Domesticating Bodies: The Role of Shame in Obstetric Violence

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Obstetric violence—violence in the labor room—has been described in terms not only of violence in general but specifically of gender violence. We offer a philosophical analysis of obstetric violence, focused on the central role of gendered shame for construing and perpetuating such violence. Gendered shame in labor derives both from the reifying gaze that transforms women's laboring bodies into dirty, overly sexual, and "not-feminine-enough" dysfunctional bodies and from a structural tendency to relate to laboring women mainly as mothers-to-be, from whom "good motherhood" is demanded. We show that women who desire a humane birth are thus easily made to feel ashamed of wanting to be respected and cared for as subjects, rather than caring exclusively for the baby's well-being as a good altruistic mother supposedly should. We explore how obstetric violence is perpetuated and expanded through shaming mechanisms that paralyze women, rendering them passive and barely able to face and fight against this violence. Gendered shame has a crucial role in returning women to "femininity" and construing them as "fit mothers." To stand against gendered shame, to resist it, on the other hand, is to clearly challenge obstetric violence and its oppressive power.

SHAMING AND GENDER VIOLENCE

Obstetric violence—psychological and physical violence by medical staff toward laboring women<1>—has been described specifically as gender violence: violence directed at women because they are women.<2> The insights of feminist theory are crucial for explaining how this phenomenon differs from other types of medical violence, objectification, and reification and for accounting for the feelings many of its victims report, including loss of control, diminishment of self, physical and emotional infantilization, and, especially, shame. We offer here a philosophical analysis of obstetric violence, focused on the central role of shame in constituting and perpetuating such violence.

The kind of shame discussed here is mainly gendered shame, a pervasive emotion that can affect women to their very core. Gendered shame, we show, tends to be paralyzing, making women's most intimate embodied selves insecure. Thus shame in this form not only perpetuates obstetric violence but is itself violent, confining, restricting, and diminishing laboring women. We base our discussion of gendered shame mainly on Sandra Bartky's analysis of the "shame of the oppressed" (Bartky 1990, 97). According to Bartky, in addition to the shame that all subjects necessarily experience when existing as social and moral persons, oppressed people—such as women—also experience pervasive shame, a product of the continuous and persistent disciplining of their embodied selves by different forms of structural oppression (such as sexism and racism). As she notes (regarding women in her classroom): "The shame of some of these women was not a discrete occurrence, but a

perpetual attunement, the pervasive affective taste of a life" (96).

Gendered shame, we argue, thus constitutes a specific form of Bartky's "shame of the oppressed." In labor, this shame derives both from the reifying gaze that transforms women's laboring bodies into dirty, overly sexual, not-feminine-enough, dysfunctional bodies and from a structural tendency to relate to laboring women as mothers-to-be (detached from their previous identities as "just" women), from whom "good motherhood" is demanded. Stereotypical good mothering, calling for total sacrifice and an exclusive concern for the baby's needs (understood in opposition to women's needs), stands at the core of the gendered shame that is often present in the labor room.

We show that women who desire a humane birth—with the woman at the center of the birth process and in control of her decisions and her body (Wagner 2001)—are easily made to feel ashamed of wanting to be respected and cared for as subjects, rather than caring exclusively for the baby's well-being as a good altruistic mother supposedly should. We explore the perpetuation and expansion of obstetric violence through shaming mechanisms that paralyze women, rendering them passive and barely able to face or fight this violence.

The shaming of women begins long before labor. It is easy to make laboring women feel shame because, as Bartky details, it is already a well-known element of their feminine personalities, a recognizable place where femininity is, in a way, safe (Bartky 1990). In patriarchal culture, shame is integral to femininity.

We focus on obstetric violence's connection to shame, specifically gendered shame. This violence is grounded in, and relies on, women feeling ashamed—mainly of breaking the rules and codes of such stereotypical femininity and maternity. Violence and shame (and shame as a violent tool) appear necessary for domesticating these women, returning them to docile femininity, and preparing them for "intensive motherhood."<3> To resist gendered shame, conversely, is to challenge obstetric violence and its oppressive power.

OBSTETRIC VIOLENCE

Women's organizations, birth activists, and feminist researchers have begun to point out that abusive and disrespectful treatment constitutes violence toward laboring women ("obstetric violence"). Michelle Sadler and her colleagues call on the medical community and policy makers to replace terms such as *mistreatment, disrespectful or abusive care*, or *inhumane birth* with *obstetric violence* to express the severity of the problem (Sadler et al. 2016). The term originated in Latin America, where women and midwives struggled to change laws and policies following reports of such practices, and in 2007, in an effort to prevent violence toward women, Venezuela became the first country to legally define obstetric violence:

> By obstetric violence we understand the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life. ("Organic Law on the Right of Women to a Life Free of Violence," Venezuela, 2007, cited in Sadler et al. 2016, 4)

Obstetric violence thus refers to actions classified as physical and mental violence exerted during pregnancy and childbirth. This definition enables us to focus on the obstetric and gendered aspects of this violence, as well as on medical hierarchies of power, and to analyze medicalized childbirth from a broader viewpoint than simply "mistreatment" or "abusive

care," through the perspective of the structural inequality and social power structures embodied in violence toward women (Sadler et al. 2016).

The World Health Organization, beginning to acknowledge the mounting mass of testimony by women describing disrespectful care, unnecessary medical interventions, and the imbalance of power between medical staff and the women laboring and giving birth in medical facilities, has appealed to the right of every woman to respectful treatment (WHO 2014),<4> an important milestone in the institutional recognition of "the global epidemic of abuse and disrespect during childbirth" (Miller and Lalonde 2015, S49).

Meghan Bohren and her colleagues, reviewing more than sixty studies from thirty-four countries, describe how laboring women in medical facilities in different countries, across all socioeconomic levels, are exposed to disrespectful and abusive treatment (Bohren et al. 2015). This includes physical violence and restraint; threats of violence toward the woman and her baby and of withholding medical care from them if she fails to follow staff orders; blame laid on the laboring woman for poor health outcomes for herself or her child; discrimination against poor women, immigrants, minorities, and women perceived as too young or too old; denial or lack of pain relief; and the performance of episiotomies, sutures, and invasive examinations without anesthesia. The researchers identified seven types of mistreatment: physical abuse; verbal abuse; sexual abuse; stigma and discrimination; failure to uphold medical standards of care; miscommunication between laboring women and medical staff; and issues resulting from the state of the healthcare system, including lack of resources and problematic policies.<5>

Bohren and her colleagues demonstrate that these failures are structural. Interview responses by medical personnel make it clear that the health-care system legitimizes the medical staff's power over women during childbirth. They often believe that they are justified in using extreme or coercive means to obtain the compliance of laboring women; some claim that they are not obliged to provide treatment to noncompliant women. In health facilities, even midwives justify coercive treatment of women as necessary under certain circumstances to ensure compliance by laboring women and safe outcomes for women and babies. Overall, medical staff accepts the mistreatment of women as normal.<6>

Suellen Miller and Andre Lalonde's review for the International Federation of Gynecology and Obstetrics provides the history of and evidence for obstetric violence, showing how the abusive treatment of laboring women affects birth outcomes (Miller and Lalonde 2015). Other analyses link obstetric violence to birth trauma that can lead to postpartum post-traumatic stress disorder (PPTSD) (Beck 2004b; Thomson and Downe 2008; Elmir et al. 2010; Harris and Ayers 2012; Simpson and Catling 2015).<7> This obstetric violence includes such extreme neglect by medical staff that laboring women are left to deliver on their own. Reports or experiences of abusive care also tend to make women avoid medical facilities in future labors, even in cases of high-risk pregnancy (Miller and Lalonde 2015).

Obstetric Violence as Gender Violence

> Shut up, close your mouth, and push . . . ; there is only one voice in this room and it is mine.
> (Goer 2010)

Sara Cohen Shabot addresses why obstetric violence must be considered as gender violence: the structural violence at its base involves a patriarchal need to tame bodies that are not properly feminine (Cohen Shabot 2016). In this account, women's laboring bodies are oxymoronic: as feminine bodies giving birth, they accomplish a major task of femininity, but

they are also usually strong, expanding, noisy, messy bodies. They challenge passive femininity, expressing an untamed and cathartic subjectivity that is in turn silenced and put in its place by a medical system steeped in patriarchal values. Cohen Shabot builds on Iris Marion Young's critique of feminine body comportment compelled to become passive, hesitant, and alienated through strongly internalized oppression within patriarchal societies. In such societies, the natural destiny of women's bodies is to be objectified. But this always creates conflict: women strive to be subjects, but if they succeed, they lose (stereotypical, passive) femininity, and if they fail, they remain alienated from their embodied selves (Young 1980; Cohen Shabot 2016, 243).

Gendered shame, experienced by women over failing to construct themselves as good women and fit mothers, is one of obstetric violence's most important mechanisms. Attempting to feminize women's bodies, obstetric violence makes continual use of gendered shame as a (violent) instrument with which to denigrate women for losing femininity or being too sexual or messy. 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.

WOMEN AND SHAME

Recent works analyze shame in (mainly phenomenological) philosophical terms, as fundamental to the constitution of the self (Zahavi 2010; Deonna, Rodogno, and Teroni 2011; León 2012) and as an emotion that might be regarded as pervasive, affecting the self more intimately and essentially than does guilt: "shame concerns one's self, one's being, and not one's doing as in guilt" (Karlsson and Sjöberg 2009, 353). Shame has also been defined as an embodied emotion, presenting clear bodily manifestations and transforming a lived-body into a body-object (Metcalf 2000; Fuchs 2003; Karlsson and Sjöberg 2009; Dolezal 2015). As early as 1956, in his account of shame in *Being and Nothingness*, Sartre discussed the embodiedness of shame and its fundamental connection to objectification by the gaze of the other, stripping us of our embodied subjectivity; this continues to be discussed in phenomenological and feminist-phenomenological analyses of shame (Lehtinen 1998; Metcalf 2000; Fuchs 2003; Dolezal 2015).

Bartky presents a phenomenology of shame as a "contribution to the phenomenology of oppression" (Bartky 1990, 84) and defines it, following Sartre, as an emotion requiring an audience: "I must feel shame before some actual Other before I learn to raise an internalized Other in my imagination" (85). 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. This shame at our recognition of being objects for the other's scrutiny is of course critical to our development as moral subjects: shame is needed in order to construct a social self that cares about and is affected by the other's gaze and judgment. However, within patriarchy, women occupy a position of subordination and objectification that consistently lowers their status and subverts their self-confidence, causing them to feel ashamed more often and more severely than men do (88).

This "shame of the oppressed" constitutes a pervasive shame that—unlike concrete feelings of guilt, or of shame deriving from the mere phenomenological self-recognition of being object-for-the-other (in addition to existing as subject), both of which are necessary for a normative moral life—is paralyzing and unproductive and not even morally useful. It is "profoundly disempowering" (97), effectively perpetuating oppression and precluding social change and solidarity because its victims—in this case women—tend to experience this pervasive shame individually and in solitude, understanding their failure to meet societal standards as a personal inadequacy rather than a badge of gender membership.<8>

Shame and Femininity in the Labor Room

Women's embodied selves are shameful because they inhabit the world as objectified, as being-for-others, and as looked at. The internalization of stereotypical femininity, bound to experiencing oneself as an object of the male gaze, perpetuates this shame. Part of this permanent gendered shame involves failing to fulfill the standards of beauty to which patriarchal society holds women.

Luna Dolezal looks at shame with a focus on its embodied aspects and from the perspective of phenomenology and feminist theory, showing how these impossible, oppressive standards of beauty are so thoroughly internalized by Western women that the shame of failing to fulfill them is inevitable, overwhelming, and paralyzing: women suffer from "chronic shame" because they are "already shame-prone" (Dolezal 2015, 109), as Bartky shows, and constantly compare their actual bodies to confusing idealized constructions of unreal bodies:

> Women's bodies . . . are continuously positioned as inadequate or inferior when compared to these elusive body ideals; shame, and body shame in particular, becomes a permanent possibility. . . . Women are already attuned to the feelings and contours of body shame; they expect their bodies to betray them and to deviate from the diffuse and invisible cultural standards of what a body "ought" to be. Failing to achieve the ideal body signals a deeper failed mastery of the body and corporeal control. This attunement to shame is so pervasive and indeterminate that it is often beyond the reach of reflective consciousness. (Dolezal 2015, 109–10)

Thus the shamefulness of women's existence derives from at least two different (though related) experiences. The more fundamental experience involves being deprived of subjectivity, permanently objectified and gazed at, as Bartky explains. Here shame stems from the constant feeling of being scrutinized by the other, for whose gaze we (exclusively) exist, and from failing to inhabit ourselves as full subjectivities provided with agency. The second experience, building on the first, involves the impossibility of being the "right" objects, that is, beautiful and self-controlled feminine objects, as Dolezal makes clear. This doubled shame is what many laboring victims of obstetric violence experience: first, shame at being turned into pure objects by the medicalization and oppressive patriarchies through which labors are managed (Wolf 2013; Cohen Shabot 2016; Sadler et al. 2016) and second, shame at failing to perform the "right" femininity—silent, delicate, obedient; not overly sexual, loud, or exuberant—in labor.<9>

Anne Drapkin Lyerly addresses this last aspect of reification in labor specifically in the context of shame, discussing the role of shame—especially body shame—in disempowering laboring women. She argues that it is not technology or medicalization per se that is to blame for the increasing feelings of discontent and frustration many women report after childbirth, but the medical staff's lack of sensitivity toward the birthing woman. The shame that plays a major role in disempowering laboring women, she argues, derives precisely from how laboring women are made to feel by the objectifying gaze that transforms women-subjects into dirty, blatantly sexual, overly noisy, incapable, unfeminine body-objects. As a resident obstetrician, Lyerly encountered cases of obstetric violence rooted in the shaming of birthing women for their "dirty" and "inappropriate" sexuality. She describes a senior male obstetrician who regularly used this form of violence in the labor room:

> Dr. P. insisted, for instance, that the perineum of every patient be completely shaved before he delivered her baby. After a 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. In exaggeratedly cleaning, shaving, and then disgustedly dismissing the importance of repair beyond adequate hemostasis, he reinforced the conception of female sexuality—and female genitalia—as dirty, impure, sullied, and may thereby have reinforced the shame of embodiment during a time in which the embodied woman was, in fact, doing an extraordinary thing: producing another human being. (Lyerly 2006, 113)<10>

Gendered shame thus serves obstetric violence twice: first, violence from the medical staff encounters less resistance and is more easily performed if the woman feels ashamed; second, the shaming appears to be a significant part of the violence itself.

Moreover, the gendered shame that women experience at the portrayal of laboring bodies as grotesque and disgusting in themselves is often already internalized and established well before any encounter with the medical staff. This sometimes even prevents women from being willing to experience certain kinds of labors, mainly those perceived as more blatantly exposing their "dirty" or "inappropriate" sexuality. Claudia Malacrida and Tiffany Boulton, in interviews with childless women about potential childbirth choices, document some women's perceptions of vaginal birth as vulgar, a violation of feminine norms. One woman described vaginal labor as: "It'll just be like icky all around, baby's gonna be all bloody, goo's going to be going everywhere. I mean, it happens to everyone, it's not like it'd be sexy no matter what, because I don't think there's a sexy way to have a baby" (Malacrida and Boulton 2012, 760–61). Another worried about the gaze not only of the medical staff but also of her husband, and about her ability to perform as an appropriate sexual and feminine object:

> I've seen C-sections and natural births and I don't want my husband seeing me in that situation; like, there's a lot of lost dignity [in] giving birth naturally. . . . And if there's tearing it can be quite severe. . . . I don't want my husband getting that sort of image, when I plan to still have a sexual life after I have children. . . . And you're naked . . . and lots of times stool is passed giving birth . . . and I don't want my husband to be involved with that. (761)

Future gendered shame in the delivery room can be prevented by undergoing a Caesarean section, as this woman further explains:

> C-sections are just so beautiful. You keep your dignity through the C-section. . . . Only your abdomen's shown and your husband's up at your head with a big screen in front of your lower half so it's not like he sees anything going on down there. (762)

Chronic, preexisting gendered shame may thus play into women's birth choices before they ever confront the actual reifying gaze of the medical staff.

"You Should Be Thankful: The Baby Is All Right": Obstetric Violence and Maternal Shame

When a woman becomes a mother, the gendered shame she has always experienced is now suddenly also applied to her maternal performance. The common perception is that this

feeling is a natural part of being a mother, inherent to motherhood (Liss, Schiffrin, and Rizzo 2013). Mothers act under the scrutinizing gaze of patriarchal society, which created and incorporated the idea of motherhood as "naturally" exhausting and self-sacrificing, testing every mother's capacity to withstand it (Sutherland 2010). Yet this patriarchal concept and institution of motherhood is of course constructed and ideological. As Adrienne Rich points out, patriarchy's assumption is that the natural mother has no additional identity and can and should spend all her time solely in the company of her children (Rich 1986). She willingly sacrifices herself; her pain and suffering are irrelevant if they gain the welfare of her children. Her love for them is selfless and unconditional. A woman who fails to live this sort of motherhood is a defective woman.

Anat Palgi-Hacker's feminist critique of the role of the mother in psychoanalytic theories shows how these theories present women as waiting to be born mentally as mothers, in the same way that babies are born physically of their mothers: the woman gives birth not only to a baby but also to her own new identity (Palgi-Hacker 2009). Palgi-Hacker shows how key theories of psychological development construe the mother as object, completely deleting her subjecthood. She has no existence in herself, no voice. Palgi-Hacker further shows how this erasure is not random but stems from patriarchal defense mechanisms that depend on silencing women's voices, denying and repressing the subjectivity of women and mothers. Men within patriarchy fantasize about creation, fertility, and birth and are therefore deeply engaged in deleting the (real) mother to preserve patriarchal power, as part of the fantasy in which men take her place and speak for her. The giving over of birth and its management to the medical staff thus reflects an appropriation of the creation of life and of motherhood. Babies are described as being "delivered" by the medical staff, silencing not only the woman's body but also her voice as an expectant mother, a laboring woman, and a patient.

Despite the abundant existing feminist critique of the institution of motherhood and denunciation of its perception as natural (Rich 1986; Beauvoir 1989), women's understanding and internalization of contemporary (white, Western, middle-class) motherhood has hardly changed. We still witness what Sharon Hays defines as "intensive motherhood" (Hays 1998), in which women expect to sacrifice themselves and to be always available and occupied with their mothering role. Precilla Choi and her colleagues describe new mothers' feelings about motherhood as being in a constant race to be a "supermum, superwife, [and] supereverything" (Choi et al. 2005, 173). Like Palgi-Hacker, they describe intensive motherhood as starting not at childbirth but rather in a gradual process beginning with the future mother's first menstrual period and continuing to accompany her through pregnancy and childbirth. Throughout this process, girls, teenagers, and women are perceived as potential mothers, as demonstrated in medical guidelines instructing physicians to treat them as always potentially pregnant: doctors are thus instructed to encourage all sexually mature women to take folic acid, avoid drinking and smoking, and maintain a "healthy weight," regardless of the woman-patient's actual intentions with regard to pregnancy and childbirth (Malacrida and Boulton 2012). Moreover, medical school textbooks depict women as mostly heterosexual, with marriage and motherhood being a natural aspiration and a self-evident part of womanhood (Lee and Kirkman 2008). When doctors are taught that pregnancy is every woman's natural aspiration and ultimate desire, it is hardly surprising that this understanding finds its way into mainstream obstetric care.

This discourse frames the ideal mother, as well as the ideal potentially pregnant and birthing woman, as an unselfish woman who has abandoned or is willing to abandon selfish, childish behavior for a higher form of femininity. The discourse of selflessness as central to ideal motherhood and femininity also affects women's perceptions of their optimal choices in childbirth, often pushing them toward a willingness to experience pain and suffering and undergo any experience identified with maternal sacrifice, or toward absolute obedience to

the medical staff (Malacrida and Boulton 2012).<11> Thus, when it is internalized by women, this discourse also contributes to the reproduction of obstetric violence.

Because pain and suffering are perceived as integral to childbirth, and childbirth is perceived as a routine, even compulsory, process for women, the experiences, particularly the violent experiences, of laboring women go unrecognized by both the women's immediate community and the medical staff. Birthing women who share traumatic, or even simply difficult, birth stories are often silenced with comments like “everybody goes through that,” “you should be grateful,” or the quintessential “all that matters is that the baby is healthy.” In her discussion on shaming mothers, Vicki Cokerill writes: "It is the secret shame among mothers—birth trauma and the devastating effect it can have, not only physically but mentally, too. You are made to feel as though you cannot really be honest about a traumatic birth, you glaze over details only to relive them on your own later. You should be grateful your baby is here shouldn’t you?" (Cokerill 2017).

This is how the stereotype of "good," selfless motherhood silences, shames, and disciplines birthing mothers. Phrases such as “you should be grateful” express that whatever happens during childbirth is insignificant, given the laboring woman's sublime role in the creation of life and selfless engagement in mothering. In Gretchen Humphries's blog “Birth Truth,” she recounts the responses she received when attempting to share with others the trauma she experienced after undergoing the violence of an emergency Caesarean section:

> Wasn't I grateful? So many people said it to me, I started to wonder. People I trusted, people I respected, people I loved. Maybe I wasn't grateful for my babies? Maybe I didn't love my babies as much as I should or as much as other mothers did? . . . I didn't *feel* a lot about them. I was depressed. Then I began to realize how evil it is to tell a woman who's experienced a physically or emotionally traumatic birth that she should be grateful. . . . It is evil to say, "All that matters is a healthy baby" because you are saying that her pain, her damage, doesn't matter. You are telling her that not only is her body broken, but so is her mind. That if she is physically healthy, that's all that matters, and to be concerned with anything else is somehow wrong. . . . Good mothers just don't have those feelings, and she's already afraid she isn't a good enough mother. And so she loses something precious, and so do we all. I discovered that there are a lot of women out there who hated the birth of their child; women who had bad surgeries, women who had good surgeries, rarely women who had necessary surgeries, women who didn't have surgery at all but did have horrible things done to them in the name of birth. I'm not the only one. (Humphries 2001; emphasis in the original)

Idealized conceptions of femininity and motherhood, which also dictate how women should behave during childbirth, can thus be seen as potentially reinforcing feelings of gendered shame, often preventing women from displaying their feelings or requesting assistance.<12> When she sees other women going through the same process, apparently happily and successfully, a traumatized mother wonders why she is unable to adequately fulfill that role and is, in consequence, deeply ashamed. Thus idealized motherhood burdens women in two ways: first, the expectation of immense joy immediately following childbirth causes women to perceive themselves as defective mothers if that expectation remains unfulfilled; and second, that perception itself, once it has taken hold, in turn closes them off from social life, ashamed as they are that someone might notice that they are not feeling what they are supposed to be feeling (Choi et al. 2005). Admitting that you cannot bond with your baby or that childbirth was not the happiest moment of your life is tantamount to admitting that you have failed to accomplish the role for which you were destined.<13>

Gendered shame causes a woman to appraise her entire self negatively. Unsurprisingly, it is associated with the highest rates of postpartum depression and social anxiety (Røseth, Binder, and Malt 2011). Pregnant and birthing women are constantly put in their place, reminded that they are above all mothers (or mothers-to-be) and should be ashamed for thinking of themselves—their bodies, their agency, their experiences. Affirmations such as "all that matters is that the baby is fine" create a hierarchy of importance, with women's feelings and experiences at the very bottom.

This feeling of shame is paralyzing to birthing women and future mothers. It works as an internal disciplinary mechanism, preventing them from speaking up about obstetric violence or straying from what is deemed appropriate behavior within the stereotype of "good motherhood." Moreover, discussing what happens in childbirth is seen as threatening the ideal bond between a mother and baby. The admonition that "all that matters is that the baby is okay" produces a profound, deterring shame, potentially damaging each woman individually while preventing the understanding of a common experience of violence and thus seriously inhibiting political action.

Breaking the Cycle of Shame

Gendered shame objectifies and diminishes women, teaching them that they are not proper subjects, they have no real agency, and if they attempt to gain it they risk losing their femininity. It puts women in their place, constantly attuning them to serve the male gaze. Most significantly, gendered shame is a resilient tool of oppression, effectively promoting silence and depoliticizing experience. Women dominated by shame tend to hide their oppressive experiences from others, believing themselves to be alone and thereby participating in a vicious cycle of silence that precludes political struggle or social change.

Obstetric violence is nurtured and fortified by gendered shame. Having already internalized shame-inducing myths of socially accepted femininity and "good motherhood," women are primed to experience obstetric violence as a normal part of being a noble woman and all-giving mother. Encountering almost no resistance, obstetric violence is thus perpetuated, turning laboring women into objects and depriving them of the opportunity to experience labor as an integrated, embodied, fully sensual experience. In his phenomenological account of shame, Robert Metcalf describes the experience (or more accurately, the moment) of shame as emphasizing disembodiment and a sense of alienation from the world that was previously ours, deeply experienced by our fleshed and lived subjectivities. Recalling Sartre's and Bartky's thoughts on shame, Metcalf writes:

> The voyeur and the un-self-conscious woman of Bartky's description are aesthetically immersed in their environment in an experience of sensual enjoyment. The shame they feel, in its suddenness, signifies a halting of the flow of enjoyment and a reflective move whereby they see themselves as objects for others. By seeing themselves from the eyes of others, they are no longer immersed in a sensual enjoyment of the world and they no longer occupy the same bodily space of the previous moment. As an experience of one's own object-being, *shame is a kind of disembodiment, for one is no longer at home in one's body*: like the shy person's bodily struggle against embodiment, the woman of Bartky's description freezes, her motions become stiff, and she experiences precisely the "internal haemorrhage" of subjectivity described by Sartre. Shame is a matter of recognition in that it attends to the real existence of powers outside myself that are able to halt the flow of my bodily projects in the world. (Metcalf 2000, 16; emphasis added)

Obstetric violence thus allies itself with shame, mainly in its gendered form: both are based on objectification, alienation, and a harsh stealing of embodied subjectivity. Structural changes in the childbirth model might help: a positive and supportive medical staff—helping to provide laboring women with control over their bodies and their decisions—has proved to be a key component of a positive birth experience and to provide a significant change in the experience of birthing women, regardless of the number of medical interventions, complications, or type of birth (caesarean vs. vaginal) (Lavender, Walkinshaw, and Walton 1999; Melender 2006).

Thus, a medical birth can be experienced as a good birth when the birthing woman is treated as a significant subject, granted autonomy and respect. Involvement in decision-making has proved to be more decisive for a satisfactory labor than factors such as age, ethnic origin, socioeconomic status, participation in a prenatal class, medical interventions, continuity of treatment, intensity of pain, or mobility during labor (Hodnett 2002).

Nevertheless, the bond between gendered shame and the phenomenon of obstetric violence can finally be broken only by creating new models of femininity and motherhood. Such new models, liberated from patriarchal patterns for womanhood and motherhood, may reveal ways to break the cycle of silence and to fight and resist gendered shame. This unquestionably difficult task is ultimately the only one with the power to bring radical change and eradicate the pervasive phenomenon of obstetric violence.

NOTES

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1. This article deals exclusively with obstetric violence and shame as reported and researched in medicalized settings. Women can also experience shame, dehumanization, and even trauma in midwife-led births outside medicalized settings—as in home births. In addition, for some women, medical interventions in their labor when they had hoped and planned for a nonmedicalized birth can itself be deeply frustrating and feel shameful (Charles 2013; Cohen Shabot 2017). But shame experienced in these contexts is beyond the scope of this article.

We also intentionally refrain from dealing with childbirth (whether led by doctors or midwives, in either medical or nonmedical scenarios) as empowering. Childbirth has been reported as deeply and positively transformative, in reports describing the experience as anywhere from satisfying to one of life's most important experiences, highly empowering and even ecstatic (Heyes 2013; Cohen Shabot 2017). We do not argue that every childbirth is experienced as violent or traumatic; on the contrary, it is because we recognize the possibility of a highly empowering labor that we find it imperative to deal with obstetric violence: that possibility is precisely the reason why obstetric violence can be so traumatic, destroying as it does the possibility of experiencing a unique, life-changing, positive event.

2. It is crucial to state that we are not claiming that the medical staff knowingly performs this violence. Describing obstetric violence as gender violence means that it is structural, not behavioral; the staff merely perpetuates the violence of the existing structure. See Bellón Sánchez 2014 on obstetric violence in Spain, and Cohen Shabot 2016.

3. We use the phrase "intensive motherhood" here as coined by Sharon Hays and later deployed by Precilla Choi and her colleagues, and by Anat Palgi-Hacker, for instance. We

deal with this concept in detail in the following (Hays 1998; Choi et al. 2005; Palgi-Hacker 2009).

4. It is difficult to determine how widespread the phenomenon of obstetric violence is. The World Health Organization statement recognizes this difficulty, ascribing it to the problematics of establishing any scientific measurement of the issue (WHO 2014, 2). Meghan Bohren and her colleagues also discuss this challenge (Bohren et al. 2015, 3). But the mere recognition, in numerous studies and by the World Health Organization, of the existence of obstetric violence, along with the legislation that has arisen to fight it, establish the topic as worthy of further research and form the basis for a call for meaningful changes in obstetric treatment worldwide.

5. Obstetric violence is of course experienced very differently by white, Western, middle-class women than it is by minorities or marginalized and poor populations. The former are more exposed to medicalization and the overuse of technology in labor, which diminishes laboring women's self-image and sense of control and agency (Smeenk and ten Have 2003; Wolf 2012; Behruzi et al. 2013), and the latter still suffer more from a lack of technology and basic medical attention. Candace Johnson explains medicalization as a problem, paradoxically, mainly for the privileged: "the preference expressed by many privileged women in affluent countries . . . for midwifery care and home births, is curiously at odds with public health data and ethical arguments. It is a rejection of privilege that simultaneously confirms it. Therefore, the problem of medicalization seems to apply disproportionately to privileged women. In fact, some of the most serious pronouncements of medical interference in pregnancy and childbirth as a 'natural, normal, woman-centered event' come from women of considerable privilege and authority" (Johnson 2013, 200).

6. Seeing obstetric violence as structural rather than behavioral (Bellón Sánchez 2014) enables us to understand how even female midwives and doctors in hospitals might reproduce and perpetuate this patriarchal violence. A gendered understanding of medicine and health care also emphasizes its construction as social and political and shows how gender relations of power are imitated and disseminated within that realm. Doctors (predominantly male) are located at the top of the hierarchy, with nurses and midwives at the bottom, under their power. Not enough women physicians occupy positions of power in the medical system. Women are still more likely to be nurses, midwives, therapists, or other midlevel medical professionals (Anspach 2010, 233–34). It might be argued that midwives and nurses participate in violent practices toward laboring women mostly out of weakness and fear of the system, whereas doctors do it as a consequence of their privileged status and “authoritative knowledge”: they believe that they know better and do not need to inform either other authorities or the birthing women about their practices.

7. Cheryl Beck informs us that women who experience trauma in childbirth, defined as "an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to mother and/or her child" (Beck 2004a, 28), report extreme fear, helplessness, loss of control, and terror. A systematic review of twenty-one studies on traumatic childbirth shows that worldwide, between twenty and forty-eight percent of women experience such trauma (Simpson and Catling 2015). Several studies recognize the difficulty of conceptualizing the problem because of the subjective nature of trauma (Simpson and Catling 2015, 203).

In the growing research on mental damage to women following childbirth, there is evidence that women associate their negative experiences with their birth experience and interactions with medical staff (Simpson and Catling 2015). In Israel, for instance, about four to eight percent of birthing women suffer from the full symptoms of postpartum post-traumatic stress disorder (PPTSD), and about twenty-five to forty percent suffer partial symptoms (Polachek et al. 2012; 2014).

8. On the paralyzing effect of pervasive shame and its deterrent effect on political change, see Locke 2007, 151; Dolezal 2015, 118.

9. Karin Martin argues that white, middle-class, heterosexual women giving birth in capitalist Western societies are characterized by hesitation and a desire to be polite and kind; using Young's analysis, she shows that this attitude may originate in women's internalization of repressive, censoring norms of feminine comportment (Martin 2003). As suggested earlier, a completely different analysis is required to describe the violence experienced by nonwhite laboring women, who are already considered "less civilized" or "more animal-like" before they even arrive in the labor room (hooks 1997): they have already been judged as "lacking in femininity" before they begin laboring. Johnson details the different treatment (less medicalized but also less cared for, with dreadful consequences) experienced by "women-others" in labor (Johnson 2013).

10. Another report of a delivery, this one by a nurse who was present, echoes Lyerly's testimony: "I have witnessed many physicians say degrading things to women in natural labor, as if punishing them for not getting pain control in order to be more passive patients, including 'I don't want to hear any noise from you,' 'Come on, you need to open your legs, obviously you didn't mind that nine months ago'" (Goer 2010, 35).

11. Alana Bibeau examines the rhetoric behind interventions during labor in the United States, showing that medical staff frequently use the terms *risk* and *safety* to persuade women to agree to medical procedures and interventions (Bibeau 2014). Women reported that staff would say "think about what is best for the baby" to get consent for interventions, even when the intervention did not affect risk. This use of "think about what is best for the baby" demands that the future mother behave herself; its constant use in the delivery room showcases one kind of obstetric violence.

12. Evidence of this can be found in online projects dedicated to providing resources for healing from birth trauma, such as "The Hidden Shame of Birth Trauma" (Bordner 2016); "Dealing with Birth Experience Shame" (Kirkham n.d.); "Grief and guilt" (Birth without Fear 2013).

13. Beck reaches a similar conclusion in her analysis of recurring motifs in the experiences of women with PPTSD. One woman expressed her feelings of living with PTSD after a traumatic childbirth as follows: "Mechanically I'd go through the motions of being a good mother. Inside I felt nothing. If the emotion did start to leak, I quickly suppressed it. I'd smack myself on the hand and put my 'robot suit' back on" (Beck 2004b, 220).

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