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ARTICLE

"Obstetric Violence," "Mistreatment," and "Disrespect and Abuse": Reflections on the Politics of Naming Violations During Facility-Based Childbirth

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Abstract

Naming performs an important function in society. Names shape our reality by creating the means to bring into existence previously unseen events or unacknowledged experiences, and naming impacts how society responds to these. This article interrogates the problem of naming the phenomenon of violence and abuse during childbirth with a focus on three principal concepts: "mistreatment," "disrespect and abuse," and "obstetric violence." Further, drawing from broader feminist literature, it exposes the hidden power struggles that inform the naming process in this context, and it challenges the notion that "mistreatment" and "disrespect and abuse" are suitable dominant discourses. In essence, it argues that should a dominant discourse emerge, it should not be one formulated by the healthcare sector (as is the case with "mistreatment") given their leading role in abuse and violence during childbirth. Finally, the article highlights that we are in the early stages of understanding this phenomenon and, as such, our communicative framework should be broad enough to include multiple communicative tools including "obstetric violence."

Reports from around the world reveal that women and birthing people are subjected to violence and abuse during childbirth. This includes verbal, physical, and emotional abuse by healthcare professionals during childbirth; and abuse can take the form of disregard for traditional rituals and customs, denial of care, unauthorized or coerced medical interventions, and can sometimes involve sexual violence (UN 2019). Despite their devastating effects and consequences, violence and abuse during childbirth remain hidden from view because broader social norms normalize gender-based violence in the healthcare context (Cohen Shabot 2016) and normalize discrimination against marginalized and racialized people (Davis 2019).

Three names have emerged in the academic literature as the forerunners in terms of labeling the social phenomenon of violence and abuse in maternity care: "disrespect and abuse," "mistreatment during childbirth" ("mistreatment"), and "obstetric violence" (Savage and Castro 2017). Even though each makes a contribution regarding the meaningful communication of different experiences, disagreement is growing about the suitability of the different names to adequately capture the violations that occur in healthcare facilities. Consequently, beyond harmful social norms that make violence invisible, our ability to see, understand, and respond to violence and abuse is further obstructed by the cluttered and disputed conceptual landscape. This article is focused on the underlying politics of naming violations during childbirth that gives rise to disputes, and it aims to contribute to the growing literature on the subject (Diniz et al. 2015; Sadler et al. 2016; Sen et al. 2018; Boudreaux 2020; Lévesque and Ferron-Parayre 2021; Salter et al. 2021).

"Obstetric violence" has gained significant traction in Latin America and before international fora (PACE 2019; UN 2019; CEDAW 2020), but it is repeatedly dismissed by healthcare professionals as inadequate (Oliveira and Penna 2017; Scambia et al. 2018) and readily rejected by global health researchers (Vogel et al. 2016; Bohren et al. 2020). Indeed, it now appears that "mistreatment" is starting to emerge in place of "obstetric violence" as the dominant discourse outside of the Latin American context. This shift away from "obstetric violence" raises questions about the politics behind current naming practices and the consequences thereof.

In this article, I offer a defense of "obstetric violence" as a concept worthy of inclusion in the available conceptual landscape. I encourage critical reflection on the arguments advanced in support of "mistreatment" and "disrespect and abuse" and explore some of the consequences of the shift away from "obstetric violence." I challenge the notion that there should be a dominant discourse developed by people not subject to the violence and abuse themselves, such as global health researchers or healthcare professionals. Further, I argue against support for a dominant discourse given that our understanding of violence and abuse in maternity care is relatively nascent but what we do know reveals that it is far too complex for one name to capture it all. Finally, different names mean different things to different people in different contexts, but women's conceptualizations should be promoted and embraced given it is their experience to name.

The article considers the power of naming life events; it explores the conceptual scope of "mistreatment," "disrespect and abuse," and "obstetric violence" in the academic literature; and highlights growing contestation between proponents of the concepts. I link this contestation to an underlying political struggle, which, I argue, builds from the drive to develop a favorable dominant discourse (reality) for the healthcare sector. I reflect on issues excluded by "mistreatment" and "disrespect and abuse" and argue that "obstetric violence" is an important concept that must remain in place but that none, in isolation from the others, can offer a full and meaningful account of experiences of violence and abuse in childbirth. The article draws to a close with reflections on why "obstetric violence" is relevant but notes the importance of a multiplicity of concepts, especially at such at early stage in developing our understanding of violence and abuse during childbirth.

The Conceptual Landscape and Emerging Contestations

Anyone who delves into the details of violence and abuse during childbirth will be confronted with several, sometimes undefined or divergently defined names used in the literature to name the phenomenon. For instance, one might find "birth rape,"

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"dehumanized care," "birth violence," "mistreatment during childbirth," "violence against reproductive rights," "disrespect and abuse," "womb violence," or "obstetric violence." It is not always clear how these names relate to one another or to what extent they might overlap. Despite this conceptual chaos, "disrespect and abuse," "obstetric violence," and "mistreatment" feature most prominently in the research (Savage and Castro 2017). Although some researchers treat the concepts as synonyms (Diniz et al. 2015; Brennan 2019; Herring 2019), notable efforts from key stakeholders distinguish them from one another. To capture the tension between the different proponents of "mistreatment," "disrespect and abuse," and "obstetric violence," I explore the concepts chronologically, starting with the emergence of "obstetric violence."

Early literature on childbirth experiences reveals that violence and abuse in childbirth has been a feature of facility-based childbirth for decades (for instance, Jewkes, Abrahams, and Mvo 1998; Diniz et al. 2015; Sadler et al. 2016), arguably since the formalization of medicine (Ehrenreich and English 2010). Violence and abuse can be traced back to obstetrics' racist, colonial, and sexist underpinnings (Davis 2019; Chadwick 2021). Despite the transnational nature of abuse and violence in maternity care, the names used by stakeholders varies between the Global North and South (Savage and Castro 2017).

In the Global South, "obstetric violence" came to the fore in Latin America when it was explicitly recognized in law as one of several forms of gender-based violence experienced by women in Venezuela (Venezuela 2007). Since then, many jurisdictions followed with national law reform efforts (GIRE 2015; Williams et al. 2018) and "obstetric violence" was taken up by activists and researchers around the world (Quattrocchi 2020; Chadwick 2021). By 2020, it had made its way onto the United Nations platform via the Special Rapporteur on violence against women (UN 2019), it was the subject of a resolution of the Parliamentary Assembly of the Council of Europe (PACE 2019), and in 2018 the Committee on the Convention on the Elimination of all Forms of Discrimination against Women handed down its first decision on obstetric violence (CEDAW 2020).

These recent developments are a result of decades of robust grassroots activism by Latin American feminist movements fighting for Latin American women's sexual and reproductive rights during childbirth (Quattrocchi 2019; González, Presas, and Mattioli 2020; Katz et al. 2020). The movement transformed individual women's personal life experiences of abuse in childbirth into a public and political issue of human rights violations (González, Presas, and Mattioli 2020) and challenged the androcentric Western medical approach to childbirth that had come to dominate knowledge systems about health and women's reproductive life cycles (Sadler 2004).

Research on women's birthing experiences in the Latin American context reveals that the Western biomedical construction of childbirth denies women their individual humanity and treats them as objects within a system (de Aguiar and d'Oliveira 2011; Castro and Erviti 2014). It frames childbirth as a pathological event thus justifying an interventionist approach and the biomedical occupation of women during childbirth (Sadler 2004; Belli 2013). This strips women of their identities, cultural and spiritual values, and traditions, and alienates them from important social networks and traditional medical assistance (Sadler 2004; Belli 2013; Gonzalez-Flores 2015; Martins and Barros 2016). Indeed, "[f]or Indigenous women, for whom the conquest of the land was also the conquest over their bodies, these intimate intrusions [mandatory vaginal examinations in clinical settings] are reminiscent of colonial practices," and hospitals become a place that reproduces domestic, structural, and political violence inherent

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in colonial practices (Kotni 2018). Biomedicine's broader social legitimization invalidated and replaced women and traditional birth attendants as agents of authoritative knowledge in childbirth and it colonized social perceptions of what counts as "normal" childbirth (Sadler 2004; Belli 2013; Castro and Savage 2019; Sadler 2020), thus rendering violations in childbirth normal and largely invisible (Sadler 2004).

"Obstetric violence" and "humanization of childbirth" were the first two terms used to describe the dehumanized nature of overmedicalized biomedical care and the violence embedded in this approach to childbirth in Latin America.

The Brazilian humanization of childbirth movement introduced the Ceará Declaration on Humanization of Childbirth (Red Latino 2000), which worked to counter excessive and unnecessary use of medical technology in childbirth. It sought to promote human rights in childbirth, reestablish childbirth as a physiological life event, reignite community-based models of childbirth, and promote the development and use of evidence-based care in childbirth (López 2010). However, according to Simone Grilo Diniz and colleagues, women have used violence narratives to describe their childbirth experiences since the 1950s (Diniz et al. 2015). At times, women specifically framed institutional childbirth as violence or used a language that resonates with the experience of violence, such as "sexual violation" or "birth rape" (Cohen Shabot 2021). Arachu Castro, Virginia Savage, Priscyla Andrade, and colleagues note that in the 1990s, Latin American researchers and activists started to formally frame dehumanized care as a form of violence against women (Andrade et al. 2016; Castro and Savage 2019). Consequently, this emerging understanding of violence is informed by the lived experiences of women themselves (Sadler et al. 2016; Cohen Shabot 2021).

This approach emphasizes that dehumanized care resembles another form of gender-based violence (de Anguiar and d'Oliveira 2011; Castro and Savage 2019). It is gender-based violence because "women are its main victims and it has its origins primarily in how women (and their (dis)abilities) are perceived and perceive themselves in Western patriarchal societies" (Cohen Shabot 2016). "Obstetric violence" therefore provides a name for the reproduction of gender inequalities and racial and socioeconomic discrimination as these manifest in clinical maternity care settings (Sesia 2020). In this way "obstetric violence" moves beyond a quality-of-care issue and the narrow confines of categorizing individual healthcare professionals' behavior (Quattrocchi 2020). It labels a social phenomenon in a way that is inclusive of the basic values through which we build our societies (Quattrocchi 2020) and underscores the structural drivers of the phenomenon insofar as the harmful conduct is grounded in women's and other marginalized groups' broader social inequality (Dixon 2015; Sadler et al. 2016; Chadwick 2021).

"Obstetric violence" is a "struggle concept" (Chadwick 2021): a powerful epistemic resource (Sesia 2020) that does the laborious political work of making visible a hidden form of direct and structural gender-based violence and of reclaiming women's reproductive life cycles from the stronghold of the biomedical approach to reproductive health. It challenges oppressive normative conceptions of pregnancy and childbirth and relegitimizes women as a driving source of knowledge and power in childbirth (Sadler 2004; Chadwick 2021).

A quick snapshot of the legislative landscape reveals that "obstetric violence" is a richly diverse concept because of its roots in lived experiences. Different jurisdictions adopt different definitions, and one is confronted with constructions of "violence" that move beyond the narrow boundaries of intentional and physically harmful acts. "Obstetric violence" can include negligent care, omissions, indirect causing of harm,

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and physical and psychological harms too (GIRE 2015). Despite the differences, individual laws all recognize that obstetric violence is gender-based violence (Quattrocchi 2019; 2020).

Arguably, the different individual statutory definitions are a consequence of an evolution in understanding of violence in this context over time, local politics and responsiveness of national governments to social activism, and effectiveness of advocacy strategies to shape law reform (Espinoza-Reyes and Solís 2020). Further, differences can be interpreted as local reflections of international and regional human rights mechanisms' broad construction of gender-based violence. Gender-based violence during childbirth manifests differently in different contexts because health systems wear the inequalities of the societies in which they function, and the nature and extent of violence will correlate with different people's social status, race, and sexual orientation/identity within those particular contexts (Dixon 2015; Erdman 2015). Thus, "obstetric violence" definitions are relative to the contexts in which they emerged, and their definitional scope tends to be broader in more contemporary law reform efforts. Nevertheless, its fluid boundaries render it a difficult concept to use in practical settings.

In the Global North and global health contexts, "disrespect and abuse" emerged as an impactful organizing framework despite the wealth of feminist success under "humanization of childbirth" and "obstetric violence." Diana Bowser and Kathleen Hill published the first comprehensive review of existing literature and labeled the phenomenon "disrespect and abuse" during childbirth (Bowser and Hill 2010). They did not define the term but proposed seven categories to synthesize and organize the broad range of violations recorded in the literature: physical abuse, nonconsented care, nonconfidential care, nondignified care, discrimination, abandonment of care, and detention in facilities. Their approach proved helpful, and researchers used the seven categories to frame research agendas and to shape local and global initiatives to address violations in childbirth (Savage and Castro 2017).

In 2014, Lynn Freedman and colleagues expanded Bowser and Hill's categories to include a clear distinction between individual, structural, and policy-level interactions that constitute disrespect and abuse, and defined "disrespect and abuse" as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified" (Freedman et al. 2014, 916). This definition acknowledges the role of harmful social norms and hierarchical structures, and creates an inclusive space to capture subjective experiences and intentional and unintentional violations too.

Although obstetric violence has been on feminist and public policy agendas for some time now (Diniz et al. 2015), healthcare professionals and institutions have actively sidestepped "obstetric violence." From the very beginning, the World Health Organization has avoided violence discourses and initially embraced "disrespect and abuse" (WHO 2014). However, its approach was quickly revised. In 2015, "mistreatment" emerged in a systemic review by WHO researchers Meghan Bohren and colleagues and was later supported by Joshua Vogel and colleagues (Bohren et al. 2015; Vogel et al. 2016). "Mistreatment" is not defined but it consists of seven typologies: Physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and healthcare professionals, and health system conditions and constraints. The typologies are supported by second- and first-order themes that help to detail the wide spectrum of violations that each typology attempts to capture (Bohren et al. 2015).

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The WHO researchers' approach to naming provides the benefit of flexibility needed in an ever-evolving field, but assigning a name is only the first step in the process of rendering an issue socially visible and worthy of action (Kelly 1993). Words can have several meanings depending on the user's position and context, and by not clarifying what researchers mean by "mistreatment" (as an umbrella concept that connects the different typologies) continuities and commonalities in individual experiences may remain hidden, which can undermine the possibility of a collective social cause to address the issue (Kelly 1993).

The WHO researchers claim that "mistreatment" is the more "incisive language" (Bohren et al. 2020) and that it captures the full range of women's experiences (Bohren et al. 2015). They explain that women's personal experiences of their maternity care should be central to descriptions of the phenomenon; and "abuse" and "violence" imply intentional conduct or "acts of commission" that do not appropriately describe all forms of mistreatment that women experience (Vogel et al. 2016). "Obstetric violence" and "disrespect and abuse" leave out behavior that might be unintentional or harms that occur because of provider omissions (Vogel et al. 2016). Finally, they suggest that "mistreatment" captures women's experiences and interactions at multiple levels including staff, the facility, and the broader health system (Vogel et al. 2016). However, their concern with centering women's personal experiences in naming the phenomenon gives way to healthcare providers' preferences:

> While "obstetric violence" discourse is grounded in women's rights and feminist advocacy in Latin America, we note that the term can be antagonizing when engaging with groups in different settings because of the implied intentionality of an act to cause harm. In our research, we have found that the term can alienate health-care workers and policy makers, with whom participatory engagement is crucial to evoke change. (Bohren et al. 2020, 818)

Ultimately, these arguments support their blanket rejection of "disrespect and abuse" and "obstetric violence" because each fails to capture the broad range of violations during childbirth, and the WHO researchers encourage the exclusive use of "mistreatment" to ensure an inclusive space for healthcare professionals.

It would be helpful if the WHO researchers clarified how they come to define and understand "abuse" and "violence" as narrowly as they do,[1] especially considering the vast feminist literature and activism pointing to more inclusive constructions of those concepts.

Distinguishing "mistreatment" from broader, violence-related narratives renders "mistreatment" vulnerable to the critique that it fails to capture the link between violations in childbirth and violence against women that is a result of structural gender inequality (Jewkes and Penn-Kekana 2015; Sadler et al. 2016). Further, Michelle Sadler and colleagues advocate for the use of "obstetric violence" because it is a concept that pulls gender to the center of our consideration and thus captures macro-level drivers of harmful individual interactions and systems. This approach emphasizes that violations in childbirth are "inherent to the structural dimensions of maternity care provision" (Sadler et al. 2016, 52), and efforts to address this issue will be ineffective without this understanding in place. Even though "obstetric violence" makes structural drivers quite clear, more recent "disrespect and abuse" scholarship continues to warn against its use.

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Gita Sen and colleagues resist a "violence" framework and instead offer a revised definition of "disrespect and abuse." Their position is that "[t]he word violence typically carries with it intentionality, which is not a consistent marker for abuse in the context of obstetric care" (Sen et al. 2018, 8). They go on to expand on Freedman and colleagues' definition by explicitly referencing the central role of dignity and highlighting structural concerns by recognizing personal characteristics that render women and birthing people vulnerable to violation. Contrary to the WHO researchers, they maintain that "disrespect and abuse" includes intentional and unintentional violations (Freedman et al. 2014).

Sen and colleagues' shift away from Freedman and colleagues' conception of "disrespect and abuse" could be representative of evolving understanding of "abuse" in the context of facility-based childbirth. A revised definition is deemed necessary to capture and emphasize those experiences that "mistreatment" does not capture, such as "abuse when it is intentional and bordering on violence" (Sen et al. 2018). Thus, Sen and colleagues have refined "disrespect and abuse" to be sufficiently inclusive to capture most (if not all) of the WHO researchers' concerns, but this is achieved under a revised construction of "disrespect and abuse."

Disputes about the suitability of "mistreatment," "disrespect and abuse," and "obstetric violence" have created three distinct factions, and each appears to discredit the others. These circumstances have given rise to a confusing and cluttered conceptual landscape, which is complicated further by the general lack of agreement about the different meanings of "abuse" and "violence" and a notable absence of theoretical foundations to support certain positions. Feminist theory underpinning obstetric violence provides rich foundations (Cohen Shabot 2016; Davis 2019; Chadwick 2021; Cohen Shabot 2021), but more engagement with theory is needed to address continued contestation. Ongoing contestation denies women and birthing people a language to communicate their childbirth experiences, it maintains the invisibility of a harmful social phenomenon, and it impedes our ability to advance research and develop adequate transformative responses.

Exposing the Underlying Power Struggle in Naming Violations During Childbirth

The conceptual landscape has witnessed an evolution of names to describe violations during childbirth, which can be expected when an issue attracts diverse stakeholders: "Depending on who is addressing the issue, different aspects are included or excluded, and what the phenomenon is called varies considerably" (Sen et al. 2018, 7). Further, according to Savage and Castro, disagreement about naming may emerge from efforts to find the most appropriate operational definition that allows for accurate measurement of violations in childbirth (Savage and Castro 2017). However, I argue that behind these efforts is a broader power struggle over who gets to establish a dominant discourse precisely because this provides a monopoly over how society will perceive the phenomenon, and this will influence how responses are developed and where interventions are targeted.

Dale Spender explains that naming performs a critical function in our everyday lives. "Names are essential for the construction of reality for without a name it is difficult to accept the existence of an object, an event, a feeling" (Spender 1998, 163). "Naming involves making visible what was invisible, defining as unacceptable what was acceptable and insisting that what was naturalized is problematic" (Kelly 1993, 139), and in this way naming processes enable us to manipulate the world (Spender 1998, 163).

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Naming helps to make sense of experiences, develop consciousness-raising initiatives, improve measures for solidarity, and develop practical ways to bring about social change (Giladi 2018). In terms of social change, names inform how an issue is measured, legislated, and resourced (Boyle 2019). As such, naming is not a neutral phenomenon.

What a name amplifies and hides depends on who does the naming, where their interests lie, and the broader acceptance of their devised name depends on whether they are socially positioned to authoritatively name events, objects, or feelings (Spender 1998; Dotson 2011). That is, social inequalities actively position some people, especially heterosexual white men and institutions developed and led by them, to hold a monopoly over defining the world (Spender 1998; Dotson 2011) and this comes with significant benefits. Authoritative namers can:

> harness communication to make oppressed people, groups and institutions doubt the world in which they live . . . [they can] rename violent behaviors as compassionate acts, and they can cast systemic racism as equality and inclusivity. . . . They make violence the normal, everyday order of things, and troublingly, something that society would celebrate because it is supposed to serve nation, community, or a higher power. (Harris 2018, 113; citations omitted)

Names can form part of verbal strategies to neutralize and rationalize actions and prevent disclosure of issues by limiting the ways in which marginalized people can make sense of what has happened (Ashcraft 2000). Those whose experiences fall outside the dominant discourse are expected to present their experience in a way that is prescribed by the dominant discourse, and a failure to do so will mean their interpretation of an event will be rejected without reference to the content of the conversation (Spender 1998). Their communicative tools will prove to be socially inadequate and if they continue to use them, they will be denied a proper hearing (Ashcraft 2000). Thus, certain names render many experiences *unspeakable*. If a name does not completely silence individuals, it can be formulated to minimize the seriousness of some harmful behaviors. Minimization renders an event as something less serious, not worthy of broader social attention, and hides the need for collective action (Kelly 1993).

This is a matter of hermeneutical injustice. It is "a gap in collective interpretative resources [that] puts someone at an unfair disadvantage when it comes to making sense of their social experience" (Fricker 2007, 1). It speaks to the injustice that one experiences when a significant social event is obscured from collective understanding because the person who experienced the event is a member of a marginalized group (Fricker 2007). Marginalization comes from the fact that broader interpretations or names for social events are biased insofar as these are insufficiently influenced by those who experience the social event (Fricker 2007). We see this manifest in earlier research on sexual violence (Kelly 1993) and more recently in street harassment (Vera-Gray 2016) and online abuse (McGlynn et al. 2020). When dominant narratives are developed without adequate inclusion of victim-survivors, those communicative tools are rendered inadequate to the extent that experiences cannot be readily or meaningfully verified to oneself or to others, underlying connections to other forms of violations cannot be envisioned, and the extent and existence of a problem cannot be meaningfully acknowledged (Spender 1998).

Returning to violence and abuse in childbirth, the WHO and the healthcare profession hold a particularly authoritative and highly influential naming position in local and

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international communities (Gostin, Sridhar, and Hougendobler 2015). For instance, the WHO is charged with developing global rules and norms that set the global health agenda to be carried out by healthcare professionals. It guides and harmonizes state priorities and activities, and it is purposefully structured to influence the behavior of states and other key actors (Gostin, Sridhar, and Hougendobler 2015). When the WHO names a problem in a certain way, there will be significant uptake and restructuring according to that position because of its international power base and its established relationships with states, healthcare institutions, and healthcare professionals. Together, the WHO and the vast corpus of the health profession occupy the prime position to control the communicative landscape and prescribe the dominant discourse within this arena.

Healthcare professionals and healthcare institutions have a long-standing discomfort with "violence." For instance, Diniz and colleagues report that in the early 1990s, the Network for the Humanization of Labor and Birth "deliberately decided not to talk openly about violence, favoring terms like 'humanizing childbirth,' 'promoting the human rights of women,' fearing a hostile reaction from professionals on the charge of violence" (Diniz et al. 2015, 3). Should they have adopted a violence narrative, it would have had an "antagonizing effect . . . on the community of clinical practitioners with whom they must engage if change is to take hold" (Sen et al. 2018, 8). Sen and colleagues frame this as a "strategic move" that was necessary to secure buy-in from healthcare professionals. Meaning: healthcare professionals have the power to dictate the parameters of the conversation around violations in childbirth. A deviation from their preferred labels comes at a very high price: a refusal to engage, and thus the prevention of collective action.

The health profession's discomfort with "obstetric violence" remains an issue. More recently, healthcare professionals claim it is a derogatory term that impedes obstetricians' autonomy, incites hostility toward healthcare professionals, encourages negative perceptions of healthcare professionals more generally, and undermines doctor–patient relationships (Oliveira and Penna 2017; Scambia et al. 2018). Maura Lappeman and Leslie Swartz claim that the use of the term is itself a form of violence against healthcare professionals (Lappeman and Swartz 2021). It is therefore unsurprising that the WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience (WHO 2018) make no reference to violence toward women and birthing people during childbirth, only to that of "mistreatment" or "disrespect and abuse" as a manifestation of mistreatment during childbirth. "Violence" is mentioned once: in relation to violence that staff might experience in their homes or communities, not within the healthcare context.

The WHO and healthcare professionals have a vested interest in avoiding "violence" to describe their own dealings. "Violence" is a particularly powerful label that influences how we perceive people, institutions, and events. Although there is underlying disagreement about the meaning of "violence," the fact remains that the label communicates negative appraisal (Bufacchi 2007; De Haan 2008). It represents a "language game": "It is a game of condemning with particular vehemence some forms of human action. In playing the game, we do not merely call the acts wrong or criminal; we use the word . . . to label them worthy of extreme obloquy" (Betz 1977, 341).

Further, the label casts a shadow over the perpetrators of violence as people or institutions that cannot be trusted. Tom Beauchamp and James Childress emphasize that the goals and structures of medicine and healthcare call for deep appreciation for moral values and "having a reliable character, good moral sense and appreciation for emotional responsiveness" (Beauchamp and Childress 2019, 31). Professional virtues

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socially expected of medicine and healthcare include care, compassion, discernment, trustworthiness, integrity, and consciousness (Beauchamp and Childress 2019). These virtues and moral principles are key features that earn social trust in healthcare institutions and interpersonal trust between patients and healthcare professionals, and it maintains their broader social authority (Calnan and Rowe 2007). To allow healthcare professionals' behavior and systems to be labeled as "violence" suggests that they are the sort of people or institutions who abuse their power, that they are a *threat* to well-being, and that they cannot be trusted with access to vulnerable individuals. Thus, with global pressure to address concerning rates of maternal mortality and morbidity (evidenced by the United Nations Sustainable Development Goals 3 and 5, for instance [UN n.d.]) and the privileging of Westernized facility-based care to support those ends, it is not surprising to find that the WHO researchers use "mistreatment" instead of "violence."

Reflecting on the Network for the Humanization of Labor and Birth's experiences with the use of "violence" (Diniz et al. 2015), it is arguable that the health professions' continued avoidance of "violence" has an impact on the development of names available in the context of violation of women during childbirth. The names used to render harmful systems and practices visible must be tailored to suit the requirements and interests of the healthcare sector, and the use of "violence" is not a communicative option.

I argue that Sen and colleagues' continued support for "disrespect and abuse" is an example of feminist efforts to overcome the oppressive power dynamic that women and birthing people must navigate to have their experiences recognized and addressed. As with "humanization of childbirth" communicative strategies, Sen and colleagues' construction of "disrespect and abuse" appears to be strategically developed to create a meeting point between "mistreatment" and "obstetric violence." Their definition of "disrespect and abuse" steers clear of "violence," which, for them, "typically carries with it intentionality, which is not a consistent marker for abuse in the context of obstetric care" (Sen et al. 2018, 8). By adopting and supporting a very narrow construction of "violence," they can secure some buy-in from the healthcare profession while still capturing some of those lived experiences that "mistreatment" hides.

This approach reflects the tension that many feminist researchers and activists navigate for there to be some form of recognition of women's lived experiences, and a form of recognition that might facilitate immediate action. On the one hand, feminist researchers and activists aim to privilege previously silenced voices and thereby transform the dominant representation of reality that reproduces and maintains systemic inequalities; on the other hand, they are not taken seriously because there is stifling pressure to use names that are acceptable or complimentary to dominant agents and their discourse (Ashcraft 2000).

These naming strategies might help to develop increased awareness and offer *initial* relief, but Catherine Ashcraft warns that this approach makes it difficult for women to "retain control over the definition of their experience and [it] frequently leads to a distortion" of the issue (Ashcraft 2000, 3). By attempting to frame the issue within the discourse accepted by dominant agents, activists tend to have to soften or omit the more threatening aspects of their reconstruction of the problem, and this enables dominant agents to control and eventually appropriate the communicative options available to women (Ashcraft 2000). Controlling options limits the success of researchers and activists to elevate and prioritize women's and marginalized people's voices, and to transform broader gender relations that support and maintain oppression (Ashcraft 2000).

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"Disrespect and abuse" capture many issues, but it is worth noting that Sen and colleagues' construction of "disrespect and abuse" distorts our view of the scope of the issue because they promote a construction of "abuse" as something entirely different from "violence." Although there are different schools of thought about the relationship between "violence" and "abuse," many scholars tend to recognize at least a measure of overlap between the two (Fraser and Seymour 2017). However, Sen and colleagues' approach suggests that "violence" is irrelevant to the maternity care context by defining it as narrowly as they do. In softening their approach with "disrespect and abuse," they do little to destabilize the WHO researchers' construction of a violence-free reality and its communicative stronghold in this area. Those who understand and construct their birth experiences in terms of "violence" continue to be silenced because, ultimately, the healthcare professions' representation of the issue remains largely unchallenged. The healthcare professions and related institutions maintain their authoritative position to reject "disrespect and abuse" because control over the narrative remains firmly within their grasp.

"Obstetric violence," on the other hand, reflects an "epistemic intervention" that instigates a sharp rupture in "assumptions about biomedical benevolence and forces us to confront the fact that the gynaecologist's office or the birthing room are not separate spheres removed from societal relations of power, human rights violations, legacies of colonialisation, and systemic prejudices" (Chadwick 2021, 109). Given the concept's grounding in "embodied struggles" (Chadwick 2021, 109) it leaves little room for healthcare professionals to soften the language because it is not their experience to name and define. However, the repeated defining of "violence" in ways that render it incompatible with women's varied experiences enables it to be discredited as unhelpful in communicating and naming a harmful social phenomenon.

"Obstetric violence" is successfully embedded and operationalized within the social and legal Latin American contexts (Savage and Castro 2017), and it has enjoyed some important gains in the United Nations and Europe, but it's arguable that its further integration beyond Latin America has been frustrated by the recent introduction of "mistreatment." Indeed, Savage and Castro note that "mistreatment," instead of "disrespect and abuse" or "obstetric violence," is most frequently used in global studies, and "mistreatment" rather than "disrespect and abuse" features most prominently in the WHO's guidance on maternal health (Savage and Castro 2017). These are strong indications that "mistreatment" is emerging as a dominant discourse outside of Latin America despite recent criticism over its continued use (Amorim, da Silva Bastos, and Katz 2020).

Arguably, "mistreatment" is the healthcare sector's replacement name for "disrespect and abuse" and "obstetric violence" and, as such, it is developed from an outsider's perspective. In rejecting "obstetric violence" and "disrespect and abuse," the WHO researchers seek to promote "mistreatment" as the only legitimate name for violations during facility-based childbirth. *It is disconcerting that the healthcare sector claims the authoritative position to name a problem it created and maintains.*

Kate Harris emphasizes that "agents of dominance erase facts and histories of violence" by framing the issue as something other than violence (Harris 2018, 113). In the context of the violator being the namer, Liz Kelly's analysis of men's authority to define sexual violence in law and in broader social interactions is illuminating: "It is in men's interests, as perpetrators of sexual violence, that definitions of forms of sexual violence be as limited as possible. At the same time as women are unable to name their abuse as abuse, men are able to deny responsibility for abusive behaviour. Language is a

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further means of controlling women" (Kelly 1993, 156). Abusers and abusive institutions would rarely call themselves abusers/abusive or structures of violence, and this fact should encourage broader interrogation of the legitimacy of the healthcare sector's dominant position in naming this phenomenon.

The WHO researchers explain that they promote the use of "mistreatment" because it is a woman-centered description that reflects women's own experiences of their maternity care, and they recognize that these factors should be central to any description of this phenomenon (Vogel et al. 2016). Proponents of "disrespect and abuse" make the same claim (Sen et al. 2018). This might reflect a well-intended effort to develop an all-inclusive name that would help to capture the essence and extent of the problem, but the above considerations suggest that "mistreatment" and "disrespect and abuse" are not entirely woman-centered. Even less so in the context of "mistreatment." Both offer incomplete depictions of lived experiences of facility-based childbirth because they shut the door on a broader recognition of the fact that we are confronted with a social phenomenon where facility-based birth manifests as gender-based violence. Their comprehensive rejection of "obstetric violence" also leads one to question the extent of their woman-centered approach given that the concept emerged from women's advocacy and communicates their lived experiences.

"Mistreatment" and "disrespect and abuse" were developed out of the drive to meet the demands of "dominant agents": healthcare professionals and their institutions. The communicative legitimacy of the terms appears to be determined by their ability to adequately complement and maintain the integrity of healthcare institutions and their professionals. In effect, they soften the blow for the benefit of the healthcare profession at the expense of developing adequate and comprehensive communicative resources for women and birthing people to meaningfully express their lived experiences and expose a phenomenon that remains hidden from view. This reflects Sheila Kitzinger's concern that:

> too often, women can find no words to describe what happened. After childbirth everything may be "explained" in medical terms—and the woman is silenced. It is similar with rape. A teenager sexually abused by her teacher said, "All the words I had were the words he gave me. He called it 'love.'" Women often have no legitimate way of describing personal experiences except in the terminology of the oppressor. (Kitzinger 1992, 74)

Indeed, this naming issue remains a concern today. In their recent ethnographic study on Mexican and South African women's experiences of obstetric violence, Vania Smith-Oka, Sarah Rubin, and Lydia Dixon emphasize that "women knew that something was not right, but there was not always a recourse for them or clear vocabulary to express their concerns" (Smith-Oka, Rubin, and Dixon 2021, 7).

Multiplicity of Names Inclusive of "Obstetric Violence" and "Abuse"

Proponents of "mistreatment" and "disrespect and abuse" advocate for the exclusive use of each term, but I propose we guard against this approach for two reasons. First, research reveals that many women who are subject to violence and abuse during childbirth do not recognize it as such or struggle to make sense of their experiences (Freedman et al. 2018; Castro and Savage 2019; Cohen Shabot 2021). This points to a need for a multiplicity of names. Second, "obstetric violence" continues to capture that which is excluded by "mistreatment" and "disrespect and abuse," and it plays an

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important political role in tackling violence against women. Consequently, it should be included in the available conceptual landscape. I explore these points next.

Missing clear vocabulary is long-standing issue for feminist activists and researchers in the context of hidden violence. Feminist work on naming previously unnamed experiences highlights the usefulness of a multiplicity of names (DeVault 1990; McKenzie-Mohr and Lafrance 2011; Vera-Gray 2016) that will hold weight in different cultural contexts (Ofei-Aboagye 1994). A single name thus universalizes experiences (DeVault 1990) and opens the door to essentialist constructions of lived experiences (Wing 1996). Indeed, a name developed through "foreign interventions" can overlook diverse cultural, racial, ethnic, and traditional nuances unique to particular contexts and communities that would render its use inappropriate in those contexts (Ampofo et al. 2004; Ampofo 2008).

When different women and birthing people are unable to accurately name their experience because of limited communicative tools, they are forced to engage in what Suzanne McKenzie-Mohr and Michelle Lafrance describe as "tightrope talk" (McKenzie-Mohr and Lafrance 2011). This is the process of precarious reliance on existing names that do not fully articulate their experiences and it forces them to tell their stories without adequate communicative resources. "Tightrope talk" is a matter of epistemic injustice (Fricker 2007; Cohen Shabot 2021), which undermines comprehensive recognition and response.

Further, a conceptual framework limited to only one term ("mistreatment," "disrespect and abuse," or "obstetric violence") leaves little room to capture "movement" toward consciousness of the violation. Kelly's earlier work on capturing the range of sexual violence experienced by a selection of women reveals that it takes time and reflection for women to recognize that they were subjected to violence (Kelly 1993). Rosemary Ofei-Aboagye notes similar concerns in the context of Ghanaian women's experiences of domestic violence where abuse is normalized through "the fabric of tradition" (Ofei-Aboagye 1994). As with other areas of violence against women, research into women's perceptions of their birth experiences and sense-making demonstrate that consciousness about violations is of equal concern because local social contexts and practices normalize abusive medicalized behaviors as acceptable (Sadler 2004; Warren et al. 2015; Bohren et al. 2016; Balde et al. 2017; Bohren et al. 2017; Freedman et al. 2018; Castro and Savage 2019).

Access to a multiplicity of names enables victim-survivors to communicate multiple feelings a person might encounter within one interaction or violation. Fiona Vera-Gray's research on women's experiences of men's stranger intrusions or street harassment highlights the fact that women experienced multiple responses to one encounter, including feeling complemented, insulted, harassed, intimidated, confused, annoyed, and terrified (Vera-Gray 2016). Similar responses in the context of facility-based childbirth, where women acknowledge "that there have been negative or violent situations, women say that this does not dampen the joy of being able to give birth" (Oliveira and Penna 2017). This research demonstrates that experiences are multifaceted and fluid, such that women move across different and sometimes contradictory states within the same encounter, and these insights underscore the need to capture movement with reference to multiple terms that can be linked back to the broader issue of gender-based violence and violence against women, even if there may be positive outcomes from negative experiences.

The above considerations make clear that there is value in having several names to communicate experiences, and that names should be developed by those working

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through the experiences. Without names, women cannot understand or make sense of the fact that what happened was something other than "normal." Initial feelings about their experiences can be discounted (Cohen Shabot 2021), and experiences can be pushed aside and treated as insignificant (Kelly 1993).

Against this backdrop, the limited communicative value of "mistreatment," "disrespect and abuse," and "obstetric violence" should not be overlooked. "Mistreatment" and "disrespect and abuse" are broad enough to capture some "movement" and many different manifestations of violations during childbirth, but the names suggest that there is little, if any, violence in hospital settings (structural or otherwise). For instance, in their quest to develop an all-inclusive name, the WHO researchers have lumped together all possible harmful events under one term, including one-off disrespectful verbal interactions with unauthorized or forced medical interventions (such as involuntary sterilizations and unauthorized vaginal examinations), and even sexual abuse (Bohren et al. 2015).

Although individual sense-making about violence and abuse during childbirth is complex, many of the individual violations that fall under "mistreatment" are formally recognized as "violence" in contexts outside of healthcare. For instance, unconsented penetration of a vagina is prohibited in sexual violence laws, and slapping or restraining a person to a bed constitute interpersonal violence and are explicitly prohibited in most criminal laws, including domestic violence laws. Indeed, Bohren and colleagues identify clear parallels between intimate partner violence and "mistreatment" in health facilities in Abuja but nevertheless continue to frame violence and abuse during childbirth as "mistreatment" (Bohren et al. 2016). This approach to naming suggests that behavior captured by "mistreatment" is exempt from the "violence" label if the behavior occurs in the healthcare context.

Consciousness-raising and the process of exposing violence in places where it remains hidden are frustrated when violence is reframed as "mistreatment." Those events and systemic concerns that are not properly captured by "mistreatment" or "disrespect and abuse" remain invisible or are minimized in seriousness. When an event is sufficiently minimized or distorted as something not serious, it can evolve into an event that is not worthy of collective action (Kelly 1993) and "mobilizes incredulity" (Chadwick 2023, 1902). Systematic distortion or silencing obscures our ability to see and meaningfully engage with and respond to lived experiences, and broader oppressive structures cannot be exposed or challenged (Kelly 1993; Chadwick 2023).

"Obstetric violence" would prove helpful here, but it has its limits too. The concept's rooting in "violence" means that it inherits broader contestations about the meaning of "violence" that might render it a difficult concept to use in a practical way (Fraser and Seymour 2017). Further, the "everyday" criminological understanding of "violence" as intentional infliction of harm (Galtung 1969; Coady 1986) continues to impede the use of "obstetric violence" to describe a broad array of childbirth experiences given that many violations are not intentional and are described as "gentle" violations (Lappeman and Swartz 2021).

Nevertheless, even under this limited construction of "violence," "obstetric violence" still captures and communicates some interactions that "mistreatment" and "disrespect and abuse" exclude. But there is more to "violence" than intentional harms, and continued exclusion of "obstetric violence" from the conceptual landscape outside of the Latin American context will embed significant injustices.

"Violence" has several definitions (Bufacchi 2007) beyond that suggested by proponents of "mistreatment" and "disrespect and abuse," and the wider violence literature is

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evidence of this fact. Broader definitions of violence, including structural, cultural, and symbolic violence, have emerged out of growing concern about the inadequacy of the narrow construction of "violence" and the harmful consequences of continuing to use this restricted construction (Bufacchi 2007; Frazer and Hutchings 2019). The narrow construction of "violence" fails to capture systemic concerns and diverse experiences that result in just as much harm as intentional harm (Bufacchi 2007; Boyle 2019; Frazer and Hutchings 2019).

Of particular concern, the narrow construction of "violence" individualizes the problem and reduces it to a freestanding issue between individuals. It detaches people from their broader social contexts and locates the problem in "deficits" in the individual perpetrator or their personality (Frazer and Hutchings 2019). Decades of feminist analysis and phenomenological work has revealed that this understanding of violence is flawed.

Feminist naming practices take place within an analysis of patriarchy and race in which an understanding of gender inequality is essential, and this approach emphasizes that different manifestations of violence against women are not discrete issues but fall along a continuum and share a common thread (Kelly 1993; Cohen Shabot 2016; Boyle 2019; Davis 2019). It is for this reason that feminist work has conceptualized violence expansively and so highlights the ways in which social systems and structures play a role in creating violence (Fraser and Seymour 2017; Frazer and Hutchings 2019). Feminists' continued efforts have exposed gaps between women's lived experiences and laws or definitions relevant to domestic violence, sexual violence, harassment, image-based abuse, and gender-based violence more generally (for instance, MacKinnon 1991; Ashcraft 2000; Mardorossian 2002; Harris 2011; McGlynn and Rackley 2017; Karimakwenda 2018; Davis 2019; Naffine 2019). The same is happening in the context of violations in childbirth.

In line with a feminist approach to naming, obstetric violence advocates (as discussed earlier) foreground the social systems and structures that play a role in creating obstetric violence. Cohen Shabot explains: "Medical violence toward women, and obstetric violence in particular, must be recognized as part of pervasive violence toward women in general. Obstetric violence may be seen as a consequence of both excessive power of hegemonic, androcentric medical authority and the ubiquity of violence against women" (Cohen Shabot 2016, 237). "Mistreatment," on the other hand, isolates violations during childbirth from their broader context of gender inequality and discrimination, and from the broader feminist political agenda to expose and address all the different manifestations of violence against women (Frazer and Hutchings 2019). "Disrespect and abuse" might become an issue here too because it seems to be a term that is not firmly established and lacks a theoretical framework, which means it can be easily reshaped to suit the needs of the dominant agents.

"Where women have renamed part of the world it is clear that values have shifted and, with them, the balance of power" (Spender 1998, 184). The balance of power shifts because feminist renaming is a political act: feminist renaming of events opens new spaces for discussion and influences national and international discourse, policies, and law, and this helps to transform institutions that oppress women. Consequently, arguments that identify "violence" solely with reference to intentionality reverse decades of feminist work to expose different manifestations of violence, and it compromises the development of meaningful legal and political responses thereto. These insights reveal an additional concern with the exclusive use of "mistreatment" or "disrespect and abuse." Through their continued adoption of a narrow construction of "violence,"

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proponents of "mistreatment" and "disrespect and abuse" immobilize collective action to address violations during childbirth.

Detachment from the feminist agenda has alarming consequences. "Mistreatment" works from a platform that prevents us from applying already-developed, gender-informed violence-prevention tools and laws against harmful healthcare systems and healthcare professionals. This is because it frames violations during childbirth as something other than "violence." Consequently, healthcare professionals and their institutions are not the target audience of existing national, regional, and international legal instruments dedicated to fighting gender-based violence or violence more generally.

Arguably, this regulatory gap has created the opportunity to develop a different set of standards to be applied to healthcare professionals and their institutions, and it also encourages the development of a different body of accountability mechanisms for "mistreatment." Violence during childbirth will therefore receive a vastly different response in comparison to violence in the home, for instance. Outside the Latin American context, most formal mechanisms developed to respond to the specific issue of "mistreatment" emerge from the healthcare system itself, such as, for instance, in the form of clinical guidelines or internal training opportunities. Unlike the specialized regulatory approaches taken in response to domestic and sexual violence, there are few jurisdictions with specific obstetric violence laws enacted to tackle violence as it manifests during facility-based childbirth.[2] This is despite international human rights law obligations on states to develop legal avenues to address gender-based violence in all its forms (UN 2019). Of further concern, health-sector-specific regulations tend to lack legal clout and are regularly defied or ignored (for instance, Pickles 2019; Brione 2020) but these breaches do not warrant the inclusion of violence-prevention services because of their effective detachment from broader violence-prevention mechanisms. These circumstances are key to ensuring that the healthcare profession maintains its dominant position by excluding outsider interrogation and intervention.

To claim that one name can capture all that women and birthing people experience in different cultural contexts goes too far. It does a serious injustice by excluding certain forms of violence and abuse or by minimizing the seriousness of those violations. The injustice is extensive when the emerging dominant discourse, "mistreatment" within contexts beyond Latin America, is not entirely woman-centered and when it restricts our ability to make broader connections with women's movements and hard-earned gains in laws dedicated to equality and to eradicating gender-based violence. It has no place as a dominant discourse. Instead, it is worth recognizing that we are still in the early stages of getting to grips with the meaning of different names and with violence and abuse during childbirth. Now is the time to broaden our conceptual landscape rather than narrow it.

This article demonstrates that naming is not a neutral process with neutral consequences. Names shape reality, how we perceive issues, and how we respond to those issues. This makes naming a political endeavor and thus a site of contestation. Those vested with the social authority to name events hold significant power to shape the direction of policy and law, and there are alarming consequences when naming practices silence people subjected to harmful practices or minimize harmful social phenomena.

It is against this backdrop that concerns emerged in relation to naming trends of violence and abuse in childbirth. Indeed, this article was motivated by the concern that proponents of "mistreatment" and "disrespect and abuse" reject "obstetric violence" without adequate regard for what this term has come to mean in the context of

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women's movements against medical appropriation of women's bodies during childbirth. Their continued framing of "violence" as including only intentional harms serves as the basis to reject "obstetric violence," and this is without good reason because it is painstakingly clear that the concept includes far more, especially given its feminist and phenomenological roots. Of additional concern, proponents of "mistreatment" and "disrespect and abuse" go further and use this limited understanding of "violence" as the basis to support arguments to exclude "obstetric violence" from the conceptual landscape outside of the Latin American context. Despite aiming to center their naming approach on women's experiences, their approach is instead shaped by the preferences of healthcare professionals and their institutions.

The complexity of the phenomenon of violence and abuse during childbirth, personal or subjective appreciation of experiences, and the real possibility of unacknowledged violations in different cultural contexts indicate that now is the time to expand the communicative tools. I argue against the position that one concept will be adequate on its own and urge collective resistance against the development of a dominant discourse. Several concerns/issues are worth noting in the context of "disrespect and abuse," "mistreatment," and "obstetric violence," but "mistreatment" is of particular concern; this article encourages researchers and activists to critically reflect on their continued use of the term. It hides the full extent of violence and abuse, ignores the broader context that drives violations during childbirth, and it undermines the development of comprehensive responses. It minimizes the central role of women as authoritative namers of their experiences through active discreditation of women's construction of violence and abuse. Further, it allows naming practices to be determined by the very individuals and institutions responsible for violence and abuse in childbirth. Consequently, the continued use of "mistreatment" merely expands and maintains the health professions' reach of power and control over all dimensions of childbirth, rather than challenge it.

Notes

1 Their approach may be explained with reference to the World Health Organization's working definition of violence, which is limited to intentional behavior: "[t]he intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug et al. 2002, 5).

2 Although victim-survivors may make use of broader human rights claims to seek redress (Odallo, Opondo, and Onyango 2018; Sen et al. 2020), the claimant's ordeal in seeking justice for obstetric violence in *S.M.F. v Spain* makes it painstakingly clear why victim-survivors need obstetric-violence focused laws (CEDAW 2020). Without clearly defined legal obligations and harm-specific causes of actions or penalties, women are required to expend significant resources to access courts and weave together laws that were never developed for the purposes of tackling the specific issue of obstetric violence.

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