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Obstetric gaslighting and the denial of mothers' realities

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Abstract

Gaslighting is a type of abuse aimed at making victims question their sanity as well as the veracity and legitimacy of their own perspectives and feelings. In this article, we show how gaslighting can operate as a key, yet underexamined, strategy of obstetric violence, or the institutional and interpersonal violation of women's rights during pregnancy, childbirth, and postpartum. We draw on forty-six in-depth, semi-structured interviews with mothers who experienced a traumatic childbirth to examine how obstetric providers gaslight mothers before, during and after childbirth when they deny – and thereby destabilize – mothers' realities. We identify and examine four core types of denials: denials of 1) mothers' humanity, 2) mothers' knowledge as valid, 3) mothers' judgements as rational and 4) mothers' feelings as legitimate. All four denials work to render mothers noncredible and their claims illegible within clinical encounters. In explicitly naming, theorizing, and examining obstetric gaslighting, our aims are threefold: 1) to uncover and theorize an underexamined mechanism of obstetric violence through a sociological lens, 2) to offer a typology of obstetric gaslighting's manifestations to aid scholars and practitioners in recognizing when obstetric gaslighting is occurring and 3) to advance a growing research program on gaslighting in medicine.

Keywords

Maternal health; Gaslighting; Obstetric Violence; Qualitative methods; United States

1. Introduction

Gaslighting – a type of abuse aimed at making victims question their own sanity as well as the veracity and legitimacy of their own perspectives and feelings (Calef and Weinshel 1981; Stern 2007) – has received growing popular and scholarly recognition as a potent power tactic. To date, the phenomenon has mostly been examined within the context of intimate relationships (Calef and Weinshel 1981; Stern 2007). However, mounting scholarship

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reveals gaslighting's presence across medical settings (Sebring 2021; Fraser 2021; Riggs and Bartholomaeus 2018). Here, we advance a growing research program on medical gaslighting to show how gaslighting can operate as an important, yet underexamined mechanism of obstetric violence, or the institutional and interpersonal violation of women's rights during pregnancy, childbirth, and postpartum (WGNRP 2017). Our analysis reveals how obstetric providers gaslight mothers when they deny mothers' realities. Drawing on forty-six in-depth interviews with mothers who experienced a traumatic childbirth, we identify and examine four key types of denials: denials of 1) mothers' humanity, 2) mothers' knowledge as valid, 3) mothers' judgements as rational and 4) mothers' feelings as legitimate. All four denials are buttressed by key features of contemporary obstetric care, as well as ingrained notions of medical professionals as rational experts and gendered stereotypes of women. All four denials work to render mothers' views noncredible and their claims illegible.

2. Background

2.1 Maternal health, obstetric violence, and intersecting inequalities

In the United States, the current state of maternity and obstetrics care represents a public health crisis (Kuznar 2010; Gingrey 2020). Maternal mortality, while decreasing globally, is increasing in the U.S.; despite significantly greater spending on maternal care (Papanicolas, Woskie, and Jha 2018), the U.S. has the highest rates of maternal mortality among high-income countries (NPWF 2020; Tikkanen et al. 2020), with important racial/ethnic disparities that disproportionately harm Black, Latina and American Indian/Alaska Native mothers (Braveman et al. 2015; Petersen et al. 2019; Ozimek et al. 2016). Overall, U.S. mothers experience uniquely high rates of preterm births, cesarean sections, postpartum infections and untreated postpartum anxiety and depression (NPWF 2020).

Maternal morbidity and mortality are linked to multiple complex factors, including but not limited to mothers' lack of access to care, as well as missed or delayed diagnoses and poor case coordination (Petersen et al. 2019). These adverse maternal health outcomes are also linked to *obstetric violence*, or the gender-based subordination of obstetric patients during pregnancy, childbirth, and postpartum (WGNRP 2017). Obstetric violence manifests in the disrespectful, undignified and/or abusive care that mothers face in obstetric settings. Obstetric violence can occur when providers follow their own plans over mothers' wishes, fail to obtain mothers' consent, negate mothers' autonomy, or blame mothers for adverse outcomes (Davis 2020; Villarmea and Kelly 2020; McLemore 2019). In doing so, this violence can negatively impact maternal health through driving maternal dehumanization and a loss of dignity, control, and bodily autonomy (Sadler et al. 2016; Diniz et al. 2015). Intersecting inequalities also increase the vulnerability of mothers of color, low socioeconomic status, immigrant background, and disabilities to obstetric violence (Vedam et al. 2019; Crenshaw 1995; Davis 1981).

2.2 Obstetric care: the medicalization of childbirth and the practice of defensive medicine

Two key, related features of contemporary obstetric care provide a critical backdrop for obstetric violence, and as we will show, obstetric gaslighting: the medicalization of

childbirth and the practice of defensive medicine (Sadler et al. 2016; Betron et al. 2018; Savage and Castro 2017).

Alongside a growing pathologizing of pregnancy (Waggoner 2017), childbirth in the US has undergone increasing medicalization, or the process of nonmedical problems becoming defined and treated as medical problems (Conrad 2007). Medicalization in obstetrics is characterized by the rising use of technology and interventions – including fetal monitoring and artificial induction or augmentation – in labor and delivery (Hall 2019). While complications may occur during pregnancy that require medical intervention, the standards of placing IVs and monitoring fetal heart rate during uncomplicated labors, as well as the increasing number of medically unnecessary cesarean sections, do not necessarily yield better maternal or infant outcomes (Hall 2019; Roth and Henley 2012). What's more, some procedures – including cesarean sections – increase the risk of maternal and infant complications (California Department of Public Health 2011; Roth et al. 2014).

High rates of interventions during birth (Seijmonsbergen-Schermers et al. 2020) are consistent with the practice of defensive medicine, or a clinical orientation that seeks to reduce legal liability through excessive testing, and unnecessary interventions (Kukura 2018). Defensive medicine has come hand-in-hand with increasing medicalization and growing fears of malpractice liability. Obstetricians, who are sued more often than other medical specialties, often intervene needlessly under the false belief that intervention increases safety without introducing additional risk, and because doing so allows them to manage mothers' labor while limiting liability. Indeed, intervention is now the norm in obstetric training, and physicians often have limited abilities to resist their standard training or defy hospital protocols (Barber et al. 2011; R. E. Davis-Floyd 2003). While such medical interventions may be necessary, comforting, and even empowering for some women, interventions that are performed without consent or clear communication constitute obstetric violence (WGNRR 2017). Indeed, the injudicious use of such interventions, along with a lack of respect for a mother's ownership and knowledge of her body, help drive such violence. This stands in contrast to a "good birth", wherein a mother – with or without technology – feels agency, respect, and personal security (Lyerly 2013). Together, the medicalization of childbirth and the practice of defensive medicine help fuel obstetric violence by exposing women to unnecessary procedures and reducing women's bodily autonomy and sense of humanity (Sadler et al. 2016; Hall 2019).

2.3 Medical professionals as experts, and stereotypes and discrimination in medicine

The medicalization of childbirth and defensive medicine exist within longstanding medical traditions of gender discrimination and a broader privileging of biomedical expertise over women's lived experiences (Jordan 1997). Women have been historically omitted from clinical trials, resulting in established treatment recommendations derived from studies with mostly men. Interpersonally, women who present with the same severity of symptoms as men are regarded as less credible (Hamberg 2008). Women must perform additional work to establish the credibility of their medical condition (Werner, Isaksen, and Malterud 2004) and are treated as personally responsible for their health outcomes (Waggoner 2017). Diseases that disproportionately impact women face delegitimization (Kempner 2014; Labuski 2015).

Gender discrimination in medicine also rests on a broader privileging of biomedical expertise over women's knowledge or experience. Power resides in medical structures and institutions, and patients with historically less power, including women, often lack authority to challenge medical decisions or care (Foucault 1980). In the context of birth, the increasing prevalence of obstetric technology and procedures has been central in devaluing women's own knowledge of their bodies and involvement in decision-making, as such technologies codify healthcare providers' possession of "legitimate" knowledge (Jordan 1997). Rather than viewing women as legitimate sources of knowledge production, laboratory and diagnostic findings are often prioritized over women's sense of their own bodies (Davis 2019a). Historically, knowledge related to childbirth was co-created by both the midwife and woman in labor; however, in the Western medicalized model of birth, the physician is often the one single decision-maker (Jordan 1997) and the data yielded by technologies are considered more valuable than a patient's perspective (Davis-Floyd 2001).

Gendered discrimination is also fueled by longstanding stereotypes that associate femininity with irrationality, ignorance, and deviance on the one hand, and maleness with rationality and normality on the other. Gendered stereotypes that shape medical providers' views of women patients as less rational, more emotional, and more likely to complain than men stem from gendered ideology within medical science itself, with theories of male superiority embedded in biological claims that men are whole and strong, while women are weak and incomplete (Ehrenreich and English 1973; Kempner 2014). Altogether, the medicalization of childbirth, the practice of defensive medicine, ingrained notions of medical professionals as "experts" and gendered stereotypes help set the stage for gaslighting.

2.4 Gaslighting, obstetric violence, and traumatic childbirth

While research on the medicalization of childbirth, defensive medicine, and obstetric violence frequently alludes to gaslighting (McLemore et al. 2018; Rosenthal and Lobel 2020; D. A. Davis 2019b), explicit discussions of gaslighting in obstetric settings have emerged almost exclusively in public discourse (Chiu 2018). Gaslighting has been primarily studied academically in the field of psychotherapy as a tactic mobilized within interpersonal relationships (Calef and Weinshel 1981; Stern 2007) and in context of medicine with parents of transgender children (Riggs and Bartholomaeus 2018) and retaliation against nurses reporting misconduct (Ahern 2018).

Sweet (2019) points out, however, that most examinations of gaslighting ignore the social dynamics and power relations enabling it. Her research on domestic violence reveals gaslighting as a *sociological*, rather than purely psychological phenomenon, and she calls upon sociologists to interrogate how gaslighting is facilitated across contexts and within other hierarchical, power-laden, intimate relationships marked by vulnerability. Here, we respond to Sweet's call with a sociological examination of how gaslighting operates as a mechanism of obstetric violence. Given the underlying dynamics of power, vulnerability, and dependence in the relationship between obstetric provider and patient – particularly within the context of childbirth – our analysis of obstetric gaslighting draws upon an examination of in-depth interviews with mothers who experienced a traumatic childbirth. Traumatic childbirth – defined as an actual or threatened serious injury or death to a mother

or to her infant, or feelings of intense fear, helplessness, loss of control, and horror during a birth experience – is common in the U.S.; of the eighty percent of women who will give birth at least once in their lifetime, between a fourth and a third report their experience as traumatic (Ford, Ayers, and Bradley 2010). Traumatic birth lies in the eye of the beholder, as mothers may experience a birth viewed as routine or medically "normal" by clinicians as traumatic (Beck 2004).

Traumatic childbirth's impacts on mothers are well-documented; it helps drive rates of postpartum anxiety and depression, Post-Traumatic Stress Disorder, decreased desire for more children and mother-child bonding difficulties (Bell et al. 2016; Beck 2009; Elmir et al. 2010). Provider maltreatment is linked to traumatic childbirth: whether a mother experiences her birth as traumatic relates more to provider treatment than to the number of medical interventions or "adverse" events (Størksen et al. 2013). While a mother's birth experience, even amidst serious complications, may be positive overall if she felt safe and cared for (Henriksen et al. 2017), traumatic childbirth is also correlated with mothers' feelings of dismissal and neglect even in the absence of serious complications (Hodnett 2002).

That traumatic childbirth is both common and linked to provider maltreatment makes it a strategic access point for examining how gaslighting operates in obstetric settings. Indeed, the literature on traumatic childbirth frequently alludes to gaslighting. For instance, studies have found that many women who experienced traumatic childbirth felt pressured by their doctor to consent to procedures (Declercq et al. 2014) or felt uninformed or misinformed by healthcare personnel (Rodríguez-Almagro et al. 2019). Other scholarship points to an environment in which mothers feel invisible, out of control, and ignored, and in which mothers were not viewed as autonomous, capable individuals (Elmir et al. 2010). Our analysis builds on these themes of dismissal and invisibility to show how gaslighting functions in obstetric settings to disorient and render mothers noncredible during childbirth.

3. Data and Methods

3.1 Data collection

We leverage a qualitative study of traumatic childbirth, for which we conducted in-depth, semi-structured interviews with 46 mothers who experienced the birth of one or more children as traumatic. Inclusion criteria included having given birth to a living child in the United States two months or more months prior, self-defining the birth experience(s) as very difficult or traumatic, and speaking proficient English. Having experienced gaslighting was neither a screening tool nor inclusion criterium.

Interviews were conducted in 2019-2020. Most interviews were conducted by phone (N=38) as a social distancing adaptation to the COVID-19 pandemic. We used purposive and quota sampling (Small 2009); participants were primarily recruited via social media (N=41) as well as personal and professional networks (N=5), and completed a brief online screening survey to determine eligibility. We used limited snowball sampling, capping referrals at two. See Table 1 for the sample's sociodemographic composition. While not an inclusion requirement, all mothers identified as women.

Each author conducted roughly half the interviews using a trauma-informed approach (MIPVW 2010). Interviews lasted between one and three hours, and mothers were compensated twenty dollars in cash. The interview guide was developed, tested, and refined in January 2019 before formal data collection began. Interviews were semi-structured, with questions about mothers' prenatal, childbirth and postnatal experiences (see supplement for interview guide). Most accounts of gaslighting arose organically throughout interviews; while we did not explicitly use the term "gaslighting" in interviews, we asked questions specifically related to treatment by and interactions with providers. Interviews were conducted until reaching saturation (Fusch and Ness 2015). With IRB approval and participants' consent, interviews were audio recorded, transcribed verbatim and anonymized.

3.2 Data analysis

Following data collection, we analyzed interview data with the qualitative software package, *Dedoose*, using qualitative content analysis, an inductive, dynamic form of analysis oriented toward understanding manifest and latent content of interview data (Graneheim and Lundman 2004). Our analyses were guided by our definition of gaslighting as a form of manipulation within an interpersonal relationship in which a person or a group sows seeds of doubt in an individual, making them question their own perception, judgment, feelings and/or sanity (Abramson 2014).

We conceptualized that a person or group is able to sow such seeds of doubt when they negate the truth or reality of the victim's experience – such as when they tell the victim that how the victim feels isn't warranted, that what the victim perceives is an illusion, and that what the victim thinks has occurred, in fact, has not. These negations work to engender a sense of confusion on the part of the victim, as the victim may become unable to tell what is real and whether they can trust their own perceptions, views, or feelings. Thus, to operationalize gaslighting, we focused on identifying and analyzing such negations.

An initial round of open coding revealed that mothers across the sample reported that providers negated or denied their realities. We developed and refined a coding scheme to capture providers' denials of mothers' 1) humanity, 2) (intellectual and bodily) knowledge, 3) judgements and 4) feelings. We engaged in focused coding to capture the occurrence of these four types of denials. Our focus on these denials distinguishes gaslighting from other forms of obstetric violence, including maltreatment or disrespect, because these serve to construct victims as noncredible. That said, our definition accounts for the fact that gaslighting can occur irrespective of the conscious intent of the person utilizing its tactics. Indeed, because institutional constraints that place pressure on physicians – including a lack of time and resources, alongside embedded hierarchies and gender inequalities (Sadler et al. 2016; Hamberg 2008) – provide the terrain upon which obstetric gaslighting can flourish, we posit that this gaslighting functions as a form of structural violence, rather than solely as an interpersonal phenomenon. Below, we discuss mothers' reports of gaslighting by physicians and nurses; we use the term "provider" when a mother referred to either or to her care team overall. Finally, our aim below is not to show how common or prevalent gaslighting is; rather, analyzing rich, in-depth interview data of mothers who experienced a traumatic

childbirth allows us to examine how obstetric gaslighting may manifest and with what consequences for mothers.

4. Findings

Mothers' experiences of gaslighting were common: most (38 out of 46) described encountering at least one instance of gaslighting from providers during their prenatal care, postpartum care, or childbirth. In most cases, gaslighting occurred within an obstetric setting (i.e. a prenatal appointment, labor and delivery room) and from an obstetric provider (i.e. an obstetric gynecologist, anesthesiologist, and/or nurse). However, there were instances where obstetric gaslighting was committed by providers outside the obstetric theater, such as in the emergency room or a postpartum mental health appointment. Thus, we show that obstetric gaslighting may occur across healthcare settings where mothers are seen and treated for conditions relating to childbirth and birth-related processes. Here, we examine the four key types of denials that mothers reported. While such denials often worked independently as distinct mechanisms of gaslighting, they could also – as we will show – operate in concert during obstetric encounters.

4.1 Denying mothers' humanity

Mothers shared experiences where they perceived that their humanity was denied – that is, they felt that they were regarded by medical providers as "bodies" rather than people. The ingrained view of medical professionals as experts and the medicalization of childbirth – which has led to a largely medical, rather than humanistic view of childbirth – helped set the stage for this denial. In a medical model of birth, mothers are transformed from agentic subjects into medical objects. When this occurs, and mothers are viewed primarily as bodies, there is little room or perceived need for mothers' perspectives as people or credibility as relevant sources of information. Mothers' emotions, judgments and knowledge are all subordinate to the physician's "expert" view. In this way, the denial of mothers' humanity lays the foundation for the other three types of denials that drive gaslighting.

Mothers described feeling that, to physicians, birth was a routine medical procedure, and they were merely vessels through which a baby was delivered, rather than a human being giving birth. Shreya, a South Asian mother, explained feeling like "a bunch of organs" to her provider, and Caitlin, a white mother, recalled feeling like a "decoration in the room" during her birth. As Caitlin navigated fear and exhaustion before her cesarean section, she felt that her physician denied her humanity as he put "a sheet over me and just kind of went, 'Oh yeah, just wheel her over to the comer. She'll be fine. Whatever.'"

Mothers' sense that physicians viewed birth primarily as a medical procedure – and mothers as medical bodies – made mothers feel like they were not regarded as whole people, but rather objects without valid feelings or concerns worthy of providers' consideration. One way this denial of mothers' humanity manifested was when providers ignored mothers in the delivery room. Ignoring mothers operated as a key mechanism of gaslighting by removing mothers' credibility in reducing them from subjects worthy of engagement to objects easily disregarded. Mothers described providers entering the room without introducing themselves, not paying attention to mothers, and/or carrying on conversations

with colleagues as if mothers were absent. Ten mothers described providers entering the delivery room during birth and casually discussing recent vacations or hospital ongoings, rather than paying attention to mothers' needs or concerns. Jessie, an East Asian mother, recalled her physicians discussing their vacation during her birth: "It would be like, Oh, you know, you want to go to Cancun or whatever? That's cool, I've been to Cancun!'" When rendered invisible, mothers began to doubt their relevance to their own birth. Actions that made mothers feel invisible communicated to mothers that their views, perceptions, or feelings as human beings were tangential to a medical operation and illegitimate compared to their providers' expert knowledge.

Mothers also described feeling that their body was primarily a "teaching tool" to providers. Mothers who gave birth in teaching hospitals, where medical residents and students attend deliveries as a part of their training, explained how large medical audiences made them feel like a didactic instrument, rather than a human being. Petra, a white mother, described feeling like a body under observation when trainees from across the maternity ward arrived at her delivery bed to observe the emergency use of forceps to extract her baby. She shared that these trainees treated the event like a mundane, everyday affair rather than the uniquely terrifying moment Petra experienced it as:

> People came in chatting. 'Oh, I haven't seen you in a while.' 'Well, I was working night shifts.' And they're babbling and we're having this scariest moment of our lives and no one seems to care.

The experience dehumanized Petra, as she described feeling "invisible and irrespected as a human being." Other mothers drew references to feelings of invisibility during their own birth. Carlota, a Latina mother, underscored that beyond birth's physical pain, she underwent an "added layer of pain" from the denial of her humanity throughout her experience – that is, from being neither heard, nor seen, nor tended to by her physician. Retrospectively admonishing her physician, she explained:

> I'm hurting because you're not listening to me. I'm hurting because you're doing things to me and not explaining them to me. I'm hurting because you're not seeing me. I'm hurting because you're not asking how I'm doing. I'm hurting because you're not asking me what I need.

That multiple mothers described feeling invisible during their birth illustrates how the denial of mothers' humanity manifested: mothers were disregarded to the point where they, as human beings, felt erased and irrelevant in a process that *their own* bodies were carrying out. This discordance between mothers' sense of self and the overt erasure of that self by providers contributed to mothers' feelings of confusion, as mothers went from thinking that birth was, at least in part, about recognizing them as mothers to realizing that the medicalized experience solely reduced them to birthing bodies. Indeed, some mothers discussed how being rendered invisible contradicted their prior expectations about childbirth as a sacred, mother-centered event and disoriented them. Caitlin, a white mother, described feeling invisible as "not what I thought I would be getting into at all. That's not what I signed up for. That's not what being a new mom is supposed to be." Forced invisibility confused Caitlin as she learned that birth was merely a medical procedure that doctors could perform without mothers' input – or even an acknowledgement of mothers' existence. In

this way, ignoring and rendering mothers' invisible functioned as gaslighting in causing Caitlin and other mothers to question the legitimacy of their preexisting views on childbirth, rendering them noncredible during the birth, and undermining their sense of selves as human beings.

4.2 Denying mothers' knowledge as valid

The denial of mothers' humanity laid the foundation for the denial of mothers' knowledge as valid. In our analysis, we conceptualized knowledge as including both mothers' a) intellectual knowledge (for instance, their understanding of medical terminology, medical diagnoses, medical history, etc.) as well as their b) embodied or bodily knowledge (for instance, their grasp of what was happening to or occurring within their own bodies). When providers dismissed or ignored either type of knowledge possessed by mothers, mothers' contributions to their own care were rendered noncredible and mothers themselves ignorant. In doing so, such denials of mothers' knowledge as valid gaslit mothers into questioning their own input as useful, relevant, or even real.

Denials of mothers' intellectual knowledge were common, as mothers described being quickly dismissed when they questioned physicians or requested more information to make an educated choice about their care. For instance, Yasmeen, a South Asian mother, leveraged her professional expertise as an infectious disease specialist to advise her physicians that the antibiotics they had prescribed for her postpartum infection were incorrect. But Yasmeen reported that the physicians would not listen to her and that she was essentially told "to shut up" as they proceeded with giving her "antibiotics that weren't even the right antibiotics."

Denials of mothers' bodily knowledge were even more common. Mothers most often reported these types of dismissal when they told providers that they were in labor and that they were bleeding too much after birth; in both types of situations, providers informed mothers that what mothers thought was happening to their bodies was not in fact happening. That is, mothers who believed they were in labor were told that they were not in labor, and mothers who worried that their bleeding was excessive were informed that their bleeding was completely normal. There are certainly cases where providers sharing information with mothers about what is normal is helpful; providers may listen to mothers, take their perspectives seriously, investigate the situation, and still provide a different perspective on the situation using their expertise; these instances do not constitute gaslighting. However, in most instances in our sample, mothers also reported that such denials were incorrect – that mothers later came to see that they had been in labor and that their bleeding had been excessive. For instance, Leslie, a white mother, visited the Emergency Room after bleeding profusely for ten days postpartum. Despite repeatedly voicing concerns about the extent of blood loss to the ER physician, she was discharged. Once home, Leslie lost consciousness due to excessive blood loss and returned to the ER by ambulance, where her red blood cell count was found to be dangerously low. Indeed, mothers reported that the denials of their bodily knowledge often transformed treatable problems into more life-threatening or grave conditions, which sometimes necessitated intensive medical intervention. With Leslie, the denial of her bodily knowledge culminated in a life-threatening situation that necessitated multiple blood transfusions, consideration of a hysterectomy, and a multi-day hospital stay.

Other denials of mothers' bodily knowledge left mothers feeling traumatized by not having been taken seriously. In these instances, providers dismissed or failed to integrate mothers' insights about what was happening to their own bodies into medical care in ways that confused or disoriented mothers. For instance, Kate, a white mother and nurse midwife, experienced the starkest example of obstetric gaslighting – and provider maltreatment overall – in our sample, when she a) unwillingly underwent an unmedicated cesarean section, and b) was later informed by her providers that they had proceeded with the surgery without medication out of respect for her wishes to have an unmedicated birth. Kate informed the operating team at the surgery's outset that the anesthesia had not taken effect, but her physician nonetheless proceeded with the operation, avoiding eye contact with Kate and ignoring Kate's ongoing pleas to stop. By dismissing Kate's input on what she was feeling physically, Kate's care team gaslit Kate into feeling invisible and irrelevant to a surgery taking place on her body.

> My doctor.. wasn't talking to me, like she wasn't checking in. I'm clearly like not doing well […] Your arms are strapped down. You can't move, I had oxygen on my mouth […] I was saying, 'I feel this, I feel this' and they won't talk to me. My doctor and the other doctor are just talking amongst themselves.

Indeed, after her baby was delivered, Kate described sensations of intense pain as she felt the needle stitching her up but felt rendered "voiceless" by the entire experience. Beyond being made invisible and her perspectives noncredible during the surgery, gaslighting continued in the birth's aftermath when the medical team repeatedly questioned and dismissed her version of events. One such dismissal occurred during a mediation Kate scheduled with the hospital's lawyer, when her providers told her not medicating her properly actually reflected their commitment to honoring *Kate's* preferences. At the same time, Kate was also given an opportunity to read her medical record from the birth and discovered it included "zero… absolutely nothing" about what had transpired medication-wise during the c-section. "They said I tolerated [the anesthesia] well, which was shocking." Confused by these interactions, Kate wondered if *she* was in fact the crazy one, which led her to seek counsel from additional third-party providers to hear if they thought what had happened was normal. Altogether, Kate's experiences of having her bodily knowledge denied during birth and knowledge as a midwife of what constituted normal rendered noncredible "haunted" the new mother for years.

4.3 Denying mothers' judgements as rational

The third type of denial reported by mothers was that of mothers' judgments as rational. This type of denial primarily manifested when mothers were informed, explicitly or implicitly, that they were not thinking about events or medical decisions reasonably. This form of gaslighting rendered mothers noncredible through delegitimizing their judgments and presenting their viewpoints as irrational or hysterical.

Denials of this kind were reported most commonly during mothers' accounts of medical interventions during birth. Most mothers in this study received one or more interventions during birth: 69% had inducted or augmented labors, and 54% underwent C-sections. Mothers reported that when they questioned physicians' use of interventions, they were

treated as difficult or irrational. Mothers' assessments of interventions as potentially unnecessary or undesired were dismissed as illegitimate. Providers' denials of such judgements as rational signaled to mothers that bringing expectations, knowledge or preferences to their birth did not make them informed patients, but rather unreasonable patients. It simultaneously reinforced the notion that physicians knew best, while mothers' perspectives were unfounded.

Mothers reported that even physicians who discussed with them potentially foregoing an intervention did so in a way that created false choices: rather than fairly describing the pros and cons of both avenues, they juxtaposed the benefits of intervening with the potential devastating harms of not. Such interactions preemptively dismissed mothers' skepticism about interventions as irrational, making mothers feel like they would be acting crazily or irresponsibly were they to choose to forego intervention. Lisa, a Latina mom, described these conversations with physicians as merely "formalities" that "kind of make it seem like you have agency, but really not. I mean, you see the language that – the way in which the doctors were speaking, right – it's like, choose option A, which is go for an emergency C-section and the hopeful potential safe delivery of your baby, or choose option B, which is like, the imminent deterioration of your child." Although concern about fetal well-being is justified in many situations, childbirth professionals refer to providers' use of unwarranted threats of poor baby outcomes as "playing the dead baby card" (Morton et al. 2018). For the mothers in this study, the threat of poor outcomes – accompanied by providers' insistence upon medical interventions to avoid these outcomes – worked to gaslight mothers and destabilize their realities by creating a situation wherein mothers' own judgments were framed as likely detrimental to their babies' well-being.

Ultimately, the introduction of medical interventions increased physician control by diminishing mothers' abilities to independently understand or manage their own birthing process. Such interventions cemented physicians' claims to exclusive expertise within the birthing process and could empower physicians to continue writing off mothers' judgements. That is, the disproportionate power wielded by physicians made it easy for them to ignore mothers' perspectives. One key way that physicians did so was by withholding information during interventions; mothers perceived that physicians did not present options, proceeded with procedures without first explaining them, and failed to update mothers about their own or their baby's health – even when mothers explicitly requested such information. These acts of withholding – whether intentional or not – undermined mothers' credibility by implicitly communicating to mothers that physicians did not believe that mothers could be trusted to handle the information. Such an implicit denial of mothers' abilities to handle information rationally and reasonably served to gaslight mothers, as providers' silence led mothers to feel confused, or even afraid, of what was happening. A lack of provider communication shepherded mothers into a feeling of disorientation and surreality, where they could not understand whether they were safe or in danger. For instance, when Emma, a Black mother, had a C-section that took longer than expected without any verbal updates from her physician, she became "afraid like the umbilical cord was wrapped around her [baby's] neck or something going on." Other mothers described how a lack of communication from physicians seeded fear, confusion, and doubt about what was going on.

4.4 Denying mothers' feelings as legitimate

The fourth and final type of denial was that of denying mothers' feelings as legitimate. These denials occurred when mothers' emotions were deemed unreasonable or overblown for the situation. Drawing on longstanding gendered stereotypes, mothers were labeled as hysterical or dramatic and informed that they should be calm or keep composure during situations they experienced as stressful, scary, or upsetting.

Mothers reported this type of denial most often in postpartum care interactions, as mothers were informed that their perceptions of their birth as traumatic was an overreaction or overdramatization of what had occurred. When providers informed mothers that they were overly alarmed by something that was actually normal – when they failed to acknowledge or validate mothers' traumas postpartum – mothers got the message that their feelings were illegitimate. Some mothers reported leaving such interactions wondering if they were in fact to blame for their trauma. For instance, Liz, a white mother, explained that even though she felt pressured into having an induced labor, her providers' denial of her feelings of distress left her assuming responsibility for what had happened: "I took so much blame. I thought, oh if I only would have done this. What would happen if I had done that? […] What if I would have refused to be induced? What would have happened if I asked for more time?" The rendering of her feelings as illegitimate confused Liz into feeling as though the trauma of her birth was in fact her fault.

The inadequacy of postpartum visits further helped drive denials of mothers' feelings as legitimate. Mothers noted that such visits did not adequately inquire about or address their mental health. Mothers reported completing postpartum depression screening questionnaires (ACOG 2018) that neither accurately captured their emotions nor allowed them to fully express their feelings. While the presence of questionnaires suggested that their providers had some interest in mothers' postpartum health, the questionnaires' simplicity and sterility – along with providers' failure to ask appropriate follow-up questions – communicated to mothers that their feelings were not valid enough to warrant real medical consideration. For instance, Yasmeen, a South Asian mother, who managed to truthfully complete her postpartum depression questionnaire, felt that her responses were ignored:

> I would fill these forms out and they would score really high on depression, right, like really high and they would go sit on the folder somewhere. I don't know what the fuck happened to any of them. It is recorded somewhere in [medical institution] that I was scoring as low as you possibly could, and nothing was ever done.

Yasmeen's postpartum depression, anxiety, and PTSD were not diagnosed until a year later when she attempted suicide. Similarly, Leslie, a white mother, described being "given a handout of what to do if you have postpartum depression. I didn't feel like anybody was kind of willing to have that conversation with me." When Leslie tried to discuss her trauma with her doctor, she was directed to the handout, as if to suggest that her feelings were not worthy of her physician's time or consideration. Similar to other instances of mothers being ignored or rendered invisible, such postpartum experiences made mothers feel, for one, that their feelings as human beings were not abnormal and that something was wrong with them. Second, that such routine clinical protocols offered little space for mothers to

share their feelings drove mothers to believe that their mental health was less important – even irrelevant – compared to their physical health, which most postpartum visits were more focused on. That providers were not interested in mothers' feelings – even denying their feelings as worthy of discussion – communicated to mothers that such feelings were unfounded and even a personal failing.

Similarly, when some mothers did speak to their physicians, and expressed their frustration or distress about their traumatic birth experience, physicians dismissed mothers' emotions by explaining "that's just the way things are". For instance, Angela, an East Asian mother, was denied that her birth was traumatic, implying that the trauma was in her head and due to her own emotional instability: "I kind of told [my physician] about a little bit of the trauma, and they just said, 'It happens.'" This discourse normalizing trauma gaslit mothers, making them feel that they were the unreasonable, crazy ones by finding fault with an apparently reasonable, rational system.

5. Discussion and conclusions

In this article, we used traumatic childbirth as a strategic access point to examine mothers' reports of gaslighting by providers. While much research on the abuse and maltreatment of women in obstetric settings alludes to gaslighting, we offer – to the best of our knowledge – the first systematic examination of obstetric gaslighting. In doing so, we make three central contributions.

First, we reveal how gaslighting can operate as a key tactic of obstetric violence often alluded to in discussions of maternal maltreatment, but never named: an underrecognized and underexamined practice of maternal harm. While gaslighting has mostly been examined within the context of intimate relationships, we build directly on scholarship pointing to gaslighting within medical encounters (Sebring 2021) to introduce and lay the foundation for a broader research program on obstetric gaslighting. Our analysis also advances an understanding of gaslighting as a sociological phenomenon, one undergirded and enabled by uneven power dynamics, gender-based stereotypes, deeply ingrained ideologies, and broader structures (Sweet 2019). Our analysis draws attention to how key features of obstetric care, including the medicalization of childbirth and practice of defensive medicine, provide the terrain upon which obstetric gaslighting can flourish. Providers are able to deny mothers' realities because of how much power is vested within physicians and the longstanding tradition of privileging providers' biomedical expertise over patients' lived experiences. That is, obstetric gaslighting is enabled by extant imbalanced power relations within medical encounters that relate to longstanding ingrained notions of medical professionals as rational experts and gendered stereotypes of mothers as hysterical, irrational and untrustworthy. Obstetric gaslighting also widens our understanding of what can constitute gaslighting and the role of intention: institutional pressures to keep labor and delivery efficient, as well as financial incentives and norms related to standard hospital protocols and training, may contribute to providers' unwitting gaslighting of their patients (Savage and Castro 2017; Betron et al. 2018). Thus, we argue that gaslighting functions as a form of structural violence, rather than solely as an interpersonal phenomenon.

Second, by focusing on how gaslighting manifests through four types of denials, we concretely, empirically reveal – in ways that scholars and practitioners can identify and leverage – how to recognize gaslighting's manifestations in obstetric settings. While prior scholarship illustrates how gaslighting operates within intimate relationships, our typology of four types of denials through which gaslighting is mobilized is useful in theorizing *how* gaslighting can manifest in obstetric (and possibly, other medical) interactions. Third and finally, we advance a growing research program on gaslighting in medicine. Indeed, while our examination focused on obstetric gaslighting, our findings align with other scholarship in suggesting that gaslighting extends far beyond obstetrics across healthcare fields and encounters (Ahern 2018; Riggs and Bartholomaeus 2018). Analyses of how gaslighting is deployed across diverse healthcare settings may help scientists better understand other forms of medical discrimination that result in poor health outcomes and disparities. For instance, analyzing how racial gaslighting (A. M. Davis and Ernst 2017) functions as a mechanism of racism in healthcare settings could contribute to efforts of dismantling white supremacy in medicine and reducing health disparities created by racist policies, practices, and interactions.

This study has important limitations. We utilize in-depth interview data, which are useful for understanding perceptions and meaning-making, but are subject to recall and social desirability biases. Our data reveal neither gaslighting's frequency nor prevalence, but rather explore the experiences of gaslighting through mothers' eyes and perspectives; future research should quantitatively investigate gaslighting's frequency, associations and causal impacts on mothers' health and collect ethnographic data to observe and assess gaslighting directly. Our sample was limited socioeconomically (to largely middle- and upper-middle class mothers), geographically (to mothers in the US), and linguistically (to English-speaking mothers). Future examinations of how diverse patient characteristics intersect to render mothers vulnerable to gaslighting are warranted. Most mothers in our sample gave birth within a hospital setting, limiting our understanding of the experiences of mothers who give birth in alternative settings or with midwives as the lead provider. Relatedly, our analysis, focused as it was on creating a typology of obstetric gaslighting's manifestations, did not apply an intersectional lens to examine how gaslighting operated in discriminatory ways to induce additional harm on mothers across race/ethnicity, socioeconomic status, and disability, among other characteristics. For instance, future research should examine how gaslighting operates as a tool of obstetric racism and how it may help drive or exacerbate racial maternal health disparities.

Overall, our findings argue for a shift in the field of reproductive health, including a reorientation toward reproductive justice – the right of women to have true bodily autonomy and choices regarding their right to have or not to have children and parent (Ross and Solinger 2017) – and institutional transformation. While modern medicine has enabled advances in patient care, the medicalization of childbirth and the practice of defensive medicine have also meant a shift away from considering birth as a meaningful, personal life event in which a woman has agency, respect, and security (Lyerly 2013) and as a deeply familial, cultural, and/or spiritual experience. Our study suggests specific systematic changes to maternal care to combat gaslighting. Connecting and insuring mothers with supportive services such as doulas, midwives, and maternity care models such as culturally-centered

birth centers could provide greater support and continuity around childbirth (Hardeman et al. 2020). A practice of soliciting feedback from mothers about their birth should be established, with standard screenings of mothers for gaslighting – drawing lessons from tools like intimate partner violence (IPV) screening (Miller et al. 2015) – informing ongoing obstetric care. Greater awareness and discussion of gaslighting within the obstetric community could aid providers in recognizing when they are falling back on gaslighting tactics in efforts to meet professional demands or norms. Ultimately, a deeper understanding of obstetric gaslighting is key to transforming routine medical practice to recognize mothers' rights to information, decision-making, and dignity.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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- Gaslighting can operate as a key, yet underexamined, strategy of obstetric violence
- Obstetric providers can gaslight mothers when they deny mothers' realities
- Gaslighting includes denials of mothers' humanity, knowledge, judgments or feelings
- All four denials work to render mothers noncredible and their claims illegible

Table 1.

Sample characteristics. N=46.

Individual characteristics	**N**	**%**	**Birth characteristics**[3]	**N**	**%**
Race/ethnicity			Number of children		
White	16	35	1	19	41
Black[1]	11	24	2	18	39
Latina[1]	12	26	3+	9	19
Asian	7	15	Birth timing, years ago		
Highest level of education			<1 year	2	4
High school degree[2]	14	30	1-5 years	32	70
Bachelor's degree or more	32	70	6-10 years	4	9
Household income			>10 years	8	17
<60k	10	22	Birth type		
60-100k	6	13	Vaginal	21	46
101-200k	14	30	C-section	25	54
>200k	16	35	Labor type		
Employment status			Spontaneous	14	31
Full-time	25	54	Augmented	24	52
Part-time	4	9	Induced	8	17
Stay-at-home	14	30	Birth setting		
Student	3	7	Hospital	45	98
Maternal birthplace			Home	1	2
United States	40	90	Birth timing		
Outside United States	6	10	Pre-term (<37 weeks)	10	22
			Full-term	36	78

[1]Includes one mother who identified as multiracial.

[2]Includes mothers with associates/vocational degrees. All mothers had a high school education.

[3]For mothers with more than one traumatic birth, characteristics of the most salient or recent traumatic birth included here.