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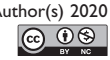

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Why 'normal' feels so bad: violence and vaginal examinations during labour – a (feminist) phenomenology

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Abstract

In this article, I argue that many women lack the epistemic resources that would allow them to recognise the practice of vaginal examinations during childbirth as violent or as unnecessary and potentially declinable. I address vaginal examinations during childbirth as a special case of obstetric violence, in which women frequently lack the epistemic resources necessary to recognise the practice as violent not only because of the inherent difficulty of recognising violence that happens in an 'essentially benevolent' setting such as the medical one, but also, and mainly, due to the pervasive sexual reification of women under patriarchy and the pervasive shame to which women are subjected. My argument is that the practice of vaginal examinations is indeed experienced – bodily apprehended – as violent by many women, but that full epistemic recognition of this violence is frequently obstructed because the experience perfectly coincides with the normal phenomenological situation of women within patriarchy and thus cannot really be framed as violent. A phenomenological analysis presenting the embodied experience of women under patriarchy as always already essentially tied to sexual availability and commodification, and to shame, will explain this epistemological impairment. A phenomenological take on Judith Butler's distinction between 'recognition' and 'apprehension' informs my analysis: I deploy it to provide a richer, more nuanced response to the question of why vaginal examinations are not fully recognised and expressed as violent – even when they are, frequently, apprehended as such. Furthermore, Butler's ideas about the epistemic 'framings' through which we make sense of different kinds of lives (grievable versus ungrievable) will help me to explain how the patriarchal sexual reification of

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women in fact already frames sexual violence as not-violence – which ultimately also prevents labouring women (and obstetrics staff) from recognising vaginal examinations during labour as violence.

Keywords
Butler, childbirth, embodiment, epistemology, labour, obstetric violence, phenomenology, sexual violence, shame, vaginal examinations

The feminist theorisation of violence has worked to reveal the integral and essential masculine elements that structure and form violence as we understand it (Butler, 2004, 2009; Schott, 2011; Butler, 2015, 2016; Karhu, 2016), making it clear that many forms of gender violence are misrecognised or remain unseeable, since they do not correspond to mainstream concepts of violence (Bergoffen, 2012; Karhu, 2016). Feminist theory has done much to broaden the spectrum of what is considered violence and to illuminate how state violence is normalised or made invisible (Lokaneeta, 2016), but much more needs to be done. In this article, I deal with one particular kind of violence that still has not been fully acknowledged or adequately articulated, whether by medical authorities or by birthing subjects themselves: obstetric violence.

Obstetric violence has been defined as physical and psychological violence performed by medical staff against women giving birth (Sadler, 2016; Cohen Shabot and Korem, 2018). Researchers have recognised this violence as structural (Bohren et al., 2015; Miller and Lalonde, 2015) and as causing serious short- and long-term damage to many women; it is sometimes related to postpartum posttraumatic stress disorder (PPTSD) (Beck, 2004; Thomson and Downe, 2008; Elmir et al., 2010; Harris and Ayers, 2012; Simpson and Catling, 2015). It has been recognised as gender violence, not simply medical violence[1] (Cohen Shabot, 2016; Sadler et al., 2016; Cohen Shabot and Korem, 2018), and as being experienced very differently by white, Euro-American, middle-class women (like myself) than it is by marginalised, poor or minority populations, a difference defined as 'too much too soon' versus 'too little too late' (Miller et al., 2016). 'Too much too soon' refers to medicalisation and the overuse of technology in labour, which has been shown to diminish labouring women's self-image and sense of control and agency (Wolf, 2012; Behruzi et al., 2013; Smeenk and ten Have, 2003). 'Too little too late' refers to a lack of technology and basic medical attention.[2] Racism itself is also now recognised as meaningfully affecting how obstetric violence is performed and the gravity of its harm. Davis (2019) explores racism in medicalised childbirth in detail, providing us with the useful concept of 'obstetric racism' — the structural racism

present at the core of medicalised childbirth that produces differential reproductive outcomes — a concept that helps to reconceive obstetric violence in the light of medical racism, showing that neither 'obstetric violence' nor 'medical racism' alone can explain the differences in harm done to non-white women in childbirth regardless of their socioeconomic status.[3]

The present investigation does not aim to explore differences in how obstetric violence affects various populations. The epistemic problematic explored here concerns the capacity to identify a particular kind of obstetric practice as violent. However, this analysis will show that class and race differences influence these epistemic capacities, as obstetric systems reproduce racist and classist discrimination.

The case of vaginal examinations

One constitutive feature of my own experience of obstetric violence was my constant subjection to vaginal examinations during labour. But I did not understand that then, nor even much later. The fact that doctors, residents and midwives frequently inserted their hands into my vagina without asking my permission, claiming that they needed to in order to understand why my dilation remained stuck for hours at eight centimetres, seemed to me just another painful 'fact of nature' – not something I imagined questioning or refusing.

As with many elements of obstetric violence, vaginal examinations during childbirth are mostly unquestioned, seen as a 'natural', 'normal' part of 'labour management'. Some labouring women experience vaginal examinations as intrusive and violent at the time (some, in fact, refuse them), but many more – like myself – experience them as just another part of the unquestionable blur of childbirth's 'typical' discomfort, pain and shame.

I argue that many women lack the epistemic resources to recognise the practice of vaginal examinations during childbirth as violent, unnecessary and potentially declinable. Throughout this article, this lack of recognition of and epistemic resources for understanding vaginal examinations as obstetric violence will be noted as being the experience of many, but not all, women. I will not claim that no women are equipped for such a recognition; some women do experience these interventions as violent at the time, even resisting or refusing them – this is how we know that these interventions are, in some important sense, actually violent. But this article addresses the reasons for the apparent under-reporting and under-recognition, both by birthing women and by the medical community, of vaginal examinations in childbirth as violent interventions. Vaginal examinations during labour as currently performed in most medical settings are indeed experienced as violent in some important sense and have been described as sexual or obstetric violence in a number of cases: Many reports of 'birth rape' emphasise descriptions of vaginal examinations or other vaginal procedures (such as episiotomies). In her graphic narrative of 'birth rape', for example, S. Richland writes: 'I was drugged and knocked unconscious. I was sexually assaulted: My vagina was cut and a

man's tool (forceps) was inserted into my body' (2008: 43). Another example is the now-infamous 'Kelly's Story', a terrifying case of 'birth rape' caught on camera in its entirety (Hayes-Klein, 2014).This is why I am interested precisely in the massive silence and the inability to epistemically grasp the violence present in vaginal examinations, on the part both of very many women and, generally, of medical staff.[4] The issue is not consent, because this analysis, addressing epistemic hindrance and impeded recognition, precedes the question of consent: the analysis undertaken here is necessary as a foundation, upon which any later analyses involving consent – our actual agency (or lack thereof) in granting or refusing to others our permission for them to act upon us – must then build.[5]

The specific case of the unrecognised violence of vaginal examinations in childbirth constitutes part of the general problem that obstetric violence is frequently not fully recognised as such by women ourselves. But vaginal examinations are more clearly related to childbirth's sexual dimension and the sexual self in general. A new discussion of the practice, deploying the frames used to address sexual violence, besides those addressing the difficulty of considering medical, benevolent scenarios as capable of displaying violence, is most needed; that is what I undertake here.

Because it involves vaginal penetration, with all its surrounding sexual meanings, the violence in vaginal examinations is much more clearly related to sexuality than are other violent practices in labour, such as, for instance, the Kristeller manoeuvre; forcing labouring women to lie down on their backs or physically restraining them; verbal threats; or the denial of anaesthesia or other medical help as retaliation when labouring women refuse to follow the medical staff's orders (as described in Silva et al., 2014 and Bohren et al., 2015). This close relationship with sexuality is precisely why, I argue, the violence embedded in the performance of vaginal examinations during labour is so much more 'invisible' and 'hard to grasp' – to conceptually grasp as violence. The difficulty lies not only in looking at systems (like the medical one) that are seen as essentially benevolent and reframing them as being capable of perpetrating violence, but also in simply framing sexual violence as violence in the first place. Even if we imagine a context in which a Kristeller manoeuvre is finally recognised as a clearly violent obstetric practice, vaginal examinations might nevertheless continue not to be recognised as such. That will not change as long as sexual violence is not 'framed'; as long as it goes unrecognised as violence; and as long as women's sexual availability and the existence of our bodies as shameful objects continue to be just a normal part of our being-in-the-world.[6] Because vaginal exams are a case more of sexual violence than simply of violent medical intervention, they remain much harder to recognise as violence. There is an important distinction to be made between different kinds of obstetric violence. While obstetric violence is gender violence, gender violence may take different forms, some involving physical control of women and verbal and physical disciplinary practices but less directly related to sexuality, and others, such as the violence in vaginal examinations, more clearly related to sexual violence. This distinction will be critical as we examine the epistemic mechanisms that

prevent both labouring women and obstetrics staff from seeing the violence in obstetric violence.

Both sexual and obstetric violence have been normalised under oppressive patriarchal systems and frequently made unrecognisable, unseeable. In order for someone to fully recognise this as violence, it must first of all be named and reclaimed as such. My argument begins from a lack – a silence. Many labouring women never consider that they could question or refuse vaginal examinations. The practice is so normalised that it is not really seen as an intervention and hardly protested against. This analysis is difficult to make because the argument relies precisely on silence, resulting from the lack of the epistemic resources women would need to fully recognise the practice's violence. But then how do we know that this constitutes a violent practice? Many women do indeed bodily apprehend vaginal examinations as violent, but full epistemic recognition of this violence is obstructed, partly because the experience perfectly coincides with women's phenomenological situation within patriarchy and thus cannot really be framed as violent. We must first examine this situation that renders sexual and obstetric violence invisible, nourishing the epistemic silence. A phenomenological analysis of women's embodied experience under patriarchy as always already essentially tied to sexual availability and commodification, and to shame, is crucial for explaining this epistemological impairment. I use a phenomenological take on Judith Butler's distinction between 'recognition' and 'apprehension' to provide a more nuanced response to why vaginal examinations are not fully recognised and expressed as violent – even when they are, frequently, *apprehended* as such. Furthermore, Butler's ideas about the epistemic framings through which we make sense of different kinds of lives, as grievable versus ungrievable, help explain how the patriarchal sexual reification of women frames sexual violence as not-violence, ultimately preventing labouring women and obstetrics staff from recognising vaginal examinations during labour as violence (Butler, 2009).

First, I present some existing investigations into the experience of vaginal examinations in labour, together with recent questions concerning their real benefits and how they might be considered part of a specific, medicalised understanding of childbirth and perhaps as 'a symptom of a cervical-centered birth culture' (Reed, 2015). These examinations, frequently experienced by labouring women as painful, uncomfortable and embarrassing, could in fact be greatly curtailed, even replaced. I then reflect on the lack of denunciations of this practice as violent, showing the silence to result not from labouring women's failure to apprehend the practice's violence but from the epistemic deficiency deriving from women's situation under patriarchy and their phenomenological experiences within the context of sexual reification and shame. Finally, using Butler's framing of grievable and ungrievable lives, I offer a possible explanation for why both obstetrics staff and many labouring women are epistemically impeded from recognising this practice – and, probably, obstetric violence more broadly – as violence. I end with reflections on a paradox that arises in the course of this investigation: the realisation of the reverse connection between privilege and the epistemic ability to recognise

obstetric violence, in that those who suffer most bluntly from obstetric violence sometimes appear to be best equipped for identifying it as such.

Vaginal examinations during labour: desperately seeking women's experience

Vaginal examinations in labour are mainly used to measure cervical dilation, in an attempt to assess the progress of labour. Several studies have pondered the practice's benefits and risks, the frequency with which it should be used and how best to teach it to new midwives or obstetricians without unnecessarily harming women (Enkin et al., 2001; Letic, 2003; WHO, 2006; Jha et al., 2010; Hassan et al., 2012; Roosevelt et al., 2018). These studies have generally found that the practice is used much more frequently than medical evidence would recommend (Stewart, 2005; Shepherd and Cheyne, 2013). Discussions are currently taking place about how to perform the examinations in a way that is as respectful to and comfortable for labouring women as possible, and studies are being developed on how to significantly reduce their use, even replacing them with less invasive practices (Stewart, 2005; Hassan et al., 2012; Shepherd and Cheyne, 2013).

It is important to recognise that vaginal examinations are not an indispensable part of labour: we can give birth without undergoing vaginal examinations at all. Labouring women should know that even for measuring progress in labour, vaginal exams are not the only, perhaps not even the most informative, option. Reed (2015) describes the practice as embedded in a 'cervical-centered birth culture' that understands the labouring body as a predictable machine (see also Martin, 1987) and that makes a direct, unquestioning connection between cervical dilation and labour progress. Referring to Downe et al. (2013) and Ferrazzi et al. (2015), Reed reminds us that cervical dilation is not easily predictable or linear and that the evidence does not support routine vaginal examinations during labour. Vaginal examinations, she notes, belong to a specific, entrenched labour culture and are as hard to get rid of as many other practices belonging to the medicalised perspective on childbirth.[7]

Reed also discusses the disadvantages of vaginal examinations, arguing that they might be 'inaccurate and misleading': again, unnecessary, and more about controlling the labour process than providing valuable information. Vaginal exams may also increase infection and/or result in rupture of the amniotic sac. But the most significant downside of the practice is probably the way that many women experience it: as a painful, invasive practice that may cause severe embarrassment, sometimes even PTSD (Dahlen et al., 2013, in Reed, 2015). Yet we know little about women's experiences undergoing vaginal examinations. The search for studies reporting such experiences unearths a considerable silence; very few such studies have been carried out (Broadmore et al., 1986; Bradby, 1998; Ying Lai and Levy, 2002; Lewin et al., 2005; Ortega-Loubon et al., 2009; Swahnberg et al., 2011; Hassan et al., 2012; Bonilla-Escobar et al., 2016), and while this scarcity has been

noticed (Reed, 2015; Bonilla-Escobar et al., 2016), it has hardly been explained or theoretically tackled. This scarcity might be explained in part by a common reluctance on the part of clinicians to use patients' experiences as a central data point when evaluating the need to perform a given practice. Cook and Brunton argue that 'clinicians' training requires them largely to discount patients' narratives in pursuit of the primary goal of a biological diagnosis' (2015: 548, referring to Good, 1994).

The paucity of studies is not, however, the main problem. In the present environment, even further studies might not reveal women's voices recounting their authentic experiences, their true apprehension of the vaginal examination. The experiences of labouring women in general – and concerning vaginal examinations in particular – are strongly linked to women's everyday experience in patriarchal society of deep sexual objectification and reification. Our bodies are experienced not as truly our own; as vehicles of our selves, but as alienated from our subjectivities. This experience of the body as fragmented, as not 'in concert' with the self, is also tainted with profound shame (Young, 1980; Bartky, 1990). And this 'normal' phenomenological experience of women under patriarchy precludes women from truly recognising the actual invasive, even violent character of the practice of vaginal examinations, at least as currently performed in most medical scenarios – even though they may in fact apprehend the violence.

'The water we swim in': the pervasiveness (and invisibility) of sexual violence

Cohen Shabot and Landry comment on the unique offerings of feminist phenomenology for observing and dealing with supposedly normal experience, which it presents as always already sexed and gendered. They analyse the #MeToo movement, showing how feminist phenomenology's insights into the 'normal' situation of women in patriarchy, embedded in sexual reification, shame and sexual violence, apply from the publication of Beauvoir's *The Second Sex* through to today – this is 'the water we swim in': 'That sexual objectification is just part of the humdrum of women's everyday lives reveals much about how women experience being-in-the-world' (Cohen Shabot and Landry, 2018: 3). Reflecting on some of the #MeToo movement's viral texts, Cohen Shabot and Landry show that sexual availability, passivity and a continuous predisposition towards, or readiness for, discomfort, even pain, are the essential imprint of women's condition – even for presumed sexually liberated millennials. They cite Loofbourow's (2018) analysis of Roupenian's (2017) 'Cat Person',[8] elaborating on why, in Roupenian's text, 'consent' need not be the significant question at all. The #MeToo movement's greatest contribution to the discussion on sexual violence is probably this: showing that before there can be debate over consent, there has to be a discussion of the pervasive normality and thus invisibility of sexual violence. It has become women's nature to be subjugated to men's desires and remain epistemically obstructed from

seeing our own. Women have learnt not to see our own pain while becoming men's objects of pleasure.[9] In Loofbourow's words:

> Women have spent decades politely ignoring their own discomfort and pain to give men maximal pleasure. They've gamely pursued love and sexual fulfillment despite tearing and bleeding and other symptoms of 'bad sex'. They've worked in industries where their objectification and harassment was normalized, and chased love and sexual fulfillment despite painful conditions no one, especially not their doctors, took seriously … I wish we lived in a world that encouraged women to attend to their bodies' pain signals instead of powering through like endurance champs. It would be grand if women (and men) were taught to consider a woman's pain abnormal; better still if we understood a woman's discomfort to be reason enough to cut a man's pleasure short. But those aren't actually the lessons society teaches – no, not even to 'entitled' millennials (2018, cited in Cohen Shabot and Landry, 2018: 5).

Loofbourow's reflection can be directly imported into the discussion of obstetric violence, and vaginal examinations in childbirth in particular: discomfort, even pain, is simply women's normal experience of their being-in-the-world. Black women's experience in this regard, as we know, differs: their pain is not even considered normal but is simply non-existent. The racist idea that black women are less civilised, more animal-like (hooks, 1997) and thus less likely to suffer pain – that their bodies are more resistant than white women's bodies (Davis, 2019) – makes black women even more prone to being quotidian victims of pain.

Shame

Women have also experienced their bodies under patriarchy as inherently shameful. This omnipresent shame has allowed structural mechanisms of violence and domination to obtain a strong grip on women and their bodies. Bartky (1990) argues that people from oppressed groups might experience a pervasive shame connected not with their own deeds but with their entire existence as objects for the other. This shame is paralysing and unproductive, a direct consequence of inhabiting the world under a disciplinary gaze that requires bodies to persistently experience themselves as scrutinised objects (Bartky, 1990: 97). Bartky's lucid analysis of pervasive shame and of women existing as permanent victims of shame belongs to a rich tradition of feminist phenomenological scholarship on female embodiment conceived under patriarchy as a shameful, defective body in constant need of being tamed and rescued from itself (described in Young, 1980; Rich, 1986; Beauvoir, [1949] 1989; Bartky, 1990; hooks, 1997; Dolezal, 2015; Cohen Shabot, 2016, in the context of black women's bodies; and Lyerly, 2006, in the context of childbirth). Dolezal, for instance, writes:

> 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 (2015: 109–110).

Home midwife and birth activist Jacqueline Vejlstrup (2017) writes about the normalisation of obstetric interventions in childbirth and the cultural construction of the female body as defective: 'As long as the "dangerous, sickly, female body" appears scarier to us than the vast number of serious injuries caused by labour interventions, patriarchy's medicalized imprisonment will falsely appear safer to childbearing women'. This suggests a correlation between patriarchal conceptions, often shared by women themselves, of inherently sick, weak, polluted women's bodies, and the assumption that medical interventions in childbirth – even violent, even non-consensual ones – are necessary and unavoidable. Thus, the epistemic obstacle to full recognition of the violence inherent in vaginal examinations in childbirth might also involve the essential shamefulness of women, women's bodies being 'dirty' bodies, existentially prone to continual shame. Indeed, shame has been thoroughly investigated and pinpointed as one important mechanism for perpetuating obstetric violence by making it invisible: the 'gendered shame' permeating women's existence allows for the hyper-medicalisation and unquestioned control of women's 'dirty', 'shameful' bodies by medical staff. Obstetric violence is perpetuated because both labouring women and their doctors frequently see it not as violence at all but as the only way to 'save' women's overly sexual, polluted, shameful, untamed bodies from themselves (Cohen Shabot and Korem, 2018).

Vaginal examinations might be the epitome of this taming of the polluted: the medical domestication of an inherently contaminated body that might otherwise go astray. One investigation considers how vaginal examinations are 'sanitised' by midwives who unnecessarily clean vaginas with various hygienic substances before or during vaginal examinations and use euphemisms when talking to women about their vaginas and these procedures. In '"I'm Just Going to Wash You Down"', Stewart (2005) argues that vaginal examinations during labour are a significant cause of embarrassment not only for birthing women but for the staff, who recognise this frequent, unquestioned part of the labour process as being very awkwardly intimate. Paradoxically, in attempting to address the embarrassment by 'desexualising' the practice, they actually sexualise it in a shameful and objectifying way: not naming the vagina, hiding it behind euphemisms, disconnecting it from a woman's embodied self (thus fragmenting her body) or even unnecessarily and literally sanitising the examination, as if the vagina were truly polluted. On such cleansing procedures – for which medical evidence provides no basis – as more than simply a way for midwives to counter

embarrassment, Stewart comments:

> the wash-down procedure described by midwives can be seen as a ritual to deal with their own discomfort about performing such an intimate examination. However, the fact that there was a wide range of practices suggests that the procedure is more than a means of dealing with embarrassment. Midwife F clearly perceived the woman's genitals to be dirty and in need of cleaning. The highly ritualized washing procedure she described and her use of a sterile pack mark the procedure as a professional event, and avoid any suggestions of a sexual encounter … However, such a performative wash-down can also be interpreted as an overt display of professional power and part of a disciplinary regime which aims to contain women's 'leaky' bodies within a stable and controllable framework (2005: 591).

In what follows, I use Butler's framing of grievable and ungrievable lives (Butler, 2009) to elucidate how this phenomenological normalcy of women existing as shameful sexual objects for themselves and for others – resulting in an epistemological blindness, again, in women themselves as well as in others – is produced and nourished by power, a political framing that marks lives as either liveable or non-liveable and thus distinguishes between what may and may not be legitimately recognised and named as violence.

Butler on (politically) framing violence

In *Frames of War: When Is Life Grievable?* Butler argues that in the context of war, certain losses are not mourned because they are never really considered lives to begin with:

> In targeting populations, war seeks to manage and form populations, distinguishing those lives to be preserved from those whose lives are dispensable … Ungrievable lives are those that cannot be lost, and cannot be destroyed, because they already inhabit a lost and destroyed zone; they are, ontologically, and from the start, already lost and destroyed, which means that when they are destroyed in war, nothing is destroyed. To destroy them actively might even seem like a kind of redundancy, or a way of simply ratifying a prior truth … Thus, there are 'subjects' who are not quite recognizable as subjects, and there are 'lives' that are not quite – or, indeed, are never – recognized as lives (2009: Locations 190–191; 198–200; 418–419).

Taylor (2018) uses Butler's framing to show how sexual violence against women is not truly recognised as violence, neither by the perpetrators nor, all too frequently, by the victims. She argues that because women's bodies are constructed in patriarchy as ambivalent – presumed to be both inviting sex (essentially available for others' sexual pleasure) and vulnerable, in need of

constant surveillance – sexual violence against women is framed not as violence but as an expected, legitimate response to women's 'nature', at least when the victim does not submit to strict gender regulations and rules of bodily scrutiny.[10] Taylor writes:

> With respect to sexual violence against women, the normative distinction at stake is not so much whether sexual violence is morally acceptable or reprehensible, but rather whether sexual violence is or is not properly violence at all . . . If simply being embodied as a woman is 'to ask for it', then any degree of male sexual attention directed at women cannot by definition be unwanted and, hence, a violation. This in turn calls into question whether such attention can be the sort of forcible and injurious action that constitutes violence (2018: 155).

Mardorossian (2014) provides another useful account of sexual violence, arguing that rape is only an extreme case, a particular form of – not qualitatively different from – violence within patriarchy. All violence, she contends, is sexual, that is, gender-coded. The victim of violence (not necessarily or always a woman) is feminised, while the perpetrator occupies the masculine position. This economy of violence is so entrenched in patriarchy that – again – it becomes normalised and in many ways invisible. The invisibility is enhanced, however, within Western societies where there is an illusion that the law regulates violence, seen mainly as violence between individuals – not between the state or institutions and the individual. Mardorossian (2014: 11–12) cites how rape is contested, resisted and protested against in India, while in the United States the same phenomenon, of the same magnitude, is not protested as a phenomenon of social importance but is seen as isolated, unfortunate cases of violence between individuals. It is not only sexual violence that is not framed, politically, as violence: it is important to note that medical violence – and specifically obstetric violence – is also difficult to frame, at least *prima facie*, as violence. This has to do, largely, with how violence is frequently conceptualised: as requiring intention, and as oxymoronic in spaces perceived as essentially benevolent or involving practices understood to be in the individual's best interest. Human childbirth is not a natural act; it is culturally constructed, and part of its medicalised construction is that it is a highly risky event in which women need rescuing by medical authorities (Katz Rothman, 1982; Chadwick and Foster, 2014; Katz Rothman, 2014). Therefore, defining what medical authorities do in childbirth as violence can seem puzzling, at the least.

Butler reminds us, however, that lives framed as 'ungrievable', as 'non-lives', by particular operations of power (2009: Location 378) are not really experienced as dispensable or valueless by those who live them. This remains true even when the attempt to recognise and formulate them as lives, or at least as lives that might be mourned when they are lost, is epistemically (or even ontologically) challenged. Butler formulates a distinction between 'apprehension' and

'recognition', apprehension being a much more elusive, less conceptual, more experiential – and, I would say, 'embodied' – way of knowing than full recognition:

> 'Recognition' is the stronger term, one that has been derived from Hegelian texts and subject to revisions and criticisms for many years. 'Apprehension' is less precise, since it can imply marking, registering, acknowledging without full cognition. *If it is a form of knowing, it is bound up with sensing and perceiving, but in ways that are not always – or not yet – conceptual forms of knowledge*. What we are able to apprehend is surely facilitated by norms of recognition, but it would be a mistake to say that we are utterly limited by existing norms of recognition when we apprehend a life (2009: Locations 425–429; emphasis mine).

When we bring Butler's explanation of the invisibility of sexual violence and Taylor's take on Butler's explanation into the discussion of obstetric violence, the question that arises is how women can epistemically frame this familiar, routine reality of violent obstetric practices as violence. How can women perceive obstetric violence as actual violence, rather than as a normal part of the 'essentially benevolent' medicalised and medically managed childbirth process? Butler's distinction between apprehension and recognition is helpful here. Even when particular, politically loaded frames forbid us from fully conceptualising certain kinds of violence as violence, a more sensitive, perceptual knowledge is available to us as a way to know differently, to challenge and even shatter existing frames.

Butler does not elaborate much on what this 'knowledge through apprehension' is like or how it is constituted, but phenomenological insights, particularly those resulting from feminist phenomenological analyses, can clarify the meaning of this distinction. Young (1980), for instance, lucidly explains how even though women's condition is one of profound objectification within patriarchy, women are never turned into absolute objects; a seed of subjectivity is always present. This also explains women's alienation from their own bodies: insofar as they perceive their own bodies as objects, women-as-subjects become alienated from those bodies:

> The objectified bodily existence accounts for the self-consciousness of the feminine relation to her body and resulting distance she takes from her body. As human, she is a transcendence and subjectivity, and cannot live herself as mere bodily object. Thus, to the degree that she does live herself as mere body, she cannot be in unity with herself, but must take a distance from and exist in discontinuity with her body (Young, 1980: 154).

Thus, women apprehend their subjectivity even under extreme oppression and reification, even without any epistemological or ontological frames for recognising or fully articulating this subjectivity. This is an embodied apprehension, through the lived body.

The Facebook page 'Birth Monopoly' quotes a doula who describes witnessing 'birth rape' against one of her clients:

> The doctor walked in, put on gloves, and stuck both hands into the laboring mom's vagina. There was no consent. He didn't tell her he was going to do that or ask if she was okay with it. Moments later, he announced, 'Oh, she is tearing already.'
>
> *I had to look away because I could not physically handle what I was seeing. My body began shaking. I felt lightheaded; I felt frozen in place. [I felt] complete helplessness and fear and anger and grief.*
>
> I walked away from that feeling responsible in a way for what had happened, and knowing that this mom had just experienced something that shouldn't have happened, that something was really wrong. And that *there was this visceral response in my body to what I was seeing.*
>
> I just kind of remember being back in that place and feeling like there was nothing that I could do to change what was happening to this mom in that moment.
>
> *[I knew] my body was responding to something . . . even though I wasn't the person that it was happening to, I was still having this response and I needed to do something to work through it.* I knew I didn't want to be in that position again, feeling so helpless and frozen (Clark, 2018; emphasis mine).

This description is illuminating because it presents the moment when the doula's 'body speaks', even though she cannot, in that moment, articulate what is going wrong, or why, or how to respond. She can apprehend it, though: her horror is visceral. Her description perfectly exemplifies the phenomenological apprehension of subjectivity notwithstanding oppression that Young (1980) discusses.[11]

Conclusion: vaginal examinations as (misrecognised) sexual violence – and a note on the paradox of who knows best

Vaginal examinations in labour might constitute a case of misrecognised sexual violence – frequently phenomenologically apprehended as violence but not epistemically recognised as such. Paradoxically, this lack of epistemic resources for fully identifying and possibly refuting the violence may be more pronounced among privileged women with access to advanced technologies and care than among marginalised, poor or mistreated women, as there is overall a strong illusion of choice and of evidence-based care and treatment in wealthy Western hospitals and their maternity wards. Mardorossian (2014: 87–89), for instance, discussing violence in childbirth, argues that the illusion of choice and the medical institution's essential benevolence and nonviolence that prevailed in her own birth (and that

prevails within medicalised childbirth in the United States) prevented her from seeing – until much later – how violent her labour actually was.

Birth experiences are deeply grounded in a concretely sexist, patriarchal reality and particular operations of power. This is crucial in explaining why certain populations are better suited to recognising obstetric violence: when medical attention is already recognised as threatening and untrustworthy, obstetric violence is more easily recognised as violence. In other words, women who suffer blunt disrespect in childbirth, poor medical care and evident verbal or physical violence during labour may be able to articulate more clearly what is wrong with medicalised childbirth, and with vaginal examinations in particular. Previous childbirth experiences outside of obstetric wards and medicalised facilities – such as home births or midwife-attended labours – also provide women with a sharper perspective on what is or is not 'normal', often allowing them to articulate how various obstetric practices might be wrong, sexually violent or unnecessary, and even giving them the power to refuse and resist those practices. Bradby (1998) gives an example of this in her study of rural Bolivian women's reactions to medicalised childbirth. The participants in Bradby's study, rural women who migrated to the city, perfectly articulated how vaginal examinations performed within medicalised hospital labours unnecessarily sexualised their births, filling them with shame, fear and anger. These women, who had previously experienced home births, exclusively cared for by traditional midwives, understood and expressed that the frequent vaginal examinations they experienced as part of medicalised labour were unnecessarily painful, dangerous, embarrassing and humiliating – and they often successfully resisted them. One woman explains: 'I was in the Maternity Hospital and there were lots of medical students, and they were putting their hands up me a lot, and I said, "Don't be poking me like that. I'm a person too. Do I look like a peasant woman for you to be poking me like that?"' (Bradby, 1998: 53).

This paradox raises complex questions about how access to better epistemic resources does not always coincide with privilege and how marginalised populations suffering from lack of proper care, mistreatment or even blunt violence might be more epistemically able to recognise this violence. This does not mean that they are somehow better off – it just says something about how epistemic mechanisms develop. This definitely requires further exploration within investigations of the recognition of violence, in particular of obstetric violence.[12]

I have discussed vaginal examinations during labour and the difficulties in framing them as violence. Many labouring women fail to conceptually and epistemically recognise them as violent. Women may, however, *apprehend* them as violent, and their embodied experiences might provide them with knowledge that could eventually be articulated and conceptualised, as we have seen here, for instance in the account of birth rape. The measure to which this is possible – resulting in full knowledge, but which could also lead to resistance – may also depend on the degree to which women are offered true choices, including exposure to alternatives to the medicalised model, in the form of home births or exclusively midwife-led births, as shown in Bradby (1998) and discussed in Mardorossian (2014). The women in Bradby's study, for instance, had been exposed to alternatives to

medicalised childbirth, which clearly affected their understanding of, and sometimes even resistance to, hospital practices. Bradby concludes: 'It is precisely because of this transitional state … where two cultural systems are in articulation with each other, that it is possible for women to articulate what for them becomes the extremely problematic nature of sexuality in childbirth. Their messages are clear and need to be taken into account in future policymaking' (1998: 55).

A further question involves the obstetrics staff's ability to recognise these practices as violent. It is unclear how the staff, inserted into a political and cultural frame that fails to recognise sexual or medical violence as proper violence, might fully and responsibly recognise this violence and thereby become accountable for it. Until labouring women both recognise and speak up about this violence, others may not begin to recognise it. Alas, the #MeToo movement has shown that even when women raise their voices to denounce violence, powerful epistemic denial mechanisms nevertheless prevent the recognition of that violence on the part of perpetrators. Thus, it might require much more – a radical deconstruction of patriarchal values and medical hierarchies – for labouring women to truly be heard, for this kind of violence to finally be recognised and for its eradication to be called for not only by its victims but, finally, by its perpetrators.

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Notes

1. This article deals exclusively with obstetric violence in medicalised settings. Women also experience mistreatment, even trauma, in midwife-led births outside medicalised settings – as in home births (Baker, 2010; Charles, 2013). However, violence experienced in these contexts is not recognised as 'obstetric violence' in the research, and is beyond the scope of this article.

2. Initially, this distinction was thought to characterise the differences between affluent and low-to-middle-income countries. Miller et al., however, propose that in fact the two extremes coexist globally because of social and health inequities within countries. Thus, they argue, 'A global approach to quality and equitable maternal health, supporting the implementation of respectful, evidence-based care for all, is urgently needed' (Miller et al., 2016: 2176).
3. The recent case of Serena Williams – who suffered from obstetric violence mainly in the form of testimonial injustice performed towards her by the medical staff during her childbirth – is enlightening. Williams's is a clear case of 'obstetric racism', since she was vulnerable to this damage in spite of her wealth and prestige. Elizabeth Dawes Gay (2018) reports: 'When discussing Williams's maternal-health emergency, it's vital to address the role played by racism and racial discrimination—a requirement to sustainably address the United States' growing maternal-health problem. Black women are nearly four times more likely to die from pregnancy and childbirth than white women, and are also more likely to experience a severe maternal morbidity such as a heart attack, hemorrhage, sepsis, or blood clots like Williams did, regardless of their level of education or income. In fact, data from the New York City Department of Health show that black college-educated women were more likely than white women who hadn't completed high school to experience adverse maternal-health outcomes. Knowledge and money aren't enough to save black women, because racism trumps all'.
4. For a more detailed analysis of the phenomenon of birth rape and the feminist questions it raises, see Cohen Shabot (2016: 238–239, mainly footnote 9). In these cases, vaginal manipulations were fully recognised as sexual violence. Here, however, as noted, I deal with the absence of recognition.
5. The mere notion of consent is itself problematic. Regarding the specific case of gynaecological examinations, see Cook and Brunton; for instance: 'The Cartesian mind–body asymmetry in western medicine educates clinicians to privilege verbal consent, not to navigate contradictory 'body talk' whereby bodies are legitimated as conveying needs contrary to those articulated … Ethical dangers include, for example, the ever-present possibility that consent will blur towards non-consent, with or without women voicing this shift. Another danger is that women may voice their assent but the clinician reads their body language as dissent' (2015: 546–547). Furthermore, the authors recognise the enormous difficulty of framing 'consent' within asymmetrical power relations like those between doctors and patients.
6. Throughout this article, I deal with the idea that within patriarchy, women and their bodies are conceived as available for sexual exploitation and consumption and as inherently shameful. There are significant differences in how non-white and white women's bodies are conceived in these contexts: both sexual availability and shame are also racially constructed. Black women's sexuality is much more often defined as promiscuous and lascivious than white women's sexuality, and shame and denigration are provoked and interiorised according to these conceptions (hooks, 1997; Davis, 2019). For the sake of my argument, however, it is enough to recognise that sexual availability and shame are essential components of patriarchal conceptions of women and are therefore importantly present in women's embodied experience within patriarchy, albeit in different forms.
7. Reed (2015) reminds us that even women labouring within less mainstream scenarios have internalised this measurement culture. They, too, often want the 'number', the 'clear measure', to be confident of their progress – sometimes even when they truly understand that the duration of labour after a given measurement is very unpredictable.

8. 'Cat Person' describes a typical, consensual heterosexual relation, insightfully revealing implicit violence and the objectification of women as our normal. Cohen Shabot and Landry write: 'This is not a fictional piece on sexual harassment, on sexual assault, or on any other kind of extraordinary experience … To borrow from Beauvoir, this is simply women's "situation". Margot is reduced (women are reduced) to a body-object: hesitant and inhibited in her (our) intentionality. This curbing of our being-in-the-world as subjects of agency and action has the deleterious effect of causing us to forgo our own desires for the sake of those of others' (2018: 4).
9. #MeToo thus appears to be relevant mainly for describing and denouncing heteronormative framings of sex and sexuality; it has certainly been criticised for this reason by queer theorists. See, for instance: Rodriguez-Cayro (2017); Small (2018); Ison (2019).
10. These gender norms are by definition impossible to satisfy; thus, even when the victim appears not to have 'deserved' violence, sexual violence elicits no authentic surprise (Taylor, 2018: 157).
11. The apprehension here of course belongs to a bystander rather than the labouring woman herself. This opens up questions – about the power of solidarity, alliances and intersubjective experience within labour and beyond – that have been developed in La Chance Adams and Burcher (2014) and that call for further research.
12. It will be interesting to explore this idea under two aspects: first, as an example of feminist standpoint theory, according to which the socially disadvantaged might in fact be epistemically privileged and the most capable of spotting oppressive patriarchal structures (Hartsock, 1983); and second, as challenging some recent scholarship on epistemic injustice, especially Fricker's (2007) notion of hermeneutical injustice, which contends that oppressed groups frequently lack the interpretative resources to comprehend and communicate meaningful aspects of their experience as a collective, thus implying that social privilege generally guarantees more epistemic power.

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