“Screaming, ‘No! No!’ It was Literally Like Being Raped”: Connecting Sexual Assault Trauma and Coerced Obstetric Procedures

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ABSTRACT

How does the victimization of women’s bodies in medical interactions contribute to their experience of gendered violence? We answer this question by joining sexual assault and birth trauma literatures with the medical sociology conversation on the power of hospitals as organizations and the hierarchy of the doctor-patient relationship to analyze the interviews of 101 women who identify as having experienced a coerced, pressured, or forced labor or birth procedure. We find some respondents analogize their experiences to that of someone who has been sexually assaulted, and they and other respondents describe the aftermath effects in ways similar to those who have been victims of sexual assault. Our research demonstrates that clinicians and hospitals are harming patients, often through the normal application of established hospital protocols and behaviors, when women do not feel involved in decisions about their care.

KEYWORDS: birth trauma; sexual assault; qualitative analysis; United States; gender.

Imagine the following scenario: a woman is lying on her back, naked, immobilized, with her legs spread. Someone stands over and touches her genitals without her consent. 1 This scenario exemplifies the definition of sexual assault: “any nonconsensual sexual act proscribed by federal, tribal, or state law, including when the victim lacks capacity to consent” (United States Department of Justice 2019). What if we told you that this scene involves a woman in labor and the person touching her body without consent is a clinician?

To make sense of this gendered scenario, it is important to examine the institutional context surrounding labor and birth. We argue that hospitals are a site for this institutional context of control where strict protocols are enforced on patients by physicians, nurses, and midwives who are trained and socialized in delivering care to compliant patients. All aspects of the hospital organization around labor and birth are gendered, which contributes to women’s experiences of birth as gendered.

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1 We use the term “women” in relation to individuals giving birth. While cisgender women are the vast majority of people who give birth, they are not the only ones victimized by the gendered dynamics we analyze. However, because only cisgender women responded to our survey, we cannot analyze the experiences of anyone else.
Therefore, when women experience birth as a victim and/or as traumatic or violent, a connection can be made to another gendered experience of violence: sexual assault (Cahill 2000; Jenness and Fenstermaker 2016). As we examine the hospital organization as gendered, we hope to also answer a larger call by researchers to investigate the structural causes of the lack of respectful treatment of women in childbirth (Betron et al. 2018; Savage and Castro 2017) by using women’s voices to understand their treatment—in line with feminist standpoint epistemology.

In this paper, we ask how the victimization of women’s bodies in medical interactions at gendered health care institutions (i.e., hospitals) contributes to the experience of gendered violence. We answer this question by joining the sexual assault and traumatic birth literatures with the gendered-organizations perspective (Acker 1990, 1998, 2006; Britton, Jacobsen, and Howard 2018) to examine how some women experience labor and birth in similar ways as women who experience sexual assault. Our research demonstrates that clinicians may harm patients, often through the normal application of established hospital protocols (Beck 2004a). When women do not feel that they are full participants in their care and do not give informed consent for procedures, some women experience labor and birth procedures as sexual assault, or, even if not themselves identifying the experience as sexual assault, they experience the aftermath in ways similar to victims of sexual assault. Our research is one example of how having a “healthy baby” is prioritized over and to the exclusion of women’s agency and autonomy.

For the purposes of this paper, rape and sexual assault are used interchangeably as both were used by women we interviewed. However, the language around traumatic birth remains inconsistent in the literature, with “birth trauma,” “obstetric violence,” “traumatic birth,” “negative birth experience,” and more used interchangeably. We find Greenfield, Jomeen, and Glover’s (2016:265) definition of “traumatic birth,” to be most closely aligned with our understanding of the subject: “Traumatic birth can be described as: The emergence of a baby from its mother in a way that involves events or care which cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature.” This definition is flexible enough to encompass the wide variety of experiences that can be traumatic to women during and after labor and birth while marking the term distinct from “birth trauma,” which is more appropriately applied to physical injury, especially fetal injury, incurred during birth. Traumatic birth can also be seen as distinct from “obstetric violence,” which we use as more of an umbrella term to recognize the range of abuse that can occur pre-, peri-, and post-partum. We propose the use of the term “birth assault” to identify those specific birth experiences which involve both a traumatic birth and in which a woman analogizes her experience to sexual assault or described her experience similarly to victims of sexual assault.

Understanding the contextual similarities and differences between sexual assault and birth assault is critical because we extensively discuss the ways in which women experience similarities between traumatic birth and sexual assault. Like sexual assault, birth assault typically, but not always, occurs at the hands of known and trusted parties. Like sexual assault, it is very difficult to seek legal recourse, for both legal and organizational reasons (Morris and Robinson 2017).

It is also important to note the key differences between these two kinds of gendered violence. First, certain aspects of birth assault can make it less likely for women to be believed or taken seriously and more likely that they remain silent. For example, the assailants in the case of a birth assault are often highly credentialed—doctors, nurses, and other professionals—who believe that they are working in women’s best interests. Second, many of these professionals are women themselves, putting the definition of birth assault as a form of gendered violence into question for some. Third, in these instances, unlike sexual assault, the incidents occur in the open, and women’s family members or friends are sometimes in the room watching the incident or, in some cases, even asked to participate. Fourth, women almost always sign blanket consent forms when they arrive at the hospital, making any legal recourse near impossible. Fifth, unlike sexual assault, birth assault is deeply entwined with fetal protectionism—doctors will do anything to “save a baby” and protect themselves from the risk of malpractice (Morris 2013). Sixth, during and after the incident, women who have just given birth are often physically restricted by intravenous tubes, pain medication, healing incisions, and...
months of late-night wake-ups. Seventh, and perhaps the hardest difference of all, women and their families are celebrating one of the most joyous events in a person’s life, the birth of their child. Women are surrounded by people who encourage them to focus on how happy they should be. This may lead women to question, “Is now really the time to talk about how I felt like the doctor sexually assaulted me?” Even though sexual assault can be difficult to discuss, report, and prosecute, our society widely agrees that it is a bad thing. In contrast, a woman who claims to experience birth assault today is often dismissed, similar to the way that Katherine Koestner was dismissed in 1990 when she bravely stood up against what she called “date rape.” Many people, including Katherine’s rapist, her college dean, and even her father, implied that date rape was simply what happened on dates (Koestner 2016). Just as someone told her, “At least you had a nice meal,” people told our interviewees, “At least you had a healthy baby.”

THEORETICAL EXPECTATIONS
Organizations are gendered and raced as fundamental processes (Acker 2006; Britton et al. 2018). Here we focus on the gendering of hospitals as organizations, although it should be understood, too, that hospitals as organizations are raced. Joan Acker (1990, 1998, 2006) demonstrates how the very nature of organizations is gendered: “advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction to ongoing processes, conceived as gender-neutral” (Acker 1990:146). Britton et al. (2018) build on Acker’s theoretical perspective by specifying that the gendering of organizations and occupations happens at three levels: culture, structure, and agency, which we explore below.

Gendered culture refers to the gendered images and symbols that are tied to particular organizational roles. The occupation of “doctor” is associated with males, who are thought to be scientific, skilled, and beyond reproach and very much associated with male hierarchy and power over patients. This cultural image of doctors has been historically noted from as early as Harriet Martineau’s ([1844] 2003) classic work, Life in the Sick-Room, to contemporary work (Rees, Knight, and Wilkinson 2007) and, specifically, research that examines this hierarchy during labor and birth (Martin 2003).

Gendered structures refer to “organizational policies and practices that presume and reproduce gender inequality” (Britton et al. 2018:121). We include in our analysis policies and practices that appear to be gender-neutral but have gendered effects. We suggest that most protocols applied during birth, including cervical checks, induction of labor, episiotomy, and cesarean section, happen only to women’s bodies and, thus, reflect organizational policies and practices that are inherently gendered.

Gendered agency occurs when physicians, nurses, and patients, along with their families and friends, act in ways that reinforce gendered norms, such as patients in labor and birth behaving passively, doing as they are told, and internalizing these expectations to discipline their own behaviors and act like “good girls” (Martin 2003). In fact, we suggest that occupations and organizations are so strongly gendered and that the organizational roles of “doctor” and “patient” and “mother” are so powerful that male and female doctors step into the “doctor” role and behave towards their labor patients in gendered ways. In addition to the medical sociology literature, the sexual assault literature instructs us that sexual assault, regardless of the victim’s sex assigned at birth, reinforces gendered norms of the “feminine” and “masculine” for both assailant and victim (Cahill 2000; Jenness and Fenstermaker 2016). Examining the gendered dynamics of both birth assault and sexual assault through an organizational lens suggests that birth assault may itself be a complex form of “gendered agency” within these gendered organizations (see, e.g., Jenness and Fenstermaker 2016).

The result of the gendered dynamics embedded in the organizational setting of the hospital leads some patients to experience labor and birth as sexual assault, a type of gendered violence. Women enter a gendered organization—gendered culturally, structurally, and through agency—such that physicians, midwives, and nurses, and even friends and family members, may not support them.
**BACKGROUND**

The literature that examines sexual assault and traumatic birth, though typically not written about in tandem (see Kitzinger 2006 for an exception), have striking parallels. We start by examining themes in the literature on sexual assault. This literature highlights a variety of psychological issues that may occur, including self-blame, a sense of helplessness, and PTSD symptoms such as anxiety, fear, depression, dissociation, traumatic flashbacks, and hindered social functioning (Badour et al. 2013; Burgess 1983; Darves-Bornoz 1997; Holmes and St. Lawrence 1983; Kimerling and Calhoun 1994; Kimerling, Clum, and Wolfe 2000; Moor and Farchi 2011; Scott et al. 2018). Research shows that sexual assault victims also may experience feelings of disgust and self-objectification (Badour et al. 2013) and have reduced self-esteem (Murphy et al. 1988).

Other effects include that victims of sexual assault commonly have trouble with relationships and intimacy (Connop and Petrak 2004; Katz et al. 2012; Mills and Turnbull 2004). Additionally, there are occupational effects from sexual assault (Resick et al. 1981; Stewart, Du Mont, and Polatajko 2018). Further, sexual assault victims often restrict their activities to avoid reminders of the assault, referred to as “traumatophobia” (Calhoun, Atekson, and Resick 1982). Some women who have been sexually assaulted experience anniversary reactions that remind them of the trauma they experienced on the day of their assault (Burgess 1983). Relatedy, in an attempt to gain control over their post-trauma symptoms, women may cope with sexual trauma with maladaptive strategies of self-blame (Moser et al. 2007; Ullman, Peter-Hagene, and Relyea 2014). Finally, becoming an advocate, such as a sexual assault counselor, is common (Frey et al. 2017; Hellman and House 2006; Jenkins et al. 2011).

We found similar themes in the more limited literature on traumatic birth. The most prevalent literature examines the experiences of women who give birth and who have been sexually assaulted in the past. Women who have gone through both traumatic sexual assault and traumatic birth experiences firsthand compare the experiences to each other, with their traumatic birth prompting memories of their previous sexual assault (Halvorsen et al. 2013). The other common stream of this literature identifies what leads to a traumatic birth. This literature identifies situational issues, such as lack of support from medical staff and partners, misuse of power by medical professionals, identification of a complication with the baby, and high levels of obstetric intervention as associated with experiencing traumatic birth (Ayers 2007b; Beck 2006; Creedy, Shochet, and Horsfall 2000; Halvorsen et al. 2013; Olde et al. 2006; Skari et al. 2003; Soet, Brack, and Dilorio 2003; Thomson and Downe 2010). Further, much of this literature focuses on defining the risk factors which make women more likely to experience birth trauma or to exhibit symptoms of postnatal PTSD. These risk factors include a history of psychological problems, pregnancy-related anxiety, a history of sexual abuse, and a sense of low self-efficacy (Fenech and Thomson 2014; Keogh, Ayers, and Francis 2010; Olde et al. 2006; Reynolds 1997; Soet, Brack, and Dilorio 2003; Zaers, Waschke, and Ehlert 2008). We note that this focus on risk factors seems to emphasize women’s culpability in their trauma, downplaying the influence of women’s perception of medical care and levels of obstetric intervention in a traumatic birth.

A much smaller part of the literature on traumatic birth focuses on the effects on women, including negative effects on their self-image, regret, interpersonal relationship problems, difficulty with mother-child bonding, anxiety, depression, PTSD, fear of future pregnancy and birth, avoidance of pregnancy topics and anniversaries, amnesia of the birth and delivery, anger, flashbacks, nightmares, and extreme guilt (Ayers 2007; Beck 2004b, Beck 2006; Beck 2009; Creedy et al. 2000; Fenech and Thomson 2014; Olde et al. 2006; Thomson and Downe 2010).

A majority of traumatic birth research remains in psychology and/or nursing and is less often examined in sociology. To our knowledge, Kitzinger (2006) was the first sociologist to examine the connection between traumatic birth and sexual assault. Kitzinger’s research is limited to the UK and is written from an advocacy and information-sharing perspective without describing method or analysis. Our research is the first in sociology to systematically examine the traumatic birth experiences of women in the United States and reflect on this connection to sexual assault trauma.
Although there are no generalizable studies to suggest the percent of women in the United States who experience a traumatic birth, the best estimate comes from Vedam et al. (2019) who found that 17.3 percent of women in their study experienced disrespectful births. A study based on a household survey in Mexico found that one-third of women who gave birth in Mexico in 2016 experienced obstetric violence (Castro and Frias 2020).

**METHODS**

In what follows, we put women’s voices at the center of our research and writing to “achieve an accurate and authentic understanding of what life is like for women today,” an approach consistent with a feminist standpoint epistemology (Brooks 2007:56). We center women’s experiences of labor and birth as the basis of our knowledge and research results. By believing women and treating their stories as reliable data, an organizational analysis shows that despite good intentions, health care providers can be socially positioned as perpetrators too, motivated by social power, fear of malpractice, and/or adherence to medical institution’s rules and protocols (Beck 2004a). We hope to make visible the often-hidden experiences of mistreatment during labor through the amplification of women’s stories that challenge the social norms of the organization. Both analytically and for research participants, examining women’s firsthand experience of birth assault as reliable data has the potential to undermine persistent, harmful social systems of inequality embedded in hospital institutions.

This paper draws on data collected for a larger project on women’s experiences with forced, coerced, and/or pressured labor and birth procedures. The first author constructed an on-line survey posted on various Facebook and Reddit pages, selected through an exhaustive search of sites that focused on pregnancy and birth. The survey was launched on July 6, 2017, and ran through December 31, 2017. The survey began with information about the survey and information about participation. Participants then continued if they consented to be involved in the research project. We received a waiver to document consent. This survey asked women questions about demographics, their births, and any procedures they defined as forced, coerced, or pressured. At the end of the survey, the women were asked to leave contact information if they would like to be interviewed. Five hundred forty-nine women completed the online survey, and 240 of these women asked to be contacted for an interview. No incentives were given for participation in the survey or interview due to funding constraints.

All women who requested an interview were contacted through October 1, 2017, when a decision was made to continue to contact for interviews only those women who identified as being non-white, had Medicaid insurance, and/or gave birth in a state in which few other interviewees had given birth. Some women did not respond to interview requests, and we were unable to find a mutually available time for a few who requested interviews. Overall, the first author conducted 101 research interviews.

2 Facebook page site posts included Adriana Lozada at Birthful: Maternity, Doula & Greenproofing Services, Alaska Birth Services, Alpenglow Midwifery, Arkansas Birth Matters, Association for Prenatal and Perinatal Psychology and Health, ATX Doulas, Austin Born, Bay Area Birth, Best Doula Training, Birth Faith, Birth Kalamazoo, Birth Monopoly, Birth Works of Central Ark, Birthing the Future, Birthtalk.org; Black women Birthing justice; Breastfeeding Mama Talk, Central Texas Doula Association, Childbirth Connection, Choices in Childbirth, Cocoon Birth, Dakota Doula-Because Birth Matters, Down to Earth, Empowered Birth Project, Equity and Education; Exposing the Silence Project; Family Centered Cesarean, Feminists for Reproductive Justice; Full Moon Rising Birthing Services, Gentle Care Doula Service, Georgia Birth Advocacy Coalition, Georgia Birth Network, institute for Birth Healing, International Cesarean Awareness Network, Institute for Birth Healing, Jennifer Swiney Birth Services, Lamaze International, Learn4Birth, Mama Lounge sf, MommaArts, Mothers Matter, MyBirth, Myrtle Beach Birth Services, National Advocates for Pregnant Women, New Life Birth and Wellness Care, nurturing YOU naturally, One World Birth, Our Bodies Ourselves, Peaceful Birthing, Perinatal Education Associates, Inc, Plano Birthplace, Powerful Mamas, Right Hand Doula Services, Rocky Mountain Doula & Lactation, Roxanne Anderson Midwife, Safer Birth in Bama, Sage Femme Birth Services, Serenity Birth Services, South Dakota Birth Matters, Sista Midwives Productions, Sister Song, Special Beginnings Birth and Women’s Center, The Birth Center Holistic Women’s Health Care LLC, The Birth Circle, The Birth Community, The Birthing Site, The Natural Parent Magazine, The Positive Birth Movement, The Unnecessary, VBAC, VBAC Facts, Welfare Warriors, Whitney Patterson Birth Doula, Your Choice Birth, 8generations Birth Services. Reddit sites included r/AskParents, r/BirthArts, r/Doulas, r/Midwives, r/Mommit, r/SampleSize, r/TwoXChromosomes, r/vbac.
All interviews were conducted by phone between September 5, 2017, and March 21, 2018, and women were asked to recall their consent to participate in the research and asked if they still consented. All interviewees consented to participate in the interviews. Interviews were semi-structured with open-ended questions. The interviews lasted between 14 and 121 minutes, with an average time of 39 minutes. The interviews began with the interviewer asking women to describe their births (Focusing upon the pregnancy in which you had forced or coerced procedure...Tell me about the pregnancy. Tell me about your labor.). The interviewer then followed up with questions about any aspect of the birth that the interviewee identified in the survey and/or interview as having been forced, coerced, or pressured to have procedures (Tell me about your forced or coerced procedure. What were your reasons for refusing [the procedure]? Did you verbally refuse [the procedure]? Did you sign a form consenting to [the procedure]? Now, tell me how you were forced or coerced to have [the procedure]?). The interviewer asked if the respondent had filed a complaint against the clinician or hospital (Did you seek legal counsel to file a malpractice suit or claim damages after [the procedure]?) and how her life had been affected by the experience. We did not ask women about any experience with sexual assault.

All interviews were transcribed and cleaned by undergraduate research assistants, using Trint. The data were uploaded and coded in Dedoose, version 8.1.21. The data were iteratively coded by the first, third, and fourth authors of the paper using Thematic Analysis (TA) (Braun and Clark 2012). Guided by this methodology, three of the authors met and decided upon a code tree based on questions from the survey and grounded in themes in the traumatic birth literature: labor and birth procedure, clinician behavior, and types of trauma women reported. We then met as a group to discuss the coding. We all identified a pattern we had not anticipated—that some women were discussing their experience as sexual assault. This is consistent with TA: “Analysis produces the answer to a question, even if, as in some qualitative research, the specific question that is being answered only becomes apparent through the analysis” (Braun and Clark 2012:57). We supplemented the codes with sexual assault trauma codes and sexual assault analogy codes and coded the data again. After all of the transcripts were coded with the final codes, the first author examined the codes for consistency. This process continued until all consistency was achieved.

The sample of 101 women who were interviewed has some diversity in terms of SES, but, unfortunately, not as much in terms of race (see Table 1A and 1B). Eighty-four percent of the women we interviewed identified as “white,” 10 percent “Latina,” 2 percent “Black,” 2 percent “multiracial,” and 1 percent “Asian.” Sixty-seventeen percent of interviewees had at least a bachelor’s degree, while 33 percent had less than a college degree. Sixty percent of interviewees covered their hospital care with private health insurance, 26 percent used Medicaid, 10 percent used another government program, such as Tricare or VA benefits, and 4 percent paid out of pocket. Eighty-six percent of women were married at the time of birth, while 14 percent were unmarried. The mean age of women at the time of the birth reported in this research was 28.04 years with a range from 18 to 39. The mean age of respondents when they took the survey was 32.54 years with a range from 21 to 53. On average, women had been pregnant three times and had given birth two times. The difference in age between when women gave birth and when they took our survey—Age Difference—has a mean of 4.51 years and a range of 0 to 27 years. All names in the paper are pseudonyms. This research was approved by the Texas A&M University Institutional Review Board, which approved the informed consent process.

RESULTS

We break the results into two sections. The first focuses on interviewees who spoke directly about feeling as though during their labors and births they were sexually assaulted. The second section focuses on the ways that interviewees discussed the outcomes of their births in similar ways that victims of sexual assault do, including traumatophobia, dissociation, anxiety, depression, anniversary worry,
Table 1A. Sample Characteristics (n=101)

| Race                  | % of total sample |
|-----------------------|-------------------|
| African American      | 2                 |
| Asian American        | 1                 |
| Hispanic/Latinx       | 9.9               |
| Multi-racial          | 2                 |
| Missing               | 1                 |
| White/non-Hispanic    | 84.2              |

| Education             | % of total sample |
|-----------------------|-------------------|
| Less than high school  | 3                 |
| High school degree or GED | 1           |
| Some college or associate’s degree | 28.7  |
| Bachelor’s degree     | 41.6              |
| Graduate degree       | 25.7              |

| Health Insurance      | % of total sample |
|-----------------------|-------------------|
| Private               | 60.4              |
| Medicaid              | 25.8              |
| Other government program | 9.9         |
| Out of pocket         | 4                 |

| Marital Status        | % of total sample |
|-----------------------|-------------------|
| Married               | 86.1              |
| Unmarried with a partner | 10.9         |
| Unmarried with no partner | 3           |

Table 1B. Sample Characteristics (n=101)

|                         | Mean  | Range   |
|-------------------------|-------|---------|
| Current Age             | 32.54 | 21-53   |
| Age Gave Birth          | 28.04 | 18-39   |
| Age Difference          | 4.515 | 0-27    |
| Gravidity (# pregnancies) | 2.95 | 1-13   |
| Parity (# births)       | 2.13  | 1-7     |

diminished social functioning, relationship problems, self-blame, not reporting the abuse, and becoming a midwife or doula.

Women Who Felt Sexually Assaulted
Of the 101 women we interviewed, twelve women analogized their labor and birth experience to sexual assault. In the following paragraphs, we highlight five of these women to allow their own words to paint a picture of their experiences.

Mary
Mary wanted a natural birth experience, which she defined as an unmedicated, vaginal birth. In fact, she would have preferred a home birth but settled on a hospital birth and began her care with a local OB group. Mary went into labor close to her due date and arrived at the hospital with her cervix dilated to three centimeters. As soon as she was able, she moved to a Jacuzzi tub in her room. However, before long, a nurse and her husband pulled her out of the tub, telling her that she could not deliver the baby in the tub, and had her lie in the bed, where she was confined due to the short cords of the monitors. Mary complained of frequent cervical exams: “I kept getting checked all the
time and I didn’t want to be checked. And, after a while I told her to not check me, [but] she [said], ‘I have to.’ Then I said, ‘Well, I don’t want to.’ And, so, I kept telling her no. So, we went through a couple of those and my husband just let them. He just sat there like a lump drinking coffee.” When Mary felt an urge to push, the doctor had not yet arrived, and the nurse forced Mary to cross her legs. Finally, when the doctor arrived, she was allowed to push the baby out. Mary experienced her birth as rape-like: “I’ve never actually had a, thank God, experience like street rape, ... but the surrender of control and the fact that ... I was owned and processed, that’s what it was.” She summed up her frustration: “If someone put a hand on my throat and put something up my vagina, everyone would say, ‘Oh my God, you poor thing, you should cut his dick off.’ ... But if you’re in labor, ... probably one of the biggest milestones in your life, and somebody goes in there and is doing something that’s hurting you that you wouldn’t let any stranger ever do, you tell them not to, and they continue ... everyone tells you, ‘What are you whining about?’”

Mary’s experience highlights all three mechanisms of gendered organizations. The structure of protocols is evident when she is not allowed to deliver the baby in the tub, must have cervical exams, and is not allowed to push until the doctor is present. The culture of the symbolic role of doctors and nurses directing what occurs is evident, as is the gendered agency of Mary’s doing what she is told and her husband’s participating in enforcing behavior—helping her out of the tub—and not intervening when she was forced to have cervical exams. These three levels of gendered organizations, combined, led to Mary’s feeling she had been raped.

**Kelly**

When Kelly was admitted to the hospital in labor, she was given magnesium sulfate, a common drug given to women who have high blood pressure because of the risk of pre-eclampsia. Magnesium sulfate can make patients “woozy” so that they need help when standing, including walking to the restroom. Even though Kelly wanted to walk to the restroom, the nurse insisted that Kelly had to be catheterized. Kelly described what happened next: “I specifically said that I did not want to be catheterized. And they forced me ... the nurse had my husband lay over my body and hold me down and the whole time that they’re doing this, I was like crying and cussing them out, like telling her, ‘Fuck you! Get the fuck off of me!’ Like, screaming, ‘No! No!’ It was literally like being raped. It was horrific ... And I have been raped before, and I didn’t mind being raped as much as I minded that. Like that is more traumatic to me than having been raped as a 14-year-old.”

Kelly’s experience makes evident the three layers of gendered organizations. The nurse insisting on a catheter is evidence of both structure (the protocol) and culture (the power of the nurse to direct care). Agency is evident by the nurse and husband forcing Kelly to lie down for the catheter when she was resisting, a type of punishment, one could argue, for Kelly not appropriately performing her gendered role of being a nice girl and complying.

**Amy**

Amy chose a practice that had both midwives and physicians but chose midwifery care. She labored in the hospital shower and tub without an epidural and with intermittent monitoring. When her midwife checked her cervical dilation, she found that Amy was fully dilated to ten centimeters. Amy moved to the bed to push in a hands-and-knees position. However, a physician from the practice walked into the room and asked her why she wasn’t on her back with monitors on and why she did not have an epidural. Amy described what happened next: “[The doctor] put one of her hands on my shoulder and told me to lay down, so I mostly rolled over on my own. But then ... [she] spread my legs and put her hand inside my vagina. It was, in any other context ... a clear sexual assault.” The doctor announced that Amy was not even completely dilated and insisted that she needed a cesarean. Amy acquiesced and scribbled her signature on an informed consent form that she did not read. She has since been diagnosed with post-traumatic stress disorder. “I’ve seen psychiatrists and
it’s complex; they call it complex PTSD. And my therapist said, ‘You are receiving the same treatment that a rape survivor gets.’”

Amy’s experience highlights the gendered agency by how she acquiesced even though she did not agree with the decision for a cesarean. The gendered structure is evident in the forced check of Amy’s cervical dilation, a common practice, and the cultural symbol of the doctor as powerful and able to dictate the necessity of a cesarean that Amy feels was unnecessary is evident in Amy’s narrative.

Megan
Megan had hoped to labor without pain medication and with few interventions. When she arrived at the hospital, she was told she had to lie in bed and have a continuous fetal monitor. She also had cervical exams every hour. She equated these exams to sexual assault: “I was in labor for like, I think, about six hours? And they gave me probably eight vaginal exams during that time . . . The vaginal exams were probably the worst part of the whole thing . . . The first one they did was so rough and so uncomfortable that I was literally crawling away from her on the bed and screaming out . . . ‘Please stop! You have to stop! You have to stop!’ And she did not stop. She just kept pushing in harder. And I feel like—I’ve never been assaulted before—but . . . I mean, I remember her face. I remember seeing things in slow motion. I remember what it sounded like. I remember what it smelled like . . . And then after that happened, I was like, ‘You better give me the epidural because if I have to go through that over, and over, and over again’ . . . I had the labor under control, but if I have to go through that over and over again, you better knock me out.”

Megan’s experience highlights how gendered culture, in this way the application of protocols—a rigid schedule of cervical exams in this case—may leave women feeling they have been assaulted. Culture, as exhibited in the organizational role of “nurse,” is also evident in the way she does not listen to Megan’s demands to stop. The structure of protocols and how Megan seemed to believe she had no control over whether or not cervical exams were performed is evident.

Rachel
Although Rachel planned a home birth for her third birth, she had to go to the hospital when she went into labor early at 35 weeks. The birth went fine and the baby was healthy. Immediately following the birth, the doctor wanted to manually extract Rachel’s placenta, an unusual procedure immediately following a vaginal delivery (Weeks 2008), but Rachel refused this. The placenta came naturally five minutes later. She told us, “[The doctor] came back after that and said because we hadn’t let him pull it out, he had to clear out the coagulants from my uterus . . . He ran his fingers up and down, and he actually put his finger in my anus. It was like the most awkward thing . . . He didn’t warn me he was going to do that. It was just humiliating in front of my husband, and my friend was standing there. I had the roomful of nurses I don’t know . . . I very much felt assaulted. I told my husband, ‘I feel like, I don’t even want to say the words, but I feel like a rape victim.’ And I didn’t want to say it like that because I knew it was very different than . . . someone who has been sexually assaulted because this wasn’t sexual in nature, but . . . to me, I had felt violated . . . to that degree.”

We see in Rachel’s story gendered culture in the physician’s symbolic power over Rachel and, seemingly, his behavior to discipline her for non-compliant behavior. She defied the gendered agency he expected of her. Notice also that others stood around, watching but not intervening, an example of gendered agency. He asserts that cleaning her uterus is normal, or a part of the structure, although she does not believe him.

Other Similarities
We also found that the 101 women in our sample discussed their lives since the birth in similar ways as women who have been sexually assaulted. We discuss these similarities below.
Avoiding the hospital. “Traumatophobia” or avoiding the cues associated with the assault was also experienced by our interviewees. Fourteen women described avoiding the hospital in which they gave birth or hospitals in general as a result of their experience. Heather avoids not only the hospital but the town in which the hospital is located. She explained, “We live in a small town. This [hospital] is in the bigger town where we’d go to do our shopping. I literally got to the point that I could not drive going into that town for a while because I would just start shaking so bad if we got within sight of the hospital.” Vanessa described, “I thought I had kind of healed from the experience until I actually drove past the hospital one day... I actually had a panic attack.” Kimberly told us, “When I went back to get the records from the first hospital, I didn’t even want to go inside... I mean, I was shocked at how strongly I reacted.”

Dissociation. Similar to a victim of sexual assault, women may dissociate themselves from labor and birth, as though viewing the event from the perspective of an outside observer. Thirteen women in our sample had symptoms of dissociation. For example, Lori said, “The actual birth... I don’t really remember anything... The only thing that I remember is just, like, at one point they take out the baby. They show me the baby, next to my head, and I feel like zero connection to it. You know, I felt like nothing.”

Anxiety, depression, PTSD, and flashbacks/nightmares. Fifty interviewees mentioned problems they had with anxiety, depression, PTSD, and/or flashbacks/nightmares that stemmed from the way they were treated during labor and birth. Michelle described, “I think it was at least a solid three months before I could even really think about [my labor and birth] much without crying. Just feeling like everything was very scary and very overwhelming.” Shannon told us, “I had postpartum panic... I became agoraphobic. I couldn’t leave my house.” Lauren described, “I mean I have nightmares about it... I have flashbacks. I don’t necessarily have sex with my husband. I had lots of trouble being a mom at first... I suffered.” Margaret said, “I had birth PTSD. I had really intense flashbacks for the first six months. Like, my husband and I would be having sex and I would have flashbacks of her head being stuck and... it was awful.”

Anniversaries. Beck (2006) was the first to examine the significance of birth anniversaries to women who had experienced a traumatic birth. She found that anniversaries may cause women significant distress, resulting in the inability to enjoy their child’s birthday (Beck 2006). This is similar to the anniversary experiences women face from sexual assaults. Five women in our sample told us how their child’s birthday caused problems for them. Michelle described her worry about her child’s one-year birthday: “I think it can be really hard for me when we hit a year... I think that week is going to be very difficult. I’m going to feel guilty that I’m not super happy and excited about it. Or at least not as happy and excited as I would be if I wasn’t kind of mixing it up with all these other things.” Carrie told us, “Birthdays are hard... Definitely. It’s not every year, but, sometimes, it, like, really gets to me... Like, it all comes back.”

Relationship problems. Other similarities experienced by women include diminished social functioning in areas of relationships, marriage, and intimacy (Frank, Turner, and Duffy 1979: Resick et al. 1981). Seventeen women in our sample had such relationship problems with their partners. Savannah felt she had no support during labor from her husband and resented him for this: “I did hold that against him for a while, because I felt like he didn’t stand up for me, and he didn’t help reassure me.” Victoria told us, “I would be like, thinking... emotionally, about being intimate with my husband. And then... it would hurt. And then I would start thinking about... the doctor... while we’re... trying to be intimate... Emotionally, it was like, ‘I can’t do this... I’m not in the moment with you because I’m thinking about my son’s birth.’” Nineteen women described troubles they had bonding with their babies. Holly told us: “I think it affected my bonding with my son... The whole time I was thinking about was the next [baby], because... I wanted to push a baby out of my vagina.
That’s . . . all I wanted to do.” Kara said, “I definitely had trouble bonding with my first kid because of that experience.”

Self-blame. We found self-blame a common theme in our analysis—forty-one women blamed themselves, which is similar to the effects seen in the literature on sexual assault victims. Women blamed themselves for a variety of reasons. For example, Kathryn had wanted a natural birth and blamed herself for her treatment because she gave birth in a hospital: “Did I do wrong by my daughter by having her in a hospital and having that horrible start in life?” Other women blamed themselves for not having left providers when they saw red flags. Lauren said, “I remember [the physician] saying a few things in my prenatal visits that should have been red flags as to somebody I really shouldn’t be able to trust . . . I should have run . . . and I didn’t.” Jasmine told us, “I should have researched vaginal breech providers. I should not have taken my doctor’s word for [there not being any breech providers].” Brooke lamented, “So that is one thing I will admit as far as my birth story goes and how things went, had I educated myself more, I feel like even if someone was forcing me into something or not telling me the whole story, had I known a little bit more, maybe I could have questioned a little bit more . . . So that’s definitely my fault on that end.” Courtney told us, “[My doctor] was like, ‘I have to give you an episiotomy.’ . . . And I said, ‘No’ . . . I’m sure if I [had] said, ‘Absolutely not,’ he wouldn’t have done it . . . I mean, I’m frustrated with myself that . . . I wasn’t better prepared.”

Not reporting. Another similarity we note in the experience of the women we interviewed is not filing a report or complaint for a variety of reasons, not unlike sexual assault survivors (Spencer et al. 2017). In our sample, 51 women indicated they took no action against the hospital or physician. Common responses to the question of whether they had filed a report against the provider were: “I think what prevented me from complaining was that I felt like it was going to fall on deaf ears anyway. It would be a waste of my time” (Elizabeth); “What good is a complaint going to do?” (Tammy); “Because I worked there and I thought it would put my job in jeopardy” (Brittany); “It’s done and over with. I mean, they’ve already cut it . . . my strongest muscles in my entire body. And . . . nothing’s going to fix that” (Morgan); and “I didn’t want to say his name again. I didn’t want to talk to him again. I didn’t want to file a complaint, because I didn’t want it to end up being, ‘Oh, well let me call you and let me talk to you about it.’” (Paige).

Becoming a midwife or doula. An effect that we had not thought of until it emerged in our research is that, just as sexual survivors may become sexual assault survivor counselors, support people, or hotline volunteers (Frey et al. 2017; Hellman and House 2006; Jenkins et al. 2011), eleven of our interviewees went on to become birth doulas and three became midwives, all after having the birth experience they reported upon. These respondents commonly mentioned this career path being chosen so that they could save women from going through the experiences that they had gone through. For example, Tina said, “I’ve gone into birth work with other women because I wanted to empower them to have a different birth experience and to be able to get their VBAC or be able to get their . . . home birth or . . . whatever birth experience that they desire . . . so that they don’t have to have the same experiences that I did,” and Lisa told us, “[My daughter’s] birth changed the course of my life . . . I became a midwife . . . I . . . didn’t want any women to have to deal with that [a birth like mine] ever again.”

3 Although relationship problems between mother and baby are not deeply examined in the current sexual assault research, there are some interesting parallels to intimate partner violence (IPV), including sexual violence, during pregnancy and trouble bonding between mother and infant (Kita et al. 2016). Further, connections have even been found between IPV during pregnancy and maternal abusive behavior towards the child later on (Chan et al. 2012). There is also some evidence that a relationship may exist between a mother’s history of childhood sexual abuse (CSA) survivors and their subsequent parenting style and attachment, though we recognize that CSA is different than sexual assault as an adult (DiLillo and Damashek 2003). There is an opportunity for future research on this subject.
CONCLUSION

In this paper we asked how the victimization of women’s bodies in medical interactions contributes to their experience of gendered violence. We found that women experience victimization in some situations of labor and birth, analogize their experiences to sexual assault, and describe their lives afterward in ways similar to women who have been victims of sexual assault. This paper contributes to feminist knowledge and theory because it is an example of how feminist standpoint epistemology suggests the importance of women’s stories as data to analyze. We do not question if these things happened to them or if there is “another side to the story.” Rather, we analyze the patterns from their interviews to understand how women can be traumatized by feeling a lack of control, by not being asked for consent, by feeling forced, coerced, or pressured into labor or birth procedures. We also add to the under-studied topic of birth assault. This topic has been lacking in the mainstream literature due to a longstanding dearth of interest in researching women’s health overall (Boston Women’s Health Collective 1973) combined with a cultural mistrust of women’s stories and a cultural narrative of the centrality of a healthy baby as the only important outcome of birth (Morris 2013). We also build on calls to identify structural causes of obstetric violence (Bohren et al. 2015; Chadwick 2016; Diaz-Tello 2016; Dixon 2015; Kukura 2018; Pickles 2015). We demonstrate how an organizational analysis shows that much of what happens in this context can be attributed to the deeply gendered organizational structures, culture, and agency in which they are embedded. While some of our interviewees experienced cold, even malicious, behavior, we recognize that most clinicians are providing health services as they were trained within institutional constraints. It is salient, however, that clinical training within institutional constraints can reproduce gendered and inequitable power distributions between provider and patient. Thus, an understanding of hospital characteristics in which traumatic births take place could indicate potential points of intervention for organizational change.

We highlight a few of the limitations of this research. First, our findings are not generalizable because we recruited respondents through social media. The way we recruited also means that bias may have been inserted into the results due to respondents’ self-selection. Second, women are recalling their experiences, and memory is imperfect. Third, although we sought a diverse group of women in terms of race, ethnicity, and socioeconomic status, we were not as successful as we would have liked. We also suggest directions for future research, which should consider strategies to reach a more diverse group of women. Also, future research should ask questions about sexual orientation, sexual identity, and prior experiences of assault, questions we did not ask. To deal with problems with self-selection and memory, a future study should ethnographically follow patients during birth to observe situations of women feeling coerced, pressured, or forced into an unwanted procedure and to document what happens in such situations and, specifically, the behavior of clinicians who make women feel empowered and others who alienate women, though the presence of researchers could change the outcome, or alternatively, cause feelings of bystander complicity. Further, future research should include the voices of clinicians alongside women, a next-step project our team has begun.

As traumatic birth becomes more a topic of public attention, the response to this emerging phenomenon is similar to America’s response to Koestner’s date rape—diffuse mobilization around individual risk reduction, including college campaigns centered around rape whistles and “watch your drink, watch your friend” slogans. When it comes to labor and birth, people are taking a similar approach. Pregnancy groups on Facebook encourage women to know their rights in childbirth, hire doulas, write detailed birth plans and disseminate them, or forgo hospital births altogether. We argue that such an individualized approach has limited effect. Our organizational analysis demonstrates that change must come at the organizational level. Women themselves point to these problems with healthcare professionals, hospital protocols and practice, and lack of informed consent. Our analysis implies that as a society, we need to change, for example, how doctors, nurses, and midwives are trained, the way hospital protocols are applied to all patients, regardless of individual patient’s wishes and autonomy, and the way informed consent happens in labor and birth.
Birth rights advocacy organizations are already taking lessons from sexual violence prevention on how to change structures and applying them to obstetric violence. For example, Birth Monopoly uses the “Rape Culture Pyramid” from 11thprincipleconstent.org, which analogizes rape and obstetric violence around issues of consent (Birth Monopoly 2020). Birth Monopoly recommends disrupting the normalization of birth horror stories, jokes about the loss of dignity during birth, and the ubiquitous “the only thing that matters is a healthy baby” mantra to prevent downstream acts of medical coercion, nonconsensual procedures, and physical force (Birth Monopoly 2020). Additionally, the reproductive justice (RJ) movement recognizes the right to have a child and parent with dignity as part of the wide variety of social justice issues related to bodily autonomy (Luna and Luker 2013). Birth justice viewed from an RJ perspective supports our argument for medical care that maintains the bodily autonomy of patients which currently requires the reexamination of the current state of informed consent in birth settings. A good example of this reexamination of informed consent exists in the current discourse around pelvic examinations by medical students on non-consenting patients under anesthesia (Hammoud et al. 2019). Currently, only seven states in the United States have laws mandating certain standards for pelvic examination under anesthesia, leaving the other 43 to the old standard of varying standards of obtaining, communicating, and documenting that consent (Hammoud et al. 2019). Patients are left vulnerable to ambiguous protocol and may be subjected to a pelvic exam while anesthetized during procedures that are completely irrelevant to gynecological care and without explicit consent. Critical investigations into these violations of bodily autonomy point to a growing call for medicine and healthcare institutions to review and improve their standards of informed consent in general, and labor and birth specifically (Hammoud et al. 2019).

This example and our analysis are indicative of the ingrained social norm of gender and, in our analysis, of motherhood—that women should be concerned only with their babies, and not themselves. This attitude, tied to patriarchal norms that view women as most useful in their reproductive capacities, is one that views women as, at best, second-class citizens because they are not seen as having the fundamental right to bodily autonomy. We end with the words of Amy, who draws out the implications of such thinking starkly:

I mean the assault itself, the [medically unnecessary and coerced cesarean] surgery itself, all of that . . . was awful and traumatic. But . . . the lack of recognition of [it being an assault is] . . . something that . . . has been worse. It’s like a . . . trigger, every time I hear, "Well, at least you have a healthy baby," and I’m like, "Yes, I do. I’m grateful. But what about me?"

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