clinic and the intersection of intensive mothering, anticipative medicalization and "toxic imaginaries" is more thoroughly explored in Chapter 2.

Toxicity is deeply embedded in the biomedical and reproductive health cultures, and has been taken up as a central focus in numerous fields that intersect with reproduction—i.e. obstetrics, nutrition, genetics, to name a few. Following its short and tumultuous history, "psychiatrists have attempted to shore up their legitimacy through the embrace of psychotropic pharmaceuticals, not only as preferred treatment for mental health disorders but also as the bedrock of their professional expertise (Scull 2022)," (Abel & Timmermans 2026). With an aimed focus on maternal mental health, reproductive psychiatry has aligned itself with pre-existing biomedical disciplines that have taken toxicity a central framework around which ideas of exposure, quantification, and responsibility are organized. Unlike biological psychiatry's embrace of psychiatric drugs however, reproductive psychiatry has only just begun to embrace the use of pharmaceuticals. It follows then, that this emergent specialty—at the intersection of reproductive health, that has long been intertwined with notions of toxicity and the maternal body, and psychiatry, that takes both the biological and social factors related to mental health as objects of inquiry—also utilizes toxicity as a technical tool. Reproductive psychiatry is the most recent of these fields to centralize toxicity as an organizing concept, and has done so at a particular historical moment. One in which the data on psychiatric medications during pregnancy remains thin, the stakes of maternal mental health have been newly framed as a public health

crisis, and the boundary between what counts as toxic and what counts as treatment has become the field's defining clinical problem.

Guideline shift/ U-Turn in the field

Against this backdrop, a reproductive health field long preoccupied with what enters and endangers the maternal body, reproductive psychiatry has undergone a striking reversal. The field has not simply absorbed existing toxicity frameworks; it has inverted one of their central premises. Reproductive psychiatry has taken a U-turn; what was once considered toxic to the pregnant patient—understudied psychiatric medications and their unknown effects on fetal development—has become the recommended standard of treatment. Guidelines cautioning physicians to take patients off of psychiatric medications during pregnancy now call for physicians to prescribe medication. According to these new standards of treatment, an untreated mother, an undermedicated patient, and her own social environment now carry the most toxic potential, affecting not only the patient, her pregnancy, but her family unit as a whole both in the immediate and long-term temporalities.

The cautionary approach that preceded this reversal had its own logic. In the absence of data, the result of decades of excluding pregnant people from clinical trials, avoiding unstudied medications during pregnancy was a reasonable precautionary measure. If the effects of psychiatric medications on fetal development were largely unknown, limiting exposure was defensible. The 2023 reversal did not produce new long-term safety data; it reframed the risk calculus. What changed was not the evidence base, but the primary site of danger.

What warranted this clinical shift in language and treatment recommendations? Despite biological psychiatry's embrace of pharmaceuticals, the use of psychiatric medications during

pregnancy was not always endorsed. In line with the rise of fetal prioritization laws (Milne 2020) and the avoidance of toxicity in the maternal body in public health discourse, doctors were counseled to discontinue pharmaceuticals during pregnancy and breastfeeding, despite patients' psychiatric needs. In an introductory lecture to incoming residents, a senior attending in this clinic summarized this marked shift in the field,

> "Research was prohibited in women who were pregnant in the 1980s. Then congress convened a conference to establish that there *is* a need for research in pregnant women. Nevertheless, limited or not, treatment decisions are needed to guide care. So," she asked "what are the guiding principles of reproductive psychiatry?"

In 2008, the American College of Obstetricians and Gynecologists' guideline on clinical management for OBGYNs recommended that physicians discontinue psychiatric medications for pregnant and breastfeeding women, despite the potential risks associated with undertreatment,

> "An estimated 500,000 pregnancies in the United States each year involve women who have or who will develop psychiatric illness during the pregnancy. The use of psychotropic medications in these women is a concern because of the risks of adverse perinatal and postnatal outcomes. However, advising these women to discontinue medication presents new risks associated with untreated or inadequately treated mental illness, such as poor adherence to prenatal care, inadequate nutrition, and increased alcohol and tobacco use." (Bulletins--Obstetrics 2008: p. 773)

This conceptualization pitted the interests of the pregnant person against the teratogenic harm to the fetus/infant. The guideline authors cautioned against psychotropics during pregnancy due their potentially toxic effects on fetal development, and while the mention of undertreatment as a risk is included, the focus is on the effects of undertreatment on the wellbeing of the fetus/infant. The logic was precautionary: in the absence of sufficient evidence, limit exposure.

By 2023 an updated version of the clinical practice guideline reversed the recommendation—stating that the undertreatment of mental health conditions was a more

pressing concern that not only carried risks for the pregnant or lactating woman who might decompensate psychiatrically, but also, this time explicitly, for "the fetus or offspring, the partner, and the family as a whole (including other children who may be affected)." (2023: p. 1263). The threshold for danger and location of toxicity shifted from the unknown effects of medication on fetal development, to the undertreatment of mentally ill mothers for the family, broadening the boundaries of patienthood, and using psychiatric treatment to ensure familial and social cohesion in the postpartum period. Notably, this shift occurred without a commensurate expansion of the evidence base. Long-term research on the effects of psychiatric medications during pregnancy remains limited.

There are models of psychiatry that extend the treatment considerations beyond the patient herself—holistic or family-centered psychiatric models of care consider how family members and social networks affect mental health treatment and outcomes for patients, for example. For pediatric psychiatric patients, in particular, psychoeducation and the involvement of family members is utilized to ensure positive patient outcomes (Gearing 2008). The difference in reproductive psychiatry as evidenced by the language of the clinical guideline, is that the patient is not treated exclusively so that she may recover herself. Rather, her recovery is put to work; she is subsumed into the family unit, her psychiatric care is reoriented toward the relational and social functions she is expected to perform. In this clinic, gendered expectations of maternal function become the very signposts by which patients recovery is evaluated. The attending lectured on the guideline shift,

> "The key issue is that it's essential for mom *and* baby to be healthy, physically and mentally. ACOG believes in this as well. Only recently do they actually establish this as a guiding principle for their practices."

In adherence to the reversal of ACOG guidelines that shifted from cautioning against drugs during pregnancy to embracing their use, psychiatrists are encouraged to prescribe medications despite the limited research, and the high medico-legal stakes of too much or too little medication for a population deemed high-risk. This may in part be in response to the framing of maternal mental health as a public health crisis; an often cited statistic in the field, and frequently in the clinic is that 20% of women have psychiatric illnesses during pregnancy and postpartum, with intergenerational consequences if left untreated. National reports on the associations between untreated psychiatric disorders and parenting practices strengthen this link, "Strong evidence now supports the breadth and extent of associations between depression in parents and adverse outcomes in children."[3] Following this, there are increased efforts to 'catch' and treat more cases through screening during pregnancy and postpartum doctors' visits, which, have been found to have limited efficacy (Haslam 2026). Expanded screening, however, is not without risk; a broader diagnostic net captures not only undertreated illness but social and structural distress that may be misread as pathology, with consequences that fall unevenly across patient populations already subject to heightened scrutiny. Further, most patients who are diagnosed in postpartum lack substantial care, leading to a wider deficit; more people are being diagnosed and too few are being treated (Farmer 2001). In the psychiatric context, undertreatment may have severe effects, with suicide and the much rarer but publicly captivating cases of infanticide heralded as pinnacles of psychiatric negligence. The ACOG reversal is thus a welcome intervention for psychiatrists in clinics focused on medication prescription and management to address maternal mental health, with psychopharmaceuticals conclusively embraced as the solution to this maternal mental health 'crisis'.

[3] https://www.ncbi.nlm.nih.gov/books/NBK215113/

Despite this shift, psychiatrists in general have not necessarily begun prescribing medications to pregnant people, yet specialty clinics like the reproductive psychiatric clinic I observed have indeed incorporated this change in their clinical norms and are paving the way for others to do so, through focused residency programs training young psychiatrists how to prescribe medications with little long-term data to these high-risk populations. Perhaps unsurprisingly, and in line with biological psychiatry's embrace of pharmaceuticals, medication use similarly became the institutional aim of reproductive psychiatry**,** "the goal of perinatal mental health treatment is to optimally provide pharmacotherapy to mitigate the somatic and psychosocial burdens of maternal psychiatric disorders."[4]

For reproductive psychiatrists, this is an opportune professional turn in the field, and is viewed as medicine's embrace of their psychopharmacology practices. Teaching resident psychiatrists how to continue medication regimens during pregnancy is one facet of this shift; the other is incorporating language in patient-interactions that encourages medication compliance despite patient hesitancy. During her lecture, the senior attending discussed the necessity of understanding patient perspectives in order to guide them toward medication use,

> "When our clinic started in 1993, we really looked at it in large part as psychopharm clinic with specific guidelines… over the course of these years we've really come to appreciate that we have a major job, we have to *listen to them*, understand where they're coming from. We can't just write out a treatment plan and expect our patients to follow that treatment plan if they haven't bought into that treatment plan. And that's largely what we'll talk about today."

Securing patient buy-in is no straightforward task, and the clinic's psychopharmaceutical focus depends on something medication guidelines cannot prescribe—patient consent, actively cultivated against a backdrop of intensive maternal ideologies, public health messaging about

[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC7207058/

fetal exposure and social network and media messaging that position psychiatric drugs as precisely the kind of substances a 'good mother' avoids. This attending's statement also marks the historical shift that occurred in the clinic, how the practices within the backstage interactions of professionalizing residents have shifted, and how the professionalization of doctors reveals the changing nature of the field. This also models what Vinson and Underman (2020) have called a shift from "detached concern" toward "clinical empathy" as a standard for physician behavior when interacting with. This emphasis in expressing emotion in medical encounters has been theorized as a result of corporatized medicine, which is focused on shifts in clinical interactions in order to increase patient satisfaction. Balancing the need for patient buy-in and satisfaction, with the adherence to the new standards of treatment requires an intentional and cohesive framework.

Navigating this tension, between the new standard of prescribing and the patient hesitancy that standard routinely encounters, required more than updated guidelines. It required a clinical culture, actively built and transmitted through the changing norms of the field and the backstage interactions of resident training. In the following section, I trace how that culture took shape: first through the guideline shift that redefined what counts as toxic, and then through the lectures and didactic training sessions in which residents learned to put that redefinition to work.

Socializing Psychiatrists About Toxicity

The historical shift in reproductive psychiatry—that went from cautioning against psychotropic medications to recommending their prescription, created a clinical problem that no guideline revision could fully resolve: long-term, robust data simply do not exist to support the recommendations with confidence. Clinicians are asked to prescribe, and recommend a patient

population that has been systematically excluded from the very research that would make these recommendations legible, to accept prescriptions. This is the puzzle at the very heart of the professionalization of reproductive psychiatrists. How do you teach physicians to act decisively in a domain defined by uncertainty? How are clinicians socialized into confident clinical practice when the evidentiary foundation beneath them is by their own admission, thin?

In my observations of the resident lectures and didactic training sessions, I observed how this puzzle is navigated in practice. Specifically, over the course of my four years of fieldwork, I attended weekly lectures on Wednesday afternoons that were delivered to incoming and continuing residents in the clinic. Following the lecture from one of the attendings or guest lecturers, residents would present their cases and receive feedback and training about how to treat the patients, and a discussion would follow about what the information from the lecture could inform for their practice going forward. These lectures and case conferences presented a curriculum that functions less as a neutral transmission of medical knowledge as an active project of professional formation .

The residents I observed in this clinic were in the training portion of their medical careers; having recently completed medical school and obtained their degrees, I observed residents primarily in years three or four of their medical residencies. They completed year-long rotations in this clinic, in addition to other clinics in the hospital. A select few residents returned or came to the reproductive psychiatric clinic as fellows, meaning they'd completed their medical education and residency, and were seeking additional expertise in the field. Attendings in the clinic varied in their career statuses; one resident I observed graduated to become an attending in the clinic, others came from previous positions or institutions. The founding attending of the clinic held a more senior, advisory role, while others worked directly with

residents and participated in their training and lectures, often alongside private practices. Some attendings in the clinic were close to retirement, having practiced psychiatry for decades and completed their medical schooling many years before. Others had more recently undergone training, offering varying perspectives on present guidelines and orientations toward diagnosis, treatment, and the psycho-social factors considered in psychiatric treatment as well.

In the weekly lectures and case conferences I observed, several themes emerged with consistency across cohorts and clinical topics, 1) the untreated mother as the primary site of risk, 2) the inadequacy of the data underlying treatment recommendations, 3) the technical management of medication toxicity, and 4) the psychosocial and environmental forms of toxicity that pervaded patients' lives. The problem of data inadequacy surfaced most relentlessly, nearly every week, whether the topic was a particular psychiatric diagnosis or a psychopharmaceutical drug treatment. "We just don't have the data," was a frustration repeatedly echoed as clinic actors navigated high-stakes treatment decisions across a landscape of sparse research. Walking clinicians through the limits of existing research opened a gap that required a particular clinical judgment to bridge—one that held together institutional guidelines, patient needs, and the authority of a specialty still consolidating its legitimacy.

Toxicity itself was a factor that I first observed in the clinic as a useful signpost in more technical lectures on medication doses, as well as during resident-attending didactic training during clinic, when residents saw patients during appointments and discussed which course of action to take with attendings on staff. Specifically, testing patients for toxic blood levels, was as something that I first started to hear for patients taking high doses of a drug used to treat bipolar disorder in effort to avoid a manic episode in the postpartum- a potentially toxic dose of a drug necessary to avoid the worst possible outcome in the clinic, a postpartum psychosis.

Over my years of observation, and through abductive analysis, I began to connect toxicity as an emergent theme that transcended the overt discussion of toxic blood-levels, to a more porous conceptualization that was utilized by physicians for its inherent urgency while encompassing the combination of factors that the clinicians adopted under its broad scope. Toxicity as a boundary object is precisely what makes this navigation possible. Its definitional flexibility allowed physicians to maintain a coherent framework; residents were not simply taught what is toxic, they were taught how to use toxicity as an organizing concept than can travel across the biological, psychiatric and social registers of their work.

What emerged across these lectures was not a tidy resolution to the puzzle, but a set of tools for living with it—communication and clinical resources that residents absorbed as they underwent professionalization. In the sections that follow, I trace how these tools were transmitted: beginning with the clinic's foremost toxic concern, the untreated symptomatic mother, then moving through how data inadequacy was parsed and risk was communicated to patients, how the technical threshold of medication toxicity was incorporated into clinical practice, and finally how psychosocial and environmental forms of toxicity were subsumed into this pharmacological framework. It is, in other words, a backstage view into how reproductive psychiatrists are made.

Toxic logic & the Untreated Mother

While some forms of toxicity included exposure to ingested medications, chemicals or physical environments, as well as psychosocial relationships or institutional inequalities, the clinic also situated untreated mental illness as a toxic environment for the developing fetus. Crucially, this form of toxicity operated differently from the others. Whereas medication,

polypharmacy and social/environmental toxins were named explicitly as toxic, untreated mental illness was adopted through a logic of toxicity: a clinical reasoning that positioned untreated psychiatric illness as an exposure to the developing fetus, one whose consequences were consistently framed as more dangerous than the uncertain risks of medication. One set of toxicities concerned what in the environment would harm the pregnancy, this logic concerned how the clinic organized risk itself.

The most significant site of toxicity from the clinical perspective therefore was an untreated, symptomatic pregnant or postpartum patient. For both the patient's own recovery trajectory and the long-term wellbeing of her baby, an untreated mother was consistently positioned as the worst-case scenario. This clinical orientation followed directly from the 2023 guideline reversal, naming undertreatment rather than medication as the primary source of harm to the patient and her family. Focusing on the untreated psychiatric patient as the primary site of risk creates space for expertise that reproductive psychiatry is uniquely positioned to address, and how physicians are socialized to represent this position is legible in the backstage interactions I observed.

The biomedical literature informing this framework made the case directly. Research has established that intrauterine fetal exposure to psychological stress—including antenatal depression—can affect the cognitive, behavioral and emotional development of the child (Talge et al. 2007; Van den Bergh et al. 2005; Oberlander et al. 2012). The stress responses associated with untreated maternal depression have been linked to reduced birth weight, preterm delivery, developmental delays and impaired language acquisition (Deave et al. 2008; Paulson et al. 2009; Velasquez et al. 2013). Epigenetic research has extended the stakes further, suggesting that fetal exposure to elevated maternal distress may produce heritable alterations to the DNA—changes

whose functional consequences remain uncertain, but which positions the womb itself as an environment of exposure sensitive to the mother's psychiatric state. The untreated mother in this framework does not only suffer, but transmits toxins.

This extension of toxicity from ingested substance to maternal psychiatric state is precisely what makes it function as a boundary object. The concept travels from teratology or the study of congenital malformations to epigenetics to psychiatry without losing its clinical urgency, adapting while maintaining its organizing logic—that there is an environment of consequence and the mother is responsible for its management.

Examining the backstage (Goffman 1956) skill development in the reproductive psychiatric training illustrates how this framework becomes enculturated into the institution (Collins 1986). For reproductive psychiatrists in training, this occurred in the weekly lectured that consistently singled out undertreatment as the worst possible outcome.

> "The key issue here is that it's essential for both mom and baby that mother is healthy. She has to be healthy, physically and mentally."

This narrative was repeatedly offered to residents as they learned the norms and practices of the clinic. Practicing adopting the clinic's particular discursive techniques for framing undertreatment as the worst-case scenario allowed for the exercise of power between clinic participants (Foucault 1982); residents learned not only what to think about untreated illness but how to say it and to whom.

The conceptualization of untreated toxic exposure was stated most explicitly during lectures and in patient appointments when residents reproduced the logic they'd absorbed in training. In a December 2024 appointment, a resident told a medication hesitant patient,

> "Untreated depression, untreated mania is not a benign thing, and can cause harm to mom and the baby. Untreated depression/mania increases risk of preterm deliver for the baby, increases risk of inadequate fetal care. If you're not feeling good, that will impact the baby's development, the attachment, the bonding. We think about untreated depression on baby versus treatment."

Attendings modeled this conceptualization in more expansive clinical terms in lectures.

> "What we know is that people who have untreated anxiety/depression, that in and off itself is an exposure to the fetus. And that can impact the health… it can cause preterm delivery, can impact bonding between mom and baby and can impact development. We weigh that risk of untreated anxiety up against the theoretical risk with antidepressants."

The phrase 'in and of itself is an exposure' is the toxic logic in its clearest form: untreated illness isn't merely associated with harm, but is the harmful environment itself. A further elaboration extended this framework across diagnostic categories.

> "We're doing risk/risk analysis. Does medication have risk, but also risk of untreated depression, anxiety… these have effects during pregnancy, and have effects on the baby. Some of those things are experiencing more negative pregnancy outcomes, baby being born early or small, difficulty with breastfeeding initiation… We also see neurobehavioral outcomes such as child developmental, social and behavioral problems and brain structural changes. There are risks of untreated depression during pregnancy. So we weight those with the medication."

This framing is the toxic logic made structural—a formal clinical calculus in which untreated illness is considered an exposure with measurable fetal consequences. For patients with ADHD diagnoses or taking stimulants, this same logic applied. An attending modeled how to discuss this with patients,

> "What kind of risk would be there for the fetus if ADHD was untreated? It's less quantifiable but we do know that untreated mental illness during pregnancy will definitely have negative outcomes. Both how you're taking care of yourself, can cause difficulty in relationships within the family, difficulty parenting. Going off of ADHD medication would be a risk to the fetus, versus the risk of stimulants."

Notably, the risks discussed here extend beyond the fetal exposure to the family structure itself. Toxic logic in this instance is not only about protecting the fetus from biochemical harm, but about restoring the mother to her role within the family structure. Adherence to treatment becomes inseparable from maternal competence, with medication offered as the mechanism through which the patient fulfills her expected gendered responsibilities to the child and household. That this language appears unremarkable in clinical training speaks to how thoroughly toxic logic has absorbed broader cultural expectations of maternal responsibility into its clinical reasoning.

This discourse in doctor-patient encounters was rehearsed in lectures throughout the academic year and reinforced in didactic trainings in which attendings modeled how to speak with patients. Despite the clinic's acknowledgement of minimal long-term research on medication safety, as discussed in the following section, the toxic potential of untreated symptoms was consistently presented as the more significant indicator of harmful outcomes. Some examples from lectures include,

> "We all need to remember that depression during pregnancy increases risk for postpartum depression. Obviously a woman who is anxious, depressed or psychotic or has some other emotional condition during pregnancy, as she marches into the postpartum, what do you think is going to happen?"
>
> "Our job is to help patients weigh not treating their illness against the risk of treating their illness, and often in our clinic that involves medication."

Once the toxic logic was established—untreated illness as exposure—the clinic then taught residents how to use it strategically with patients. The sequencing of the information became a clinical skill. As one attending instructed directly, "Don't send data to patients without mentioning the risks of untreated depression… in the context of the effects of untreated depression, anxiety, bipolar, the risk of medication are much more digestible." This sequencing is

the toxic logic in action, establishing the maternal body as the primary site of risk, introducing the medication as the lesser of two exposures afterwards. Attendings often coached on the precise language to use,

> "So we talk about the risk of medication, we sometimes forget the risks of being decompensated in mental health too. Like heightened anxiety during pregnancy is associated with a host of other risk factors, and just 'you being healthier now will set up your baby… and definitely untreated anxiety in the pregnancy leaves you at risk for postpartum depression,' which I know all of us are very concerned about."

The notion that patients' psychiatric symptoms were heritable and that untreated symptoms could result in offspring with similar vulnerabilities was introduced early on in residents' training. Toxicity from this perspective could be passed down generationally.

> "We know that a baby that develops in a biochemical environment of untreated anxiety, right, that can affect the development of the HPA axis and, you know, sort of the cortisol issues and sort of all of that, right? So we say 'untreated anxiety is bad for the baby's likelihood of being able to manage anxiety,' right?"

Even in the rare cases where medication carried enough documented risk to warrant serious discussion, the toxic potential of medication was always weighed against, and typically subordinated to, the consequential effects of untreated illness. In an exchange about benzodiazepine exposure versus untreated anxiety, a resident and attending illustrated this directly:

> *Resident:* "Exposure to a benzo right, that's going to maybe lead to anxiety? And so whether that's an anxiolytic or untreated anxiety, your baby may be set up for anxiety. It's like how do you consider both of those things as being true?"
>
> *Attending:* "Maybe it's genetics or epigenetics. You know, don't forget, we're learning so much more about epigenetics. That in utero there are factors that turn on and off various genes, things we never even knew about. Cortisol being one of them. This is such a baby science, in so many ways."

The clinical equivalence drawn here, between the risks of medication and the risks of untreated illness, resolved, in practice, toward medication. Regardless of where the toxic location was identified, the emphasis in this clinic was that untreated psychiatric disorders were worse than treatment, and carried worse infant outcomes.

This framework was also transmitted through explicit exercises in patient-facing language. Attendings modeled this when discussing their conversations with patients,

> "I just said, you know, 'you are the template!'"
>
> "Don't forget — 'you are the template for your children. If you do well, they do well.'"
>
> "And now… if you're an anxious or depressed mom, are you talking much to your baby? Not so much! So how do babies learn to speak and relate and react? It's because *you* are the template. You are the person the baby is relating to… you're really important. So how you react is… daddy is important too, but… for those first few months, you're there. So that's the reason we think medication is a good idea."

The template language is significant. It collapses the distinction between psychiatric recovery and maternal function, making treatment adherence and good mothering effectively synonymous. Residents absorbed this clinical argument and toxic logic—a way of speaking to patients that mobilizes maternal identity in the service of medication compliance. What begins as a clinical framework for conceptualizing untreated illness as fetal exposure becomes, in the template language, a moral framework in which the symptomatic mother is not merely at risk but the source of potential harm.

This training was made explicit in how attendings described their own patient interactions. The data on untreated depression, its continuity across the perinatal period and its consequences for infant outcomes was not only clinical information to be shared, but a tool to be strategically deployed. As one attending stated plainly, "With postpartum depression, the longer you're depressed, the worse it is for infant outcomes." While clinical in register, the function of

this statement in the lecture was motivational; the duration of untreated illness, rather than the uncertain risks of medication became the primary site of danger. The same attending elaborated on her patient-facing strategy directly,

> "So it looks like about a third of postpartum depression actually begins before pregnancy. So it's a continuation of a depressive episode that was before pregnancy, continues during pregnancy. So it's helpful for people to understand that sometimes… people understandably just really want it to go away, right? They just hope that something's going to change, either when they become pregnant or when they deliver. And what we know is that that's just not, it doesn't typically change. What I will also tell people, if I'm, like, really trying to get them to buy into their own treatment, or to, like, seek out treatment, is, I'll say, like, it doesn't get easier with pregnancy, and it certainly doesn't get easier with a baby."

What is striking about this account is not the clinical content, the continuity of depressive episodes across the perinatal period is well documented, but the attending's candor about its purpose. She offers the data not as information to inform a patient's autonomous decision, but as a tool for persuasion: something she reaches for when she is "really trying" to move a patient toward treatment. The temporal arc of untreated illness, stretching backward before pregnancy and forward into the postpartum, functions here as a form of managed urgency—one that makes delay feel as toxic as the uncertain risks of medication use.

In this way, the clinic's deployment of the untreated mother as the primary site of toxicity comes full circle. What begins as a genuine clinical concern, the real and documented harms of inadequately treated psychiatric illness, in practice becomes a strategy for managing the patient hesitancy that the inadequacy of data has itself produced. The patient who resists medication because she fears its toxic potential for her fetus is met with a counter-toxicity: the harm of her own untreated depression to that same child. She is left caught between two sites of risk, both organized around the infant's wellbeing, and both pointing toward the same clinical conclusion.

The toxic logic is, in this way, one more iteration of toxicity's work as a boundary object in the clinic—extending its reach from the chemical to the psychiatric, nameable to the structural, without ever losing its organizing force.

Data inadequacy

The untreated mother as the clinic's primary site of toxicity did not emerge in a vacuum. It was shaped, in part by a structural problem that the clinic could not resolve—the data to support confident medication recommendations simply do not exist. A complicated factor following the clinical shift in guidelines is that there remains a profound inadequacy that would allow clinicians to definitively recommend medication to patients without risk. This absence is a structural inheritance, produced by decades of exclusion of pregnant women from clinical trials, which has left clinicians tasked with treating a population for whom the evidentiary base was not built. The clinical recommendations that now govern psychiatric medication use during pregnancy do not rest on a settled foundation, but on a series of substitutions; extrapolated data standing in for direct evidence, institutional consensus standing in for clinical trials, and carefully managed uncertainty standing in for answers that neither clinicians nor their patients can conclusively access.

By their own accord, the data that clinicians relied on to make recommendations in this clinic were often incomplete, contested, or derived from populations with altogether different clinical profiles. In their weekly lectures, attending psychiatrists gave presentations summarizing the most current available research on particular medications and conditions—combining their findings of the meta analyses with clinical experience to stand in for the often inadequate data. Clinicians understood their role as one of excavation and interpretation, digging through a literature they openly characterized as frustrating and insufficient, shaped by a federal regulatory

context that had drawn broad strokes against medication use during pregnancy without, in their view, adequately accounting for the harms of undertreatment. The work of the clinic, then, was to collect, interpret, teach and present what they considered to be largely inadequate findings to patients in a manner that aligned with updated ACOG guidelines and the clinic's overarching goal of treating psychiatric illness during pregnancy.

Clinicians began by contextualizing the data itself as methodologically compromised. A recurring framework in the clinic held that existing research had systematically failed to isolate the effects of medication from the effects of the untreated psychiatric conditions those medications were prescribed to treat. As one attending explained during an orientation,

> "Lots of studies don't control for untreated depression during pregnancy, because if someone comes to us depressed in pregnancy, they are at risk for worse pregnancy outcomes, for child neurobehavioral outcomes. You can find tons of studies that SSRIs lead to bad outcomes, but what they're not accounting for is depression during pregnancy. Because without the control, it looks like SSRIs lead to the negative outcomes, but it's the depression that leads to the negative outcomes."

This methodological critique extended to federal regulatory bodies, "The FDA's whole stance is that antidepressants lead to bad outcomes in pregnancy," one attending noted, "but they were citing a lot of studies that don't control for depression in pregnancy. It's really sad." Clinicians experienced the data landscape not merely as a technical problem but as an institutional failure, one that left them defending medication use against regulatory guidance they regarded as scientifically inadequate. Another attending made the stakes of this uncertainty explicit,

> "This is why it's so frustrating, we just don't have very many studies on medication treatments. Sometimes our patients come to the clinic and we can't satisfy them one way or another, because we don't know! We ourselves don't know, and we debate this all the time in our clinic."

The clinicians' perspective of data inadequacy ran deeper than contested findings. Even the foundational question of what constitutes fetal exposure was debated. In a case conference, a senior attending posed the problem directly when discussing at what point during gestation and medication use the clinic pinpoint exposure at all,

> "Whether you know, our blastocyst or early stage embryo has been exposed or not exposed and how, how do we even define exposure in those first few weeks?"

For individual medications, the available data was often derived from populations whose relevance to the clinic's patient base required interpretive labor. Naltrexone's safety profile in pregnancy, for instance, was drawn largely from studies of opioid use disorder, a clinical context with a different risk calculus and a different patient population altogether.

> "And in that setting, it seems to be likely safe in pregnancy. There is some evidence that it alters the development of opioid receptors in the brain of the fetus. And it could have long lasting impacts. We just don't have enough data to say for sure."

For stimulant medications, the available neurodevelopmental data that was referenced in the clinic came from studies of methamphetamine-exposed infants. An attending walked residents through these studies in lecture, noting her frustration with the incongruencies between patient populations,

> "There's really little to report on in terms of neurodevelopmental stuff. I can go over these studies… basically there's very little to report on. Some of the findings like in this study looked at infants born to addicted mothers, or studies are small or are case reports, like this one of 421 meth-addicted mothers had abnormal functioning in a year… the ideal study is more informative. Over 400 mother infant pairs from birth to 7.5 years, again of methamphetamine exposed infants, found prenatal exposure greater risk of NICU admission, small size. Another report showed heavy meth exposure associated with attentional problems and anxiety and depression at age 5/6 then aggression, behavioral problems, ADHD, cognitive impairments... There are these findings, none of these are really great studies, we don't have a lot of studies still."

Even where signals existed in the data, their clinical significance was uncertain and their interpretation contested. One resident described this interpretive labor,

> "It's like, if you really, *really* dig into the data, maybe there's a *slight* increased risk for left ventricular outflow tract. Not all studies have shown that, there's a small, possible specific risk."

In this quote, the attending's response also reframed the finding in terms of clinical manageability. Most such defects, she noted, are correctable, and when pressed on whether that was definitively the case, she acknowledged, "I'm not 100% sure." The reassurance was not that the risk was absent, but that its consequences, if realized, could likely be managed—a reorientation of the risk calculus that quietly shifted the terms of the conversation from uncertainty about harm to confidence in its remedy. In this section, attendings modeled to residents how to manage the lack of evidence, socializing them in interpretation and analysis of the literature and content related to reproductive psychiatric treatment. In the following section, I illustrate how residents were socialized to communicate inadequate data and convey the clinic's logic to patient/mothers.

Learning psychopharmaceutical toxicity

The data inadequacy that shaped how clinicians framed untreated illness as the primary site of risk did not dissolve once a medication was prescribed. It followed physicians into the next clinical problem—how to manage a drug whose therapeutic and toxic thresholds were, in many cases, only marginally understood for this population. While the preceding sections traced how toxicity was located in the untreated patient and managed through a pedagogical strategy of strategic disclosure, this section turns to toxicity in its most technical form, measurable in blood,

quantifiable by threshold, and taught to residents as both an inevitable potential and a clinical signpost. The management of toxic levels of medication was taught to residents in lectures throughout academic year; illustrating the technical utility of toxicity, its quantification, and the clinical orientation toward it as a data point to inform treatment. During a lecture on the use of Lamotrigine, for example, symptoms of toxicity were reviewed to teach residents what to look out for,

> "What can happen is if you increase [Lamotrigine] significantly, like if you go from 400 to 600 or 800 in the postpartum as the estrogen decreases, the Lamotrigine level's going to rise and you might become, the person might become toxic.[…] And just as a reminder, Lamotrigine toxicity consists of double vision, ataxia, nausea, dizziness, so it's kind of like that central nervous system toxicity. So if you see those symptoms in the postpartum and you've increased Lamotrigine significantly during pregnancy, you definitely need to check a level and properly decrease."

From this perspective, medication levels in a patient's blood was the most significant indication of toxicity, a measurable quality, that is then quantified, evaluated in relation to normal ranges, and determined to be within or outside of the threshold for safety. This was managed through repeated blood tests to measure levels of medication in a patient's blood to determine if they were in the normal range, which patients were responsible for completing. This practice depended on collaboration with a patient's reproductive health team—OBs, pediatricians, and psychiatrists—further biomedicalizing her care in an expanding reproductive surveillance regime. Patients were responsible for completing these blood tests to determine toxic levels, with variation in compliance. For the patient who complied, toxicity could be read in her chart, for the patient who did not comply, physicians were taught to look out for symptoms of toxicity in clinical interactions.

Once a medication was prescribed at a certain dose, or a patient's level approached the numerical threshold, toxicity could be expected. Psychiatrists read patient interactions with an eye of toxicity; in patients' first appointments, psychiatrists took careful account of their histories and affect for evidence of medication doses or combinations that might suggest toxicity during pregnancy, or for signals of mental health conditions that they determined were undertreated, which held its own toxic potential. Resident psychiatrists were primed to comb through any potential root of toxicity in patient cases, and relied on clinical guidelines and information from lectures on disorders and drugs to help measure at what point medications tipped from therapeutic to toxic in their patients' bodies.

The clinic's goal in relation to medication toxicity was to keep patients below toxic levels throughout pregnancy and postpartum, ideally avoiding this type of toxicity altogether. While doses of medication and their corresponding levels varied amongst patients, the capacity to quantify, track and prescribe based on the numbers that determined toxic levels kept toxicity as something easily manageable from the physicians' perspective. This mirrored the way physicians calculated risk in medication use—following patients closely, and shifting methods or changing course when close monitoring determined that negative effects were outweighing therapeutic effects. The testing ground for this experimentation was the maternal body, once a medication level reached the threshold of toxic, symptoms of toxicity could be observed in the patient.

The clinical threshold for risk during pregnancy also affected how medication toxicity was interpreted. In a clinical lecture, an attending psychiatrist reiterated the notion of pregnancy as an inherently medically risky experience, which had the effect of minimizing any potential consequences of medication toxicity,

> "Most people don't think of pregnancy as inherently risky. They're excited, but 3% of pregnancies incur a risk of some sort. Major malformations, many can be fixed but nevertheless… pregnancy is inherently risky. Yes, there has to be some concern on the safety of psychiatric medications, *all* medications. Consideration needs to be given on its necessity, side effects for mother and baby, teratogenicity, long-term developmental issues… all these things and more need to be considered."

Critically, toxic levels of medications, unlike the inherent risks of pregnancy, are iatrogenic—doctor ordered—and a normalized component of psychiatric care. Up until a particular blood level, medication is interpreted as therapeutic, after a particular threshold, the prescribed dose turns toxic.

Thus residents walked a fine line; on the one hand, adhering to biological psychiatry's use of pharmaceutical medication and ACOG's guidelines to treat mental illness in pregnant people despite lack of data, and on the other, avoiding toxicity by overprescribing medication. Despite lectures on the potential harm of too much medication, such as one attending's warnings, "Make sure you're not giving them toxic levels, don't overshoot it," senior doctors often referred to their clinical experience to warrant treatment recommendations that differed from the literature on toxic levels. For example, despite serious risks of toxicity in the immediate postpartum,

> "Sometimes people get concerned if they increase lamotrigine in the postpartum as the estrogen levels drop that the person will become toxic. You have to be really careful in the postpartum."

An attending responded with her clinical experience to counter the risk narrative,

> "I see people all the time go on and off of it without having symptoms of toxicity."

The liability for toxicity in this clinic extended to the maternal body; clinicians were primarily concerned with toxic levels in the mother's blood, though recommended to patients to ensure

pediatricians, OBs or other specialists monitor fetal blood levels too, signaling a potential for toxicity in the infant without taking on the medical ownership of the results**.** In cases of breastfeeding, medications could become toxic to the infant. During a lecture on the use of lithium during breastfeeding, an attending reviewed data that signaled this,

> "The relative infant dose, if it's less than 10%, we feel good about it. Unfortunately, lithium levels are higher than that, with infants it's about 25% of the maternal weight adjusted dose. But, there aren't that many reports of adverse effects with breastfeeding."

Using lithium to treat symptomatic patients carried risks of toxicity for the infant that was supported in the literature. In the case of infant toxicity, however, attendings often minimized potential adverse effects or punted responsibility to pediatrics.

> "In a 2007 paper, with an N of 10, maternal lithium average dose was 840, only one case of TSH elevation in the infant. So you probably need to check labs, there are reports of toxicity, TSH changes- caution if the infant becomes dehydrated. There are some reports, if infant gets a rash while mom is on Lamotrigine, mom needs to stop breastfeeding. There is a case of a 16 day old baby who had an apneic episode, mom was on lithium. Infants can also get thrombocytosis – increased platelets. This is where you have a conversation with pediatrician- have them check platelets, could consider levels as well."

As with other instances of risk in the clinic, this discussion of lithium's potential for toxicity in an infant is revealing of the diffusion of causality in locating the root of the toxin, or the specific site of risk when using medications. On the one hand, the data is sparse—the study referred to was over 15 years old, with a sample size of 10. On the other, there is the potential for serious adverse effects of the medication for the infant. However, the responsibility for infant outcomes is deferred to the pediatrician. Instead of counseling residents to avoid the use of lithium, residents are taught to continue using it despite the risks, and shift the responsibility to another specialty. Although fetal toxicity was a secondary consequence of medications in this clinic, it

had effects on patient care, as some health care teams offered competing narratives to patients about fetal drug exposure. Commonly, patients came with recommendations from other specialists that this clinic worked to undo. An attending referred to this in recalling a patient's plan to self-taper off of her medication, a potentially dangerous endeavor for psychiatric symptoms, based on her OBs recommendation,

> "'My OB told me Zymbalta was toxic for the fetus,' she said, 'so I'm going to self-taper off.'"

Polypharmacy

The location of toxicity sometimes had to shift, or be shifted, in order for medication use to persist as the first line of treatment. This was especially true in cases of polypharmacy, or the concurrent use of multiple medications simultaneously, a more complicated case of toxic potential. By reframing toxicity from medications' effects to individual behavior or environments, responsibility shifted from the clinic to the patient. To do so, the language of responsible and 'good' maternal and patient behavior, an identity and quality patients often sought or were at least expected to try to embody, were enacted to activate this shift. In the case of polypharmacy for example, data is even more sparse than for single psychotropic medications. Despite this, in practice polypharmacy during pregnancy is the norm rather than the exception (Viguera 2022), as meta-analyses have highlighted, "reproductive safety data reflecting this common clinical reality are crucial, yet remain inadequate," (Viguera 2022). Concerningly, some medications thought to be relatively safe for use during pregnancy or breastfeeding, have been found to cause congenital malformations in fetal development when used in combination with other drugs (Grigoriadis et al. 2019).

The danger of polypharmacy was a complicated topic in the clinic; in many cases, patients arrived on a combination of medications that ranged from potentially unnecessary to lifesaving. Attending psychiatrists were careful when referring to the potential consequences of polypharmacy in order to maintain professional authority when prescribing and managing medication—the clinic's primary role—and to avoid responsibility for potentially harmful consequences. In backdoor interactions, polypharmacy was acknowledged as a serious topic of concern—one of the few definitive sites of potential toxicity in the literature and the clinic. Further, the problem of polypharmacy undermined the clinic's authoritative power, limiting the already thin data that doctors were able to share with patients about the safety of particular medications. An attending reflected this in a lecture to residents**,**

> "When patients come to us referred by others, they want to know, are these medications safe? And we can address each of those medications and say, what we know about this one, and that one. Polypharmacy puts a wrinkle in the whole thing, right?"

In another case, a senior attending lecturing about polypharmacy referred to a case in which a patient's medication regimen was potentially causing the multiple miscarriages she had suffered,

> "We really don't have data on polypharmacy… I wanted to raise the issue that we should be at least questioning ourselves about the medications we're using. Even though the data for stimulants are relatively okay, we do know that theoretically they can cause placental vasoconstriction."

Despite this clinician's insights, she shifted the site of toxicity onto maternal behavior when modeling to the resident psychiatrists how to manage the case in their appointments. Instead of doubling down on the patient's regimen, the attending modeled patient care that questioned the patient's desire to go through with a pregnancy in the first place, shifting the location of toxicity from the patient's medication to her maternal behavior,

> "[Here's] the case of a patient who has two healthy children and multiple miscarriages and pregnancy losses going into basically the second trimester. That's a serious thing. She… I think there comes a point where we ourselves have to examine… what are the medications we're using? Is there anything in our regimen we could tweak? She's gone through five serious pregnancy losses. One after another. We really don't have data on polypharmacy, [and] she wanted definitely to go ahead with stimulants. So I asked, 'you have two healthy children, given your quite prominent recent history, why is it you'd like to have a third child?'"

Shifting the location of toxicity was taught in didactic training sessions as a matter of patient etiquette,

> "[Polypharmacy] is problematic, you have to appreciate that. But… there are ways to kind of, you know, to kind of… formulate it in a constructive way."

Using appropriate mothering as a motivator not only continues a historical pathologization of women's behavior as a threat to normativity and stability during reproduction, but serves as a placeholder to judge patients' psychiatric status (Metzl 2003; Story 2019). It also situates the problem of uncertainty in psychiatry back onto the patient, and the potential of toxicity from medication to maternal behavior.

There are cases in this clinic in which patients are attached to their medication regimens, either as patient consumers (Ford 2020) or because they've finally found combinations that manage their symptoms or, as psychiatrists sometimes posit, as a symptom of their psychiatric disorder. Besides in more severe cases or hospitalization, patients make the final decisions about their medication use. Managing patient care in this context sometimes leads to the tactical use of good mothering narratives to direct patients toward particular interventions or reproductive choices. In the case illustrated above, instead of centralizing the potential of polypharmacy as the site of toxicity, the attending taught residents to question the patient's decision to go through with

a third pregnancy in the first place. This way, the attending shifts the location of toxicity from polypharmacy to the patient's maternal behavior and tips responsibility from the clinic to the patient/mother. Instead of doubling down on the lack of data on polypharmacy during pregnancy, she asks, with two healthy children at home, what was this patient doing seeking a third?

The potentiality of drug toxicity was constantly hovering over patient care. While toxicity was regarded as something to be avoided in the clinic generally, it was also useful to clinicians when operationalized as a tool, as exemplified in the case of polypharmacy. It could be used as a technical tool to help quantify the effects of medication if and when they shifted from therapeutic to iatrogenic; it could also serve as a communication strategy to influence patients towards or away from particular psychiatric interventions, behaviors or environments deemed toxic while under psychiatric purview. The subjectivity of toxicity allowed psychiatrists to operationalize its esoteric but feared effects. In doing so, this affirmed the authority and legitimacy of psychiatric knowledge, framing the presence of toxicity as something that could only be read or managed from the psychiatric viewpoint.

This experimentation required of toxicity management was of particular importance in this clinic, as doctors managed cases without sufficient data. Thus for physicians, toxicity was inevitable amidst the clinical guidelines to treat patients with psychotropics as the frontline treatment. Adhering to these guidelines required a degree of experimentation, and toxicity in blood levels then served as a signpost for when to ease up or change a particular medication, prescription or dose. Measurable changes in a patient's body or blood marked the presence of toxicity. Despite patient feedback, preferences or reports of unwanted somatic or psychological effects of medications, only became clinically significant toxins once these became quantifiable.

While useful for clinicians as a quantifiable and communicative tool, this framework of toxicity could have consequences. In a clinical lecture, at attending acknowledged the potential that the clinical framework of quantified toxicity could lead to unnecessary interventions. Normal levels and the lack of toxicity present in patients' blood could be used as motivation to increase a medication, despite patients' symptoms or feedback to the contrary,

> "Yes, it's really nice to have a number to follow, but what you see clinically doesn't always match up with what you expect to see based on those objective measurements. If you want to get a baseline level, you may end up increasing the dose, and if the person's feeling fine, you're just increasing the dose to chase a level."

Another way physicians utilized toxicity as a tool to manage patient care was by locating it in patients' environments—including the physical, social, relational and behavioral. In this use, toxicity became a communication strategy.

Communicating Risk

How physicians maintained a cohesive narrative around medication use, the safety of particular medications and their professional interpretation of the data was visible in the backstage interactions I observed. These didactic training sessions, lectures and conversations offered a window into how causality is diffused and information collectively shaped before it reaches patients.

One afternoon, following the weekly lecture that discussed some potential risks of a particular medication that was often prescribed in the clinic, a resident asked a question about how to discuss this potential risk of hypertension with patients. One attending reminded patients that despite the risks associated, the risks of untreated depression were also important to keep in mind,

> "If you look in the literature, there is that risk, but we have to compare that risk with risk of reoccurrence of depression."

Another confirmed this dilemma of weighing risks in disparate studies about the treatment and undertreatment of depression,

> "This is such a difficult thing we're doing. To say it's all fine is not true, but, the risk is very small in absolute terms."

This prompted a broader discussion about communicating risk with patients. A senior attending turned to the residents with explicit guidance,

> "How you talk about risk is very important. Don't say [medication] doubles risk, say it goes from 1 out of 1000 to 2 out of 1000."

Residents nodded and took notes.

> "You can mention this to patients," she added, "but it's not right to emphasize it, because if you look hard enough, you'll find that there's always the possibility of confounding bifurcation."

Another attending offered her own approach,

> "I always talk about meds saying that all or most of the studies are flawed. We have conflicting information more than other areas of medicine, we need to draw difficult conclusions."

A colleague agreed,

> "Yes, when you explain to patients, they get that, they feel like they're on the same team as you are."

The question of how much data to share, with which patients and in what language was thus not left to individual discretion, it was modeled, discussed and collectively refined in these backstage interactions. Clinicians were explicit that disclosure was not simply a matter of conveying what the evidence showed — it was a communicative practice calibrated to what patients could be expected to tolerate hearing without abandoning treatment altogether. The goal, in other words, was not transparency but therapeutic compliance, and the two were understood to be in tension. Depression patients, attendings observed, tended to arrive already anxious about medication, while patients prescribed stimulants for ADHD were often more accepting of comparable levels of uncertainty,

> "Patients with depression are often very worried about medication, whereas stimulant patients are often like, 'oh [the risk is] pretty low'— I don't know if it's an ADHD thing, maybe it's that [stimulants] are so much more effective than antidepressants."

The implication here is significant: the same element of uncertainty was disclosed differently depending on the clinician's read of the patient's capacity to receive it based on their diagnosis. The practical consequence was a set of informal disclosure norms that translated contested, incomplete findings into language designed to maintain rather than fully inform patient decision-making. The attending laid out the problem directly,

> "If you say Prozac has a slightly increased risk for cardiac malformations but we recommend you stay on it, patients would be like, 'what!' Mentioning that maybe there's a signal for higher cardiac defects, which I would tell patients… again it's the risk/benefit conversation you have to have."

The preferred formulation to use with patients, such as an attendings example, "You could say, 'most data doesn't concern me'," performed clinical confidence without requiring patients to absorb the granular uncertainty in the data.

What the attending was describing was not deception exactly, but a deliberate act of reframing—the clinician positions herself as having already done the interpretive labor, absorbed the uncertainty on the patient's behalf, and arrived at a conclusion the patient can act on. The patient receives the conclusion, despite the data inadequacy. The attending was explicit about the epistemological principle underlying this practice,

> "The absence of evidence of risk is not evidence of absence of risk… you should consider that there is some risk, but present the data that we have."

The instruction to "present the data that we have" is also an instruction about what not to present—the gaps, the extrapolations, the studies of methamphetamine-addicted mothers standing in for therapeutic stimulant use, the cardiac defect findings that required residents to "really, really dig into the data" before surfacing even a tentative signal. What patients receive is a curated account of an already thin literature, further edited for tolerability. The calibration is clinical and arguably protective in its intent, and it is also, structurally, a transfer of epistemic authority from patient to clinician at precisely the moment when the evidentiary basis for that authority is most precarious. This is where toxicity as a boundary object becomes most consequential—when the data cannot definitively locate the harm, the flexible terrain of toxicity can be strategically deployed to fill the gap, redirecting patients concerns about medication risk toward the more vivid and tractable dangers of untreated mental illness—the very framework the previous section illustrated in detail.

Environmental and Psychosocial Toxicity

One Wednesday of my observations, Shawna, a physician pregnant with her first child through IVF arrived in what her resident psychiatrist interpreted in their first appointment as a

hypomanic state. Having read the literature on medication use during gestation, Shawna had decided to stay off of her medications throughout her pregnancy, specifically citing the inadequate data she'd read in the literature in her reasoning. She was however, very agitated with her family dynamic. Her psychiatrist reflected this dynamic back to her, using the language of toxicity to interpret her situation,

> "What you've been describing is this, like you said, a very chronic, stressful, toxic environment with your family. There's all these different dynamics with your mom with your dad and their relationship with your sister, and her relationship with your father and aunt and… you know, a big family for some people and in some situations can be a real blessing and a source of support and sometimes it's not, sometimes it really can be the source of all of this incredible stress."

Applying pathological language, 'chronic, stressful, toxic environment' to Shawna's family dynamic was tactful, extending the framework of toxicity that Shawna applied to her medication, now to her interpersonal relationships. Medication was one site where toxicity could be located in the clinic. While legible in a patient's blood levels, toxicity was also connected to patients' relationships, workplaces, neighborhoods and the structural conditions of her life. While pharmaceutical toxicity was managed through blood tests and dose adjustments, psychosocial and environmental toxicity was less easily measured, and as a result, more flexibly deployed. In lectures and didactic trainings I observed, residents like Shawna's were taught that toxic environments were clinically relevant and psychiatrically consequential, even as tools for addressing them remained overwhelmingly pharmacological.

Beyond the quantifiable effects of too much medication, environments, jobs and relationships were also identified as potentially toxic. While environmental toxins were briefly discussed as influential in maternal health outcomes during clinical lectures, I never observed them being directly discussed in patient care. During an introductory lecture however, an

attending did acknowledge the potential impacts of chemical toxicity on maternal health, though on a clinical basis, patients were not asked about the safety or chemical toxicity of their lived environments,

> "We know that maternal health outcomes are worse when pregnant and postpartum women are housing insecure, hungry, live in areas of toxic environmental chemicals based on financial instability, lack of workplace protection and benefits…"

The gap between naming structural toxicity and acting on it was significant and revealing. Unlike with medications, and environmental toxins, psychosocial toxins were less easily managed than tapering down or changing prescriptions or limiting exposure; they were not quantified with blood levels, yet were understood to be psychiatrically harmful to the patient, as well as potentially developmentally harmful to the fetus/bloodline. What determined a psychosocial toxin was somewhat subjective—a 'you know it when you see it' de facto measurement—so counseling patients on how to manage these toxins was case-dependent too.

Despite their nebulous quality, psychosocial toxins had serious implications for the lived experiences of patients, from signaling domestic violence, to warranting patient-disability paperwork to avoid toxic work environments, to affecting family dynamics, to impacting maternal mortality. Toxic stress, toxic relationships and behavior patterns were explicitly linked to the US' poor maternal health outcomes in clinical lectures. Pedagogically, residents were taught that toxic environments existed on scales much broader than in clinical observations, which tended to be more about interpersonal, workplace, or individual toxic stressors. In an introductory presentation on the differences between US postpartum depression rates versus in other nations, an attending lectured,

> "A lot of people quote this like 'one in seven' statistic, 'one in seven women will get postpartum depression'. Europe has the lowest rate at 8% which is thought to be because it's like, paid parental leave, social support, guaranteed health care, all those things that help people feel more stable and secure."

Access to institutional and social support was linked directly to mental health outcomes and psychiatric diagnoses. For the introductory lecture for another class of incoming residents, the attending included access to abortion and the changing political landscape as affecting rates of diagnoses in the clinic,

> "There was a study from 2024 that showed that countries with more liberalized access to abortion had lower levels of depression in women ages 25 to 49… not, not significantly accurate if you adjust for confounders. But what they were thinking is that basically, in countries where women have better rights and higher social standing, there is less depression."

Additionally, institutional racism, medical racism and chronic stress related to the lived experiences of women of color, and Black women in the US especially were identified as toxic stressors with serious consequences,

> "The higher [maternal mortality] rate in black women is multifactorial. There's marginalization, there's a social disadvantage, there's also this idea of the cumulative effect of chronic stress, this idea of allostatic load that is like, really causes their bodies to age faster because of the marginalization and the social disadvantage they face. Studies have shown that women who experience racism and discrimination have negative birth outcomes."

The clinic taught residents that the effects of toxicity could be perceived on various scales, from the cellular, to the institutional to the socio-political. They also taught that toxicity lingers in the bodies, environments, and interactions that patients existed within, making it both porous and omnipresent. Toxicity's porousness was a clinical asset—as a boundary object, it retained its

urgency precisely because it could operate across scales simultaneously. For example, during a lecture from a therapist in the clinic, toxicity was located in romantic partnerships,

> "A lot of my patients are young 20 year old mothers and, and just like, kind of in more toxic relationships. More toxic patterns and just toxic, really, in these young relationships."

In another case, a patient's relationship with her overbearing doctor was determined toxic, reiterating the potential of medical care as a site of toxicity,

> "She was a personality disorder, but also bipolar patient from IOP, who had a very toxic relationship with her outpatient psychiatrist. He was like, very paternalistic."

Patients like Shawna had what her doctor described as a toxic family dynamic. Work environments were also potentially toxic, as was the case of a new mother with no mental health history and a challenging workplace dynamic,

> "She said throughout her life she had no prior issues with mental health, she'd done this job for four years prior and had like, done great, but this new job just really does seem like it's really toxic."

For another patient, the confounding effects of her postpartum depression, taking time off to manage her mental health and new baby turned her workplace into what her psychiatrist described as a toxic environment,

> "[The patient] more recently has had a lot of stress at her work related to having to take medical leave after the delivery of her second child when she had postpartum depression. And since then, has been like really struggling at work. [It's] become like a very toxic and negative environment for her and making her have a lot of a lot of distress and anxiety."

Framing toxicity as relational taught resident psychiatrists that relationships could be understood as environments of consequence for both the patient and her developing fetus, and that her behaviors could contribute to her own and her fetus' toxic exposure.

Effects of socially locating toxicity

Despite its ubiquity, classifying behaviors, environments and relations as toxic had substantial effects. Psychiatrists had discretion over when to submit disability paperwork for patients, for example, and when to extend maternity or medical workplace absences, or involve authorities in cases of toxic relationships that exhibited abusive behaviors. Although toxic environments were considered harmful to patients' mental health, there was also limit to the psychiatrists' capacity to manage them, or willingness to assist patients through bureaucratic methods, versus psychopharmacological methods. Instead, in line with the ACOG guidelines and goals of reproductive psychiatry, patients' exposure to environmental, social and relational toxicity were often managed with medication. When counseling a resident on how to move forward with a patient whose work environment was described as toxic, an attending illustrated this,

> "I mean, you can get short term disability and try and treat the depression and anxiety. And while she looks for another job… that can be a slippery slope because it can be really hard to find a job and she may not be able to stay out… Like yeah, there are a lot of people who hate their job and have toxic environments and it's hard to like, be the person saying that they're permanently disabled because the job environment is bad."

Identifying elements of patients' environments as toxic also helped psychiatrists to deprioritize the toxic potential of medications. In labeling more toxic correlates, psychiatrists could influence patients to consider the route of not medicating to be as toxically potent as medicating itself.

As Vinson (2016) has shown in her study of physician communication, patient-centeredness and shared decision-making can become appropriated by physicians as a mechanism for securing patent buy-in to a predetermined clinical plan, rather than as a genuine expansion of patient participation. In this clinic, the acknowledgement of psychosocial toxicity functions similarly. Naming a patient's toxic relationship, workplace or structural environment is not a prelude to structural intervention, but a way of clearing the path toward medication compliance. The patient's toxic world is taken seriously enough to be named, without being taken seriously enough to be addressed on its own terms.

Even toxic social and institutional effects of racism were interpreted as treatable via psychopharmacology. In fact, prescribing medications was presented as a tangible solution that reproductive psychiatrists could contribute to, in order to combat the maternal mortality disparities in the US,

> "Studies have shown that women who experience racism and discrimination have negative birth outcomes. Where we come in is that mental health conditions also contribute to maternal mortality. In the postpartum, suicide is one of the biggest causes, it's a major cause of maternal mortality, for black women there are also physical issues and for white women mental health conditions are at a much higher risk. As psychiatrists, we treat this population, we need to remember that our patients are at risk of suicide, and one of the ways we can help decrease maternal mortality is by treating this. Okay?"

As Vinson (2016) found, physicians often understand their strategic communication not as manipulation but as professional responsibility—getting patients to comply with treatment was framed as clinical competence and ethical obligation, rather than paternalism. The same logic can be applied in this clinical setting—psychiatrists who positioned medication as a response to maternal mortality disparities were enacting a genuine belief in the efficacy of their intervention. The tool of intervention remained pharmacological even while the problem was identified as

structural, and was not experienced as a contradiction but as the most proximate solution available.

Offering psychiatric treatment as the solution to environmental, social and relational stressors and conceptions of toxicity also reflected an epigenetic framework that was often referenced to in the clinic. Instead of focusing on the potential long-term effects of medication exposure on genetic expression, the psychiatrist emphasized the social environments as consequential for the long-term developmental effects of fetuses as well as gene expression across generations. In her ethnography of an epigenetic lab, Natali Valdez (2021) found that environments had different meanings from the various specialists she encountered. Similarly, what constitutes a consequential exposure had various conceptions in this clinic, as locations of toxicity were varied and broad. Whether the toxic exposure was linked to the workplace, a relationship, or the allostatic load associated with racism, the long-term effects of untreated mental health symptoms linked to these exposures were clinically intolerable, and counter to the its goals.

Conclusion

This chapter traced toxicity as it moves through the reproductive psychiatric clinic—from its long history in reproductive health discourse, through the U-turn in clinical guidelines that repositioned the untreated mother as the primary site of risk, to the backstage curriculum through which resident physicians learn to navigate data inadequacy, manage medication thresholds, and locate toxicity in the social and structural conditions of patients' lives. Across these registers, toxicity functions as a boundary object: capacious enough to hold together what is biological and what is social, what is measurable and what is felt, what is in the blood and what is in the

relationship, without having to resolve into any one of them. In each of its forms, medication emerges as the clinic's solution.

What reproductive psychiatry has inherited from the broader history of toxicity in maternity is the framework of the maternal body as an environment of consequence. What it has added is a reversal; the most consequential toxic exposure is no longer what enters the body from outside, but what goes untreated within it. Residents are socialized into this inversion through years of lectures and didactic training, taught not only what is toxic, but how to say it, to whom, and with what degree of emphasis. The data inadequacy that underlies these recommendations is not concealed but managed, collectively refined into a clinical language that maintains professional authority at precisely the moment when the evidentiary basis for that authority is thinnest.

The physician framework of toxicity does not arrive to patients as neutral clinical information. It meets patients who have been primed by public health messaging, intensive mothering ideologies, and epigenetic logics to understand their bodies as environments of consequence long before they enter the clinic. In the following chapter, I turn to those patients, tracing how they understand, negotiate, and at times resist the toxicity frameworks this chapter has traced from the other side of the clinical encounter.

CHAPTER TWO

Purifying: Being a Good Mom with Mental Illness

I met Jess after the birth of her first baby. A neuroscientist with a demanding career, she was to the point, direct and made her decisions in a calculated, research-backed way whenever possible. She bonded easily with her doctors, speaking almost as a peer while asking incisive questions about data and the clinical significance of the relevant research. When the attending on Jess' case asked her where she'd rate herself on a spectrum of anxiety symptoms she half-joked that she hated qualitative scales, so they translated it numbers. Jess had been treated with ADHD medication since college, self-weaning until her demanding science consulting job required a workload she could only upkeep with the support of medication. Like most patients, she didn't like to take medication if she felt it was unnecessary, and harbored shame for her need of it in the first place. She imagined the effects of the medication were taxing on her body and brain, so refrained from taking her medications on weekends and holidays too, whenever she wasn't working.

When Jess became pregnant, she immediately stopped all of her medications anticipating their negative effects on her fetus' development. When I asked her what drove this decision she told me, "It's almost like my mom brain already knew to not take the meds." In this chapter, I uncover what drives Jess, and many patients like her, to make decisions about medication use based on their lay understandings of exposure and toxicity. Where might Jess have received messaging that her medications were potentially harmful, or toxic to her fetus? What is a 'mom brain' and how do cultural and biomedical narratives of risk and responsibility shape treatment decisions and behaviors during pregnancy? And lastly, what do these choices, and decision-making processes reflect about the state of reproductive psychiatry?

Introduction

There is an extensive body of research that shows how mothers are encouraged to behave with their children or even potential children's best interests and health in mind. The expansion of biomedicine into preconception care—or the idea of caring for non-pregnant people to alleviate any risks to potential future pregnancies—illustrates clinical preoccupation with both measurable risks and subjective feelings of risk as they relate to pregnancy (Conrad, Waggoner 2017). Some literature on reproduction has theorized prenatal care expanding to include the period before conception as an ethic of anticipatory motherhood (Waggoner 2013). Early on, medical decision-making in relation to female bodies implicates narratives of maternity. This complex network of surveillance and practices of regulation directed at pregnant or 'pre-pregnant' women has also been interpreted as 'extending parenting culture backward' (Lupton 1999 59-60; Lee et al 2010), whereby the increasingly intensive expectations of parents before birth have become part of parenting, and blur the line between prenatal and postnatal subjects (Weir 2006). What people eat, drink, where they go and what they're exposed to, and even what they think may be measured in relation to their fetus', or future fetus' health. If the potential maternal subject is overweight, drug using, smoking or drinking, they're subjected to discourses of 'bad mothering' because of the potential long-lasting harm they are considered to inflict on their offspring (Valdez 2021; Ballif 2020, 2023; Humphries et al 1992; Lee 2014; Oaks 2001).

These discourses do not arrive to patients as abstract cultural forces, but often as convictions—specific beliefs about what they should avoid, ingest and expose themselves to during pregnancy. The patients I observed arrived at the clinic having already acted on this too; including stopping medications, avoiding products, seeking out expensive prenatal vitamins, etc. Ideas of causality and responsibility are central to how patients make decisions about beginning,

continuing, or stopping psychiatric medications during pregnancy. These ideas are closely linked to normative and long-standing ideas of gender roles, patienthood and immorality. Monica Casper's (1998) work has documented the historical roots of this link, in her research of fetal alcohol syndrome and the long cultural work of connecting maternal behavior to fetal harm. On the one hand, patients arrive in the reproductive psychiatric clinic having been steeped in cultural messages of purification versus exposure during gestation that shape their conceptions of what makes some maternal behavior appropriate/inappropriate, safe/dangerous, or good/bad. Many of these ideas that inform patient perspectives come from previous clinical knowledge that has linked maternal exposure during pregnancy to negative fetal health outcomes. On the other hand, many of these same logics of maternal responsibility for fetal, and child development are used to compel patients toward maintaining medication regimens, relying on expectations of individual and intensive parenting practices, that medication is positioned as a tool to achieve.

On top of this is the proliferation of the fetal subject through increasing reproductive technologies, along with the increasingly expansive view of what is considered an environment of consequence or a toxic exposure through the explosion of epigenetic research in the past decade. Maternal bodies have never been more intensively surveilled, nor held as much potential consequence for future generations' health. Consequences are not only reflective of exposure-related choices made during gestation, but are framed as a reflection of maternal morality. As Hays (1996), Lee (2014a) and others have argued, in recent decades, parenting has also been transformed in a way that centers risk and uncertainty, reiterating the characteristic of contemporary reproduction that assumes that the fetus is a vulnerable entity that must be protected to develop safely (Ballif 2023). What Jess called her 'mom brain'—the maternal intuition to stop medication during pregnancy—reflects decades of cultural messaging that

women have received in relation to their ingestion and fetal health outcomes. In the clinical environment that encourages medication use despite the 'risk-risk' context, Jess' ideas of what is toxic to her fetus are tested, and her understanding of toxicity shifts from medication, to her untreated mental health symptoms and her own maternal behavior.

In the following section, I focus on the biomedical and public health discourses that have shaped patients toxicity imaginations related to ingestion—prescribed and illicit—during pregnancy. I then follow patients chronologically: from pre-conception when toxicity imaginations are formed and acted upon before clinical contact, through pregnancy when those imaginations meet and often clash with clinical recommendations. I find that prior to psychiatric appointments, patients' understanding of ingestion and their mental and reproductive health decision-making has been informed by decades of cultural messaging related to morality and appropriate maternal behavior. Using observational data, I illustrate how patients express their toxicity imaginations, how they're responded to, and ultimately, how the clinic emerges as a solution to the dilemma.

Literature

The Clean/Non-Toxic Mother

Contemporary good mothering discourse is infused with toxic imaginaries that have been shaped by decades of biomedical and public discourse on ingestion and parenting. Where does Jess' idea that a good maternal decision is to stop medication during pregnancy? Previously, racialized targeting of what was considered toxic maternal behavior during pregnancy focused on fetal alcohol syndrome and illicit drug use leading to the now debunked but incriminating depiction of "crack babies". This followed the historical devaluation of Black and poor women

as mothers (Roberts 1991). In the early 21st century the emergence of the "opioid epidemic" depicted another story. This widely reported and bio-psychosocially complex epidemic elucidated that women, and specifically White women of reproductive age, were at particular risk for the co-prescription of opioids and benzodiazepines—particularly for pain and anxiety—leading to excess mortality. These "deaths of despair" (Case & Deaton 2020) have been studied in relation to false beliefs that providers hold about race and pain, that may partially explain the racism in the health-care system that led to a differential diagnoses, prescriptions, and ultimately a greater mortality burden among Whites (Kolata & Cohen 2016; Singal 2016). As Knight (2019) has observed, the role of anxiety should be excavated as a central role in the US opioid epidemic, particularly for women of reproductive age. In her structural and social analysis of the epidemic, she charts the complexity of racialized/gendered anxiety diagnoses and subsequent prescriptions, particularly for women, who are about twice as likely to receive anxiety diagnoses than men (McLean, Asnaani, Litz, & Hofmann, 2011; Olfson, King, & Schoenbaum, 2015). The specificity of anxiety diagnoses for women, like all psychiatric disorders and diagnoses, is socially and historically contextual. This means that instead of exclusively reflecting a patient's biological state, despite the popular depiction of psychiatry as biological, diagnoses and prescriptions are imbued with expectation of gender, race, sexuality, power, time, reputation, and a host of other social and environmental factors (Metzl 2003).

Many researchers have interrogated the empathetic depiction of opioid dependency among White populations in the media as markedly different from previous responses to addiction, especially for mothers of color (Hansen, Siegel, Wanderling, & DiRocco, 2016; Hansen et al., Hart, 2017; Savali, 2015, in Knight 2017).

> "Because the crack cocaine scare of the 1980s was racialized as black, the nation decided to try to imprison its way out of it. Because the contemporary opioid crisis has been racialized as white, the nation has been receptive to trying to treat its way out of it. (Bridges 2020; 793)."

When it comes to pregnant women however, the state's approach has been much more punitive than rehabilitative. Widespread panic about the impact of opioids on women's ability to mother caused both public condemnation—viral videos of overdosing mothers circulated widely—and psychological experiments, such as one in which opioid-dependent adults' brains were studied in their apparently weak responses to cute baby pictures (De La Cruz 2016). Further, fears of criminalization and loss of child custody for both prescription and illicit drug use during pregnancy lead a significant percentage of women to avoid prenatal care (ACOG Committee on Health Care for Underserved Women 2014; in Knight 2017). In her research on prescription medication, race, gender and motherhood, Kelly Knight illustrates the stakes of opting into biomedical surveillance and care during pregnancy while taking medication.

> "Having a previous baby born 'dirty'—with a toxicology screen—can mark a woman with a residual biomedical trace that carries over into subsequent parenting custody negotiations; and poor women and women of color are disproportionately targeted for criminalization." (Knight 2017).

While most states and the federal government criminalize drug possession versus use, it is generally not a crime to test positive for a controlled substance. However, in cases in which pregnant women face custody or criminal charges after a positive drug screen, it is because "pregnancy has transformed otherwise legal behavior into a crime," (Bridges 2020;778); social anxiety around the ingestion and behavior of pregnant women makes pregnancy a uniquely contentious period.

Jess' 'intuition' to stop taking her medication when pregnant, is the contemporary expression of public anxiety related to medication and mothering. Decades of research have helped to "situate drug epidemics as social constructions of specific historical milieu," (Knight 2017, see also: N. D. Campbell, 2000; Herzberg, 2009; Metzl, 2003). The anxieties of medicated mothers—their impulse to stop prescriptions, avoid toxicity or imagine the potentially toxic outcomes of their treatment, even if legal and prescribed by well-intended providers—is the current expression of the social constructions of ideal American motherhood, one that is informed by previous decades of public health and public opinion related to drug use and reproduction—what a good patient and mother would do.

The information landscape that patients navigate reinforces this. The proliferation of individualist and neoliberal parenting and health behavior (Reich 2014) shapes the widening scope of what is considered health expertise in the complex political terrain of misinformation (Thompson 2023; Smith & Southerton 2023).

Social Media and the Digitization of Pregnancy

Patients arrived at the reproductive psychiatric clinic having already navigated a dense and often contradictory informational landscape. Cultural messaging shaping their toxicity imaginations did not reach them through clinical encounters alone, but through social media feeds, online communities, and the ambient and ever-present content of digital maternal life. While earlier decades' scripts of 'good mothering' were transmitted through cultural norms including guidebooks, parenting magazines, and the advice of OB-GYNs, today these scripts move faster, feel more personal, and come from a far wider cast of authorities delivered through feeds, algorithms and personal profiles. Scholars of digital reproductive culture have argued that these platforms do not simply extend existing modes of health advice but transform them—

recruiting pregnant women into continuous practices of self-monitoring and self-assessment that older media could not sustain in the same way (Johnson 2014). Apps and social media surface comparisons, push notifications, and embed the evaluation of maternal behavior into the one's digital daily life. In doing so, they position pregnant women as active managers of their own and their offspring's biological futures—responsible not just for what they do but for tracking, optimizing, and accounting for it (Johnson 2014).

Patients in my study were acutely aware of this landscape and often described it as a site of both information and anxiety. One patient described the contradictory terrain directly,

> "There are a lot of people on Instagram who will talk about the not so great sides of parenting and you know… taking medication. And then the uber crunchy people who… everything is a toxin. You have to be meticulous about what you're eating, and putting on your body, body care products."

Another patient made her medication decisions by outsourcing to social media,

> "My decision boiled down to going on Reddit and seeing what they would do and going on Instagram and following accounts of people who used sort of… data and science to say, you know, this product is better than that product and this is why. Whether or not it was true, it made me feel better."

Reddit communities organized around due dates or diagnoses functioned as informal clinical spaces, but they also transmitted normative scripts; when one patient noted that "people on Reddit do it all the time, go no contact with their toxic family," she invoked not only a social practice (withholding all communication) but a whole vocabulary of contamination that had migrated into her conception of what healthy mothering required.

The comparative logic of social media intensified this. Patients described a "boss-girl mentality" circulating on Instagram and television, a pressure to "rush back into work" and perform seamless maternal competence. One patient measured herself against a colleague whose

transition to motherhood appeared effortless—travel, a big baptism—and noted that even knowing it wasn't the full picture, the comparison still stuck, "We talk too, so I know it's not just Instagram happy. I feel like I'm broken," she reflected. What social media delivered was not only health information but a visual norm of good mothering that patients measured themselves against even when they recognized it as constructed. By the time patients arrived for their first appointment, they carried with them not only symptoms and histories but a whole set of prior determinations about what safety, toxicity, and good maternal behavior required.

The actions of detoxification patients described—stopping medications, auditing products, purging anything that might harm their fetus—didn't come from nowhere, but were the end point of years of scrolling, comparing, and absorbing a cultural script that had made purification the default of good pregnancy. This, in combination with the shadow of previous decades of heightened scrutiny over ingestion during pregnancy, brought patients to the clinic riddled with questions that had few clear answers: Would a good mother stop taking her medications for her fetus' development? Would her medications poison her kid, or would her untreated depression poison her family? Would she trust her doctors to continue medications despite the lack of data on her medication combinations? Were exacerbated mental health symptoms manageable—something to suffer through to maintain the good mother identity, or dangerous for herself and her child? These were some of the questions patients contemplated upon arrival at the clinic.

Data

Patients could arrive at the reproductive psychiatric clinic at any point in their reproductive journeys, and the stage of that journey shaped both what brought them in and what they were looking for in clinical encounters. Those who came before or during early pregnancy

typically carried prior psychiatric diagnoses and sought guidance on medication safety or counseling for managing mental health through gestation; most of these patients continued their care into the postpartum. A second group arrived during pregnancy by referral—from OBs, midwives, or other specialists who identified psychiatric need mid-gestation—which is why the referral landscape described above mattered so acutely for this population. A third pathway into the clinic was through the postpartum period, when patients presented for the first time following delivery. These patients often had no prior psychiatric contact with the clinic, and their first visit frequently signaled an acute exacerbation—postpartum depression, anxiety, OCD, or in rarer cases, mania or psychosis. The overwhelming majority of patients I observed fell into the first two groups; postpartum-first presentations, while significant, were less common and often more acute. Being a 'new' patient to the clinic, in other words, did not necessarily mean being new to psychiatric struggle—but it sometimes did. Many of the excerpts that follow reflect first-contact intake dynamics, though that first contact could happen at any stage of a patient's reproductive arc.

Pre-conception: Preparing the Non-Toxic Body

Pregnant and pre-conception patients came to the clinic in the throes of decision-making and treatment dilemmas, and at different points in their gestation periods, some pregnant, others anticipating pregnancy, but sharing a common posture—they'd often already begun managing toxicity before they ever came to the reproductive psychiatric clinic. They experienced an impasse in how to move forward, and sought clinical expertise to quell the inundation of cultural and biomedical messaging that encouraged 'clean' conception and pregnancies in order to achieve good mother and patient conceptions of self—with their real or perceived psychiatric needs. This was a grueling decision-making process for patients already suffering from acute or

lifelong mental health struggles, in some cases that made their day to day lives unbearable without medication. This already stigmatized patient population came for answers, to ensure the avoidance of toxicity for their developing or anticipated fetuses and for assurance from their doctors on the safety of the path forward.

Before arriving, many patients had already acted; they'd self-tapered off of medications, consulted podcasts and online forums, compared notes with friends and arrived with toxicity imaginations already sharpened by the information landscape described above. Researchers have sought answers to who seeks health information and why—meaning information regarding personal health concerns from people other than their doctors. Patients with more information can participate more in their healthcare management, which has been found to improve effectiveness of healthcare services and better clinical outcomes. (Faiman & Tariman 2019). But, structural factors shape both who seeks information and what they find: economic recession trends, frustration with healthcare utilization, increasing health related information exposure from media and internet sources, insurance problems, limited provider time, and direct to consumer advertisements and technology all influence the information landscape (Cunningham and Elland 2008; Tai-Seale, McGuire & Zhang 2007; Tu & Cohen 2008). Sociodemographic variables also contribute to health information seeking; younger people, those with higher education, health insurance, women and people of color are more likely to use the internet to obtain health information than older people, those with lower education, uninsured, men and white people (Rao, Tighe, Feinberg; 2022). Pregnancy specifically amplifies this behavior; the internet and social media apps in particular, are a frequently used and highly valued resource for a majority of pregnant women (Conrad 2024). Women with greater health needs during pregnancy are also more inclined to seek information on the internet (Coglianese et al., 2020).

Mental health conditions play a role in online health information seeking too—several studies have found that people who use digital media for pregnancy related information reported negative mental impacts during pregnancy. The accuracy of health-related information is also concern. One study found that despite 69% of women acknowledging that they'd visited a website with wrong or misleading information, 83% still considered the quality of online information to be generally 'good' or excellent (Davis, Palda, Drazin & Rogers 2006). Crucially for this clinic, previous research on clinician responses to engaged pregnant and psychiatric patients including those who digitally seek information, has found that health information seeking can create friction in the clinical encounter. This can fact lead to further stigmatization, as engagement with outside information is sometimes conceptualized as a symptom of psychiatric disorder (Abel & Timmermans 2026).

One of the primary ways patients managed their preconception toxicity imaginations was through purification. Laura came to the clinic feeling angry and helpless. She became pregnant immediately after removing her IUD, without time to begin processing her next chapter as a mom. In other ways however, she had already begun preparing her body for pregnancy; after ten years on medication for her ADHD, she had recently stopped taking it after listening to a podcast that convinced her of its long-term harm. She was also taking Welbutrin up until recently, but self-tapered off a few months ago, hoping to conceive while "clean." Laura came for recommendations on managing her ADHD symptoms and creeping depression. Following her intake, she tearfully agreed to begin antidepressants. Her psychiatrists had imparted that depression might be more harmful to her developing fetus than a low dose of her medication. This reconciliation of her doctors' recommendations with her previously held notions of what was best for her and her fetus reflected a combination inherited public health and media

discourse on ingestion and pregnancy, as well as her own sources of information—from podcasts to personal online research. Despite her doctors' recommendation, and her agreement to begin her medication, Laura's toxicity imaginations persisted; she remained convinced that her medication could negatively affect her fetus, and that taking it somehow revealed a maternal wrongdoing on her part. This was an extremely common stance among patients in this clinic.

As Laura's example indicates, pregnant people are culturally and biomedically conditioned to consume in ways that indicate their understanding and commitment to non-toxicity during pregnancy. This logic of purification extended backward into the pre-conception period for many patients—a kind of anticipatory cleansing in which the body was detoxified and made ready. The boundaries between ingestion and behavior, and good/bad parenting were further distorted, as a pregnant person's conduct during pregnancy was interpreted in relation to her psychiatric history and status, another indicator of her maternal capabilities. Women were encouraged to self-surveille during pregnancy when it came to what they ingested and exposed themselves and their fetuses to in a clinical context oriented toward alleviating any potential fetal risk. This anticipatory logic "can be defined as a regime of temporality where the present is always thought of and acted upon in reference to possible futures," (Adams et al., 2009; Anderson 2010; Tavory and Eliasoph 2013; in Ballif 2023). Like intensive parenting, anticipatory consumption and the ingestion and avoidance of particular materials, foods, products and drugs during pregnancy also revealed class differences, as desirable products marketed as safer during reproduction were often more expensive.

Patients in this clinic described their avoidance of products, foods and materials they considered toxic during pregnancy in ways that mirrored consumer choices, and as ways to model 'good' mothering prior to birth. One of the preliminary ways that toxicity was

conceptualized in this clinic from the patient perspective was in relation to consumption of products during pregnancy. For example, Leah, a first time mom sought expensive prenatal vitamins prior to pregnancy that indicated to her their superiority to cheaper alternatives:

> "I was focused a lot on that being healthy, and I think as a person who has access to those resources and the financial ability to buy all these products, you get the messaging that like, more expensive is better. Better is you know, better quality. And so I bought the fancy vitamins. I could've gone to CVS and gotten the cheapest bottle of prenatals. And it probably would have been fine, but I had to seek out that one brand online that's 10 times more expensive in the hopes that my baby will be better off because I bought these prenatal vitamins instead of those. And I have the ability to do that. I have the financial resources and time to do that[…]What I was putting in my body, in terms of food and vitamins and nutrition was very front and center throughout my entire pregnancy, and leading up to getting pregnant, making extra sure that my nutritional needs were being met that was really important to me."

While Leah described herself as "leaning toward organic as much as possible", she compared her own behavior to what she considered more extreme cases, "The uber crunchy people who think everything is a toxin and you have to be meticulous about what you're eating and putting on your body." Reich (2014) and others (Murphy 2000; Wilkins 2014) have illustrated the connection between neoliberal ideologies of individual choice and chosen mothering projects such as "nutrition, consumption or birthing practices" (Reich 2014; 682). Frameworks of 'free choice' organize decision-making into categories of safe/unsafe, order/disorder, life/death that both categorize maternal behavior as good/bad and also exist in policy, institutional and economic structures that confine them.

The impulse to control toxicity—by cutting it out, avoiding it or purifying around it--extended beyond food and consumer products into patients medication regimens. Some of the boundaries that influence toxicity imaginations were institutionally enforced. In Kiara Bridges' work, she documents how black and brown Black and Brown pregnant women who received

prenatal care through Medicaid had to follow nutrition plans to avoid penalizations for fetal neglect and harm (Bridges 2018; in Valdez 2021). In other contexts, pregnant women with high BMI were framed as having "risky wombs or intrauterine environments," (McPhail et al. 2016:98). On the tails of the crack baby hysteria and hyper fixation on pregnant and postpartum women in the opioid epidemic, it is clear that the criminalization and ostracization of some maternal behavior as illegal or inherently risky influences the toxicity imaginations of patients in the clinic. Avoiding toxicity has become a cornerstone of contemporary motherhood and in the reproductive psychiatric clinic, it is also an indicator of appropriate patienthood, as patients' mental health status is tied up in perceptions of their maternal behavior. Whether patients located toxicity precisely in a specific medication or more diffusely in everything around them, its presence undoubtedly shaped their behavior.

In clinical intakes, resident psychiatrists took an hour and a half to discuss patients' health, family, mental health, reproductive and medication histories. They took note of the histories patients narrated, in addition to patients' affect, speech patterns and appearance. Residents asked questions about childhood, trauma, internal thoughts, relationships and work, and compared responses to their clinical notes. As the intakes were meant to establish care in the clinic, psychiatrists asked patients explicitly what brought them in, so that they could create a treatment plan. Patients most commonly asked about the safety of their medication regimen during pregnancy- what would happen to their developing fetuses or children's behavior in adolescence if they continued medication, or whether particular medication combinations were particularly harmful.

Krupa, for example, is a lawyer with an ADHD diagnosis who I met in the clinic during her first pregnancy. She reflected on the complicated distinction between avoiding toxicity in some ways, while continuing potentially toxic medications.

> "I stopped drinking when we were trying to get pregnant. Marijuana too because it can have a detrimental effect on the baby. Maybe me relying on a doctor saying I can take ADHD meds is an excuse. In the same way, I'm ashamed of needing this med, I'm growing this baby. If there's any harm… if this negatively affects my baby, that's terrible. I didn't take any Advil or other things I was able to stop… I assumed I'd have to be off of this, but I would've had to stop working."

As Krupa indicated, one of the differences between exposing fetuses to what some patients considered to be toxic foods and products, and psychiatric medications was both the potential severity and haunting uncertainty of the psychiatric medications' effects. Unlike Jess, who discontinued her medication because of the cultural messaging regarding ingestion during pregnancy, or what she referred to as 'mom brain', Krupa's doctors recommended she maintain on her medications, despite clinical uncertainty. Her medications were considered useful, even essential despite their potential toxicity. Her demanding workload was untenable without her ADHD medication, though exposing her fetus to a substance that she imagined could have potentially "detrimental effects" left her feeling regretfully responsible and ashamed.

Krupa's case also reveals a continuum of acceptable exposures during pregnancy, that shift over time and across context, and prove difficult to exist within without contradiction. That continuum—from alcohol and marijuana on one end, to Advil and prescribed psychotropic medications on the other—was both clinically derived and culturally assembled. Patients moved along this continuum differently depending on their circumstances, but nearly all felt its pull.

What made psychiatric medications' position on this continuum particularly unstable was a collision embedded in the cultural script itself: the same purification logics that demanded the

removal of alcohol, marijuana, and recreational substances also cast any chemical exposure during pregnancy as suspect, including prescribed ones. Patients were simultaneously told to keep taking their medications, and received the cultural message that ingestion of any kind carried risk.

Further, the shame that Krupa described—of needing medication at all, amplified by pregnancy—surfaced consistently across patient narratives. In a telling exchange, I observed a patient arrive to the clinic in 2022 for a pre-conception intake. After reviewing her history, her doctors asked what she came to the clinic for: "My fear is the kid taking the medication," she said. "Even if there's *some* risk of something happening, I wouldn't want to take that risk. Is there *any* risk?" Already anticipating her pregnancy and conceptualizing her future fetus as a kid, she had a low risk tolerance for any potential effect of medication use during pregnancy. This exchange was representative the cases I saw—cases like Danielle's, a woman who'd been trying to start a family for four years, who came unsure how to move forward while on psychiatric medication. "Should I go off? Or go on something that won't be as harmful to myself and a potential child?" My weekly observations were full of cases like these: general questions of medication safety informed by public health and biomedical discourse, both intentionally and unintentionally consumed by patients, that crystallized into toxicity imaginations related to their medication and their fetus' safety.

Shaina was another patient who came to the clinic for a pre-conception intake. After a miscarriage and two years of trying to conceive, her psychiatrists sent her to the clinic with a suspicion that her medication might be impacting her fertility. The competing recommendations Shaina received from different providers—each with their own risk calculus—was disorienting,

and typified the information environment patients navigated before and during their time in the clinic.

For example, a patient taking medication for ADHD came to the clinic anticipating decreasing her medications after achieving pregnancy. She'd heard mixed messaging regarding the safety of her medication that magnified the stigma she already felt while taking it. "I'm a little overwhelmed," she said tearfully in her intake. "Being on meds has been a struggle for the last decade. There's a stigma, and you feel it a lot more when you're going to have a baby, I think."

While some questions from patients were about the general safety of medications, it was not uncommon for patients to arrive with specific questions related to their medications and fetal development outcomes. In another pre-pregnancy consultation, a young doctor who'd just completed her residency came to the clinic regarding her ADHD medications. Anticipating a pregnancy, she thought it would be best to discontinue her medication, but due to her intensive work in an emergency room, she concluded, "There's no world in which I go off my meds and go to work, people might die." Despite this, she articulated specific toxicity imaginations in which her prescribed medication use might result in 'dirty' toxicology screens, or having a baby born addicted to her medication: "I don't want my baby to be high on stimulants!" She also expressed long-term toxicity imaginations related to her medication use, asking about mental health and behavioral conditions that might result from her ADHD medication during gestation:

> "Is my kid going to be 15 and institutionalized with horrible depression and schizophrenia because I took stimulants with them? Is there reason to believe that stimulants during pregnancy would result in behavioral issues in my children later?"

Her case was striking precisely because her clinical rationale to remain on medication was unusually clear, and yet her toxicity imaginations were among the most vivid I encountered. The professional knowledge that made her an outlier in one sense did nothing to insulate her from the cultural messaging that shaped everyone else's.

Other patients voiced similar long-term toxicity imaginations, consistently inquiring about the potential future diagnoses their children might face if they continued medication during pregnancy,

> "Will exposing my baby to stimulants increase the likelihood of them having ADHD? And does the medication… I don't know the science behind it. I imagine there is a chemical imbalance where the meds have an effect on what my brain produces. I'm wondering how that would impact the baby. Whether we know about, chemically, if there are any long-term impacts?"

Another patient asked about the potential of her medication causing autism spectrum disorder:

> **"**With autism spectrum disorder or anything, of course I'll still love my child, but in theory, you don't think there's any reason to assume that there would be higher risk of mental health conditions based on taking stimulants during pregnancy?"

While for some patients, reassurance that medication continuation was supported and theoretically safe dispelled these imaginations, for others they persisted regardless of clinical guidance, a pattern that would only deepen once pregnancy began. Notably, even as patients voiced fears about their medications' effects on their children's neurodevelopment, they were careful to signal their good maternal intentions, 'of course I'll still love my child.' The toxicity imagination and the good mother identity were not in conflict for these patients; they were two expressions of the same thing.

Not all preconception toxicity imaginations were oriented toward fetal outcomes. For some patients, the question was whether medication was preventing pregnancy from happening

at all. I met Hilary after a week of MRIs, imaging and intense medical appointments, "I feel like a petri-dish," she told me. After several miscarriages, her life became a flurry of doctors' appointments in her attempt to maintain a pregnancy. She was unable to focus at work, felt tense and burnt out from all the appointments, and on top of this, her prolactin levels were elevated, potentially keeping her from getting pregnant again. Hilary's endocrinologist thought it could be her Prozac, so she came to ask her psychiatrist if this could be the case. Hilary specifically requested that she stop her medications in every effort to get pregnant. Despite her psychiatrists' hesitation, and her already low mood, she insisted that stopping her medication was preferred if it helped her to potentially maintain a pregnancy. Besides, she insisted, "I'm not suicidal," suggesting that she could handle the mental health challenges that might come with her decision to prioritize her pregnancy over her mental health. Hilary's case illustrates what was true across most pre-conception presentations in this clinic; patients had already decided where toxicity lived, and considered its removal an expression of 'good mothering', a calculus that the clinic would spend considerable time and effort attempting to reorient.

Pregnancy: scanning for toxicity

Once pregnant, patients toxicity imaginations did not dissolve but often intensified. The questions that had driven pre-conception decision making sharpened under the weight of an actual pregnancy, and the clinical recommendations patients received were not always sufficient to quiet them. Despite psychiatrists making clinical recommendations that related to fetal development, they were not responsible for fetal health outcomes; medical responsibility was often passed to different specialists, which left patients wondering who's advice to heed. Confusingly, many of the specialists often gave opposing advice, keeping toxic uncertainty central to patients decision-making processes. Elana, a first-time mother in the clinic was

hesitant to continue her medication after her psychiatrist and OB offered countering advice on its safety,

> "My OB doesn't really talk about the side effects of the medication. I feel like there may be a disconnect between the OB and the psych departments. I think I had to reiterate to this clinic to get in contact with [my OB] a couple of times, because there I feel like there hasn't been like a lot of communication between the two. […] Once he comes out, I'm sure he's gonna have, well, they've told me that he's probably going to have withdrawal symptoms. And I don't know, I guess I don't know if and how involved the clinic will be at that point."

For Lily, another first-time mom with questions about medication safety, her doctors' inability to directly respond to her toxicity concerns left her feeling guilty and untrusting of the information she was receiving,

> "My OB says go see a pediatrician, fertility specialist sends me here. I'm not a doctor. What are the costs to my baby? There's gotta be some effect that isn't just weight. Otherwise I'd be fine. I wouldn't feel guilt. I monitor my baby's weight, and I still feel really guilty."

Lily's guilt and Elana's sense of responsibility for coordinating communication between specialties reflect the burden patients undertook to ensure their ingestion during pregnancy did not have toxic effects. Despite the clinic's influence on their decision-making during pregnancy, both mothers anticipated bearing individual responsibility for their choices postpartum. Historical, social and scientific knowledge production has enforced the illusion that female bodies are solely responsible for fertility/infertility while male bodies have been largely understudied in relation to reproduction and responsibility (Almeling 2020). The expansion of prenatal and genetic testing and advanced reproductive technologies, mostly practiced on female bodies, reifies this deterministic framework that links maternal behavior and ingestion to fetal outcomes (Rapp 1999). In this clinic, physicians tried to alleviate patients' concerns of

medication toxicity on fetal development by encouraging increased screening and surveillance technologies throughout gestation. This mechanism of alleviating the inherent uncertainty of medical knowledge by showcasing a professional attitude of objective expertise has decades of research in the medical sociological literature (see Fox's (1980, 2002, 2013) claim that uncertainty was a hallmark of the medical field, Katz (1984) analysis of doctors' reluctance to disclose uncertainty by way of imposing order and professional authority on complex and inexact situations, and Timmermans and Berg's (2003) challenge of evidence-based medicine (EBM) as a method to counter uncertainty in medical socialization.. The management of uncertainty through displays of professional authority and systematic procedure is a hallmark of medical practice—and the anatomy scan was the reproductive psychiatric clinic's version of this.

Physicians posited that seeing fetuses develop on anatomy scans, for example could alleviate patient hesitancy toward medication's potentially toxic effects. Ari, a patient hesitant to continue their medications explained their doctors' attempt to relieve their uncertainty through scans that could help them visualize seemingly normal fetal development as a signal of medication safety,

> "Dr. G had told me, you've got to make it through. Right? And things like the anatomy scan will show us if the baby is developing okay, and if everything's on the right track, and that I would just… me and my husband would have to understand that if something went wrong it could possibly be the medication… that felt relieving and scary at the same time. It was definitely a double edged sword in that… it felt selfish for me to choose to do the medication even if there was a percentage chance that it could hurt the baby. But at the same time, knowing that I wasn't going to have to struggle fully through the pregnancy in order to make it through."

Ari's account captures the double bind that scanning created for many patients: the offer of added biomedical surveillance was also an implicit acknowledgement, or suggestion that something might be found, making the anatomy scan a reassuring and destabilizing force simultaneously.

Postpartum: the persistence of toxic imaginaries

Patients often imagined the effects of medication having cognitive impacts that scans would be unable to capture, such as mental health and neurodevelopmental disorders, as explored previously. These imagined effects of toxicity ranged from long-term cognitive problems, to behavioral issues, to or other unseen effects that patients anticipated might stem from medication use during pregnancy. In some cases, toxic imaginaries took hold for patients despite, as physicians presented, adequate research to support medication safety. Most commonly however, these imaginaries arose in the absence of clinical reassurance; in the face of uncertainty, patients often anticipated toxicity. A patient described to me her imagined effects of her ADHD medication during an interview,

> "Of course I'm wondering how these meds will affect my fetus. It's mostly the brain and the unknown stuff. I know there's a concern about the baby's weight. My baby's growing great. I've been getting more checks because I'm on this medication, he's not smaller than he should be. My concerns are really these things that are unknown. That's what it does to me… don't want my baby to be born addicted to something that's similar to meth."

Kira, another first time mother explained the insufficiency of anatomy scans to relieve her anxieties of the toxic potential of her medication,

> "It's a lot easier to see the baby isn't smaller then he should be, but I know there's gotta be other effects. So you feel guilt about that… It really puts it into perspective- at what cost? I need more information, but I don't know where I would go. This [clinic] is where I would go, and I still don't have enough information to make a better, more informed decision I would feel totally comfortable with."

While many patients struggled with the decision to remain on medications during pregnancy because of their potentially toxic effects, others planned to continue their prescriptions, and had other toxicity concerns. Eliza, a first-time mother with bipolar disorder

was determined to remain on her medication to avoid another manic episode and traumatizing hospitalization. Her concerns of medication toxicity were related to the immediate withdrawal symptoms her baby might exhibit following delivery,

> "I asked [doctors] directly if he's gonna have withdrawal because like, he's on these medications with me right now. And of course, he's not getting the full dose that I'm getting, but I just started thinking like, once he's not in here, and I'm not breastfeeding, and like, he's not going to be exposed to that anymore. Is he going to go through withdrawal? And I asked them that. And they said yes, but he… we may need to stay in the hospital a little longer to monitor him. And just to like to see how he reacts, you know, to not being exposed to it anymore. That's what they said."

Similarly to the use of anatomy scans to manage the uncertainty of medication on fetal development, more intensive postpartum monitoring was recommended to alleviate the uncertainty of medications' effects on the baby following delivery. This necessitated in-hospital childbirth with intensive biomedical surveillance in the immediate postpartum. For many patients, the offer of more monitoring was not the same as the offer of more certainty, however. Even when clinicians confirmed medication safety directly, some patients remained unconvinced. For example, a breastfeeding patient questioned her psychiatrists' confirmation of her medication's safety, for both her own and her child's safety,

> "I can't help… and this is really no research involved… I think it's kind of like an antibiotic. Isn't it going to potentially harm me long-term? Harm [my baby] long-term? Despite science not saying that?"

The persistence of these toxic imaginaries, in the face of clinical reassurance, anatomy scans and professional expertise, point to the limits of what the clinic could offer. Patients did not arrive with toxicity imaginations that their reproductive psychiatrists could correct, but with

convictions pre-formed by cultural messaging that clinical encounters would try to redirect, but rarely resolve.

What the postpartum period made clear was that the clinic's tools—scans, monitoring, reassurance—could manage toxic uncertainty, but not completely dissolve it. Patients carried their toxicity imaginations across the threshold of birth, where they would meet a new set of clinical and cultural expectations in the postpartum period.

Conclusion

The patients in this chapter arrived at the clinic having already begun the work of what they'd been told is 'good mothering' in relation to ingestion; stopping medications, avoiding particular products, beginning the process of 'purifying' their bodies for pregnancy. This is consistent with what researchers have documented about the biomedicalization of the pre-conception period, and the anticipatory logics that govern reproduction. The mothers are expected to begin managing risk before pregnancy, and to continue in its management indefinitely. For the patients in the reproductive psychiatric clinic, these expectations were further complicated by their psychiatric histories. Opting into the identity of the careful, self-surveilling mother was a mechanism of demonstrating that mental illness had not compromised their maternal judgment. They were still, despite their stigmatized diagnoses, appropriate patients and 'good mothers'.

The continuum patients navigated, and the purification logic that organized it, structured their clinical encounters as much as any symptom or diagnosis. Psychiatric medication remained in an unstable position within it—legitimate enough to be prescribed, but never fully absolved of its toxic potential in patients' minds, no matter what their doctors said. That instability was not

incidental, but the product of decades of cultural and biomedical messaging, that made purification, rather than treatment, the default behavior of 'good' mothering.

The stakes of this purified, 'good mother' identity are significant. The hyper-surveillance of pregnant bodies—criminal, epigenetic, and increasingly political—makes good mothering not merely aspirational but necessary. Epigenetic research has expanded the scope of what counts as a consequential maternal exposure, linking behavior, ingestion, and environment to child outcomes across generations. At the same time, the criminalization of maternal behavior during pregnancy, documented extensively in relation to drug use and poverty, has made the costs of failing to perform good mothering concrete and severe. Avoiding toxicity has moved beyond a cultural expectation of good mothering, into a legal and biological one.

What the clinic offered was not a relief from this framework but a re-orientation of it. The toxicity of untreated psychiatric symptoms, clinicians posited, was comparable and in many cases exceeded the toxicity of medication. Patients absorbed this redirection while holding onto the toxicity imaginations they arrived with, often simultaneously. This accumulation of toxic concern—medication, in addition to cortisol, neonatal adaptation syndrome, long-term developmental outcomes, etc.—did not resolve into a clear clinical path. It compounded the 'risk-risk' framing that physicians used to represent the genuine uncertainty within the clinic, often confirming what patients had feared, that there was no completely safe option to both treat their disorders and shield their children from toxicity, no matter its location.

Underneath both the patient and physician frameworks of toxicity lie parallel, if unspoken, eugenic logics, that I explore more thoroughly in the following chapter. Patients arrived hoping to protect their future children from the very diagnoses they themselves carried—anxious that stimulants might produce ADHD, that SSRIs might produce autism, that their own

psychiatric histories might be inherited. Physicians, meanwhile, framed untreated mental illness as dangerous to fetal development, positioning the 'severing' of maternal psychiatric symptoms as necessary for healthy child outcomes. Both frameworks locate the source of potential harm in the maternal body and its management, and both orient that management toward the production of a fetus unburdened by the mother's condition.

The anxiety present in patients' toxicity imaginations saturated many of the clinical encounters I observed. It was palpable and persistent, despite recommendations of anatomy scans and clinical reassurance. The patients I observed are indicative of a broader cultural movement in which the pregnant body has continued, as medical sociologists have long argued, a primary site for anxieties about environmental harm, pharmaceutical risk, and uncertainty within the clinic. The specific contours of that movement, including what it signals about the current political moment in reproductive and psychiatric care, are explored in the dissertation's conclusion. What this chapter has established is the ground on which the clinical encounter takes place—the continuum of acceptable exposures patients had assembled before arriving, the purification logic that organized it, and the conviction that any deviation from it constituted maternal failure. The following chapter examines what happens when that framework meets the physicians', and what the friction between them reveals.

CHAPTER THREE

Enforcing Psychiatric Authority: The Clash between the Voice of Psychiatry and the Lifeworld of Patients

Introduction

In the previous chapters, I've illustrated the way resident psychiatrists are socialized and taught to respond to patients, what language they should utilize in patient interactions and which logics help facilitate decision-making in the reproductive psychiatric clinic. I also explored the patient's perspective, unveiling how toxicity permeates pregnancy discourse and maternal and patient logics as patients strive to perform 'good' patient and maternal behavior under clinical surveillance. How patients and physicians actually interact in the clinical context, however, allows us to understand the way toxicity is negotiated in clinical terms, how and in what instances patient preferences are prioritized, what methods and logics clinicians rely on to encourage patient adherence with professional objectives of medication use, and what frameworks are relied on when the tension between the perspectives threatens professional authority.

In the following chapter, I rely on ethnographic data from clinical appointments with patients in pre-conception, pregnancy and postpartum phases of their reproductive journeys. In each of these interactions, I observe a tension between clinical and lay perspectives—moments of incongruence that result in both clinicians and patients doubling down on their respective viewpoints regarding medication, mental health, and motherhood. The central argument of this chapter is that clinical authority is maintained through two characteristic tactics deployed in response to patient engagement about medication: outsourcing responsibility and repositioning danger as undertreatment. Patients in this clinic arrive with two primary forms of concern—fears

about the short-term toxic effects of medication, and fears about the long-term toxic, heritable effects of medication on their children—but the tactics clinicians deploy in response do not map neatly onto these concern types. Both tactics appear across both forms of engagement, and most revealingly, within single clinical exchanges.

What I highlight analytically in this chapter is not simply that clinicians maintain authority, but how. Patients in the clinic, as illustrated in the previous chapter, arrive with their own ideas of purification, concerned with ingestion and the neurochemical effects of their medication. The tactics clinicians deploy in response, and the limits of those tactics, reveal the stakes of maintaining professional authority. If the clinic fully acknowledges the scientific uncertainty surrounding psychotropic medications in pregnancy, it risks undermining the treatment recommendations it makes to patients.

To illustrate these dynamics, this chapter is organized as follows. I begin by situating these interactional dynamics within the literature on medicalization, patient engagement, and psychiatric authority. I then introduce the clinical cadence of the reproductive psychiatric clinic through the case of Cristina, a first-time mother whose intake appointment illustrates the typical arc of clinical interaction and previews the two tactics this chapter examines. The subsequent sections examine each tactic in turn—outsourcing responsibility and repositioning danger as undertreatment—before turning to cases where the two tactics combine within a single exchange, and finally to the case of Sophie, whose experience reveals what happens when those tactics break down. Throughout, I draw on two related but distinct analytical concepts: biological logics, which refer to the clinic's operating framework—the clinical claim that the maternal body, and specifically the maternal mind, constitutes a biological environment of consequence for the developing fetus, such that untreated psychiatric symptoms become a fetal exposure as

consequential as any chemical the clinic might prescribe—and eugenic logics, my characterization of what that framework enables at a structural level. By this I do not mean eugenics in the sense of reproductive prohibition, but an improvement logic, the organization of care around producing a psychiatrically unaffected child, premised on the assumption that treating the mother can interrupt the transmission of psychiatric difference to future generations. I conclude this chapter by considering the broader implications of these dynamics, including the eugenic logic that underwrites the repositioning of danger, the incommensurability patients live with long after the appointment ends, and what this interactional exchange reveals about reproductive psychiatry's organizing priorities.

Background

To understand the interactional exchanges and dynamics between patients and providers in the reproductive psychiatric clinic, it's useful to situate the contemporary experience of pregnancy and patienthood in the literature and history of medicalization. Irving Zola (1972) singled out medicine as an institution of social control half a century ago, originally critiquing psychiatry (Conrad and Schneider 1980) and then most other areas under medical jurisdiction, with pregnancy heralded as the most "illuminating illustration" (Zola 1972; 211) of medical dominion over everyday problems. Since however, and in the contemporary healthcare marketplace, consumers have become active participants in medicalization, shaping the demand of their medical treatment and requesting increased or decreased medicalization in their experiences of care. This has resulted in increased patient engagement in their own care, in part facilitated by patient activism and advocacy groups (Epstein 1996), the online democratization of health information, and the embrace of individualist and consumer models of care enabled by insurance market restructuring and the rise of patient-centered care models (Rose & Novas 2005;

Timmermans & Oh 2010). In this shift toward more engaged doctor-patient interactions, patients have become foregrounded in their care, with patient-centered health care policies, alternatives to paternalistic medical approaches, and empowerment of patients to express their healthcare preferences and aim for shared decision-making (Stivers & Timmermans 2020). As a result, patient engagement in their medical treatment often results in clinical negotiation, with medical providers no longer able to assume authority in exchanges, nor that patients will necessarily accept or follow their professional recommendations (Stivers and Timmermans 2020). Engagement has been both embraced and decried — particularly the rise of "Dr. Google" for causing unnecessary work to address unfounded concerns (Lee et al. 2010)—but patients have also been encouraged to rely on outsourced medical information on the internet (Lupton 2013).

In many ways, patient engagement has become institutionalized in the current health care system, particularly as it moves toward care delivery models that rely on patient engagement for financial stability (Shortell et al. 2017). Engagement is institutionally encouraged, and investments in patient engagement have been argued as promising to improve quality and decrease the costs of care (Cosgrove et al., 2013). However, other researchers (Fleming, Shim et al., 2017) have suggested that the imperative of patient engagement has the potential to exacerbate health disparities, particularly as distributing care based on engaged patients and withdrawing care from unengaged patients might create a health care system established on "deservingness" (Willen 2012)—based on providers' perceptions of who deserves treatment according to implicit ethical norms that favor patients who are more agreeable and have apparently "fixable" problems (Higashi et al. 2013). Fleming, Shim et al. (2017) have found that racial minorities and socioeconomically disadvantaged patients are more likely to be labeled as non-compliant and to be seen as refusing care (Maskovsky 2005; Rouse 2010), while patients

who are more socioeconomically marginalized or have faced sustained barriers to care appear less willing to engage in care to their providers.

Psychiatric patients, and particularly women living with mental health conditions, face unique consequences in the case of their engagement with psychiatric providers. I and others have found that for this group of patients, engagement in the context of mental healthcare has the capacity to label patients as unreliable narrators in their own health (Abel & Timmermans 2026; Moncrieff 2009). The stigma of mental health, particularly for women, has led to constructions of hysteric illness that have long reflected male domination, paternalistic medical authority, and constrained and discredited women (Chodoff and Lyons 1958; Micale 1990). The phenomenon of psychiatric gaslighting (Abel & Timmermans 2026) can occur as a psychodynamic, sociological, and institutional phenomenon, in which cultural scripts about both gender and mental illness shape patients' credibility in their engagement and may affect the outcomes of their care. In the reproductive psychiatric clinic, these dynamics take on additional charge; patients navigate not only the gendered credibility dynamics that psychiatric stigma produces, but within in a context where their engagement is simultaneously read as evidence of good (or poor) maternal behavior and as a potential symptom of the very conditions they are seeking treatment for. To inquire about medication safety is to perform responsible motherhood, however to inquire too insistently, or to resist clinical recommendations, risks being interpreted as non-compliant, medication-resistant, or insufficiently oriented toward the wellbeing of one's fetus.

In the clinical interactions this chapter outlines, the tension between acceptable and marginalized patient engagement can be clearly observed. Moreover, with the background understanding of medical providers' socialization into the reproductive psychiatric clinic, as well as the foregrounding of patients' perspectives on toxicity and appropriate maternal behavior, we

can understand the professional and identity-based stakes this interaction reveals—for clinicians working to maintain authority under genuine scientific uncertainty, and for patients navigating the impossible position of being simultaneously encouraged to engage and penalized for engaging too much. These dynamics are further complicated by the biomedical context in which they unfold; the reproductive psychiatric clinic operates not only as a site of clinical negotiation but of reproductive governance, in which the organization of care around fetal outcomes has structural precedent in longer histories of eugenic management (Duster 1990; Roberts 1997; Avila and James 2024). Scholars of reproductive medicine have documented how these logics can operate through clinical encouragement rather than prohibition (Rapp 1999; Tremain 2006), which is directly relevant here, revealing that the stakes of patient engagement in this clinic are not only interactional but structural, shaped by a long history of organizing reproduction toward normative outcomes, often at the expense of maternal autonomy.

Data

The Clinical Cadence

Patients arrive at the reproductive psychiatric clinic on Wednesday afternoons, between 12pm and 3:30pm. Clinicians have between one and five patients per day to see, so I make sure to join the Zoom meetings about five minutes early. This is when clinicians and I check in with each other, make small talk as we finish our lunches, and I'm provided candid backgrounds on the patients, read to me from their charts. *Patient X is a 32 year old first time mom experiencing intrusive thoughts about her son, history of depression and anxiety and acute trauma. Patient Y is a 45 year old in fertility clinic, whose OB recommends she discontinue all medications. She's currently being treated for anxiety and bipolar 2. This is a follow-up, you remember Sara? She*

gave birth last week, let's see how she's doing, we're following closely for symptoms of psychosis.

This is often when I receive signals of transference from clinicians; *I remember her, difficult case*, or *she's very lovely, accomplished woman*. From the shared Zoom meeting room, me in my home office, doctors in the clinic, I take in the details from the providers: patients' cases, symptoms, personalities, and details about their pregnancy or postpartum experience—the age of their babies, the dose of their medications, and details that the clinicians find relevant to share with me for background context on my observations that day. This ranges from their medical details regarding their psychiatric histories and pregnancy and delivery, to auxiliary information including their profession, details about their partner or family life, or typical affect according to the clinician. These pre-appointment briefings are themselves analytically significant, they establish the interpretive frame through which I, and the clinician, will encounter the patient. By the time the patient appears on screen, she has already been narrated.

One telling detail about how an interaction will play out is whether the appointment is an intake or a follow-up. Intakes can stretch to about three times the length of follow-up appointments—often over an hour to an hour and a half. Follow-ups typically run between 20 and 45 minutes. Follow-up appointments begin with often a simple question from clinicians: "How's your mood?"

Intake appointments are essentially a guided history of the patient's life story and psychiatric history. In the following section, I walk through the typical cadence of one patient, Cristina's, intake to showcase how the clinical interaction operates: who sets the agenda, what topics are prioritized, how much room there is for patient engagement, what strategies are utilized to respond to patient engagement, and where the interaction ends. Within this, a few

interactional dynamics will be introduced—the way Cristina's history is inquired about and incorporated in her doctor's treatment recommendations, the way medication is framed and brought up in the interaction, and how Cristina asks about the short and long-term safety of her medication, and the strategies her clinician uses to respond. Following the themes introduced in Cristina's example, I turn to additional patient cases that highlight the elements of this interactional clash.

Cristina

On a Wednesday in March 2023, I observed Dr. V, one of the program's few male residents, introduce the clinic and himself to the intake patient that day.

> "I'm a fourth year psychiatry resident within the clinic, so four years after medical school, and I, so I'm, while you're in the clinic, I'm your kind of touch point for, like, prescriptions, for messages, for questions, things like that, but we exist within kind of this larger clinic, and so at a certain point, usually we'll talk for in this initial conversation, we'll talk for about an hour, and then we'll pause, and I'll grab one of our attending psychiatrists, who are folks with a bit or, or sometimes much further along in their career, who specialize in women's mental health, and they'll kind of collaborate with us then, one of them will kind of collaborate and be part of the, the planning. Can you give me a little bit of context on how you were referred to our clinic?

The patient in this intake, Cristina, a first-time mother from Brazil, was referred by her OB after a traumatic birth. For the next thirty minutes, she walked Dr. V through her reproductive history:

> "I was pregnant and was told that my baby was dying in the womb. In a very short amount of time, 2 weeks, it went from she's dying, to yeah she's okay, yeah we need to deliver, not sure if she's going to survive, and not sure what she's going to have. It was very traumatic. We had like 15 specialists on top of her when she was born. I wasn't able to see her until 8 hours after she was born, only was able to hold her 4-5 days after she was born. It was a delicate situation, it was too, too much in a short period of time. So when I saw [the referring clinician], I was crying, couldn't stop crying. It was tough for us."

Following her traumatic pregnancy and delivery, Cristina was shaken and tearful in her follow-up doctor visit. She described feeling guilty about not knowing that her baby was dying while she was pregnant with her, afraid that she couldn't protect her, and nervous about leaving the house. In this state, she was referred to the WLC for psychiatric treatment. In the remainder of the intake, Cristina was asked about her childhood, parents, marriage, work, relationship to substances, general moods, and—since her psychiatric history was nonexistent—her history with therapy and mental health in general. Intakes are extremely comprehensive; providers ask a wide range of questions to get a sense of patients' life histories, in addition to gathering information about how they narrate their lives, their logic, and what motivates them.

> "I'm gonna ask more detailed questions about how you're doing a bit later, but it would be helpful before we do that, just to back up a little bit, and for me to get a fuller sense of who you are and have been before all of this, to start off, can you just give me some kind of big picture sense, like, I understand that you're from Brazil, just some of your kind of background, like your education, your work, just like a little bit of overview what's been important."

After their non-reproductive histories, patients are asked about their relationship to their pregnancy or babies, how they relate to motherhood, or often, what they explicitly enjoy about it, and how well they're able to care for their babies. The topic of medication is reserved for the end of the intake. Cristina answered Dr. V's questions about her dose of Zoloft; with no psychiatric history and a recent experience of trauma, Cristina's referring clinician had prescribed her Zoloft and referred her to this clinic. She had taken about half of her dose, saying the medications made her sleepy, nauseous, and gave her headaches, and she was concerned about caring for her infant daughter with these side effects. Her hesitancy was not a rejection of treatment, she had, filled her prescription, but a negotiation about terms and what kind of medicated self she could afford to be while responsible for her fragile newborn. Dr. V followed up with guiding questions about

medication, steering the conversation toward treatment and encouraging Cristina to think about its usefulness despite her negative side effects and hesitation:

> "What were the *positive* things [about the medication] you noticed?"
>
> "I don't know if it was because of the medication or because I was feeling better," Cristina replied. "I felt more confident, more happiness and joyful thoughts. I'm not sure if it was because of the medication, or because my child was getting better."

While Cristina came into the clinic following an acute traumatic experience that she was medicated to manage, her pushback against the clinical logic that the medication was responsible for positive outcomes in her treatment was reflective of many patient experiences in the clinic. Even those who came in with long histories of medication use often described intense side effects or negative psychological impacts from medications. For some patients, however, medication did represent a dramatic positive shift—often still with side effects, though typically deemed manageable or worth it to achieve their desired psychiatric outcomes. ADHD medication was a common example in which patients relied heavily on their prescriptions to achieve particular work outcomes or remain focused throughout the workday. For those with bipolar disorder or histories of psychosis and hospitalization, medications were critical tools of self-management (Martin 2007)—means to keep themselves in neutral states or out of psychiatric hospitalization, which patients and clinicians alike understood as one of the worst possible outcomes of their diagnoses. In either case, whether for patients heavily reliant on medications or for patients like Cristina who felt ambivalent about their use, the conclusion of the clinical appointment turned to the usefulness of medications to maintain, improve, or progress patient wellbeing. In their final minutes with the patient, residents relied on patient histories to incorporate what motivates them. For Cristina, this was taking diligent care of her fragile newborn. She was offered clinical recommendations accordingly:

> "From my perspective you've got some good things in place. You're a very important part of everything and sometimes it's hard to focus attention on yourself. Your first priority is Emma, but for your own sake and for Emma, taking care of yourself is important. I hope that with therapy and with the medication that we'll discuss, that will be activating, it can cause a cycle of increased energy… I'm really optimistic about the path ahead, we have a lot of resilience built in us. In terms of medication, we have two options. One would be restarting Zoloft, and the other would be to consider an alternative like Lexapro."

It is worth noting that Dr. V also mentions therapy in this recommendation; clinicians in this clinic sometimes did. But therapy occupied a secondary position in the clinical logic, understood less as an alternative to medication than as a complement to it. The clinic maintained a list of therapists whose approaches were considered compatible with the clinic's orientation, and therapy was consistently framed as a way to enhance medication outcomes rather than to replace them. The primary intervention, in every case I observed, was pharmacological.

The structure of this recommendation is also worth noting; the options presented to Cristina were not whether or not to take medication, but which medication to take, a choice that forecloses the possibility of non-medication while preserving the appearance of patient agency. Cristina's hesitancy, her side effects, and uncertainty about whether the medication had even been responsible for her improvement did not lead the potential of an unmedicated postpartum; the clinical focus was on medication type and dosage. Details about Cristina's history were incorporated by her doctor in his recommendations: her role as Emma's caregiver, her resilience, her path forward, framing medication use as both clinically indicated and as a component of proper maternal behavior.

Cristina left the clinic with a prescription for Lexapro. Her initial hesitancy toward medication use was managed through the promise that an alternative medication might produce fewer side effects, ensuring that her maternal capacities—her ability to care for Emma—would not be compromised. Her short-term inquiry about chemical effects was addressed through the

clinical logic that inadequate data suggested safety. Her long-term concerns about heritability were managed through the reframing of her biological fears: rather than medication causing long-term harm to her daughter, it was the undertreatment of her psychiatric symptoms that posed the biological risk. In his presentation of her case to his attending psychiatrist, Dr. V introduced Cristina's case as unremarkable. And in the terms of the clinic, it was—a patient's hesitancy surfaced, was managed, and resolved within a single appointment, the patient leaving with a prescription as planned. This patient's case, while rich with analytical signals about the clinical cadence and logics within the reproductive psychiatric clinic, represents a typical interaction, one in which patients' toxicity imaginations and the clinic's biological logics clash under the temporal and biomedical demands of reproductive care, and in which both the clinic and the patient must act.

Cristina's case previews the two tactics this chapter examines in full. 1) Her short-term inquiry about medication safety was met with outsourcing—the clinical interpretation of thin data as suggesting safety, the benefits-outweigh-risks script. 2) Her long-term concern about Emma's development was met with repositioning—the framing of danger as undertreatment, her own psychiatric symptoms were cast as the greater biological risk. That both tactics appeared within the single intake is significant, and reveals that the tactics are not responses to different kinds of patients, but a flexible set of clinical responses, calibrated to whatever form patient engagement takes, in service of a single destination, the prescription.

Clinical Tactic 1: Outsourcing Responsibility

Across the varied interactions I observed in the clinic, one of the most consistent responses to patient engagement was the outsourcing of clinical responsibility to external authorities—including to the limits of the research involving medication, to other medical

specialties, or parallel pharmacological specialties or to the profession at large. This tactic appeared across both short-term and long-term patient concerns, and functioned not as an admission of ignorance, but as a clinical tool aimed at persuasion: to close down inquiry by naming its limit, while the recommendation remained intact.

Like Cristina, many patients came to the clinic primarily concerned with the chemical, short-term effects of medication on their pregnancy. These concerns were not abstract, they were grounded in the same neurochemical framework the clinic relied upon, and patients had absorbed, extended to the body of the fetus. If medication worked by altering brain chemistry, patients reasoned, what was it altering in the brain they were in the process of creating? Cristina's first follow-up question to her provider's recommendation highlights this outsourcing tactic in action,

> "My question is… for the medication, is it safe? For breastfeeding?"

Dr. V's response reflects the outsourcing strategies that clinicians use: first, the clinical interpretation of inadequate data as suggesting safety, and second, the clinical logic that well-treated psychiatric disorders outweigh the often unknown risks of treatment:

> "Yes, it is. There's not a lot of kind of… research, and our clinic specializes... and the benefits, there's… of like, 'well treated' depressive symptoms meaningfully outweigh any, any [medication] risks. And, those risks are kind of, not statistically significant in studies that have been, kind of… done to assess these risks. They don't, there aren't higher risks in… when breastfeeding."

The hesitancy in Dr. V's response, the pauses, restarts, and qualifications, is analytically telling. He is not misleading, but navigating genuine uncertainty in real time, relying on the clinical script that benefits outweighs risks while acknowledging, in that the data are thin.

On one afternoon of my clinical observations, I was introduced to Anna, a patient in her late thirties, with a high-stress job as a lawyer. She was happily pregnant with her first child after

having struggled with infertility, and had spent decades managing mental illness that she had wondered if she would regulate enough to feel comfortable having a child. I met her a few weeks before her scheduled induction. She had self-tapered off of her high-dose Adderall prescription prior to her delivery and was struggling at work. The psychiatrists in the clinic recommended that she restart her medication prior to delivery and encouraged her to maintain her dosage throughout breastfeeding as well.

> "This is confusing to me," she responded to these recommendations. "The psychiatrist I saw before [this clinic] said she recommended I don't go on medication. A fertility doctor also told me to come to you. To hear that I should stay on it is… surprising."

Anna was particularly concerned with the short-term effects of her medication—specifically the developmental outcomes, APGAR score of her fetus, and any potential heart defects that taking a stimulant might produce. Heart defects were a commonly cited concern among patients in the clinic who had sourced medical information from online sources, podcasts, or other providers. The concern was not unfounded—it circulated widely enough in lay reproductive health spaces that it had become a kind of shared patient knowledge, arriving in the clinic pre-formed and necessitating clinical response. Anna's anxieties about the effects of breastfeeding were managed through clinical deferment to the leading resource for up-to-date information—a blog on Mass Gen hospital's website,[5] largely regarded as the authoritative source on safety recommendations for reproductive psychiatrists in the United States. The most recent blog posts clinicians cited were from 2017, interpreting research on stimulants and pregnancy that found effects were not statistically significant.

In this clinic, one of the late-career attendings who lectured annually on stimulant use during pregnancy and the under-diagnosis of ADHD among women was the de facto expert on

[5] https://womensmentalhealth.org/

stimulant safety during pregnancy. Between the advice of the attending, links to Mass Gen's blog, and clinical reassurance in interactions, attendings made sure that residents were armed with information, resources, and language to manage patient hesitation about stimulant use. Behind closed doors, residents routinely checked with their attendings about the safety, dosage, and effects of stimulant medications on short-term reproductive outcomes. The reassurance patients received in appointments was thus the product of a backstage rehearsal—residents learning not only what to say but how to say it, how to hold uncertainty without transmitting it. In another example of outsourcing, an attending defers to pediatricians,

> "I hope this has been helpful to open the possibility of not having to choose between medication and breastfeeding, to maybe doing both. I've noticed that pediatricians who are open to these issues are good pediatricians to have."

The referral to the pediatrician is characteristic of the outsourcing tactic; by directing the patient toward a collaborating provider, the clinic signals the limits of its responsibility, while maintaining its recommendation. Perhaps the most compressed version of the outsourcing tactic appeared when patients asked directly about data on long-term neurological effects. In these exchanges, clinicians named the limit of research explicitly, then utilized that limit to keep their recommendation.

In another case, a patient nearing her delivery date came to the clinic for guidance on continuing her ADHD medication throughout her pregnancy. She exhibited fears of the medication's short-term chemical effects on her fetus.

> "Tell me about withdrawal," she prompted her resident psychiatrist. "I've never had it, so would the baby? Tell me about that."
>
> "It's a very sleepy feeling," her doctor replied.
>
> "Not life threatening?"
>
> "No."

When the patient pressed on, asking about any long-term consequences of withdrawal, she was met with a common clinical response: "Again, we don't have the data on it," coupled with the reassurance that the psychiatrist felt comfortable moving forward with the medication despite the clinical uncertainty. The phrase "we don't have the data" functioned here not as an admission of ignorance but as a clinical tool—a way of closing down the inquiry by naming its limit, while the recommendation itself remained intact. Uncertainty, in this clinic, was consistently deployed in the service of continuity.

A similar dynamic played out when patients asked not only about withdrawal, but the broader neurochemical effects of their medication on fetal brain development. In these exchanges, the outsourcing tactic took a slightly different form. Rather than deferring to external authorities or the limits of the data, clinicians outsourced the evidentiary burden to the state of the science itself—acknowledging uncertainty while simultaneously using it to limit further inquiry from patients. One patient engaged her clinician directly in the neurochemical framework the clinic itself relied on:

> "Does the medication… I don't know the science behind it. I imagine there is a chemical imbalance… where the meds have an effect on what my brain produces. I'm wondering how that would impact the baby? Whether we know about, chemically, if there are any long-term impacts?"

This patient had internalized the clinic's neurochemical framework and was extending it, logically, to her fetus. Her question was less a rejection of psychiatric knowledge, than an application of it. The response of her clinician maintains this narrative—that medications change the very biology of the patient—while acknowledging that how this affects the fetus remains beyond the scope of psychiatry's current knowledge,

> "[Your medication] increases release of some chemicals and stops the release of other chemicals. We have some idea of what downstream effects that has as well. But that change in the chemical milieu isn't the end of the story. That change in chemicals drives

> connections between neurons… it sometimes affects pathways in the brain as well. We have a basic understanding of what's going on… in psychiatry we are in our infancy in understanding the brain and all the ways these medications work. And all the impacts these chemical changes have. I can't say how that's changing your baby's brain and development."

The clinician confirms the neurochemical framework—yes, the medication does change brain chemistry, and those do have downstream effects—then outsources the question of fetal impact to the limits of psychiatric knowledge itself. "I can't say," is not a refusal but a redirect, the science can't answer the question yet so the inquiry closes, while the recommendation remains intact.

The exchange between Anna, the lawyer introduced previously in the chapter, and her resident psychiatrist further illustrates the outsourcing tactic's reach. Anna's strategy of pitting professional recommendations against each other—citing a previous psychiatrist who recommended against a medication, and a fertility doctor who referred her elsewhere—is a classic method of patient engagement. By doing so, she asserts her investment in her care, fact-checks her clinicians and requires a justification for an unexpected or unwanted recommendation. Her clinician responded by deferring to an external source—Mass Gen's website—and the attendings expertise, outsourcing the evidentiary burden to an external authority. The recommendation for medication was unchanged and Anna left the clinic with her prescription.

For pregnant psychiatric patients, this signal of engagement can serve as especially symbolic, offering evidence of their commitment to finding the safest solution for their own mental health, signaling their role as a proactive psychiatric patient, and demonstrating their concern for the safest outcome for their fetus, thereby signaling good maternal behavior in their own treatment decisions. The two identities, engaged patient and vigilant mother, are, in this

clinic, difficult to disentangle. A patient who asks hard questions about medication safety is simultaneously demonstrating psychiatric engagement and maternal responsibility. The clinic must manage both.

What the outsourcing tactic manages across all of these forms is the evidentiary burden of uncertainty. Whether clinicians defer to another clinic, another doctor or specialty's expertise, or the limits of the data, the effect is the same: the recommendation remains intact and the responsibility for uncertainty is relocated elsewhere.

Clinical Tactic 2: Repositioning Danger as Undertreatment

Where the outsourcing tactic manages uncertainty by relocating the evidentiary burden, the repositioning tactic manages it by reframing the stakes. When patients expressed concern about the effects of their medications on their fetus, clinicians often redirected it: shifting the focus from the medication to the untreated psychiatric symptoms as constituting the most substantial biological risk. The danger, in this reframe, flows the other direction.

To contextualize why this repositioning tactic lands as effectively as it does, it helps to understand the conceptual framework patients had already adopted before arriving to the clinic. In his account of the neurochemical self, Rose (2007) traces how neuroscience and psychopharmacology have transformed how we understand our own minds. In his view, how humans have come to understand themselves is a reflection of the growth of neuroscience and its focus on the brain, resulting in the molecular becoming the new level for understanding how we feel. The development of this self-understanding was driven by the launch of pharmaceutical drugs created to target explicit biological processes. As Sandell (2016) contextualizes this shift in her ethnographic research on the neurochemical self and antidepressant use: everything about how we feel can potentially be explained by causal processes mapped onto biology, the body, and

the brain. The shift was fueled by the launch of new psycho-drugs, primarily the SSRIs—a class of drug that seemed to fulfill psychiatry's ideal of curing a well-defined abnormality by targeting underlying biological processes. Patients in this clinic had internalized this framework; their psychiatric symptoms were not merely experiences of neurochemical events, but addressable through medication. The repositioning tactic works precisely because it speaks this language back to patients: if biology is malleable, and the maternal body is the environment in which the fetus' biology is being formed, then untreated symptoms are not merely a personal problem but a fetal exposure. In Rose's words, "Life is not imagined as an unalterable fixed endowment; biology is no longer destiny," (Rose; 2007; 40). For the pregnant patient, this cuts both ways, it promises treatment can improve outcomes and implies that non-treatment carries biological consequences.

This framework is what the repositioning tactic draws upon. The neurochemical self is, for these patients, not only a lens for understanding their own minds but a framework for understanding their culpability. If biology is malleable and they are the environment in which their fetus' biology develops, then their decisions about their own neurochemistry is simultaneously a decision about their child's.

Biological logics occur within and shape the reproductive psychiatric clinic; emphasizing pregnancy and the first few years postpartum as critical periods for psychiatric intervention. The roots of this operating framework within the clinic can be traced to gendered assumptions of risk and responsibility, which has emphasized the focus on the maternal body—and as this research contributes, the maternal mind—as an environment of consequence. This biological logic appears in the clinical emphasis on treatment during pregnancy in order to avoid the long-term effects of illness on fetal development, making the patient's untreated psychiatric symptoms into

a fetal exposure, as dangerous in this framing as any chemical the clinic might prescribe. The clinic does not consider the choice between exposure and non-exposure; it chooses between exposures, and consistently determines that the exposure it can manage—medication—is preferable to the one it cannot. As one attending put it plainly,

> "There's no such thing as no exposure, because anxiety and stress can have their own *biological* impacts."

This is perhaps the most compressed version of the clinic's repositioning; there is no neutral position available to the patient/mother nor an option that does not involve exposure of some kind. The only question is which exposure the clinic can and feels most comfortable managing. And the answer, in this clinic, is consistently medication. This view, that medication is a safer option than untreated psychiatric symptoms, followed the pattern that untreated mental illness was harmful not only to the patient herself, but to the development of her fetus. In the clinic's view, an unmedicated mother was not only psychosocially more harmful to the structure of the family, particularly in the immediate postpartum, but could be biologically more harmful to the development of the fetus both in utero and to the development of the baby's brain postpartum. The following examples illustrate how this logic was deployed in clinical interactions:

> "What we simplify it as is… is someone ending up with a diagnosable disorder based on symptoms? What is more clinically relevant is, is someone exposed to a drug or medication and do they develop a diagnosable symptom later on?"

The framing here is not whether the child will be affected, but whether a diagnosable disorder will result. Since no psychiatric diagnosis can be directly traced to medication exposure, the exposure itself becomes acceptable. In another example that showcases the biological logics of the clinic, a senior attending confers with a patient,

> "And let me tell you, you are the template for your child. If you're anxious, how can you not have an anxious child? You don't want that. So we really want to push that."

This statement is among the most explicit articulations of the biological logic in the clinic. The patient is not merely a person with anxiety, she is a template, a developmental environment and direct transmission mechanism to her fetus. Her untreated symptoms are not her problem alone, but her child's inheritance. The stakes of her non-compliance become generational.

This logic was at times deployed in its most explicit form at moments of patient vulnerability, when distress about medication was met not with clinical reassurance about safety, but with a reframing of medication use as an act of maternal care.

> "I'm a little overwhelmed," a patient says, "Being on meds has been a struggle for the last decade. There's a stigma, you feel it a lot more when you have a baby I think. I really started out nine months ago thinking, 'I'm gonna do this,' but I really don't know what's doable."
>
> The attending responds, "The reality of it is it's such a wild time. You're gonna go into next week and see how it is. You'll learn your baby, your baby will learn you. We're here to support you in that. There's no stigma or judgment on being on medication here. We're very pro women and moms feeling the best that they can in this crucial time in their lives. There's no choosing, you don't have to choose between feeling well and being a good mother, or being safe and having a healthy baby. You don't have to choose."
>
> And the resident psychiatrist adds, "[It's] better for baby too, for you to take medication if you need it."

The reassurance offered here, 'you don't have to choose' is, a foreclosure of choice. The patient is told that medication and good mothering are not in tension, and that she need not sacrifice one for the other. The subtext is that the clinic has already determined that medication is the appropriate choice, and what is left to be managed is not her decision but her distress about the decision that has already been made. The addition that this is "better for baby too" completes this logic, medication use is reiterated as an act of maternal care.

Returning to Cristina's case, her follow-up appointment illustrates the shift from short-

term to long-term engagement. She shifts her focus toward the long-term effects of medication use, including questions of heritability, extending the temporality of her inquiry from the immediate chemical effects of medication postpartum to the psychiatric future of her child years, even decades, down the line:

"And will it [the medication] affect my… Emma, long-term?"

Dr. V's response emphasizes the clinic's biological logics of heritability—that the undertreatment of the patient's symptoms is in fact what could cause biological and psychiatrically diagnosable disorders in the child's future. Co-opting the patient's anxieties about medication use as having long-term effects on her child, the doctor reframes the danger as undertreatment:

> "There's… so if we can find something that's effective, then the treatment of depression does, like the… the risks of depression are pretty, pretty significant. They cause all sorts of physical and mental effects. So from our perspective, it… the benefit [of treatment] outweighs the risk."

In this reframe, Cristina's fear that medication will harm Emma is not dismissed but redirected. The harm, the clinic insists, flows from the other direction—it is not the medication but the untreated depression that threatens her daughter's development. Her own psychiatric symptoms become the risk to manage, not for her own sake, but for Emma's. The maternal body, once again, is the environment of consequence, with the patient responsible for its management.

Long-term consequences held particular anticipatory weight for patients in this clinic. Beyond the hospital stay in the immediate postpartum, would symptoms of medication use during pregnancy arise in the development of their child for years to come? Might their own psychiatric treatment choices have cognitive or developmental outcomes perceivable in their children? Would it increase the potential for psychiatric illness in their children that patients

might assume responsibility for?

While long-term consequences on fetal development can be understood as a rational concern for patients taking medications without robust long-term research verifying their safety, this logic also assumes the weight of individual maternal responsibility for the developmental outcomes of their children. How a child's brain develops, how their behavior is exhibited or categorized as normal or abnormal, could signal to the patient, or to their imagined or real social environments, their faults as a maternal figure or as the primary environment for their fetus's development. It forces patients to confront the boundaries of their belief in psychiatric treatment for their own diagnoses; what might feel acceptable as a medication regimen for the patient herself—despite her own long-term health concerns or side effects—could be interpreted as unacceptable when the real or imagined effects of the medication trickle down to her fetus or child. The temporality of this concern is also significant: patients are not only managing their present symptoms but narrating their child's psychiatric future, a future they fear they may have already shaped through decisions made under duress, with incomplete information, in a clinic that encouraged them to medicate.

How patients asked about long-term effects of medication, as well as how clinicians managed these inquiries, also reveals the eugenic logics that operate implicitly within the reproductive psychiatric clinic. Specifically, how psychiatric disease and mental health is managed by clinicians discourages any expression of psychiatric symptoms whatsoever, in order to protect the fetus or newborn from the harm of those symptoms. Patients were repeatedly told that a treated mother was best, and that a depressed mother had all sorts of "biological impacts" on the development of a child. For patients who adopted this logic, passing on any cognitive difference, psychiatric symptom, or signal of psychiatric medication use during pregnancy

disrupted the promise that medication or treatment could effectively 'sever the genetic tie' (Duster 1990) of their illness to their offspring. On the one hand, they were told that unmedicated psychiatric disorders could affect the neurodevelopment of their children. On the other, they were concerned with the developmental effects of the medication itself on their fetus' development. In either case, the maternal psychiatric symptoms were undoubtedly the problem to manage—not for the sake of the patient's own wellbeing, but for the direct impact on the brain development of her child. The patient's choice was thus constricted; medicated, she risked exposing her fetus to unknown chemical effects; unmedicated, she risked exposing her fetus to the biological consequences of her untreated illness.

An interaction between a new patient in the clinic and her resident psychiatrist illustrates this layered tension. This patient came in during her first pregnancy with a history of ADHD and anxiety, and questions about the effects of her ADHD medication on her pregnancy:

> "[Here's an] unfair question. I'm concerned about… my mom had a healthy pregnancy but then, I had all these issues, disabilities."

Already, the patient connects the behaviors of her mother during pregnancy with her own ADHD and anxiety diagnoses. She positions her own "issues, disabilities" as surprising in relation to her mother's "healthy pregnancy," revealing an inherited assumption that psychiatric difference is gestationally developed. She continues:

> "In terms of… is my kid going to be 15 and institutionalized with horrible depression and schizophrenia because I took stimulants with them?"

Connecting this framework to her own pregnancy, the patient elaborates on her logic of inherited psychiatric disability, asking whether her own treatment could affect the psychiatric diagnoses of her child.

> "There's no data to support that," her physician responds. "ADHD and bipolar are the most genetically heritable."

In response, her resident psychiatrist invokes the clinical script: the data do not exist to affirmatively address the patient's anxieties. However, she confirms the logic of genetic inheritability. The move is subtle but consequential: by affirming that ADHD is highly heritable, the clinician introduces a different trajectory for the child's potential diagnosis –one rooted in genetics rather than medication exposure. The medication is thus partially absolved, but the patient's psychiatric history is not. Her child may well develop ADHD, not because of what she took, but because of who she is.

This particular connection between ADHD heritability and patient fears of inheritance based on stimulant use was a common theme in the clinic. In another clinical interaction, a patient asked directly:

> "Will exposing my baby to a stimulant increase the likelihood of them having ADHD?"
>
> Her resident psychiatrist responded similarly:
>
> "It's hard to answer that because genetically your baby is already at higher risk because you have it."

Many patients reflected this logic of ADHD being particularly heritable, but made distinctions between ADHD and other psychiatric or neurodevelopmental conditions their children might express. Another first-time patient in the clinic with ADHD illustrates a spectrum of tolerance in relation to her own potentially heritable diagnosis and the additional long-term effects of her medication use on her offspring:

> "I anticipate my child having that ADHD. Autism spectrum disorder or anything [like that]… of course I'll still love them, but in theory, you don't think there's any reason to assume that there would be higher risk of mental health conditions based on taking stimulants during pregnancy?"
>
> "There's no data to show that," her physician responds.

This exchange is particularly symbolic of the confluence of moral and clinical factors influencing decision-making in the reproductive psychiatric clinic. The patient straddles demonstrating morally acceptable maternal behavior—a figure that would love a child with ADHD, autism, or any neurodevelopmental condition—and one that inquires about the safety of her psychiatric medication, hoping to avoid causal links between her treatment and her child's development. By explicitly performing this maternal morality to her psychiatrist as she asks about medication safety, she is communicating two things. The first is that her inquiry is not a condition of her mental illness, but of appropriate gendered behavior as a pregnant person protecting the future condition of her fetus. The second is that there is a limit to her acceptance of psychiatric treatment if it means a higher risk of mental health conditions in her fetus. Her pushback against her medication regimen, she communicates, is not that of a patient resisting treatment, but of an engaged, attentive mother.

The psychiatrist's response maintains the clinical narrative that a lack of data confirms the suitability of continuing medication—equating uncertainty with safety, at least until proven otherwise. The patient pushes back further, asking the clinician to expand upon this narrative and offer more subjective advice:

"What about opinion?"

The patient's request for opinion is a direct challenge to the outsourcing tactic—she asks the clinician to step out from behind the data and offer her subjective expertise. This is where the two tactics begin to converge, and where I turn to next. The patient continues, looking for confirmation about the differences between alcohol and marijuana during pregnancy and her prescribed medication,

> "In theory… there shouldn't be a reason why… it's not like drinking alcohol or smoking weed during pregnancy?"
>
> "Yes," the resident responds, "that's why we still prescribe it. Of course if something comes up later [in the data] we'd stop."

This patient's inquiry reflects the outcome of the social construction of fetal risk—particularly fetal alcohol syndrome—and its effects on lay expertise and patient engagement. As Armstrong (2003) and others have shown, the emergence of fetal alcohol syndrome in reproductive medicine has illustrated how medical knowledge is socially constructed and often situated beyond empirical evidence, intertwining morality and women's roles in reproducing the fitness of future generations with medical findings about ingestion, alcohol and reproduction. The patient's inquiry about her psychiatric medication in contrast to alcohol and marijuana is very much situated in this moral milieu—she is motivated to separate herself from the deep-seated associations between ingestion and unacceptable reproductive harm as she seeks treatment for her psychiatric diagnosis. To be like someone who drinks during pregnancy is to be a bad mother, the logic goes; to take a prescribed medication, even one whose long-term effects are unknown, is to be a patient following clinical guidance. The distinction matters enormously to her, and the clinician's confirmation, "yes, that's why we still prescribe it," provides the moral as much as the medical clearance she seeks.

Across these varied exchanges, the repositioning tactic works by turning the patient's own conception framework against her concerns. Patients arrive having internalized the clinic's biological logic—that the maternal body is an environment of consequence, that neurochemistry is malleable, and that what a mother carries shapes what her child becomes. The repositioning tactic extends this: if the maternal body is the environment of consequence, then the most dangerous thing in that environment shifts from the medication to the untreated psychiatric symptoms. The patient's concern is not dismissed, but redirected. In every case, the maternal

body remains the site of risk, what the tactic manages is only which risk requires the most urgent attention, and which the reproductive psychiatric clinic has the ability to address.

When the Tactics Combine

The preceding sections examined the two primary clinical tactics—outsourcing responsibility and repositioning danger as undertreatment—as analytically distinct responses to patient engagement. In practice however, they rarely appeared in isolation. The most revealing clinical exchanges were those in which clinicians moved fluidly between both tactics within a single appointment, deploying each as patient engagement shifts register. This flexibility is not incidental, but professional dynamic working as intended, calibrated in real time to whatever form patient resistance takes.

The patient who asked "what about opinion?" in the previous section when pressing her psychiatrist about their thoughts on the potential harm of her ADHD medication illustrated this combination most fully. Having exhausted the available data on stimulants and pregnancy, she asked her clinician to move beyond the clinical script and offer a subjective assessment. By asking for opinion, she directly challenged the outsourcing tactic. The clinician's response triangulated from methamphetamine and antidepressants, outsourcing the evidentiary burden to adjacent pharmacological categories:

> "I mean we know that for example taking meth could cause people to have psychosis, drug induced psychosis, but in terms of that exposure causing that long-term… there's just no data to show that. I will say that they did just start following children for a little bit longer, data usually only follows children for a certain amount of years. There's something that just came out looking at kids until 12 or 13 post exposure to antidepressants during pregnancy. From what it seems to show, it's unlikely to cause long-term harm."

Without data on the long-term effects of the patient's stimulant medication, the clinician triangulates from information that is available—methamphetamine, presumably for its chemical

similarities to prescribed stimulants, and antidepressants. The move is less a comparison than a demonstration of how the clinic reasons under uncertainty: by anchoring to cases where consequences are known, the clinician maps the edges of what the data can and cannot say. The absence of meth-like outcomes in studies of prescribed stimulants becomes, in this logic, a form of provisional reassurance—not proof of safety, but the closest the clinic can get to it. When the patient pressed further:

> "There's no reason to believe that stimulants during pregnancy would result in behavioral issues in my children later?"

The outsourcing tactic and the repositioning tactic converge,

> "If you talk to different psychiatrists they'll say different things," her psychiatrist responds. "Some would say come off all meds. Some would say something else."

By acknowledging clinical disagreement, the clinician outsourced uncertainty to the profession at large—this is not one doctor's opinion, but a contested field. Simultaneously, she repositioned the patient's inquiry, shifting the focus from whether to medicate to which clinical perspective to trust.

This dynamic is also visible in the exchange around biological risk, where the repositioning of danger as undertreatment and the outsourcing of responsibility to scientific authority operated together. When patients asked about the long-term effects of their medication on fetal brain development, clinicians consistently acknowledged the limits of available data—outsourcing the evidentiary burden to the state of the science itself—while repositioning that very uncertainty as a reason to continue medication rather than a reason to stop it. The absence of data confirming harm became, in clinical practice, evidence of safety. The logic is circular but effective: we cannot say the medication is safe, but we cannot say it is harmful either, and in the absence of demonstrated harm, the risks of undertreatment, which the clinic can speak to with considerably more confidence, justifies its continuation.

The following exchange captures this combination of tactics. A pregnant patient who had agreed to continue her stimulants asked her doctor about the safety of the medication in her breastmilk long-term:

> "Do we know if there are any chemical effects, imbalances or changes because my baby is exposed to medication… is any of that permanent? I'm really concerned about this with the baby, too."
>
> "Two answers," her psychiatrist responds, "for the concerns about appetite and sleep, that is not permanent. That will disappear as soon as meds are out of their system. The question about changes to the brain is the same answer. If there are permanent alterations in your baby's brain chemistry or pathways, we don't have the data to say for sure. But, if there are permanent changes… it's hard to say if it would be due to medication or genetic risk they carry for ADHD."

The response moves in three steps. First, it outsources the short-term concerns to pharmacokinetics or how the body interacts with a pharmacological substance. Thus, when the medication exits the system, by this logic, the effects disappear. Second, it acknowledges the limits of the data on long-term neurological effects, clinical uncertainty made clear. Third, it immediately repositions even the possibility of permanent change: if it exists, it may be genetic rather than pharmacological. The patient's psychiatric history absorbs the remaining risk, rather than the medication. She leaves the appointment having been told, in effect, that she cannot know whether her medication will permanently alter her baby's brain, but that if it does, it may be because of who she is rather than what she was prescribed.

This combination of tactics, outsourcing and repositioning often within a single exchange, reflects the underlying goal of the clinical logic: not to resolve uncertainty, which the clinic cannot do, but to manage it in a way that keeps the medication recommendation and professional authority intact. What is maintained beyond this clinical authority is a specific vision of what reproductive psychiatric care is for—the treatment of maternal psychiatric symptoms as a precondition for fetal and infant wellbeing. The tactics, whether used individually

or in combination, are in service to this vision.

The following section turns to the case of Sophie, whose experience reveals what happens when those tactics are pushed to their limit, and ultimately break down.

When the Tactics Break Down

Sophie

The cases examined in this chapter so far present the tactics as professionally managed—deployable, flexible and effective at containing patient engagement within the bounds of the clinical recommendations. Sophie's case reveals what happens when they are not; Sophie was a first-time mother who hoped to deliver at a birth center. Before getting pregnant, she had been counseled to remain on her SSRI, reassured by the clinic that her medication was safe for her, for breastfeeding, and for her baby long-term. She followed these recommendations. However, when she announced her intention to deliver at a birth center rather than a hospital, the clinical script flipped.

> "They told me oh, you'll be completely safe if you're on these 2 prescriptions. We have very low concerns about this. It'll be fine for your baby if you breastfeed, 'It's safe!' right? Then I got pregnant and then they… after I found out I was pregnant and decided I wanted to give birth at a birth center. [The clinic] really didn't like that. Because I was on the antidepressant. They kind of scared me. It was unfortunately a big miscommunication, or a big oversight on their part that they didn't let me know that sometimes babies who are born to people on SSRIs have neonatal adaptation syndrome. And [the clinic] was really not happy with me wanting to give birth at a birth center- 'your baby might need oxygen, your baby might shake!' Really scared me. I was like, 'you told me if I got down to a certain dose it would be okay' and… of course nothing's without it's risks. But I was really unhappy to find out that neonatal adaptation syndrome was one of their primary concerns that they didn't voice to me when I was first trying to get pregnant. So that was really scary. Made me feel like, shouldn't I get off more of this? They said no, it's always a risk factor. You versus the baby at risk. But I couldn't help but worry. But if I want to give birth at the place I want to, am I putting my child at risk?"

What Sophie's account exposes is the conditional nature of how uncertainty was managed in the clinic. In the cases that preceded hers, uncertainty consistently served continuity, "we don't have the data" was a reason to stay on medication, not to stop. The risks of medication were minimized; the risks of undertreatment were highlighted. That asymmetry held as long as Sophie remained under close biomedical purview. The moment she chose a birth setting outside of hospital surveillance, the same uncertainty that had been used to justify her medication was redirected against it. The medications the clinic had deemed safe enough to continue throughout pregnancy were now risky enough to require in-hospital monitoring at delivery. The data had not changed, only Sophie's position within the system that managed it.

This is what the tactics, when examined together, ultimately reveal. Uncertainty in this clinic was not a fixed epistemic condition but a resource, utilized to encourage medication when patients hesitated, and redeployed to constrain autonomy when patients moved outside the clinic's preferred protocols. Sophie's experience shows the degree of risk clinicians were willing to engage in; with Sophie under biomedical purview, she'd be able to continue her medication and have her baby closely monitored postpartum. The toxic imaginaries the clinic had spent appointments minimizing were confirmed the moment she tried to exercise a choice it could not contain.

Conclusion

The clinical interactions examined in this chapter reveal a consistent pattern: patients arrive at the reproductive psychiatric clinic with concerns about their medications, and clinicians use a combination of tactics to manage those concerns while maintaining their treatment recommendations. The tactics, outsourcing responsibility and repositioning danger as undertreatment, are learned and rehearsed in didactic training, refined in case conferences, and

transmitted from attending psychiatrists to residents through the backstage briefings that precede each appointment. They are institutionalized responses, characteristic moves of a clinic with a clear orientation toward medication as the primary tool of reproductive psychiatric care.

What makes this clinical exchange analytically revealing is not simply that it maintains clinical authority, but what it reveals about the stakes of that authority in this particular setting. Patients in the reproductive psychiatric clinic are not simply psychiatric patients; they are pregnant people and new mothers, navigating a medicolegal context that has consistently positioned their bodies, behaviors, and now their neurochemistry as environments of consequence for their children. Their engagement with their clinicians is shaped by this context: they arrive having already absorbed, to varying degrees, the clinic's own frameworks, including the neurochemical self, the biological logic of maternal-fetal transmission, and the imperative of treatment as an act of maternal care or 'good' mothering. Their concerns about medication are not rejections of psychiatric knowledge, but extensions of it, patients use the clinic's own language to question its recommendations.

The clinical tactics in this chapter are responses to precisely this form of engagement. When patients invoke the neurochemical framework to ask how their medication might alter their fetus's developing brain, clinicians outsource the evidentiary burden to the limits of the science itself, "we don't have the data" while simultaneously repositioning that uncertainty as a reason to continue rather than a reason to pause. When patients invoke the biological logic in concern about the long-term psychiatric consequences of medication exposure, clinicians redirect: it is not the medication but the untreated depression, the untreated anxiety, the untreated ADHD, that constitutes the biological risk to the child. In each case, the patient's own framework is co-opted in service of the recommendation. The clinic does not argue against the

neurochemical self or the biological/heritable stakes of pregnancy, it agrees with them, and then uses them to arrive at the same destination it was headed toward: the prescription.

This flexibility, the ability to move between outsourcing and repositioning within a single exchange, to respond to whatever form patient engagement takes with a tactics utilized to maintain the recommendation, is a critical finding of this chapter. It reveals that what is being maintained is not simply a clinical judgment about a patient's medication, but a broader institutional logic about what reproductive psychiatric care is for. That logic, as the preceding chapters have shown, centers the maternal-infant dyad: maternal psychiatric symptoms are treated not as a problem in their own right but as a precondition for fetal/infant wellbeing. What this chapter traced was how this plays out in clinical interactions.

The eugenic logics that underwrite this dynamic deserves explicit attention. How psychiatric disease is managed in this clinic discourages any expression of psychiatric symptoms whatsoever, not for the sake of the patient's own wellbeing, but to protect the fetus/infant from the biological consequences of those symptoms. Patients were told that a treated mother was best, that a depressed mother had biological impacts on fetal development, that they were the templates for their children. The implicit promise of treatment was not simply relief from suffering but an interruption of transmission—the possibility that adequate treatment could 'sever the psychiatric tie' between mother and infant, and produce a child unburdened by its mother's condition. This promise is eugenic in its structure, even if it is not eugenic in its intention (Duster 1990). It does not put forth that women should not reproduce, but that they should reproduce under optimized conditions, with psychiatric symptoms managed so that the child they produce is not at risk of inheritance. Historically, eugenics pursued the elimination of psychiatric difference through explicit reproductive restrictions—institutionalized "deviant"

bodies were subject to compulsory sterilization on the grounds that preventing transmission was preferable to managing its consequences, a logic that the Supreme Court ratified in Buck v. Bell (Avila & James 2024; Roberts 1997). The reproductive psychiatric clinic represents an implicit eugenic logic through treatment, which if the patient follows, is framed as a mechanism of maternal protection, what Rapp (1999) might call reproductive optimization, achieved not through exclusion, but clinical management of maternal conditions. Medicated, the patient risks exposing her fetus to unknown chemical effects; unmedicated, she risks exposing her fetus to the biological consequences of her untreated illness. Her body was framed as the source of risk in either direction, and the clinic's recommendation of medication was the only available response to a problem that was, in either case, located in her—a structure that crip scholars have described as the normalization imperative operating through the idiom of care rather than coercion (Tremain 2006). Sophie's case makes this structure visible in its starkest form. The clinic that had spent appointments reassuring her that medication was safe revealed, the moment she chose to birth outside its surveillance, that the uncertainty it had been managing was conditional.

Patients, for their part, did not leave these encounters without consequence. Many were haunted by the temporality of their decisions, not the temporality of the clinical appointment, managed and closed within forty-five minutes, but of their child's psychiatric future, which stretched decades into a future they had already begun to imagine. Would their children, at fifteen or twenty or thirty, exhibit symptoms that could be traced back to a medication decision made under duress, with incomplete information, in a clinic that encouraged them to medicate? The clinical script, "there's no data to support that," closed the question in the appointment. It did not however, close it for the patients' imagined reproductive future. These temporal asymmetries between clinician and patient are themselves a form of inequality; clinicians

manage the present appointment; patients inhabit the long aftermath and consequences of their decisions. The tactics examined in this chapter are calibrated to the former, to closing down uncertainty in the appointment, maintaining the recommendation, and moving to the next patient. They are not calibrated to the latter, the years of second-guessing, potential scrutiny of a child's behavior for signs of 'damage', the impossible accounting of what was caused by illness and what by treatment.

CONCLUSION

This dissertation has sought to understand how clinical uncertainty, particularly its management in the nascent specialty of reproductive psychiatry, shapes the care and management of psychiatric patients through pre-conception, pregnancy and postpartum. I examined this through a longitudinal ethnography of an academic teaching hospital in Los Angeles and situated this clinical practice within a broader set of forces: the socialization of resident psychiatrists into a field that lacks definitive evidence, the decades of public health messaging and cultural discourse that have made the pregnant body a site of intensive scrutiny, and parenting ideologies that sort maternal behaviors into good and bad long before a patient enters the consultation room. The ethnographic study of American reproduction, mental health, and medical socialization all constitute substantial bodies of scholarship. Their intersections however, particularly ethnographic research on the particular institutional form of the reproductive psychiatric clinic, have remained largely unexamined**.** This is where my dissertation makes a contribution.

As an academic teaching hospital, my field site provided an opportunity to go backstage to examine this gap. In this conclusion, I situate my dissertation's contributions around three main topics. The chapters of this research build an argument that is most visible collectively, therefore the three interlocking findings emerge across each of them. The first is that the clinic does not only manage clinical uncertainty, but displaces it. Residents, as I show, are trained to navigate incommensurability with professional confidence, strategically sequencing information, and utilizing the lack of data as a clinical move. The data inadequacy is not resolved, but rerouted from the prescription back onto the patient. I situate this finding within a broader

critique about what a psychiatry organized around structural rather than pharmacological response might look like, particularly one attentive to the sociogenic conditions the clinic names but fails to act on.

The second finding is that patients arrive in doctor-patient interactions as already formed maternal subjects, saturated by purification discourse and epigenetic messaging, for many of whom stopping medication was felt as the intuitive default of good parenting, even if in contrast with good patienthood. Much of the clinic's work, as I found, was not to inform patients of risk, but to reorient patients' perception of risk that had already been internalized, ironically leaving the maternal body as an environment of consequence entirely intact. Rather than dissolving what I call patients' *toxicity imaginations*, clinical encounters added to them, leaving patients to carry both their original concerns and the clinic's redirection. This finding contributes to a broader set of questions in STS and feminist health studies around chemical entanglement and co-embodied life, about what it means to inhabit, rather than merely pass through, a world of chemical exposures, and thinking through more porous conceptions of patient/subject in relation to exposure.

Third, is that clinical authority is maintained through the tactical management of patient engagement. I find that outsourcing responsibility and repositioning danger as undertreatment are strategic responses to patient engagement in the reproductive psychiatric clinic, which, I argue, is legible within a longer history of reproductive governance, but names something new within it. The *biological logics* that organize clinical care around the maternal mind as an environment of consequence enable what I call *eugenic logics*: not the prohibition of reproduction among psychiatrically diagnosed women, but its optimization, meaning prioritizing the birth of child

unburdened by the mother's condition. Finally, I interpret the patients in this study as bellwethers of more widely distributed cultural anxieties about toxic exposure and reproduction.

Theoretical Contribution 1: The Sociogenic Gap

One of the most striking findings of this dissertation is the clinic's own awareness of the psychosocial dimensions of mental health. In the chapter on resident physician socialization, I uncovered the varied ways that physicians are taught to understand how cultural, structural, environmental and interpersonal conditions shape patients psychiatric experiences. This included explicit lectures on how housing insecurity, racism, and the absence of paid parental leave, and relational stress measurably affect maternal mental health outcomes. This awareness itself is significant, and signals that the clinic operates with a cognizance of the conditions that shape its patients' lives. Yet, as I found, the clinic funneled these structural facts through a biomedical frame—pathologizing simultaneously individual and social conditions into psychiatric diagnoses. Patients, as the data show, left with prescriptions.

This is not a new dynamic. Foundationally, Fanon's (1952, 1961)'s account of colonial psychiatry traced how political and structural violence could be reframed by clinical authority as individual pathology to be treated, rather than as broader structures to be changed. This redirection of structural harm into the register of the symptom is one interpretation of the clinic's logic, at a contemporary and domestic scale—the metabolization of broader social conditions through the lens and treatment of psychiatric pathology.

Rose's (2003) account of the neurochemical self clarifies this mechanism, at a different scale. The molecularization of psychiatric life, he argued, has produced subject-positions defined by chemical vulnerability and managed at the individual level, such that structural conditions like

racism or poverty must "pass through" the brain and its neurochemistry before becoming legible as psychiatric problems. Allostatic load and its effects are named in lecture, while SSRIs are the response in clinical appointments. The pharmacological response to patients' broader concerns is not a deviation from this framework, but its logical output.

To be clear, this is not an anti-psychiatry argument, nor a claim that pharmaceutical treatment is without genuine clinical value to patients navigating real psychiatric distress. However, as this dissertation found, pharmaceutical use in the reproductive psychiatric clinic cannot be reduced to pathology management exclusively. Dertadian (2023) has shown how pharmaceutical use is at times organized around the production of neoliberal citizenship as much as the treatment of illness. The reproductive psychiatric clinic can be understood as operating between these two positions—treating diagnosable psychiatric symptoms, while simultaneously using treatment to restore patients to expected social functions as mothers, partners and workers. Read through Dertadian (2023, the pharmacological frame is not simply a clinical tool but a technology of neoliberal self-governance; this dissertation's contribution is to show how in this specific clinical context, that technology is utilized in the service of gendered and maternal normativity in particular, restoring patients to the social functioning of good mothering rather than orienting treatment around patient wellbeing alone. The clinic does not *produce* the surveillance regime in which the patient/subject finds herself, surveilled intensively by her OB, psychiatrist, family and her own internalized good mother/patient imperatives, but it participates in it, and its pharmacological orientation drives it forward.

What would it mean to take the clinic's own diagnosis seriously? I draw here on Hansen and colleagues (2023) who argued from within the discipline that psychiatry has organized itself around biomedical individualist models, precisely in contexts where the social production of

distress demands collective or structural response. A reproductive psychiatric clinic organized differently might ask what kind of policy infrastructure—paid leave, housing support, structural reduction of conditions that produce allostatic load—would address the same outcomes without requiring the laboring, intensive-mothering patient to become and remain pharmacologically optimized at the price of her own and potentially her infant's safety. This dissertation's contribution in that goal is to make visible the gap between what the clinic knows about the social production of psychiatric distress in its institutional form, and what it does about that knowledge, a gap that I argue is not incidental but a reflection of what reproductive psychiatry is in its current form.

Theoretical Contribution 2: Toxicity Imaginations & Their Afterlives

The most portable theoretical contribution of this dissertation comes from the patient perspectives, specifically, what I name *toxicity imaginations*. Through the conversations and observations of the patients in the clinic, this concept names what the patients carry—durable, culturally assembled frameworks for understanding exposure and risk. I found that patients arrived at clinical encounters already having been exposed to frameworks that would influence their maternal subjectivity, through purification discourse and messaging from their doctors, social networks, to previous psychiatrists. While for many this resulted in the instinct to stop medications, or apprehension to begin—which felt like the intuitive default of 'good mothering' even when clashing with 'good patienthood' ideologies—I also found that toxicity imaginations carried throughout and beyond clinical encounters, despite the work of the clinic to reorient patients internalized perceptions of risk away from medication and toward untreated psychiatric disorders. While Chapter 2 highlighted where the toxicity imaginations arrive from and the forms

they take, Chapter 3 illustrated the clinic's attempt to manage them. The central finding here is that toxicity imaginations rarely became tolerable through clinical counseling—instead, they multiplied. The risk-risk framing meant to honestly represent clinical uncertainty instead compounded patients' toxicity imaginations that they were designed to ease.

By the time patients had navigated competing provider recommendations, internet research and their own convictions about maternal responsibility, many had arrived at an impasse: medication felt toxic, but so did the prospect of going without it, particularly as the clinic framed untreated psychiatric symptoms as biologically harmful. Patients who came to the clinic with initial concerns about medication's effects on fetal development encountered clinical guidance that redirected the risk toward the toxicity of stress, depression, anxiety and mental instability during gestation. Patients absorbed the clinic's reframing as an addition to rather than replacement for their existing fears—accruing guilt on both sides of the decision to medicate or not.

Jess' case captures this dynamic directly. Her 'mom brain' led her to stop all medication during pregnancy, a decision that her prior psychiatrist confirmed. When she arrived at the reproductive psychiatric clinic however, her toxic imaginaries were instead weighed against the potential toxicity of her untreated symptoms, and she was encouraged to resume her ADHD medications, and add an antidepressant. Jess pushed against taking any medication, let alone both. The tension between her instinct and the clinic's reframing of risk illustrates the central dynamic of this finding: patients did not simply accept the clinical redirection of toxicity, but absorbed it alongside their own toxicity imaginations.

Alice's account makes the same dynamic visible from the other direction. Despite her existing fears about medications' effects, she developed fears about the consequences of her own

untreated stress, cortisol's effects in particular, as her doctor described them to her, leading her to restart her medication,

> "The levels of stress affecting my child, how will that impact her development and growth? My understanding is that the way that the body reacts to levels of stress with cortisol and all of those hormones, how they can negatively impact a developing fetus… scared me a little bit. That sort of, my mental state and how it affects the body, on a physiological level, could then affect my child was scary. It was scarier to me—how that could affect her growth and development and my connection to her—than the possible side effects of taking the drug. So I was weighing those two things, what are the consequences of taking this drug versus what are the consequences of staying unmedicated?"

Other patients arrived in sustained uncertainty—holding both fears simultaneously rather than resolving toward either. Two mothers reflected on this shifting location of toxicity:

> "I am scared. But I think I'm… I was more scared that… I didn't want to flush him with cortisol while he was in there. Because I knew that could be just as dangerous, right? For him long-term?"

> "Ultimately I decided that the levels of stress and depression were not something I wanted to expose my baby to. […] I didn't take it lightly."

The clinic's risk-risk framing, its attempt to honestly represent that no option was risk free—was intended to alleviate patients toxic imaginaries about continuing medication. In practice, it often had the opposite effect, in part because patients sensed that the underlying data remained too thin to support confident reassurance. Two mothers reflected on this in interviews:

> "I think it depends on the doctor like… I feel like some of them say, 'there's plenty of women that have been on this medication and their babies are normal.' Like, you'll hear that, and then there some attendings that are more realistic and are like, you know, there isn't a lot of data to back this up."

> "When they talked about the research, which they tried to chop down into bite-sized pieces that I could understand, they were talking about such small sample sizes. And they were like, you have to recognize that there's always going to be a certain amount of risk in any pregnancy, whether that be with medication or without medication. There's always going to be a certain number of heart defects, there's always going to be a certain number

> of miscarriages or spina bifida or like, neural tube defects. That was the biggest thing is the neural tube defects was what I was the most scared of I think, that was just the scariest thing to me. Yeah, it was definitely terrifying, 'risk-risk'. I just couldn't believe that there hadn't… I understand why there wasn't any research but, I wish I had been a part of a research study because I *was* willing to take the medications, I was *on* the medications. You're dealing with something that could have a severe impact on somebody's life, on the mother's and on the baby's life. So, it was terrifying. It was, it was terrifying."

This risk-risk framing landed with patients as confirmation that there was no safe path; their toxic imaginations thus found new vectors of maternal guilt. This is my dissertation's central theoretical claim about toxicity imaginations—that they are not a deficit to be corrected by better information, but a durable interpretive framework that clinical encounters can redirect, multiply or compound, but rarely dissolved in my observations.

This connects to Packer's (2021) framework, drawn from transdisciplinary scholarship in critical feminist studies of toxicity. Packer argues,

> "Toxicants cannot be put back in their bottles, but cultural-scientific spaces can center the embodied experiences of frontline communities and relational onto-epistemologies of other/ed cosmogonies, " (Packer 2021; 36).

The afterlife of exposure—material, and imagined—persists across bodies and generations. Toxicity imaginations in this clinic work in a similar way—they emerge from a biomedical context that has and will likely continue to center pharmaceutical treatment as a response to the combination of social and structural forces that affect mental health, and once absorbed, do not stay contained to the appointment in which they were formed. What my dissertation found is a temporal asymmetry regarding the effects of this exposure; clinical encounters end after the appointment, while the patient's relationship to exposure stretches across years and potentially generations. The patients inhabit the aftermath alone. Incorporating Packer's (2021) contribution, what would it mean for psychiatric care to take that aftermath seriously, centering the embodied, longitudinal experience of this population, rather than the bounded clinical encounter alone?

Theoretical Contribution 3: Biological and Eugenic Logics

The third theoretical contribution of this dissertation refers to the logics that emerge in the clinical 'clash' or tension from Chapter 3, but are shaped by findings in the previous chapters as well. I theorized *biological logics* as the clinic's operating framework that untreated psychiatric symptoms treated as fetal exposure are as consequential as any medication, reiterating the maternal mind as an environment of consequence. I also theorized *eugenic logics*—what biological logics enable structurally. Not eugenics as prohibition, but an improvement logic, biomedical care organized around producing a psychiatrically unaffected child, premised on the assumption that treating the mother interrupts intergenerational transmission of psychiatric difference. Again, the clinic does not tell patients not to reproduce, but encourages them to do so under optimized conditions, so that the resulting child is 'unburdened' by the mother's condition.

The reproductive psychiatric clinic's organization of care around producing a psychiatrically unaffected child is eugenic in structure, even if not in stated intention (Duster 1990). This follows from previous research distinctions between eugenic by intention and eugenic by consequence. Historically, and as some have found, consistently particularly in carceral settings (Johnson 2013; James 2024), explicitly eugenics projects in the United States operate through forced prevention—notably compulsory sterilization of institutionalized "deviant" bodies, argued by legal scholars as disproportionately applied to poor women and women of color (Roberts 1997; others). The reproductive psychiatric clinic operates through a logic of optimization (Rapp 1999). While coercive eugenics has historically worked through exclusion, the clinic works through a normalization imperative (Tremain 2006), operating

through an idiom of care rather than coercion. The distinction between these should not be understated. However, the structural continuity is also critical to highlight. The reproductive psychiatric clinic represents a new institutional form of a very old logic: that the bodies of some women, in this case those with psychiatric diagnoses, require management in the reproductive context, and the goal of that management is the optimization of a child born without a mother's condition.

What the biological and eugenic logics together foreclose is precisely what Simms (2009) calls a placental ethic—a framework that recognizes the pregnant subject not as an individual conduit for fetal outcomes, but as a co-embodied subject whose entanglement with the developing life inside her exceeds the clinic's capacity to manage, optimize or account for it.

Broader Contributions

The theoretical contributions of this dissertation also point toward questions that extend beyond its own empirical scope. The patients I observed in my research occupy a unique clinical space but are not an exceptional population—they are an intensified version of a more widely distributed cultural anxiety about ingestion, risk and futurity. Reproductive psychiatric patients harbored fears about what enters the pregnant body, organized around discourses of biological responsibility, amplified through cultural messaging and landing with particular force with this population already navigating psychiatric stigma, and in a biomedical context of minimal research and institutional uncertainty. They are a persuasive example of a more expansive undercurrent that is already shaping cultural anxieties around exposure, and biomedicine.

Reproduction and pregnancy in particular have long occupied a generative theoretical place in medical sociological literature, representing a confluence of potent social forces, and

whose management, under rigorous theoretical analysis, offers insights to populations that extend beyond those immediately under study. Similarly, I understand patients in the reproductive psychiatric clinic in this way—as bellwethers inhabiting a space where cultural contradictions are most concentrated because the stakes are the highest and the temporal constraints of their treatment require immediate action, but that point to something greater. The findings of this study speak to contemporary pregnancy culture more broadly, to the future of psychiatry, and to how American culture is currently organizing its relationship to risk, responsibility, toxicity and harm. The current political moment makes this legible in new ways. The same anxieties about chemical exposure and developmental harm that shaped my clinical observations are diffusing through mainstream culture in the form of food dye bans, scrutiny of ingested foods and products, governmental pushback against psychiatric treatment, and a resurgent public discourse about toxic environments and their intergenerational effects, even as the material conditions producing those exposures intensify through climate denialism and the ongoing expansion of industrial chemical production. The patients in this clinic were navigating in their most concentrated and consequential clinical forms, anxieties that are becoming increasingly generalized.

What this dissertation contributes is an account of how those anxieties are formed and institutionally organized, how they're transmitted through clinical socialization and training, how they multiply rather than resolve, and what they cost the people who carry the burdens of them. But the frameworks this research draws on also suggest what a different organization might look like. STS scholars have developed alternative frameworks of relating to toxicity, and responsibility that offer a generative way forward. Simms' (2009) placental ethic—developed by Ford (2020) in relation to chemical toxicity and reproduction—offers one such opening. Where

the reproductive psychiatric clinic's biological and eugenic logics presume a bounded maternal individual responsible for managing what crosses into the fetal environment, the placental ethic refuses that presumption, and recognizes the pregnant subject not as a discrete agent whose body constitutes a controllable border, but as a co-embodied actor nested within a larger ecological, social and chemical system that no individual decision can fully govern. Read alongside MacKendrick's (2014) account of how precautionary consumption reproduces the fantasy of the bounded maternal individual who can control chemical exposures through informed choice, and Scott, Haw and Lee's (2017) argument for a corporeal citizenship that positions the subject as interconnected to wider communities, ecologies and economies rather than separable from them, Simms' (2009) placental ethics suggest a different set of questions for future research at the intersection of reproduction, psychiatry and exposure—questions that this dissertation's findings make newly urgent.

These alternative frameworks speak directly to each of this dissertation's theoretical contributions. Against the sociogenic gap—the clinic's capacity to name structural conditions and failure to act on them—a placental or corporeal citizenship framework would refuse the translation of structural harm into individual neurochemistry, and insist instead on the shared and distributed nature of the conditions that produce psychiatric distress and its effects. Against the afterlife and continuity of toxicity imaginations, the way risk-risk framing leaves patients with compounded maternal guilt, a placental ethic would offer a conception of exposure as relational and collective rather than individually managed. Finally, against the biological and eugenic logics that organize care around the optimization of the child, it could offer a framework in which the co-embodied entanglement of the pregnant subject and fetus is recognized as exceeding any clinical calculus of individual risk and individual outcome. Reproductive

psychiatric care organized around these frameworks might include policy infrastructure and a clinical culture that incorporates collective responsibility. What that looks like in practice remains to be built. What this dissertation has done is make the current framework's costs visible, which for the clinicians, patients and researchers who come after, is where the work of building begins.

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