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Forensic Sense:

Sexual Violence, Medical Professionals, and the Senses

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Abstract

Sexual violence is a pervasive form of abuse. Understanding reactions to sexual abuse requires a critical historicization of medical responses to sexual abuse and the history of the emotions, specifically disgust and shame. This chapter historicizes ways of thinking about sexual harms in modern British and American contexts.

Keywords

Sexual Violence, feminism, medicine, emotions, disgust, shame

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On 12 June 1993, the editors of the *British Medical Journal* (*BMJ*) published a personal account by a male doctor of being sexually assaulted by a colleague. In light of the sensitive nature of the account, the editors took the unusual decision of allowing the victim to remain anonymous. The doctor described how a male medical friend had sexually abused him when they were sharing a hotel room during a medical conference. Although the doctor was angry, he was also ashamed. He fretted about whether he was partly culpable for what had been done to him. After all, he admitted, he had been drinking alcohol and, during the attack, had frozen instead of fighting his abuser. He noted that the attack had left no physical scars; psychologically, though, he was still in turmoil.[1]

A month later, the *BMJ* published a response from psychiatrist Donald John Brooksbank, a senior medical officer in the Department of Health. He advised the upset doctor to contact the voluntary organization Survivors, which had been founded in 1986 to support male victims of sexual assault.[2] SurvivorsUK (as it came to be called) had been established to deal with the fact that male rape was imbued with tremendous shame and stigma but was being ignored by most of

[1] Anonymous, 'Male Rape', *British Medical Journal*, 306, 6892 (12 June 1993), 1620-621.

[2] Donald John Brooksbank, 'Male Rape', *British Medical Journal*, 307, 6899 (31 July 1993), 323.

the specialist assault services (particularly feminist ones) that had been set up to support female victims.[3]

However, not all medical professionals who read the anonymous doctor's harrowing account were sympathetic. The editors of the *BMJ* found themselves having to defend their decision to protect the victim's anonymity, informing readers that 'we accepted that the author might suffer unnecessarily if the article was signed'.[4] But a particularly vicious response came from Stephen Due of the Medical Library at Geelong Hospital in Victoria (Australia). Due began by sneering that the unnamed author 'apparently believes that his self revelations will benefit readers', before suggesting that the doctor's wish to remain anonymous was really because he was ashamed. Due maintained that the doctor's shame was an appropriate response since the letter was a 'sorry tale of childish behavior which reflects no credit on him, for he claims to have been indecently assaulted while in a drunken stupor at an international conference.' The *BMJ* was beginning to read 'like a lonely hearts club', Due complained, adding that 'sordid personal confessions add nothing to our understanding of a subject, but they do demean a scholarly, professional journal'.[5]

These 1993 exchanges between an anonymous doctor, a kindly psychiatrist, the editors of the journal published by the prestigious British Medical Association, and an unforgiving medical librarian address some of the themes of this chapter. These include the role of medical

[3] Michael King, 'Male Rape. Victims Need Sensitive Management', *British Medical Journal*, 301, 6765 (15 December 1990), 1345.

[4] The Editors, 'Anonymity in the BMJ', *British Medical Journal*, 307, 6899 (31 July 1993), 323.

[5] Stephen Due, 'Anonymity in the BMJ', *British Medical Journal*, 307, 6899 (31 July 1993), 323.

professionals in debates about sexual violence, contested understandings about the emotional aftereffects of sexual abuse, anxieties about the gendered nature of assault (particularly when it involved male victims), victim culpability, and the powerful impact of shame on victims. Such issues would resonate with millions of people worldwide. The statistics are startling. In times of societal conflict, sexual violence against women, girls, men, and boys routinely reach extreme levels.[6] But even in those societies that only rarely experience war on 'home soil' (and these are the societies I will be focusing on in this chapter), levels of sexual abuse are high. For example, according to Rape Crisis, in England and Wales today, 11 people are raped every hour, affecting approximately 85,000 women and 12,000 men; another half a million adults are sexually assaulted.[7] In the US, 33 residents over the age of 12 are raped and sexually assaulted every hour. That makes 288,820 legally acknowledged victims annually.[8] These figures do not include the millions of victim-survivors who never report their assault.

Understanding reactions to sexual abuse requires a critical historicization of medical responses to sexual abuse and the historization of the emotions. I will do this in the context of British and American discourses from the late nineteenth century to the 1980s. Historical framings of sexual violence has tended to focus on important questions of law enforcement, legal outcomes,

[6] See discussions in Raphaelle Branche and Fabrice Virgili (eds.), *Rape in* Wartime (Basingstoke 2012); Elizabeth D. Heineman (ed.), *Sexual Violence in Conflict Zones. From the Ancient World to the Era of Human Rights* (Philadelphia 2011); Gaby Zipfel, Regina Mülhäuser, and Kirsten Campbell (eds.), *In Plain Sight. Sexual Violence in Armed Conflict* (New Delhi 2019).

[7] Rape Crisis England and Wales, at https://rapecrisis.org.uk/get-informed/about-sexual-violence/statistics-sexual-violence/, viewed 10 December 2019.

[8] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *National Crime Victimization Survey, 2010-2014* (Washington DC 2015).

and public responses. The public health dimensions have been neglected, which is significant given that only a small proportion of abuses then (as well as now) are ever reported to the police, let alone reach the courts. As a result, the negative health outcomes for victim-survivors who remain silent about their experiences of violation is an important topic of enquiry. This chapter will argue that an analysis drawing on the history of the emotions can illuminate some of the harms of sexual violence. In particular, I will focus on the complex emotion of shame and cognate feelings and experiences, exploring its situated constructions and meanings in relation to a neglected field of power: that is, the pivotal role played by medical discourses in the production of victim-shame. Although many of these arguments are relevant to the experience and treatment of rape victims today, this chapter focuses on the late nineteenth century to the 1980s, the period before the dramatic (although, in retrospect, ineffectual) revisions of legal procedure and introduction of feminist-led crisis interventions. The first section begins by examining ways that physicians have contributed to the shaming of victims. Medical and forensic textbooks used by police surgeons, hospital physicians, and other medical examiners are saturated with shaming tropes. I ask why even medical professionals who are sincerely dedicated to caring for ailing and distressed people, and who are also accustomed to visceral sights that untrained observers usually find upsetting, might respond negatively to victims of sexual abuse. In caring for victim-survivors of sexual abuse, why have medical professionals been complicit in shaming practices?

The second section directly addresses the experience of shame for victim-survivors themselves. Given that they are not responsible for the abuse perpetrated against them, why do so many victim-survivors report feeling high levels of shame? How can we understand the embodiment of victim-shame?

Language needs to be addressed first, however. The words used to write about sexual harms is complicated. In this chapter, I use concepts like rape, sexual violence, sexual assault, and sexual abuse interchangeably. This is only a shorthand way of referring to a range of harms. It is not intended to imply that these acts are identical; nor that there is a continuum in seriousness, starting with emotional hurt and ending with sadistic violence. I am not concerned with the hierarchies of harms that pervade legal texts and public discussions (for example, notions that physical harms are 'worse' than psychological ones or that women can be 'raped' while men are 'assaulted'). Rather, I seek to draw attention to the unique context and quality of suffering for each victim-survivor for whom the physical and psychological are emmeshed. I also use concepts like 'victim' and 'survivor' cautiously. The term 'survivor' is anachronistic for much of the period I am writing about but, in general, the term 'victim-survivor' is helpful.

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There is a sophisticated literature on why victim-survivors of rape are reluctant to report their abuse to the authorities and, when they *do* go public, on their discriminatory treatment by law enforcement agents (who routinely 'no-crime' or 'unfound' complaints) and by court systems (where jurors and judges fail to convict all but a tiny proportion of offenders).[9] Given these failures,

[9] This is a huge literature. In the British context, see Liz Kelly, Jo Lovett, and Linda Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases: A Home Office Research Study* (London 2005); Jennifer Temkin and Barbara Krahé, *Sexual Assault and the Justice Gap: A Question of Attitude* (Oxford 2008); Jennifer Temkin, *Rape and the Legal Process* (Oxford 2002).

exploring the significant health outcomes for the vast majority of victim-survivors whose accounts of abuse remain unheard is imperative.

It is well known that the harms caused by sexual abuse are legion. They include physical injuries, sexually transmitted infections, unwanted pregnancies or parturitions, and psychiatric illnesses. Even those victim-survivors who do not suffer such harms routinely report experiencing debilitating and painful emotions. The most shattering to their self-esteem is shame, which is complex, multi-formed, and contextually contingent. It is thus an often elusive emotion. Clinical observations and empirical evidence, together with first-person accounts of extreme forms of abuse (such as sexual assault or torture), testify to high levels of personal and social shame.[10]

[10] This is evident in first-person rape accounts. For medical literature about sexual abuse and shame, see Bernice Andrews, Chris R. Brewin, Suzanna Rose, and Marilyn Kirk, 'Predicted PTSD Symptoms in Victims of Violent Crime: The Role of Shame, Anger, and Childhood Abuse', *Journal of Abnormal Psychology*, 109, 1 (2000), 69-73; Bolanle Akinson and R. Nicholas Pugh, 'Patients' Perspective is Also Important', *British Medical Journal*, 324, 7350 (8 June 2002), 1397-398; Jonathan I. Bisson, Sarah Cosgrave, Catrin Lewis, and Neil P. Robert, 'Post Traumatic Stress Disorder', *British Medical Journal*, 351 (14 April 2007), 789-93; T. J. Gerrald and J. D. Riddell, 'Difficult Patients: Black Holes and Secrets', *British Medical Journal*, 297, 6647 (August 1988), 530-32; Paul Gilbert and Beatrice Andrews (eds), *Shame: Interpersonal Behavior, Psychopathology, and Culture* (New York 1998); Sir Basil Henriques, 'A Magistrate's View', *British Medical Journal*, 2, 5267 (16 December 1961), 1629-30; Tessa Richards, 'Medicine and the Media', *British Medical Journal*, 289, 6458 (8 December 1984); Jan Welch and Fiona Mason, 'Rape and Sexual Assault', *British Medical Journal*, 334., 604 (2 June 2007), 1157. For other empirical studies, see Emily J. Ozer, Suzanne R. Best, Tami L. Lipsey, and Daniel S. Weiss, 'Predictors of Posttraumatic Stress Disorder and Symptoms in Adults: A Meta-Analysis', *Psychological Bulletin*, 129, 1 (2003), 52-73; Angela Ebert and Murray J. Dyck, 'The

Victim-survivors often refer to feeling culpable and dishonoured. Indeed, feelings of shame are central to many of the *other* harms inflicted by sexual violence. Shame is entangled with powerful feelings, such as sadness, anxiety, or self-hatred. It contributes to destructive behaviours, including sexual and social dysfunction, drug and alcohol abuse, and self-harm. The emotional distress of the anonymous doctor with whom I started this chapter was typical. He was troubled by an overwhelming sense of shame for what happened to him. Despite being intellectually aware that any feelings of shame rested solely with his attacker, he nevertheless felt culpable. After subtly questioning whether the assault had even taken place ('he *claims* to have been indecently assaulted'), the judgmental interlocuter explicitly contended that the anonymous doctor *should* be ashamed, not only for drinking alcohol and failing to fight off his abuser but also for daring to publicize his 'sordid' tale. The anonymous doctor summoned up emotional and professional resources to make his abuse known to others but, for most victim-survivors, shame was the main reason they were reluctant to report their experiences.

There is a huge corpus of research documenting the numerous ways that victim-survivors of sexual harms are led to feel ashamed. In *Rape: A History from the 1860s to the Present*, I argue that today, as in the past, every-day knowledges, including institutional ideologies and practices within law enforcement, judicial systems, and the mass media, attack the self-esteem of victims. Powerful 'rape myths' (including 'no means yes', 'it is impossible to rape a resisting woman', 'women make false accusations', 'no wound, no rape', and 'many kinds of forced sex are not really rape') ensure that victims of sexual violence struggle to make their voices heard, let alone believed.[11] Sexually

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Experience of Mental Death: The Core Features of Complex Posttraumatic Stress Disorder', *Clinical Psychology Review*, 24 (2004), 617-35.

[11] See my *Rape. A History from the 1860s to the Present* (London 2007).

abused boys and men face further hurdles. Shouldn't they have been capable of fighting off any attacker? Are they consciously or unconsciously gay? Are they 'real' men anyway?

I will not repeat these issues. Instead, I turn to the contributions made by medical discourses to the shaming of victim-survivors. Textbooks in medical jurisprudence are influential in propagating 'rape myths' that attack the esteem of complainants. These texts became increasingly important from the end of the eighteenth century, starting a process that resulted in the declining role of midwives and local women in medically helping girls and women who had been sexually molested. Male physicians rapidly became the 'experts' responsible for examining the bodies of victims, assessing their states of mind, and adjudicating on their claims. As part of this process, the professional field of medical jurisprudence was introduced and grew in status. By the mid-nineteenth century, all countries in western Europe and all states in the U.S. had introduced medical jurisprudence courses in universities. Elsewhere, I have discussed the ways textbooks on medical jurisprudence routinely disparaged women's complaints of sexual assault.[12]

Less frequently analyzed is the role of everyday medical practitioners – especially police surgeons and forensic medical examiners – in promoting practices that shamed people who reported having been abused. These medical professionals shared knowledges concerning how to judge 'true' violation. Because they were seen by the police, courts, the media, and indeed complainants themselves as providing 'objective' knowledges based on a comprehensive, reproducible analysis of the body, their judgements of victim-survivors of sexual abuse were prescriptive, not merely descriptive. In other words, for a woman's complaint to be taken seriously,

[12] See my *Rape. A History from the 1860s to the Present* (London 2007).

victim-survivors were required to comport themselves according to a script that was composed and policed by physicians and other medical professionals.

Medical examiners were taught to cast a formal, forensic eye on complainants' body language. Were they acting like 'innocent' victims of sexual assault, or might they have 'precipitated' their own assault? Did complainants look strong or physically fit? Were there signs that they vigorously resisted? Surely 'true' victims would have visible lesions and bruising to corroborate their accounts? As one commentator quipped in 1967, 'a woman can run faster with her skirt up than a man can with his pants down'.[13] Previous sexual experience was also used to shame victim-survivors: 'it's not been the first time, has it?', asked one medical examiner.[14] Wearing sexy clothes or hitchhiking was condemned as risky behavior that made victim-survivors at least partly culpable. Might they be unconsciously inviting abuse? This was the view of forensic expert Charles G. Wilber. Writing in 1974, he criticized the 'patterns of behavior, deportment, and dress' of the 'healthy, adult, sexually mature girl… in our modern society'. Such young women 'consciously or subconsciously stimulate a rape response in the susceptible male'. Of course, he hurriedly added, he did not want to 'justify the serious invasion of the personal integrity of one person by another through the crime of rape'. Nevertheless, he contended, 'it is a fact that many kinds of modern female dress do, in fact, present an image which can trigger the rape response in the susceptible type of male'.[15]

[13] R. McCaldon, 'Rape', *Canadian Journal of Corrections*, 9 (1967), 39.

[14] Barbara Toner, *The Facts of Rape*, revised, 1st 1977 (London 1982), 176.

[15] Charles G. Wilber, *Forensic Biology for the Law Enforcement Officer* (Springfield, Ill. 1974), 209.

These are not isolated examples. Medical professionals were *taught* to draw inferences about the veracity of assault from the comportment of complainants. The 1978 Royal Commission on Criminal Procedure, for example, instructed physicians to note 'the method of undressing' of the victim. They were advised to observe the 'general appearance and demeanour of the victim', including any 'eccentricity of dress and use of cosmetics'. They should ask themselves, 'Is the woman a shy retiring child, or is she a professional stripper?'[16] In 1974, Irving Root, Wendell Ogden, and Wayne Scott issued similar instructions in their article entitled 'The Medical Investigation of Alleged Rape'. Police surgeons should question whether 'the emotional attitude or affect of the patient' was 'appropriate or inappropriate to the history and physical findings?' They maintained that the complainant's comportment was important for police surgeons since victims would have already undergone 'extensive, pointed, and often embarrassing questioning before and after the medical examination'. This would have been a 'very traumatic and emotional ordeal' for any 'innocent' complainant. Therefore, 'if the woman appears to be distraught, emotionally upset or frightened', this increased the likelihood that the rape actually happened. 'Conversely', they continued, 'a casual or almost nonchalant attitude after an alleged vicious and forcible attack might cause some doubt about the truth of the history'.[17]

It might be argued that such suspicions about the post-rape behaviour of victim-survivors would have declined with the increasing acceptance of Rape Trauma Syndrome (RTS) and Post-Traumatic Stress Disorder (PTSD) from the 1970s onwards. After all, nurse Ann Wolbert Burgess and sociologist Lynda Lytle Holmstrom had invented RTS in 1974 precisely to teach medical professionals that victims responded in a huge variety of ways to rape. Some were 'hysterical' and

[16] *Rape, Police, and Forensic Practice* (London 1978).

[17] Irving Root, Wendell Ogden, and Wayne Scott, 'The Medical Investigation of Alleged Rape', *Western Journal of Medicine*, 120 (April 1974), 331.

teary while others maintained an emotionally blank calm, at least outwardly. It was not uncommon to hear victims nervously laughing. Many delayed reporting having been assaulted for days, weeks, even years. Crucially, Burgess and Holmstrom noted, all these responses were 'normal'.[18] By the 1980s, the varied ways that victim-survivors behaved after rape was widely acknowledged. However, the replacement of a 'trauma script' for the previous 'distress script' brought its own forms of shame. Diagnoses of RTS or PTSD did help victim-survivors understand why they reacted in contrary ways to their abuse, but it also retained the focus on the behaviours of victims while also characterizing them as suffering from a mental illness. As educationalists Corrine C. Bertram and M. Sue Crowley explain, 'labelling is not a socially neutral process'. Victim-survivors of sexual abuse

> may prefer to avoid health-care and counselling services after experiencing sexual violence, since survivors may perceive these institutions not as sources of help or advocacy, but as locations of blame and additional trauma.[19]

The ways in which medical services might be experienced as part of the 'bad event' itself – rousing self-blame, for example – will be explored shortly.

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[18] Ann Wolbert Burgess and Lynda Lytle Holmstrom, 'Rape Trauma Syndrome', *American Journal of Psychiatry*, 981 (1974), 981. For a detailed analysis, see my 'Sexual Violence, Bodily Pain, and Trauma: A History', *Theory, Culture and Society*, 29, 3 (May 2012), 25-51, open access at PMC 40012.

[19] Corrine C. Bertram and M. Sue Crowley, 'Teaching About Sexual Violence in Higher Education: Moving from Concern to Conscious Resistance', *Frontiers: A Journal of Women's Studies*, 33, 1 (2012), 67.

These professional procedures and practices meant that victim-survivors routinely reported feeling shame, anger, and distress. In 1983, for example, Gerry Chambers and Ann Millar conducted a survey of rape complainants. They found that 42 per cent made negative comments about their treatment by police surgeons and an additional 18 per cent gave mixed positive and negative views.[20] Typical complaints included the painful nature of the examination, the amount of time they had to wait prior to the examination, inadequacies with the room, the unavailability of a female doctor, and the lack of privacy. Some even objected to the fact that male police officers were allowed to sit behind a screen in the medical room during their examination. Women described how their clothes had been taken away, but they were not given alternative garments. Police surgeons were described as 'insensitive', 'unsympathetic', and 'abrupt'. Victims were upset that the collection of samples and the tests took precedence over the treatment of their injuries. They resented being questioned about whether they had resisted sufficiently. One complainant was even asked if she enjoyed it. 'It was as if I was on the slab in the morgue', said another.[21] In other words, the forensic examination was experienced as part of the rape 'event' itself. In *The Story of Pai*n (2014), I argue that it is useful to distinguish between *what* is experienced and the *way* people experience something. Distress is a manner of feeling or a way of perceiving an experience. It is practiced within relational, environmental contexts. For victim-survivors, the forensic

[20] Gerry Chambers and Ann Millar, *Investigating Sexual Assault. A Scottish Office Social Research Study* (Edinburgh 1983), 99.

[21] Gerry Chambers and Ann Millar, *Investigating Sexual Assault. A Scottish Office Social Research Study* (Edinburgh 1983), 100-1. This was also the conclusion drawn by Robley Geis, Richard Wright, and Gilbert Geis, 'Police Surgeons and Rape: A Questionnaire Survey', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain*, 14 (October 1978), 7-14 and reprinted in the journal (October 1984), 56-66.

examination is evaluated in the context of the rape itself: it becomes part of the pain they experienced.[22]

This point was acknowledged by the London Metropolitan Police. In 1991, they carried out their own survey. Although one third of all reported rapes in England and Wales took place in the Metropolitan Police district and the Metropolitan police offered training in the medical examination of rape victims, nevertheless, the survey concluded that 'many of the police surgeons who examine rape victims, though professionally competent, are unsympathetic'.[23] Forty per cent of women surveyed who had reported their rape to the police complained that the doctors who examined them had acted in ways that lacked sympathy.[24]

How can we explain the propensity of physicians and other medical professionals to engage in practices that shamed victim-survivors? Obviously, their training in medical jurisprudence, with its pervasive hostility to and mistrust of female complainants, was one reason. But there were others. First, police surgeons were uniquely sensitive to being falsely accused of sexually abusive actions. Unlike other professionals, medical personnel are regularly required to have intimate contact with the sexual organs of strangers. From their first year in medical school, they had been schooled in the risk of false accusations of sexual assault and they were advised to

[22] Joanna Bourke, *The Story of Pain: From Prayer to Painkillers* (Oxford: Oxford University Press, 2014), introduction.

[23] Caroline White, 'Police Surgeons are 'Unsympathetic' to Rape Victims', *British Medical Journal*, 303 (20 July 1991), 149.

[24] Caroline White, 'Police Surgeons are 'Unsympathetic' to Rape Victims', *British Medical Journal*, 303 (20 July 1991), 149.

always have a chaperone present when conducting intimate examinations. All would have been aware of cases where fellow practitioners had been (falsely or not) accused of sexually abusing their patients. They were particularly susceptible, therefore, to believing the most powerful of all the rape myths: 'women lie'.[25]

Second, police surgeons were immersed in police culture. This includes a generalised suspicion towards people seeking their services, an awareness of the need to seek collaboration for any witness testimony, and a greater familiarity with aggression than most people, especially girls and women, which make them less sensitive to how others might respond to displays of belligerence. In this period, the job of police surgeon was a highly masculine one. As late as 1985, the Medical Women's Federation found that the ratio of female to male police surgeon was a dismal 1 to 7.5.[26] They were also more distanced than most physicians from the usual patient-doctor dynamics. After conducting the medical examination, police surgeons rarely saw the victims again. Victim-survivors almost never became part of their regular medical practice, which meant that physicians were ignorant about their families and communities as well as not being required

[25] For an extended discussion, see my 'Police Surgeons and Victims of Rape: Cultures of Harm and Care', *Social History of Medicine*, 31, 4 (November 2018), 679-87, at http://doi.org/10.1093/shm/hky016.

[26] 'Are Doctors Trained to Deal with Rape?', *British Medical Journal*, 2291 (7 December 1985), 1655.

to forge longstanding duties of care towards them. Victim-survivors were not really conceived of as 'patients'.[27]

These explanations for the failure of medical professionals to exercise more than an abstract, professional variety of sympathy towards the victims they examined contributed to the shaming of rape complainants. But they are insufficient. In order to understand why medical professionals who were sincerely dedicated to caring for ailing and distressed people might respond negatively to victims of sexual abuse, we need to turn to the history of the emotions. In the historiography on sexual violence, the emotional lives of medical professionals have been ignored. There is abundant evidence that many medical professionals disliked examining rape victims. As Wilber frankly admitted in 1974, physicians were 'openly hostile to the idea of becoming involved in a rape case' and their hostility 'extends to their resistance to examining a rape victim'.[28] In the early 1980s, one survey found that physicians and hospital workers believed that working with rape victims was 'dirty' and 'beneath dignity'.[29] Interviews with over 200 professionals who dealt with victim-survivors in 130 organizations in Florida between 1983 and 2004 also showed that there was considerable distaste for the work.[30] In other words, despite the

[27] Patricia Yancey Martin, Douglas Schrock, Margaret Leaf, and Carmen Van Rohr, 'Crisis Work. Rape Work: Emotional Dilemmas in Work with Victims', in Stephan Fineman (ed.), *The Emotional Organization. Passions and Power* (Oxford 2008), 54.

[28] Charles G. Wilber, *Forensic Biology for the Law Enforcement Officer* (Springfield, Ill. 1974), 203.

[29] Lynda Lytle Holmstrom and Ann Wolbert Burgess, *The Victim of Rape. Institutional Reactions*, revised ed., 1st 1978 (New Brunswick 1983), 64.

[30] Patricia Yancey Martin, Douglas Schrock, Margaret Leaf, and Carmen Van Rohr, 'Crisis Work. Rape Work: Emotional Dilemmas in Work with Victims', in Stephan Fineman (ed.), *The*

fact that intimate examinations of vaginas and anuses are common practice in medical contexts, the rape exam was regarded as something different. In the words of one male Chief Resident of a hospital obstetrics/gynaecology ward, rape cases

> make us all uncomfortable…. I always had a feeling when I walked into the victim's room that I was not wanted, needed maybe… but not wanted. I felt like I was an intrusion at a very sensitive time. We all dislike the rape exam; it's a distasteful time.[31]

It was a telling statement, registering both an acknowledgement that he was dealing with a distressed person who might resent and fear his Intrusion", as well as his own feelings of helplessness in overcoming his own emotions and those of his patients. Rape victim-survivors could not help but register the reluctance of medical professionals to 'deal with' them.

One way to approach this question is to note that the medical professional not only *has* a body, she or he *is* one, to paraphrase Merleau Ponty.[32] As with shame (which I will be turning to soon), disgust is a social emotion. It is a culturally constituted and socially inscribed reaction to the

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Emotional Organization. Passions and Power (Oxford 2008), 53-4. Also see P. Y. Martin and D. DiNitto, 'The Rape Exam', *Women and Health*, 12 (1987), 5-28.

[31] Cited in Patricia Yancey Martin, Douglas Schrock, Margaret Leaf, and Carmen Van Rohr, 'Crisis Work. Rape Work: Emotional Dilemmas in Work with Victims', in Stephan Fineman (ed.), *The Emotional Organization. Passions and Power* (Oxford 2008), 54.

[32] Maurice Merleau-Ponty, *Phenomenology of Perception* (London 2002), np (Part 1).

perception of contamination. The doctor's disgust was powerful because the rape victim was perceived as a threat or pollutant. Rape complainants often arrived in a disarranged state. They were typically distraught, stained with blood and semen, and barely able to make consistent statements. Many were considered to be the 'dregs of society': drunks, prostitutes, and other 'unsavoury' characters. The abused child was too knowledgeable about sex; the raped girl, a seductress; the sexually assaulted older woman, a fantasist who was going through the 'climacteric'. In all cases, cultural anxieties about the boundaries between good/bad, men/women, and self/other needed to be policed. It was no coincidence that one of the few other instances where medical professionals openly expressed disgust was in response to intersex children, that is, another category of patient who blurred boundaries.[33]

Of course, it is important to note that disgust was not an attribute of the victim-survivor but was a response or projection of *another* person. In addition, medical professionals might cognitively know that their disgust response was inappropriate and unfair to victim-survivors. But despite being aware that they should feel no more disgust with the victim than they would for any suffering person, they still felt it. As we will see in the next section, this disengagement between cognition and feelings was mirrored in the emotional lives of victim-survivors and their shame.

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[33] Ellen K. Feder, 'Tilting the Ethical Lens: Shame, Disgust, and the Body in Question', *Hypatia*, 26, 3 (summer 2011), 633-50.

This final section turns to the various ways that victims embodied shame. In the last section, I explored certain medical norms, values, and practices that might have *incited* shame in victim-survivors. Although they may have noticed that medical examiners recoiled from their bodies, it is still not at all clear why victim-survivors might have felt *shame* (as opposed to embarrassment or anger, for instance)? What explains the paradox that victim-survivors might *intellectually* have known that responsibility lay solely with the agent of harm and they might have consciously resisted the shaming eye of medical examiners – but were nevertheless ashamed? What does the politics of shame contribute to the harms of sexual abuse?

The gendered element of the recent history of shame that makes it of particular interest to scholars exploring the emotional lives of victim-survivors of sexual abuse. When looked at through the lens of sexual violence, many philosophical explanations for shame are highly problematic. Arguments that shame is about policing propriety or that it is an 'enforcer of proper behavior'[34] are unconvincing: after all, given the widespread condemnation of sexually violent men, why do victim-survivors report feeling ashamed immeasurably more frequently than those who offended against them? Evolutionary approaches also stumble when attention is turned to the shame of victim-survivors. For example, humanities scholar Jörg Wettlaufer contends that shame is a 'universal, pan-human emotion' that 'has been selected as part of evolution and thus is a functional adaptation'. He claims that shame 'is elicited by behaviour that is deemed inappropriate in terms of in-group norms'. It 'only works', he insists, 'if everyone agrees on the norms and if the culprit [sic] identifies themselves with the norms of the group'.[35] Of course, Wettlaufer did not have rape victims in mind when he wrote these words nor was he concerned with other communities who report systemic feelings of shame, such as survivors of the holocaust or other atrocities. However,

[34] Eve Kosofsky Sedgwick, 'Queer Performativity: Henry James's *The Art of the Novel*', *GLQ*, 1, 1 (1993), 6.

[35] Jörg Wettlaufer, 'The Shame Game', *RSA Journal*, 161, 5564 (2015), 36 and 39.

such an explanation cannot address the lived experience of victim-survivors of rape, unless one adopts the view of some evolutionary psychologists that rape is an evolutionary adaptation and the rape victims really *are* partially culpable.[36]

Feminist approaches provide more productive tools to think about shame and why victim-survivors might feel it. Many feminist philosophers point to the fact that people are constituted through interactions with other people, objects, and institutions. Rather than being a personal or private emotion, shame is fundamentally a *social* response to being-in-the-world: it is an inter-relational response to societal values and practices. It is not about what a person has done (which, as Helen Block Lewis argues, is more like guilt),[37] but about how victim-survivors believe *other* people think about them. This way of thinking about shame offers a powerful critique of the liberal view of shame as an *individual* response to having not lived up to ideals that the shamed person agrees with. As ethicist Elisa A. Hurley explains,

> When who we are is partly determined by others' treatment of us and, more specifically, by the evaluations and interpretations of us implicit in their treatment, then the contingency in the relationship between shaming treatment of us and our shame, presupposed by the liberal view, dissolves.[38]

In other words, a relational approach draws attention to the link between 'shaming treatment' and an individual's feeling of being shamed. It insists on the importance of the social contexts in which

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[36] Randy Thornhill and Craig T. Palmer, *A Natural History of Rape: Biological Bases of Sexual Coercion* (Cambridge Mass. 2000).

[37] Helen Block Lewis, *Shame and Guilt in Neurosis* (New York 1971), 30.

[38] Elisa A. Hurley, 'Pharmacotherapy to Blunt Memories of Sexual Violence: What's a Feminist to Think?', *Hypatia*, 25, 3 (summer 2010), 536.

shaming ideologies and practices take place, or what philosopher Sandra Bartky calls the 'condition of dishonor' that 'is woman's lot in a sexist society'.[39] Accordingly, shame is not a personal attribute, but a social emotion that is deeply rooted in historical time, geographical place, and a myriad of institutional regimes of power.

Although this approach takes as its focus the diminished lives of women within patriarchal societies, it remains important to acknowledge the vulnerabilities of all bodies. This was one reason why I started this chapter by exploring the experiences of a white, middle-class man. Shame is refracted through people's multiple, intersectional selves, which includes a wide range of genders, races, ethnicities, religions, sexual orientations, ages, generations, and so on. It is inequitable in its distribution, since it is inculcated through relations of domination, including sexism, racism, colonialism, and economic inequalities. As Ann Cvetkovich explains in *An Archive of Feelings* (2004), 'sexual trauma seeps into other categories' of oppression.[40] Although common, shame is a particularly strong emotion amongst socially subordinate groups.[41]

A person's intersectional identities are also influential in framing *responses* to shaming ideologies and practices. Theorists like Jennifer C. Manion believe shame can be a positive emotion, encouraging reflection in the shamed person and thus enabling her to reevaluate her life

[39] Sandra Bartky, 'Shame and Gender', in her *Femininity and Domination: Studies in the Phenomenology of Oppression* (New York 1990), 85.

[40] Ann Cvetkovich, *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Cultures* (Durham 2004), 36.

[41] Helen B. Lewis, *Shame and Guilt in Neurosis* (New York, 1971) and Frantz Fanon, *Black Skin, White Masks* (Oxford 1967).

and principles.[42] However, most subordinated peoples do not have access to the personal, emotional, and financial resources that would enable such transformations.[43] They are less able to reject external evaluations of their worth, especially when those assessments take the form of systemic degradation. In the words of Ullaliina Lehtinen in her article 'How Does One Know What Shame Is?', too much of the literature assumes 'the moral agent is autonomously free' and is fortunate enough to either 'internalize or to defy the episodic dis-esteem and de-valuation'.[44] Privileged persons might be able to reflect on their shame, transforming it into a moral tale; for the underprivileged, it is either a confirmation of their lowly status or a pervasive, corroding affect. This is not to imply that shaming behaviours cannot inflict serious harm on white, young, elite, western men, such as the anonymous doctor with whom I started this chapter. But it is to draw attention to a range of different responses to shame. After all, this deeply shamed doctor was able to persuade the editors of the prestigious *British Medical Journal* to publicize his experiences and ensure that his identity remained secret. This did not prevent those same editors from also publishing Stephen Due's shame-endorsing letter in a later edition.

This approach to shame helps explain the common paradox that a person might *feel* shame yet intellectually know that she or he has done nothing to warrant *being* ashamed. There is a term for the kind of shame that a person *feels* despite his or her beliefs conflicting with those feelings: it is called 'recalcitrant shame'.[45] Again, this was experience of the anonymous doctor who

[42] Jennifer C. Manion, 'Girls Blush, Sometimes: Gender, Moral Agency, and the Problem of Shame', *Hypatia*, 18, 3 (2003), 21-41.

[43] See Kathleen Woodward, 'Traumatic Shame: Toni Morrison, Televisual Culture, and the Cultural Politics of the Emotions', *Cultural Critique*, 46 (autumn 2000), 210-40.

[44] Ullaliina Lehtinen, 'How Does One Know What Shame Is?', *Hypatia*, 13, 1 (winter 1998), 62.

[45] For discussions, see Justin D'Arms and Daniel Jacobson, 'The Significance of Recalcitrant Emotion', *Royal Institute of Philosophy Supplement*, 52 (2003), 127-45 and Heidi L. Maibom,

maintained that he was not responsible for his own abuse but nevertheless felt ashamed for having been victimized. There are several ways to explain this paradox, including claims that victim-survivors of sexual abuse had internalized a self-hating message (and were suffering from false consciousness), were being irrational (and therefore need to realign their cognitive understandings with their emotional responses), or were neurotic (and required treatment). An understanding of shame as inter-relational – a social practice – leads to a rejection of such victim-blaming explanations. Crucially, a relational approach does not assume that a person must *share* the values of the Other in order to feel ashamed. Victim-survivors don't have a free-hand in choosing the witnesses who can make them feel ashamed, notes philosopher Cheshire Calhoun. All that is needed is that they feel that other people, with whom they share social spaces and moral practices, are disparaging them.[46] Gender scholar Liz Constable concurs, adding that shame is not something 'inner' or intra-psychic since to feel shamed 'is *already* to have encountered others' values and principles, and to have sensed the force and forms of their affective articulation'.[47] Shame is constituted within historical times, geographical places, and the full range of communities in which the shamed person cannot help but be emmeshed.

The emphasis on shame as a social emotion allows for the separation of the feeling of shame from the endorsement of harmful belief systems based on prejudices such as misogyny, racism, and homophobia (to name just three). This is why ideologies and practices that devalue victims can have devastating consequences even when a person might intellectually reject their fundamental premises. Shame *reveals* a person's felt experience in a world not of her own making.

'The Descent of Shame', *Philosophy and Phenomenological Research*, 80, 3 (May 2010), 566-94

[46] Cheshire Calhoun, 'An Apology for Moral Shame', *The Journal of Political Philosophy*, 12 (2004), 127-46.

[47] Liz Constable, 'Introduction – States of Shame', *L'Esprit Créateur*, 39, 4 (winter 1999), 6.

There is another way to express this: shame is part and parcel of the process of constituting women and other denigrated people *as* subordinate and dis-respected. Philosopher Robin S. Dillon explores the 'multiple layered' frameworks that women employ in their attempts to make sense of the world. These frames 'shape conscious experience and can conflict with avowed beliefs and judgments without themselves being explicitly represented in or even representable to the individual'. To the extent to which these structures of meaning are invisible, a person's 'understanding is resistant to modification through reflection, criticism, or reconceptualization'.[48] Some of these commonplace, free-floating, and sometimes invisible discourses and practices include those 'rape myths' mentioned earlier, especially ones that contend that rape-survivors precipitated their own abuse or were 'asking for it'.

Rather than individualizing shame, acknowledging the often obscure yet harmful frameworks of meaning offered to groups within societal contexts draws attention to the historical and institutional structures that create shame. This strengthens critiques of the liberal, individualizing notions of shame that remain welded to ideas of pathology, dissonance (such as between a victim-survivor's cognition and emotions), and irrationality. As Elisa A. Hurley explains,

> When rape is an integral part of a system of oppressive social practices that uphold the subordination of women to men, then, in that society, a woman's experience

[48] Robin S. Dillon, 'Self-Respect: Moral, Emotional, Political', *Ethics*, 107, 2 (January 1997), 240. I have silently corrected the typo 'multiply' to 'multiple'.

> of shame in response to being raped starts to look not only psychologically understandable and unsurprising, but reasonable and, indeed, appropriate.[49]

Dillon takes this argument further, contending that the 'divergence of emotions and beliefs' is simply a mirror image of the 'ambiguities in the sociopolitical valuings of women', including the 'contradictions between the official story of equality and the devaluation actually instantiated in the myriad circumstances of women's lives'. She devastatingly concludes that women 'believe that they are supposed to believe about themselves, but they also feel what they are supposed to feel'.[50] The victim-survivor of rape dwells in social worlds that convey the message that she is esteemed while making her feel the opposite.

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The shame-making world is not inevitable. It can be changed, in part because victim-survivors are not wholly constituted by violence. Shame bears witness to injustice and, like anger and contempt, can be employed in political ways. Shame is a particularly powerful emotion because it is constructed in societal contexts that deny the pervasiveness of sexual harms. In other words, victim-survivors feel ashamed because the silence around victimization conveys the message that they are not like other, more 'normal' people. This feeling of invisibility makes them reluctant to

[49] Elisa A. Hurley, 'Pharmacotherapy to Blunt Memories of Sexual Violence: What's a Feminist to Think?', *Hypatia*, 25, 3 (summer 2010), 537.

[50] Robin S. Dillon, 'Self-Respect: Moral, Emotional, Political', *Ethics*, 107, 2 (January 1997), 247.

speak about their experiences and more likely to assume that others hold them in lower regard because of their abuse. As Sedgwick argues, shame is a feeling 'whose very suffusiveness seems to delineate my precise, individual outlines in the most isolating way possible'.[51] In contrast, publicizing the extent of sexual abuse in our societies conveys the message that victim-survivors are everywhere. It creates a visibility that makes the internalization of the values of harm-supporters less likely. As Amanda Holmes argues in an article entitled 'That Which Cannot be Shared: On the Politics of Shame' (2015), shame

> seems to dissipate when it is made public or when it is shared. That is, the negative and isolating qualities that are constitutive of the affect of shame are negated when it is confessed. To confess one's shame is to destroy it.[52]

Indeed, the 'public reclamation of shame' turns it into the opposite. After all, shame varies according to its audience. A victim-survivor may feel ashamed to speak in a room full of harm-ignoring, violence-minimizing, or rape-excusing people; but not ashamed in a room full of feminist, activists, and angry survivors. For male victim-survivors as well as gender-nonconforming ones, this has created additional concerns given the reluctance of many women's consciousness-raising groups and feminist organisations (including most rape crisis centres prior to the 1980s) to admit male victims. Their shame and distress was effectively sidelined by anti-rape, feminist activisms until the 1990s.

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[51] Eve Kosofsky Sedgwick, 'Queer Performativity: Henry James's *The Art of the Novel*', *GLQ*, 1, 1 (1993), 14.

[52] Amanda Holmes, 'That Which Cannot be Shared: On the Politics of Shame', *The Journal of Speculative Philosophy*, 29, 3 (2015), 415-16.

I have attempted to set out some of the issues relating to sexual violence. I argue that understanding the mechanisms of shame can help reverse its pernicious effects for both victim-survivors and those who harm. Shame is dependent upon witnesses who 'do' the shaming; but those witnesses equally have the power to deny shame. Jettisoning the power/sex dichotomy and paying more attention to intersectionalities can deepen and productively complicate our understanding of sexual violence. The chapter calls for closer attention to be paid to the bodies and emotions of victim-survivors as well as to those who have the task of caring for them. Understanding of the mechanisms of disgust and shame can help reverse their pernicious effects for both victim-survivors and those who (often unintentionally) harm. An emphasis on the emotions does not simply reveal underlying human experiences: it suggests political responses to the harms of sexual abuse.