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Voicing Labouring Bodies: Women's Narratives and Gender Violence

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ABSTRACT: This paper takes shape from the debate on the role of human rights in maternity care, following several emerging cases of obstetric violence and aggressive and intolerant treatment permeating care during labour and delivery (Freedman *et al*.). In 2015, the WHO released a statement to prevent and eliminate disrespectful, non-dignified behaviour by health professionals during childbirth, highlighting a physical as well as emotional and psychological violence. Early in 2019, a UN report warned against obstetric violence as being still widespread and systematic in nature, acknowledging it has not been fully addressed from a human rights perspective so far. Despite the fact that the phenomenon is gaining recognition worldwide, there seems to be a lack of theoretical engagement on the issue (Dixon). This study, therefore, explores how women's experiences are discursively construed, taking into account the stories shared on social media—in advocacy websites, blogs, Facebook groups, and a series of relevant hashtag threads. Indeed, social media are being used by patients as a platform for exchanging their views, writing their testimonies, thus creating a (safe) site for the production of meanings (Baumann). While projecting the image of suffering bodies facing abuse, humiliation and unconsented medical procedures, these narratives allow a critical thought on practices of discrimination which heavily affect women's agency and act like a prism reflecting dominant dynamics in society.

KEY WORDS: obstetric violence; gender violence; birth stories; discourse analysis

> Medicine could not exist without the sharing of personal narrative. […]
> [T]he patient, as a storyteller, will share his or her experience of health and illness, and the doctor, as an active listener, will be able to take that story and make sense of it in the world of science and medicine.
> (Whitaker 12)

This paper takes shape from the debate on the role of human rights in maternity care, following several emerging cases of obstetric violence and aggressive and intolerant treatment permeating care during labour and delivery (Freedman *et al*.). While a woman's relationship with her maternity caregivers is vitally important—not only for lifesaving health services, but also to avoid lasting damage and emotional trauma—data from the wealthiest to the poorest nations worldwide show that women are susceptible to human rights abuses during childbirth, which is already, in itself, a time of intense vulnerability (Bohren *et al*.). Disrespect and abuse of women seeking maternity care has become an urgent problem spanning the domains of healthcare, education, social sciences, human rights and civil rights. Therefore, by exploring women's narratives and investigating the discursive construal of their experiences, this study tries to bring visibility on the phenomenon, to then examine wider societal issues underpinning it.[1]

INTRODUCING OBSTETRIC VIOLENCE

Obstetric violence occurs at the intersection between institutional violence and violence against women during pregnancy, childbirth and the post-partum period, both in public and private practice. It can be manifested through the denial of treatment, the disregard of women's needs and pain, verbal humiliations (judgmental and accusatory comments), invasive practices, physical violence, unnecessary or forced use of medication, dehumanising and rude treatment, discrimination based on age, ethnic, religious or economic background. Despite being a widespread phenomenon, it has not been fully addressed until very recent times, and it continues to be an extremely controversial issue raising conflicting views. Lack of information on the topic further complicates the implementation of public policies to prevent and eradicate it.[2]

In 2005, the UN Educational, Scientific and Cultural Organisation (UNESCO)—through its *Universal Declaration of Bioethics and Human Rights*—recognised that "health does not depend solely on scientific and technological research developments,

[1] This article deals with the phenomenon of obstetric violence as reported by women's stories online, but it does not argue that every childbirth is experienced as violent or traumatic. Moreover, when quoting instances from the online stories, it will not go through the most gruesome details.

[2] See www.may28.org/obstetric-violence/. Unless otherwise specified, all websites were accessed in Feb. 2020.

but also on psycho-social and cultural factors" (UNESCO 2005). In this view, it stressed the need to make women the focus of maternity care, calling for adherence to the basic legal principle of informed consent, which advocates for the right of each person, in particular women, to have their dignity respected—the unlawful touch of a stranger being deemed an assault or trespass.[3]

A fundamental lack of formal research on the topic was revealed, in 2010, by the report *Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth* (Bowser and Hill), which took into account available scientific literature together with interviews and discussions with experts. The report identified seven major categories of abuse that women may encounter in maternity care: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities.[4]

In 2014, the World Health Organization (WHO) acknowledged the testimonies by women describing disrespectful care and imbalance of power between them and the medical staff, and appealed to the right of every woman to respectful treatment, with a milestone in the institutional recognition of "the global epidemic of abuse and disrespect during childbirth" (WHO 2014). For this purpose, it released a statement directed at preventing and eliminating non-dignified and abusive behaviour by health professionals in maternity care, highlighting that a physical as well as emotional and psychological abuse is embedded in obstetric violence (WHO 2014).

Obstetric violence has grown in popularity among activists' movements in Latin America, with Brazil pioneering the debate with the foundation of ReHuNa (Rede pela Humanização do Parto e do Nascimento—the Network for the Humanization of Birth) in 1993 (see Tolton and Signorelli), and then officially recognising the circumstances of violence and harassment in which medical care happens. In 2007, Venezuela became the first country to formally define obstetric violence through the *Organic Law on the Right of Women to a Life Free of Violence*, a document that codified obstetric violence as one of the 19 kinds of punishable forms of violence against women (Sadler *et al*. 4). Argentina and (partially) Mexico have also framed obstetric violence in relation to gender inequalities within their legislations, stressing the unequal position of women—especially pregnant women—in the healthcare system and society. Moreover, since 2014, five Obstetric Violence Observatories led by civil society groups were founded in Chile, Spain, Argentina, Colombia and France, and they jointly released a statement declaring that "obstetric violence has been one of the most invisible and naturalised forms of violence against women", constituting a serious violation of human rights (Sadler *et al*. 4).

[3] See birthrights.org.uk/.

[4] See also Cassiano *et al*. on the (scarce) scientific literature available on this issue. The review shows that the majority of scientific publications was published in Latin America—with a significant number of articles in Brazil, Venezuela, Argentina and Cuba. Interestingly, it observed a small number of publications in English-speaking countries, which is one the reasons why this article concentrates, instead, on this context.

Despite the fact that the phenomenon has been gaining increasing recognition worldwide and at institutional level, early in 2019, a UN report warned against the fact that obstetric violence is still widespread and systematic in nature, acknowledging it has not been fully addressed from a human rights perspective so far (UN 2019). Indeed, it describes it as a serious violation of women's human rights occurring across all geographical and socio-economic settings. Similarly, in the same year, the Council of Europe (CoE) tackled the issue of obstetric violence as a form of violence that has long been hidden and is too often ignored, commanding the commitment of health-care personnel to disseminate good practices that respect human rights and human dignity (CoE 2019).

VOICING DISCIPLINED BODIES

Drawing on these assumptions and moving from a lack of theoretical engagement with the issue (Dixon), this study aims at investigating the phenomenon of obstetric violence not from a medical or institutional viewpoint but rather from the perspective of those who undergo it: women.[5] It is, therefore, meant to explore how women's experiences are discursively construed, specifically taking into account the stories shared on social media—blogs, advocacy websites, Facebook groups, and Twitter—which were collected for analysis in a corpus. Indeed, social media are being increasingly used as a platform for exchanging views on birth stories and writing testimonies, thus creating a (safe) site for the production of meanings (Baumann). As a form of personal narrative of real experiences, birth stories were deemed worth scientific investigation since they exist in a space that is, at the same time, public and deeply personal; this liminality thus poses a challenge for analysis and discussion.[6] The texts were gathered from available online material in English (since the focus of this research is on English-speaking countries), specifically from the blog The Obstetric Justice Project,[7] the advocacy websites Birth Monopoly[8] and Birth Trauma Association,[9] and Twitter hashtag threads

[5] Research on this topic has been mostly carried out from a medical standpoint, but very little has been done from a discourse analytic perspective, focusing on how women portray their own experiences.

[6] The birth stories posted by mothers/parents constitute a unique resource of available narratives, since medical stories involving interactions between patients and clinicians are covered by privacy restrictions. Moreover, compared to real-life support groups, social networks allow a more 'private' disclosure due to the anonymity of users and physical privacy (also ensuring hidden emotional reactions to comments).

[7] *The Obstetric Justice Project* is a patient advocacy initiative working to expose obstetric and gynaecological violence in Canada, https://obstetricjustice.org. In the instances that follow, the blog will be referred to with the acronym OJP. Time-span for the collection of texts: Jan. 2018-Jan. 2020, total number of 84 stories shared online and pertaining to the subject of the paper.

[8] *Birth Monopoly* is an advocacy group raising awareness on obstetric violence and offering a platform to women who have had a traumatic childbirth experience, mostly across the United States, to tell their stories, https://birthmonopoly.com/obstetric-violence/. In the instances that follow, the platform will be referred to with the acronym BM. Time-span for the collection of texts: Jan. 2018-Jan. 2020, tot. number of 79 stories shared online and pertaining to the subject of the paper. See also their FB profile www.facebook.com/birthmonopoly/posts/1716638828587405/.

[9] The group Birth Trauma Association is a UK-based charity supporting parents suffering from Post Natal Post Traumatic Stress Disorder and birth trauma, www.birthtraumaassociation.org.uk—also on

such as #obstetric violence, #birthingtrauma, #metoointhebirthroom.[10] Overall, the corpus amounts to a total of 207 stories (mostly gathered from platforms based in Canada, the US and the UK) and about 290 tweets, ranging over a time-span covering the last two years, namely 2018-2020 (in fact it is only recently that large numbers of birth stories have become available online, which justifies the choice of the time-span).

Following Halliday's systemic functional approach for text analysis (*Explorations*; *Introduction*; "Grammatical"), which theorises language as a systemic resource for practices of meaning-making, in combination with a feminist poststructuralist theoretical framework influenced by Michel Foucault's work (Foucault, *Discipline*; *History*; "Body"; Butler, *Gender*; *Bodies*; Grosz; Allen), this article investigates emerging and recurrent patterns and themes in women's narratives, questioning not merely power dynamics in the health-care system during childbirth but also, and most importantly, existing power relations in society. If, as Halliday states (*Explorations* 53), a clause is the product of three simultaneous semantic processes or functions, "it is at one and the same time a representation of experience (ideational), an interactive exchange (interpersonal) and a message (textual)", these online stories offer interesting insight into how women semiotically realise their childbirth experiences. In particular, the article addresses three research questions: 1) how women's emotion patterns and states are discursively construed, 2) what are the most recurrent plot units or topics through which the phenomenon of obstetric violence is framed, and 3) what are the underlying questions of power and gender relations and to what extent these narratives of abuse can also bring healing through agency.

Analysing the relationships between power, knowledge, and the body, Foucault (*Discipline*) maintains that power operates through the mechanisms of law, taboo and censorship. More specifically, disciplinary power targets the human body as an object to be manipulated and trained through a series of practices which are carried out in settings such as prisons, hospitals, schools and military contexts. Discipline subjects the body to a process of constant surveillance that allows a pervasive control of the individual conduct; it is, therefore, used to normalise individuals, to turn them into 'docile' bodies (Foucault, *Discipline* 138-9). In modern society, according to Foucault, the behaviour of individuals is pervasively controlled through strategies of normalisation which work by resorting to normative and repressive constraints existing in a range of domains, such as medicine, psychiatry, criminology (Foucault, *Discipline* 138-9).

Foucault's work was extremely influential among poststructuralist feminist scholars who concentrated on the intersection between sexuality, gender and power, claiming that the body is always gendered, and highlighting the existence of disciplinary acts that specifically target women to render their bodies docile (see Butler,

Facebook www.facebook.com/groups/TheBTA. In the instances that follow, the group will be referred to with the acronym BTA. Time-span for the collection of texts: Jan. 2018-Mar. 2020, total number of 39 stories shared online and pertaining to the subject of the paper.

[10] These threads were launched on Twitter after the British newspaper *The Guardian* published the article "Mothers are being abused during childbirth. We need our own #MeToo" in December 2018, stressing that many women are scared to speak out about their treatment at the hands of medical professionals as they give birth. About 290 tweets were collected as pertaining to the subject of the paper. Although the number of texts in this case is considerably higher than the other platforms, texts are very short (comparable to an SMS).

Bodies; Allen). Feminist scholars developed their critique on the basis of Foucault's understanding of power as exercised rather than possessed, as circulating throughout the social body rather than emanating from top down. In this regard, his contention that the body is the principal site of power was extremely relevant to explore issues pertaining to the social control of women's bodies and sexuality. Body and sexuality are, in fact, jointly theorised as the direct locus of social control, the target of variable regimes of bio-power. In this respect, the stories of obstetric violence published online constitute a public collection of evidence which can shed light on how bio-power acts, patronising, disrespecting, infantilising, mocking women's needs and bodily autonomy.

ANALYSIS AND DISCUSSION OF DATA

One of the reasons in analysing a corpus of birth stories uncovering cases of obstetric violence is that, unlike artificial story collections (like fictional stories), it comprises naturally occurring, real stories, constrained by topic and sharing common structures. In fact, clear patterns of events could be expected in predictable (and, therefore, comparable) sequences, due to biological processes and overall standardised medical protocols: the stories usually begin with similar events (arrival of the due date, water breaking, contractions starting) and end with similar events (birth, breastfeeding, leaving the hospital) (see Antoniak *et al*.).

THE DISCURSIVE CONSTRUAL OF EMOTION PATTERNS: PARTICIPANTS AND PROCESSES

The task of examining narrative structures was carried out, in the first place, mostly identifying the participants and processes—using Halliday's terminology (*Explorations*; *Introduction*; *Introduction Revised*)—through which these experiences are construed: birth stories usually feature a limited number of participants besides authors and their babies, namely healthcare professionals (doctors, midwives, nurses, doulas) and partners or other family members. Further investigation concentrated on plot units, namely narrative paths and emotion states as described by narrators. Such emotion states were examined taking as a benchmark the negative polarity emerging from a previous landmark research on birth stories (Antoniak *et al*.) and highlighting the emerging differences: while negative narratives generally refer to the pain of contractions, worry that the birth plan might change, fear for the baby's health, and the painful effects of postpartum (see Antoniak *et al*. 10), this case-study calls attention on different and differing trends which will be discussed in this paragraph.

Table 1 below provides detailed information on the participants who could be identified by resorting to some keywords that were frequently employed, specifying the number of mentions for each participant.

Participant	Keyword	Total no. mentions
Author	I – me – myself	20,859
We	we – us – ourselves	3,771
Baby	baby/babies – son – daughter – child/children	2,963
Midwife	midwife – midwife student	2,740
Nurse	nurse	2,052
Partner	husband – partner – wife	1,639
Doctor	doctor – dr – doc – obgyn – gyn – ob – anesthesiologist	1,591
Family	mom – mother – dad – father – sister – family	1,097
Doula	doula	285

Table 1. Participants identified in the online stories

Besides the author—soon followed by references to 'we/us' implying both parents—and, expectably, the baby/babies (whose mentions usually peak towards the end of the stories), the midwife is the most frequent mention, although with a definitely negative profile. In contrast with this emerging view, the professional figure of midwives is supposed to provide care and support to women and their families, helping them make informed choices about the options available in childbirth.[11] They should be able to understand the emotional, physical and psychological processes women go through during pregnancy and birth. Further on this point, the WHO defines midwifery as "skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families".[12] Despite such provisions, midwives seem to be involved in most of the negative experiences reported in the online stories, as instances will show. Among the medical staff, the doula—who sometimes attends births, although it is the least frequent participant in the stories—is portrayed in very positive terms.

Initial qualitative reading of the texts collected revealed that authors recurrently employ lemmas bearing an extremely negative connotation to express their emotional states and feelings. Not surprisingly, they resort to lexical items—such as *horrified*, *petrified*, *terrified*, *shocked*, *appalled*—which fall within the semantic domain of terror as a response to their feeling threatened and in danger in childbirth, as some of the instances quoted below show:

1) I was *terrified* something was wrong with my baby, but the OB never gave me any explanation. (Twitter, Jan. 2019)

2) *I have nightmares still*. I knew that giving birth would involve pain but didn't know how *utterly disregarded* I would feel during the process. (Twitter, Feb. 2019)

3) Looking back *I find it absolutely disgusting*. (Twitter, July 2019)

4) *My birth was* needlessly *terrible*. My dr who I trusted didn't show up despite my being admitted during the timeframe she said she would be available for. (Twitter, Aug. 2019)

[11] See https://www.healthcareers.nhs.uk/explore-roles/midwifery/roles-midwifery/midwife.

[12] https://www.who.int/maternal_child_adolescent/topics/quality-of-care/midwifery/en/.

5) *I was petrified* about if my child would have ended up with a condition like cerebral palsy if she had stuck longer. (OJP, Sept. 2019)

6) *Both myself and my husband wept from the pain*, *exhaustion and anguish*. […] When I think about this experience *I am furious and appalled*. *The trauma of this experience* has made me decide not to have another baby. (OJP, Oct. 2019)

7) *I never called it a trauma*. […] But more than a decade later *I am still dealing with the emotional and mental repercussions from my son's birth*—from what I now recognise as *one of the more prominent traumatic experiences of my life*. (BTA, Feb. 2020)

The above-mentioned instances from some of women's narratives display how they linguistically construe their childbirths: they do not merely rely on encoding their experiences through pain or fear, but rather call upon feelings of anguish, terror or panic. In stark contrast with the kind of stories that could be expected in what should be one of the most heart-warming occasions of a person's life, these women tell stories of medical abuse characterised by multiple violations and discriminatory practices which surface, tentatively breaking the traditional culture of silence. Such stories constitute a channel to externalise their emotional and psychological sufferings, which could not be verbalised at the time of labour and childbirth. By enacting practices of meaning-making, language allows women to elaborate their trauma through forms of understanding and action. They can, therefore, linguistically realise their experiences by employing semantically-related adjectives which are invariably connected to the domains of fear, shock, terror, disgust, and anger. Through writing and sharing, they seem to address, and somehow respond to, their feelings of disempowerment, inadequacy and disappointment in medical contexts.

Analysis of the emotion patterns was then carried out by taking into account the verbal phrases—processes, in Halliday's words (*Introduction Revised*)—most frequently recurring with the main participants. Investigation shows that authors tend to privilege mental, relational, verbal processes (Halliday, *Explorations; Introduction*; *Introduction Revised*) to construe their experiences. In fact, the verbal phrases they employ mainly pertain to:

- perception (seeing, hearing, etc.), affection (liking, fearing, etc.), cognition (thinking, knowing, understanding, etc.), or desideration (wanting, desiring, wishing)—in the case of mental processes;
- being, possessing or becoming—in the case of relational processes;
- modes of expression and indication—in the case of verbal processes.

Mental processes certainly feature the highest number of occurrences, women's narratives having the main goal of giving voice to their perceptions, feelings and thoughts—mostly referring to what they did *not* understand or know about what was happening and being done to them and/or their babies. Relational processes are also very frequent—as evident from the above-mentioned instances where participants

define an entity (themselves or their childbirth) with a series of attributive or identifying clauses (*I was terrified*, *my birth was needlessly terrible*, *I was petrified*, and so forth). Verbal processes soon follow, in terms of occurrences, as processes of saying, women reminding their many requests (for information, pain relief, help, different medical procedures) at the time of labour or once the baby was born. According to their stories, their verbalisations usually went unheard or unnoticed by the intended receivers, namely the medical staff. Authors are very often the grammatical subject (although not the logical one) of verbal processes and phrases in which they are told how to (not) behave, what to do (or not to do) by an implicit agent, the medical staff.

Interestingly, almost no material processes, implying action and doing, could be found in relation to authors. On the contrary, all verbal phrases expressing material processes usually relate to the medical staff, which gives a measure of the power relations existing between the different participants and the (disproportionately asymmetrical) agency they have in childbirth. In fact, the participants grouped under the label 'medical staff' are frequently mentioned with material processes such as: check(ed), decide(d), make/made, restrain(ed), place(d), lock(ed), give/gave, strap(ped), strip, break/broke, pull(ed), do/did, get, keep/kept, hold/held, stitch(ed), assault(ed), leave/left, as instances 8-10 below show.

8) *A member of the labor team pushed me flat on my back*. The OB said '*Pull her down on the bed and grab her feet*.' Suddenly *I was dragged down the bed, my feet were lifted into the air*. I was unable to move at this point. There was no communication as to why this was being done. I could feel the OB's hands in me pulling on the baby. It was extremely painful and unexpected. (BM, Nov. 2018)

9) *They placed me* on an operating table and *restrained my legs*. These were not stirrups, they were locked boots so I was not able to move my legs. (OJP, July 2019)

10) *They strapped me down* so I couldn't get into labour positions. […] Once the baby was out *she gave* a local injection and didn't wait for it to take effect. I kept screaming 'I can feel that', but *she continued stitching me* […]. I passed out and when I woke up *some guy was continuing to stitch my vagina*. (Twitter, Aug. 2019)

In the above-mentioned examples as well as in several other cases, while the medical staff (above all midwives) invariably appear as the *actor* of material processes, authors of stories always find themselves in the position of *goal* (Halliday, *Introduction* 131). They are not the doers of actions, but rather those to which something is done.[13] Labouring women seem to lack the ability to make decisions and act according to their perceptions (and when they do happen to be the subject of material processes, they are always in the negative form, to express something that they were not able or allowed to do—as in instances 8 and 9—*I was unable/not able to move*—as well as 10—*I couldn't*

[13] The only material processes co-occurring with authors are: get, start, push, wake.

get into labour positions). Overall, texts highlight that most birthing decisions are made by participants other than authors. In fact, they frame themselves as having the least power among the participants involved in childbirth, which confirms the assumption according to which they felt disempowered and this lack of control might have motivated their writing. In this respect, questions of power and asymmetrical power relations between physicians and patients result in a technical knowledge differential and the dismissal of patients' voices as unreliable or meaningless. In order to process the trauma of birth, women need to "fill in 'missing pieces' of their experience to regain control" (Antoniak *et al*. 16).

IDENTIFYING PLOT UNITS AND THEMES

As women's (virtual) voices resonate through the Internet, analysis of the plot units allowed the identification of two main forms of violence: physical and verbal violence.

Physical violence, which is certainly the most common theme (it could be found in 87% of the stories), is carried out through the use of unnecessary medical procedures and interventions (see examples 11 and 12 below), which are cited as unwanted, traumatic and painful. The adoption of the supine position—which is usually justified because it facilitates medical work—is perceived as an imposition: women trying to stand in a vertical position are apparently identified as practicing rebellious acts, to be contained (and sometimes even immobilised, see examples 8-10 above) in the supine position on the delivery table. A lot of women complain about the use of vaginal touches, without authorisation and prior explanation, performed by multiple examiners, at small intervals or at the same time. The extracts from the online stories below voice extremely harsh moments in childbirth, portraying them with lexical items which can be mainly and explicitly subsumed into the domains of aggression and assault:

11) *The most traumatic aspect of the delivery was the forced manual placenta extraction*. […] I wasn't bleeding and there were no other concerns but *after pulling on the umbilical cord to the extent my midwife was afraid the OB was going to prolapse my uterus*, *the doctor reached up her hand inside my uterus to force the placentas out*. […] Even as I screamed in pain she would not stop until she mutilated the placentas. (BM, Dec. 2018)

12) #MeToointhebirthroom is why I became a midwife. *An episiotomy with no consent was assault*. I never complained. I was grateful for a healthy son I thought I could never have. I never forgot though. *I carry a physical scar & I carried the emotional one into my next birth.* (Twitter, Aug. 2019)

13) *My OB stitched me up without anaesthetic after delivery, despite my protests*. Everyone was with the baby—I was alone in stirrups. *He also reached inside me and pulled on the cord to deliver the placenta which goes against all protocols*. (Twitter, Mar. 2020)

The online stories often refer to disrespect of privacy, imposition of force and brutality in procedures, no use of analgesia, but seldom refer to trauma explicitly, which reveals how complex the psychological process of awareness and recognition can be. In most of the texts, women complain about lack of respect for their pain and refusal to adopt strategies to minimise it because it is widely accepted that women *must* endure suffering as biologically inherent in their femininity. When, in some cases, they pleaded to have a C-section after hours and hours of gruelling labour, they were ignored until delivery became unmanageable and potentially dangerous for the baby. In their words, childbirth bears the effects of a disease, something that injured them and left a scar, a physical and emotional scar, formed to repair a wound.

Verbal violence, the second main kind of violence that could be detected in the online stories,[14] generally refers to absence of clarification, rude behaviours, misinformation or denial of information, absence of dialogue, verbal aggression, impatience, cursing, ironic or rough treatment, intentional humiliation, threats, discriminatory offenses, repressive criticism, disregard of opinion, indifference, inattention. The instances below can give a glimpse of how women were (or felt) treated:

14) The nurse I had for 12 hours was horrible. *She spoke to me like I was a child*, *and berated me* a few times when I couldn't pull myself up due to not being able to feel my legs from the epidural. […] I begged as the pain was unbearable, but now I was delirious. Lost my ability to speak and my speech came out slurred. *I heard the nurse telling the fellow that I was conked out*. (OJP, Sept. 2019)

15) I was denied pain relief, simply because I wasn't significantly dilated. *I was insulted and left, humiliated and sobbing with pain* on a general antenatal ward. *It was very public and very humiliating to be in such a state in front of people who did not know me* […] *and probably thought I was being ridiculous*! It was hideously, undescribably painful, but, when asked for help *I was told not to be ridiculous and called stupid*. (BTA, Oct. 2019)

16) I was told *I was exaggerating my pain* and that *I should suck it up*. (OJP, Nov. 2019)

17) "Now, no screaming", *the doctor commanded* as she entered the delivery room. […] Being told not to scream felt eerily similar to other moments in my life, moments when *I felt silenced by someone with more power than me*. (Twitter, Mar. 2020)

What emerges from women's linguistic construal of their experiences is their inability to speak or make themselves heard, the medical staff usually silencing them. Their inability to act is further stressed by the use of the passive voice—*I was told*, *I was*

[14] Verbal violence could be found in 52% of the online stories collected. Percentages of stories featuring physical and verbal violence are over 100% because they are sometimes both present in the same story.

denied. The medical staff are, once again, the grammatical and/or logical subject of the main verbal processes that were found in the collection of texts. Numerous women report the practice of talking to them with derisive comments, derogatory jokes, criticism at their crying and pain during childbirth, showing disrespect to their physical pain and the trivialisation of their suffering. Women are often not trusted when describing their pain, despite the fact that pain is subjective and can only be measured via self-reporting (see also Antoniak *et al*. 16); distrusting pain reports implies a distrust of women's experiences and stories, of their feelings that something is wrong or just not suitable for them. Blame is often laid on labouring women for lack of effort, disregarding the psychological impact this might have on them. This kind of violence disturbingly results in the fact that a delicate time such as childbirth ends up being marked by rough treatment, impatience, shouts, intentional humiliation and repression. Most of the stories shared online recall a helpless state, women feeling lonely, isolated, ashamed, unable to resist violence, which causes a sense of psychological paralysis and profound disempowerment at the time of labour.

In broader terms, both forms of violence appear to be increasingly ascribed to an asymmetry in power relations within society. Indeed, following many views (Bohren *et al*.; Jewkes and Penn-Kekana), clear parallels can be drawn between the mistreatment of women in childbirth and violence against women, where the essential feature in both cases is that it stems from structural gender inequality. Gender is, therefore, central to the conceptualisation of obstetric violence.

According to some scholars, it is of the utmost importance to analyse obstetric violence separately from other forms of medical violence and overall mistreatment of patients, but rather as a specific case of gender violence: since labouring women are usually healthy and have no medical condition, obstetric violence is often experienced and interpreted as a symbolic form of rape (Martin; Cohen Shabot). It is a kind of violence directed at women because they are women. Far from claiming that the medical staff knowingly perform it, what is posited by a number of studies (and this paper also holds such view) is that they merely perpetuate the violence of existing societal structures. Thus, it is a structural, not a behavioural, violence (Cohen Shabot).

In this context, the role played by medical hierarchies and biomedicine seems worth mentioning: they can be said to operate as a social, historical and cultural system responding to and, at the same time, reproducing gender ideologies across health professions (Bohren *et al*.). The power of biomedicine in health systems has been often underestimated or downplayed, which has made it a silent, unnamed factor when considering the mechanisms enacting abuse and mistreatment in maternity care. Such mechanisms should be investigated as forms of structural—and invisible—violence that is built into the fabric of society, producing and reproducing inequalities. The health system appears to legitimise the medical staff's (doctors, obstetricians, midwives, and nurses) power over women during childbirth, justifying the use of coercive means to obtain compliance of labouring women, accepting it as normal (Bellón Sánchez). This view of obstetric violence offers a gendered lens to frame it as a form of patriarchal violence, revealing the extent to which gender relations of power are disseminated within the realm of medicine and health care. Labouring, noisy, messy bodies in the act of giving birth need to be tamed, silenced and put into place (Cohen Shabot). Women

are expected to be submissive, passive and obedient due to the hierarchical power of health professionals. They are, therefore, the targets of various attempts at normalisation. They are made invisible and silent in connection to important decisions pertaining to their body and their children, they are deprived of the power to act and autonomy over their bodies. Indeed, powerlessness and normalisation surface from the online narratives when women mention an idealised conduct they were expected to adopt, a conduct deriving from some specific social and cultural norms and implying a sense of shame for those who do not comply with it. Besides conveying narratives of pain, the stories shared online also reveal women's perception of themselves, which is deeply affected by subtle evaluative mechanisms they are exposed to, which lead them to feelings of awkwardness and inadequacy, as instances 18-22 below show.

18) The next few hours were a nightmare. I passed out more than 5 times. I was sick, I was prodded and examined internally…very roughly…*I was made to feel very inadequate*. (BTA Jan. 2018)

19) She held me back when I said I was getting sick from pain and needed to run to the toilet. And then *shamed me and lectured me* for vomiting on the floor because of that. *I felt stupid, a nuisance and completely diminished as a person*. (BM, Jan. 2018)

20) The midwife […] rolled her eyes at me when she failed to reach a vein with a needle and blood seeped onto the bed sheet. […] My partner arrived and was horrified to see me strapped on my back, unable to move, covered in vomit. […] *I am a wimp, I thought, a failure*. (BTA Aug. 2018)

21) A senior midwife insisted *I was flipped* and my legs [were] put in stirrups, *I was made to feel 'awkward'* because I wanted to stay on all fours, the doctor wandered in now and again to mention ventouse. (BTA, Aug. 2018)

22) When it came time to push *my OB repeatedly told me that I wasn't doing a good job. He started getting angry with me and yelled that the last mother whose baby he delivered did an amazing job and she delivered in one push. Then he would look back at me and tell me I was nothing like that mother*. (BM, Oct. 2018)

As a matter of fact, analysis of plot units revealed an additional frequent topic emerging from the collection of texts, shame,[15] which is precisely caused by feelings of inadequacy and awkwardness. According to Cohen Shabot and Korem, gendered shame, which is experienced by women over failing to construct themselves as good women and fit mothers, is one of obstetric violence's most important mechanisms: "gendered shame [is] a (violent) instrument with which to denigrate women […]. It is performed and perpetuated by shaming women for being bad mothers-to be and for acting against the myth of altruistic, self-sacrificing motherhood" (Cohen Shabot and Korem 387). In their philosophical elaboration of the concept of shame as fundamental

[15] The topic of shame could be found in 39% of the stories.

to the constitution of the self, Cohen Shabot and Korem move from Sartre's discussion of shame intended as a process of objectification by the gaze of the other (*Being*)—which is often a male gaze—and then refer to shame as "a contribution to the phenomenology of oppression" (Bartky 84). Shame is needed to construct a social self that cares about and is affected by the other's gaze and judgment. In their words, "to feel ashamed is to look at oneself through the eyes of others—to be object-for-the-other—and feel judged for one's inability to meet others' expectations" (Cohen Shabot and Korem 388).[16] Labouring women experience this pervasive shame while they are made to perceive their failure to meet societal standards, they are made to feel inadequate in the very moment they are giving birth to another human being, their child. It is thus a peculiar kind of shame which makes women's most intimate selves insecure, because they fail to perform the 'right' femininity—silent, delicate, obedient. For the suffering body in labour, unlike other suffering bodies, shame derives from a reifying (and objectifying, male) gaze that frames women's bodies as dirty, overly noisy, not-feminine enough, grotesque, incapable and dysfunctional.[17]

In this perspective, obstetric violence can, indeed, be viewed as a reflection of how female labouring bodies are perceived as threatening the norm because they are undisciplined and unruly bodies—violence then becoming necessary to tame and dominate them, to restore their submission and expected passivity (Cohen Shabot). Maternal care can then be depicted through a series of patriarchal forces and dynamics—with the various participants trying to coach and control labouring women. It is interesting to notice that, although forms of intervention are predominantly male and most doctors are men, women working in the health-care system too tend to incorporate the attitudes of their professional category. Accordingly, gender asymmetries and power relations appear to be in place not only between men and women but also among women, thus acting transversely. If all aspects of social life appear infused with power relations—and the central question does not concern the existence of violence, but the extent to which individuals participate in, or foster, an institutionalised violence (Bourdieu)—obstetric violence should not be approached as a simple act of mistreatment. It should rather be viewed as a set of socially constructed symbolic meanings allowing the different participants to childbirth to frame the violence as if it were natural, expected and accepted, reinforcing specific gender dynamics not merely in maternity care but in society.

[16] Violence and shame (and shame as a violent tool) appear necessary for domesticating women, returning them to docile femininity (see Cohen Shabot and Korem 385). Because pain and suffering are perceived as integral to childbirth, and childbirth is perceived as a routine, even compulsory, process for women, the violent experiences of labouring women go unnoticed and unrecognised by both other women and the medical staff (Cohen Shabot and Korem 392).

[17] Cohen Shabot and Korem (390) mention a case of obstetric violence rooted in shaming women by quoting an obstetrician describing a senior male obstetrician using this form of violence: "After delivery, he would order 'hurry, hurry, hurry, goddamn it, hurry; nobody's going to look down there for a long time', when I tried to sew up women's lacerations with some attention to aesthetics."

CONCLUSIONS

Despite little academic and scientific attention, birth stories have become increasingly common on the Internet, providing detailed descriptions of emotions, decisions, relationships. Especially after traumatic experiences, mothers/parents seek healing by speaking up, writing, telling their stories, for a wide range of complex motivations: as a way to re-work the trauma, disrupt and resist against surveillance and abuse of their choices and bodies, re-negotiate power after a disempowering medical experience, unburden themselves, find relief. In some cases, the process of writing and posting these unsolicited stories helps giving them closure; in other cases, it helps them sort through their feelings, looking forward instead of looking back. Either way, it can have physical, emotional and social health benefits, acting as a sort of therapy, negotiating social norms and roles. Re-writing their stories of childbirth can help women re-frame their power and agency in comparison to (mostly) the medical staff, escaping imposed (societal) narratives.[18]

While projecting the image of suffering bodies in labour facing abuse, humiliation and unconsented medical procedures in what should be, instead, an intimate and joyful moment, women's online narratives allow a critical thought on practices of discrimination which heavily affect their agency and act like a prism reflecting dominant dynamics in society. Such dynamics convey covert forms of subjugation enacting practices of discrimination which represent the expression of historical, social and cultural values that are buried and disguised in the naturalised order of things. In this respect, obstetric violence appears different from other forms of medical violence because labouring bodies are suffering, unruly and noisy, but they are not ill; they suffer from a structural kind of gender violence, a form of subtler normative oppression aiming at a diminishment of their agency (Wolf; Cohen Shabot). They are caught in the cycle of silence and shame: they tend to hide their experiences, believing to be alone, thus precluding social change and political action.

Despite the fact that significant changes have occurred and the debate is currently framed in terms of violence and human rights violation, there seems to be a need for broader analysis, centred in the cultural and social dimensions embedded in the phenomenon of obstetric violence. Apart from focusing on victims and victimisers, it would be more useful to acknowledge naturalised gender roles together with the concealed forms of violence and power dynamics operating in society. Similarly, the power structures reproduced in biomedicine should be made visible, paying more attention to the emotional dimension of maternal care—which appears too often neglected—rather than to the acceptance of mechanisms to impose norms and discipline (Sadler *et al*.). The results of this analysis could then be useful to medical professionals to frame their actions differently and help them in the process of decision-making, potentially paying more attention to the patients' needs and feelings of agency during childbirth, prioritising their voices.

[18] Although this case-study has dealt with the issue of obstetric violence as emerging from online narratives as a whole, it would be interesting to investigate the phenomenon introducing some demographic variables, such as ethnic origins, education level, socio-economic status, marital status, private hospitals vs. public hospitals, and so forth.

In this regard, social scientists can offer a significant contribution on the issue, reflecting on unequal and asymmetric gender power relations and investigating how labouring women are disempowered. Academic research, professional education, and public policies failing to engage with the structural dimensions of obstetric violence should tackle the micro- and meso-level 'symptoms' as much as all the macro-level causes of this form of violence (Sadler *et al*.). To this extent, an integrated perspective on the question of obstetric violence is desirable, involving a dialogue between the fields of medicine and social sciences which could recognise it as a multi-faceted phenomenon requiring a multidimensional approach. The issue should be addressed from the lens of medical humanities, gender studies and human rights, because the gender-related dimension of obstetric violence appears pivotal in such a violation of rights. To expose the silence that blankets women's traumatic experiences greater effort is needed to overcome practices of structural gender discrimination.

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Nisco, Maria Cristina. "Voicing Labouring Bodies: Women's Narratives and Gender Violence", n. 24, *La narrazione come cura: la rappresentazione della malattia nelle nuove pratiche delle Medical Humanities*, pp. 121-138, November 2020. ISSN 2035-7680. Disponibile all'indirizzo:
<https://riviste.unimi.it/index.php/AMonline/article/view/14549>.
Ricevuto: 15/02/2020 Approvato: 01/06/2020
DOI: https://doi.org/10.13130/2035-7680/14549