

"Okay, well, everyone else has babies. Why shouldn't I?"

How women with mental illness make reproductive decisions

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy
under the Executive Committee
of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2023

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Abstract

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Estimates suggest that about eight million American teens and young adults experience clinical symptoms of mental illness. For many, these mental health challenges will develop into a diagnosable and potentially life-long psychiatric disorder. Together they form a large population of adults who enter their prime reproductive age as psychiatric patients.

Though individuals with mental illness enjoy the same reproductive rights as those without psychiatric conditions, social and medical discourses often portray their parenthood as risky and undesirable. Women with mental illness are in a particularly difficult position. As women, they are subjected to the gendered expectation that they become mothers. Yet at the same time, their mental illness results in their motherhood being frowned upon. Carrying these contradicting values, this study asks how women with psychiatric disorders make reproductive decisions. Do these women think of their reproductive capacity through the psychiatric framing of risk, or through gendered narratives of desired motherhood?

Using open ended interviews with women with a psychiatric diagnosis, this study shows that women with mental illness approach their reproductive decision-making by utilizing narratives of both normal reproduction and disability. Some women portray their mental illness as an obstacle to motherhood while others create a separation between their mental and reproductive health. Still others defy the distinction between psychiatry and normalcy and

describe their reproduction as a way to bring the two together. Despite the difference in framing, all the women in this study engage with the discourse of risk(s) that is brought on by their mental illness. To weigh risk and act upon it, they visit their and their peer's biographical stories of illness, assess their fitness into normative ideas of good motherhood, and evaluate the worth of medical and scientific information. They question the way medical information is created, distributed, and made applicable to the idiosyncrasy of their reproductive life. In doing so, these women draw boundaries around trust as well as redefine medical neutrality.

Finally, we show that women with mental illness and their health providers rely on a vaguely defined stepwise plan to approach reproduction. This plan brings normativity – and desirability - to their reproduction at the same time that it threatens to exclude them from motherhood.

By bringing these arguments together we arrive at the overall conclusion that women with mental illness do not approach their reproduction as a monolithic group. Nor do they organize along diagnosis lines. This study shows that women across psychiatric diagnoses share similar reproductive desires, some hoping to have children and others wishing to avoid motherhood altogether. The popular idea that certain psychiatric diagnoses render women unsuitable for motherhood is not echoed by the women in this study. Instead, their embodied experience of mental illness allows them to embrace the newfound reproductive choice of psychiatric patients and highlights the stigma that perpetuates fears of motherhood with mental illness.

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Acknowledgments

A special shout out to my advisor Prof. Gil Eyal, and my doctoral committee, Prof. Sahmus Khan, Prof. Adam Reich, Prof. Maya Sabatello and Prof. Amy Zhou. Thank for reading my work, engaging with it, giving me much to think of and improve on, and, finally, trusting its worth. You believed in me even when I did not. To Prof. Helle Thorning from the NYS Psychiatric Institute and the ACT institute, many thanks for meeting with me and giving me a boost of encouragement. I look forward to more opportunities of collaboration. To Dr. Steve Behnke, thank you for the time you spent teaching and directing me. I wish you luck in your fight. To Prof. Rachel Adams who invited me to the world of disability studies and filled me with new ideas and perspectives.

To my former student, Rhea LaFleur who helped me in this project. I'm so glad to have had you by my side and look forward to many years of friendship.

To my nurse psychiatrist Crystal Kim and therapist Dr. Andrew Newsom who pulled me from the quicksand of depression and PTSD and kept me going.

To my friend, teacher and role-model, Dr. Teresa Sharpe. I appreciate you so much. And to Dr. Sarah Sachs and Dr. Adrianna Bagnall-Munson – you are the best! Your comments, edits and ideas are always on point, and hanging out with you is a pleasure!

To my mom, I wish you were here in corporal form. I miss you dearly. Wherever you are, I know this fills you with love and pride. To my family and friends in Israel and NY, thank you making fun of my never-ending PhD. I love you all.

And finally, to my chosen one, Menny Even-Danan. Thank you for sticking with me through this rollercoaster of a Ph.D. and for always being at my side. You're an amazing partner and wonderful father. I could not have done this without you, nor would I have wanted to.

Dedication

To all the women and men who shared their intimate stories with me, no words can rightfully express how grateful I am. For the time, honesty, friendship & trust that you showed me. This dissertation is for you and about you. I hope it does you right and brings light and empathy your way.

Chapter 1: Introduction

1.1 The case of Mary Moe

Mary Moe was 32 years old when she was admitted to a psychiatric hospital in 2012. As is routine for incoming female patients, the hospital administered a pregnancy test to M, who had schizophrenia and bipolar disorder. Unexpectedly, the test results came back positive. Mary was pregnant. Grippled by psychosis, Mary denied the pregnancy. Moreover, she said that had it been true that she was pregnant, she would keep the pregnancy because abortion is against her religious beliefs.

Mary had been pregnant before. The first pregnancy happened before her mental illness diagnosis and was terminated by Mary. The second pregnancy came to term. The son born of that pregnancy was later removed from Mary's care and placed under the guardianship of her parents.

With help from the Department of Mental Health and support from her care providers, Mary's parents petitioned the courts for temporary guardianship over Mary for the specific purpose of terminating her pregnancy. The judge who presided over the case accepted the parents' request. He ruled that Mary be "coaxed, bribed, or even enticed ... by ruse" into a hospital where she would be sedated, and an abortion be performed." Proactively going further than asked in the petition, the judge ordered the clinicians to use the opportunity to sterilize Mary "to avoid this painful situation from recurring in the future" (Schworn 2012).

The publication of the verdict caught the attention of disability advocacy groups who appealed the ruling. The appellate court repealed the sterilization directive but refrained from removing the abortion order. About the pregnancy itself, that judge did two things. First, he recommended a reevaluation of Mary's "true" wishes regarding her pregnancy and abortions.

These “wishes” will be taken into consideration when a decision about her pregnancy is made. Yet the judge gave little direction on how to conduct such an evaluation and how to use its results in deciding on the pregnancy. The judge’s second action regarding Mary and her pregnancy was to keep the guardianship order in place. Under this order, Mary’s parents gained the legal right to make decisions on her behalf over Mary’s “medical care, health, and welfare, including, as appropriate, the duration, condition, and viability of her pregnancy.” (Guardianship Of Mary Moe. [Fn1] No. 12-P-18. January 10, 2012. - January 17, 2012)

The appellate court’s order to include Mary’s wishes in the decision over her pregnancy signals a recognition of her agentic self. Despite her mental illness, she is seen as a meaningful party to decisions over her body and pregnancy. Yet while Mary is granted agency, she is also removed from it.

The agency that the court extends to Mary is limited to the condition of her health. When the court instructed social workers to re-examine her “true” wishes, they explained them as the choices and decisions Mary would have made had she not been ill. By situating Mary’s “true” or authentic wishes within a “healthy” self, the court pushes a view that sees illness as a barrier to agency. In this view, as long as Mary is ill, her statements or actions are an untrustworthy representation of her true desires. They are interferences made by her mental illness that conceal and distort what her true self wants. In other words, the claims Mary makes when she is ill do not reflect an agentic self but an unhealthy mind. Agency becomes bounded by illness, and Mary, in her current state, remains outside of it.

Mary is so far removed from self-agency that a hypothetical “what if” takes precedence over her statements. Because Mary was unaware of her pregnancy before becoming psychotic, there is no way to know what she would have done with it had she been well. Yet that is what the

court demands. Social workers are therefore tasked with creating a parallel reality - they need to imagine Mary as pregnant but not ill and imagine what she would do. Though Mary is right there and pregnant, and though she says what she wants, her illness gives this imagined scenario legal power. For example, Mary's thoughts about abortions - developed when she was "healthy" - are taken as more truthful of herself than the real-time decisions she made when she was pregnant because of her illness. In conclusion, in her illness, Mary's agency is accessible only through the translation work of care professionals, who, in turn, use hypotheticals to create and communicate her authentic self.

The fate of Mary's pregnancy is unknown to me. There are no publications about her case beyond the appellate court's decisions. Yet, her story raises lingering questions about truth, choice, risk in pregnancy, and mental illness.

1.2 The research questions

Far from the public moral panic around the reproduction of women with mental illness of the past, the current state of affairs is that of silence. Nowadays, medical, and mental health professionals do not engage in discussions about the morality of clients' reproduction. The eugenic practices of preventing pregnancies have been replaced with legal recognition of the reproductive rights of women with mental illness and their protection from discrimination. To summarize, the current formal response to the reproduction of women with mental illness is a shrug, their reproduction being legally on par with that of the rest of the population.

Nonetheless, stories of coerced abortions such as that of Mary Moe and sterilization program such as the one practiced in Californian prisons between 1997 and 2014 put a pin in this flowery image of neutrality. They suggest that there is more to the reproduction of women with

mental illness than formally revealed. They are evidence of an undercurrent of thoughts and practices that separates psychiatric reproduction from “normative” reproduction.

Depending on where one looks, pregnancy with mental illness could be seen as an occurrence of normative or disabled reproduction. In contemplating reproduction, women with mental illness must navigate between the two frameworks: the normative idea of desired reproduction and the disabling discourse of risky motherhood.

1.3 Findings

We will show that women with mental illness approach their reproductive decisions through negotiation. To decide about motherhood, women engage in self-reflection in which they draw on “normative” and “disabled” ideas. In broad terms, women who identify their selves as defined by their illness tend to avoid motherhood, whereas women who carve a self that is independent of their illness are on both sides of the fence regarding motherhood. Some choose to pursue it, while others don't. Still, the explanations they give for their decisions tend to follow normative reasons for reproductive decisions, focusing on affection for children (or lack thereof) rather than on risk.

None of the women in the study argue that women with mental illness should, as a rule, avoid motherhood. Moreover, all the women say that reproductive decisions should remain individual and the woman's choice. None welcomed intervention in reproductive decisions and health.

Though risk was not the central theme with which women describe their reproductive decision, it certainly had an important place in their thinking. Women engage with the framework of risk that mental illness carries, and they do so in several ways. Some women accept the risk as defined by health providers, while others find ways to personalize it, drawing

on their understanding of their illness. Other women turn to statistics and the process of creating scientific knowledge to challenge prevailing clinical standards. The experiences of peers and family members help women fill in the medical and scientific knowledge gaps about their particular reproductive risk and smooth out contradictions between different actors.

Finally, to prove and solidify their reproductive decisions, women in the study engage with ideas about moral parenting. Not only do women use tropes of normative reproduction to explain their reproductive decisions they also follow mainstream ideas of motherhood. They pursue motherhood as a middle-class endeavor in a dual-parent household with a concerted cultivation style of parenting. They do so through what I refer to as a “stepwise plan.” This plan allows the women to bridge the gap between their illness and the requirements of moral parenting. The steps they take to become mothers are not only required for moral parenthood but also signal responsibility and commitment to care. Yet beyond the normative aura of the stepwise plan lies their mental illness. For example, having a partner is not only necessary for the well-being of the child but also as support to the woman if her mental illness disturbs her ability to perform desired motherhood. In successful motherhood, women can link normative conditions to the needs of their mental illness. In other cases, the normative framing of the plan failed to account for the reality of the illness. In these cases, the desire to normalize reproduction left the women outside their desired motherhood, as their stepwise plan was crushed in the face of their reality.

1.4 Structure of the chapters

The next chapter will describe the study and discuss some questions that any research on mental illness must confront. Chapters 3 & 4 focus on the historical processes that brought us to this current time in which women with mental illness have reproductive rights and a say in their

treatment, alongside a general increase in scrutiny over health and individual risk management. Before delving into the interviews and the study's main findings, we will stop to give a complete account of one interviewee. We will follow Keren, whose story is at the center of chapter 5, as she learns of her mental illness and works to align her life with her new status. Through her story, we will lay the foundations for ideas that will later shape the core of the study. Those include negotiation of self, truthtellers, narratives of disability and normalcy, patientism, and support. Chapter 6 delves into the interviews and the ways women construct their reproductive stories. We will show that women reflect on themselves in ways that correspond to ideas about normalcy as well as those of disabilities. Chapter 7 will turn to the concept of risk and how the women use it in the context of their reproduction. We distinguish between three risks associated with reproduction and mental illness: genetic, behavioral, and medicinal. We show that despite the generalized conception of risk in psychiatric settings, women use risk in an individualized way. They interpret what is at risk and their specific level of risk through their biography, understanding of science, and their illness. The next chapter focuses on the plans that women and clinicians make for reproduction. In those plans, women define a set of steps that they believe to be prerequisites for their moral parenting. We argue that these plans, which we refer to as Stepwise Plans, have dual purposes; they normalize reproduction by placing it in normative settings of good parenthood and disable it by ignoring the reality of mental illness. This is particularly true when plans fail, and women are compelled to account for their unsuccessful accomplishment of normality. In this chapter, we also lay down a new definition of support, which is surprisingly missing from disability and care literature and came up in the narratives of the women who participated in this study. The final chapter offers a conclusion to the study and suggestions for further research.

Chapter 2: Research design and methodology

2.1 Design and analysis

The semi-structured interviews for this paper were conducted in the summer of 2018 and fall of 2019. They were done in person or by phone and revolved around the women's mental health history, romantic history, and reproductive life. Interviews lasted 1 to 3 hours and were recorded and transcribed. We followed the women's narratives to analyze the interviews and identify themes that organically arose. In addition, we looked in the interviews for references to ideas mentioned in the literature as central to reproduction decisions. Using both organic and non-organic coding allowed me to see not only what women found essential to their stories but also what they thought was less important to their decision or left unsaid.

Defining mental illness for the study

There were two qualifications to be included in the study: being an adult (18 years and older) and having a psychiatric diagnosis under the DSM.

The decision to use a broad definition of psychiatric conditions rather than focus on specific illnesses or categories of psychiatric disorders was not taken lightly. Severe mental illnesses (SMI), like schizophrenia and bipolar disorder, are qualitatively different from conditions such as depression and ADHD. Most apparent is the strikingly distinct public face of these illnesses. SMI is understood to be a debilitating condition that threatens to remove the "sufferer" from normal society. Anxiety and depression, on the other hand, are considered to be a byproduct of modern life. With over one in eight Americans taking antidepressant medication in 2016 (Aagmon et al. 2017), these conditions are put under the umbrella of "well-being" and linked to the flourishing market of healthy living advice. Because anxiety, depression, and the like, were distanced from the realm of mental illness and cast into mental health, they were

normalized and neutralized. But the normalization of less-severe forms of mental illness may also bring misunderstanding. My choice to move away from illness categories allows this study to capture the diverse ways subjective mental health experiences shape one's reproductive life. It allows me to see what people value when considering their reproduction beyond the labels that mark them. Finally, by including a diverse set of diagnoses in the study, I can investigate the distinction between mental health, mental illness, and disability.

2.2 Mental illness, mental health, and disability

First, a word about disability and mental illness: mental illness exists in both spheres, and none of them. Legally speaking, mental illness is accepted as a basis for disability status. Moreover, mental illness is represented in disability advocacy groups, organizations, and research. More substantially, if disability is a limitation that lies in the intersection of the body and society, mental illness falls within this definition. Many people with mental illness will argue that they feel disabled due to their illness. At the same time, mental illness is the “black sheep” of disability. Most disability work focuses on physical, intellectual, and developmental disabilities. In the hierarchies of disabilities, mental illness is far at the back. Even within the world of disability, mental illness is stigmatized, with groups gaining social capital by distancing themselves from any association with mental illness. Moreover, mental illness differs from many more politically recognizable disabilities. While the idea of “fluid disability” is getting more traction, most disabilities are relatively linear in their progress. Though intellectual disability might pronounce itself differently in different surroundings, people don't step in and out of their intellectual disability. Yet, mental illness is often cyclical or episodic. For example, people with depression may show no symptoms between episodes of depression, and people with bipolar disorder may experience periods when they are neither depressed nor manic.

This awkward position of mental illness within disability groups was captured in Don Kulick and Jens Rydström (2015): “While people with psychiatric impairments like schizophrenia or mood disorders have historically been subjected to the same kind of institutionalization and medical interventions as people with intellectual impairments, the social worlds of people with congenital intellectual and physical impairments and those with psychiatric impairments tend nowadays to be quite separate, as is the expertise and practices or the professionals who work with them” (ibid: 29)

Mental illness does not quite fit into categories of illness, too. It is widely accepted that mental illness has a firm root in environment and trauma, and more often than not, effective treatment includes treatment in addition to (or instead of) medication. The stigma against mental illness also separates it from other illnesses and suggests a qualitative difference between mental illness and, for example, diseases such as cancer or the flu.

The blurred distinction between mental illness and mental health keeps mental illness’ position within the categories of disability and health ambiguous. This in-betweenness makes mental illness valuable for studying disability and health. It allows us to see when mental health becomes mental illness or, in a more general way, what makes something a disability. By framing the question in this way, we highlight the relational status of disability, yet, what exactly it is in relation to remains unclear. It gives room to subjective and objective observations of disability and health and rejects biological theories that prescribe morality to health and blame for illness. This relationality is a crucial point in the world of disability theory. For, in rejecting the medical model of disability that emphasized an individual’s biology, social model of disability advocates left the bodily experiences of disability behind and theorized that disability is the result of social structures that discriminate against otherwise neutral differences in bodies

and minds. This separation of disability from impairment found harsh critique among others in the community, who refused to dismiss their experiences of pain and limitation as irrelevant. Referring to disability as relational, one could, for example, define disability by observing the relationship between impairment and pain. At the same time, others can define it by looking at the relationship between impairment and education policies. What's more, the possibility of disability as relational leaves room for changes. One might find that the line between disability and health is constant across contexts in some instances, while in others, it is not stationary. Last, thinking of disability as relational gives it social power. As relational suggests, a two-way direction: disability is defined in relation to the world as much as the world is defined in relation to disability.

2.3 Gender

Our choice to focus on the women we interviewed came for two reasons. First, reproduction is often considered a women's issue. Thus, as we recruited participants for the study, primarily women responded. The men whom we interviewed were few and far apart. The second and more profound reason we eventually chose to focus on women is that women carry most of the responsibility around reproduction. Even before their bodies are biologically capable of procreation, girls are directed to think and orient themselves toward reproduction. Sibyl Grundberg and Stephanie Dowrick, editors of the 1980's radical feminist anthology "Why Children," ponder on the role of choice in women's decisions about children. "Motherhood," they wrote, "has been for so long the central fact of women's lives that the idea of *choice* ... is almost beyond our grasp. To ask women why they have children is "to start a revolution" (pg7). Indeed, as we were interviewing clinicians and administrators, their answers often focused on

women. Academic literature on reproduction and psychiatry is also blindsided by gender; men rarely appear in it.

While we believe there is room for studies about men's reproductive decisions and that a different framing of the question could be read as relevant to them, we feel that women's stories are more acutely needed now. As long as they are the ones who carry the brunt of it all, it is their voices that should be heard.

2.4 Who are the women? Characteristics and data

(For a summary of participants' characteristics, see Appendix A. table 1)

Most women were in their reproductive age - the youngest was 19 years old, and the most senior was in her 60s. Sixteen of the women had children, and 18 did not. But stopping at this statistic to lay claims about the reproductive desires of the women will be too hasty. A closer look at the narratives they provide shows that not all the women who are mothers planned to have children, and that of the women who do not have children, some wish they did. This more complicated picture highlights a core idea of this study. Reproductive desires do not always correspond with reproductive status. This, of course, is true for everyone and anything. Plans and outcomes rarely match. Nonetheless, this gap is sociologically valuable. By looking at reproductive desire and accomplishment, this study aims to reveal something that might go unnoticed if parenting rates are measured separately from parenting desire. The detailed narratives of reproductive experiences and desires, as well as mental health biography, presents such an opportunity. Seven women reported being and having been single for most of their lives; the rest were either married, divorced, or in a committed relationship. Of the latter, some had partners who had children, though most were grown, and in other than one of these cases, the women did not see the children as hers to raise.

With regards to diagnosis, most of the participants had multiple diagnoses - either co-occurring or over a lifetime. This is not unique, as people with mental health conditions often transition between diagnoses to reflect their mental health state at a particular time or as part of establishing a “correct” diagnosis. This process will be further discussed later in the article when the idea of diagnosis as a “truth teller” is presented. Five of the women in the study identified as having schizophrenia or schizoaffective disorders; 14 were diagnosed with bipolar disorder, 12 with major depression, 1 with severe anxiety, 1 with Post-Partum Mood Disorder (PPMD), and one with Dissociative Identity Disorder (DID). All but four of the women identify as white, which is an important caveat as women of color are often penalized harsher for being ill, poor, and having children. Class is a tricky concept for people with disabilities or mental health. While some women in this study are comfortable in their current livelihood, they are poor, unemployed, and rely on disability payments. The strong dependency that some of the women have on others includes financial dependence, making their class hard to capture. The women, who are adults, are in a low economic class, but their reliance on their parents allows them the privilege of a higher class. While studies on children use parental class, it would not be wise to do the same in this case first because they are not children and should not be treated as such. Second, the financial gains of the parents are not easily transferred to children with disabilities and mental illness. Often parents of children with a disability prefer to pass their wealth to their non-disabled children in the hope that they will continue the financial support of their disabled or ill siblings. Thirteen identified as poor or lower middle class, eight as upper middle class, and the remaining twelve as middle class¹.

¹ One participant did not report her socioeconomic status

Two women reported having lost children immediately after birth or within a couple of months after birth. One participant, a woman of color, had her first son removed from her care by court order. Many of the women experienced times of homelessness or unstable housing. In several interviews, women described being sexually assaulted and pregnant due to rape. A few of the women shared that they had terminated past pregnancies. None of the women had a child voluntarily given for adoption, though two women considered it. Many women described past suicide attempts and suicide ideation; some were hospitalized for it.

Chapter 3: Stratified reproduction

3.1 Good mothers

Desired reproduction creates good citizens. It is done by and produces individuals who can "carry the state and govern themselves collectively" (Mol 2008: 33). Changes in labor and domestic life brought by the industrial revolution and the religious shifts of the Victorian era moved this responsibility to women. They redefined the home as the domain of the woman and redefined the woman as pure, innocent, and pious. No longer believed to be sexually cunning and immoral, the women of the 19th century were seen as naturally morally adapt to raise the (newly believed to be) equally pure and innocent child. Though themselves denied civil rights, white middle-class mothers were now seen as vital to the nation. Good mothers were the foundation of the future of the nation. Bearing responsibility for birthing and raising the next generation, they were assigned "informal responsibility for the moral education of their citizen-sons. This education was considered essential to democracy; citizens' self-control could make or break the American political experiment" (ibid).

Neoliberalism, and its occupation with population measurements, was the birth of the Foucauldian biopower. Realizing that their survival and success rest on their capacity to produce, governments turned their focus toward control and management of bodies, both on the individual level and the collective citizen body. Sex became the focal point on which these two poles of biopower rested; control over sex allowed governments to measure and manipulate the population's birthrate and gave them entry to individual bodies, which allowed surveillance, regulation, and optimization of bodies. The government's interest in population management brought new life to the concept of "normal." While the "normal" as a descriptive category of statistical frequency was first introduced in medicine to differentiate between health and

pathology, its usage has transformed as the concept expanded into other fields. Health became a sign of morality within social contexts, bestowing the "normal" with ethics of righteousness and desirability (Mary Louise Adams 1997, Hacking 2007). The new normal described how things should be, while deviance from it became a sign of unhealthy and immoral conditions. Instead of being silenced, deviance was dissected, discussed, and marked for supervision. Its knowledge and management were the prerogatives of experts.

The scientific pull of the late 19th century stirred motherhood once again. Instead of the religious frame of the Victorian era, motherhood became the domain of experts, to which good mothers adhered. Good mothers were to use scientific methods to chart their menstrual cycle, document children's development, measure their growth, optimize their achievements and monitor their progress toward becoming the citizens they were meant to be. To be a good mother, a woman has to sort through and follow the latest scientific advice on nutrition (for themselves and the children), routine care, language, and even feelings, when dealing with pregnancies and children.

The early 20th century tightened the link between the mother and the nation and increased its supervisory gaze over mothers. The authoritative rise of childrearing experts was boosted by the development of public health programs and compulsory schooling, which gave states more intimate access to the family and opportunities to surveil mothers. While these institutions "provided much-needed assistance to families," they also "narrowed the range of acceptable behavior" (Ladd-Taylor and Umansky 1998: 11).

At the same time, changes in gender roles, particularly the increase in the number of white middle-class women who sought work outside the house, the early sexual revolution, and the suffragette movement, brought new life to the mother's blame. This "new woman" was

portrayed as a "menace to civilization." She faulted for her "contributing to the decline of the race" (ibid: 10). As a counter-response, maternalistic activists of the Women's Rights movement built on their maternal role. They called for social reform, justifying its power to unify the mother/women experience. They saw motherhood (or the potential for it) as the thing that "united all women, regardless of class, race, or nationality..." (ibid: 11) and joined other social reformers who found the solution to all sorts of social problems in mothers. To that effect, they worked to, among other things, create health education programs for new mothers, abolish child labor, and establish funds for new mothers (which later became the Aid to Families with Dependent Children). Despite their vision of the uniting power of motherhood, maternalists also embraced eugenic thinking. They supported programs aimed at preventing the reproduction of "lower stock" and promoted the procreation of white middle/upper-class able-bodied/mind citizens.

The rise of Neoliberalism in the post-world war years brought even more strength to the mother-nation link. To protect society, individuals needed to practice self-regulation over an ever-growing part of their life. This Neoliberal thought linked individual actions to collective characteristics through the idea of risk. Good citizens do everything they can to avoid risk through constant self-examination and self-improvement. They follow the advice of experts and scientists who not only define and identify risk but also prescribe how individuals can optimize their chances of avoiding it. In neoliberal society, "personal rights are intimately tied to obligation... scientists, doctors, and government institutions emphasize individual responsibility, and good citizens are idealized as those who take care of themselves and exercise personal control. A neoliberal risk culture is, in short, a personal responsibility culture" (Wolf 2010: 192).

Again, mothers were at the center of the moral panic. Neo-Freudian thought, which dominated psychiatry and reached popular audiences in the mid-20th century, created a typology of bad motherhood, specifying the immoral cost of each type. The seductive and smothering mother made homosexuality, and the cold and distant mother was responsible for the "emotionally withdrawn child." Excessively permissive mothers created delinquency, and African American mothers emasculated their sons by dominating the household. Finally, there was the "schizophrenogenic mother, who literally drove her children into a state of psychosis" (Harrington 2019: 94-95)

From the family unit to the mother-child relationship and the psychic of the mother, women became the source of all social evils. Parenting manuals of the time publicly declared bad mothers as responsible for all the "delinquents, criminals, and alcoholics" of the nation (Ladd-Taylor and Umansky 1998: 13).

Alas, how to be a good mother remained elusive. The potential for risk was so great that the possibility of failure - of ruining not only their child's life but the nation's future - was everywhere, all the time. The scientification of reproduction and motherhood offered little help. In fact, as is the nature of scientific investigation and knowledge, experts gave continuously contradicting instructions to women, and the room for missteps grew smaller. Women were told to be warm and caring but not too soft and permissive. They were told to trust their maternal instincts but were blamed if they did not submit to professional advice. They had to cherish family values and, at the same time, reject traditional systems of support and maternal knowledge. They were to hug but not be too affectionate, scold but not penalize, and encourage but teach humility. It seemed that "good" mothers are but a pin drop away from becoming "bad" mothers.

Scientific developments of the late 20th century, particularly the shift to molecular biology and the creation of the fetus as a patient, made things even worse. This new biomedical knowledge was a "step change" in risk culture (Rose 2001: 4). It created a "sense that all life down to the cellular level may be manipulated, planned, and controlled much like a consumer should make purchasing decisions" (Blum 2015: 28).

This endless and expanding universe for self-regulation creates a double burden on women. If good citizens must make rational choices to improve their health through continuous risk assessment, mothers "must also do this for family members" (ibid). Women are expected to tend to and optimize their reproductive capacity years before actually becoming mothers. They are tasked not only with regulating themselves but also the life of their children. They must become experts on everything regarding reproduction and child development and devote themselves to the management of all risks. Good mothers not only protect their children from immediate danger but also work to predict and preemptively eliminate all possibilities of less-than-optimal outcomes, no matter how small or unlikely. Children are not just created in this intense risk culture; they are designed. They become a project on which mothers work and based on which they are evaluated.

3.2 Bad mothers

Opposite to the desired reproduction of good mothers is "bad mothers." Those are people who, through stratified reproduction, are disempowered to produce and raise new humans (Ginsburg and Rapp 1991; Ginsburg and Rapp 1995; Rapp and Ginsburg 2001; Rapp and Ginsburg 2007; Colen 1995; Almeling 2015).

The "bad mother" occupied the social imagination for centuries. As Molly Ladd-Taylor and Lauri Umansky (1998) write in their historical review of the "bad mother," "virtually every

culture in historical record has had its wicked women, and in many cases, their wickedness revolved around the reproductive function" (6). Yet what constitutes undesirability is neither fixed nor natural. These hierarchies are created within the social norms and structures of the society in which they exist. They are ingrained in social categories of class, race, sexuality, and disability and are political as much as they are individual. Desired reproduction is historical, reflexive, and imaginative. It represents not only contemporary beliefs and institutions but also transition and the possibility of change. Finally, to use Wilson, the social category of "bad mothers" creates a "kind of people" by "shift[ing] our attention away from a specific act to a whole person and even to entire categories of people" (ibid: 3).

One category of "bad mothers" are individuals with disabilities. Indeed, it is practically impossible to disentangle the social history of reproduction from the social processes that classify certain people as mentally deviant.

The mental asylums and institutions of the 19th century, for example, were promoted not only as sites of care but also as a solution to the social problem that happens if the wrong people reproduce freely (Charles P. Kindregan 1966; Trent 1994; Kallianes and Rubenfeld 1997; Kline 2001; Rothman 2002). James W. Jr Trent, in *Inventing the Feeblemind* (1994), makes this point when he writes of the link between idiocy and family trouble. He explains that American reformers believed that idiocy resulted from faulty parenthood. Fathers, specifically, were responsible for their sons' idiotic condition (idiocy was mostly a male condition) through their many sins: poverty, consanguinity (marriage between cousins), insanity, illness, licentious habits, failed attempts at abortions, and even "too much" greed. This link between idiocy and parental behavior informed the reformers' response to idiocy by making institutionalization - i.e., separation from the family, the ideal treatment for idiocy.

By the mid-century, this link between reproduction and idiocy changed course, moving from fathers to women. Now, it was women who were seen as responsible for the vice of their children and their idiocy. Through their sexuality and reproductive behaviors, women destroyed the flock and caused social deterioration. Trent explains that "before the war, moral idiots were... almost always male...portrayed as responding to the good efforts of the asylum to rescue them from their moral degeneracy" (ibid: 23). Superintendents described the positive "intellectually and morally" (ibid) affect the institution had on its male patients. In the post-war years, however, this positive image of the institution and its rehabilitated "idiot" was no longer the prevailing tone of the reformers. Trent writes that "the discovery of female moral imbeciles, whose moral imbecility included the ability to bear illegitimate children, added a new urgency to the type ... In a few decades, the threat of a baby in the arm would substitute for the promise of a book in the hand. "(ibid: 23)

The image of the dangerous sexual woman at fault for social degeneracy was captured in the two opposing models of womanhood that developed at the time. One was of the "mother of tomorrow," and the other of the "moron." The first was the white middle-class woman, whose procreative potential was to be harnessed and celebrated, whereas the moronic woman "symbolized the danger of female sexuality unleashed" (Kline 2001: 3). sexuality became the link between disability (to use current terminology), and dangerous reproduction "indicated her primitive savagery - trapped in the mind of an adolescent, she was both mentally and morally deficient and a threat to the race" (ibid: 29)

As eugenic theories took hold, attempts to curtail the reproduction of women believed to skew from the normal became more pronounced. By the 1950s, over 60,000 involuntary

sterilizations were conducted, most on institutionalized populations and the majority on white women (Trent 1994; Kline 2001; Stern 2005; Schoen 2006).

3.3 Eugenics

The eugenic movement, which emerged in the late nineteenth century, along with the new social disciplines of criminology, sociology, and anthropology, had its roots "in the emerging biomedical regulation of human populations through technological means" (Wilson 2018: 6). Indeed, Dikötter (1998) explains that eugenics was "not so much a clear set of scientific principles as a "modern" way of talking about social problems in biologizing terms" (467).

Like all big social phenomena, the rise in popularity of eugenic sterilization was not the result of one process. Multiple social actors and ideas converged to make sterilizations the sought-after solution to undesired reproduction. For example, Trent (1993; 1994) explains the lure of sterilizations in the Superintendent's professional struggle for status in the face of a growing institutionalized population and diminishing funds to run it. Steven Noll (1998), too, points to forced sterilization's role in maintaining control over asylums and defusing critique over their success. An answer to the growing unrest with institutions' promise of rehabilitation, sterilizations were incorporated into therapeutic discourse. The sterilized patient, so it was argued, will be happier and more productive when relieved of their damning sexual urges. Women, in particular, would be safe from the harm of their feeble-mindedness when they can no longer procreate. Without their reproduction, feeble-minded women would be able to "focus" on themselves, earn wages, and even "pursue happiness."

Economic factors played their role as well. Beyond the cost of the institution itself, states and communities were restless with the loss of potential income, especially during and after the

economic depression of the early 20th century. Anger grew over the loss of labor that institutions represented. Institutionalized patients, after all, did not contribute their share in productive labor. Sterilization offered a solution to this problem as well. Sterilized patients were considered safe to be released to the community and rehabilitated enough to join the labor force. In 1932 Superintendent Priddy of the Virginia State Colony of the Feeble-minded explained sterilization's therapeutic and economic benefits. With sterilizations "state has thus been relieved of the immense financial burden incident to the care of them [mental patients] and the long line of defective descendants that would naturally have followed" (Noll 1998: 42). Priddy even went as far as to declare that it is the patients themselves that request to be sterilized "because they know it means the enjoyment of life and the peaceful pursuit of happiness outside of the institutions wall" (ibid: 41)

Wendy Kline, in *building a better race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (2001), offers another explanation for the growing interest in forced sterilization. She argues that an intersection of gender, class, and race stands behind the newfound scientific popularity of sterilizations. The sexual revolution, on the one hand, and the scientification of deviance increased the number of white middle-class women who were determined to be feeble-minded. But white middle-class families did not want to see their "moron" women institutionalized, especially not with the "poor" and "immoral" women who occupied the institutions until then. Sterilization became the solution. It was a path to cure and safety without the shame of having a child in an institution. Kline cements her argument by distinguishing male and female sterilization: "Many women were sent to Sonoma [state hospital in California] because of their perceived "sexual delinquency" and were sterilized for the same

reason, while men were commonly sterilized for therapeutic reasons. Men were sterilized for their own benefit, while women were sterilized for the protection of society" (ibid: 53).

And race scholar Dorothy Roberts (1997) traces the eugenic program and its allies to earlier violence against slave women's reproduction and the continuous moral panic of miscegenation in America. Moral inaptitude, she argues, was linked not only to sexual behavior within the racial group but also to "wrong" interracial behavior. "One sign of the trait was a patient's failure to display "the normal aversions of a white girl to a colored man who was perhaps nice to her" (Aptheker, in Roberts 1997: 69)

These socio-political explanations for forced sterilization, and not the scientific and therapeutic explanations pushed by scientists and superintended, explain the distribution of forced sterilization among institutionalized patients.

Until the 1940s, involuntary sterilizations of institutionalized populations were split somewhat equally between "mental defectives" and "the insane." Toward the middle of the century, mental defectives' share of involuntary sterilization increased dramatically. Between 1940 and the formal end of the eugenic program, insane patients were sterilized at half the rate of "mental defectives." This lower rate of sterilization among the insane was not a happy coincidence. While mental defectives were freed from the institutions at growing rates and therefore needed sterilizations, "insane" patients were believed to be beyond repair and unlikely ever to leave the institution. Thus their "sterilization seemed hardly urgent" (Trent 1994: 222)

The end of the Second World War marked the beginning of the end of state-sanctioned eugenic forced sterilizations. Revelations of Nazi campaigns for euthanasia and genocide, as well as of the involvement of the American Eugenics Committee in it, caused an uproar. The U.S began to abandon its negative eugenic policies and removed forced sterilizations from its law. As

we've seen in "good motherhood," this denouncement of the previous policy did not end eugenic ideas. Instead, it shifted the focus toward positive eugenics, encouraging the reproduction of those deemed to be of "better stock," with a particular emphasis on the mother.

Nonetheless, evidence of forced or ethically questionable "voluntary sterilization" show up sporadically. A notable example is the forced sterilization program that took place from 1997-2014 in California women's prisons and coercive or ethically compromised practices to encourage poor, rural, black, immigrants, and welfare recipients to undergo sterilization (Chappel 2013; Naftulin 2020; Anon 2021)

3.4 Disabled reproduction

Looking at disability, the categorical distinction between the good mother - healthy, productive, and disciplined - and the bad mother - unregulated and ill, educates and disciplines women. It tells which women are socially allowed to reproduce and which are immoral in doing so. Of the latter, disabled people have come to define the very boundaries of desired reproduction: "Ideas about disability and disabled minds/bodies animate many of our collective evocations of the future; in these imaginings, disability too often serves as the agreed-upon limit of our projected futures." (Kafer 2013: 27)

To capture the stark difference between normal, desired reproduction, which is embedded in cultural perceptions of womanhood, and the undesirability of disabled reproduction, I turn again to Kulick and Rydstörm's ethnographic work on the ethics of sex of people with intellectual disabilities (2015). In their comparison between the care practices around sex in Denmark and Sweden, they observe interactions between staff and residents in a group home. Surprisingly, reproduction does not come up very often in their data. This has a larger context. Despite the growing interest in sexuality and disability, reproduction remains a subdued topic,

even within the disability rights movement. The newfound discussion on sexuality rarely tips into reproduction. Nonetheless, Kulick and Rydstorm give us a brief look into the ethics of reproduction in the group home, where pregnancy in one of the residents is the staff's "worst fear." To prevent such events, the staff use programs to dissuade female residents from becoming mothers. The highlight instances in which women with intellectual disabilities had to give up their child, they "encourage" and supervise the application of long-term contraceptives and focus their sex education on preventing pregnancies. If, despite all these measures, some residents still insist that they would like to be mothers, the staff provides them with "reborn dolls." Susanne, one of the residents, treats her doll like a real-life baby. She carries it in a stroller, pretend-feeds it, changes its diapers, and helps it when it "cries." The staff explains why they gave Susanne the doll: "we wanted Susanne to make a well-considered decision about having a baby" (ibid: 169). But when the staff realizes that Susanne is doing well with the doll and giving it good care, they do not re-evaluate their position against her motherhood. Instead, they "decided we needed to make more demands on her" (ibid).

What comes out of this snippet is a mirror image of normal reproduction. Whereas normal reproduction encourages women to see themselves as mothers and punishes those who choose to avoid motherhood, disabled women are praised when they reject motherhood. In care settings, good care happens when the care provider successfully erases the patient's desire to become a mother. Michel Desjardins describes this as "the conversion of the [intellectually] disabled person's desire for offspring into a desire for infertility" (2012: 79)

Going back to the idea of good motherhood, we find that the reproduction of people with disability is nothing short of a cautionary tale of risk and avoidance. "Everything from sterilization to institutionalization, from bone-lengthening surgeries to growth attenuation, has

been justified on the grounds that such acts will lead to better futures for the disabled person and/or for their communities. Within these discourses, disability cannot appear as anything other than failure" (Kafer 29)

Chapter 4: Reproduction and mental illness

4.1 Self-determination and patient's choice

While reproduction and psychiatry remain somewhat at odds, changes in law and medicine give women with different abilities, including those with mental illness, a right to reproduce. The end of the 20th century changed disabled reproduction by denouncing eugenic policies and redefining the rights of people with disabilities. The civil rights movement brought newfound ideas about disabled people's autonomy and their right to lead self-directed life. Among them were deinstitutionalization, a policy and a movement that brought a dramatic decrease in the number of people who spend their lives in psychiatric hospitals. Instead of being treated in psychiatric institutions, patients were sent back to society to be their agents and pursue self-determination. Proponents of deinstitutionalization envisioned a conglomerate of organizations, providers, policies, and services that will allow people with mental illness normative life as members of society. This change in the physical care setting from total institutions to the community was accompanied by another change, this time in how care is understood and done.

The model of care that dominated mental institutions imagined the health provider as an all-knowing entity tasked with making decisions on behalf of their morally questionable patients. In this model of care, the patient was an object on which the care provider - with their superior understanding of mental illness and moral takings - was to work.

The new model of care, the context of disability rights, turned that relationship around. It placed the patient at the center and the health provider in a supporting role. Instead of a paternalistic relationship in which the clinician sets the moral compass, the new model of care revolves around the patient's informed decision-making. It establishes care as an exchange

between an active patient and a passive provider who supports the patient's choice without judgment. Instead of rigidly understanding care as a top-down one-fits-all process, the new model frames care as patient-led and individualized.

The problem of insight: a catch-22 of choice and mental illness

This newfound right to choose is not only a statement of disabled autonomy but also a political act. The right to choose places the responsibility for a disciplined body and mind that can follow the rules of society on the individual (Link and Phelan 1995). It hinges the right to membership in society on "citizens who govern themselves and one another" (Mol 2008:14).

Unlike other disabilities, mental illness's image as located within one's mind blurs the distinction between illness and choice. The problem of choice and mental illness rests on the assumption that people with mental illness are "poor self-observers and unreliable informants" (ibid p. 67). Because mental illness is believed to disturb the person's ability to grasp reality (Bagnall and Eyal 2016), individuals who have it "can and do experience difficulty in making decisions about their health care, including family planning interventions to prevent pregnancy" (McCullough, Coverdale and Chervenak 2004: 21) which puts them at a precarious position vis-a-vis the new ethics of care (Estroff 1992; Jeanette 2006).

Indeed, the link between awareness and illness is at the root of the clinical transformation of insight. Neil Gong (2017) shows how deinstitutionalization transformed the meaning of insight from a symbol of self-agency into a symptom of mental illness. Through processes of scientification and medicalization, "insight" (or lack thereof) became a tool to be deployed when an individual's choice is seen as faulty, i.e., risky. Estroff et al. (1991) documented this transformation in their study of clinicians and patients in a psychiatric hospital. Patients described themselves using a mix of illness and normalcy-related statements. Through illness,

talk patients identified the role of their illness in their identity, whereas normalizing statements hinted at shared experiences and refuted the absolute otherness of illness. Where patients used the two types of statements to describe themselves, clinicians identified only illness talk as true. In their search for the patient's "self-labeling," clinicians interpreted statements as either insight or denial. When patients agreed with the clinician over their illness's presence, nature, and extent, they were believed to be aware of their illness and readiness for treatment. At the same time, patients that declined the self-labeling of illness identity were believed to be in denial of their illness and need for treatment. This denial, it is believed, is not only a lapse of judgment but a symptom of illness. It is an important indicator of the very illness that it denies. By turning insight (or lack thereof) into a diagnostic criterion, clinicians redefine the boundary between choice and illness. Without insight, actions or decisions are reclaimed as impulses of illness rather than autonomous choices. It, therefore, requires intervention, prevention, and supervision. (Estroff et al. 1991; Gong 2017)

In the context of reproduction, insight is central. Studies show that women with MI have positive feelings toward motherhood across diagnostic categories. Dolman, Jonaes, and Howard (2016) interviewed women with bipolar disorder about their reproductive health and found that they saw reproduction and motherhood as central to their lives. They viewed motherhood as their "female fulfillment" and mark of "normativity." women with schizophrenia expressed similar attitudes toward their reproduction. Indeed, in a study about views on motherhood among women with mental illness, Jrimm and Becker (2006) find that the desire for normalcy that women with mental illness express includes a wish to become mothers.

Women with mental illness who are mothers also express strong feelings toward their motherhood. They refer to motherhood as a central focus of their life, a role that gives them

personal enrichment, goal, and motivation to take care of themselves and their illness. Motherhood increases their self-esteem and is described as a break in their feelings of "patient," allowing them to feel "adult" and "normal" for the first time. However, this normative desire to be a mother could be seen as a sign of a lack of judgment and poor insight if the woman has a mental illness. Evidence shows that Mental health professionals tend to view women's attempts at normalcy as pathological. They interpret them as denial of illness, not as a desire for normalcy. This makes the reproduction of women with mental illness particularly tricky. It is seen as an assertion of choice and autonomy by the women and a reason for concern and intervention by clinicians. The conflict between the two is summed up in this quote from the opening pages of *Madness and Loss of Motherhood* (2013), "The reality of high risk (for mother and child) associated with pregnancy in this group of patients, coupled with their strong desires for normalcy and parenthood, creates a most difficult situation for treaters" (ibid:13).

4.2 Risks and ethics

Psychiatric discussions on ethics in reproduction contend that all patients are free to choose to have children. Nevertheless, a closer examination reveals a hierarchy of concerns. Many of the ethical discussions we encountered were framed in one of two ways. One is by specifying the diagnosis that raises such ethical concerns. This literature tends to focus on bipolar and schizophrenic disorders. The other subset of ethical discussions refers to the more general object of the "psychiatric patients." Despite the broad catchphrase, they tend to center on the psychotic female patient. Equating ethical concerns with certain illnesses, commonly referred to as severe mental illnesses (SMI), and less so with other mental illnesses, particularly depression and anxiety, reveals the truth about psychiatry. It suggests that a qualitative difference

exists between mental illnesses with respect to reproduction, making some illnesses riskier than others.

The psychiatric focus on SMI and reproduction is especially surprising when considering the connection between depression and reproductive-related death. In "The noonday demon: an atlas of depression," Andrew Solomon, a researcher at Columbia University and an author of best-seller books on mental illnesses and disability, discusses depression among pregnant women and new mothers. Highlighting the story of Mary Guest, a 37-year-old woman who committed suicide when she was six months pregnant, Solomon argues that antenatal depression is an under-discussed cause of risk for women and children. Indeed, the few studies that do examine antenatal depression and motherhood and infant outcomes show that untreated or incompletely treated depression could lead to adverse consequences; the most striking is maternal death. Severe depression is a significant cause of maternal and fetal death (Oates 2003; Bowen and Muhajarine 2006; Míguez and Vázquez 2021). Despite these findings and the increased attention to postpartum depression (Almond 2009), the related and highly correlated antenatal depression remains absent from clinical and reproductive practices, studies, and policies (Solomon 2014). These studies explain that the inattention to antenatal depression stems from a biased assumption about women's responses to their pregnancy. They argue that the expectation of maternal joy leads physicians to interpret depressive symptoms as related to the physical and hormonal changes that occur during pregnancy rather than an underlying psychiatric depression (Bowen and Muhajarine 2006; Solomon 2014). simply put, physicians' assumptions about normal behavior during pregnancy prevent them from identifying the symptoms of mental illness. They cannot accommodate mental illness and reproduction under what they presume to be a "normal" pregnancy.

Going back to the theme with which we opened, which maintains that reproduction is a social site on which categories of desirability are created, we argue that the focus on SMI in psychiatric reproductive discussions and the lackluster response to depression and anxiety creates a hierarchy of risk that fits into categories of disability and normalcy. Women whose reproduction provokes an ethical dilemma - i.e., women with SMI - are viewed through the framework of disability and all that it connotes. At the same time, women with "light" and "less disabling" mental illnesses are perceived as "normal" and therefore do warrant special reproductive attention.

This correlation between types of mental illness and reproductive risks was often made with respect to this study. Every time we presented the study's premise, we were asked about the type of mental illness the study focuses on. The assumption that some illnesses are inherently different for reproduction than others stood behind that question. More specifically, people assumed that only "severe" mental illnesses influence (or should influence) reproductive decisions. The flip coin to this is the assumption that the reproductive experiences of women with depression and anxiety are normal. Therefore, they do not warrant a study in which they are placed in the same group as SMI and singled out from the general population.²

Psychiatry's response to women's reproduction

Psychiatry has been slow to respond to changing trends in sexuality among its clients. Not only did deinstitutionalization move patients away from the ever-observing gaze of clinicians, social changes in gender norms and contraceptives increased the sexual behavior and

² A term that I use for ease of writing, despite having reservations to it. because anxiety and depression are often treated as "light" mental conditions (not even illnesses) they are not excluded from the control group of the "general population". This means that they are counted in the control as well as the treatment group. In other words, when people argue that women with depression and anxiety are "normal" in their reproductive experiences it is because they were counted as part of that "normal". The question we ask is "normal" looks once we remove this group of women from it.

number of pregnancies among women with mental illness. Still, clinicians were largely caught off guard, with few services to offer and little inclination to treat (Miller 1997). Clinicians who treat pregnant or potentially pregnant women describe it as an ethical dilemma (Seeman 2004). They suspect that the women will not be able to be good mothers and that they are harming the fetus and themselves. As such, they feel that they are caught between two conflicting demands: The demand to respect the patient's autonomy and the demand to prevent harm (McCullough, Coverdale, and Chervenak 2002). On a personal level, therapists talk of feeling 'anger' toward the pregnant patient or frustration that an unfit woman gets to be pregnant while more fitting women do not (ibid). In a study of the attitudes of mental health providers toward patients' reproductive desires, Krumm et al. (2014) give this response from one of the participating clinicians: "Well, I did feel rather inhibited (...), because I thought there are certain things I am not allowed to say. I had to be as objective as possible. Although I personally thought it was senseless (to have another child), because there were already two children, and the patient was schizophrenic and had already been a threat to these children who had to be taken into care." (7)

The challenges that might arise when treating a pregnant woman with mental illness sprouted extensive literature on ethics. A 1992 paper in the official journal of the International Federation of Gynecology and Obstetrics sought to solve the problem of preserving choice while protecting against risk. It offered guidelines for clinicians to engage in family planning in psychiatric settings. However, the title of the paper revealed its true intention. "Ethically justified guidelines for family planning interventions to prevent pregnancies in female patients with chronic mental illness" (McCullough et al. 1992) did not view pregnancies of "chronic and variably impaired autonomy" positively.

While such negative attitudes to the reproduction of women with mental illness are no longer bluntly declared, study after study frame pregnancy and motherhood of women with mental illness as a perilous event that requires delicate "clinical consideration" (McCullough, Coverdale, and Chervenak 2004). These studies never fail to provide an extensive list of adverse outcomes. Among other things, they cite worsening mental health for the woman, inadequate prenatal and postnatal care, high rates of abortions and miscarriages, silent births, development delays for the child, and inheritance of mental illness. Only a few of the articles we read about the reproduction of women with mental illness mentioned the positive sides to it; the sense of purpose that women with mental illness find in their role as mothers, the motivation it gives them to continue their treatment, and the resilience and increased empathy of their children (Nicholson, Sweeney and Geller 1998).

In the most acute cases - as when the woman is actively psychotic, as in the case of Mary Moe - ethical guidelines allow clinicians to be circumspect about the woman's choice by utilizing a legal tool that transmits her right to choose to a surrogate. By declaring the woman lacking insight, clinicians create boundaries around the right to choose, effectively making it contingent on health. Through surrogate decision-making, choice becomes a right only for people with a healthy and sound mind.

However, most individuals with mental illness do not spend their lives in institutions or in acute psychosis. The overwhelming majority of women with a psychiatric diagnosis live in society and are cared for by community mental health providers. In these cases, clinicians lean into their professional neutrality to resolve the ethical conflict of psychiatric reproduction.

4.3 Reproduction talks in clinical setting

As mentioned above, psychiatrists explain their disengagement from patients' reproductive health by arguing that reproductive decisions are a moral matter. As such, they are not part of psychiatric expertise and governance. Psychiatric involvement in reproductive decisions is seen as not only unprofessional but also unethical, tantamount to the paternalistic care of the previous era and its restrictive practices. Far from the moral regulators of the past modern mental health providers see themselves as health experts tasked with supporting clients' decisions (Brantlinger 1992; Cort et al. 2001; Aunos and Feldman 2002; Krumm et al. 2014).

Krumm summarizes this attitude by stating that "from the perspective of participants [care providers, EP], it was naturally always the patient who takes the decision for or against parenthood. These statements were closely linked to the overall principle of patient autonomy as an unquestioned and commonly shared professional value" (Krumm et al. 2014:4).

This, however, turns out to be an embellished - wishful maybe - version of reality. Studies found that although clinicians emphasize their role as providers of information, many tend to avoid discussions on sexuality and reproduction with their patients, including patients who are known to be sexually active and do not use birth control. Assumptions on race and gender played their part, as male mental health providers were less willing to discuss birth control with patients, and health providers of both genders assumed that their African American patients were more sexually active and less inclined to use birth control than their white patients. (McLennan and Ganguli 1999).

The psychiatric silence on reproductive health was at the center of the 2013 National Task Force on Women's Reproductive Mental Health. Its final report described the insufficient response to issues of reproduction and mental illness, underdeveloped and underfunded

psychiatric services for pregnant and postnatal women, and scant institutional support for their children or the family unit as a whole. The root of the problem, the Task Force concluded, is psychiatry's mind frame and training that is captured by the fact that "The American Board of Psychiatry and Neurology does not offer any official fellowships or certifications in reproductive psychiatry...Anecdotally, most medical school programs offer at most one to two lectures on women's mental health, and even psychiatric residencies may offer only a few hours of teaching on the subject." (Dossett 2014:302). As a result, "many general psychiatrists are unwilling or unable to treat clients who are pregnant or postpartum" (Osborne et al. 2015:946 note on p.946)".

To address the problems that were identified in its report, the task force pointed to general psychiatrists. Jennifer Payne, the director of the Women's Mood Disorders Center at John Hopkins University, explains that "every psychiatrist should and does treat women, and all psychiatrists will have female patients and/or their partners who either become pregnant unexpectedly or experience a planned pregnancy." (Payne 2019:208). Therefore, the task force recommended that psychiatrists be trained and educated on reproductive health and that clinicians address reproductive health in routine psychiatric care.

In addition to training general psychiatrists, the task force expressed its support for the subspecialty of reproductive psychiatry. Indeed, in the second decade of the millennia, the subspecialty of reproductive psychiatry began to emerge. Physicians associated with it provide reproductive AND psychiatric care with up-to-date knowledge of reproductive risks and personalized patient advice. Despite the growing need for such support, reproductive psychiatry remains on the fringes of mental health care. It suffers from accessibility problems, understaffing, and lack of awareness or even support for the service by general psychiatrists. Many patients remain unaware that such a specialty exists and, relying on their treating

psychiatrist (if they have one), do not consult with them. Finally, a 2015 petition for the subspecialty to be formally recognized by the American Board of Psychiatry and Neurology has been rejected.

4.4 Women's perspectives on psychiatry and reproductive health

The psychiatric silence on reproduction has real-life consequences for the patients. If the choice is based on the careful weighting of information, then the absence of conversations around reproduction in clinical settings leaves patients ill-equipped to make informed reproductive decisions. Many women who participated in the study said their clinicians did not discuss reproductive health with them. Keren, a 30-year-old single woman, diagnosed with schizophrenia, put it in her typical straightforward way: "I have a psychiatrist, yeah. I see him. I don't think we've ever spoken about kids ever." Lital, a 40-year-old mother of three biological children and two stepsons who has bipolar disorder, pondered her experience

You know I think I've been asked if I was on it [birth control] but nobody ever talked about anything further than that... I mean thinking as you're asking the questions, it sounds logical that they should. that they should ask those questions. I do think they should

Other women experienced their psychiatrist's hesitance to consider their reproductive health in more direct ways. Shira, a 33-year-old stay-at-home mother of three, who is diagnosed with bipolar disorder, felt dejected by her psychiatrist's response to her observation that her mood swings are related to her reproductive health.

I'm pretty in tune with my body that way. I'm noticing my moods are very cyclical. That would be ... In my opinion, I'm starting to notice, "Hey, hormones are really related to this stuff. Why have doctors never asked me about this before?" I'm thinking that, as a woman, people, the doctors, should be asking more about our [menstrual] cycles. When I ask doctors, they have

said things like, "Well, that's gynecological. You need to talk with them." My thought on it is that, if we're trying to treat me for bipolar, which is a mood disorder, how can you not talk about hormones at the same time? It needs to be ... I feel like ... I don't know. There's a little bit of a gap of the knowledge of what the doctors have in psychology, it seems, then they do with gynecological stuff. Which is frustrating for me because, when you get medication involved, it gets complicated ... It's very thorough. I feel like that ... I know this is off topic of what you're talking about with reproductive stuff. But a big part of the problem is not ... I mean, as individuals we're so complex. I mean, there's so many facets to why we are the way we are in our mental health

While Shira felt that her mental and reproductive health were connected, her psychiatrist insisted on a separation. In doing so, they not only held on to their silence but also silenced Shira. By sending her to a gynecologist, Shira's psychiatrist turned down her claim for expertise on herself and re-established their governance over her. Shira felt that rejection, and it gnawed at her. As we were talking, Shira was heading to Mayo Clinic for a second opinion. She believed they would give her a new diagnosis of Premenstrual Dysphoric Disorder (PMDD), which would confirm her suspicions that her mental illness is linked to her reproductive health. Getting the correct diagnosis will ensure Shira that she is getting the correct treatment for her needs. More so, it will tell her something about who she is: "So, I wanted to be certain, go to Mayo Clinic, and find out for sure do I have what they've been saying I have for the past 12 years."

Shira's feeling of being ignored came up in other women's stories. In discussing their relations with health professionals, women talked about being reduced to their mental illness in ways that overlook their personhood and question their truthfulness. Esther (31 years old, cohabiting, Dissociative Identity Disorder), whose complaints of abdominal pain were ignored

for months before doctors realized she had a molar pregnancy, explained her experience by reflecting on clinicians' attitudes toward mental and reproductive health

According to my reproductive health, my mental health is always checks first...It was bad. It was really, really bad. And it caused me to go to my psychiatrist again and then I ended up having lithium poisoning overdose from it. So it was a whole fiasco is awful ... it was completely ignored. So I don't think that reproductive health is even paid attention to for people, much less mentally affected people

More than anecdotes, Keren, Lital, Shira, and Esther's stories capture a trend among women with mental illnesses. Studies show that the psychiatric silence around reproductive health may dissuade women from talking with their clinicians about reproductive matters. Women viewed it as too risky (Chernomas, Clarke, and Chisholm 2020; Zatliff et al. 2020) to engage their clinicians about their reproductive health. Adva, a 30-year-old married mother of one with bipolar disorder type 2, explained what is at stake:

I talked to my friend about it [the fear of her daughter being taken away from her because of the MI] a little bit, but she was very much like, "You're a fantastic mom, I don't think that you have anything to worry about." I didn't really talk to my therapist about it, because I didn't want to, I was very afraid of putting the idea in her head, too

Some women experienced overt discrimination (Chernomas, Clarke, and Chisholm 2020) by health professionals. A 2002 study about the reproductive decisions of women with bipolar disorder found that 45% of the women in the sample reported being advised against becoming pregnant by their psychiatrist, primary care physician, obstetrician, or even their spouse (Viguera et al. 2002)

More frequently, the silence around reproductive health makes it difficult for women to access information about pregnancies, contraception, and parenting. Even relatively well-educated women were revealed to be "not adequately informed about family planning, pregnancy, parenting, or menopause in light of their illness and its psychopharmacological treatment" (Chernomas, Clarke, and Chisholm 2020: 1520). To fill the gap, they turn to non-traditional sources that are less reliable.

In studies and this research, women tended to interpret their psychiatrist's avoidance of reproductive health topics as a sign of disapproval of them as potential mothers (Dolman, Jones, and Howard 2016). Esther, again, brings words to this feeling:

Those things [that she can't have a child] are really instilled in the people before that even happens. When you're in treatment and in psychiatric care. If you're under psychiatric care, not like in a home but just going to the doctor, but when you're under psychiatric care, it's kind of instilled in you without them being blunt about it

These women's stories reflect the psychiatric ambivalence toward their reproduction. Because psychiatric reproduction raises ethical questions about the psychiatrist's responsibility to their patient, the potential future child, and their profession, there is no clear answer to women's questions of risk and choice. As a result, psychiatrists scramble when issues of reproduction surface. Therefore, the so-called "silence" around reproduction is more accurately described as an uncomfortable secret. It reveals the unguided psychiatric response to women's reproduction and clinicians' complex position toward it. More than anything, it shows that the women are caught in limbo. On the one hand, they are treated as moral agents that can make and are responsible for their own reproductive decisions. On the other, their reproduction is an

uncomfortable reality that is ethically questionable and absent from the care that supports their moral agency.

Chapter 5: Keren

5.1 “I love life. I mean, I’m schizophrenic”

Seating at the back of her eleventh-grade classroom, Keren started chuckling. Her classmates, who couldn’t detect the cause of her laughter, were baffled. “What are you laughing at?” they asked, and Keren, who was “just thinking in my head and ... cracking up,” answered, “Oh, nothing.” But Keren’s laughter was anything but “nothing.” It was a symptom of mental illness that would shape her life and, with it, her relationships with friends, family, and herself.

Though Keren did not come to the interview with a ready narrative of life with mental illness, many of the experiences she described were shared by other women in the study. Vibrant in details, her story calls attention to how women with mental illness negotiate selfhood as they become - and continue to be - female mental patients. It shows that women with mental illness are constantly working to create a shared understanding of how “ill” and “normal” they are, without which support is impossible. Through this negotiation of selfhood, they participate in setting expectations, norms, and rules that govern their life. These, in turn, define what these women could be held accountable for as “normal” adults and what is beyond their reach as part of their “ill” and uncontrollable selves. In other words, they negotiate the boundaries of their agency through the negotiating of self.

5.2 Keren’s story

We met Keren (30 years old, white) at a local cafe near her house. It was a small place with three tables stacked so close that other patrons and staff easily overheard conversations. A week earlier, we emailed Keren about the study. Her response, “sounds interesting,” came through quickly. Now, we wondered if we miscommunicated the research premise and did not accurately describe its intimate object of it. It turned out that Keren knew precisely what the

study was about but was unconcerned by the lack of privacy. She likes that particular cafe and feels comfortable in it. She does not even mind if we use her real name in our writing.³

We sat down at the corner table and started chatting. Keren is easy to talk to. She is upbeat and engaging. Her stories flow out, punctuated with jokes, profanities, and slang. Soon, the interview breathed life, shifting smoothly from the mundane (our shared love of cats) to the intimate - Keren's relationship with her parents and her experiences with mental illness. Keren spoke of her illness's early stages, learning about it, and coming out to friends and family. She described her daily life, the challenges, and the strengths she has. And she talked about the difficulty of planning for a future into which she has little insight.

The whole narrative of Keren's story helps synthesize this research's central themes. It allows us to see how the negotiation of self occurs in interactions with health professionals, family members, and peers. We observe how women with mental illness use actants to advance a specific narrative of themselves and how, through that selfhood, they claim agency on the one hand and care on the second. Reproductive ideas come through organically in Keren's story. We see how reproduction appears and disappears from professional interactions with mental health providers and how disagreements about selfhood can undercut supposed agreement about parenthood. Through Keren's stepwise plan, we can observe the power of the good mother narrative in directing Keren toward motherhood while also distancing her from it.

Becoming schizophrenic: truth-tellers and the mental patient

Keren's innocuous classroom episode of unexplained laughter was followed by menacing paranoid thinking. First, it was her mother who she thought was plotting to murder her, and then,

³ Nonetheless, I chose not to use Keren's real name to protect others from being identified through her stories.

in college, “all of a sudden, I’m thinking about my roommate and I’m like, I think she’s trying to kill me. She’s doing this and this”

At that point, Keren - at 18 years old - realized that “something’s not right with me. I think I need some help”. She contacted her college’s health center and was sent to see a mental health provider. After a brief intake, Keren was given a diagnosis of bipolar disorder, a prescription for medication, and a pamphlet with information about her illness.

Though Keren appreciated the easy access to a mental health provider, the actual care was unsatisfactory. For one, Keren thought that her diagnosis was incorrect. She read about bipolar disorder online and realized that “I don’t fit these symptoms at all.” Still, knowing that diagnosis provides access to treatment, she decided to “just stick with it.”

Keren’s decision not to contest her diagnosis was part of a negotiation to find who she truly is. Because “ill” and “normal” represent disparate expectations, norms, and rules, Keren has to establish a self on which others agree. Only then can she find support in the form of supervision, care, and agency to which all sides are held accountable. Indeed, as Keren and other participants in the study show, the negotiation of self is relentless. It happens in every interaction, including with friends, family, and health professionals. The bipolar diagnosis that was assigned to Keren represents such negotiation. Keren adjusted her understanding of herself to reach a shared agreement of who she is - represented by her diagnosis - and with it, the support of psychiatric experts.

Nevertheless, Keren’s agreement on the diagnosis was incomplete, and despite her decision to “stick with it,” her commitment to the treatment was haphazard. Instead of taking her medication as advised, she tinkered with it. She missed dosages and often took them at irregular

hours. The result was always negative “I’d kind of go up, up, then down, up, down, up...”. Not taking her medication as prescribed was “Not a good idea. Bad idea.”

In her first two years of college, Keren was hospitalized three times. The first two happened following suicide attempts. At first, Keren overdosed on pills and was taken to the hospital by the police. The second time, her Lacrosse coach brought her to the hospital. It was during her first hospitalization that Keren learned a valuable lesson about mental health care and the role of the Mental patient. She describes it as the “best worst advice I’ve ever gotten.” This is how Keren describes the episode:

Another girl in the place came over to me and she was telling me about ... She kind of said to me, “If you tell them what they want to hear, you can get out of here.” And so, when asked about her attempted suicide, Keren gave an answer that she believed will assuage the staff’s concern about her health. Instead of telling the truth about her mental health she said “I’ve never felt depressed before. I don’t know why I did that. I don’t even know why. I must have been drunk

Keren’s answer is an example of “strategic disclosure.” A negotiation technique in which women mentally calculate how “ill” or “normal” their response may seem and alter it accordingly. In this case, Keren used strategic disclosure to frame her actions as “normal” and, therefore, not requiring supervision. True to form, Keren was released from the hospital the next day.

Keren did not enter the hospital knowing how to behave; she had to learn it. She did so by observing and interacting with everyone around her: the medical team, administrative staff, other patients, etc. Thinking of “patient” as a role that needs to be learned rather than a naturally occurring status, as Ervin Goffman (1961; 1963) suggests, helps us understand the advice that Keren received as more than a suggestion of the best way to get discharged fast. It was a lesson

that will carry itself throughout Keren's life and help her to carve space for the agency even in unbalanced power relations. At that moment, at the psychiatric hospital, Keren learned to use psychiatric ambivalence to her (subjective) benefit. As a patient, Keren was subjected to the power of psychiatric and care experts. But, the lesson goes, the subjective nature of mental illness diagnosis gives some power to the patient. Because health providers rely on information from the patient to form their professional judgment, patients who divulge this information strategically can help shape their care. That "best worst advice" that Keren received was meant to teach her that she is both powerless and powerful. To have control over her life, she must constantly attend to and negotiate the boundaries between "normalcy" and "illness" in herself.

The line between power and powerlessness is thin, and Keren's third (and final) hospitalization shows the cost of miscalculating it. Her last stay at a psychiatric hospital, in the first semester of her sophomore year, was different from the previous ones. This time Keren was taken (again by the police) because of her behavior. Even when we met, some ten years later, Keren didn't know why she was hospitalized" I just was telling somebody in the school that I was not feeling good. I was feeling all crazy, and they called the freaking cops on me". Keren was held for six days, and unlike her earlier hospitalizations, which she referred to amusingly, her reflection on this one was negative. She describes her stay at the hospital as awful. She was bored, had nothing to do, and was surrounded by men who, she felt, were in a worse mental state than her.

Unlike the image of the asexual sterile hospital (Ruchti 2012), sexuality and sexualization are abundant in hospital settings. Being one of few (if any) female patients in a ward dominated by male patients made Keren feel uneasy. Despite her shared status with them, her female gender made Keren a target of unwelcome desire. When she was finally released from the hospital,

“they all gave me their numbers... I got a million phone numbers. Garbage”. She threw all of them away.

Keren’s final stay at the hospital reveals the truth about her life as a person with mental illness. Though she did not (and does not) believe that her behavior warranted the extreme measure of calling the police, taking, and keeping her at the hospital, she had no power to prevent it. Failing to reach an agreement of selfhood leaves Keren at risk. Once her behavior was determined to be a symptom of mental illness, she was recast as “ill,” and her dispute over it became further proof of her illness and evidence that she needed supervision.

Keren’s series of hospitalizations exposes the difficult task of negotiating “normalcy” and “illness” among people with mental illness. It is precisely because Keren was able to persuade the doctors at her first hospitalization that she was “normal” that she did not receive the treatment she needed. Moreover, it is precisely because she was determined to be “ill” during her third hospitalization that she was denied agency.

Learning to be a “good” mental patient

Keren’s failure to secure a self that includes agency (normalcy) and care (illness) made her rethink her approach to treatment. Though taking her medication three times a day was challenging and required sacrifices that Keren was not keen to make, she decided to “just ... get over it. I’m going to take it when I’m supposed to take it”. Committing to treatment as prescribed indicated a shift in Keren’s negotiation toward a shared agreement of herself. She was no longer a “bad” mental patient who rejected the reality of their illness but a “good” patient who accepted the responsibility to be “better.”

As with the patient who gave Keren the “best worst advice” during her first hospitalization, her decision to become a “good” mental patient was made through interactions,

that Keren's lacrosse coach was instrumental in this decision, exemplifies the ubiquity of negotiation of self, inside and outside psychiatric settings.

When we asked Keren how taking medication changed her behavior, she referred to her coach. Without medication, "I'd want to punch her [the coach] in the face. I kind of said that to her face once, too. That's what I do." Though Keren never actually discussed her illness with her coach, she heard her talking to herself "many times" and told Keren that "I can tell within 30 seconds whether you have taken your medication or not."

Keren's lesson on the conspicuous nature of her illness and the superiority of accepting care did not end with her coach's comment on medication. Her shift from a "bad" mental health patient who is untreated and unpredictable to a "good" patient who commits to treatment was rewarded when she was promoted to captain of her lacrosse team. Keren's story about that interaction highlights the opposing experiences of her unmedicated and medicated self. The first comes to apologize, the latter to be celebrated:

One day in her sophomore year, Keren was called into her Lacrosse coach's office. Prior "invitations" taught her that this was not a good thing.

I think I'm going to get in a lot of trouble. My assistant coach is there. They shut the door. I'm sitting there, I'm like, oh my God. In my head, I'm going, "Just apologize. Just apologize. Just apologize." To her surprise, the meeting took a different direction. Instead of reproach, the coach congratulated Keren. Making a direct reference to the change in her mental health care, they offered her a promotion: "we've noticed you've changed recently. You're acting really good. So, we were wondering, do you want to be captain?"

Excitedly, Keren took the role.

Keren explains her successful Lacrosse career as a combination of self-agency, medication, and support. Ironically for Keren, success can lead to problems.

The structure of mental health care in the states made it so that her successful graduation from the college directly threatened the well-being she worked so hard toward. Because she received her mental health care from her academic institutions, graduation meant that she lost access to her mental health provider, and with it, to her medication.

Keren moved back in with her parents and tried her hand at various professional jobs, but none worked out. Not having medication, her hallucinations and delusions returned, and “I couldn’t... I was trying to intern, and I’d be at the computer, and I’d be hallucinating in front of my face ...” Finally, Keren gave up on working regular jobs and reached for help.

Because she no longer had access to her college mental health services and without a job to give her health care benefits, Keren enrolled under her parents’ health insurance.

Keren’s mother disagreed with Keren’s definition of herself. She did not believe that Keren had a mental illness and was happy she was no longer taking medication.

She’s like, “Okay, you’re not on it?” I was like, “No, I’m not on my medicine anymore.” She’s like, “Okay, good.” And it’s like, it’s not good. I’m hearing things, seeing things, sure, whatever. I told her that I had to go see a doctor and she didn’t understand why”. So, when Keren needed mental health care, she first had to negotiate it with her mother, “I was like, “Ma, I need to go see a doctor, I need to go see a doctor

When she finally convinced her mother to send her to a doctor, the result was far from self-affirming

I see this woman she’s older like 65, 70, and English. And I go there and I’m like, “Hi.” And she’s like, “Hello.” And I’m just like oh my God I don’t want to talk to this lady. And then she says to me, “You’re just not acting like a woman of your attractiveness should be. And I’m like ... the fuck is this old lady saying to me?

Like with the bipolar diagnosis, Keren immediately knew this was wrong. She also knew that she was on thin ice. That one wrong move could make her seem too ill that she risks being sent to the hospital or too well that she risks being sent home without psychiatric care. So, similar to her earlier diagnosis, Keren decided to make the best of the cards she was dealt. Instead of expressing her frustration, she enacted the role of the good mental patient by deferring to the institutional power of the “expert” provider. At the same time, she used strategic disclosure to stir the interaction:

So, I’m just trying ... The thing is, at this point, I kind of know that I’m schizophrenic. And I’m like, “I’m hallucinating. I’m seeing things.” And she’s asking me about the hallucinations and I’m just saying yes to everything because I want to see the psychiatrist so badly. So eventually she’s like, “Okay, let’s set you up with a psychiatrist.” I’m like, “Okay, thank you. Thank you, yes. Yes, thank you. Yes, oh yes, thank you, yeah.” It was just ridiculous

As before, Keren knew what she said, to whom, and when is crucial. At the hospital, she minimized her depressive thoughts to be seen as more mentally healthy - that is, normal. At the health provider, she doubled down on her hallucinations to seem ill enough to warrant the referral she needed.

With the referral at hand, Keren was finally able to see a psychiatrist. At their meeting, she again engaged with mental calculations of normalcy and illness to reach an agreement of selfhood. Unlike her first meeting with a mental health provider in college, to which she came “unprepared,” this time, Keren had a reasonably secure idea of what her diagnosis should be. Knowing what she wanted out of the meeting, Keren was strategic in her answers. She emphasized the things that fit into her definition of herself and minimized others in the hope that

her psychiatrist would give her the diagnosis that she already knew to be true. She has schizophrenia, not bipolar disorder.

As is often the case in psychiatry, the change of diagnosis brought a change in medication. When she supposedly had bipolar disorder, Keren was put on mood stabilizers (anti-anxiety and antidepressant). Now that her diagnosis was revised, Keren started taking antipsychotic drugs. At the time of the interview, Keren took seven types of medication daily; five were to treat her mental illness, and two were for the side effects of the first five. She says, “it’s a lot of medication, but like, yeah.”

Keren still talks to herself and sees a psychiatrist regularly. She also has a college degree, friends, and a small artistic career. She lives by herself, not far from her parents. Overall, Keren feels that her schizophrenia is under control. The quote at the beginning of this chapter - “I love life. I mean, I’m schizophrenic” - captures Keren’s belief that schizophrenia is not antithetical to a satisfying life.

5.3 Being too normal

Despite reaching an “agreement” with her health provider about her correct diagnosis, Keren’s self is not secured. The chronic state of her illness, and the ebbs and flows of it, mean that she will always need to prove herself as both ill and normal. If in the process of diagnosis and treatment, Keren’s focus was on getting care without losing agency, now she is faced with the opposite problem. Her success in “normal” life makes some people question her account of being ill. Maybe unsurprisingly, this mistrust comes from within.

Keren has an active online presence where she talks openly about her mental illness and posts videos about her life. This draws the ire of some of her viewers, particularly individuals

who, like Keren, are diagnosed with schizophrenia. In one exchange, Keren was even accused of being “an actress” who researched mental illness and now pretends to have it.

While Keren believes that normalcy and illness are reconcilable, her critics consider them mutually exclusive. With that in mind, Keren’s “high functioning”⁴ becomes evidence that she does not have schizophrenia. “People just think I don’t have schizophrenia because I... live too much of a normal life they think. They think I’m too well-adjusted “. Keren is convinced that the animosity she experiences comes from a fundamental disagreement about the possibility of being schizophrenic and normal. Though the social label of schizophrenia is far from desired, people already placed in that group are protective of it. If Keren is allowed in, the successful management of her illness will further castigate other people with schizophrenia who are not as “normal” for their failure to manage their illness.

Keren does not subscribe to this schema of individualized blame. Like the structural framing she used to explain her success (having support, resources, suitable medication, and self-agency), she views other people’s experiences as confounded by external factors. Keren believes that her detractors are those “who have really bad experiences with schizophrenia either through their family or through their life or maybe they’re just not well-adjusted. They don’t think they’ll ever reach a level of stability, [they] see a person like me, and they’re like, “They can’t be schizophrenic because if I can’t be like, they can’t be like that.”

Knowing that support is built on an agreement of the self, Keren looked for ways to convince her listeners of her authenticity.

⁴ High functioning is itself a concept of normalcy vs illness.

As before, Keren used strategic disclosure to move viewers into believing her account of herself. She told a story of experiencing a common form of psychosis - the feeling of godliness - and steered away from the paranoid thinking she had, which, being more socially threatening, carries a greater risk of being seen as too ill.

We [Keren and her colleague] get accused of not really having our illness. So, we were like, “Here are some stories that prove we are crazy. So, I have this story when I was on Birthright [Keren went on Birthright immediately after college, around 22-23 years old] that I went to the Western Wall and I was at the Western Wall kind of like touching the Wall with eyes closed and I was like, “I’m here. I’m going to pray for anything that I’ve prayed for. What have I prayed for? I don’t know.” And then all of a sudden, I had a very godly experience where I felt something shoot through my head, through my arms on the Wall and all of a sudden, I just kind of knew what was most important in my life. And I felt like this very godly... And basically, I said, “That’s my story proving I’m crazy because I think I had a godly experience at the Wall”

In addition to stories of symptoms, Keren pointed to her medication to authenticate her schizophrenia. Truth-tellers - medication being one of them - are actants that expose a supposedly objective and undeniable truth. These are people, experiences, and inanimate objects that have a narrative power of truthfulness and, as such, can compensate for the questionable reliability of the storyteller.

Beyond its therapeutic role, medication is believed to expose the truth. In the psychiatric diagnostic process, medication is often used as a litmus test for diagnosis. Effective medication is treated as evidence of a correct diagnosis, whereas medication that does not alleviate symptoms could become a sign of misdiagnosis.

Medication’s power of truthfulness extends beyond the diagnostic process to other interactions. Because medication exists outside of Keren, it is not tainted by her unreliability.

Moreover, because a mental health provider must prescribe it, it also carries the truth-telling power of mental health experts. When Keren responds to her accusers by saying, "...I take seven medications daily. If you think I don't have schizophrenia, why do I take seven medications daily?" she is substantiating her claim of illness with her need for medication as well as the expert authoritative power behind the medications.

The second part of Keren's response, "If you think I'm too stable, it's because I take seven medications daily. Like, stop", is at the core of disagreement over her selfhood. By explaining her stability through medication, Keren exposed the messy backstage to her successful front. Her "normalcy" is built on the murky foundations of her illness and is scaffolded by psychiatric medication. In her negotiation of self, Keren reshaped normalcy into an achievement. Her "normalcy" is achieved through work and must be maintained constantly.

Negotiation and support

Keren's assertion that she is schizophrenic and normal may distance her from peers or (at times) her parents, but it is also the basis of her social support network. Keren tells two stories about her friends and their interactions that show that support happens when a shared agreement of a self is reached and normalized.

Though Keren suspected that schizophrenia was the correct diagnosis for her, the stigma of the illness held her back "...Because with the stigma, the whole thing [of having schizophrenia]. So, it's like, "No I don't. No, I don't. No, I don't." I think I had the whole stigma in my head that I didn't want to be schizophrenic, so I didn't want to admit that I had it either." Her friends did not mind the stigma the same. They already suspected that she had schizophrenia and were discussing it among themselves. So, when Keren finally admitted her illness to them, their response surprised her

So, when I told them ... gathered them around the table. I remember when I told them, K was here, S was here, W was here. And K was like, "I thought that's what you had the whole time." And S was like, "Yeah, that was really obvious." And W was like, "Yeah, we told you that." ... they already knew. They would hear me in my room talking to myself and they'd say ... They would pretty much tell me I had schizophrenia...They all knew beside me

Keren's diagnosis-reveal story became one of their friendship's myths. Her friends love it when she tells this story because it makes them "feel famous," Keren likes it because it affirms what she believes to be the basic elements of their friendship. Instead of the rupture that Keren feared would happen after her diagnosis-reveal, she felt acceptance. Not only was she not rejected, but her selfhood was also worthy of love and inclusion: "I kind of figured from there, if anyone was ever going to judge me for it [having schizophrenia], I mean it doesn't really matter because my best friends already knew and loved me..."

The second story about Keren's friends involves dogs. Again, we see how successful negotiation of selfhood can create support. As mentioned earlier, Keren still hears and talks to her voices. This prompted the following interaction:

My old roommate when she was living with me, if I'd be talking to myself, she'd make it like a joke. She'd be like, "Oh. So, you want to talk to other people? You don't want to talk to me? You don't want to talk to me? You're just going to talk to your friends over there?" I'd be like, "Leave me alone. You talk to the freakin dog. The dog doesn't... You're talking to your dog"

Engaging with the voices in her head is a behavior that could cast Keren as more "ill" than she feels and warrants uninvited intervention. To mitigate this risk, Keren must successfully reframe this behavior as "normal." The exchange with her roommate reflects a shared agreement about this behavior. Instead of separating Keren into illness, and her roommate into normalcy,

Keren and her roommate redefine the terms by bringing them together. Keren's quintessential symptom of schizophrenia is contextualized into a friendly banter in which both she and her roommate are complicit. In this shared agreement, normalcy and illness become indistinguishable, removing the risk that Keren was facing.

5.4 What about kids

Keren's definition of herself as both "normal" and "ill" shapes her reproductive desires and experiences. On the one hand, she wants to have children. On the other, she lists all the reasons why she might not do it.

... If I could [have children] in a way that it was possible. If I knew that it was safe, healthy, and that I could raise it well with somebody else, then yes, I would like to have a kid. I would like to. If I don't have all my ducks in a row, if there's not a person, if things don't work ... If I can follow a plan of action that I think would be responsible and suitable and good for a child, then yes. If I'm not stable enough, if there's no one with me, if I don't have a responsible way to do it, then I don't think it's a good idea. I don't think that would be good for me or the child. I think everybody would want to raise a child in a very good environment. I wouldn't want to be the schizophrenic single with a kid. Stuff like that

When Keren thinks of motherhood, she does not think of having, carrying, and raising children. Her reproductive deliberations are made in relation to a specific model of motherhood - that of the "good mother." Keren must first achieve stability and support to be a good mother who constantly manages risks through self-regulation. Only then will she be able to avoid the immoral mothering of the "schizophrenic single mom."

Like most of the women in the study, Keren's reproduction is nowhere and everywhere. Despite the omnipresence of motherhood in society, there is little talk about it with Keren. In

fact, Keren can think of only three occasions when her reproduction was brought up. All were fleeting exchanges, one with her mother and the other with her psychiatrist. Keren's stories of these interactions show how ideas about her “illness” and “normalcy” shape other people’s expectations of her reproductive future.

Keren’s mother shares Keren’s rejection of motherhood, although in a more definite way. While Keren believes that she has a choice in her reproduction and that she could, if she wanted, be a good mother. Her mother believes Keren is incapable of good mothering and should not be a mother. Though reluctant to accept Keren’s diagnosis, her mother later came around and now views Keren as severely mentally ill. This feeds into her rejection of Keren’s reproductive choice, adamantly believing that Keren should not have children. This rejection of Keren’s potential motherhood is so strong that her mother does not think it merits any discussion. Instead, the two have a short exchange at a family event, in which Keren’s mother declares to Keren, “Oh you’re never going to have kids, right?” as if there is nothing to talk about.

Unlike her mother, Keren thinks her psychiatrist agrees with her definition of herself. Because of that, Keren uses him to gauge suitability to be a mother, both normal (age) and illness-related (medication).

Though Keren planned to have children in her 30s, now that she has reached that age, she is revising her plan by a decade

people have kids in their 40s. I think things kind of shifted as you get older, all those things ... “I know he [Keren’s psychiatrist] has kids that are very, very young and he’s turning 50. Like his oldest kid is maybe seven years old. So, he had kids very late in life. He’s told me about them

Keren looks at her psychiatrist for proof that - at least when it comes to age - she can be considered “normal” even if she became a mother at an older age. Despite the psychiatrist’s role

in Keren's reproductive plan, the two never discussed the topic. Keren remembers only two brief exchanges between them about her reproductive future. One focused on her reproductive desires

I don't think we've ever spoken about kids ever. He might have asked me [about kids], but I think I just went, "Eh", and another on medication - "I once asked him if you could be on medication and have children and he said, "You can"

While the psychiatrist's reproduction is (literally) visible via family photos in his office or stories about his children, Keren's reproductive health, desire and options are absent from the interactions. One can interpret the lack of discussion about Keren's reproductive health as a sign of normativity. Reproduction is seen as a personal decision that has nothing to do with psychiatric expertise. Just as people without mental illness can decide their own reproductive life, so are psychiatric clients. By removing any psychiatric intervention, psychiatry is normalizing their patients' reproduction. Others disagree with this argument. Where psychiatry sees neutrality, they see avoidance. They argue that because mental patients are already marked as "ill," their reproduction is positioned as undesirable. Psychiatry has the power to change it by creating the conditions to make their clients' reproduction normative. Therefore, by not addressing the matter, psychiatry is, in fact, actively disapproving of their reproduction and cementing it as undesirable disabled reproduction. Instead of normalizing reproduction, the psychiatric silence around it further disables it.

Of course, for Keren, normalcy, and illness are connected. Keren recognizes that she has not had children yet partly due to her mental illness. But the link goes deeper than circumstantial. Every step outside the normal could be used as evidence of Keren's illness. She needs to not only take care of her illness but do it in a way that would make her fit into normalcy. Having children

outside of normal expectations might propel Keren into “immoral” motherhood even if she did everything right about her illness.

Stepwise plan: untangling the knot?

To achieve the stability and support required for good mothering, Keren comes up with a two-step plan. She will find the medication that is safe for the prenatal, pregnancy, and postnatal period and have a partner. Only after these two steps are fulfilled will she pursue her plan to have a child. Without this, her motherhood will be undesirable:

I would like kids, if I could handle them, I don't know ... maybe, maybe, one day. But I don't know how I could take medicine and have a kid, because I wouldn't want to go off meds and be pregnant. That would just be like psychopath, oh my God. That would be great. Off meds and baby hormones would just be insane

Keren's inquiry with her psychiatrist about safe medication is a step toward good mothering. It represents her adherence to risk and expert advice on its management. The lackluster response she received did little to reassure her that she was on the correct path to responsible parenting. The neutral position that her psychiatrist assumed left Keren at the helm of the interaction. At the same time, Keren's calculation of normalcy and illness suggests that further inquiry into her reproductive options could make her seem too ill for motherhood.

In place of further conversations with her psychiatrist Keren looks at her peers to learn about medication and reproduction. These interactions help her give meaning to the statistical data that her psychiatrist used for his response. One such interaction involves a woman who took psychotropic medication during pregnancy and whose child is autistic

She was on that antipsychotic, had a kid, and now he's autistic. That makes me anxious. She said that the pill she was on she was told was absolutely fine. But I mean, a lot of kids are autistic, so I mean ... That just goes into my head

as oh no, is that why B is autistic? ... I think I just have too much anxiety to have a kid because I don't want to be off meds and I don't want to mess up a child and stuff like that

Despite her psychiatrist's assurance of the safety of her medication, Keren is worried. The possibility that her friend's son's development was harmed by the medication she was told is safe to take during pregnancy leaves Keren anxious about her reproductive options. She realized that she was in a bind. To be a good mother, she needs to take medication. But the same medication can also cause harm to her child - a thing that she does not want and is contradictory to good mothering.

Keren's plan for reproduction is already facing a challenge to which she has no answer. The second part of Keren's dread of being "the schizophrenic single mom" points to the importance of shared parenting.

I don't know ... That's a lot of work. I see my friends and my family and stuff and they're like ... That seems like a lot of work for one person. I don't know if I could do that on my own...

I would have to find a guy to raise a kid with me that could be a daddy. But I mean, I would just need help. I don't want to raise a kid on my own, for sure

As with being stable, the prerequisite of having a partner proves to be more complicated than it first seemed. Keren has never been in a serious relationship. Unlike other things in her life, Keren is bothered by her failure to form relationships. In fact, when we initially asked her about relationships, she shut it down and asked to move on to other things. Later in the interview, Keren opened up and talked about her ex-partners, which she does not consider meaningful to her life.

Keren is bothered by her failure to form relationships and thinks she is to blame. She says, “I’m just bad at them [relationships]. Just not good. I can’t make a good relationship happen. I have no idea. I don’t know. I just can’t do it. I don’t know. I just never could make it happen. I don’t know. I just can’t get people to stick around, or I don’t know.”

Conclusion

Stability and support are part of normative reproduction but are also related to Keren’s illness. Stability is needed to curtail the irregularity of her schizophrenia and support to overcome other challenges her illness creates. However, the more Keren talks about them as steps to fulfilling her wish to be a mother, the further they get from her. Stability requires medication that could harm the fetus, and forming a partnership is something that Keren is “not good at.”

Keren is aware of the fantastical quality of her reproductive desires and jokes that “if it’s never right, then oh well, you know, whatever...I got other people’s [kids] to hang out with”. Nonetheless, this lighthearted response does not fit her wish to have children. At other times during the interview, she said, “I try not to think [of the possibility of not finding a partner or safe medication] because it’s too stressful.” And of the chance that she will never have children, Keren says, “I think I would be upset. I think I would be upset”.

This gap between wanting to have children and knowing she might not be able to forces Keren to reevaluate herself. She realizes that the scaffolding that helped her achieve a self that is both normal and ill (medication and support) cannot be used for reproduction. Because of that, she must decide on one or the other. Either she is ill and therefore unfit for motherhood, or she is normal and therefore unfit for care. Faced with this dilemma and knowing it, Keren chooses to press on.

Not wanting to give up either part of herself, Keren reframed the situation. She turned not-having-children into a choice. Reminiscing on the tedious and unwavering task of raising children and referencing her history as a “difficult child,” Keren lays the groundwork to argue that she does not have children because she is disinterested in them and in the demands of parenting. This reframing borrows from “normal” parenting views and avoids the illness that makes it impossible.

Chapter 6: Women's dilemma: am I ill or normal?

I just was like, “Okay, well, everyone else has babies. Why shouldn't I?” I like to tell myself just because I have bipolar doesn't mean that ... There's nothing I can't do because of it. But part of me does kind of ... I don't think that I can't have, it's a bad idea to have kids. It's just, it's harder. It's a lot harder...

Shira (33, married with children, bipolar)

Shira's questions about the relationship between her mental illness and her reproductive choices are not unusual for women with psychiatric diagnoses. Many women, and all the women in this study, grapple with similar thoughts. They wonder whether their mental illness means they should not be mothers and what say they have in the matter if any. The stance of neutrality and patient choice that characterizes medical care in general, and mental health care in particular, renders providers ill-suited to answer these questions.

Our first finding will show that these women are unable to obtain clear answers; they turn to narratives of normalcy and disability to better understand themselves and their reproductive options. Women whose narratives leaned toward normalcy described their reproductive decisions (whether in favor or against having children) as separated from their mental illness. They framed their reproductive desire as separate from their mental illness and rejected the idea that their psychiatric health should define their reproductive life. Other women used a different approach. They drew from narratives of disability to explain their reproductive experiences, linking the two together. In these narratives, mental health and reproductive decision discussions mix, entangling one from the other. The link between these women was sometimes so strong that they could not tell precisely how their mental health impacted their reproductive decision and where the two

were separate. More than women who leaned toward narratives of normalcy, these women emphasized risk in their reproductive thinking, thus echoing narratives of disabled reproduction that equate disability with child, mother, and social harm.

Another important finding of this study is that narratives of normalcy and disability did not meet diagnostic categories. Women with the so-called Severe Mental Illness (SMI) did not always see their reproduction as unwelcome, and women with Depression and Anxiety did not necessarily think of their mental illness as separate from their reproductive health. The stories the women told show that women with different diagnoses of mental illness - including categories of severity - sometimes made similar reproductive decisions or provided similar narratives to their decisions. The other side is true as well. Women with similar diagnoses did not always reach the same conclusion about their reproductive health. In other words, despite the focus on diagnosis or severity in psychiatric writings about reproduction, women's real-life narratives did not align with clinical categories.

Next, we will complicate our earlier argument by showing that the heuristic categories of normalcy and disability that women use in their stories tend to blur into each other. Women's narratives of their reproductive decisions evolved or changed during their interviews. What might seem as belonging to one category turned out to display the characteristics of another. Some women started their interviews by explaining their reproductive decisions in normative terms, separating them from their mental illness. In other cases, women began their story by referring to their mental illness as central to their reproductive health, only to pursue other, more "normative" reproductive narratives. However, as they continued to talk, these two parts of their lives came together, showing that despite the initial differentiation, their reproductive experiences and mental illness were linked.

Finally, we will argue that more than “mental illness,” the women in this study engage with the idea of the “good mother” in their thinking. Shira, with whom we started this chapter, encapsulated this in the second part of the quote above:

Just really. I just truly want the ... It's so hard when [because] you want the absolute best for your kids. When their mom is not at their absolute best because she has a mental illness, it's hard to take that. If you could look through a catalog and be what you want for your kids in a mom, most people aren't going to sign up for a mom who has bipolar disorder with irritability. You don't want to be an irritable mother, you know? It's disappointing

Indeed, whether a woman saw her reproduction as normal or as disabled was primarily driven by how she measured herself compared to the “good mother.” Taken together, these mental calculations both strengthen the exclusionary power of the good mother and offer a critical examination of it. Women who saw their illness as the antithesis to practices of good motherhood accepted the exclusionary power of the “normal.” At the same time, other women used vulnerable resistance to reshape it by incorporating their mental illness into good motherhood. To be clear, these women did not brush their mental illness aside. Instead, they created space for it in their motherhood while asserting that they are, indeed, good mothers.

This chapter will examine women's narratives regarding whether or not to have children. First, we will attend to the narrative of women who identified their reproduction through the terminology of risk characterizes disabled reproduction. We will show how they measure themselves with the good mother and how this mental calculation informs their decisions about reproduction and their understanding of their mental illness. Next, we will discuss women whose narratives separated their mental illness from their reproductive decisions. Some women chose to have children, while others opted not. Regardless of their reproductive decisions, the rationale

they used was of normal reproduction. Of those who chose to have children, we will show the mental hoops they had to go through to negotiate an image of themselves as good mothers despite their illness.

6.1 Narratives of disability

Dorit, a 40-year-old science professor who is in a long-term heterosexual relationship with a man who has a child from a previous marriage, explains her decision not to have children of her own:

I've known for a long time, since I was about 14, that I didn't really want children of my own and as I got older and thought about a lot of the issues of having children. To be honest, my mental health status actually was partly a factor in my decision. I've known that I had depression completely for most of my life, and honestly, I didn't really want to inflict that on somebody else

Not only is Dorit concerned about her mental illness when it comes to motherhood, but her partner's newly diagnosed depression also adds worries for the well-being of their potential children. Since his diagnosis some years earlier, her husband no longer suggests that they have a child together.

We've had more discussions, and his diagnosis and his acceptance of having major depression has also influenced his perspective on having children because he doesn't want to do that to anybody else, either

Regarding herself and her husband, Dorit worries about "inflicting" depression on her child, though what that actually means is unclear. Whether Dorit worries that her child will experience depression firsthand or by proxy, it is evident that Dorit sees depression as harmful. So much so that she would rather not have a child than have one who will be affected by it.

Nonetheless, when we asked Dorit to describe how her mental illness impacted her life, Dorit gave a surprising answer. She does not think that her mental illness was a particularly bothersome part of her life, and in some ways, she even credits her successful career to it:

It [mental illness] has been a huge influence on the development of my internal picture of who I am. It is a huge part of who I am. I recognize that and I'm reasonably comfortable with that. I don't actually even really want it to go away because I don't think I would recognize myself . . . This is fundamentally important to who I am, and it is a huge part of who I am. That's just me. It did not stop me from getting a PhD in sciences and being an active researcher and having a career that I greatly enjoy teaching at the university. I didn't so much as fight through this as I just kind of hung on with persistence for a lot of that

How come Dorit, who does not think that her depression inhibited her, finds it so concerning when it comes to her reproduction that she (partly) bases her reproductive decision on it? How does Dorit hold these seemingly opposing views?

The answer is the idea of a “good mother.” Like Shira, when Dorit considers motherhood, she thinks of good motherhood. As a good mother does, she wishes to protect her child from harm. Dorit must then consider her mental illness not from the perspective of the individual but as part of the relationship between herself and her potential child:

Whether or not I choose to go to graduate school, that has to do with my life.
Whether or not I choose to have a child, that impacts somebody else's life.
That's where that difference lies for me. Between the choices I make for myself versus the choices that I would make that would impact this growing and developing human being

From the perspective of the good mother, Dorit's mental illness, while not devastating for herself, is a pre-conceived (pun intended) damage to a child. In Dorit's thinking, her depression

prevents her from creating the optimal conditions for her child, thus standing in the way of becoming the good mother she wants to be.

This part of Dorit's story captures a trend in other women's narratives. Whichever way they framed their reproductive decisions, women engaged with their mental illness in coexisting and sometimes contradicting ways. In Dorit's case, her mental illness is both a barrier and a strength. It is part of who she is and, at the same time, irrelevant to what she has accomplished. While Dorit can hold on to this contradiction when it comes to herself, she cannot sustain it for her child. Because reproduction involves another person, Dorit is compelled to conclude. What is the meaning of her mental illness? Does it allow choice, or is it a source of risk? Her decision to avoid motherhood because of her mental illness suggests that Dorit accepted Disabled reproduction's view of her mental illness as a risk. Once she accepted it, Dorit had no choice but to denounce motherhood.

6.1.1 Narratives of direct and indirect disabled reproduction

Women drew a direct line between her reproductive decisions and her mental illness, other women made more complicated connections.

Noga, a 49-year-old professional writer, diagnosed with clinical depression, is one of these women. In the story she told, reproductive choice is, directly and indirectly related to her mental illness. Narratives of disabled reproduction appear side by side with narratives of normal reproduction. However, as we will see, the latter obscures Noga's reality of living with a mental illness and, therefore, is not entirely "normal."

Already at the beginning of the interview, Noga talked about her reproductive decision:

So now I'm 49 and I've done a lot of work over the years to better get an understanding of who I am, what I came from, what works for me. I don't have children, and that's where maybe too where I was ... I thought it'd be

interesting to talk to you because I have had some feelings that might be different than the other people around wanting to have children or whether I should or whether I could, and ultimately, I made the decision not to have children and there was definitely a lot of consideration given to my own mental illness in that decision making process

How does Noga connect her mental illness to her reproductive health? First, she talks about genetics. Considering her mother's mental illness, Noga considers the familial trajectory of mental illness and the risk of passing her illness to her children. Beyond the genetic risk, Noga is concerned about her ability to be the good mother she would like to be. She believes that motherhood and the demands of managing her mental illness are in contradiction, that to do well in one, she would have to give up on the other.

I really did have concerns that not only could I genetically pass on some mental illness, but that given my own mental, at times, fragility, that it would be extra difficult for me to parent, and so I just never felt that I could . . . I just could not ever envision myself in that role and doing it well, or that perhaps I would do it well, but it would be at the expense of my own health and well-being.

When Noga found out that she had fibroids and needed to have surgery, she asked to use the opportunity to get a hysterectomy. Her husband, who had a vasectomy only three years earlier, was with her. When she woke up from sedation, her uterus was the first thing on her mind.” Literally, when I woke up from surgery. She [surgeon] came to see me, I said, “Do I have a uterus?” And she said, “Nope. You weigh less though”⁵.

⁵ Noga's positive view of her hysterectomy as liberating reflects the continuous work of avoiding pregnancy. In “Childfree and Sterilized: Women's decision and medical responses” (1999), Annily Campbell discusses the social and medical experiences of women who chose to remain childfree. Though the advance of contraception gave these women more control over their sexual and reproductive health, it also required ongoing work to administer, manage and acquire them. Moreover, because access to contraception is controlled by medical providers who are often hesitant to believe women's desire to remain child-free, these women must negotiate their decision every time they

Although Noga opened her story by making an unambiguous link between her depression and her reproductive decision and asserting that she is “different than other people,” she later offered a more normative explanation of her reproductive decision.

I guess also, to be fair, part of it is that I also grew up as quite an independent and adventuring sort. I like my solitude and I like to travel alone, and it was important enough to me that I felt like I didn't want to give that up to be a parent, to be a mother, because I guess it also is very closely tied to my well-being, my identity and my well-being. So, for sure I have some of the standard garden variety selfishness or self ... just what do I want for my life questions that everybody goes through, and mothering didn't seem like it fit in for me lifestyle-wise, but then, like I said, the other part of it is the ability to cope, and how would I cope?

Women who opted into childlessness explain their decision as a personal choice to maintain their lifestyle, their freedom, and their “spontaneous mobility” (Blackstone and Stewart 2012; Campbell 1999; Harrington 2019). While some women recount being uninterested in motherhood from an early age, others chose childlessness as they grew up. Whichever the case, women who avoid motherhood - particularly those who live in traditional heterosexual marriage - are often seen as “selfish,” too occupied with themselves to sacrifice it for a child. In this context, Noga's use of “selfish” to describe her decision to avoid motherhood is normalizing in two ways; it reframes her decision as a “choice” and acknowledges it as “abnormal” (though not “disabled”). By referring to her decision to remain childless as “selfish,” Noga moves away from the narrative of disability that she used earlier that suggested that her mental illness was a barrier to motherhood, to a narrative of normalcy, in which childlessness is a choice.

require contraception. In this context, the permanent removal of the woman's reproductive capacity is seen as freeing.

The question Noga raises at the end of the quote captures the complexity of her reproductive experiences. Is her decision not to have children driven by her mental illness, or is it a lifestyle decision situated within - though on the fringes of - normative reproduction?

The answer lies in an anecdote she tells of her forthcoming book. When her publisher asked her why she does not talk about not having kids in her memoir, Noga paused. She realized that her decision not to have children was not as obvious as she thought it was.

I said, “You know, I think I could cover it [not having children] in a paragraph or two,” because it was really never a big ... I mean, it was the big consideration, but I didn’t go back and forth on it. I didn’t struggle with it for years and years and should I or shouldn’t I have children. I just always felt that I just wasn’t the kind of person to have kids, and part of that, when I say kind of a person, I just felt I wasn’t equipped to be a fully engaged mother and to also retain my own mental health in the process

Noga’s argument that she wasn’t “the kind of person to have kids” tells us about how she sees her mental illness, lifestyle, and reproductive decision. For Noga, her lifestyle and her mental illness are related. The lifestyle she cherishes results from- and responds to- her depression. Viewing it that way allows us to normalize and disable her story simultaneously. Noga’s garden variety concerns are as normal as could be and, at the same time, a disabling narrative. For Noga, her life is inseparable from her depression, and so are her reproductive decisions.

6.2 Mixing normative and disabled narratives

The mix of normative and disabled narratives in Noga’s story reflects a larger trend among patients with mental illness. Sue E. Estroff and her colleagues from the Department of Social Medicine at the University of North Carolina, Chapel Hill, interviewed patients in a psychiatric hospital to learn how they understand their Self concerning their mental illness. They

found that patients interchangeably use two ways to talk about themselves. One is by evoking their illness, the other by claiming normalcy in illness-identity statements patients reflected on their Self through descriptions of illness and symptoms. On the other hand, normalizing statements were those in which patients referred to themselves as normal, placing their illness and symptoms on a spectrum of normalcy. Using both types of statements interchangeably, patients challenged the categorical distinction between normal and pathological and undermined the clinical focus on self-labeling as a measure for insight. The authors concluded that instead of interpreting normalizing statements as evidence of a lack of insight, clinicians would be better off seeing them as an indication of a desire for normalcy (Estroff et al. 1991).

A similar observation, and more tightly linked to reproduction, is made by Roberta J. Apfel and Maryellen H. Handel in “Madness and loss of Motherhood: sexuality, reproduction, and long-term mental illness” (1993). This book, geared toward clinicians, describes the desire for normalcy that is folded into patients’ desire for motherhood. They explain that women with chronic mental illness wish to have children as part of a desire for normalcy “normal has the meaning of being usual or regular, and free from a mental or emotional disorder. Paradoxically, the very people we consider abnormal because of their mental illness have a subjective sense of Self revolving around normality. Their desire to be ordinary and usual is often quite clear, even in the midst of a thought disorder, and normality is a central life goal for many individuals who have a chronic mental illness (ibid: 2)

While Apfel and Handel assume that all women wish to become mothers, Noga’s story shows that it is possible to use narratives of normalcy to reject motherhood, not desire it. Like the patients at the hospital, Noga’s mixed narratives of disabled and normative reproduction do

not represent a lack of insight into her illness but a complicated framework with which she negotiates a reproducing self.

The link between Noga's mental illness and her reproductive decision is most apparent when she reflects on her life. Having gone through extensive treatment, Noga no longer feels that her depression defines her. Though she does not regret her decision not to have children, nor does she think that it was the wrong decision to make, being able to see herself through lenses that are more accepting of her depression introduces new feelings to her reproductive biography "for me now it elicits some sadness that I've never known the role of being a mother, that I've never had that kind of a relationship or bond with a child."

As in Noga's story, narratives of disabled reproduction often exist in tandem with those of normalcy. Rarely do women explain their reproductive decisions solely on their mental illness. Instead, they draw from various parts of their lives, notably their lifestyles, health, and relationships.

The following case gives another example of a mixed narrative though a more conflicted one. Meital (40 years old, single, schizoaffective disorder) feels torn over her decision not to have children. To solve this conflict, she turns to the ableist framework of age as the natural advancement of time. Doing so allows Meital to hide the social interactions that linked her mental illness to limited reproductive options.

Meital does not have, nor does she plan to have, children. Despite loving children and wishing she had some of her own when Meital looks at her life, she does not see children in them. Like other women who wish to avoid pregnancy, she describes being pregnant as her "biggest fear." She tells of a psychotic episode in which she was (falsely) convinced that she was pregnant and had to be admitted to a psychiatric hospital.

Why does Meital, a single woman with a graduate assistance degree and a steady job, so vehemently refrain from motherhood? Meital explains it as having to do with “both” her mental illness and her “personality.” Yet when each of these explanations starts and when they end is unclear. See, for example, Meital’s explanation of the “personality” side of her decision:

I think it’s personality because I did try to go into teaching and I don’t know, I mean it’s not that I don’t like kids, I like them, but in that whole group setting it was really stressful. Sometimes I feel sad that I’m not going to have them but then the logical side says, “Well, you know you can’t even really support yourself, how are you going to support a kid and then a guy and all that?” So, I just don’t think I’m really cut out for it

A similar mix of normative and disabled narratives appears again when Meital attempts to describe what makes her ill-suited to motherhood. Like Noga, she refers to her wish to maintain her lifestyle instead of having children as “selfish.” Though Meital begins by talking about a personal inclination toward child rearing, the quote finishes with a question of ability.

... you know I like to work. I’m not the type of woman that wants to stay home all day with the kids. I would feel really selfish doing that. And I sleep a lot too. Weekends come, my butt is in bed until like ten, 11 o’clock in the weekends. Yeah. And I’m like, “I can’t imagine getting up with a screaming baby and then having to go to work the next day.” What if I’m too much of like permissive parent, I feel bad disciplining them and everything. But I guess I just always felt like that’s what ... I didn’t want to do it. I thought it would be too stressful

Sleep, work, and concerns about parenting are not unusual worries regarding reproduction. Many people think of these parts of their life when considering having children. However, for Meital, these seemingly normative concerns carry another meaning. Earlier in the interview, she summarized her feelings toward motherhood by saying, “I don’t feel well enough

to have them [children].” This is because Meital’s sleep, her status as a single woman, and her stress are tied to her mental well-being. They are an outcome of her illness and the very thing that keeps her well. In Meital’s point of view, they are also the things that stand between her and motherhood:

I would say a lot of it [worries about having children] has to do with it [mental illness] because I feel tired a lot and I don’t have the best relationships with men, and I don’t think it would be wise...I guess I just feel like I couldn’t treat it [a child] properly. I would be a bad mother and then that would make me feel bad

Meital’s mixed narratives of normalcy and disability find a shared conclusion when met with the demands of good motherhood. Whether related to her experience with mental illness or her personality, they prevent her from being the mother she would like.

Unlike Noga, whose decision not to have children did not elicit much hesitation, Meital describes a continuous process of self-reflection in which her mental illness and motherhood were placed against each other. That choice does not represent a singular moment, but a continuous process is documented in other reproductive contexts. One is of people who chose to limit their family size to zero or one child due to environmental concerns. A study into their reproductive reasoning showed that most participants examined their reproductive futures at least once. In most cases, the re-evaluation concluded with an affirmation of the participants’ initial inclination toward reproduction. In their conclusion, the authors note that this reproductive decision “should not be viewed as a definite choice made at one specific time. Rather, it is a choice that is under intentional development” (Nakkerud 2021: 206). Introducing time into reproductive choice opens the door to multiple explanations. Nakkerud found that though participants referenced their environmental concerns as the primary reason for their reproductive

decisions, they tended to accompany those explanations with other, more mundane, reasons such as disinterest in the role of parenting, dislike of children, and biographic experiences (Nakkerud 2021).

Though Meital says she always knew she was not fit to be a mother, her feelings toward peers who chose to have children changed. She became less demanding and more open in her thinking and encourages others to acknowledge the responsibility that comes with parenthood and discuss it thoroughly before having a child. Regarding her reproductive history and future, Meital talks about being conflicted. She describes feeling sad and relieved at the same time. Now that she is 40, Meital uses her age to solve that conflict. When she says, “I’m going to be 40 in May, so I think that I’ve missed my opportunity [to have children] anyway, so ...” she is reframing her reproduction—moving it away from choice, into biological forces beyond her control. Though this might strike us as the natural procession of time, we would be remiss to ignore the relationship between age, reproduction, and mental illness.

Meital did not become a 40-year-old-single-woman-with-no-children overnight. She was made into one over a lifetime of attention to her mental illness and an equally staunch absence of attention to her reproductive health. The role of age in shaping reproductive life is a common thread among women with mental illness. As we will see later, when discussing the stepwise plan for reproduction, age plays a central part in reproductive decisions, either to delay reproduction or to explain why it is no longer a viable option.

In Meital’s story, we see how inattention to women’s reproductive life can work to narrow their options. In all the years of mental health disturbances, Meital recalls only one time when a mental health provider mentioned her reproductive health. This was when her psychiatrist mentioned that her medication was safe during pregnancy. Even her pregnancy-

scare-psychosis did not elicit any discussion, in the hospital or outside it, about her reproductive desires and options. Though Meital does not think of her psychiatrist as a source of support for her reproductive health, she believes a therapist could be. Her old therapist did mention to her once that they believed that Meital could be a great mother. While Meital would have liked to explore her options regarding motherhood further, the high co-pay makes therapy inaccessible to her, thus closing the door to an essential source of professional information and support.

Looking at Meital's age in the context of her meant health biography, it becomes clear that her current parental status is not the result of the natural progression of time. Instead, it was created through social interactions (and lack thereof) in which her mental health was cemented as the priority and her reproductive health as unimportant. When Meital talks of her age as a "biological take-over" of her reproductive choice, she erases the social forces that brought her to this so-called point of no choice. By reflecting on her age as the natural end to her reproductive choice, Meital attempts to remove her childlessness from the thrones of disabled reproduction and place it under normative assumptions of biological development and reproductive age.

Unfortunately, while Meital's age solves the tension between disabled and normative reproduction, it does not normalize her. She feels she stands out in society because she does not have children. To deal with the feeling that whatever she does in her reproductive life, she does not fit in, Meital surrounds herself with other childfree women and men. This "counterculture" social network (as she calls it) she created for herself is the only place Meital feels secure. It is there that she finds the support and understanding that mental health professionals were unable to give

My friends, female friends that are older than me, they're the ones that I'll go talk to about this stuff. The shrinks, not so much. They don't want to push me, I think. I think that's what it is

Meital lives by herself in an apartment that she rents. She is educated, and she has a rich social life. Indeed, even amid mental health episodes, she says, “I functioned. I got up, I worked every day.” It is precisely because Meital is doing well that she feels she cannot have a child. She believes that managing her illness does not go along with the demands of “good motherhood,” forcing her to choose between sacrificing her well-being and forgoing motherhood. However, this is a false choice; Meital has no way out from being cast as “different.” She believes that if she pursues normal reproduction - as normal adulthood prescribes - her mental illness will overshadow her devotion to her children and bring her back to the realms of disabled reproduction. However, her choice to maintain normalcy by refraining from motherhood emphasizes her difference as a childless woman and again casts her outside of what expectations of normalcy.

6.2.1 Mid conclusion

Dorit, Noga, and Meital's reproductive and mental health accounts show a strong connection between their mental illness and their reproductive decisions. The stories they tell are upfront about the impact their schizoaffective and depressive disorders have on their decision not to have children. The mechanisms they describe by which their mental illness impacts their reproductive decisions are direct and indirect. They included feeling unfit for motherhood because of their illness, concerns about medication, and genetic heritability. Other links were less evident in their connection to their mental illness. Love of travel, need for a long sleep, age, and unwillingness to disturb a chosen lifestyle were described as more "normal" arguments for not wanting children that exist alongside their "disabled" arguments. However, a closer look revealed that these reasons for choosing to be childfree, which assign the women "normal" reproduction are also a way to hide the truth about their lives with mental illness. Dorit, Noga,

and Meital link their "normalcy" to successfully managing their mental illness. They believe motherhood jeopardizes this balance and threatens to cast them into the realm of the undesired, i.e., disabled reproduction.

Before we move to the next group of women, who describe their reproductive decisions as independent from their mental illness, it is important to point to the diagnosis issue. Notice the similarity in these women's accounts despite their different diagnoses. While Meital's diagnosis is often labeled "severe mental illness," Noga's depression is sometimes mocked as the illness of "the worried well." The diagnoses are also different regarding reproduction. Bipolar and schizophrenic disorders are believed to have a hereditary component, while the heritability of depression is much less substantiated. Nonetheless, the women's concerns about motherhood - and their decision to avoid it - do not reflect these differences in their diagnoses. This shows that diagnostic labels do not fully capture experiences of mental illness and that scientific knowledge about reproductive risks is not a sufficient explanation for women's choices. Instead, Dorit, Noga, and Meital, as well as the other participants in this study, use their personal experience, biography, knowledge, and resources to give meaning to their mental illness and, consequentially, their reproductive capacity. As Rapp shows in her study of women's decisions around amniocentesis, women confront the moral questions about membership in a society that their pregnancy raises through their idiosyncratic lives. Rapp's conclusion that "the limits women individually placed on normalcy for entry into the human community varied considerably according to how they interpreted the severity of the specific diagnosis, and how they imagined their responsibilities, powers, and aspirations as mothers" (Rapp 2002: 308) seems to be true for the participants in this study as well.

6.3 Narratives of normalcy: claiming desired reproduction

6.3.1 Stepping away from mental illness

While some women's descriptions of their reproductive decisions lean toward disabled reproduction, others frame their stories with ideas of normalcy. They invoke affection for children, normative adulthood, or family size, to claim good motherhood in the presence of their mental illness. Building on Rafaela Granja Manuela Ivone P. da Cunha and Helena Machado (2015) research, we argue that through creating normative space within their otherwise disabled reproduction, these women perform "vulnerable resistance."

6.3.2 Vulnerable resistance

Granja, Cunha, and Machado looked at the narratives incarcerated women in Portugal use to describe their motherhood. Confined with the reproductive technology that is the jail (Sufrin 2018)⁶, these incarcerated women both accept and resist their castigation into "bad mothers." On the one hand, they accept the framing of good motherhood as individualized responsibility and carry guilt and self-blame over their failure to act as it prescribes. At the same time, the individualized framing of good motherhood allows them to circumvent the structural barriers that being in jail places on their motherhood. Their actions toward their children, who are in foster or adoptive families, leave room for them to do "good motherhood."

First and foremost, they define themselves, not the caretaker of their children, as "primary mothers," making biological relatedness the basis of true motherhood. Second, they perform rituals of good motherhood. They talk about feeling frustrated that they cannot help their

⁶ In Sufrin's study of incarcerated women in a California jail, she refers to jail as a sight of reproductive technology, in which reproduction is managed, supervised, created and recreated through rules, programs, and the actors that inhibit it. Viewing jail as a reproductive technology, surfing argues, allows us to observe how it negated normal, desirable motherhood and recreates it. For some women, the jail's is the only place in which they can perform "good motherhood", because it is the only place where they are removed from the structural barriers that constrict their parenting in the community.

children when they are experiencing hardship; they frame sending money to their children as "providing for them economically" and perform attentive and supervisory parenthood by trying to keep tabs on their children's daily activities.

The women's attempt to access "good motherhood" extends beyond their relationship with their children. Their actions toward "good motherhood" should also be viewed in the context of the watchful gaze of child protective services and other supervisory gatekeepers, who is constantly assessing the women. By resisting the jail's power to subdue their motherhood, these women challenge the assumption that they are, and always be, unfit mothers. They use their actions to prove their ability to be fully-fledged good mothers in the community when they are released from jail.

Framing themselves as good mothers is the women's vulnerable resistance to a world that tells them otherwise. It is "a creative negotiation by which this particular group of underprivileged and criminalized women creates a space within which they can define themselves as "good mothers" (Sufrin 2018: 1227).

We do not, in any way, intend to argue that the barriers that incarcerated women experience to their reproduction are similar in magnitude or shape to those that the participants in this study face. Jail has no reproductive choice in it, whereas the very premise of this study is that its participants can choose, to a degree, their reproduction. Nonetheless, we find the idea of vulnerable resistance useful in this study. First, it refers to discursive and subtle resistance. The incarcerated women in Granja, Cunha, and Machado's study, and the participants in this study, do not see themselves rebelling against the larger forces that define their reproduction as undesirable (which does not mean that they are unaware of their subjugation). Instead, their resistance appears spontaneously in the narratives with which they describe their actions and the

symbolic meanings that they give them. Second, vulnerable resistance gives prominence to the position of risk in which these women exist. Jailed women depend on a large number of actors to enact motherhood. Any misunderstood sign of resistance to these actors can disrupt the women's connection to their children and their claim of good motherhood. The same thing is true of the participants in this study, who face the possibility of a diminishing agency if judged too ill. This risk confines their resistance, making it small, almost unseen. It also magnifies it, enlarging women's claim into a more extensive social critique of their embodied exclusion from desirable reproduction.

We will begin to untangle this argument with the story of Naama, a 40-year-old married woman diagnosed with bipolar disorder who recently celebrated her son's first birthday.

6.3.3 Strategies of normalization

6.3.3.1 Love

When asked about her decision to have children, Naama said, "I wanted to have children because I love kids. I love children. I'm super good with them. I used to be a Sunday school teacher. for like three-year-old, four-year-old, but it's like, when I was in high school. Yeah. Love it. Yeah. And um, did it like when I was in college, like I just love kids in general."

Naama's reproductive story cannot be more different than that of Dorit, Noga, and Meital. Where the last three saw a condition that makes motherhood suboptimal, Naama believes that she can be a good mother even with her bipolar disorder. To that effect, Naama replaces the image of the "crazy" mother that narratives of disabled reproduction produce with that of the affectionate and loving mother of normal and desired reproduction.

Indeed, motherhood as an act of love and a source of good is the cornerstone of normative reproduction. Darren Langdrige, Paschal Sheeran, and Kevin Connolly (2000) show

that, more often than not, women portray their desire for reproduction as driven by "love and affection to child." In their study of couples who were expecting a child or attempting to have a child through fertility treatment (IVF and donor insemination), they found that all 30 couples used intimate feelings toward a child as the main reason for their reproductive attempts. This includes the desire to give love, receive love, and have something "that is part of both of us." (ibid: 327). Love for children is found to be the central motivation to becoming a mother in Raji P. Grewal and John D. Urschel (1994) study as well. In this study, commissioned by the Ontario Ministry of Health, 133 Canadian women in different reproductive stages (trying to conceive, pregnant, and mothers) were asked about their reproductive decision-making. All of the women, regardless of their ethnic backgrounds, said they intended to become mothers. They explained their desire for motherhood as an emotional decision, most commonly citing love for children as the driving force behind their reproductive ambitions.

6.3.3.2 Normal adulthood

Sarah, a 29-year-old college student, shares Naama's blissed view of motherhood. Like Naama, Sarah is diagnosed with bipolar disorder. Regarding her reproductive future, Sarah, too, uses love when she says that: "I would love to [have kids]."

Using expressions of love for children as the ultimate reason to become a mother reflects Sarah's attempt to position herself at the center of normal reproduction and reject the narrative of reproductive risk that her mental illness imposes on her. Indeed, Sarah's framing of her reproductive desires as normative goes beyond affection for children. Sarah uses ideas about normal life stage, time, and age, to convey normal development into motherhood and dismiss assumptions that she is unfit to have children.

Summoning presumptions about normal adulthood and parenting, Sarah reflects on her development:

Growing up I was always like, they're loud. I would never want kids; I will never want kids. And people were like, "Oh, just you wait. Once you get to your late twenties." And then of course I did hit my late twenties and I'm like, "I want kids"

The narrative of normal adulthood suggests that to become an adult, one must first shed the selfishness of childhood and assume (and cherish) the responsibility of having a child. In this narrative, parenting is equated with a matured self and is seen as the pinnacle of desired adulthood (Harrington 2019). As we have seen earlier, this framework stands in stark contrast to the requirements of disabled adulthood. In it, responsibility and self-growth are marked by a denouncement of parenting, not its embrace (Kallianes and Rubenfeld 1997; Asch 2015; Gill 2015; Kulik and Rydström 2015). To be considered an adult, a disabled individual must first accept the immorality of their reproduction and agree that any desire in that direction is valid only as long as it is "constructed as a "wish" and not "reality"" (Gill 2015: 108).

Sarah's negotiation of normal reproduction takes place amidst a background that is anything but normal development into adulthood. Sarah's symptoms of mental illness began as early as first grade when she was profoundly depressed and suicidal. By 13 years old, her mental health deteriorated even more, and she later attempted suicide. Sarah spent her senior year of high school on medical leave and, after taking a gap year, started college. At this point, she was already experiencing rapid cycling - feeling deeply depressed one moment and elevated the next, on repeat. After an attempt at a semester abroad, Sarah's mental health became too debilitating and dangerous, and on an emergency order from a psychiatrist, she was sent to a psychiatric hospital. After weeks at the hospital, she returned home only to be readmitted again. She dropped

out of college and, over the summer, received two dozen electroconvulsive therapy treatments. By 21 years old, Sarah had spent six months in inpatient psychiatric units and was dealing with severe short term memory loss due to the ECT treatments. She was now living at a residential program for women with an eating disorder. Three months later, when she graduated from the program, she moved to a different residential program, where she remained for three years. At 25, Sarah could finally live independently outside of psychiatric institutions. Looking back at her life from her teenager to a young adult, she says

It's like if you fell into a coma when you were 12 years old, and you came out of it when you were 27. You've missed a lot...

Through her story of transformation from a younger and child-averse self into a child-loving adult, Sarah tries to distance herself from the image of the troubled mother that her experiences with mental illness place on her. She shows that even though the past decade of her life was defined by illness, her reproductive desires are unaffected by it and are, therefore, normal.

Another method Sarah uses to negotiate normal reproduction is the creation of temporal separation between her illness and reproduction. She talks about her life in the last couple of years as a new start toward everyday life, thus creating a break between her "disabled" past and her "normal" future

... I guess an adjustment, because you have not been adjusting to growing up as everybody else has." It's the thing is you're meeting me right at the point where it's kind of ending. This [bipolar] chapter is sort of closing and so I'm now sort of beginning the rest of it. And so, this kind of topic is what I'm thinking about now

Sarah believes that her tumultuous experiences with mental illness are history and that now she can fill the gap that those years have created and build a "normal" life. This temporal break is another tool meant to frame Sarah's reproduction as normal and refute claims against it. It allows her to hold on to the image of normal reproduction, love, responsibility, and social worth.

Last, to make her claim to normal reproduction even stronger, Sarah shows her ability to be a responsible mother. She does so by demonstrating her knowledge of baby care and, finally, looping back to love:

And I think every time someone in my life has a baby, "Let me get you a baby blanket. I know just where to get baby blankets." The best baby blankets. That's what I love to do, so. I do really want kids. I would love kids. I never thought I would, but then I did

Unlike Naama and Sarah, some of the women in the study became mothers before they were diagnosed with mental illness. In these cases, we were interested in their reproductive decisions following their diagnosis. Adva and Chava represent two of these cases.

Because both women started identifying as having mental illness after they became mothers, they did not reflect on the link between mental illness and reproduction in their earlier pregnancies. It was only after they were diagnosed that Adva (30, married, bipolar disorder) and Chava (35, married, postpartum mood disorder) formed their view on the matter. Despite the change in their mental health status, the two women retained their claim for normative reproduction as they sought to expand their families. Explaining their decision to have more children, they referenced ideas about the ideal family size. They wanted to have another child because they believed that having siblings is "best for the child" and, therefore, an act of good

parenting. Adva, who had a manic episode and a suicide attempt after the birth of her first child, said,

I always saw myself as having two . . . I have six brothers, so I'm very, having siblings was a really important part of me growing up

And Chava, who became dangerously depressed and suicidal after having her firstborn, said

[I'm] a big fan of siblings. I always planned on having more than one kid If I was going to have kids, because siblings are important

Chava's decision was also rooted in her experience of losing her mother at an early age:

This is gonna sound strange because my mom died when she was 58 and she had me when she was 36 . . . And I think that was what tipped the scales for me was realizing my age in comparison to hers . . . It was like the fact that I was 35 when I had her [Chava's second child]

Though we will later see that Chava and Adva did think about their mental health as they approached their reproductive health, their desire to have more children was explained as separate from it. Like Naama and Sarah, Adva and Chava used normative ideas about families and motherhood to negotiate their reproductive decisions. As before, these types of explanations allow them to frame their reproductive in normative, and therefore desirable, terms.

6.3.3.3 *Normative life stages*

Not all the women who claimed normative reproduction wanted to be mothers. Some women chose to avoid motherhood. Just as age is used to justify wanting children as part of good motherhood, it could also be made into a normative argument against motherhood. Having children beyond a certain age defies the "normative" idea of life stages and is also clouded with risk assumptions. Pregnancy at a late age is labeled as "high risk" and associated with harm to

the fetus, the child, and the mother. It is, as Joan B. Wolf (2010) writes, "a subject of bitter public debate about women's responsibility to produce healthy offspring and the ethical uses of reproductive technology" (ibid: 77).

Natalie, who is 52 years old and diagnosed with depression, defers her age when she reflects on her childlessness. She explains why she does not have children as a decision that was "almost made for me." Her first marriage at age 35 was to a man whom she thought "would not have been good father material." She later divorced and married again to a man who had two teenage sons.

Natalie and her husband discussed having a child together; she says, "We talked about having a child together. We decided against it only, not anything to do with my state of mind. It was because we were getting older. At that point if we had had a child, I would have been in my early 40s. We thought it was better not to start with a baby at that age. We wanted to kind of start winding down."

Though Natalie describes episodes in her life when her reproductive and mental health intertwined⁷, and instances in which she worried whether she could be a good mother while battling depression, she frames her decision not to have children as separate from her mental illness. Her age is a time to "wind down," not embark on motherhood.

Natalie's choice to use the normative time to explain why she decided not to have children should be viewed against Kafer's "Crip time." Deviating from the prescribed order of things, Crip time highlights disabled bodies/minds' tendency to "do too much of the wrong thing at the wrong time" (Kafer 2013: 35). Indeed, Natalie's story contains episodes of time disturbed

⁷ Natalie had a miscarriage in her first marriage which "was the catalyst of my mental issue going off the charts. I had severe, debilitating anxiety, severe depression..." Later on, and also in that first marriage, she had a pregnancy which she chose to terminate. She reflects on the mental toll of that marriage and abortion by saying "so I want to say that the abortion and the subsequent relationship issues exacerbated my anxiety and depression."

by mental illness. She even contributes her mental illness to having "missed her time" for reproduction. Yet despite that, Natalie does not think that her reproductive decision concerns her mental health. The way she sees it, her decision not to have children, reflects her normalcy, not her reproduction being "disabled."

6.4 Entangling normalcy and disability

Finally, Talya, a 33-year-old single woman with schizophrenia who works in the film industry, presents a mirror image of Naama's reproductive desires. She, too, does not think of her reproductive desires as having to do with her mental illness. Where Naama cherishes motherhood, Talya chooses to forgo it. She explains:

I've never had that urge to necessarily, like I know I grew up and I would have, do you know, friends, you know, in high school and stuff, talk about like wanting to get married and wanting to have kids and that has never been something that I'm like, Oh God, I really want to have a child and have like this perfect, you know, family style wise. Like that's never, you know, I'm more of, I want to have a life of adventure. And that just wasn't like a thing I wanted. Um, like I felt intensely about in any way. And even now, you know, people will make jokes saying, you know, is your biological clock ticking? Most people just want a kid, um, of their own. And I don't feel any of that. So, I don't think, yeah, it [not having a child] really affects me at all just because I don't have those feelings. Period.

Living openly with schizophrenia (Talya manages a mental illness social media platform), she has ample socially acceptable reasons for declining motherhood. Talya could have explained her decision not to have children by referencing the potentially hereditary nature of her illness or by reflecting on the toll of managing her illness. Pinning her decision to avoid motherhood on risk calculations would have painted Talya as morally responsible. It would also place her within the context of disabled reproduction and social undesirability, which Talya

rejects. Instead, Talya explains her decision not to have children through normal motivations, i.e., her feelings toward children and motherhood and her disinterest in being a mother of young children. Like Noga, she would rather have “a life of adventure” than be a mother to young children.

Through reflecting on love’s role in parenthood, Naama and Talya position themselves within expectations of normative reproduction. Naama, because of her love for children, and Talya, because of her disinterest in them. If love and wish to care for a child’s well-being are acceptable reasons to have children, then surely disinterest in children should be accepted as a reason not to have a child. Though Talya is not entirely within normal reproduction (choosing to avoid motherhood is still treated with suspicion and disbelief), her normal framework portrays her reproduction as a choice rather than a moral obligation to avoid risk.

As with Natalie, Talya’s story has more to it than appears on the surface. A closer look at her narrative reveals more of what Talya thinks of her reproduction. Though she gives normal reasons for not having children, she links them to her mental illness. Talya believes that her inability to “feel” is “part of just the schizophrenia or depression or whichever.” Her illness makes it so “that I just don’t really feel normal things that people feel.” The link Talya draws between the flatness of her feelings, and her reproductive decision goes beyond general disinterest in children. Talya thinks that her mental illness makes her less interested in having sex which makes relationships and reproduction harder to obtain: “The desire to have sex [inaudible] yeah, a lot of schizophrenics like just don’t have that desire. So that’s another reason. Like they don’t really care about reproduction. Things are connected, and they just don’t really care.”

Despite the link that Talya creates between her mental illness and her reproductive decision, she sees the two as separate. Not only does she reject the idea that there is an inherent

risk in her reproducing, but she also sees good in her motherhood, so much so that she considers adopting in the future.

6.5 Conclusion

The participants' stories reveal how women contextualize their reproductive capacity with their selfhood and mental illness. They show that women do not identify themselves through measures of severity, nor do they contemplate their reproduction through hierarchies of illness. By refusing to do so, these women challenge the notion that categories of mental illness describe inherently and profoundly different styles of being. Moll (2008) makes a similar argument when she writes that "diagnostic categories, however, are not based on what people are likely to want, but on what they might need" (ibid: 26). Taking a step further, we argue that the similarities in reproductive thinking between women with different diagnoses, and the differences between women with similar diagnoses, pushes the critique of diagnostic categories further. The misalignment between reproductive narratives and diagnoses destabilizes professional ethics and popular discourses that differentiate categories of mental illness into disabled and normal reproduction.

Instead of diagnostic categories, women use currencies of normalcy and disability to negotiate their reproductive framework. Despite the heuristic binary between normalcy and disability, women's stories incorporated both narratives. In their stories, women often moved between normalcy and disability in ways that both highlighted the dichotomy and blurred it. They talked of their diagnosis as a breaking point of the selves they needed to rebuild. They questioned what and how they knew themselves and, consequently, the futures that were available to them. For some, this break led to a re-evaluation of their life, while others moved passed it without overhauling their selfhood. Whether or not they created a new self, the women

contemplated the role of mental illness in their life. Many women used disability as the inverse of normalcy when they wondered how their mental illness would affect their life. They asked if they were still normal and wondered which life they should orient themselves to, disability and confinement or normalcy and choice. However, as their narratives developed, this opposition between normalcy and disability began to shutter. In some cases, narratives of disability and normalcy co-existed, suggesting a life that can incorporate both. In other cases, the shift from disability to normalcy (or the other way around) occurred with a change in circumstances. Getting treatment or going through a severe mental health episode brought women to change their narrative of self, which again suggests a more fluid relationship between disability and normalcy.

Moving between the narratives of disability and normalcy gave women space to evaluate their reproductive capacities. For some, the risk was the motivating factor. By framing their reproduction around the risk of their mental illness, they drew heavily on ideas of disabled reproduction, which sees childlessness as the moral imperative of women with disabilities. Other participants rejected this logic and instead used tokens of normalcy to make their reproductive decision and gain support for it. They utilized ideas of normal adulthood and good mothering as evidence of their ability to participate in “normative” and “desired” motherhood despite their mental illness. To be clear, women who explained their reproductive decisions using the terminology of normalcy (love, disinterest in motherhood, ideal family size) did not ignore the discourse of risk around mental illness and reproduction. Instead, they framed it as a practical matter to be dealt with and not a factor in the decision itself. By insisting that they, too, can be good mothers, these women engage in vulnerable resistance. Bringing mental illness into normal

reproduction and blurring the line between normalcy and disability, choice, and reproductive risk.

Chapter 7: Managing risks

7.1 Women engage with reproductive risks

Often missing from these studies are the women themselves. Their thoughts on childbearing and motherhood are rarely told, and the reasons why, despite all these risks, some of them chose to have children are reduced to a clinical desire to become “normal.” The idea that women with mental illness see motherhood as a tool to feel and be treated as “normal” hides the author’s point of view on the “normalcy” of the women, not that of the women themselves. As discussed in the previous chapter, participants do not see their reproduction as a tool for achieving normalcy. Instead, they refer to their reproductive capacity and aspiration as an integral part of the complicated way they define themselves and their mental illness. Whichever way the women understood themselves, their commitment to their potential child’s well-being was unhinged. Their stories described repeated engagement with the reproductive risks associated with their mental illness. The women sifted through countless sources of information, contradicting or missing data and questionable advice to make their reproductive decisions as safe as possible for their child and, if possible, themselves. As before, most women found that they are alone in the process. Despite feeling confused and wishing they had more support, women rarely initiated meaningful conversations about their reproductive options with their mental health providers.

We will show that most women accepted the distinction between morality and neutrality drawn by psychiatric care. This distinction frames reproductive decisions as an individual moral act that rests beyond the profession’s expertise and responsibilities. In light of this, mental health providers are often reluctant to discuss reproductive issues with their patients. The women in this study accepted this professional boundary even when its consequence bore on them. Most

participants did not expect their psychiatrist to be involved in their reproductive health beyond their role as prescribers, nor were they surprised at their lack of attention to it. Even as they contemplated the effects of their mental illness on their reproductive life, they did not think of their mental health provider as a source of support or information.

Accepting choice as the driving mechanism behind their mental and reproductive health and bearing the moral weight of their decisions, women engaged in the process of interpretation. They drew from their understanding of their illness, selves, and network to weigh the risks of their reproduction. Overall, we find that women who thought of their illness as fixed and believed it had a defining power over their selves tended to view their reproduction as risk prone. Other women, who believed their illness was more malleable and controllable or were not bounded by it, tended to have a thinner interpretation of risks.

The multitude of ways in which women evaluate and calculate risk is a stark contrast to the uniformity in which these risks are discussed in clinical, legal, and policy settings. By offering their interpretation of risks, women turn the generalized risk of mental illness and reproduction into a uniquely individualistic choice and, as they do so, redefine mental illness.

The following chapter will provide a detailed discussion of how the participants in this study interpret the risks associated with their reproduction. We identify three dominant types of risks. Behavioral risk relates to concerns about one's ability to perform the role of the good mother. Biological risk centers around genetics, particularly the potential to pass the mental illness to an offspring through biological mechanisms. The third, Medicinal risk, focuses on psychiatric medication and is linked to biological and behavioral concerns. Here, the child's interests are seen as conflicting with those of the mother, prompting a re-evaluation of the relationship between the two.

Participants used self and social reasoning to measure behavioral risks and scientific arguments to weigh biological risks. Each type of risk brings a different calculation to the women's reproductive decision. For medicinal-related concerns, women described trust in mental health providers as important, as well as biographical narratives about medication and illness.

7.2 Behavioral Risks

No one ever told me I wouldn't be able to have kids, physically, but some of the other insinuations were that I wouldn't be able to actually keep them ... It's through direct comparison to something that happened to one of their friends or family members or something like that. It's not because it was necessarily what they believed. It was just something that they had seen in their life before, what ifs and "Oh, I had a cousin" or "Oh, but I went with my sister to get her abortion and it only took two hours. Everything was fine. She's fine," stuff like that.

It didn't take me into consideration. And I totally understand speaking from your own experience and not knowing exactly what to say, not wanting to actually give advice, and a lot of it was that. It was, "I'm not actually going to give you advice because it's your decision. However, here's some stuff that's going to go around your OCD brain for another however long." You know?

(Esther, 33, Dissociative Identity Disorder)

Behavioral risks focus on what parents do or do not do. By measuring fitness to ideals of good parenting, behavioral risk asks if people with mental illness can provide the optimal environment required to raise healthy and productive adults. Put simply, can they be good parents?

Indeed, concerns about parenting with mental illness often appeared in the interviews. Women shared stories of self-doubt about their ability to be the mothers they wanted to become. They responded to these behavioral concerns in three ways. The first is an acceptance of risk.

Women who responded as such are those who believed that their mental illness - directly or indirectly - makes them unsuitable for motherhood. The second type of response was of women who re-evaluated behavioral risks by expanding the meaning of good parenting. If mental health care could be aligned with good parenting, it is no longer a source of risk. The last type of response was made by women who flipped the argument of risk on its head. These women argued that rather than a source of risk, their experience of mental illness makes them better mothers. Their illness makes them particularly suitable to support their child's emotional needs and raise empathetic adults.

Tzipora, a married insurance salesperson in her mid 30's, captures this ambivalence in her story of mental health and reproductive decisions.

Her depression started at an early age and has followed her since. She describes it as "I've been depressed most of my life, since I was a child, probably since I was, geez. Since I can remember, I remember feeling depressed and having a lot of anxiety". Her parents, who are "kind of old school," were not unsupportive of her, but they didn't understand what she was going through. Tzipora says, "if I had told them I want to be a therapist, they probably would have said, you don't need one."

At some point during her childhood, Tzipora was sexually molested by an older boy, a trauma that she carries with her still. Sadly, this was not the last time she was attacked. On different occasions throughout her school years, Tzipora was sexually assaulted "I had been kind of sexually attacked by other people on other occasions. Not raped, but just grabbed or fondled in some random way by someone who I didn't even know, or I went to school with. Up until I was in, I think most of my grade school years, something happened almost every year that was similar". When talking about this part of her biography, Tzipora wonders about the relationship

between her trauma and depression. Was depression part of who she was, or was it a response to the assaults? She eventually settles on the former

I don't know if maybe I was genetically prone to be this way or why, but it seems like I've always kind of had these issues since very young

Questions over who she is and her mental health continued through college, where Tzipora took up learning about mental health. She explains it as a quest to her Self

I was really interested in mental health pretty early on, I think in high school, even. And, when I say that, I mean I didn't study it in school, but if there was a book about it, I would read it. Or if there was a course that was an elective that I could take, I would take it... I was seeking it out a little bit, maybe to understand myself better

The self-revelation from learning about mental health brought Tzipora to the conclusion that she is unfit to be a mother. She believes that her anxiety, amplified by her own traumatic experiences, would stand in her way of being a good mother.

And I think the more I read about it [mental health], the more I realized that I didn't think that being a parent was right for me . I'm anxious just in general about everything, but I think I have a lot of anxiety about the responsibility of having a child. And I can't... I guess I tried to think of a good reason that was not selfish, for having children, and to this day I can't come up with one. And I'm not saying that people who have children are selfish, but I can't think of a selfless reason ... I think about my own life and how I've been harmed and how, even though I don't think that my life is a waste of time or anything like that, I would feel really guilty and horrible about bringing someone else into this world and for them to experience any of those negative things that I've experienced. And since it's impossible to protect them from any of that, I just can't imagine going through with it and being able to be a good parent. I mean, I just imagine not allowing them to go to school, not allowing them to play outside. I think I'd be extreme in that sense where I'd want to protect

them and I'd be so afraid of something happening to them, that it would make me a bad parent because I would be protecting them too much

Unlike Meital, who decided not to be a mother, Natalie never made such a decision. Instead, she describes moments of agency that, taken together, create her reproductive biography. One such moment happened during her first marriage. She was pregnant for the second time (the first ended in a miscarriage) and chose to abort the pregnancy. She describes the clarity it brought to her:

So, we were together maybe about a year, and I had gotten pregnant. I did not know that I was pregnant. I actually had some bleeding, spotting. I went to my doctor, and she said, "You had a miscarriage." So, I was kind of surprised about that, but yeah. So, I want to say about a year later, I had gotten pregnant, and I told him [her husband]. He was not supportive at all, and that's when I decided I couldn't have this with him. I couldn't have that sort of a relationship with him. So, I don't want to say I was forced into the abortion. I mean he was very, very clear that he did not want that for us. So, at that point too, I think my mindset changed about him and I thought, "Well, if I were to have a child, it certainly would not be with him," you know?

Like Meital, Natalie's story can be read in two ways. In the first, her reproductive choices manifest moments of control; in the second, they reveal deep doubt about her fitness to be a mother. Talking about her reproductive intentions, Natalie shows this ambivalence.

As I got older, it wasn't a burning desire for me. When I was younger, I think I wanted children more. And as I got older, I guess maybe I was more set in my ways. I could come and go as I pleased. I also, during certain parts of where I would have my anxiety and depression, where I was unable to work, I also felt too like, "Would I be able to take care of a child on my own? What if I fell into a depression and couldn't function," you know?

Even the abortion has an undercurrent related to her mental health:

And I think I thought, “I am not going to have a man dictate to me either what my child’s life is going to be.” So maybe that was part of it too because I look back now and I think, “Well, he made my life miserable. He would have made my child’s life miserable,” you know? I mean ... But again, who knows? I was in such a state of mind at that part of my life that it was like walking through a haze every day. It was a very difficult time.

In this second narrative, Natalie reveals her reservations about being a mother. It is not just the men she dated that were not equipped to be good fathers. she was skeptical of her “mother material” too. Here, Natalie weighs parenthood not against her first husband's control over her but against the lack of control that her depression brings to her life. Even now that she is happily married to a supportive husband and feels stable in her mental health, she has resigned from motherhood.

I kind of feel now that even though it ... I want to say it wasn’t my specific intention to not have children because of my mental illness, consciously. Maybe subconsciously along a lot of levels, maybe. But I can say now that I feel relieved that I didn’t have children

While some women reflected on their selves as they contemplated having children, others turned their attention to their parents, who, too, had a mental illness (Dolman et al. 2016). In their stories, they talked of their parent's mental illness (diagnosed or suspected) and the trauma it inflicted on them. They measured the risk of parenting with mental illness using their experience growing up.

Noa mentioned how her mother’s mental illness made her avoid parenthood herself. Looking at her experiences growing up with her mother, she believes that she poses behavioral risks to her children. Her fear of causing unjustified pain to her children made her decide against becoming a mother herself

EP: Why do you think you thought that you'd be such a terrible parent? Noa: Well, because my mother was so terrible. She was physically very abusive, emotionally abusive. She would just do hideous things ... so I was convinced that if I did love anything, bad things would happen to it

Dorit, too, looks at her mother in order to evaluate the behavioral risks of her own motherhood. She says:

I know how my mother's depression influenced me when I was growing up. The one incident that really kind of stands out in my mind is she went through a particularly bad period and for a straight week the only thing she made were peanut butter sandwiches. Breakfast, lunch, and dinner. I hate peanut butter at this point ... In some ways maybe my experiences with depression would make me more attentive to that as a parent but I hesitate to do that and I hesitate to, I use the phrase "inflict that on someone else in the future" but I know what I went through as a teenager growing up. I wouldn't wish that on anyone. It was very dark; it was very bad. I would not want to live through that again. I'm surprised I lived through it in the first place. I don't know if I could see my child live through that.

Because the dogma of moral parenting is binary in nature, one can either be a good parent or a bad parent. In fact, anything short of good parenting is taken as risking the child and, therefore, a sign of immoral parenting. Feeling ill-equipped to fill the mounting demands of good parenting, Tzipora, Meital, and Natalie believe that their mental illness makes them unfit for motherhood, making them "bad mothers" in potential.

7.2.1 Expanding good mothering

Not all women agreed with this notion. Some women created narratives that break the link between mental illness and bad parenting. In their stories, they incorporate mental illness

under practices of good parenting, giving themselves room to exist in it. By doing so, they shift the discourse around their reproduction from their illness to their selves.

Shira's story illustrates this point. In it, we can see how bringing mental illness under the umbrella of good motherhood allows Shira to respond to the behavioral concerns of her parenting without giving up good motherhood.

At 19 years old, Shira was diagnosed with bipolar disorder type 2. She was a college student, engaged to be married to her longtime boyfriend (now her husband), and severely suicidal. Now, over a decade later, Shira is a stay-at-home mother to three children and an online advocate for women with mental illness. When talking about parenting, Shira mentions her love and joy for her children, as well as how taxing motherhood is. She describes the mental toll and physical challenges of attending to her children's needs, especially when she feels depressed or easily irritable.

When I get overwhelmed ... I am a stay-at-home mom. I think with every stay-at-home mom, I don't think bipolar or not, I think when you're around kids that much, I mean, it's not easy. It's not easy. We know my limits. As soon as he gets home, there will be days when I say, "I need to go to my room." I will give myself a Mommy timeout. I need to go decompress in my room. Whether it be I watch tv, read a book, lay there, or whatever it is, he's right there and says, "Okay." He helps with the kids

Shira admits that she does not fit the image of the supermom. Unlike the good mother, who is always attentive to her children and enmeshed in feelings of love for them, Shira sometimes needs a break. She relies on her husband to come home and take charge so she can find the distance from her children and focus on her own needs.

But Shira does not treat these episodes of exhaustion from motherhood as a sign that she is a bad mother. Notice, for example, that Shira does not simply "check out" when she feels

overwhelmed, nor does she call a sitter to watch over her children. Instead, she waits for her husband to come home. By ensuring that her children are cared for, particularly by their father, and by describing her recluse as “mommy timeout,” Shira brings the challenges of motherhood back under the umbrella of “good” parenting. Despite feeling emotionally overwhelmed by her children, Shira remains devoted to their care - either by being with them personally or by enlisting the support of her husband.

Disability rights advocates and mental-illness activists argue that many of the obstacles that people in these groups face could be removed or minimized with appropriate support. With support, people with disabilities can work, live and learn in the normal world. This framework sees support as a bridge between disability and normalcy. A more critically oriented faction of disability advocates goes further ahead to dismantle the link between support and disability. These group of disability scholars and advocates maintain that no individual is fully independent of others and that all people rely on support in their life. In other words, support is integral to every person’s life, regardless of their disability.

Shira’s framing of support echoes this critical scholarship. Though she talks about her need for support in relation to her mental illness, she also links it to the most traditional form of motherhood - the stay-at-home mom. Shira believes that by talking about the emotional stress of motherhood and the need for the support, she is exposing the lie of blissful motherhood. The truth, she believes, is that all mothers need support. Shira’s need for support is not an issue of accessibility - which would highlight her mental illness’ “otherness” - but the true basis of good mothering. In other words, rather than a sign that her illness renders her unable to be a good mother, her need for support is proof of her being a good mother.

Like Shira, Vered, a 44-year-old married woman with a child, referred to support as a lifeline. Though it was her mental health that made her need support, she sees it as a beautiful moment of growth and community around parenthood.

7.2.1.1 Breastfeeding and support: redefining good motherhood

Vered says that she came into marriage “relatively late in life” and not long after became pregnant as planned. This sense of control was shattered when within a week after giving birth Vered experienced a full-on psychotic break

You know, me stepping all over the broken glass and asking [husband] to throw [the baby] to me through the wall. And that I might have thrown her through the wall if she were in my arms

With help from her family, Vered was admitted to a psychiatric hospital where she stayed. At the hospital, she was told she had bipolar disorder and was put on medication. It took Vered over a year to recover from that episode.

Being a new mom, Vered had to mitigate the needs of her baby with those of her recovery. Sleep became a major problem. Vered realized how important sleep is to her well-being and that without it, she could become psychotic once again. The problem was that her husband, who had just started a new job that also paid for the health insurance they so badly needed, could not take the night shifts. Vered and her husband had to ask for help. She describes it as a breaking point that turned into a learning opportunity:

So, what happens? Well, in my mind, the unimaginable. I mean, I, I had always been a bridge builder, a mediator, a peacemaker. Uh, you know, I'd always been a friend that, oh gosh, you're, you're having a hard time. Well, let me help you through. But I had never been the one having a hard time deeply leaning on other people. That was just not, that was not my role in my family as a kid. Um, and it wasn't my role growing up. And so, you know... It

was a very painful lesson and, looking back, very beautiful that five nights a week for three or four months ... One night, [husband's Mom] would stay the night and get up with [the baby] during the night. One night my dad would stay the night and get up and feed her during the night and one night my uncle, who never had children would stay the night and get up and feed her during the night and you know, all three of these people are in their seventies ... And um, and then our only two girlfriends that did not have a husband or partner or husband or wife or a pet or children. So, no obligations. We had two girlfriends with no obligations that would also stay the night one night a week ... So, between the five of them, they were the lifeline five days a week for Gosh, three or four months

Soliciting support from outside the family unit is not the only way that Vered expands the meaning of good parenting and reflects on the behavioral risks of her parenting. Her experience leads her to challenge other demands of good parenting, breastfeeding being a central theme in her story.

Vered's long stay at the hospital separated her from her newborn daughter and put a stop to breastfeeding. At the hospital, she pumped and dumped in order to keep producing milk, and later, when she returned home, she tried to re-teach her baby to the nurse. None of this worked, and finally, Vered had to accept that she would not nurse her daughter. This felt like a huge loss for Vered; not only was she missing out on something that she really wanted, but she was also worried that it would hurt her daughter's development.

I had always imagined loving breastfeeding and imagine that being such a sweet and tender and connecting, I'm kind of warmed my heart to even see moms breastfeeding and it just seemed so bonding and sweet and natural and healthy. Um, you know, I think in my worldview it just seemed really sacred. Um, it never occurred to me that it wouldn't get to do that. And you know, one of the bigger traumas of the whole experience [was not being able to

breastfeed] ... And I had a lot of shame about, could I hurt her... I thought that um returning her to the breast, could be a way to reassure her that I was her mama, that I have not abandoned her, that I wasn't dead, that I loved her and, and kind of. you know I had a lot of fears that we wouldn't bond without breastfeeding and that, that would deeply impact her emotionally and developmentally and this is her heart and mind

Though Vered still regrets not nursing her daughter, she no longer sees it as a sign of bad motherhood and risk. If not-breastfeeding could happen within good motherhood, then her inability to do should not constitute a source of concern. Thus, the risk of her being a mother is diminished.

So, I think not breastfeeding was huge in terms of ... And I, and I had a long road to heal from the shame and just feeling the sadness and loss about not being able to breastfeed, but I did. And I fully healed from that and it's almost sweet and a little bit. It makes me giggle a little bit and it's sweet to me. And I'm relieved when I think about how panicked I was that we wouldn't bond because I wasn't breastfeeding her because I was gone for a month, and I look at her now and how unbelievably bonded we are

We see in Vered's story an evolving calculation of behavioral risk. Early after her psychotic break, Vered abandoned her plan to have two children because she believed she was unfit to be a good mother. This reevaluation represented a shift in Vered's thinking of herself and her reproductive life. She moved from thinking that her reproductive prospects were desirable to believing them to be harmful and risky. As time progressed and her recovery progressed, Vered revisited her reproductive plans again. She no longer thinks of herself as she did before the diagnosis but no longer feels lost and desperate. Now she thinks of her illness as manageable, even a gift. As for her reproductive thinking, though she must engage with the risks associated

with her disorder, she does not consider her disorder a negation to good parenting. Her illness is manageable, and so are the behavioral risks of parenting with it.

7.2.1.2 Time and support: redefining good motherhood

If Vered alters her thinking on breastfeeding to place herself under the realm of good parenting, Shlomit does so with Time.

A 30-year-old mother of 5 children (four biological and one stepdaughter), Shlomit was only recently diagnosed with bipolar 2 disorder, PTSD, and OCD. The diagnosis of depression which was given to her in her early 20s didn't make enough sense to her. She describes the decade it took until her diagnosis as "going from one doctor to another, telling them this isn't right. Something's wrong. And this is a long time to have a doctor finally listen and say, yeah, you're right. This isn't okay".

When her son was a baby, Shlomit went through periods of rapid cycling, switching back and forth between manic and depressive moods. Her husband, a military man, was stationed far away, and her family did not offer much support. Her social anxiety was also taking a toll, making it especially difficult for Shlomit to spend time outside her apartment, where social interactions are likely. Looking back at that time, Shlomit observes her behavior, and though still struggling with it, she gives it a new interpretation.

Though her time with her child did not meet the standards of "qualify" - outdoor activities and social play - he was taken care of. Shlomit's guilt is "surface" guilt because she was able to be a good mother even when in the grip of her mental illness.

I feel like I should have been able to take him out to play more. I should have been able to do these things, but it's only a surface built. Because now that I'm more aware of the situation I was in, I try very hard to remind myself you did that on your own with a bipolar disorder that you didn't know about. Your

husband was 6,000 miles away. You raised a kid by yourself while you were pregnant. And then, you were raising two kids by yourself after he went back. So, I try very hard to remind myself that, you know what, he played. He was never hurt. He was always safe. He was always fed. He was always bathed. It's not like we would go weeks without bathing or things of that nature. I was very vigilant on making sure he was always well taken care of.

7.2.2 Making lemonade: turning risk into strength

Finally, some women added a twist to the behavioral concerns of their parenting. Though they did not dismiss the risks of their mental illness, they argued for a new way of thinking about their parenting. In their remarks, they suggest that alongside risks, there is a virtue to their parenting. When they look at their experiences with mental illness, they find parental strengths not weaknesses. Being a mother with a mental illness may be desirable for their children and society.

Going back to Shira, we find her saying,

I am teaching my children what the real world is and to be able to read people's emotions. They are very in tune to emotions, my kids are. To look at the silver lining of it, I think that ... I really do believe I'm raising amazing kids. I feel like my bipolar has not affected them negatively. They're extremely loving children

Sarah makes a similar argument, only this time about the larger social context. Not only would she be able to support her children better and possibly prevent their potential mental illness from disturbing their life as it did hers, but she would also be doing good on a social level. Through her compassionate and open parenting, she would disturb socially harmful gender roles:

When I do have kids, if I have kids. I would talk to them at a very young age about it [mental illness] because I have thought a lot about how I would talk about this to my children, and I would talk to them about it at a very young

age. I would get them comfortable talking about their feelings, especially if I had a son because boys in our society are not supposed to talk about their feelings, so I would want to get them very comfortable talking about their feelings, and very open to talking about their feelings. I would want to have good relationships with them ... That's what I would do, so that it wouldn't, because with me, if I had been told at a very young age, this is what could happen, I do believe I would have spoken up, and this would have been caught way before, and I never would have deteriorated like this because it would have been obviously caught before, and years, and years of my life would have been saved. So that's what I would do. That's how I think about that. Yeah.

Moran and Naama share Sarah's framing of her motherhood as advocacy and the common good.

Moran: I don't know if it's like common now, but it's not this thing where no one has the illness [inaudible 00:31:09]. People have some form of mental illness and we've got medications and we've got therapy and because of mental illness, I will know what to look for in my child. I can put them in therapy, all the understanding and talk to them. We have medications now that can help. And even if I didn't have this illness, there would still be a chance that my child would have it because it runs in my family. There are so many families that at least one member has mental illness, it could show up in their child. You never know...

Naama: It's okay to feel sad. It's okay, but when you're having these thoughts, you have to come to mommy and tell me. Yeah, because it's genetic. Some of it's already pre predisposed with genetic. It's. I mean people don't realize that mental disease is actually part of it is also carried on through genetics. So, I'm going to be having these conversations with [her daughter] when she's older and say, you know, sometimes it's okay to feel sad, but you know, when you feel sad sometimes it happens a lot and what happens a lot and you start thinking like kind of like scary thoughts. Then you've got to come talk to mommy.

7.2.3 Good motherhood lost custody and mental illness: Batya's story

Finally, we move to Batya. A 44-year-old black woman who is a three-time divorcee and a mother of three living children and one deceased. Her oldest, a teenager, has a developmental disability and the tween daughter has a heart disease. A year before the interview, Batya lost custody of her oldest son, and he was sent to his father. She says that she was “deemed unfit.” Batya’s ability to be a good mother was challenged years before. Of losing her third born in a stillbirth, she says

I lost my daughter as a result of that [preeclampsia], but when I kept telling them something was strange, something was going on, she was acting funny in utero the entire third trimester, they asked to put me, because of my history with depression, they thought I was going through something other. I was in the hospital for two weeks

Despite everything she is told, Batya believes she is a good mother. Initially, she did not want to have children. Her growing up and her family’s history made her feel she was not cut up for parenting. But having her first son, who was not planned, taught her otherwise.

But it’s funny how it’s like the best job ever. I look at my children and they genuinely respect me. And I look at other kids with their parents and there’s no connection. I’m very connected to my children, which is a beautiful thing. I feel more connected to them because I’ve worked so hard not to be my mom

Batya tells of her friends and even her therapist, who praise her parenting:

It’s funny, I have some excellent moms telling me that I’m a great mom and what even better is one of my dearest friends, the one who keeps me grounded when he sees that I’m spiraling. He doesn’t like children. He’s never had children, but he loves my children. And he told me that that speaks volumes and shows that I’m a great mom

And,

But nobody could really tell how I would react to motherhood until I actually became a mother. I had a support system. My therapist at the time said that she had no doubt that I would be a good mom

Despite the dire circumstances, Batya's narrative reveals the same determination we see in other women's stories. Even when it repeatedly told otherwise, Batya insists that her mental illness does not render her a bad mother. Instead, her illness is the basis not only for cherishing motherhood but also for excelling in it. She sees her experience as evidence of the narrow-mindedness of doctors and CPS, who cannot see her through their prejudice about mental illness.

7.2.4 Conclusion

Confronted with doubt about their ability to provide a safe and nurturing environment for their children, women evaluate their selves as mothers. Some women, like Noa, Natalie, and Meital, see a self that cannot accommodate motherhood if it wishes to preserve itself. Their declaration that they are not fit to be mothers, points to the root of it. The problem they see with motherhood is not related to external circumstances such as finance or housing but to the root of their being. Their mental illness fashions their Self, and to control it, they must oblige with behaviors that contradict motherhood. The risk of not doing so means a loss of Self and immoral parenting. The experience of being parented by parents with mental illness is also brought up in response to behavioral risks. Women who grew up with parents with a mental illness talked about the harm their parents caused them and used it as proof that they, too, would harm their children if they had them. It is interesting to point out the difference between women's thoughts of their families regarding genetic risks and their thoughts about behavioral risks. As mentioned earlier, none of the women expressed the idea that, as a general rule, people with mental illness should not reproduce. Even women whose parents had a mental illness (or who had siblings with mental illness) did not argue that they should not have children because of the genetic risk of

inheritance. Nonetheless, reflections on familial mental health were made in relation to behavioral risks. This was when women were seen to suggest that their parents should have realized that they were not fit for parenthood. This has not been the case; their parents had children and caused predictable harm to them. In other words, though the genetic risk of their parents' reproduction has proved to be true, women do not think of genetics as a reason to avoid parenting. At the same time, their parents' harmful behavior contributes to the women's decision not to repeat their mistakes and have children.

Other women reflect quite differently on the behavioral risks of their reproduction. Some, like Sarah, reject the risk by separating mental illness from their potential motherhood. Sarah believes that by the time she has children, she will be "normal," i.e., no longer be a mother with mental illness. Shira, Vered, and Shlomit make a different attempt to answer for the risks of their motherhood. They engage in an attempt to expand the definition of good motherhood such that it will include the needs of their mental illness. If good motherhood can accommodate the need for support, time spent at home, and no breastfeeding, they can perform it AND maintain their mental well-being. Last, some women articulated positive thinking about parenting and mental illness. They argued that their parenting is socially valuable despite the potential hurdles they might face. Their experience with mental illness gives them an advantage as mothers. It makes them equipped to raise compassionate and emphatic children, who, as they see it, are acutely lacking in our society.

7.3 Genetic risk

Talya, who we met earlier, is concerned with the possibility that her mental illness will be passed on to her offspring

Mental disorders very obviously run in my family. It's just super obvious. Uh, everyone, like in my mom's side of the family has a mental disorder. Um, so I

know if I were to have kids, they would like nine out of 10, have like schizophrenia or something

Dorit, too, worries about the genetic component of her illness. Though scientific research about the genetic risk of depression is far from conclusive, she believes that her illness is more than likely to be passed on to her offspring.

I've known that I had depression completely for most of my life and honestly, I didn't really want to inflict that on somebody else and I've had people tell me this is a stupid reason to not have kids, but I don't know that I agree...

Her partner's mental illness adds to Dorit's perceived level of genetic risk

My partner also has major depression and the chances that our genetics combined would make a very depressive child are probably not zero and I can't assign actual numbers but it's a risk that I wasn't willing to take

Both Dorit and Talya engage with the new field of genetic psychiatry.

7.3.1 Genetic psychiatry

Nature magazine's first editorial of 2010 declared the new decade as the "decade for psychiatric disorders" (Philip 2010). Recent breakthroughs in genetic and neural sciences promise to identify the genes behind mental illnesses and revolutionize the diagnosis and prognosis of illnesses. DNA testing will allow earlier intervention among people who might not even realize they are at risk of developing a mental illness. Studies in genetic psychiatry would lead to the development of new, improved, and precise medications for psychiatric disorders, reinvigorating a field that has seen little development in decades. These gene-based medications will not only be more effective than current medications in treating mental illnesses among those who are already ill but could curtail or even cure people whose genetics tell of a potential illness. Finally, and not less importantly. The genetic revolution of psychiatry will change the social

dynamics of mental illness. It will allow those suffering from it to live “normal” and “productive” lives as part of society and cut the social and financial costs of psychiatric disorders. Geneticization will remove the stigma of mental illness not just because of the better prognosis. Finding the genes that cause mental illness will exonerate those who carry the illness, relieving from blame and recasting them as worthy of support (Phelan 2002; Phelan 2005; Schnittker 2008; Insel 2009; Insel and Wang 2010).

A decade later, genetic coding of mental illnesses remains an unfulfilled promise. Though genetic factors of some mental illnesses were identified, they remain small and insufficient in diagnostic or treatment procedures. Studies now show that the relationship between genetic material and mental illnesses is far from straightforward: most illnesses seem to be linked to multiple genes, not one. This makes it harder to identify a causal relationship between genetics and illness and develop the genetic test for prediction and diagnosis. The problem goes beyond finding which genes are linked to mental illness. It now seems that the link between biomarkers and psychiatric disorders is more sophisticated than initially thought. Studies show that genetics and mental illness do not form a monotonic relationship; that is to say that having fewer biomarkers of mental illness does not correspond to a more negligible risk of developing the illness. In other words, a person with a more minor genetic disposition might develop a mental illness, whereas a person with more biomarkers might not. Last, genetic psychiatry makes categories of mental illnesses more difficult to detect and study as it now seems that conditions that are believed to mark different illnesses (such as bipolar disorder, major depression, and schizophrenia) share genetic risk factors, further complicating the move from genetics to lived experiences.

The slow progress in finding the genetic roots of psychiatric disorders did not quell the belief that genetics can and will change psychiatry for the better. The idea that genes hold the key to understanding and “solving” the problems of mental illnesses has solidified in medical and popular culture. Jason Schnittker (2008) showed that genetic or chemical explanations for mental illness grew in popularity in the first decade of the millennium and even surfaced in direct-to-consumer DNA tests that promise to detect mental illness (Grohol 2010; Abbate et al. 2014). In psychiatric settings, there is a growing interest by patients and clinicians in genetic diagnosis of mental illnesses and disorders. While the popularity of genetic psychiatry is growing, actual knowledge of the field remains lacking. Many psychiatrists and patients overestimate the genetic heritability of mental illness, thus inflating the risk associated with pregnant women with mental illness (Insel 2009).

Though scientific research on the heritability of schizophrenia did not reach a definitive conclusion about whether, how, and when the illness can pass on, Talya did. Because she wants to protect her offspring from harm, she cannot wait for genetic research to conclude the heritability of her illness. Being stuck between the ethics of informed choice on the one hand and an absence of concrete information on which such choice is to be made, on the other, she looks for a new date on which to assess the genetic risk of her illness. Talya turns to personal observations on the recurrence of mental illness in her family to concretize and individualize the ambiguous discourse around her genetic heritability. This mix between rigorous science and lay assumptions becomes the basis on which she derives the morality of her reproduction:

I really don't have any desire to, to, to do that. I'm much more for like adoption and I would be totally fine adopting a kid with schizophrenia, but I don't think as far as I could handle having a child knowing that going in, this is what they were pretty much going to have or something close to it...

Sigalit is currently in a relationship with a father of two. They've been together for six years but are not living together (Sigalit lives and supports her stepfather). The topic of children sometimes comes up with her current boyfriend, but not in meaningful ways. He asks, "do you want to have children." She replies, no. Sometimes he adds, "shame, you'll be a good mother." Sigalit does not think she will be a good mother or at least not believe she is fit to have children. "It's not good for anyone to have children if you don't want them. To the children and the parent". Sigalit can't talk to children on their level - that's part of her not liking people and not wanting to be with people for a long time. The other reason is that she does not want to pass the genes for the illnesses to her children. While the first reason seems to be independent of her illness, after our conversation Sigalit linked her dislike of people to her illness. When asked if her illness impacted her life, Sigalit said that very much so. Her career choices were shaped by her need for restricted contact with people. If she thinks this is part of the illness, she said yes. Not liking to be with people for a long time is part of schizophrenia, not personality. She backtracked this statement slightly and left more space for it is "benign," but it's clear that up to that point, she attributed her social taste to her illness, which makes the case that her choice not to have children is driven by her understanding of her mental illness.

The relationship between her two arguments for not having children is also interesting. Even though the first thing she mentioned in our conversation was the genetic aspect, a central point in her FB post, it was the second consideration throughout the rest of the conversation. Most of the time, Sigalit talked about not wanting to have children and that even if she wanted to, she wouldn't go because of the genetic component. The genetic piece seems to be a second wall, a hypothetical argument that doesn't need to be tested. In some ways, making it secondary allows one to avoid generalizations and genetic determinism. In making it subsidiary to an

individual-taste decision, Sigalit avoids criticizing others for passing their undesirable genes, as well as avoiding the question about herself being born.

I personally have decided not to have children. My biological father had some type of mental health issue (we don't know for sure, and he isn't in contact with anyone in the family) and my psych and I are pretty sure mine was inherited. I a) don't want children to begin with and b) wouldn't want to bring a child into the world that I knew before conceiving would have a high probability of having crippling mental health issues. Again, a personal choice. I'm not great with small humans, anyway. It's just me

7.3.2 Bioethics

The guilt that Talya wants to avoid is an inherent part of the contemporary bioethics' regime. The Foucauldian biopower of state population control through measurements of health, birth, and mortality (Foucault 1977; Foucault 1978) has taken what Nikolas Rose calls a "step change" with the advent of genetic sciences (Rose 2007: 4). We now live in a new biological era in which life is understood at the molecular level, and so is our responsibility to it. From pre-birth to post-death, our existence has been revolutionized by technologies of self-improvement, optimization, and harm reduction that reach as deep as our genetic coding. The moral imperative to improve oneself encompasses every aspect of our being, calling attention to how we eat, sleep, move, interact with one another, reproduce, parent, think, and so on. Indeed, it is life itself that is the subject of this bioethics of self-improvement, it is "medicalized, or cast as a body project that requires the continuous monitoring and judgment of medical science, and health becomes a defining characteristic of responsible selfhood and citizenship" (Wolf 2010:17)

The geneticization of an extensive array of conditions and traits, from intelligence to criminality to illness, removed the rug from underneath the distinction between health and illness. Now, healthy or ill are no longer helpful categories of existing. Instead, risk is the state in

which we live, and the continuous management of it is our moral obligation. We are constantly reminded of the fragility of our being and are required to act upon it. As such, risk exists in two places at once: it denotes a potential future and demands action in the present. The calculation of risk that genetic technologies call upon requires imagining multiple futures and relationships and placing guilt at their center. “Genetic counseling,” rose writes, “entail intense bidirectional affective entanglements between all the parties to the encounter, and indeed generate multiple “virtual” entanglements with parties not present—distant relatives, absent siblings, potential offspring. In these entanglements, the ethical relations of all the subjects to themselves and one another are at stake, including the experts themselves. The consultation acts as an intensifier of ethicality. It mobilizes effects of shame and guilt, and the respective claims, scope, and limits of freedoms for the self and obligations to others.” (Rose 2007: 74).

Talya’s guilt comes from the belief in the genetic heritability of schizophrenia and the moral demand to prevent harm to the future child. Its genetic context becomes even more evident when Talya talks about the possibility of adopting a child with schizophrenia in the future. By separating schizophrenia from her genetics, Talya admits that it is not the illness per-se that she wishes to avoid but the feeling of responsibility for the less-than-optimal *molecular* life of her child. This individualistic and intimate feeling drives her thinking around genetic risk.

7.3.3 Choice

We see this distinction between private choice and moral argument again when Talya talks about her brother’s potential parenthood. Talya knows that her brother, who she suspects has schizophrenia too, and his wife plans to have a child. Though Talya assumes that the child will inherit her brother’s mental illness, she is adamant that the decision should be theirs to make

I absolutely think their [Talya's brother and sister-in-law] child will have some sort of mental disorder. I mean, my brother totally does. Um, but I mean that's between him and his wife

Instead of a moral argument about reproduction and genetic heritability, Talya views her decisions as an individual choice that does not, and should not, be forced on others with mental illness. Like Talya, Dorit believes that reproduction should remain a personal choice even for people with genetic risks. But unlike Talya, Dorit is less comfortable with the way these risks are being addressed. On the one hand, she wants to keep reproductive choice; on the other, she fears that people approach reproductive decisions lightly. To make this critique, Dorit has to walk a fine line between denouncing the reproduction of people with depression and embracing their moral right to choose.

Honestly it is their decision, but I sincerely hope that they have considered whether or not they are probably going to pass that on to their children and how their own depression will impact their ability to raise their children. I hope they have been somewhat proactive about that. I don't necessarily think that everybody's major depression precludes them from being able to raise healthy, happy, psychologically well-adjusted children but I don't see as much attention paid to that. It doesn't seem to be as big a consideration maybe as I would like it to be

Unlike Dorit, who reflects on genetics in personal terms, Noa links her argument to societal changes, particularly the history of eugenics

Not enough is known about the causes of mental illness. Heredity and environment. So, it's perfectly possible for people with mental illness to have families and be successful at raising children. I completely believe that. Plus, no one knows if it's inherited or not. I mean, I guess there's some mental illnesses that are more likely to run in families, but I still don't know that the research is definitive on that. And so, if people wanted to have children even

though they have a mental illness, if they had enough support, I think they should go ahead. I think all those times when people with mental illness were sterilized in the past... I thought that was terrible. They took away all their possibility of making a decision about their lives. So, I would never advocate something like sterilization or telling people they can't have children because they have a mental illness

7.3.4 From eugenics to newgenics

Talya and Dorit's thinking about personal choice, morality, and heritability, illustrates the shift from old eugenic policies to contemporary practices of reproductive risks. The eugenic fear of negative hereditary traits drew on a direct link between private behavior and public mores. Morality was equated with the collective good, and anything believed in risking the advancement of the social body was taken as immoral. The risk was a means to categorize people and justify mass sterilization based on group affiliation. If Talya were to use this eugenic logic, we would have expected her to make a solid argument about the bad ethics of having children with a genetic illness. She would have made a moral point encompassing other people with similar genetic traits. But Keren does not use eugenic logic in her story. Instead, her argument follows the bioethics morality of genetic science and the logic of newgenics.

Jo C. Phelan (2005) discusses the genetic revolution of psychiatry in the context of two competing theories. The first, genetic attribution, is prominent among activist groups, most notably the National Alliance for the Mentally Ill (NAMI), which is the largest mental illness advocacy organization in the U.S. This theory, which was briefly mentioned above, argues that moving mental illness from the realm of psychological disorders to genetic biomarkers, will absolve from blame those who are suffering from the illness, and induce empathy towards them. The second theory - genetic essentialism - maintains that genetics reveal the individual's true essence. Situated well within the individualized moral obligation to optimize oneself, genetics

creates a novel type of eugenics. Phelan (2005) explains how genetic essentialism might affect stigma:

“When applied to negatively valued qualities, genetic essentialism should exacerbate stigma via its influence on several perceptions: (1) that the person is fundamentally different from others, (2) that the problem is persistent and serious, and (3) that the problem is likely to occur in other family members. These perceptions in turn should increase behavioral orientation of social distance and reproductive restrictions” (ibid: 309).

Phelan found that invoking genetics as the root of mental illness (full or partial) correlated with beliefs that the illness was more severe, unavoidable, and likely to “spread” to family members of the ill individual. Though it did not increase the already high social exclusion of the impacted individual, geneticization of mental illness did cause people to distance themselves from siblings of the ill person, especially when it comes to an intimate relationship. This finding suggests that genetic essentialism expands reproductive risk beyond the impacted individual. Through overestimating heritability and spreadability, genetic psychiatry stigmatizes and rejects a larger pool of people, from the impacted individual to those genetically connected to them.

Because genetics supposedly “reveals the true nature of a person” (Schnittker 2008: 1372) and their inescapable essence, pre-birth knowledge about one’s genetic coding can shed light on the value of their future life. Wilson (2018) captures this genetic essentialism in his analysis of the guidelines for genetic counseling that were put in place by the Society of Obstetricians and Gynecologists in Canada in 2007:

“The first point is that nowhere in this practice guidelines is any space devoted to describing what Down syndrome *is like* [italics in original text]. By this I mean not only a characterization of what it is like for an individual or a

family to “live with Down syndrome” but also even a description of the medical symptoms of, or variation of the symptoms of, those individuals with Down syndrome. One might think that there is no real need to provide such descriptions in a practice guideline. Yet what the absence of such detail conveys, at least implicitly, is the view that the only thing that at least obstetricians and gynecologists need to know about infants, children, and adults who have been diagnosed as having Down syndrome is that they are infants, children and adults, with Down syndrome.” (ibid: 147)

This new genetic ethics, where individual choice is heralded, shifted eugenic ideology from the state to individuals (Heimer 1988; Rothman 1991; Kelly and Field 1996; Anspach 1997; Rabeharisoa 2003; Tremain 2006; Pitts-Taylor 2010). The moral obligation to optimize the self from the level of molecules, coupled with the belief that disability is a failure of the self, have come to justify individual choices even when, on a societal level, the outcome is “removing some unacceptable biological differences from the human community.” (Rapp 2000: 249; Rapp 2001). Disability scholars argue that the proliferation of genetic technologies, the institutionalization of genetic reproductive discourse, and the moral norms of genetic testing manifest a systemic and inescapable agenda to eradicate disability through individual choice. The expansion of choice brought by genetic testing and counseling comes together to be eugenic in “sheep’s clothing” (Shakespeare 2006; Rose 2009).

Using Phelan’s description of genetic essentialism, it is easy to see that, like Down syndrome in Wilson’s quote above, Talya and Dorit apply genetic essentialism to paint a particular life to their potential child. In this imagined future, mental illness is genetically coded to their child, unavoidable and unalterable, condemning them to a life that is not worth being born to. Unable to provide the optimal life to their child because of the genetic heritability of mental illness, they both decide against biological parenting.

7.3.4.1 Moral pioneers

Still, it would be wrong to exploit Dorit and Talya's decision to make a larger argument about the immorality of having children when the genetic heritability of illness is involved. As we've seen above, framing reproductive decisions as a choice is at the core of the current bioethics' regime. It is also part of what Rayna Rapp terms "moral pioneers" (Rapp 2000).

In her study about women's engagement with reproductive genetic testing, Rapp argues that women are both "conscripts to technoscientific regimes of quality control and normalization, and explorers of the ethical territory its presence produces" (ibid: 306). Like Talya and Dorit, pregnant women from all corners of life must now confront the genetic discourse of their reproduction. Knowing that, as women, they will be responsible for the child(ren), they carry the burden of weighing the genetic risk and acting upon it. They investigate the limits of life and society, bringing to the surface social values around motherhood, normalcy, and quality of life that are otherwise kept silent. In doing so, they turn the social into a private matter and, at the same time, shape it through their actions. Observing, delineating, and defining those values makes them the "philosophers and gatekeepers of the limits of who may join our current communities "(ibid: 317)

7.3.5 Coexisting contradiction

Unlike the women in Rapp's study, Talya and Dorit's thinking about genetics is not promoted by the prospect of amniocentesis testing. The responsibility to confront their genetics begins not with pregnancy but at the moment of diagnosis. Because they are aware of their mental illness and the genetic discourse around it, they must engage in "moral pioneering" before they become pregnant. Furthermore, while Rapp studied women whose relationship to the potential disability of their fetus was second hand if at all, Talya and Dorit rely on first-hand

experience with the mental illness that might afflict their child. This makes for a surprising finding. While we might expect that women who had a hard time with their mental illness will weigh the genetic heritability of it heavily in their reproductive decisions, Dorit and Talya's stories show otherwise. Though both women describe mental hardship, they appear satisfied with their lives. Their narratives of selves challenge the idea that mental illness brings a life of suffering that is better not lived. Yet the genetic logic behind their reproductive decision suggests just that. While some women in Rapp's study, as well as in this study (as will be discussed later), raised the question about the move from statistics to the individual outcome and the ability of genetic information to depict personal lives, Dorit and Talya interpret genetics as definitive. Not only do they overestimate the scientific risk of genetic heritability of their mental illness, but they also fully embrace the essentialism of it. Their reproductive decision is based on a view of the genetics of mental illness as determined and severe.

The bioethics of choice as a private matter, coupled with the force of the "good mother" ethos, lets Talya and Dorit hold the two contradictory visions about genetics and mental illness simultaneously. In the previous chapter, we've already seen this when discussing Dorit's view of mental illness. The distinction she drew between herself and her child proves helpful in the context of genetics as well. Talya and Dorit downplay the genetic essentialism of mental illness on their selves but not on their potential child because of their desire to be good mothers. As good mothers, they are invested in managing risk that seeks to remove any potential harm to their potential child. Thus, the flexibility with which they understand their genetic selves is thrashed against the inflexibility of the expectations of good mothers. The same goes for their double interpretation of mental illness as both livable and unworthy of living. While their mental illness is a disturbance, their children will be their ruin. Though Talya and Dorit see no room for

chances in the context of reproduction, their choice to avoid biological children does not reflect an internalized devaluation of life with mental illness, as suggested by the newgenics theory. To fully understand and respect their reproductive decisions, we must let the contradicting narratives of Dorit and Talya's life with mental illness coexist.

7.3.5.1 Time and genetics: Retroactive management of risk

While Talya and Dorit reflected on the genetics of their illness in their decision on whether or not to have children, other women reacted retroactively.

Lital is a 40-year-old mother of three adult sons. She is married and has a diagnosis of bipolar disorder. Of her mental illness, Lital says:

I probably hit every stereotypical manic problem ... I spent it [inheritance] all. I was around people that were really bad people, like in and out of jail type people. I tried drugs and drank a lot. I started having some psychosis and not sleeping. I quit my job and I left my husband too. I moved out of the house and left my youngest son with him, and I took my middle son with me. I feel bad because I exposed my middle son to a lot of my behavior didn't see anything wrong with it

During her manic episode, Lital had an affair from which she became pregnant. Knowing that she doesn't want to raise the child with the father and sensing that something is not well with her, she decided to terminate the pregnancy. Though she supports abortion rights, Lital carries an enormous sense of guilt over the termination of that pregnancy. The interview was one of the few times she talked about that part of her life.

The ruins left by her mania and the guilt over the extra-marital pregnancy brought Lital to reflect on her reproductive history and future. When Lital had her children, she did not consider the genetic heritability of her mental illness because she did not know she had it. Though she suffered from depression and anxiety all her life, her diagnosis of bipolar disorder happened only

after she had her children. Now, when Lital looks at her children, she sees signs of mental illness that she believes were passed on to them from her:

I'm afraid of would have passed it on to my kids. Two of them show signs of depression one got severe anxiety, so it just makes me feel guilty like this is what I've done

Even though Lital's children already exist, she is invested in managing reproductive genetic risk. Accepting the geneticization of mental illness, Lital interprets observations of her children as evidence of the genetic heritability of her illness. What's interesting is that the objects that prove her culpability are depression and anxiety, not bipolar. Lital's use of depression and anxiety as evidence of the genetic heritability of bipolar disorder expands and disrupts genetic science. The interpretation she gives to her genetic risk makes mental illness unavoidable, and at the same time, the illness itself remains unknown. Once Lital established a genetic basis for her children's mental illness, she revisits her reproductive decisions. With the benefit of (interpreted) hindsight, Lital addresses the morality of her reproduction:

Honestly if I had this [bipolar] in the severity that I have it now, that I've experienced over the last couple of years, if I would have had that in my teens. I don't regret them [having children] at all but at the same time honestly if I would have known then, I probably wouldn't have [had children] because it would break my heart to see them go through it. It's going to make me cry sorry...I definitely don't regret them, but I wouldn't want them to have to go through what I've gone through because I've dealt with being suicidal. I've been in the hospital, and I don't want them to ever have to go through what I've done

7.3.6 Mid conclusion

Lital, Dorit, and, Talya's narratives show their engagement with the genetic discourse of reproductive risk. First, they accept that their genetics exist beyond their reach and are

inseparable from their reproduction. Second, they prescribe a morality that evaluates the genetic risk they pose to their offspring and demands action following it. To ignore genetics will not only be seen as a failure of their motherhood but also of themselves. As women with mental illness, they are also mindful of their precarious position as reliable entities. They know that ignoring their genetic risk has its own risk. If they were to dismiss the genetic discourse around their reproduction, their insight and ability to behave morally would be questioned.

This thinking reflects the contemporary bioethics of genetic heritability. Instead of discussing the public good as the goal of managing heritability risk, the three women frame their reproductive decision as personal and private. This liberal idea of individualized choice lets them hold on to their decision (proactive or retroactive) against having biological children without extending it beyond themselves. It allows them to see their conclusion about the unsuitability of life with mental illness as an isolated event that carries no social or moral meaning.

While no participant ignored genetic risks, others saw it differently. In the next part, we will show narratives of women who engaged with the genetic discourse of their reproduction by questioning its risk. Two central questions stand out. One is about the usefulness of statistics for individual decisions. The second is about genetic essentialism. Through these questions, the women participated in the genetic discussion about their reproduction but avoided the conclusion that it is immoral for them to have children. These two views of genetics come out nicely in the story of Moran, 23 years old, who lives with her partner and is diagnosed with schizoaffective disorder.

7.3.7 Questioning risk: statistics as chance and genetic essentialism

Moran always wanted to have children. Even as a teenager, she was planning for a future of motherhood. Her diagnosis of mental illness threw a wrench in this fantasy. On social media,

books, and blogs, she read about her illness and her reproductive future. She found that many of her peers with schizophrenic spectrum disorders and other mental illnesses believe that it is immoral for her to have a child:

... that was about a year where I decide that I wasn't going to have kids at all because even if I did it could hurt the unborn child or whatever. So, that really made me sad... It might have been right after I was hospitalized ... And I was just completely convinced... The only reason I've thought that is the books I read, the forums I'm going online "It's morally wrong for the mentally ill to have a child. To bring a child into this world knowing that they could have mental illness problems

Despite the heartache that giving up motherhood brought, Moran did not talk about it with her mental health providers. She vaguely remembers a conversation with her therapist in which they expressed their belief that she could become a mother. She does not recall any discussion with her psychiatrist on the matter.

It took about a year until Moran changed her mind and started reincorporating motherhood into her future. It happened after a conversation with her aunt, who, like Moran, did not fit the normative ideal of motherhood:

I talked to my aunt because she's 46 or 47 and she has a one-year-old child. So, she had a baby kind of late. She thought that I can have children too and I think she was the one who told me that she had a friend who was on psychiatric medication and her doctor worked with her and she was able to have a healthy child and all that.

Moran's older sister also came to her support, telling her that she would help her to become a mother. In her offer, she makes a distinction between pregnancy and child-rearing, thus creating a path for motherhood for Moran

I don't think she worries about passing on mental illness or anything like that. She definitely believes that I do have a serious mental illness and she supports me, and she listens to me. But she doesn't have any... I don't think she has any worries about that ... She was saying, "Yes you can, I'll help you. And then I'll give birth to her." So, she offered to have a child for me, which I was never on board for that. It was sweet but I just thought that it's definitely not for me. I know that she could be like inseminated or something. I would just rather adopt or something. She was really sweet with the offer though

Though neither aunt nor sister mention genetics specifically, their support brings a different outlook on Moran's genetic risk. Not only do they reject the genetic essentialism of Moran's online peers, but they also separate it from motherhood. By offering to be a surrogate for Moran's baby, her sister highlights the context of biological parenting in which genetic risks exist. Because there is no test to identify schizophrenia in fetuses, geneticist look at parental mental illness to assess the risk of it in the fetus (Uher 2010). Thus, women like Moran, who wish to be mothers but are concerned with the genetic heritability of their mental illness, can turn to non-biological motherhood as a solution to their problem. Yet, few do. One reason genetic concern remains a barrier to motherhood is the social hyperfocus on biological parenting.

Because pregnancy is seen as the quintessential manifestation of womanhood, non-biological motherhood signals a flawed way of being a woman and a mother. Second, and no less important, adoption, surrogacy, and other non-biological means of becoming a mother are resource-heavy and inaccessible to most women. Finally, as Moran mentions when she wonders about her ability to adopt children, non-biological parenting brings a special type of surveillance. For women with mental illness, this surveillance carries a heightened risk to their autonomic selves. (Kaplan et al. 2009; Callow, Buckland, and Shannon 2011).

With her sister and aunt by her side, Moran rethinks the genetic risk of her illness. Where she first thought of genetics as absolute, she now views it as chance and a poor predictor of real life. She explains her new way of thinking as a "guessing" game":

I know that my illness can be passed down and just keeping an eye out for that and stuff like that. I do know people that don't want to have children because they don't want to pass down their illness and they think that it's like unethical [...] I don't agree with that. So, I do want to have a kid or children. People have some form of mental illness and we've got medications and we've got therapy and because of mental illness, I will know what to look for in my child. I can put them in therapy, all the understanding and talk to them. We have medications now that can help. And even if I didn't have this illness, there would still be a chance that my child would have it because it runs in my family. There are so many families that at least one member has mental illness, it could show up in their child. You never know. It's a guessing game and I'm not going to not have a child because of something that might happen ... because of a guessing game

Moran's new interpretation of genetics is a far cry from the genetic essentialism of Talya, Dorit, and Lital. While she does not deny or ignore the possibility that her children will inherit her illness, she has come to view genetics as a starting point at most rather than an accurate picture of her future child's life. She makes several arguments in support of her new calculation of genetic risk. First, she repositions the risk away from the biological - beyond her reach - and places it in the behavioral, particularly the good mother. She argues that the risk is not genetics but the real-life response to the illness. With proper support and effective treatment, a good mother can manage the harm of genetics. Moran's second argument is directed at the usefulness of statistical measurements for individual decisions. Unlike other women who believe that their child will most definitely inherit their mental illness, Moran entertains the possibility that her

child will not have a mental illness—being able to see risk as a probability shifts her calculation of the cost of benefits. Her strong desire to have a child is not weighted against a chance - not a determination - that her child will have an illness that Moran believed manageable.

Moran's point about chance unique is how she expands it outside the boundaries of parental mental illness. When she asks why it falls on women like her to prevent mental illness, when a child can develop that illness even when their parents do not have it, she is revealing the unequal terrain on which moral arguments of genetic risk exist. If, as her peers online seem to argue, having a child with mental illness is unethical, and if the risk of developing mental illness exists regardless of parental illness, then every reproducing adult must acknowledge and act on that risk. The fact that only women with mental illness are subjected to the moral demand to make sacrifices to avoid mental illness in their offspring reveals the weak link between risk and morality. The unreasonable attempt to prevent mental illness through reproduction makes the argument that people with mental illness should not reproduce mute. Simply put, if mental illness will happen anyway, why does Moran need to give up on her dream of motherhood?

Unlike Talya, Dorit and Lital, Moran chooses to look at her own experience with mental illness to inform her reproductive decision. In the following quote, we hear Moran use the same logic that is made toward her reproduction on herself:

And also, I wouldn't want my parents to have said, "Oh, let's not have a child because what if she has this illness?" I still have a great life, a fulfilled life. I love writing, I love my family and friends. My illness can be hard to deal with, but I also think, I can't imagine my life without it in it. It's become a part of who I am a little bit. And I wouldn't want my parents to be like, "Oh, let's not have kid," and me not exist because I might... Because I have this illness

Moran points to her own life to argue against genetic essentialism. Unlike Talya and Dorit's contradicting narratives on hereditary risks in which they ascribed genetic essentialism to

their child but not to themselves, Moran's genetic narrative remains consistent. Using her own life as a starting point, she argues that not only does genetics not tell the whole story about the concrete experiences of mental illness, but also that having a mental illness does not make life better not lived. Her point that personal experiences shape one's view on genetic risks is then turned around toward those who advocate genetic essentialism. It is their maladjustment that leads them to assign moral value to the genetics of mental illness:

The people who are saying if you are mentally ill, you shouldn't have children are people with mental illness who are not in recovery that are doing very badly, and they can never even imagine being that place of stability. And I think they're angry. I definitely, I do think there's some truth to what they're saying a little bit, it's definitely something to consider. Think on, "Will this affect my child?" I need to be conscious; I need to be aware, educated decisions. But I personally think they took it too far. And I also think that their opinions are their own and they shouldn't put them on me

Moran's story illustrates several themes in other participants' responses to genetic risks. First, It shows the effect of professional neutrality on patients. We see Moran, shocked and confused with her new diagnosis and having no professional recourse to her questions. Though she is already concerned with her reproductive future, the topic is silenced. Neither she nor her mental health provider makes room for reproductive health in formal psychiatric care. However, Moran's search for answers on motherhood in online communities that serve people with mental illness shows that mental illness and reproductive care are intertwined. Peers fill in the gap of professional intervention and provide their interpretation of risks and morality.

Second, support is crucial. Moran came to view her reproductive options as wider than initially thought because of a diversity of opinions. Whereas online communities pushed in one way, and professional actors excluded themselves, the people who knew Moran gave her another

perspective. Feeling that her desire for motherhood is being taken into account, Moran was able to recalculate the genetic risk and benefits of motherhood. Her longtime dream to become a mother became part of the equation of risk and gave her a sense of selfhood that was missing from the patientism of her online and professional interactions.

Third, Moran places her personal reproductive choice within a larger moral argument. Unlike Talya, Lital, and Dorit, who were conscientious about avoiding any argument about the larger good, Moran links her personal decision to a social goal. Her claims about risk outside of paternal mental illness, her rejection of the idea that her life is not worth living, and her argument that good motherhood can overcome genetic illness create a connection between her personal decision to become a mother and society. Each of these comments highlights the social context in which genetic risks exist. She shows that the expectation that she will give up on motherhood because of genetic risk is a social scapegoating of women with mental illness. She claims that devaluing offspring's life because of their genetics is akin to devaluing her existence. And finally, she frames risk as contingent on a social support system.

7.3.7.1 From many to one: risk, statistics, and support

Sarah, the college student who has bipolar disorder, also thinks of her genetics in relation to her future child. Like other women, she has yet to discuss her reproduction with mental health providers (even though she has been treated for years by a world-renowned reproductive psychiatrist !), and her knowledge of the statistical risk of her genetics heritability is vague. So like Talya, Sarah looks at her family for clues.

But I mean, the other thing that you think about is, what if my kid gets my genes. But what if that happens? ... I think the disorder would have manifest itself differently in [different people in her family], so I don't know how it would in my child, but if I ever had a child, chances are they would not get it,

just because other than me, and my sister, and grandpa, I'm the only person who has it ... I mean, look, there are some severe cases where it just freaking takes over your life, but for the most part it's pretty treatable

Absent professional support, Sarah judges the genetic risk of her reproduction. Observing the small number of psychiatric disorders in her family makes Sarah conclude that the genetic risk of her reproduction is low. Her child, she believes, is not likely to have a mental illness such as hers. Because she estimates the genetic heritability of her illness as small, she summed her risk calculation to favor motherhood. Her love for children outweighs the risk that they will carry her "faulty" genes.

Sarah's reflection on genetic risks goes further than assessing the chances of heritability. The point she makes at the end of the quote reveals a more profound critique of genetic risk. Unlike genetic essentialism, Sarah sees genes as a partial-at-best predictor of lived experiences. She believes that even if her future child will carry the genes of her illness, the actual meaning of it in their life is unknown. Not only does mental illness come in many shapes and forms, but its experiences could also, in most cases, be shaped for the better.

Like Sarah, Adva is asking what genetic risk refers to. She, too, believes that her illness is manageable with effective treatment and a good support system. With this in mind, Adva changes the meaning of genetics from a child's life of illness to a maternal obligation for treatment.

On the subject of her daughter having bipolar disorder, Adva says:

That occurred to me once I was diagnosed, and I would be lying to say that I'm not nervous about it, but I also think that if it happens, I'll be in a position to be supportive through that. It's really when I was first diagnosed, it really felt like the end of the world kind of thing. Like, everything that I knew was gone. I don't really know how to explain it, but it really was like a moment of

complete panic about what the rest of my life was going to be like. But as I've stabilized and learned more about it, it's really not the end of the world to have bipolar disorder. It's very treatable, it's very manageable. So, if it happens, it happens. I certainly hope it doesn't, because I don't want her having to deal with especially the depression component of it, but we have very age-appropriate conversations about how brain chemicals can get messed up sometimes.

Believing that their mental illnesses are manageable allows Adva and Sarah to question the risk of their genetics. By placing genetics in conversation with good motherhood, they argue that though their children might carry the genetics of mental illness, the true risk of the illness is determined by the maternal response to it. In this view, genetics become a signal of a condition that needs to be addressed, not the bearers of an essential truth about the person.

7.3.8 Conclusion

All the women we talked to gave some thought to genetic concerns regarding their reproduction. This should not come as a surprise. Because the question of insight forever hangs above their heads, they must prove themselves morally responsible to maintain their right to choose. By engaging with the genetic risk of their mental illness, they present themselves as such. By showing awareness of their "true" state as ill individuals, they attempt to prove that they can be trusted to act on their illness and become "normal."

Though the framework of genetics as a source risk is situated within eugenics/newgenics discussions, the women in this study do not share its essentialist paradigm. Even when framing their genetics as a source of risk, they did paint it as an individual choice, not a moral standing on genetic traits and mental illness. Evidence is that none of the women in the study thought that people with mental illness, as a group, should avoid having children because of their genetic attributes.

Other women looked at the genetic risk more critically. They refrained from seeing their genes as a source of risk on which decisions should be made. Instead of rejecting the statistical notion altogether (which might have raised questions about their mental capacity), they rejected the interpretation of the data. Statistical risk is, they argue, exactly what the name suggests. It is a manifestation of chance rather than a prediction. As such, it reflects both realities: one in which the offspring has a mental illness and one in which it doesn't. Interpreting statistical chance this way allowed these women to engage with the talk of their genetic risk and reject it simultaneously without being suspected of lacking insight. Others questioned the idea that genes reveal the essence of the person. They focused on the relationship between genetics and lived experiences and asked what would be passed on.

Finally, Nurit (29 years old, bipolar disorder) offers a refreshing look at genetic risk. Discussing the possibility that her future children will inherit her mental illness, Nurit addresses her genetics more holistically, making her genes a place of risk as well as pride and self-love

I'm a little concerned that I have a mental illness and that my kid might have one, I also really liked who I am, so I think that having a baby with my genes would be pretty cool

7.4 Medicinal risk

We've already seen reproductive choice as both freeing and overwhelming, at which women must contend with their sense of self and illness, the demands of motherhood, and the ways others perceive them to be. This sentiment is ever so vital when it comes to medicinal risks. Shira's narrative gives us a glimpse into the emotional toll of having to choose the lesser of two evils

I worried every day, every day. you take your pill and it's a reminder. You're just like, "Please, God, just helps this baby be safe"...With any mother, you

want the best for your baby. I mean, you'd give your life for your baby. I don't know. Just that little percentage, in the back of your mind, that says, "There could be something that happened because you took this pill." It's very hard. It is

Medication is key to the stories the women in this study give. Unlike the ambiguity of genetic heritability or the subjectivity of behavioral risks, the medicinal risk is backed by a plethora of studies that provide a relatively coherent narrative on the relationship between medication and fetal development. This literature is highly technical, both in its description of the potential harm ("Phenothiazine for hyperemesis gravidarum," neurotransmitter levels, dopamine receptor sites, necrotizing enterocolitis) and of the route from medication to the fetus (Monoamine oxidase inhibitors, Plasma concentration, Presynaptic serotonin) (McConnell, Linn and Filkins 1998; Patton et al. 2002; Payne 2021). The overall agreement surrounding medicinal risk, on the one hand, and the technomedical language in which this risk is clouded shape how women engage with this risk.

Women must contend with a conflicting view of medication. On the one hand, medication is the golden rule of treatment and is believed necessary for women to be good mothers despite their illnesses. On the other hand, psychiatric medications are a source of risk. All psychotropic drugs cross the placenta and are found in the amniotic fluid, suggesting a potential risk to the fetus. This conflict and its institutionalization are described in a study of women with bipolar disorder, "Many women in this study were also fearful that they might harm their baby by remaining on their medication...Weighing the chances of damaging their unborn child against the possibility of becoming ill when medication-free was described as extremely difficult and provoked much anxiety. Some women reported that their fear of getting ill when

pregnant or postnatally was greatly exacerbated by being told their pregnancy was officially labeled ‘high risk’” (Colman, Jones and Howard 2016: 297)

This damned if you do, damned if you don’t, the situation leaves women suspended in space as they make decisions about their medication during pregnancy. The following stories bring out several themes in women’s response to the problem of medicinal risk. First, we see women evaluate the risk that mental health providers relay to them. While silence remains the dominant response to reproduction in psychiatric settings, it does not mean that no discussion ever happens. These stories reveal that reproduction enters the psychiatric relationship in a specific way. It happens in brief exchanges on the medicinal risk and tends to be one-sided. The psychiatrist conveys the information to the woman using technomedical language and sets the boundaries for her reproduction. Second, women use different methods to calculate risk. Some women use oppositional ethics in which the mother and fetus have contrasting interests; others use a relational approach that bounds the mother and fetus. A third theme that comes up from the narratives is trust. Women use trust to find their path between the risks of medication use and the risks of medication-free pregnancy.

Shira who we met earlier, talks about the communication of risk:

Many times, psychiatrists will say that it's up to you what you want to do. It's overwhelming because they're saying, "This medication is class whatever," I don't know, C, D, whatever it's called. I'm not sure. You're having to make these big decisions, like, "Okay, if I take that, which is considered the safest option, it could still cause heart defects in a child

The “class” that Shira mentions refers to the FDA system of categorizing medications on their presumed risk to fetal development.⁸ This classification is then communicated to health providers who are meant to use it in their clinical practice when they decide on medication treatment. It is also, as Shira shows us, a technology of communication.

7.4.1 Standardizing risk and the black box

In the bioethics of choice, information on risk - such as this class system - is the basis on which informed decision is to be made. The FDA classification of medications is a powerful communication tool, partly because of the supposed clarity of its bottom line. Each of the six risk categories, marked by a letter, describes a different level of risk, from no harm to the fetus to extremely harmful and dangerous. Class A, for example, represents medications that are considered safe during pregnancy; class C, on the other hand, represents medications to which “risk cannot be ruled out,” and class X are medications that are “contradicted in pregnancy” (Armstrong 2004).

Yet, this supposedly clear bottom line conceals a more complicated relation to risk. Already in the description of the categories, we observe the link between the assertion of risk and the scientific method for studying it. Note, for example, the definition of “class A.” Medications that fall under this category are those to which “no controlled studies showed to carry risk to the fetus.” Scientifically, this definition translates to no risk, as none has been shown to exist. But

⁸ Following criticism on the applicability of a six-category classification to capture a complicated and highly individualized risk, the FDA removed the letter-system in 2014. Instead of the old system the FDA now requires pharmaceutical companies to provide information on pregnancy risk on the drug’s label. This information is delivered in three subsections: summary of the risk to the fetus, clinical considerations to be discussed with the patient, and detailed data from animal and human subject studies on the medication. Like Shira, the participants in this study made their reproductive decisions before this change. They had to engage and evaluate their risk through the old classification system. What’s more, even though the FDA no longer labels medication with the old method, psychiatrist often refer to it when they discuss medication. Classes of risk remain an important technology in the communication, assessment, and management of medicinal risk.

this definition can hold a different meaning for women who are to carry a pregnancy. For them, class A means that no risk has been found to exist. It does not necessarily mean that there is no risk.

This difference in translation makes communication of choice more difficult. Where a psychiatrist might see a clear indication of a level of risk, women may regard the information as insufficient for decision. Of course, this translation level can only exist if the psychiatrist does not already interpret the scientific language of classification to the patient. As we will see later, psychiatrists often create shortcuts in their description of risk. They replace the technomedical focus on research findings with a conclusive assessment of real-life risk. For example, one would simply assert that a class A medication is safe during pregnancy, or a class C drug isn't.

The room for different interpretations of risk that the technomedical language creates is one limitation of using the FDA classification for communicating medicinal risk. Another problem goes deeper into the ways classification happens. In their paper about the benefits and risks of psychotropic drugs during pregnancy, Randy K. Ward and Mark A. Zamorsky (2002) discuss the backstage of the FDA categorization of pregnancy risk, "These rating have a number of limitations, including a lack of internal consistency within classes of medications; attempts to aggravate diverse information, such as risks, into a single rating; poor discrimination between different medications within a class; and lack of agreement with the findings of other credible sources" (ibid: 630)

Shelia Jasanoff (2004) refers to this backstage of knowledge production as "black box." It contains "the normative choices that get made ... in the resolution of conflicts; the classification of scientific and social objects; the standardization of ethnological practices; and the uptake of knowledge in different cultural context" (ibid: 278). The point she makes about the black box of

scientific and technological knowledge goes back to the idea that said knowledge is created and embedded in social life. The way we know the world is inseparable from the methods with which we approach and study it, which, in turn, is inseparable from the social structures that bind us. The black boxing of knowledge is the process in which this co-production is sealed, and scientific knowledge is stabilized.

Criticism regarding the assumptions behind the classification of medicinal risk suggests that the black box of that standardization technology is not hermetically sealed. Indeed, In 2014, the FDA overhauled its system for communicating pregnancy-associated risks.

Whether Shira is aware of the true nature of the classification system or not, her response to the information regarding her medication class illustrates the chasm that opens between her and her psychiatrist. The technomedical language allows medical professionals, such as psychiatrists, to pass the information on risk without appearing invested in the outcome. The assumptions about the objectivity of scientific knowledge protect Shira's psychiatrist from accusations of moral judgment and affirm their neutral position. For Shira, however, this technomedical language is deeply moral. Within this exchange, a gap develops between the neutral psychiatrist and the morally burdened patient. This disjunction stands behind Shira's tepid response to the information her psychiatrists provided her. The technomedical assessment of risk does not quite capture the moral weight of the decision she must make.

Knowing the risk level of her medication forces Shira to make a detailed calculation of the potential costs and benefits of taking medication during pregnancy. She uses her psychiatrist's assessment of the medicinal risk to the fetus and places it against the alternative future in which she does not take medication during pregnancy. Unlike fetal risk, this risk is not defined through biological malfunction (heart defect) or developmental stages. Instead, it is

embodied in Shira's life story. To imagine a pregnancy without medication, Shira goes back to her past and reviews her life without medication for her bipolar disorder. Having established these two visions of risk, Shira moves toward a decision:

Because I figured that if I stopped taking medication altogether, I knew how depressed I got. I mean, I had been in the psychiatric hospital for suicidal thinking. I was thinking that is worse than any ... They tell you ... I don't know what the percentage is but ... the percentage is very small that anything would happen to the baby being on that low dose of Zoloft. So, I chose that, weighing my options... I was more concerned with the baby's well-being, of course, out of everything. I mean, I could care less if I just felt depressed or whatever that day. That wasn't it. See, I was told by the doctors that if I'm depressed, that affects the baby negatively. That I did not want

The ending of Shira's quote reveals a twist in Shira's interpretation of risk. Instead of viewing medication as the source of two different risks, one to the fetus and one to the mother, Shira places the two together. Her argument that harm to herself will cause harm to the fetus brings a new way of calculating medicinal risk. Reproductive psychiatrists refer to this type of thinking as "relational ethics."

7.4.2 Ways to calculate risk: oppositional vs. relational ethics

Instead of the oppositional framework that places the mother's well-being and the fetus/newborn's development in conflict, "relational ethics" places the interests of the mother and the interests of the fetus in tandem. This risk calculation looks at the mother and fetus/child as a unit of two tightly linked objects. At its base is the assumption that both mother and fetus benefit from each other's well-being and face risk when both are harmed. In other words, if the mother is not well, so is the fetus, and if the fetus is harmed, the mother's mental health will suffer too.

This view of the mother and child as one unit instead of two separate entities helps reframe medication risks. Using this holistic calculation of risk, reproductive psychiatrists might advise a woman to take medication; if not taking it will not only harm the mother but also, as an indirect consequence - the fetus. In other cases, women might be advised to refrain or even stop using medication if it is believed that the harm that the fetus might suffer will cause indirect harm to the mother. Risk calculation includes the possibility of harm to the fetus, the mother, and their relationship.

Shira's look at medication and pregnancy has changed by the time of the interview. The calculation of risk that brought her to take Zoloft during her pregnancies no longer holds. She explains that as a younger woman, she was so excited to get pregnant that she was willing to endure the anxiety of changing her medication. Now that she is a mother, and after going through so many traumatic medication changes, she would not go down this path again. Shira's calculation of risk has changed, and she decided not to have another child.

I was a lot younger then. It [changes to her medications] didn't bother me that much. I was a little nervous to do it. But I was so excited about the prospect of starting a family that I think it just, that didn't bother me so much. Now, let's say I want to have a baby right now. If people want to mess with my medication, there's no way. I've dealt with medication so much, it's traumatic for me now every time a medication is changed and going down one. There's just no way. At this point in my life, I do not ... I could not have another child

Shira's new assessment of risk stands out: the importance of reproductive desire and medication consistency in the decisions about medication risk. Though Shira did not mention her excitement to have children, and the relative ease with which she changed medication when she was younger, when she explained her decision to remain on Zoloft during her pregnancies, their centrality to her decision comes out when they are no longer relevant. This revised story of the

decision to remain on medication brings in a new type of risk: the emotional toll of giving up on a desired reproductive dream and the burden of medication change. Though these are non-medical risks per se, we realize their dominance in Shira's evaluation of risk. The change in her calculation of medicinal risk does not reflect a change in the risk to the fetus or herself. It is a change in her desire for children and her willingness to endure the toll of medication change that shifted the balance of risk.

Adva shares Shira's current thinking about medicinal risk, though her path is different. The medication she takes for her bipolar disorder carries such a significant health risk to the fetus that her psychiatrist told her that pregnancy while on this medication "would result in the child dying within hours of being born." Adva was told she "needed to get on birth control because I couldn't get pregnant on this medication."

Adva, who has one child, trusts her psychiatrist's judgment. She follows their directive about her reproduction even if it means that her (and her husband's) plan to have two children will not pan out. She describes her current calculation of risk and her hope that it will change in the future:

Right now, with the medication that I'm on, if I were to get pregnant, and abortion would be the only option, because of the risk of serious birth defects. Which is something that I actually only found out about recently, and I'm still processing a little bit because this medication combination works really well, but it's something that my husband and I both would like to have another one, and we're trying to be optimistic that maybe in some point in the next couple of years, we'll be able to give it a try, but we're not positive if that's going to happen...

He's [Adva's husband] very supportive. He's happy because, like I said, we've been together since we were teenagers, minus that separation. He sees the tangible shift in me being on actual stabilizing meds, so he really sees the

benefits of them. He's sort of like, he accepts it, but he's also like, "Man, I really hope that we're able to have another kid."

Finally, Adva talks about what is at stake and the ensuing balancing act that she and her husband must engage in:

He would prioritize me staying on the meds, if that's what's needed, over having another kid

Unlike Shira's psychiatrists, who passed the moral weight of the decision on to her, Adva's health provider left little room for Adva to decide about pregnancy and medication. There is no moral ambiguity in their statement that pregnancy is out of the question for her. Because Adva trusts her psychiatrist, she does not question their warning and has no qualms about the conclusion they draw. Adva relies on her psychiatrist not only to define the boundaries of her current reproduction but also to determine her reproductive future. She accepts their role as arbitrators of her reproductive future through ongoing measurement of her stability and risk.

Adva's story goes back to the black box of classifying medication and the translation of technomedical language to communicate risk. Though no medication is certain to cause fetal heart malformation or fetal/neonatal death, Adva's psychiatrist makes it seem like it is. Their statements about Adva's reproduction turn statistical probability into certainty about fetal harm. In doing so, they teach Adva to treat her potential pregnancy as guaranteed tragedy, leaving little room for doubt about the right thing for her to do. Adva sees the decisiveness of her psychiatrist as a reflection of risk and care, not as an infringement on her agency. She welcomes the psychiatrist's involvement and trusts their judgment about her medication and, as made obvious, her selfhood.

7.4.2.1 Psychotropic drugs and pregnancies

Medicinal risk is a relatively new phenomenon in psychiatric care. Up until the middle of the 20th-century psychiatric use of drugs was limited to palliative purposes. Drugs were considered a tool to keep patients tranquil enough for institutional care. The introduction of chlorpromazine in the early 1950's changed that. The newly developing field of psychopharmaceuticals ushered in a new era in psychiatry. New psychotropic drugs promised to lift symptoms of mental illness and even cure it. Indeed, the belief that medications can solve mental illness was central to the deinstitutionalization movement. With medication, it was thought, people who were until then considered unfit to live outside institutions would be able to assimilate comfortably into the community as normative members of society.

The decades since have shown that the promise of normalization through psychotropic medication painted a too-rosy picture. It is true that for some patients' psychiatric medication made life with mental illness manageable. In many cases, psychiatric medication allows people to live normative lives despite their mental illnesses. It relieved symptoms of stress and depression and helped to treat psychotic thinking and manic episodes. Nevertheless, the idea that psychiatric medication will make mental illness mute ignores the reality and limitations of this type of medication. For stater, psychiatric medication has proven to be more elusive than initially thought. Many psychiatric medications are notorious for their side effects. These range from nausea and weight gain to loss of sexual drive and damaged liver to deep depression and increased suicidal thoughts and attempts. Even interviewees who discussed the beneficial outcome of their medication or described their life as "normal" dues to it made anecdotes about the side effects with which they live. Keren, for example, talked about her medication's impact on her concentration, which makes verbal and written communication difficult, and Meital

mentioned her discomfort with the weight gain that comes with her medication. Other women reflected on their sexuality, which medication may dampen. In other words, the benefits of medications must be viewed in the context of their costs. Women reflected on their medication by weighing the cost of not taking it against the cost of staying on it. As we have seen so many times before, it is a calculation of risk. The idea that psychiatric medication is a clear choice for treating mental illness falls short of a reality in which there is a possibility of harm in both options.

Besides the side effects, the efficacy of psychiatric medication is not entirely understood. Psychiatrists and patients often treat medication as an experiment, a trial-and-error process to find what works and does not. It turns out that some medications work well on some people, while other patients cause discomfort and ill health. The reasons for the different experiences remain unknown, turning the medicinal treatment into a long process of trying and changing medication. The long and often agonizing process of finding suitable medication is often the initiation stage into the moral career of a mental health patient. It creates ample opportunities for supervision and corrections to the patient's behavior and sense of self. To reach an agreed upon a psychotropic treatment, both patient and psychiatrist must agree on who the patient is and where the illness resides. Psychotropic medications are unlike other medications because their administration is tightly bound to moral assessments of agency, self, and illness.

Beyond the problems of side effects, unpredictable responses to medication, and moral judgment, there is the simple fact that some mental conditions (and patients) remain harder to treat with psychiatric medication. Severe depression, for example, has proven to be hard to treat with medication. Some patients (such as Sarah) go through multiple prescriptions without satisfactory results. It is not unheard of for people who suffer from severe depression to be told

that they have exhausted all the medicinal options for their condition and that the only treatment left for them is ECT. Like Sarah, medication could sometime become effective after ECT.

Despite the apparent need for new and improved psychiatric medication, their development has halted. Since the 1990s, the burgeoning field of psychopharmacology did not introduce any new drugs to the market (Harrington 2019). Still, medication has become the face of psychiatry and the symbol of the field's medical orientation (Luhrman 2001; Bourgois and Schonberg 2009; Brodwin 2013). Psychotropic medications are the centerpiece of psychiatric treatment and policies and are considered a necessary and irreplaceable part of any recovery process. Considering its centrality in psychiatric care, it is no surprise that medication has become a litmus test for patient insight. Compliance with the medication regime indicates that the patient recognizes their "true" state as an ill individual and is working toward health. On the other hand, the rejection of medication is believed to be an act of defiance and evidence of inability to see the illness (which itself is a sign of illness). This lack of insight indicates risk and justifies authoritative action.

Other women experienced reactions similar to Adva's to their reproductive life, though not necessarily from their psychiatrist. Lilach, a married 30-year-old white woman with bipolar disorder, wants to have children but is having difficulty conceiving. With her husband, she is looking to be seen by fertility doctors. Unfortunately, her attempts to schedule an appointment or receive treatment have been cut short every time she discloses that she is taking medication for bipolar disorder. This is incredibly frustrating to Lilach, who has worked closely with her psychiatrist to find a medication that works for her and is safe for pregnancy.

I saw a doctor about three weeks ago and she refused to see me as a patient because of the medication that I was on for bipolar. So, I had to find a different doctor. ... when I went in and she goes, so these medications you are

on, what are they for? And I explained to her that I was on medication for bipolar disorder and she looked at me and looks back at the file and said, there's no way I'm going to let you have a child being on this medication. And I was like, what do you mean? She goes, this could cost severe birth defects. And one of the conversations I had with my psychiatrist was I need a medication that will be acceptable during, um, you know, uh, the period gestation for the child. So, we worked very hard on that, and she just dismissed it and told me that I needed to see somebody else, or I need to stop my medication

The fertility doctor with whom Lilach spoke did not share Lilach's (and her psychiatrist's) approach to relational ethics to medication. While Lilach believed that the risk from stopping the medication would be greater for both fetus and herself, the fertility doctor separated the two. They insisted on measuring risk to the baby separately from risk to Lilach. Having established them as distinct from one another, the doctor continued to prioritize the fetus's well-being. This, Lilach thinks, exposes the doctor's ignorance about her illness. She believes that misunderstanding of her illness stands behind the fertility doctor's risk assessment:

you know, I, I felt like she didn't understand the disease and she didn't understand what I dealt with on a day-to-day basis, and she didn't understand that non-medication is not an option for me. Like within certain parameters. I mean if it's a late-stage pregnancy drugs that you know shouldn't be used during the third trimester, I am okay with that. But the way she was making it sound was that I had to be completely off the medication or any medication for the entire nine months. And I just felt like that wasn't safe for me. That wasn't safe for my child. And so, I, you know, I agreed with her that I was going to go see another doctor.

Another way to look at Lilach's story is through trust. Looking at Lilach's narrative, we see that she trusts her psychiatrist to decide on her medication and her reproductive prospects. At

the same time, trust is absent in her interaction with the fertility doctor. Lilach feels that the fertility doctor does not trust her. This lack of trust in Lilach's ability to truthfully convey the risk that she is facing is at the root of their disagreement.

7.4.3 The role of trust in risk management

Julie Brownlie and Alexandra Howson's (2005) conceptualization of trust give us a way to understand and contextualize Lilach's experience with a fertility doctor. They address the role of trust - or leap of faith - in parental decisions about immunization, mainly when there is (or perceived to be) insufficient information to weigh risk and benefit. Their analysis, which borrows from Simmel and Möllering, situates trust within personal interactions informed by the systems and institutions that shape them. They argue that "when we think of trust in terms of immunization practices, it is useful to locate interaction between parents and health professionals within other relationships - including those between health professionals, those within the organizational context of the health providers, and those between parents, professionals, health system and society generally" (ibid: 225).

Conceived that way, we can begin to recognize how trust between health actors might shape their response to patients, making them less or more inclined to provide an individualized assessment of risks and acknowledge alternative sources of information (Nettleton 2004; Brownlie and Howson 2006). It contextualizes trust in health professionals within the broader response to the institutions with which the actors are involved.

This articulation of trust as a multifaceted relationship helps us understand Lilach's relationship with the two health professionals. Placing it within a more extensive professionalization system, we can see how Lilach falls between the cracks. Lilach's attempt to extract reproductive care from two separate realms of expertise, psychiatry, and fertility,

challenges a system that is responsible, among others, for the poor exchange of knowledge between disciplines (Lawley et al., 2022). It is sadly unsurprising that the fertility doctors that Lilach talked to did not share the nuanced assessment of risk that her psychiatrist did. Within this larger context that relationships of trust may or may not develop.

Considering how Lilach described her mental health when she is not on medication, it is pretty reasonable to believe that the fertility doctor would not have taken her as a patient if she had done as was told and stopped her medication. The mania or deep depression that she risks by not taking medication will surely not improve her chances of getting the fertility treatment she needs. The real-life consequence of the fertility doctor's response to Lilach is that unless she finds a fertility clinic that accepts her calculation of risk, she will not be able to receive the fertility treatment she needs.

In a health system where the patient is a customer and the medical expert a provider of services, the refusal of the fertility doctor to see Lilach is not immediately seen as an infringement on choice. After all, Lilach can choose to see a different doctor. This, of course, is a falsehood. First, Lilach reached out to other fertility doctors and received a similar response from them. The fact that she was rejected from multiple fertility clinics reveals the hardship she must go to exercise her reproductive choice to have children. Second, and maybe more crucial, is the message that these interactions sound. Though Lilach remains optimistic about her reproductive future, the moral undertone of the fertility doctor's response is clear. Lilach's pregnancy is a risk when she is medicated and when she is not.

Not all women agree to make that leap of faith. Some women felt that the assurance of safety their health providers gave was not enough to subdue their hesitation. In Meital's case, her

endocrinologist's, and psychiatrist's positive outlook on the safety of her pregnancy was rejected. Meital did not trust them enough to lower her guards on motherhood:

They don't say that, actually. It's funny because my doctor, my psychiatrist who I've been with for years, is telling me I can do it [be mother]. And with the Clozaril I'm on now I could remain on it and ... I used to see this endocrinologist in Staten Island, and he said to me that he had a patient who went bipolar and had PCOS like I do and then once she conceived, she was fine. She didn't have to go on any bipolar meds or anything like that. And then that got me thinking, "Well, maybe." But then, I don't know, I always say, "No." I don't think I really want it.

7.4.3.1 Trust in scientific processes

Women's trust in health providers was also shaped by their outlook on the scientific process and the knowledge it creates. Dvorah, for example, describes her discomfort with the scientific process of evaluating medications risk in pregnancy:

Because of the safety of the baby, because really none of them is 100 percent proven fine in pregnancy because there's so little research. Most people do try to come off of it because it's, you just don't know the side effects of a lot of the mental health medications on babies

Dvorah's awareness of the ethical concerns in research on pregnant women shapes her risk calculation. Instead of accepting risk classification as is, she opens up the black box and reveals the inherent limits to the scientific ability to measure risk. Instead of scientific reasoning, which sees no evidence of risk as no-risk, Dvorah argues that the lack of evidence says more about the creation of knowledge than about her and her future child's life. She concludes that the true risk of her medication is greater than what the data describes. Next, she looks at her own embodied knowledge about medication and finds that they bring little benefit to her life. Even when she takes medication as prescribed, she experiences mania and hospitalizations. In her

calculation of risk, she balances the small benefit she draws from her medication against an unknown risk to her fetus. From there, her decision to stop is clear:

I mean I had been off the medication for my other pregnancy too and was fine during the pregnancy. I had some depression, but I was functioning and working. It was just a depression that was a functioning depression, and then we had a backup plan if anything was showing up with depression or mania. And really honestly for me, I've been on medication throughout, on and off throughout all of that time and all those manias were when I was on medication. It didn't really make enough of a difference for me that it was like a fail-safe, and I didn't get manic. I still got manic and depressed on all the different medications they've tried. I've tried probably upwards of 28 to 30 different medications ... and I still had six hospitalizations

7.4.3.2 *Trust in health processes*

The idea of trust does not only refer to the scientific process. While Dvora talks about trust in processes of scientific knowledge, Rivka links it to the medication change process. She, too, is hesitant to believe that her medication is fully proof safe during pregnancy. Hearing different opinions about risk makes her uncomfortable with the data that shows that antidepressant medication is safe. On this basis, Rivka believes that she will have to switch her medication if she were to be pregnant. Now, the medicinal risk that she is to evaluate consists not only of the potential harm or the harm of not being on medication but also the process of searching for safe medication. Looking at her embodied knowledge of risk, she decides that switching medication will be too harmful:

And then the role of depression meds, too. I've read a bit about staying on antidepressants, getting off them, and the prospect of changing the meds, let alone dealing with pregnancy hormones just sounds like a recipe for disaster. So that's my perspective on that...I would say it is a strong contributing factor ... I try to stay out of the whole controversy about people talking about

medicine when they're not doctors. But my understanding is that it raises risks for various things as in pregnancy. And that's as far as I've researched it. People have said its fine, people have said it's not. I have a friend who's actually right now pregnant with, she's taking an anti-psychotic and so it's interesting to hear her experience. But long story short, I would say the prospect of changing meds or coming off meds or changing something like that is way too big of a hassle and it's too scary. And I feel like the potential for me to crash and end up in a bad place is so high that I would not want to do that basically. So, it's one more reason why it's like, Yeah, I don't think pregnancy is, at least the short term, in my plan

7.4.4 Conclusion

In addressing the problem of medication during pregnancy, women engaged in a complicated calculation of risk. Because the nature of medicinal risk is such that no pathway is safe (other than forgoing reproduction), women had to choose the lesser of two evils. They were made to imagine not only the risk of continuing medication during pregnancy but also of stopping their medication. Suspended between these two choices, some chose to re-orient the ethics on which risk is calculated. Instead of viewing the interests of their fetus as separate - and oppositional - to their own, they engaged in a relational calculation of risk. This not only allowed them to reframe their medicinal risk but also establish themselves as a good mother. The connection they drew to their fetus/child echoed a good mother's intimacy with her offspring. Doing so gave these women respite from the potential judgment that oppositional risk carries. When oppositional ethics of risk is used, women are left to choose between their well-being and that of their fetus. The risk of coming off as a bad mother who places her interests before her child is great and can potentially develop into the risk of being determined too ill to have that agency of choice, to begin with.

Whether or not women used oppositional or relational methods to calculate medicinal risk, trust was at the center of their calculation. This includes trust in health providers as well as trust in science and processes of treatment. Mental health providers were key in how women addressed their medicinal risk. The information they relayed and their position of power as prescribers made women dependent on their judgment. At the same time, their neutrality gave women space to engage in their interpretation of risk (so long as it was not lower than what the health provider assumed) and reach a decision that fitted their individualized comfort of risk.

Chapter 8: Attempting normalcy with a stepwise plan to Reproduction

8.1 Curbing the future, making plans

Planned reproduction is a moral good that brings desirable outcomes on individual and societal levels. It is fundamental to women's health and their status in society. Being able to plan if, when, and how, to have children, opens opportunities for women in the work force, allows them to obtain education, accumulate wealth and material resources and manage their health. On a social level, planned pregnancies are associated with improved antenatal and postnatal care, better health outcomes, and economic upturn (Wulf and Donovan 2002 ; Wu et al 2008 ; Bongaarts and Sinding 2009 ; Canning and Schultz 2012).

Indeed, women are encouraged to plan their reproduction. From young age they are told to prepare for their future as mothers, how many children then would have, with who, when and how. Girls are given toy dolls and directions how to care for them, as practice for the "real thing". As they enter adolescent, women are called to think of their reproduction in relation to other parts of their life, be it education, career, partnership and so on. whatever they do, they are expected to carve room and prepare for their pregnancy and motherhood.

The moral right of planned reproduction is contrasted with the wrongfulness of unplanned pregnancy. Each year, about half of pregnancies are either unwanted or mistimed. These unplanned events, when carried to term, are associated with a variety of undesirable outcomes, including poor health, infant mortality, developmental delays, poverty, and low educational attainment. Risk of unplanned pregnancies follow social lines. A 2001 survey found that 69% of pregnancies among black women and 54% among Hispanics were unplanned,

compared to 40% among white women. Economic factors play a part as well, with close to two-thirds of pregnancies among lower income families being unplanned, relative to 38% among higher earners. uninsured or underinsured women are at higher risk of unplanned pregnancies as well as younger women. Eight out of 10 pregnancies among women aged 15-19 are unintended (Dehlendorf et al. 2010 ; Sonfield et al. 2013). Unplanned pregnancies are associated with mental illness as well. Women who experience unwanted or mistimed pregnancy are at risk for mental illness, including depression and psychotic events. At the same time, women who are already living with mental illness are at an increased risk for unintended pregnancies.

The normative expectation that women will plan their reproduction, on the one hand, and the problem of unpredictability and agency that mental illness brings to reproduction, makes the stepwise plan a normalizing and disabling venture. Participants planned to finish their studies or find a job and become financially secure before they had children. most notably women talk about finding a long-term partner and being stable. What makes the stepwise plan important is its role in defining disability and normalcy. The goals the women set, are not only achievements on the path to good motherhood, but also signals to their commitment to normalcy. It is, therefore, a response to their dual moral careers: as women, and as mental patients.

This commitment to normalcy is what Kafer (2012, 2013) refers to as curative time. Only through cure and normalization can people with disabilities enter the future as parents. It is the fundamental pre-requisite to moral parenthood: “Futurity has often been framed in curative terms, a time frame that casts disabled people as out of time, or as obstacles to the arc of progress. In our disabled state, we are not part of the dominant narratives of progress, but once rehabilitated, normalized and hopefully cured, we play a starring role: the sign of progress, the proof of development, the triumph over the mind or body. Within this framework of curative

time, then, the only appropriate disabled mind/body is one cured or moving toward cure. Cure, in this context, most obviously signals the elimination of impairment but can also mean normalizing treatment that work to assimilate the disabled mind/body as much as possible” (2013: 28)

By creating a stepwise plan, women not only signal their desire to be included in normal reproduction, but also give evidence of their ability to follow it. In other words, creating the stepwise plan is first step in it.

Shira emphasizes the idea that planning is the path to moral parenthood when she reflects on her own reproductive experiences. Looking back at what she went through, and hearing other people’s story, Shira argues that there should be more awareness to the challenges of being a mother with mental illness, and that women with mental illness should address these challenges ahead of time

I was sick of people not talking about their mental health. I mean, you get the diagnosis and I'm like, "Okay, now what?" I had nobody to talk to about parenting, let alone getting pregnant, any of that. ... You're going to have to figure out, "Okay, how am I going to get my kids to school? How am I going to feed my kids?" Little things that you don't think about. When you're that depressed, you don't have the luxury of staying in bed all day, like you did before you had kids. I mean, it's a huge responsibility. Having a plan in place, saying, "It is not an option for you to not go to therapy" ... that kind of thing, is not something that you should just say, "Okay, yeah. I might do that." It's something that you have to do to be a responsible parent. It's just incredibly helpful to have that plan in place and say, "If I want to have kids, these are the steps I'm going to have to take." That says, "This is how we're going to make parenting work." I think it would be very unfair to say to people, "Don't have kids. You have bipolar." When people say that to me, I mean, it's very hurtful. I'm like, "I am a mom. I have three kids. I have bipolar." I think my kids have

turned out really amazing. To have more of a plan [for parenting with MI], I think people like plans, to know they have an element of control in things, and to stick with that plan

Sarah too, talks about planning as a way to gain control over one's life and a strategy for motherhood

My goal is to eventually get married, and have kids, and that is definitely something I'd like, and the clock is ticking, unfortunately. But yeah, I'm still trying to figure that out. So yeah....One of the reasons I'm an Economic major at college is because I hope to get control over my own finances someday...Right now my parents, they run it, if you will, but I don't want to be dependent on them. I'm 29, and I'd like to get control over it someday...

One thing that comes out of Sarah's plan is how "normal" it is. In fact, most women I spoke to frame their desired motherhood in traditional settings: a committed relationship (preferably married) to one partner, living independently and having financial security. Sarah brings this point home, when she expresses certainty that her plan will work out because she no longer thinks of herself as ill. Having recovered from her mental illness, she frames her life from now on as "normal" and accept a normal future to unfold:

and the good news is that this disorder, because it is under control, and will stay under control I'll be able to lead my life pretty normally for the rest of it. I expect so

8.2 Normalizing the future

Normalcy is not only central to the stepwise plan it also makes it invisible. Women talked about their goals as natural steps toward reproduction. Their belief in the necessity of these achievements to their reproduction, is the reason they delay discussing their reproductive health. As long as their goals are not accomplished, their reproduction will wait. The stepwise plan gives

their health providers an out from discussing reproduction too. Because they viewed their reproduction as something in the future, women were not particularly bothered by the absent of reproductive discussions in their mental health care. In fact, it was assumed by all parties that there is no need to discuss reproduction before the normative settings for it are achieved: intimate partnership, financial security, independent living, and mental health stability.

A closer look at the stepwise plan reveals a dent in its aura of normalcy. Nurit, for example, explains why she wants to find a partner to parent with, by reflecting on the challenges of her with mental illness. The normative expectation of dual parenting is tangled in Nurit's management of her status as a mental patient:

I just, I want to have kids and I don't think that I can have kids alone. I think that it would be too hard for me. So, I know that that's like an option for some people, but I don't think it's really an option for me because I don't think that I could care for myself and the kids by myself...I think like once I get a boyfriend and like if I, if once it becomes serious, I'm gonna plan to have a family. Yeah. I mean I'm on birth control and I use condoms like I am, I'm planning to have a family, so I'll talk about it then. But like if a guy were to ever ask me like do you want a family or can you have a family, I say yes.

Talya, who has schizophrenia also explains her normative expectation to find a partner, through the disabled narrative of care.

Because I can't fully take care of myself alone. I won't help out a kid if I can't, you know, so I feel like I'd have to be in a good place mentally and you know, in a relationship that is stable with somebody else

At the same time that Talya explains why her mental illness means that she needs a partner to co-parent with, she also explains why her mental illness makes it hard to find said partner

...desire to have sex [inaudible] yeah, a lot of schizophrenics like just don't have that desire. So that's another reason. Like they don't really care about reproduction. Things are connected and they just don't really care.... because like the fact that I don't really feel anything. Like I, I rather if I'm going to be with someone, I want to really, really like want to be with them and like them. ... I mean my life, is a downer as it is, you know, I sure don't want to drag another person and take them down. If I'm not like, you know, 100 %, I'm totally fine if I don't ever have that, you know, I'd rather be alone than unhappy

Similarly, Maria's worries about finances go beyond regular concerns of money and parenting. For Maria, the need to be financially stable as a parent is directly related to her mental health. Because money is a significant stressor in her and her partner's life, they will not feel mentally well to raise children if they feel insecure financially. Moreover, Maria refers to her wish to gain financial stability as both a step toward moral parenting and a chance to assess of her ability to be a good mother. She hints to that as she talks about time. The process of becoming financially stable will be an opportunity to "review" and work on herself toward becoming a good mother

We've sort of talked about if we want to [have children] and we kind of do, we think it would be cool, except there's so many, there's so many roadblocks in between now and then. I mean, the financial stability that we would want to have before we brought another creature into the world is very far from us. ... we would at least want to have bought a house, if not paid off a house. We would want to be able to give those kids a good life and like have not have them worry about money and all that kind of stuff. ...My fiancé actually does have depression and we get a lot of anxiety both independently and as a couple when we think about money. So, part of the financial stability conversation is also assuming that the amount of stress that we feel about money will be one of those things that is either resolved partially for taken

care of, for the most part, before we talk about having a kid. So, the mental health conversation and the financial conversation are sort of hand-in-hand with that for us... So, I think part of wanting to be financially set and mentally set does give me a bit more time to really review myself and figure out what I might need to do or how I might need to grow to be a good mom. Because I would hate to be a shitty mom

The stories that Nurit, Talya and Maria tell show the multiple roles of the stepwise plan. The wish to find a partner, become financial stable, and even live independently as other participants mentioned, is part of a larger attempt to navigate the tension between normalcy and mental illness. By setting these steps, the women signal their desire and commitment to normal parenting. At the same time, the steps function as therapeutic tool: they attempt to organize an otherwise unpredictable future and create a system of support.

8.3 Opportunities for assessment

Yet while the stepwise plan promotes normative reproduction, it is also entrenched in ideas about disability and supervision. Through the stepwise plan, women and health providers use sketches of normalcy to exhibit and ensure the correct way for motherhood.

The centrality of choice and agency that shapes mental health care in general, frames the stepwise plan as well. The goals are presented as self-oriented, meaning that is the woman's responsibility to work toward them⁹. This framework of choice turns the stepwise plan into an opportunity to assess the woman and measure her progress toward normalcy. An accomplished goal is a sign of the woman's morality and her dedication to improvement. An unachieved goal is a failure of morality and a sign of the woman's disabled status.

⁹ For an extensive analysis of goals as technomedical tools for supervisions and regulation, see Levinson 2010.

Shlomit's story shows how the two things happen simultaneously. Shlomit wants to be pregnant, but first she needs to find medication that works for her and that is safe to take during pregnancy. She works with her psychiatrist toward that goal. This creates an opportunity to measure and judge Shlomit's self. Shlomit explains how she and her psychiatrist agreed to use process of finding safe medication as a tool of care. The psychiatrist will assess Shlomit's fit for motherhood and determine if her reproductive intentions are morally justified, and whether she is fit to be a good mother

And so, he [psychiatrist] discussed with me the effects of contraceptives and different medications and how they interact and stuff. So that was really as far as that went. But then he turns to say the same thing as Dr. W said. If it ever comes back around and it [having another child] is something you guys would like to discuss, you need to make sure you come to me and you discuss everything with me. Don't leave anything out ... and he said, you need to be prepared that, that would be like a six month conversation. That would not be something I'd be willing to do more than a six-month conversation about having, before agreeing that it would be a good option for you guys.

He wants me to come to him and start having, yeah, six months before because he wants, he wants to have six months to evaluate when we start the conversation, he wants six months from that point to evaluate where we're at, what kind of position we are in mentally. Is it just we're missing having babies again or is this really, we would want to add to a family. It's something we really want. Am I mentally stable enough? So, he wants to see how I stand for six months. Then as a pregnancy is nine months. So, he said, I want to see through for at least the majority of the pregnancy, where the hormones really kick in. I want to see where your mental facility is on a tone before agreeing. I mean, and he said, you know, you're adult, you can do whatever you want, but this is my recommendation

The dual role of the stepwise plan exposes the link between medical expertise and moral judgment. women's experiences reveal a moral undertone in their interactions with health providers and throws a wrench into psychiatry's claim of neutrality. Psychiatric medication helps to illustrate this moral scaffolding of mental health care.

As discussed earlier, psychotropic medication was promised to bring relief from symptoms and return patients to normal living. having no biological markers to measure the effectiveness of psychiatric drugs, patients, and psychiatrists' resort to subjective measures of normalcy. The closer the medication bring its user to normal living, the more effective it is. Going back to Shlomit's story, we see that the process of finding safe medication goes beyond attending to risks to the fetus or mother. An effective and safe medication is one that will bring Shlomit closer to normative reproduction. Anything short of that, could be made into an argument about Shlomit's moral standing vis a vis parenthood.

Adva, who was told that her medication will bring death to her fetus, described a similar experience. The first step in her reproductive future was to get off or switch her medication. As with Shlomit, setting this goal as a step to becoming pregnant, gave Adva's psychiatrist an opportunity to assess her fit to ideals of good motherhood. Despite their declared role of neutral informants, Adva's narrative describes her psychiatrist as the one that holds all the power over her reproduction

EP: Did you talk to your therapist about it [not being able to get pregnant]?

Adva: Not really. We've been working on more of the childhood issues. Right now, we're on a roll with those, and dealing with some of the PTSD symptoms. So, that hasn't come up just yet. My therapist did say, or my psychiatrist did say that it's possible, in a couple of years, if I continue to be stable, to cut back on the meds, or the other option would be to plan out a pregnancy, and carefully wean off them just for the duration of the pregnancy.

Under that, I would have to have more frequent check-ins, and obviously my therapist would be keeping tabs as well ... We're hoping maybe in two years. That's the time frame that we're looking at now, and my psychiatrist was very clear that it's not a guarantee, but that's what my husband and I are hoping for.

Adva's narrative reveals another way in which the stepwise plan is used to assess moral parenthood. For women with mental illness, proper timing of reproduction is not just about when to have children. Women with mental illness must also learn to time their reproductive conversations with health providers. Adva's story highlights how timing this conversation is itself a signal of fitness to moral parenting. Adva explains that she has not yet talked to her health provider about her wish to have children because it "was not the right time". Though having children is clearly on her mind, Adva thinks that it is better for her to postpone discussing it with her health providers until she is further ahead in her recovery. Although she already knows that she would like to have children and that it will be a long process, she decides not to talk about it at the moment. Adva is afraid that bringing the topic up now, will not only disturb her recovery, but might also put her at risk of seeming to lack insight into the reality of her mental illness.

Sarah too tells a story that reveals the importance of timing reproduction. When she was in her 20s, Sarah was seeing, for her ongoing care, a renowned mental health provider who specializes in reproductive psychiatry. Even though their specialty is medication and reproduction, the psychiatrist never discussed the topic with Sarah. They did not talk with her about her long-term plan to become a mother, or the potential risks that her medications pose to a fetus. When we asked Sarah how come the topic never came up, she answered by referencing the stepwise plan. She was still young and unstable, two statuses that do not go well with reproduction:

Well, he, and I never discussed it just because I was in my mid-twenties, and still dealing with the illness very much. I wasn't fully out of it

Finally, Lital, who decided not to have more children, describes her psychiatrist's refusal to change her medication. She imagines how they would respond had she wanted to be pregnant again and reflects on the power dynamic that the stepwise plan can create.

He'd probably tell me not to [be pregnant]. I could see him saying that because he won't even change ... I'm trying to get off the lithium altogether and he won't take me off of it because he said, "Look how long it took you to get here to this good place. I don't want to take you off of it and then get into a bad place and it take you just as long to get back." I think he's trying to get me just to not change anything...Well he [psychiatrist] keeps telling me "Let's wait 30 days and see." Then 30 days comes, "Well let's wait 30 days and see." He is never going to take me off this."

8.4 Creating support

Health providers are not the only people with which women need to negotiate their self, and as a byproduct, their reproduction. Support from intimate partners, family and friends was another recurrent theme in women's plan. More than a step, support emerges as a seal of approval, the glue that brings the plan together.

To illustrate this point, see Moran and Adva's thinking about the importance of support to their reproductive plan:

Moran: I do. Yeah. I want it [to have children]. But it's going to have to be something where I'm going to have to really make lifestyle changes before, I do that. Because I take a medication at night that helps him sleep and if I have a child who needs me to wake up in the middle of the night and feed them. I'm going to have to stop taking my medication so that I can tend to my child. Of course, I plan to have a partner to help me, but I can't just rely on that. Just

little things like that I'm going to have to plan for and really keep in contact with my therapists and doctors and having a support system ready.

I do think that with proper treatment in place, and treatment teams and support systems. It's not something that people should just take off the table outright, because they have a diagnosis...I think having a good, they say it takes a village to raise a child. I think having good, natural supports around you, like friends, and hopefully some family who are able to provide extra healthy supports for both you and your child

Sometimes, support can stand-in for missed steps in the plan. Dvora had her first pregnancy when she was in her 20's and in an abusive relationship. By then, she had already been hospitalized three times, and was aware of her mental illness. In fact, the pregnancy happened during one of her manic episodes. Dvora felt depressed and ashamed about her pregnancy and contemplated giving the baby up for adoption. She says:

Just knowing that I had a very chaotic life that I never knew if I would go nuts. And less about being pregnant with a mental illness, but more about a life with a child, when I don't know how bad my bipolar could act up, and being responsible for another human being ... I finally, I spent some time online talking to people on forums, either way about deciding about adoption. And then, I finally talked to my family about it, and let them know I was pregnant, and we talked to an adoption counselor. And when she [adoption counselor] came to the house, that's when my sister was there too for the family meeting, and said, "If something happens to Dvora, I volunteer to be there, because I know she's a single parent, and it might be hard for my parents, the grandparents, my parents to be there." So, she said, "I'll be there." So, that was part of the decision to definitely keep the baby.

I'm very glad I made the choices I made, and I love my daughter and I'm very glad I have her in my life and that I didn't give her up for adoption as is,

because I did have a really strong support network with my mom and dad and my sister

8.4.1 What is support?

It is widely agreed that support is a central component of care, that good care gives support, and support creates care. Having and support and feeling supported, have been shown to help people cope with a large variety of personal calamities. It mitigates the negative effects of experiences such as unemployment, illness, trauma, mental health and disability (Roy 2011). Support is prominent in disability and mental illness literature. Tom Shakespeare, a leading disability studies scholar, dedicates a chapter to “Care, Support and Assistance” in his seminal book “Disability, Rights and Wrong” (2006), Paul Brodwin (2013) writes about the Community Support Systems that were established to help psychiatric patients after deinstitutionalization, Michael Gill (2015) points to support as a way to expand sexual rights among people with intellectual disabilities, Karp (2002) reflects on family support in his cutting-edge book “the burden of sympathy: how families cope with mental illness”, to list a few.

Yet, despite its importance, support is poorly theorized. In my research in disability and psychiatric literature, I did not find definition for support. While examples of supportive practices abound, they do not coalesce into a theoretical framework for support. Outside this literature there is, to my knowledge, little on the matter. Roy, who’s work I cited above, offers the most extensive review of studies of social support that I’ve found. To theorize support, he refers to Caplan (1974) and Cobb (1976) who he calls “two early protagonists of social support” (Roy, 2011: 4). Though their definitions of support are slightly different , they both break support into similar three functions: making the person feel loved and worthy, creating a safe place of refuge, and creating a sense of belonging.

Another source of theoretical thinking of support comes is Catherine Penny Hinson Langford et al. (1997) who offer a typology of social support. They suggest that social support is composed of four different types: Emotional, Instrumental, Informational, and appraisal support. Of the four, they argue, emotional support, which “involves the provision of caring, empathy, love and trust” is “the most important category through which the perception of support is conveyed to others” (ibid: 96).

The support that the participants in this study mention in their stepwise plan, as well as in other places in their narratives, encompasses all four types. They look for material (i.e., instrumental) support, informational support, and appraisal support. Yet the most significant to all was emotional support. Even when resources were few, or information was lacking, or appraisal was high, women looked for emotional support to their reproductive decision. But the stories they tell are built on a different idea of support.

Looking at their narratives, we find that women felt supported when they felt that they share an agreement of who they are with the person with whom they were interacting. When there was a shared agreement on their selfhood, they felt supported, whereas when such an agreement did not occur, they described feeling unsupported. Making agreement on selfhood at the center of support, allows us to move away from support as action or as moral statement about agency (yes, you can!). It lets us see support even when disagreement on action occurs, or, as we’ll see below, when trust or enthusiasm is minimal. In other words, it lets us see support from the point of view of the recipient, not the provider. The four examples below, show the usefulness of this definition, over those that center on love or active agreement.

At some point in our conversation Keren recalled this episode with her mother

My mom mentioned the other day at my cousin's kid's birthday party, when Addy turned two. She was like, "Oh you're never going to have kids, right?"

And I was like, "No." I kind of said that. And then I was like, "Oh maybe I should have a kid," and Mom goes, "No." And I'm like, "Why?" And she goes, "You're going to raise a kid?" I was like, "I could just give it to you." And she goes, "Yeah, that's what I'm afraid of". I just said no just to... because if I said yes, then it would have opened a whole conversation. So, I just said no

Despite their shared conclusion, Keren does not feel very supported by her mom. She uses her psychiatrist's words to express her feelings: "Your mom thinks she knows a lot but she's very uneducated. She looks a lot of stuff up on the internet, I can tell." And he goes, "Your dad just doesn't know anything.""

The reason Keren let the conversation drop even though she was feeling irritated by it, is that she knew that this exchange about motherhood is the tip of the iceberg of a deeper disagreement on who Keren is. Their difference understanding of Keren goes directly to matters of choice & agency. Keren's mother believes that Keren and her illness are one and the same, and that whatever difficulties she experiences are permanent and detrimental to motherhood. Keren, on the other hand, believes that many of her challenges are a combination of illness and social powers. Though it is her mental illness that sets the stage, access to medication, support, social services, and psychiatric expertise, make the difference between disability and normalcy.

Esther's story offers another example for the usefulness of thinking of support as an agreement on the self. In this case, Esther and her friends disagree about her reproductive decisions; Esther feels that she should not have children, while her friends believe she could. Unlike Esther's friends, other people accepted her decision. Despite disagreeing with her friends about her reproductive choice, Esther feels supported by them, whereas the people who do agree with her, make her feel unsupported:

EP: How did the topic [of reproduction] come up with those two friends?

Esther: Me telling them that I had decided to get the hysterectomy, or I had had it. I think one was before and one was after ... they [friends who said she'll be a good mom] see me as open and honest and strong and smart. strong and smart and talented and with a lot to offer, while the people that used to tell me otherwise that I should never [have children], that I should consider other options, those people felt more like I was weak and not well and never made the right decisions before and I needed so much help. ... So maybe your idea is skewed, person over there that's telling me this. I sure wouldn't abandon my child at a place. I sure wouldn't do that. I don't care what's up against me. I don't care if DFS is fighting me. I wouldn't care. I'd go down as the crazy person fighting for their kid

Understanding support as an agreement on the self, helps us understand Esther's reaction. Her friends see her the same way she sees herself: open, honest, strong, smart. Their disagreement on her motherhood does not take away from it. On the other side are the people who agree with her decision not to have children. The alignment of action (not to have children) does not make them a source of support to Esther because they disagree on who Esther is. They look at her as incapable, defies how she feels toward herself.

As mentioned above, support does not necessarily elevate the recipient's sense of self, as the focus on "self-worth" and "appraisal" in Caplan and Cobb's definition suggest. Sarit's story shows that support can happen around agreement of disability. Here, we look at Sarit's relationship with her husband. This time, it was Sarit's ability to work that was on the line. After receiving a diagnosis of bipolar disorder, Sarit thought the worse, "I thought it meant it was over, I was done. That I would never work again. that that was the end of the world". In defiance, she decided to get a job, her husband did not agree: "And now my husband says there's no way I could work. I can't even do jury duty". On her first day on the job Sarit felt so drained that she left. When getting back home, her husband responded: "I told you, you cannot work". Despite

her initial reluctance, Sarit has come to accept her husband's and therapist's version of herself, and has given up on work, even though it has been central to her sense of self since young age:

I realized that I couldn't work because every time I tried to work, I would have problems going and working, coming home... eventually I was happy about it [being put on disability by her doctor] because I found that my memory was going, my moods were so unstable that I needed to be off work". Sarit's belief in her dependency grew even bigger after a suicide attempt that landed her in the hospital. Wanting to keep the suicide a secret from her husband, she told him that she accidentally took the wrong medication. Since then, her husband handles her pills "he doesn't trust me to do my own pills. so, he does them, keeps the pills, up high in the closet. and he'll do my pills for two weeks at a time, that's all

Even though Sarit's husband and doctor have little trust in her, Sarit feels supported by them. She has come to share their version of herself, and with that agreement between them, she finds support.

Finally, we turn to Maya, who's reflection on her mental illness, highlights the power that successful negotiation of selfhood has on feelings of support.

Maya's story starts in middle school when she was diagnosed with Oppositional Defiant Disorder, which frames her refusal to go to school as an act of defiance. Following this diagnosis, her explanations that she suffers severe phobia at school are rejected as made-up stories for attention. Though Maya feels that the diagnosis is not right for her, her parents do. The diagnosis informs their response to Maya, they interpret her behavior as disobedience and treat it with penalties. They force her to attend school, and, when she continues to refuse, they call the police on her. This situation continues to escalate until Maya is sent to an emergency psychiatric facility where she stays for five days. In the facility, new tests are run, and Maya's diagnosis of Oppositional Defiant Behavior is overturned. Instead, she is told that she has severe

anxiety, and major depression. Equipped with this double diagnoses, Maya's parents move her to a different psychiatrist who helps them reframe their understating of her. Now, they believe her when she says that she cannot go to school because of her phobia. Finally, after several episodes where her phobia flared up and her parents couldn't leave their work to retrieve her from school, Maya is sent to live with her grandparents and attends a school in their town. It was during that time, that Maya began to do well at school and was even able to graduate on time. Maya credits this positive turn of events to being believed

And the key factor for me at that time and what I understood to be true is that ...first of all, nobody believed me [before than] because I had this horrible track record of doing it [calling her parents to ask that they take her home] all the time. But secondly, they [Maya's parents] both worked, and they couldn't necessarily leave to come get me if I was sick. My grandparents were both retired, and so in the case that I was genuinely ill, I didn't feel like I was ever going to be in a position again where I was really sick, and I wasn't going to be able to go home

This shared agreement on her diagnosis created a support network around Maya that provides her with the help that she and others around her, believe she needs for her recovery. The emotional support created access to an agreement over which active support (being picked up from school when needed) would help Maya.

Bringing stability

Another thing that makes the stepwise plan somewhat different from "normative" reproductive planning is the overarching expectation of being mentally stable. To be a responsible mother, the argument goes, one has to be mentally healthy and remain so. Psychiatrists hint at this when they suggest that patient "get better" before they attempt to get

pregnant. Naama's therapist response to her telling them that she wants to have children shows how "getting better" created the counter for her reproduction:

Um, he didn't say it like that. He said it. I just said I'm concerned about having kids and bringing up a child and he just acknowledged, you know, coming from your background and how you grew up, it's understandable ... Yeah, he just focused on, on um, you should get better first. If that makes sense. If that makes sense

8.4.2 Creating order

But stability is a complicated idea to grasp and even harder to achieve. One problem that the requirement for stability creates, is that it delays reproduction.

In mental health treatment, stability is an end goal and a necessity. When a patient reaches stability it marks a shift, or potential end, to their treatment. At the same time, stability is a basic condition for self-regulation, a necessary status for becoming a rational actor. The process of reaching mental stability is one of temporality. It prioritized the present over the future. It makes whatever problems the patient is facing now, more urgent than their future. This temporality explains Avda's concern over bringing up her future reproductive goals. She believes that talking about her future before she is done addressing the present will destabilize her process toward stability. A similar thinking of temporality and stability, prompts Naama's therapist to suggest that she "gets better" before they begin discussing her reproductive future.

While stability is seen as a progress toward more agency, the temporality that is demands brings out another side to it. The search for stability extends the present and pushes the future away. It leaves the patient in a "queer time" where only the present matters and the future doesn't exist. This creates a problem with the stepwise plan. Because planning is essential to being a moral parent, especially a parent with mental illness, the future must be addressed in the

present. Yet, the focus on the present that the goal of stability requires leaves no room for such discussions.

Natalie's story brings this problem to the surface. In her account of why she didn't speak about reproduction with her health providers, we see the tension between present and future that stability create. While in treatment, her health providers were focused on her present. Her future was pushed to when she was stable, but by then, she was no longer in treatment. This cycle kept on going, causing more delays to her future:

I think as far as the mental health, psychologist, seeing a psychologist, I think that they were kind of, we say putting out fires with me. Where it was trying to get me back on track to be able to function normally again, and part of the problem too, like I said, was when I would feel better, I would stop going to therapy. So even if that had been the course of their treatment, was to discuss that with me [reproduction], I think it was my fault that it was cut short

Maya and Tzipora, too, reveal how ideas about time, specifically what needs to be discussed in the course of their treatment, shaped the response to their reproductive future. Maya would like to be a mother but her intense phobia of vomit, which has already derailed her life, makes her doubt if motherhood will be within her reach. While she is single, some of her friends are married and pregnant, which makes the issue of motherhood more present in Maya's life. We asked Maya if she talked to her psychiatrist about it.

I have. When I've said things like this to a doctor or a therapist, the focus for me for a long time I was in therapy was not on the future. It was very much on how can we get you through this next week? How can we get you to be in class as much as possible?

Tzipora too, recalls a short exchange with a therapist about her reproductive desires (she does not want to have children). As in Maya's case, the conversation was cut short. Tzipora

wonders whether it is because the therapist thought that there is not much to discuss, or because the future was not the focus of their clinical assessment of Tzipora.

EP: Did anyone else ever talk to you about that [reproduction]? What about your therapist?

Tzipora: Yeah, but we [with the therapist] kind of touched on it briefly. And when we talked about it, she seemed to be kind of, not in agreement with me, but she understood what my reasons were and didn't really question it further. So, I'm not sure if that's because she thinks it's perfectly fine, or she's going to get to it later after we've gone through my other issues.

8.5 Problems with the stepwise plan

8.5.1 The problem of stability

The second problem that the prerequisite of stability creates for the women, is that stability is an ill-defined and amorphous object. It is not clear what stability means, how it looks or how to ensure its continuation in the future. Participants mentioned the fleeting nature of stability in their stories. Some, like Natalie talked about being stable for short periods of time, others mentioned long periods of stability that ended abruptly with a suicide attempt or manic episode. Even women who considered themselves “stable” at the time of the interview, often wondered whether this stability would carry to their future and for how long.

The question about future stability makes the demand for stability in motherhood difficult. Vered’s story reflects this problem. Recall that Vered had her first (and at the time of the interview, her last) manic breakdown a week after giving birth to her first child. Though she was diagnosed with bipolar disorder, Vered believes that her episode was a consequence of Post-Partum Mood Disorder (PPMD), and not likely to happen again, especially outside the context of birth. Nonetheless, in her yearlong recovery, Vered and her doctor worked on tools to help her

remain stable and reduce the chances of another manic episode. This reassures Vered and her health providers that she can safely have another child, as she and her husband initially planned. Despite the confidence that Vered and her health providers have that her current state of mental stability will continue, even with birth, her is reluctant. Rather than measuring stability by observing Vered now, he leans on their past experiences. To him, the past is a stronger indicator of the future than the present, and this past is not in line with good motherhood. This difference in the way stability is measured, creates a gap between Vered and her health provider's view of Vered's reproductive future, and the view her husband holds. So, while Vered's doctor says that whether or not you are bipolar, if we stay on top of the way that you are doing self-care and your hormones and neurotransmitters, we can both keep you less vulnerable and address the problem as it comes up. And this does not mean you have to not have another child", Vered's husband's response is "No fucking way" (laughing).

Vered explains what is at stake:

He's concern was that the same thing would happen, but we wouldn't get off what he perceives to be scathed free ... the idea of leaving me at home with [daughter] and a baby and what could happen, he just thought, why, why she's perfect, she's beautiful, she's healthy, you made it, you're well, why would we risk that?

Not all women shared Vered's confidence in her ongoing stability, or her husband's conclusion that without assurance of stability, reproduction is unwarranted. For some women, the problem of stability is the very essence of the stepwise plan. It is a goal and the engine behind it. We've seen this in Nurit and Talya's discussion about needing a partner to co-parent with. Beyond the normal idea that a partner can compensate for the things that they find hard to

do, they pin their need for a partner as backup in case they experience remission in their mental state.

8.5.1.1 Stability & Medication

Finally, medication brings another problem to the prerequisite of stability. Most of the participants in this study use medication, and credit it for improving their mental health. Adva shows this when she explains how she achieved stability: “Regular sleeping, getting exercise, eating well. When I do those things with the meds...my symptoms are pretty nonexistent”

But, as already discussed, medication creates a double bind for women. There is risk in taking medication during pregnancy, and risk in not taking it. In the previous chapter, we discussed the way participants respond to this problem by looking at it through the prism of risk management. Now, we will turn to the same problem as it relates to planning. We will look how women manage this contradiction within the stepwise plan. How they reconcile the goal of stability and medication with the overall goal of good mothering.

Mika brings this point home when she talks about her medication and the fear of relapsing into deep depression, if she were to get off it for a pregnancy:

I think about the fact that I am on antidepressants. It does worry me, having to possibly consider if, a big if, if I decided that I wanted to go down that road [getting pregnant again], I won't be able to take the antidepressant, or very much a modified low dose of it. How is that going to affect me, not only during the pregnancy, but afterwards, if I choose to breastfeed? There's all these factors to have to consider now. Yeah, I haven't got there. I think it just really scares me, the fact that I've finally got a pretty decent cocktail of antidepressants that have been working for me. I've done all this hard work. It really does frighten me that, shit. If I have a baby, how am I going to be able to cope? Because the hormones and being this peace of mind that I've worked

hard to be at. It still takes a lot and of work. It's still hard work now, but to add another person in this is scary

We find that for most participants, this problem defines the limits to the stepwise plan. When push comes to shove, and they cannot find medication that will be safe for the fetus and keep them stable, they will abandon their reproduction plans.

Moran describes her stepwise plan to have children. She would first marry her partner, then, when they decide to have children, she will make a plan with her psychiatrist to find medication that is safe for her and the fetus. Note, then Moran is using oppositional ethics in her description of medicinal risk, making her and her fetus at odds with each other. If, in the process of trial and error, her psychiatrist will determine that there is no medication that is safe for the fetus and keeps her stable, she will give up on being pregnant and end the stepwise plan:

If we got married and we were thinking, "Okay, well let's have kids," and then when we get to see a specialist, we talk to my psychiatrist, and they say there's no way that this can happen. You know what I mean? Like I try to get off my meds [...] and get on meds that will not hurt the child or get off all my meds and just do coping skills and just have a really stress-free environment, maybe not work for a little bit and it still doesn't work. I'm still psychotic, maybe even getting to the point where I'm hurting myself and I have to be a danger to an unborn child, ... who knows when or not the medication, what will happen. If those things start happening and my doctor says to me, "This isn't working. You're going to be a danger to your child, or these medications are going to hurt the child," or things turn bad. I would definitely say 100% we are adopting and if we weren't able to adopt even then I had to just get some pets

8.5.1.2 *Stability and time*

Considering the crucial part medication has in the stepwise plan, it is surprising how little attention it draws. In none of the stories, was there a plan what to do if it turns out that no

medication is safe for the fetus and mother. Over and over again, women brushed this limit to their stepwise plan aside. The focus on stability and the trial-and-error process of psychotropic drug treatment, left this issue up in the air. On their part, psychiatrists enabled this delay, by holding off on mentioning the pregnancy risk of medications, by treating the process as a step-by-step experiment and limiting discussions on reproduction desires.

Nurit's story captures this delay

They said that lithium has been shown to be fine when you're pregnant. So, I guess kind of a newer thing and so I'm cool with that because I take a lot of lithium, that's one of my main medications and beyond that, that I might have to change if I'm taking other medications, which I am. Right now, I am on top of that. [inaudible] But that was just kind of a road that we'll cross when we get there. I think it'll just be kind of a play-it-by-ear situation. And with my psychiatrist he kind of taught me to look at everything as kind of like a small trial period. So, like even with the pills that I'm on right now, we agreed that I would try it out for four months. And so, I have a feeling that when I'm pregnant we'll just see, you know, doing that, like he's pretty slow-moving day. So, I'm not sure what would happen is I would get manic and need to take anti-psychotics. I have no idea

Even Sarah, who is confident that the worst of her mental illness is behind her, leaves the problem of medication and stability to a later phase.

Sarah already figured out that she will likely need to change her medication before she gets pregnant. She has a vague knowledge that her medication is not safe during pregnancy. But she has yet to talk to her psychiatrist about it. This delay is particularly astounding considering Sarah's history with medication. For years, Sarah and her health providers looked for medication that will help her. She has gone through many types of medication and spent years getting on and tapering off the psychotropic drugs that were prescribed to her. Eventually, as we've seen

earlier, it was several rounds of ECT that helped stabilize Sarah and made medication affective for her. Despite this history, and despite her belief that her stability is very much due to her medication, Sarah is not bothered, nor does she give much thought now, to the issue of medication in pregnancy. Her focus is turned to her other goals: acquiring education, becoming financially independent, finding a partner and getting married. Even though medications can bring all this down, it is last on her mind:

Well at this point I don't know anything about it [if her meds are safe during pregnancy] obviously, but as I got closer to thinking about that kind of a decision, that would be something that I would talk about, but at this moment, right now in my life, I'm looking to find someone, branch out, meet someone, and then you cross that bridge when you come to it

8.5.2 Delays

As discussed before, the stepwise plan does many things at once. It normalizes the women and their reproductive career by following scripts of morally desirable motherhood. It also disables them by linking those scripts to their mental illness and thus giving them an added level of urgency. We've also seen the stepwise plan's embeddedness in therapeutic settings. How it creates opportunities for surveillance and become a supervisory tool over the women. We see how the importance of stability to the plan shapes therapy along temporal time and produces "queer" time for the patients in which the future is never present. Last, we've touched on the power of medication to collapse the plan at the same time that it allows it to exist.

Indeed, the power of the stepwise plan to delay discussions about reproduction, is one of the findings in Silvia Krumm and colleagues' 2014 study about the attitudes of mental health professionals towards patients' reproductive desires. In their research, they find that mental health professionals tend to use the stepwise plan to delay discussions on the issue of

reproduction. They write: “Finally, there was a tendency to mask professionals’ reluctance with respect to a patient’s desire for children / reproduction by talking about the “right time” for reproduction in the future. Rather than disapproving of a female patient’s desire for children, many participants talked about their suggestions to ‘postpone’ motherhood or parenthood to a later date” (Krumm et al. 2014: 8)

We can see that the stepwise approach to reproduction does two things simultaneously. It offers a tangible plan for the future, bringing reproduction closer to the present by detailing the steps toward moral parenting. At the same time, the stepwise plan shifts the focus from the long-term goal of having children to short term steps. It defines any discussion about medication, pregnancy and parenting that is misaligned with the order of the stepwise plan, untimely and a potential sign of the woman’s moral inaptitude. In other words, as it brings the future closer, the stepwise plan also delays it.

These delays may prove detrimental to some women.

Studying women with bipolar disorder, Clare Dolman, Ian R. Jones and Louise M. Howard (2016) found that time was a confounding factor in their pregnancy decisions. They explain that “many had delayed having children due to their illness, or sometimes due to the associated instability in their lives, and were now very anxious that time was running out for them, as this woman on the e-forum expressed: ‘Having bipolar has ... greatly delayed the decision and now due to age ... I have to make the choice’” (ibid: 295).

Some participants in this study shared this sentiment. In their case, the stepwise plan made reproduction a forever receding target. Unlike Noga or Meital, these women did not plan to not have children. Instead, they spent their years coming to terms, and recovering from their

mental illness, only to emerge on the other side feeling that they missed their opportunity to have children.

All her life Natasha assumed she will have children. She babysat from age 11 to college and loves children. That was her plan. But her life began going sideways when she came back from a year in Africa after graduating from high school. Natasha began feeling very depressed and contemplating suicide. the depression quickly turned into an episode of hypomania. Her pastor reached out to help her put her in touch with mental health providers: a therapist and a psychiatrist who prescribed her medication that she later realized were for bipolar disorder. Throughout the years of battling her mental illness Natasha was unable to work. She went back to college, but the side effects of her medication made her drowsy and she found it hard to stay alert enough for school, so she dropped out. The drowsiness also led to a car accident until Natasha stopped driving all together. It took Natasha close to a decade to get mentally better and feel ready to date. But the time she met the man who would be her husband she was in her mid 30's.

They both wanted to have children but recognized that in their age (mid-30s) they might be too late. At their age, she says, they will have to get pregnant right away instead of transitioning into it after getting married. adoption too seemed to be out of the question because of the lengthy process. "We will be 60 when the kids leave the house", she says. Still, Natasha consulted her psychiatric nurse and found her to be "very supportive and did not try to influence my decision". With the nurse's advice Natasha successfully switched her antidepressant to one that is safe for pregnancies but when she attempted to reduce the dosage of another medication she was on, she felt the darkness coming back. She quickly decided to go back on her regular dosage and called off the trial. Natasha took the experience as a proof that she cannot change her

medication regime (which took years to find) and therefore cannot have biological children. She does not want to put herself or her husband through the experience she had in the past, nor does she think it will be fair for her fetus or the newborn. The psychiatric nurse did not refute or argue with Natasha's conclusion and the decision was made. The couple gave up on their desire to have children and instead said: "we will spoil our nephews". Occasionally Natasha mentions that had she and her husband were younger they will probably have children. We asked her how so, seeing that the medication issue would not change. She says that if she was younger maybe she had more time to try different medication or dosages, although she sounds skeptical. They would have been able to adopt, she says.

Looking at Natasha's story, the consequences of delaying discussions about reproduction in mental health settings become clear. The desire to be stable, to find a partner - to do everything "right" - caused her to miss her opportunity to fulfill her dream of motherhood.

8.6 Reproductive loss

Researching reproductive experiences of LGBTQ people, Christa Cavern (2019), addresses the concept of loss. She builds on feminist and queer scholarly work that challenges the heterosexual and biological focus on women's pregnancy loss to call attention to other types of reproductive experiences. Following the narratives of her queer participants, Cavern expands loss to capture a wider scope of reproductive experiences. A third of those who interviewed for her study experiences reproductive loss as the non-gestational parent. Other used the terminology of loss to describe their experience of having their adopted child reclaimed by their biological parents. Loss was also a theme among LGBTQ people who dealt with infertility or other obstacles to their desired reproduction.

It is a grief that often goes unnoticed. Non-gestational parents feel conflicted about the place of their grief over a lost pregnancy, women who had early term miscarriages describe a medical response that reframes their pregnancy to “chemicals” and devalues their loss, and adoptive parents reflect on a terminology that ignores their feeling of “losing children” by turning their experiences into a procedural “disruption”.

In this expanded terminology, reproductive loss reflects grief over failed reproductive desires. It identifies the intimate feelings of loss and devastation that giving up on one’s dream of becoming a parent, can stir. Indeed, looking at women with Schizophrenia, Wanda M. Chernomas, Diana E. Clarke, and Francine A. Chisholm (2000) find that “some women chose to avoid pregnancy altogether because of their illness and were variously angry, sad, or resigned about their decision” (ibid:1519).

As we’ve seen earlier, some of the participants in this study describe their decision not to have children as a choice between two, morally defined, options: bad motherhood, or no motherhood. Their feeling that their mental illness gives them no choice but to reject motherhood, echoes the sentiment that Rapp (2000) details among women who went through selective abortion after learning of that their fetus is at high risk for genetic disorders: “the idea of “choice” is one to which women returned again and again... Yet for some the very notion of “choice” is unbearable and must be abolished from the vocabulary of grief: when we asked about decision making, I heard again and again, from women of diverse backgrounds, “I had to have an abortion” or “it was a forced choice”. Some were even more explicit [saying that they wish the doctor or nature would have spared them the choice with spontaneous abortion]” (ibid: 225)

Though none of the women I spoke to thought that their reproductive decisions would have looked differently had they had more, or earlier, discussions about it, some expressed grief and feelings of regret over their decisions not to have children.

Noga, who felt from early age that she is “not equipped” to be a mother, partly because of her mental illness, describes what that decision means for her now. Though she by no means regrets her decision or frets over it, it does give her a little pinch

I mean obviously it's a big decision I think for people to make, and for me now it elicits some sadness that I've never known the role of being a mother, that I've never had that kind of a relationship or bond with a child

Noa too, expresses feelings of loss. This feeling is exacerbated because of the change in the how she understands her mental illness. Being able to see her mental illness as manageable, makes her re-evaluate her decision to get her tubes tied. Now that she realized that there are more than two options to parenting with mental illness, she grieves over the lost opportunities:

I was so terrified of possibly being a bad parent that I was just so determined for that not to happen. I was raised Catholic and the... I'm totally in favor of reproductive choice, but for myself, I could never have an abortion. And so, I was terrified that I might get pregnant just by accident and then I couldn't have an abortion myself and then I would be stuck with a child and then that would just, to me, be the worst thing in my life. So that's why I wanted to be absolutely positive that I could not have children. But, in the last couple of years, I've been going to therapy and now I really regret that decision. It was the best I could do at the time. I wanted to go and live my life and not harm anybody and that was the best I could do at the time. So, I'm sad that I'll never have children. I only have two nieces and we're not very close. I feel like I missed out on the whole thing...I've never had that feeling of being able to love a child the way that a parent loves a child, and so, I really feel like I missed out on all of that

Unlike Noga and Noa, who's reproduction years are behind them and who, made the decision to avoid reproduction, Moran is looking forward to having children. While she chooses to have children, she is achingly aware of the possibility that her choice will be met by inhospitable conditions. In such a case, she too, will convert her choice into a decision between two options, and grieve her loss:

I will definitely grieve. I will definitely be very sad having off to rearrange some expectations for my life and it wasn't expected to happen, which I've already done because of my diagnosis. I've already sort of had to rearrange, my expectations of what I'm capable of and stuff like that. But I feel like after I get too wild, maybe I'll just end up being one of those people who put their dog in a stroller. I don't know. If that's the way I cope. So, I don't know because I do definitely want to have some sort of family, even if it's only my partner and a dog

8.7 Conclusion

Like other women, the women in this study who wish to be mothers, want to do it well. They prescribe to the contemporary model of good motherhood that centers on risk management and self- (and child's) improvement. To create the best possible conditions for their child (as defined by a multitude of social actors) they create a list of prerequisites to good, i.e., moral, motherhood. On first sight, none of the prerequisites that are on the list seem out of the ordinary. They wish to have a child with a partner who will participate in raising the child, to have finances to support the child's needs and growth, to have a stable home in which said child can be safe, be healthy to attend to the child, and have a network of support as backup. This set of self-prescribed conditions to motherhood are so normative that neither women nor clinicians spend much time laying them down. In fact, most of the participants described these prerequisites to motherhood as so obvious that they don't warrant discussion. Yet, behind the

stepwise plan's veil of normal motherhood, exists a reality that is sometimes at odds with normalcy and desired reproduction.

In their stories, women share the difficulties that their mental illness brings to intimate relationships, finances and job stability, housing, and, most notably stability and support. They talk about the struggles that their mental illness brings to intimate partnership and that denies them the coupling that they wish to have to become mothers, they discuss the job instability that comes from depression, mania or psychosis and that keeps them at a precarious financial position, or the difficulties of finishing school or acquiring a diploma. Maintaining stability and having support, which are often described as the defining conditions for good motherhood, carry their own unique contradictions especially when medications are involved. In those case, medication is both the problem and the solution to mental illness and motherhood. It is also the center of the psychiatrist-patient relationship, where professional ethics, patient choice, and trust, are uniquely intertwined. Despite the fact that intimate relationship, financial security, housing stability, health stability and support, are known to be particularly challenging to many individuals with mental illness, their role in the stepwise plan remains undisturbed. The ethos of good motherhood as planned, coupled, and middle class, remains intact as the women struggle to navigate their mental illness toward these goals.

This makes the stepwise plan a sophisticated tool of care. On the one hand, the plan establishes goals that are not only self-defined but also curative. These goals will help women get better both in relation to the markers of their illness by reducing hospitalizations, remissions and fluctuations, but also as functioning citizens who work, contribute to society, and self-improve. Yet on the other hand, the stepwise plan can function as symbol of their illness, a list of items that their illness prevents them from ever achieving. As mundane as the list might be, some

women feel that their mental illness makes it so unobtainable that they must give up on motherhood. In these cases, stepwise plan is not so much a curative tool of goal setting, but entrenchment of the women's "otherness", a descriptive list of the obstacles between themselves and motherhood.

Women's stories reveal that the distinction between a stepwise plan that is a tool of motivational goals and a stepwise plan that is a receding target, is often at the hands of the mental health professional. More than once, women told stories of mental health professionals whose remarks re-orient women to their "true" position on the stepwise plan. These remarks can refer to the medication the woman is taking and whether she has achieved a certain clinical goal that the psychiatrist associates with her medication. Other remarks may reflect on her stability to either support her claim regarding it or reframe it. In other cases, women shared instances in which clinicians and therapists hinted at their correct position on the stepwise plan: their age, their marital status, their finances. The picture that these stories draw suggest that the stepwise plan serves as a tool within care settings in more than one way. Beyond its role in advancing life goals (including motherhood), the stepwise plan is a supervisory and assessment tool for clinicians. Because it is so normalized and because it renders very little discussion within clinical and therapeutic settings, clinicians can use it to observe and measure the woman's mental health, and the women themselves accept this intervention as neutral and within professional boundaries. In other words, the stepwise plan is another way by which reproduction enters mental health settings without disturbing the status quo of neutrality on the one hand, and patient's choice on the other.

Conclusion

In this study, we asked how women with mental illness make decisions about their reproductive life. We were particularly interested in the role that their mental illness has in their decision, and the ways they navigate the discourses of mental and reproductive health. Our findings demonstrated the centrality of narratives of normalcy and illness in women's decisions, especially as they pertain to ideas of risk and choice. Observing their narratives, we identified two main types. The first, to which we referred as narrative of normalcy, was made by women who describe their reproductive decisions as separate from their mental illness. These women use tropes of normalcy to express their reproductive desires, whether in favor or against having children. In narratives of normalcy, women often cite love or disinterest in children, normal life stages, ideal family size, and age, as motivations for their reproductive decisions.

Other women, when asked about their reproductive desires, turn their gaze to their mental illness. In their stories, the decision to have or not to have a child was closely linked to the effects of their illness. These narratives were described as narratives of disabled reproduction because of their similarity to discourses on the reproduction of people with disabilities or of fetuses with disabilities. In the case of disabilities, be it the parent's or the fetus', reproduction is seen as irresponsible and undesirable, a failure of the optimized self. Similarly, women who leaned toward disabled narratives paint their reproduction as harmful and morally wrong due to their mental illness. They describe direct and indirect causation between their mental illness and being ill adapt to motherhood.

Looking beyond narratives of reproductive desires, we wanted to understand how women make reproductive decisions; how they engage with, and make sense of, the reproductive risks that are associated with psychiatric reproduction. We identified three categories of risk. The first,

genetic risks, involves the possibility of passing the illness to an offspring. This type of risk bypasses the woman by existing within her biology and beyond her reach. As such, genetic risks force women to think not of balancing their own interests with those of their child, as medicinal risk does, but of the value of life. Because they carry the illness that their offspring might inherit, this moral question of which life is worth living, requires them to reflect on their own life with mental illness and investigate its role on their life.

Next, we looked at the ways women manage and assess behavioral risks. Here, women are required to consider the possibility that their mental illness will interrupt their “motherly” duties. Implicit in the behavioral risk are the images of the “good” and “bad” mother. We showed that some women believe that their mental illness imperils their ability to be good mothers, and that the only way for them to be responsible and moral mothers is to forgo motherhood all together. Other women took a different approach to behavioral risks. Here, two arguments were made. One is that there is meaningful overlap between being a good mother and being a good mental patient. These women use the moral imperative of self-work and risk-management to argue that the things that define a good mental patient - commitment to treatment, self-care, and support – are the same things that make good mothers. By creating this symmetry, they transform mental illness from the realm of dangerous motherhood to that of the good and responsible mother. The second argument that women make in response to behavioral risk is based on an even more radical logic. This argument turns the table on the idea that women with mental illness fall short of good motherhood. Instead of causing harm to their kids, some women argue that their mental illness is beneficial to motherhood. Not only does it not cause harm, but it creates children – and by virtue a society – that is more empathic, less stigmatizing, and attuned to emotional needs.

A third category of risk which women regularly engaged with, is that of medicinal harm. Many women who take medication for their mental illness, describe the emotional and institutional difficulties of managing the risks of teratogenic harm to their fetus. To assess the risk of harm women, turn not only to their psychiatrist and their scientific expertise but also to their peers, family members, and their own biography. Trust in scientific research, in health professionals, and in the integrity of processes, were crucial to assessments of medicinal risks. Furthermore, in some cases, medicinal risks revealed the limits to the relationship between women and psychiatrists and exposed the different interpretations of neutrality and support that each of them holds.

Finally, women create a stepwise plan for reproduction. Through this plan they attempt to demonstrate not only their commitment to normalcy but also their engagement with risks. The stepwise plan is therefore both a treatment plan toward normative reproduction, and a proof of normalcy. In other words, the existence of a stepwise plan is already a step toward normative reproduction. At the same time that the plan paves the way to normalcy, it also carries the potential to disable the woman. In its focus on normalcy, the plan risks ignoring the reality of some lives with mental illness. When this happens, women might find themselves in a bind. On the one hand, admitting that the plan failed risks being seen as unable to achieve normal reproduction. On the other hand, holding on to the plan, risks not getting the help that is needed, and failing it once again. In these cases, the stepwise plan becomes a barrier to reproduction, not a tool of support.

Taken together, these findings reveal a complicated interaction between mental and reproductive health. They expose a layered, nuanced, and dynamic relationship between normalcy, mental illness, and reproduction. Zooming out from the minutes of the narratives,

these findings beg us to think of mental illness, and question whether it is a meaningful category for reproductive research. Again, we find that the answer to this question is far from simple. On the one hand, this study shows that women with mental illness approach their reproductive life in normative ways. They do not prescribe to the popular images of the dangerous mentally ill woman whose motherhood is a risk to her child, herself, and society. The women's normative reproductive desires also felt ill-fitting to the psychiatric literature that paints their reproduction as ethical dilemma and professional risk. In fact, the women who participated in this study expressed reproduction thinking that is so normative, that it called the entire study into question. Was studying their reproduction separately from "non-ill" women an ethical mistake that perpetuates the stigma of their otherness?

Yet, at the same time that the finding of this study suggests that women with mental illness use normative thinking on reproduction, it also reveals the centrality of mental illness to their discourse. In their normalized thinking about reproduction and good motherhood, these women insert their unique experiences with mental illness. In their stories, mental illness is intertwined with questions about childbearing, good motherhood, and bad motherhood. To untangle the illness from reproduction, women had to dig deep into modern bioethics notions that equate illness with bad motherhood, and health with good motherhood. While most women did not quite break these links, many of them attempted to redefine them as they sought to decide on their own reproductive health. In doing so, they stretched the boundaries of good motherhood, reimagined mental illness and claimed it on their own terms, shifted evaluations of risk, and pointed to the limitations of science.

The Stigma of mental illness hovers above the final conclusion of this study. What we found are women who, despite having a serious mental illness that derailed them from normative

life stages, live a full life that is, in many ways, normative. More than anything, the stories they shared pointed to the role that society has in shaping their lives. Yes, they argue, the illness is hard and serious, and in most cases, it cannot be solved only by increasing social support. Mental illness, they argue, is not a difference among others, a simple human variability akin to differences in eye color or intellect, as some disability scholars argue in relation to physical and intellectual disabilities.

Mental illness, the participants in the study argue, is a condition that exists within the individual and is real. It is not a social invention. However, many of the hardships that come with mental illness are caused or exacerbated by the social response to psychiatric disorders. Lack of access to mental health professionals, stigma and prejudice against mental illness or toward psychiatric medication, disinterested psychiatrists, and high cost of care, shaped the women's path. Abstract social structures were also central to the women's narratives, most prominently ideas of choice and professional neutrality. Women welcomed their choice over their reproductive life at the same time that they wanted more help in making these decisions. This help, while theoretically available to them, was not as ready as they wished it was because of the power imbalance between them and their health professionals. Women had to be strategic in their interactions with health professionals in order to avoid being seen as too ill or too well. When it comes to reproduction, the risks of seeming out of place and thus too ill to parent, held women back from discussing reproduction with their clinicians. We believe that there is room for psychiatrists and other mental health providers to be more forthcoming in their willingness to create space for women to talk about reproduction. It seems that all sides can benefit from more discussion on reproduction, provided it is educated and sensitive.

Last, to the question of mental illness, mental health, and disability. This study joins other scholars who showed that these categories are fuzzy and contextual. Disability in one setting can become anything but in another, and vice versa. In this study we see that categories of disability, normalcy, mental health, and mental illness are fluid and inter-related within one's narrative. In fact, women incorporated all four categories in their narratives, often shifting from one to the next without visible explanation. Their stories showed that contradicting descriptions of selfhood can co-exist, each being used at a specific context within the self. A woman might feel herself normal in some ways and question her own "normalcy" in others. Mental illness can be viewed as a disabling condition in relation to reproduction but not so much in relation to work or other life pursuits. Some women experience their mental illness as severe, even when others label it as "mental health", while others describe their severe mental illness as an aspect of their life, that while it makes some things harder for them, does not diminish the quality of their life or their enjoyment of it. These contextualized, and existing-in-contradiction view shows that labels of illness and normalcy are insufficient to grasp people's lives and choices. To fully understand how people behave and make decisions about their selves we must accommodate these labels, and look beyond them, at the same time.

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