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The Double-Edged Sword

Trauma, Mental Health, and Sexual Violence Testimony in England and Wales

By Emma Yapp

A doctoral thesis submitted in partial fulfilment of the requirements for the award of
Doctor of Philosophy in Criminology
Faculty of Humanities and Social Sciences,
Birkbeck, University of London

Supervisors: Dr Tanya Serisier; Dr Rachael Dobson; Professor Joanna Bourke

I declare that the work herein is all my own.

Abstract

This thesis critically examines how the interaction of feminist, legal, and psychiatric discourses shape the experiences, and testimonies, of people who have experienced sexual violence and identify with psychiatric diagnoses in England and Wales. This is an interdisciplinary mixed-methods qualitative project analysing case law (n=11), policies (n=5), and qualitative interviews (n=9) with people who have experienced sexual violence and identify with psychiatric diagnoses. In bringing these materials together, I reveal the ways in which societal stereotypes and norms concerning the relationship between sexual violence and mental health come to bear on sexual violence testimony. The injustice of the law's treatment of sexual violence and mental health here extends beyond the courtroom.

This socio-legal project contends that the success of legislative reform concerning sexual violence and mental health must be understood in dialogue with both societal norms and stereotypes, and the experiences of people who have experienced sexual violence themselves. In a critical review of secondary feminist scholarship, I demonstrate how people who have experienced sexual violence are represented as "not sick" (hysterical), but "traumatised". Norms and stereotypes then come to bear on the adjudication of cases, and the relationship between sexual violence and mental health is constructed as "legitimate trauma" or "abnormal" psychology. Interview participants discussed how identification with psychiatric diagnoses complicates the narrative demands of sexual violence testimony, by introducing new ways to diminish credibility that were mobilised along structural inequalities, producing "testimonial injustice". Participants had to find ways to articulate sexual violence to both emphasise that they were "not sick", but still "sick enough" for their experiences to be legitimate, revealing the "double-edged sword" of the medicalisation of sexual violence (McKenzie-Mohr & Lafrance, 2011). This thesis provides insight into how engaging with lived experiences of mental (dis)abilities can deepen, and support a more expansive, feminist anti-sexual violence politics.

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I am grateful to Lauren Gutterman, Rhian Kheyse, and various anonymous reviewers of journal article submissions for providing invaluable feedback on iterations of the work presented herein. I would also like to thank my unfathomably patient supervisors: Tanya Serisier, Rachael Dobson, and Joanna Bourke. Joanna's work and support has been foundational to the formation and endurance of this project, and it simply would not exist without her. Rachael has been similarly formative in shaping the eventual thesis, but I particularly want to thank her for her emotional acuity, and her ability to hold space for me when I needed her to. Academia is challenging, and intellectual language is often used to retreat away from difficult conversations and (at times) painful feedback, but navigating both of those things was simpler in Rachael's presence. Finally, and most importantly, I want to thank Tanya, who has been unwaveringly thorough and engaged throughout this project, and equally understanding and supportive. The analysis presented here is significantly more nuanced and expansive on account of her input. However, most of all, I'd like to thank her for her honesty throughout; usually when I needed it most. Even when she told me that a supervisory relationship can be difficult, I think my experience is unusual in my ability to say that those words never applied here.

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Finally, there are many stories that haunt this thesis, and some of those people are alive, and others are not. This work is dedicated to all of those that have been harmed by sexual

violence and psychiatric diagnoses, and all that have been failed by the existing structures that surround them.

Glossary

APA – American Psychiatric Association

CPS – Crown Prosecution Service

DSM – Diagnostic and Statistical Manual

ECHR – European Convention on Human Rights

EWCA Civ – England and Wales Court of Appeal (Civil)

EWCA Crim – England and Wales Court of Appeal (Criminal)

HM Government – Her Majesty's Government

ICD – International Classification of Disorders

ISVA – Independent Sexual Violence Advisor

NSUN – National Survivor User Network

PTSD – Post-Traumatic Stress Disorder

SOA – Sexual Offences Act

UKHL – United Kingdom House of Lords

VAMHN – Violence, Abuse, and Mental Health Network

WHO – World Health Organisation

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1. Introduction

In the late 1990s, a major review of sexual violence legislation was conducted in England and Wales, which had significant input from feminists and activists (McGlynn 2010). The British feminist anti-sexual violence movement had begun to gain momentum in the early 1970s, as feminists became increasingly outraged by the medical and legal treatment of people who had experienced sexual violence (McGlynn 2010; Jones and Cook 2008). The review itself culminated in two enduring pieces of legislation: a "rape shield"[1] law implemented in 1999, and the *Sexual Offences Act* (SOA) in 2003 (McGlynn 2010). Rape shield laws are intended to restrict the admission of a person's sexual history evidence in trials, and the SOA was explicitly intended to 'give victims of rape more confidence in the system' (Home Office 2002, 10). This period of legislative overhaul was considered a feminist "success story"; as legal scholar Clare McGlynn has written, these 'reform[s] appeared to constitute a significant feminist victory' (McGlynn 2010, 143).

In the early 2000s, however, scholarship revealed increasingly high rates of attrition in sexual violence cases, and declining rates of conviction at trial (Liz Kelly and Regan 2001; Regan and Kelly 2003; Kelly, Lovett, and Regan 2005). In 2006, the UK Government commissioned feminist scholars Liz Kelly, Jennifer Temkin, and Susan Griffiths to examine the effectiveness of the rape shield law, and specifically, to see whether it had been 'successful' (Kelly, Temkin, and Griffiths 2006, 4) in countering stereotypes about the unreliability of women's testimony. The report revealed that legal practice continued to draw on stereotypes, as well as high rates of attrition at every step of the criminal justice process (Kelly, Temkin, and Griffiths 2006, 41–43).

This story draws attention to some of what socio-legal scholar Rose Corrigan, writing in the US, calls the "failures of success" of feminist legal mobilisation in relation to sexual violence (Corrigan 2013). In England and Wales, Clare McGlynn has referred to the "success" of these reforms as 'a Sisyphean struggle' (McGlynn 2010, 139), in which each step forward is followed by several steps back. However, while McGlynn tends to focus

[1] I use double quotation marks to signal contested concepts or phrases, and single quotation marks for direct quotes.

on the effectiveness of legislation, Corrigan insists on the centrality of the socio-legal dimensions of feminist mobilisation around the law. The failures of these reforms cannot be understood without considering both societal norms and stereotypes, and the wider legal harms for people who have experienced sexual violence themselves.

For example, the SOA has been criticised for inviting increased scrutiny of the behaviour of people testifying to sexual violence (McGlynn 2010). Legal scholars Andrew Ashworth and Jennifer Temkin have warned that this legislation provides 'no real challenge to society's norms and stereotypes' (Temkin and Ashworth 2004, 342). Criminology scholar Olivia Smith then evidenced this claim in 2018, in her analysis of trial observations. She demonstrated that prejudicial stereotypes about gender, ethnicity, and class all contribute to impugning the credibility of people testifying to sexual violence (O. Smith 2018). Similarly, prosecutorial decisions about whether a case should proceed to trial have been criticised for unduly scrutinising individuals testifying to sexual violence even before a trial (Temkin and Krahé 2008). In England and Wales, these decisions are made by the Crown Prosecution Service (CPS). The CPS is a body established as independent from the police and the judiciary in 1986 (Quick 2006). They publish extensive policies that contribute to practices of case-building, charging decisions, and trial conduct.

In 2002, the CPS published one such policy that was intended to curtail the effect of stereotypes on trial conduct, but it had wider consequences for the testimony of people who had experienced sexual violence (Crown Prosecution Service 2002). The policy recommended that anyone pursuing criminal justice reparations for sexual violence should not talk about what happened in therapy before a trial (Kale 2019a; Chakrabarti 2019). Mental health records could be used to establish inconsistencies in individuals' testimonies at trial, but the policy effectively pitted mental health support and legal redress against each other as mutually exclusive choices. It limited access to mental health support after an assault, but it was also especially damaging for people who were already in touch with mental health services, in its implication that mental health evidence could impugn credibility.

This policy serves as an example of how the role of mental health and psychiatric diagnoses has largely escaped critical scrutiny of the new sexual offence legislation and

prosecutorial policies implemented between 1999 and 2003. It demonstrates that there has been scant attention to date on the specific effect of stereotypes about mental health on sexual violence testimony, both inside and outside the courtroom. For example, in Smith's comprehensive book, just four pages are dedicated to the effect of invoking stereotypes about mental health on trial outcomes (Smith 2018, 130–34). Further, as Corrigan briefly draws attention to in her book, stereotypes and norms surrounding mental health and sexual violence can have wider societal effects. Ideas about a "good victim" versus someone with "mental health issues" come to bear on how the legitimacy of sexual violence testimony is adjudicated both in society at large, and in legal practice (Corrigan 2013, 90–91). Laws and associated policies have implications that extend beyond the courtroom, and the 2002 policy has since come under scrutiny for producing wider discursive effects: 'What it's like to be raped and told you can't talk about it with anyone' (Kale 2019b).

Examining the relationship between sexual violence and mental health in England and Wales is the goal of this project. In this introductory chapter, I will first summarise the approach taken, and the reasons for situating this contribution as both a socio-legal one, and one with "double-edged" implications for sexual violence testimony (Gavey and Schmidt 2011, 452). Then, in section 1, I will briefly lay out the legislative context in England and Wales, which is partly informed by some of the analytic work that forms this thesis – the analysis of policy documents, and the doctrinal examination of legislation and case law. I will explain this methodology in full in the next chapter, but it is usefully placed here as context for the reader, and for this project. In section 2, I outline the aims and scope of this research, before summarising the structure and argument of the thesis in general (section 3), and my personal investments in particular (section 4).

I situate this contribution within wider concerns about the relationship between sexual violence and mental health, and their consequences for sexual violence testimony, which have previously been characterised as a "double-edged sword" (McKenzie-Mohr and Lafrance 2011). This term, and the title of this thesis, have been chosen to represent several key things. It was originally used by Canadian feminist scholars Suzanne McKenzie-Mohr and Michelle Lafrance to describe how the medicalisation of sexual violence was not a straightforward feminist "success", but individualising and

depoliticising, as it ‘constructs women’s suffering as individual pathology rather than a response to social injustice’ (McKenzie-Mohr and Lafrance 2011, 50). They show that, outside of this medicalised register, people who have experienced sexual violence conduct complex discursive negotiations to articulate their experiences, which they term ‘tight-rope talk’ (McKenzie-Mohr and Lafrance 2011, 64). As we will see over the course of this thesis, psychiatric diagnoses complicated these narrative demands even further.

This concept serves as a poignant metaphor for understanding the complexities inherent within narratives of trauma, psychiatric diagnoses, and sexual violence testimony exposed by a socio-legal project. The arrival of the language of trauma (Marecek 1999), and the emergence of the diagnoses of PTSD in 1980, was also heralded as a feminist victory (Haaken 1996; Bourke 2012; Sweet 2021). In articulating previously inexplicable experiences, feminist mobilisation through the psy disciplines had successfully “given voice” to people who had experienced sexual violence. At a 1993 annual conference for therapists treating people who had experienced sexual violence, the victorious words reverberated through the audience: ‘The world has split open. Women have broken the silence’ (Haaken 1999, 13). However, just as a double-edged sword can both protect and harm, the narratives surrounding trauma and psychiatric diagnoses here simultaneously provide frameworks for both understanding and silencing people’s experiences of sexual violence.

This is a interdisciplinary project, including a critical appraisal of secondary feminist scholarship, an analysis of case law and policy documents from England and Wales, and qualitative interviews at the intersection of sexual violence and mental health. In bringing these materials together, I reveal the ways in which societal stereotypes and norms concerning the relationship between sexual violence and mental health come to bear on sexual violence testimony. The injustice of the law’s treatment of sexual violence and mental health extends beyond the courtroom. This project contends that the success of legislative reforms to sexual violence and mental health must be understood in dialogue with both powerful societal norms and stereotypes, and the experiences of people who have experienced sexual violence themselves.

My critical literature review of feminist scholarship reveals a dichotomous understanding of "normal" or "abnormal" mental health in relation to sexual violence. I demonstrate feminist efforts to re-characterise a range of psychiatric diagnoses as normal and understandable positions from which to articulate sexual violence. I expose in this scholarship a foundational conception of sexual violence as a threat to those who are psychologically "normal" before an assault. This distinction between normal and abnormal psychology concerning sexual violence emerges in more extreme and binary terms in the legal materials. This project is concerned with so-called "mental illness", rather than learning (dis)abilities (cf Bourke 2020; Clough 2014). Legitimate "trauma" in the case law is characterised by being physically incapacitated and psychologically "normal" before assaults. It is discursively constructed by the judiciary as preferably either corroborated, or unspoken before a trial. Stereotypes about abnormal psychology in the case law are constructive of ideas about "malingerers", or being manipulative and attention-seeking; prior disclosures of sexual violence were damning. These discursive constructions complicate the narrative demands of sexual violence testimony for people who identify with psychiatric diagnoses, and prejudicial stereotypes tracked individuals' testimony through their embodied experiences, which incurred not just "testimonial injustice" (Fricker 2007), but secondary harms in institutional practices: denying participants access to criminal justice, or mental health support, for example.

1. Legislative Context

This section outlines the legislative context in England and Wales, and some of the residual legislative debates in relevant scholarship. There is no unified judiciary in the UK, nor a central system of prosecutions. England and Wales has a distinct justice system to Scotland and Northern Ireland, and each of these jurisdictions additionally have different prosecutorial systems. The judiciary represents one branch of the state, where the other two are the executive (the Government), and the legislature, which is constituted by the two Houses of Parliament. In England and Wales, the police are responsible for the initial investigation of cases, and the principal role of the CPS begins after the police issue an initial charge. The CPS then reviews the available evidence to decide whether the case has a "realistic prospect of conviction" (Ashworth 2000). The

burden of proof in criminal trials in England and Wales is "beyond reasonable doubt", which additionally issues a high threshold for a realistic prospect of conviction, and the CPS has therefore been previously criticised for focusing on evidentiary weaknesses rather than comprehensive case-building (Temkin and Krahé 2008).

In legislative debates and legal scholarship, the role of trauma and mental health in sexual violence has been a topic of extensive discussion. In 2006, the Government held a consultation on whether the rules of evidence should be reformed for sexual violence trials in England and Wales (Home Office and Office for Criminal Justice Reform 2006). This included a question of whether expert evidence should be admissible that speaks to the general "trauma" behaviours of people who have experienced sexual violence, including delayed reporting, or providing inconsistent or fragmented accounts. The Government concluded that this evidence could either "complicate" or "usurp" the jury's function (Ward 2009; Ormerod 2006), and the implementation of this evidentiary measure was thus abandoned in 2007 (Criminal Justice System 2007).

These proposed reforms to the rules of evidence in 2006 were objected to, in part, because there are additional rules surrounding the admission of mental health evidence. Although mental health evidence can impugn the credibility of people testifying to sexual violence, admitting evidence of a diagnosis of post-traumatic stress disorder (PTSD) is also not allowed, as this would prove 'unfairly prejudicial to the [defendant]' (Ward 2009, 99). When considering whether mental health evidence should be admitted in sexual violence trials, the defendant's right to a fair trial under the European Convention on Human Rights (ECHR) must be balanced with the "complainant's" right to privacy (European Convention on Human Rights 2021). The right to privacy pertains specifically to mental health evidence, as a person's relationship with their therapist is confidential, but this right is regularly overridden in sexual violence trials (Leahy 2016).

In the Government's response to the consultation on expert evidence, a group of legal scholars at King's College London are quoted as saying that the proposed reforms could 'give the prosecution a distinct and unfair advantage which would serve to increase the number of miscarriages of justice' (Criminal Justice System 2007, 13). This is partly because the diagnosis of PTSD requires the presence of a traumatic event, which may be

particularly persuasive to a jury. Despite the Government's conclusion, the judiciary have since intervened to change the rules concerning mental health evidence in sexual violence trials (R v Adam Eden 2011). The consensus is currently that expert evidence of "psychological injury" such as PTSD is now admissible in criminal trials, as long as the experts speak to the nature of the diagnosis in general, rather than the credibility of individual testimony in particular (Crown Prosecution Service 2021a; R v Adam Eden 2011); and it now falls to the judge to direct the jury on the nature of psychological trauma following sexual assault (R v D 2008; Maddison et al. 2023, s 20; Ellison 2019).

As this development demonstrates, judicial decisions in the higher courts directly influence case law in England and Wales. The higher courts include the Court of Appeal, and the Supreme Court, which covers the jurisdiction of the whole UK (previously the House of Lords). The admissibility of expert mental health evidence in sexual violence trials is additionally directed by a judgment from 1975, which is still cited by the judiciary in sexual violence cases heard at the Court of Appeal (R v B 2018). The debates surrounding the relationship between sexual violence and mental health are usually traced back to this passage in the Turner judgment (R v Turner 1975a), which states that

> Jurors do not need psychiatrists to tell them how ordinary folk who are not suffering from any mental illness are likely to react to the stresses and strains of life (R v Turner 1975b, 74).

The distinction between 'ordinary folk' and those with 'mental illness' is clearly premised on a binary distinction between the "normal" and "abnormal" psychology of people testifying to sexual violence, but the additional phrasing around 'the stresses and strains of life' has led to debates about what constitutes abnormality in this context. Feminist scholar Louise Ellison has asserted that while 'victims are "ordinary folk", the abuse to which they have been subjected exceeds the strains of life well understood by the average person' (Ellison 2005, 264). She argued that the sexually violent experience is abnormal, and thus that expert psy evidence about the nature of sexual trauma should be admissible. However, as PTSD is a diagnosable "mental illness", residual debates have ensued about whether evidence of this diagnosis should be admissible at trial – on the one hand it meets the abnormality threshold as articulated in Turner, but on the other,

the Turner judgment also dictates that 'in general evidence can be called to impugn the credibility of a witness but not led in chief to bolster it up' (R v Turner 1975b, 75).

However, these debates also largely fail to capture the norms and stereotypes that come to bear on the uses of mental health evidence in sexual violence trials in England and Wales. The international evidence suggests that the two feminist-inspired legal reforms are likely to have introduced increased reliance on stereotypes about mental health. The implementation of rape shield laws in Canada and Australia has specifically led to an increase in defence counsel seeking psychiatric or psychological evidence to undermine the testimony of people who have experienced sexual violence, in lieu of sexual history evidence (Bronitt and McSherry 1997). The 2002 CPS policy can then be viewed as a protective measure, that was intended to limit the production of mental health records that could prove damaging to credibility. Similarly, while the SOA introduced a consent condition to sexual violence legislation, the nature of the definition is such that consent is understood as a 'state of mind' (Dowds 2022, 829). The consent condition introduced in 2003 required that a defendant's belief in consent be "reasonable", which replaced the previous definition of an "honest" belief in consent. This definition is subjective, merely requiring that *this* defendant's belief be reasonable, rather than an objectively reasonable condition. This invites straightforward scrutiny of individuals testifying to sexual violence, to see if their behaviours contributed to a defendant's "reasonable" belief in consent (McGlynn 2010). This puts the onus on the person experiencing sexual violence to externalise their state of mind, and communicate their non-consent (cf du Toit 2009; Dowds 2022).

There is preliminary evidence that these reforms have led to intense psychological scrutiny at trial in England and Wales. In an analysis of case law presented alongside transcribed documentary footage broadcast in 2000, Ellison demonstrated some preliminary examples of this, where prior experiences of post-natal depression and self-harm impugned the credibility of sexual violence testimony, whether 'wittingly or unwittingly' (Ellison 2009, 32): in other words, whether they were considered "mad" or "bad". Smith similarly describes how mental health evidence – from "low self-esteem" to a history of taking "anti-depressants" – was used to render people testifying to sexual violence as damaged, and hence, unreliable (Smith 2018, 130–34).

This project offers an intervention into this scholarship. Most scholarship in England and Wales that examines mental health evidence in sexual violence cases is focused on improving the execution of the law (Hohl and Stanko 2015; Ellison et al. 2015; Ellison 2005; 2009; Ormerod 2006; Ward 2009; Rumney and Taylor 2002). It adopts a position of political neutrality and objectivity, and approaches the law as a "good" system being exercised badly, and something that is reformable. Instead, this project has been conceived to question the very discursive construction of the relationship between sexual violence and mental health: psychiatric diagnoses are socially constructed categories, after all (Kafer 2013). Where this scholarship has discussed how evidence of "trauma" or PTSD may play out in trials, this has been exclusively in debates of whether it should be admissible, rather than examining how it is discursively constructed. For example, extant feminist discussion of the Turner judgment fails to mention the discursive implications of the construction 'ordinary folk' versus those with 'mental illness' in relation to sexual violence, nor their broader societal consequences for sexual violence testimony (Raitt 2004; Ellison 2005).

Understanding how the relationship between sexual violence and mental health has been constructed in feminist, psy, and legal discourse within this specific legislative framework is a core aim of this project. An equally important aim is how this framework, and the legal discourses it authorises, have impacted the experiences of people who have experienced sexual violence, and who identify with psychiatric diagnoses. Critical disability theorist Merri Lisa Johnson has noted the relative neglect of psychiatric diagnoses within feminist scholarship, and the importance of centring the embodied experiences and testimonies of individuals who identify with psychiatric diagnoses (Johnson 2021).

These concerns then shaped my central research question: how has the interaction of feminist, legal, and psychiatric discourses shaped the experiences of people who have experienced sexual violence, and identify with psychiatric diagnoses? I was additionally interested in how the intersection of sexual violence and mental health is discursively constructed by the law and its associated policies, and how this aligned (or not) with the experience of speaking about sexual violence from a position of psychiatric diagnosis.

This led me to ask two additional primary questions. Firstly, how is the intersection of sexual violence and mental health discursively constructed by law and policy? Second, how do discursive constructions of the intersection between sexual violence and mental health affect or constrain opportunities for speaking about sexual violence for people who identify with psychiatric categories? Within this second question, I was particularly interested in individuals' experience of talking about sexual violence: their embodied experiences, and when and where they could talk about it.

2. Scope, terminology, and definitions

Before I continue, it is worth clarifying the overall approach of this project, including how its parameters are defined and articulated. I analyse case law and policies to examine how the relationship mental health is discursively constructed within the legal treatment of sexual violence, as well as in their broader policy context. I also conduct a qualitative study of the experiences of people at the intersection of sexual violence and mental health to understand this situated and embodied experience of speaking about sexual violence. This combination of materials reveals the wider effects of these legislative reforms, and their contemporary discursive effects.

I focus on experiences of sexual violence in adulthood. This is chiefly because the relationship between feminism and the psy disciplines has been primarily explored in relation to sexual violence experienced in childhood, due to the literature on the "memory wars": debates around "false memory syndrome" and the contamination, or implantation, of memories of sexual violence by psy professionals (see, for example Haaken 1998; Ashenden 2004; Armstrong 1994). The experiences of people affected by sexual violence in adulthood are often obscured by the focus on experiences in childhood, which constitutes a novel focus for this project. Given the relative lack of scholarly attention to this topic, I sought to provide a broad overview of my objects of study. As such, I did not restrict materials as to gender, nor whether people identified with or accrued psychiatric diagnoses before or after assaults. This was also to enable an assessment of how the "norms" of sexual trauma function within and between psychiatric categories: which diagnoses are considered normal, and which are associated with being "sick" (McRuer 2017; Sweet and Decoteau 2018).

In describing people who have experienced sexual violence, some use the term "victim", and others "survivor". Some argue that the terms have to be self-designated (L. Alcoff and Gray 1993, 262), while others have opted for the term "victim-survivor" such that people can identify anywhere on this spectrum (Downes, Kelly, and Westmarland 2014). For my project, these terms all have significant problems. The terms "victim" and "survivor" both inscribe an identity onto people that is static and fixed, and the spectrum "victim-survivor" term inscribes a medicalised view of sexual violence, implying that individuals move from "victim" to "survivor" through recovery and empowerment. I therefore choose to refer to "people who have experienced sexual violence" – "people", in recognition of the fact that sexual violence can affect all genders, and "experienced" because I do not want to imply or assume that this experience defines individuals' identity, but rather makes up a component of their whole and complex existence.

In line with anti-psychiatry writers, I also reject the language of "disorder" and "illness" to challenge a medicalised and decontextualised account of mental health. This has been helpfully articulated by mad studies scholar Mohammed Abouelleil Rashed, who describes 'psychological states [that are] widely understood as mental illness or psychological dysfunction: as negatively evaluated deficit states, rather than potentially meaningful phenomena and components of people's identities' (Rashed 2021, 299). For some writers and activists, this insight has led to a reclamation of words such as "mad", evident in activist movements such as Mad Pride, which built on work highlighting the carceral aspects of Psychiatry; notable UK campaigns around this ideology include the Campaign for Psychiatric Abolition, for example. While indebted to this literature, referring to participants as "mad", when not self-designated, felt uncomfortably close to reinscribing the epistemic violence caused by psychiatric labelling. Instead, I primarily refer to people as "identifying with" psychiatric diagnoses or categories. At times, I also draw on critical disability studies to trouble definitions of psychiatric diagnoses as either a social construct or a medical reality contained to the "mind". In line with critical disability scholar Sami Schalk, I therefore refer to individuals as "bodyminds", and use this author's definition of mental (dis)abilities as the overarching categories of norms that include ability and disability, which is here differentiated from the lived experiences of those categories (Schalk 2018, 5–6; see also: Blackman 2021; 2012; Carter 2021; Kafer

2013). Seeking to describe both lived experience and the institutional rendering of this experience means that it is impossible to maintain absolute rules around terminology. I therefore end up using a variety of terms at different points, and attempt to make clear when and why I depart from these preferences. For example, while my use of the term "bodymind" is intentionally disruptive to Cartesian dualism, a sharp separation between mind and body was generally articulated by participants, and enacted by the law.

Finally, I focus on the *legitimacy* of sexual violence testimony, as this concept is particularly useful for a project that is built around the law. There are various dimensions at play in determining who is considered a "legitimate" victim of sexual violence, and who continues to be denied support and sympathy. Legal adjudication, as well as societal understandings of legitimate sexual violence testimony more widely, are influenced by the confluence of factors such as race, class, gender, and psychiatric diagnosis. The concept of legitimacy is further useful here in order to question the legitimacy of the law writ large: in how far it constrains sexual violence testimony, and in the legitimacy of its discursive construction of the relationship between sexual violence and psychiatric diagnoses as a whole.

3. Thesis Outline

In chapter 2, I outline the methodology of the empirical portion of this project, including my theoretical orientations and the specific methodological approaches to data collection, analysis, and ethical challenges and limitations. This is an interdisciplinary mixed-methods qualitative project analysing case law, policies, and qualitative interviews with people who had experienced sexual violence and identified with psychiatric diagnoses. The analytic methods used draw from critical feminist literature, and the tools that I employ are informed by discursive analyses and phenomenological methods. I bring these materials together to examine how the relationship between sexual violence and mental health is discursively constructed in the legal materials, and the material and social effects of this for both trial outcomes, and for sexual violence testimony more generally. In this chapter I explain how each of the differing materials for analysis are conceptualised, and the consequences of this for answering my research questions. I here argue, in line with critical disability scholars, that phenomenological

analyses of “embodied experience” are particularly valuable for surfacing participants’ experiences. This utility is found both in centring neurodivergence as an intervention into the discursive construction of sexual violence and mental health; and in examining how prejudicial stereotypes followed participants in their embodied experiences of speaking about sexual violence.

In chapter 3, I present a critical review of feminist scholarship engaging with the psy disciplines. I review prominent Anglo-American feminist texts on the subject of sexual violence and psychiatric diagnoses to consider the various ways and times in which feminist scholarship has denounced, debated, and endorsed psy expertise over time. In the first half of this chapter, I present three separable narrative episodes in feminist scholarship. The first concerns feminist attention to what I call the historic “psy”lencing of sexual violence testimony; the second presents feminism’s entanglement with the psy disciplines; and the third and final episode culminates in the “discovery of trauma”. The narratives are at times intersecting and at times contradictory, and are intended to emphasise that people who have experienced sexual violence are “normal”, they are not “sick”. They also coalesce to produce a narrative arc, or as feminist scholar Clare Hemmings would call it, a ‘political grammar of […] *progress’* (Hemmings 2011, 3, emphasis mine). Hemmings suggests that “progress” narratives can evade critical scrutiny, and accordingly, in the second half of this chapter, I take up the critical invitation to appraise the category of “trauma” in relation to psychiatric diagnoses. I here demonstrate some norms and exclusions within feminist work on trauma by drawing on critical race and disability literature, before briefly appraising the legal treatment of the category, and finally turn to the question of what “normal” really means in this context.

Chapter 4 presents my discursive analysis of case law in England and Wales. In case law, the distinction between “abnormal” psychology and “normal” trauma identified in the previous chapter emerges in predictably binary terms. Legitimate (normal) trauma is characterised by pathological memory and dissociation, and is preferably unspoken before trial, regardless of diagnosis. Those who were adjudicated as legitimately traumatised were either corroborated by other evidence, or were “successful” because they had not spoken about their experience previously. Further, in line with some of the critiques identified by critical disability theorists in the previous chapter, sexual violence

is constructed as an extremely horrifying event that causes extreme damage to someone who is psychologically "normal" before an assault. "Abnormal" psychology, in contrast, is characterised by prejudicial stereotypes about femininity and "madness": being a "malingerer", or manipulative and attention-seeking. Mental health evidence is invariably used to discursively construct individuals as either "mad" or "bad" (sometimes both), and "legitimate" cases required corroboration to testify to their medical injuries, or emotional distress. Towards the end of this chapter, I discuss the law's discursive construction of the relationships between mental health and sexual violence testimony, by drawing on my analysis of legal policies published by the CPS and the surrounding case law on capacity.

In chapters 5 and 6, I move to examine how people who identified with psychiatric diagnoses spoke about sexual violence. In chapter 5, I present my analysis of how the intersection of sexual violence and mental health was discursively constructed by interview participants. To do this, I first explain how the presence of psychiatric diagnoses complicates the narrative demands of sexual violence testimony, sharpening the discursive "double-edged sword". In line with my analysis of existing feminist scholarship, participants had to establish that their experiences were normal, they were not sick or "hysterical". However, they also sought to establish that they were "sick enough" to be taken seriously. Feminist, psy, and legal discourse has contributed to a conception of traumatic memories as pathological, stored in the unconscious, accessible only in flashbacks and dreams. While participants used this language to describe their experiences, descriptions that were embodied and somatic were more valuable for rendering their experiences both real, and available for interventions to assuage their distress.

In the second and larger part of this chapter, I turn my attention to participants' discursive construction of the nexus of sexual violence and mental health. In placing participants' embodied experiences in dialogue with the wider feminist, psy, and legal discourses on sexual violence and trauma, I reveal the articulate ways in which their accounts exceed and disrupt the category. Articulations of "trauma" were largely much more expansive than feminist and psy conceptions, and were disruptive to common assumptions, such as the notion that experiences of sexual violence are like a "timebomb"

that will eventually cause an inevitable breakdown. Participants also found creative ways to negotiate mental health services in ways that worked for them, while refusing to be subordinated to their experiences of psychiatric labelling. However, while using somatic language to describe their experiences of trauma was valuable for rendering their experiences real, it additionally left some feeling an enduring sense of permanence, as though they had "failed to recover".

In chapter 6, I trace participants' experiences of speaking about sexual violence. Here, I demonstrate the wider injustices of participants' interactions with the norms and prejudicial stereotypes surrounding sexual violence and mental health. In order to flesh out both this effect, and its material and embodied consequences, I introduce philosopher Miranda Fricker's notion of "testimonial injustice" (Fricker 2007). This concept reveals how prejudicial ideas about identity categories in general, and "madness" in particular, not only impacted participants' ability to speak about sexual violence, but incurred additional material injustices. For example, in financial kind, and in preventing access to criminal justice. In the latter half of this chapter, I continue this analysis to attest to the affective and epistemic harms caused by "testimonial injustice", to demonstrate how judgments compound the injustice of sexual violence itself.

In the concluding chapter, I explain how the interactions between feminist, legal, and psy discourses have combined to produce an extremely narrow conception of sexual violence and mental health. In demanding that the legal treatment of sexual violence and mental health be understood in the context of both relations of power, and their wider discursive and embodied effects, the harms of the criminal justice system are brought into sharp relief. This project demonstrates that the harms of this discursive construction are not limited to the courtroom. The norms and stereotypes surrounding the legal adjudication of sexual violence and mental health contribute to their adjudication more broadly. In this final chapter, I outline the project's practical and theoretical implications.

4. **Personal statement**

Writing on sexual violence, critical scholar Tanya Serisier discusses the tradition in this literature of writers declaring their personal investments in the topic, and whether or not

they have experienced sexual violence. She rightly points out that, on the one hand, those who disclose experiences of sexual violence then start their writing from a place of vulnerability, which may in turn be used to devalue or discredit the contributions that they make (Serisier 2018). On the other hand, within feminism, and within mad and crip literatures, writing from "lived experience" is considered to provide a degree of epistemic authority, whereas writing as an "outsider" risks reinscribing epistemic violence caused by "experts" (Haraway 1988; Oakley 1981; Chesler [1972] 2018; Ussher 2011). While I take forward the significance of this work to feminist literature, and the valuable insights made by standpoint theory (Haraway 1988; Hill Collins 1990; Garland-Thomson 2002; Wendell 1989), I am compelled by Serisier's point. I am additionally concerned that there is a tradition of the confessional mode within feminist work. Scholarship may start with an enumeration of identity categories and experiences, fore-fronted by the ones that express an experience of oppression, marginalisation, or "trauma", in an effort to improve its credibility (Murray 2020). I want to avoid this for these two reasons: I do not want to start this project from a vulnerable place, and nor do I want to suggest that any of my experiences, or the ways in which I identify, lend my work more credence in a largely unproblematised way.

In saying this, I do not intend to undermine the centrality of lived experience: to feminism, and to this project. This project has evolved such that it is guided by me and my evolving investments. However, rather than following in the tradition of disclosing what those guiding experiences are, and assuming that lends this work authority, I want to instead write about how my academic work, and this project, have guided me. This thesis has transformed me – how I identify, how I understand sexual violence and trauma, and how I understand mental distress and psychiatric diagnoses. In coming to understand how my own bodymind has been shaped, as well as some of the old investments I held – in carcerality, for example – I can now see with greater clarity what brought me here. In critical disability scholar Angela Carter's thesis, she quotes bell hooks in her discussion of what brought her to the subject of the thesis, who writes that

> I came to theory because I was hurting – the pain within me was so intense that I could not go on living. I came to theory desperate, wanting to comprehend – to

> grasp what was happening around and within me. Most importantly, I wanted to make the hurt go away. I saw in theory then a location for healing (hooks 1991, 1).

This is what brought me here. hooks draws attention to the conditions that have made this pain possible, and the liberatory and transformative potential of making new knowledge and theory that is attentive to those conditions. She writes of this knowledge that 'in its production lies the possibility of naming all our pain – of making all our hurt go away' (hooks 1991, 12). hooks' reference here to 'all our pain' is additionally significant here, as the pain that brought me here is not mine alone, and grappling with my ability or entitlement to tell the stories of other people is ongoing throughout this thesis – all of my work exists in an ongoing dialogue with the experiences and literatures I engage with, and in this vein I am accountable for any criticisms of my approach along the way (Alcoff 1991). In my capacity as researcher, I "speak to" these experiences, rather than "speak for" them as they were felt by those involved.

Rather than starting this project from a position of vulnerability and disclosure, I begin with resistance, understanding that there are more options for sexual violence, justice, and distress than presently understood. My resistance is threefold. (1) Carceral solutions are not the only or best available option for sexual violence. (2) The medicalised language of trauma is no longer tenable as the only discursive register for speaking about sexual violence. And (3), experiences of "trauma" or "mental health" do not break people; constructions of human fragility reveal who society conceives of as woundable, and this ultimately does all of us a disservice. This disservice is constituted by the fact that we will all experience mental distress, and events that could be considered traumatic, at some point in our lives. Rather than enacting futile efforts to "eradicate" affective distress, we need to forge a world and a society that can accommodate it, better understand it, and live alongside it.

2. Methodology

Introduction

In this chapter, I will explain the methodological approach taken to answer my research questions. The chapter is divided into three parts. In part 1, I provide a theoretical outline, which is influenced by critical feminist theory and an understanding of discourse informed by Michel Foucault. Here I produce the specific analytical prompts that I used to approach the discursive analysis of the data. I explain that different analytic strategies were operationalised for different materials, and these were additionally conceptualised in different ways. For example, I conducted a second conceptual reading of the interview data, to enrich my analysis of participants' embodied experiences of the nexus of sexual violence and mental health, and their experiences of speaking about it. The centrality of embodied experiences to this project is reflected in my central research question. My definition and analysis of embodied experience is indebted to the theorising of Toril Moi (Moi 1999), which I explicate in section 2C, and like critical disability scholars working on psychiatric diagnoses (Johnson 2021; Mollow 2006), I contend that this analysis is essential to both foreground experiences of neurodivergence, and to reveal some of the limitations of how sexual violence and mental health are discursively constructed. Bringing embodied and highly situated experiences into dialogue with feminist, psy, and legal discourses is a core aim of this project.

In part 2, I go through in detail the specific methods of data collection and analytical strategies used for the case law (sections 2A and 2B) and policy documents (section 2C), as well as some of the challenges and ethical considerations associated with them (section 2D). Critical feminist Alison Phipps has conducted a Foucault-informed discursive analysis of sexual violence policy documents in the UK, which included an analysis of the 2002 pre-trial policy published by the CPS (Phipps 2010). She suggests that, in order to provide a broad representation of policy and legal narratives, it is essential to afford consideration to the wider contexts (Phipps 2010, 363). Informed by this rationale, I discuss how within both the case law documents, and the policy documents, some

additional documents[2] were read in either descriptive or doctrinal detail, while others were consulted for important explanatory context (Phipps 2010, 363). Finally, in part 3, I will explain the processes undertaken to collect (sections 3A and 3B) and analyse (section 3C) interview data. The description of data collection includes both the recruitment process in section 3A, and the specific interview strategies and design in section 3B. Within all of these decisions lie complex ethical challenges, and discussion of these is integrated throughout this chapter, but especially concentrated in the final sub-sections of each part of the chapter detailing specific methodologies (sections 2D and 3D). Both people who have experienced sexual violence, and those who identify with psychiatric diagnoses, are regularly subjected to having their "inner" reality interpreted for them. My interview strategy, and the associated analysis, required careful consideration in my efforts to avoid reinscribing this violence, and to expose it instead.

Some challenges that I encountered were anticipated, and some were not. For example, this project was conducted during the COVID-19 pandemic, which brought with it unprecedented challenges, as well as the requirement that my planned course of research be entirely reconceptualised. Like Olivia Smith and other feminist researchers, I had originally planned to conduct court observations of sexual violence trials (Smith 2018; Lees 2002; Powell, Hlavka, and Mulla 2017). The pandemic arrived six months into my project, and with it shut down the operations of in-person trials, which rendered this research design impossible.

Instead, I conducted a mixed-methods interdisciplinary project. The project had three components. I enacted a critical literature review of feminist secondary scholarship on sexual violence and psychiatric diagnoses; a discursive analysis of case law and policies at the intersection of sexual violence and mental health in England and Wales; and a qualitative study of experiences at the intersection of sexual violence and mental health. The qualitative study employed a combination of discursive analysis and phenomenological methods. I detail my approach to the critical literature review in the next chapter, in order to focus here on the empirical components of this research project.

[2] These documents are not captured in the "n" numbers presented in the abstract on page 2.

1. Theoretical outline

There are multiple different ways to analyse discourse and the discursive (Potter and Wetherell 1987; Fairclough 1992; Anderson and Doherty 2008; Gotell 2008b; Pillow 2003a). Due to space constraints, I am not able to enumerate all of these different methods in turn, but the approach to discursive analysis taken here is informed by critical feminist work that implements the theoretical ideas of Michel Foucault (Alcoff 2018; Gavey 2005; Shepherd 2008; Phipps 2010; Pillow 2003; Alcoff 2000). Specifically, I adapted analytic prompts suggested by Jane Ussher and Janette Perz (Ussher and Perz 2014). It should be briefly noted here that Foucault's work in relation to sexual violence (Alcoff 2000, 52), and his rumoured participation in sexual harms (Campbell 2021), work against the grain of this thesis and what it is trying to achieve. I therefore engage in a citational politics that instead leans on the work of feminist theorists, and keep citations to his work to a minimum.

This approach to analysing materials acknowledges that our meaning and knowledge of sexual violence is discursively constructed and constituted through language (Gavey 1989). Here, discourse is not analysed as merely linguistic, but constructive of how we make meaning. This framing attends to the relationship between subjectivity, discourse, and the material and historical contexts under which these all occur (Gavey 1989; 2005; Shepherd 2008; Ussher and Perz 2014). As critical feminist Laura Shepherd has noted, this notion of discourse gives power analytical primacy, as it is through power that discourses construct meanings (Shepherd 2008, 23).

Power is here conceptualised as 'a productive network which runs through the whole social body, much more than […] a negative instance whose function is repressive' (Foucault 1980, 119). As this quotation demonstrates, power does not simply operate in 'repressive' top-down form, but on this account is *constructive*, in that it is additionally operationalised in relation to 'the power of the Norm' (Foucault 1977, 184). This framing acknowledges that individuals will speak about and make sense of their experiences in relation to discursive "norms" surrounding sexual violence and mental health. For example, psy understandings of trauma shape how we understand the experience of sexual violence for ourselves and for others (Gavey and Schmidt 2011, 451). The second

useful feature of this account of power is found in how it is ‘productive [of the] social body’ (Foucault 1980, 119), which speaks to the ways in which discourses are additionally diffused in our everyday social and cultural lives, rather than solely confined to institutions, such as the law, for example. This conception of power is useful for this project, as it speaks to how individuals’ experiences can be shaped by discourses and institutions in ways that are not limited to the courtroom.

I define discourse as including both the contents of language, and how those are made meaningful and intelligible through operations of power, and material and social conventions and norms. In Nicola Gavey’s words, discourses are here ‘organized systems of statements that provide the socially understood ways, or rules almost, for talking about something and acting in relation to it’ (Gavey 2005, 80). This is to be distinguished from “discursive practices”, which are considered specific instances of discourse that involve the use of language in particular ways. To paraphrase from Laura Shepherd, discursive practices are here embodied in technical processes, institutions, and general patterns of behaviour (Shepherd 2008, 19). There can be multiple and contradictory discourses at a different time in an instance of discursive practice, and distinct discursive constructions offer different subject positions for people to take up, which carry different possibilities for meaning and action.

There are myriad ways to conceptualise and analyse processes of subjectivation, even within specific works concerning psychiatric diagnoses that draw directly from Foucault’s theorising (Rose 2007; Spurgas 2020; Sweet and Decoteau 2018; Gavey 2005). Again, in the interest of brevity, there is not space to detail each of these nuances here. However, in this project, I do not draw direct links about processes of subjectivation, but rather draw connections between my observations about different aspects of the discursive formation of our social worlds and experiences. A similar method is operationalised by critical race theorist Wanda Pillow, who analyses policies alongside interviews with the subjects of those policies, to operationalise ‘a methodology through which to identify and trace these discursive practices and their effects’ (Pillow 2003a, 151). I attend to how discursive practices contribute to certain effects. In my examination of discursive social and material “effects”, I specifically focus on the effects on sexual violence testimony, and on the embodied experiences of interview participants. While

possibilities for agency and action are importantly influenced by both the discursive, and operations of power, this framework does not preclude opportunities for meaning and action that crucially resist and reconfigure given norms that are discursively constructed (Gavey 2005, 85; Butler 1992, 13).

To conduct the discursive analysis of case law, policy documents, and interview data, I adapted the following prompts suggested by two scholars who have conducted discursive analyses informed by Foucaultian and feminist theory, Jane Ussher and Janette Perz (Ussher and Perz 2014). They suggest that, as a guide, analysis should proceed as follows:

> *Steps*: Discourse and discursive constructions: Locate the various discursive constructions of the object and identify their association with wider cultural discourses. If conducting a genealogy, examine the historical development of such discourses and discursive practices.
> *Function*: What is the function of such constructions? What is gained by constructing the object in this way?
> *Positioning*: What subject positions are offered by the text?
> *Practice*: How does discourse open up or close down opportunities for action? What are the implications in terms of power relations?
> *Subjectivity*: What are the consequences of taking up, or resisting, the subject positions made available? What can be thought, felt or experienced from within various discourses? (Ussher and Perz 2014, 226, emphasis original)

It is important to clarify the distinctions between my approach and these suggested prompts. Firstly, I did not conduct a 'genealogy', but a discursive analysis: while attentive to the historical and material contexts in which materials were produced, I did not analyse the specific moments and reasons that discourse changed over time. Secondly, it is important to distinguish the prompt concerning "practice" from a "discursive practice", as I used this prompt to specifically examine "practice" in terms of the social and material effects on speech.[3] This was in service of getting to the heart of my research questions. Finally, using this as a guide to analyse my interview data was supplemented with a

[3] I will provide further clarifications on this distinction in the analytical strategies in section 2B.

phenomenological approach to the final two prompts: the embodied experiences of "speech", and subjectivity. This methodological approach entailed what other feminist sexual violence scholars have termed a 'double reading' (Shepherd 2008, 26).

Feminist sexual violence scholars including Laura Shepherd, Nicola Gavey, and Linda Alcoff have each conducted a second conceptual reading of their data on top of a Foucault-informed discursive analyses (Shepherd 2008; Gavey 2005; Alcoff 2000). For both Gavey and Alcoff, this method is intended to foreground the lived experiences of people who have experienced sexual violence. Gavey, being a psychologist, conducts a second reading to get at participants' veridical interior subjectivities, treating language as a transparent medium of description, while Alcoff supplements her analysis with tools from phenomenology (Gavey 2005; Alcoff 2000). Like Alcoff, I enact a second conceptual reading of my interview data that draws from phenomenological methods, and that is attentive to participants' embodied experiences. Unlike Gavey, I neither treat subjectivity as a 'thing, nor an inner, emotional world' (Moi 1999, 81), but as always embodied in a specific situation. On this account, there can be no identity divorced from the world the person is experiencing, which includes interactions with various stereotypes and norms. This is another crucial framing for the socio-legal orientation of this project.

The phenomenological reading deepens the analysis of interview data in two ways: it reveals the rich variation of participants' embodied experiences in relation to psychiatric diagnoses; and it brings to the fore how participants' experiences of testifying to sexual violence were specifically curtailed. I will briefly summarise the utility of Alcoff's approach for these purposes. Alcoff critiques Foucault's analysis of sexual violence (Alcoff 2000). He examines a "shift" in the discursive construction of sex over time, and a point at which sexual activity with children went from being considered "innocent" to an act warranting professional intervention. He reproduces a case from 1867 France to mark this shift (Alcoff 2000, 54). Alcoff contends that re-examining this event through a phenomenological focus on the child enrichens the analysis by demonstrating that, regardless of whether sex with children is considered "innocent", the child would have had an embodied experience of the event marked by fear and confusion (Alcoff 2000, 54). Centring embodied experiences attends to both the rich variation of experiences of sexual violence, and here additionally highlights specific implications for speech. When people,

here children, do not have the available language with which to articulate their experience, this enacts a specific kind of testimonial harm; what philosopher Miranda Fricker would term, 'hermeneutical injustice' (Fricker 2007, 147). Alcoff's reading brings attention to both embodied experiences of sexual violence and this testimonial harm, which is not captured by Foucault's discursive analysis.

In addition, centring embodied experience and phenomenological analyses is a core tenet of critical disability studies, and one that I will expand on in section 3C of this chapter, after summarising it here (Johnson 2021; Mollow 2006; Price 2015). Building on the work of feminist and critical race theory that has illuminated the intersectional axes of power that determine what counts as "normal" (Ahmed 2007; 2017; Crenshaw 1989; 1990; Hill Collins 1990; Collins and Bilge 2016), centring the embodied experience of psychiatric diagnoses is additionally a way of resisting, and speaking truth to, medicalised designations of normalcy. Crip philosophers Corrine Lajoie and Emily R Douglas write that

> The work of feminist, critical race, and queer phenomenologists reveals that our bodies are positioned along different axes of power that determine what counts as "normal." The long-standing privilege of the able-bodied, white, middle-class, cisgender male subject is slowly giving way. In its place, phenomenologists (and philosophers, more generally) are finding a rich variation of bodyminds whose lived situations and horizons greatly vary (Lajoie and Douglas 2020, 3).

Stereotypes and norms surrounding whiteness, heterosexuality, gender, and madness affect what bodyminds can do in the world. While analysing these axes of power can thus illuminate how our social and material worlds are organised, attending to embodied experiences sheds additional light on the disparities between discursive constructions and particular 'lived situations and horizons'. This method additionally resists medicalised discourses which construct those who identify with psychiatric diagnoses as *objects* of medical scrutiny (Moi 1999).

Finally, a note on this theoretical orientation before I outline the specific methodological strategies. As Laura Shepherd additionally highlights of her "double reading"

methodology, I should be clear that it is not the aim of this project 'to juxtapose the different readings with a view to dismissing one or another of the narratives as "untrue"' (Shepherd 2008, 31). Examining participants' inner "truths" is precisely one of the pitfalls I intend to avoid. Focusing on the discursive instead brings attention to "regimes of truth" in the materials I analyse, and those discourses that appear "natural", "seamless", or "true". As Foucault said in an interview with Alessandro Fontana and Pasquale Pasquino, this approach focuses on the 'systems of power which produce and sustain it [truth], and the effects of power which it induces and which extend it' (Foucault 1980, 133). By putting the discursive in dialogue with participants' embodied experiences, this orientation challenges dominant discursive constructions, disrupts power dynamics, and advocates for more inclusive and equitable frameworks that honour the transgressive potential of sexual violence testimony (Alcoff and Gray 1993).

2. Methodological Strategies for Law and Policy

A. Data Collection of Case Law

Legal judgments published since 2001 were included for analysis, as 2001 marks the beginning of the period of legislative change that was likely to introduce more scrutiny of the mental health of people testifying to sexual violence. 2001 effectively re-introduced judicial discretion to the feminist inspired rape shield law, followed by the guidance on mental health evidence in 2002 (Crown Prosecution Service 2002), then the most recent overhaul of sexual violence legislation was implemented in 2003 (McGlynn 2010).

Cases were identified through keyword searches of relevant databases (WestLaw, LexisNexis, JustisOne and Bailii). Methodologies for acquiring case law are typically opaque in legal scholarship. Further, lawyers will often cite case law as if it constitutes an objective fact about legal precedent, without being clear about how those cases were acquired (Baude, Chilton, and Malani 2017). In an effort to make legal scholarship more transparent, legal scholars William Baude, Adam Chilton, and Anup Malani suggest researchers should make clear not just the search terms used, but the consequential number of cases found on each database, as well as the criteria for inclusion (Baude, Chilton, and Malani 2017). This was the approach taken here (see appendix 1), and two

additional cases were identified through citation tracking (R v Gabbai 2018; R v Boulton 2007). Cases were included where full judgments were available, and where those judgments included evidence of trauma or mental health in relation to an experience of sexual violence occurring on or after age 16. Both civil (n=4) and criminal cases (n=7) were included, and judgments were up to 84 pages in length.

Additional cases were identified through citation tracking within judgments, although none met criteria for inclusion in the discursive analysis. However, while excluded from the discursive analysis, several other cases (n=8) were read in detail doctrinally, to clarify the judiciary's position generally on evidence of trauma, mental health, and capacity. Some of this information was presented in the introduction, to explain the legislative context in England and Wales. Where relevant, I will either refer back to section 1A of chapter 1, or weave this information into the discussion of the law in chapter 4. Details of cases, and their corresponding analytic centrality, are presented overleaf in table 1.

Table 1. Case Law Documents and Analysis

Title	Case type	Pages	Analysis type	Year
London Borough of Haringey v FZO (2020) EWCA Civ 180	Civil (Court of Appeal)	36	Analysed	2020
R v Adams (2019) EWCA Crim 1363	Criminal (Court of Appeal)	5	Analysed	2019
R v Gabbai (2019) EWCA Crim 2287	Criminal (Court of Appeal)	23	Analysed	2019
R v Gabbai (2018) Kingston Crown Court	Criminal (Crown Court)	54	Analysed	2018
DSD & Anor v The Commissioner of Police for the Metropolis (2014a) EWHC 436 (QB)	Civil (Queen's Bench Division)	84	Analysed	2014
DSD & Anor v The Commissioner of Police for the Metropolis (2014b) EWHC 2493 (QB)	Civil (Queen's Bench Division)	46	Analysed	2014
Lawson v Executor of the Estate of Dawes (Deceased) (2006) EWHC 2865 (QB)	Civil (Queen's Bench Division)	23	Analysed	2006
R v Allison (2006) EWCA Crim 706	Criminal (Court of Appeal)	11	Analysed	2006
R v Soroya [2006] EWCA Crim 3120	Criminal (Court of Appeal)	9	Analysed	2006
R v Smith (2002) EWCA Crim 2074	Criminal (Court of Appeal)	7	Analysed	2002
R v Boulton (2007) EWCA Crim 942	Criminal (Court of Appeal)	7	Analysed	2007
R v Jones & Anor (2019) EWCA Crim 1570	Criminal (Court of Appeal)	15	Consulted	2019

IM v LM and others. 2014. EWCA Civ 37.	Civil (Court of Appeal)	24	Consulted	2014
R v A (2014) EWCA Crim 299	Criminal (Court of Appeal)	7	Consulted	2014
A Local Authority v TZ (2013) EWCOP 2322	Court of Protection	12	Consulted	2013
R v E (2011) EWCA Crim 1690	Criminal (Court of Appeal)	4	Consulted	2011
R v ER (2010) EWCA Crim 2522	Criminal (Court of Appeal)	7	Consulted	2010
R v C (2009) UKHL 42	Civil (House of Lords)	9	Consulted	2009
R v JD (2008) EWCA Crim 2557	Criminal (Court of Appeal)	5	Consulted	2008

Legal judgments were obtained for analysis because transcripts of either criminal sexual violence trials, or their original associated judgments, are prohibitively expensive for research in England and Wales. The documents that are freely and publicly available for research are then limited to the cases in which a defendant appeals against their conviction, which are subsequently heard by the Court of Appeal, where they are adjudicated usually by at least two judges. The documents trace the judicial treatment of the appellant's case, and how their consequent decisions are rationalised. One of the criminal judgment documents analysed pertains to the judge's summing up at the original trial of a particularly central case in extant debates (R v Gabbai 2019; V. Lewis 2020; Thomason 2020), which was kindly paid for, and shared with me, by an external colleague (Alexandra Fanghanel, pers. comm., March 10 2023).

In contrast, some of the civil judgments are representative of the original judgments, rather than appellate ones. Three of the included civil judgments for analysis were produced in the Queen's Bench Division of the High Courts, which represents the adjudication of the original civil claim.[4] The final civil judgment is from the Civil division of the Court of Appeal, in which a London Borough appealed against the original ruling, which adjudicated that they were liable for a sports teacher subjecting a pupil to multiple counts of sexual violence (London Borough of Haringey v FZO 2020).[5] One of the cases consulted on "capacity" was adjudicated in the England and Wales Court of Protection, which deals with decisions or actions taken under the Mental Capacity Act (2005). Another case consulted on "capacity" was adjudicated by the highest court in the UK: the House of Lords (R v C 2009), which is now known as the Supreme Court, as mentioned on page 13.

B. Data Analysis of Case Law

[4] In light of the Queen's death, this court is now called the King's Bench Division.

[5] Civil cases use different standards of proof to criminal trials in England and Wales, as well as different general procedures and notions of justice. In a civil trial, the liberty of the accused is not at stake, and as such the scales of justice 'are theoretically balanced' (J. L. Herman 2023, 86). Psy evidence is more regularly admitted in these trials as evidence of "psychological injury", partly on account of these lesser evidentiary restrictions. They therefore provide important insight into how the law discursively constructs sexual violence in relation to trauma and psychiatric diagnoses.

All documents were input into NVivo 14 for analysis. Within NVivo, I conducted a thematic analysis to draw out key themes, and then subjected these themes to the framework of feminist discursive analysis outlined above. This method of combining discourse analysis with thematic decomposition exposes some of the separable meanings behind discursive constructions (Ussher and Perz 2014).

I analysed the materials using a combination method of handwritten notes, and assigning codes within NVivo. I first extracted content in materials pertaining to the relationship between sexual violence and psychiatric diagnoses or the psy disciplines more generally. I then underwent a process of familiarisation with the data, in which I first took detailed handwritten notes, and conducted a detailed coding process of the data, line by line. I constructed and reviewed a thematic framework as I went, according to Braun and Clarke's guidance for conducting thematic analysis (Braun and Clarke 2021; Braun et al. 2019). As I was interested in the "legitimacy" of sexual violence testimony, which side the judgment fell on was additionally taken into consideration in relation to these themes, and hence which cases were adjudicated as "legitimate". Once I had an initial thematic framework, I sought to identify the discursive constructions of the relationship between psychiatric diagnoses and sexual violence, and to locate these within their broader context, as well as their implications for sexual violence testimony. This is the point at which interpretation of identified themes was conducted with reference to relevant literature, and Foucaultian and feminist discursive theory.

In relation to Ussher and Perz's specific prompts for guiding this analysis, it may be illustrative to work through an example of this analytic process. My adapted prompts examine the relationship between: discursive constructions, their functions, and the associated subject positions, social and material effects on testimony, and subjectivity. In the analysis of case law, I identified a *discursive construction* of "legitimate trauma", which was located within a biomedical and legal *discourse*. Some of the themes identified within this discourse include the notion of "freezing", and being psychologically "damaged". My analysis is that the *function* of this discursive construction is that it legitimates experiences of sexual violence, as well as the legitimacy of the law to intervene and protect its feminised subjects. The *subject positions* offered up by this are however restrictive, and represent feminised subjects as psychologically normal before sexual

violence, and psychologically damaged thereafter. In *the effects on testimony*, opportunities for speaking about sexual violence are seriously impeded by this discursive construction: the legal materials demonstrate that legitimate trauma is preferably unspoken before a trial. Finally, in terms of *subjectivity*, I ask what the consequences are of being represented as "normal" before sexual violence, and damaged afterwards. Within this final prompt, this included ethical considerations of interpreting subjectivity from legal texts, which will be discussed in section 2D.

As mentioned in the theoretical outline, my approach to analysis, and to answering these prompts, was different for both the legal judgments and the interview data. This partly reflects a distinction in how they are conceptualised. Specifically, I distinguish between them as "instances" of discursive practices, and as "articulatory practices". This distinction is made by Laura Shepherd, but I will briefly explain it in the context of this project (Shepherd 2008). The legal cases are all delivered in the form of judgments, and are hence technically discursive events, produced in a particular context. In the analysis I approached the case law materials as "texts" (Shepherd 2008, 24), which is a common method in socio-legal research (Gotell 2008b; Stefan 1994). As such, they are analysed as *instances* of discursive practice, as examples of certain power relations in action produced in a particular context: at a certain time, under certain understandings of mental health, produced by a particular judge. Yet they are nevertheless examples of discursive practices that contribute to the social construction of subjects and objects. In contrast, the interview data, while additionally in a transcribed text form, is treated as an articulatory discursive practice: as both manifesting discourse, and being a moment of *meaning-making* for participants in their articulation (Shepherd 2008, 25). Although I do not doubt that the judgments were sites of meaning-making for individual judges, I am not concerned with their experiences, but with the more general legal meanings the texts contain.

C. Data Collection and Analysis of Policy Documents

Again, as with the case law materials, while some policy documents were subjected to a discursive analysis, additional documents were consulted to appraise the broad legislative landscape on sexual violence and mental health (Phipps 2010). Government

documents concerning legislative and policy change on the relationship between sexual violence and mental health were consulted for these purposes (n=3). These ranged between 35 and 85 pages. These documents were read in detail to provide further insight into the position of the Government on mental health and sexual violence. Some relevant extracts were presented in section 1A of chapter 1 on the legislative context, while others are presented in the introduction of chapter 3 to introduce the contemporary policy landscape. For the discursive analysis, policy documents (n=5) published by the CPS were obtained using the updates to the 2002 pre-trial policy. Updated policies were published between 2019 and 2022. These documents are detailed, with some as long as 219 pages (see table 2).

Documents were put into NVivo, and passages pertaining to the relationship between sexual violence and mental health were extracted. This data was similarly analysed as "texts", but the analytic process is distinguished from the analysis of case law in two ways. Firstly, these documents are given secondary analytical primacy. They provide important contextual information pertaining to the wider discursive treatment of sexual violence by the law, and their institutional logics, but they are not arbiters of legitimacy in the same way as the case law produced by the judiciary. The analysis is brought into the thesis to enrich the assessment of the legal discursive context at the relevant points (Phipps 2010). Secondly, these documents do not interact with individuals' accounts of sexual violence and are not "sites" of testimonial violence. They do not represent a judgment of individual testimony in relation to stereotypes and norms.

The analysis instead pertains to the wider legal discursive construction of sexual violence and mental health, to enrich my answer to this research question. To again work through the analytic prompts used: the single discursive construction identified revealed a "state-based" understanding of mental health, which is instantiated in a criminal-legal discourse, as its function is to "prove" sexual violence. Trauma is represented as a pathological state, associated with improved memory retrieval and therefore, evidence. In contrast, "madness" is associated with a compromised relationship to reality and evidence. The consequential subject positions, opportunities for speech and subjectivity, are hence highly restrictive on this discursive construction. This finding reflects the

themes identified in the analysis of case law, and the materials are then integrated into this analysis where appropriate.

D. Ethics and Challenges

Although the legal judgments are conceptualised as texts, those texts refer to real people with experiences of both sexual violence, and the subsequent violence of navigating the criminal justice system, and psychiatric evaluations. The legal materials, and how they are conceptualised, are unable to fully capture the effects of discursive constructions of sexual violence and mental health on speech. The case law documents are themselves sites of 'testimonial violence', on the basis that they eradicate or distort sexual violence testimony (Powell, Hlavka, and Mulla 2017, 21). The discursive analysis goes some way to capturing this institutional violence, insofar as it speaks to the stereotypes and norms that come to bear on sexual violence testimony. However, being unable to access the specific discursive operations of the original trial, I cannot lay claim to the extent of this testimonial violence, as I do not know the discursive shape of the original testimony.

Further, this presented a challenge in my analytic consideration of the effects of discursive constructions specifically on speech and subjectivity. In some cases, individuals' testimonies are reproduced in the judgment while the judiciary rationalise their decision. It is important to acknowledge, however selective this reproduction is, that these quotations are the veridical accounts of these individuals: whether how they actually felt, or how they felt they had to testify within the strict discursive operations of a trial context (Young 1998; Larcombe 2002a; 2002b). I aim to be sensitive to this in the associated write-up, but additionally want to clarify that the theorised impacts on speech are generally not considered in relation to these testimonial extracts, as again, I cannot know the testimonial violence incurred. Instead, I focus on how "speech" figures in the judgments more generally: on whether the judgments note that individuals had disclosed their experiences previously, or were corroborated. While this is again a limited consideration of "speech", as the original trial information would have been much more detailed, this aspect emerged in the analysis as particularly significant in determining "legitimacy". Further, demographic information pertaining to those testifying to sexual violence is largely not available in the judgments, and the conclusions drawn in relation

to demographics tend to focus on diagnoses, which are generally present in the materials. Within the limited information available, the identified cases pertain mainly to women, which additionally reflects wider societal dynamics around how sexual violence is adjudicated.

This additionally presented an ethical problem of anonymity. The legal materials are all publicly available, and include civil cases, in which individuals who experienced sexual violence are occasionally identifiable from the citation itself. The original convicted parties are additionally identifiable in full. I considered various ways to anonymise these materials, but ultimately, on account of reproducing extracts from the judgment in so much detail, it would be straightforward for a determined reader to identify them. In service of analytical transparency, and to enable reproduction of extracts that are illustrative of the points I make, I have kept the citations as they are.

A notable point pertaining anonymity was found in my approach to analysing the trajectory of Edward Gabbai's case (R v Gabbai 2018; R v Gabbai 2019), which was subject to extensive commentary in the media and in legal scholarship (Lewis 2020; Thomason 2020; Telegraph Reporters 2018). Gabbai's conviction was overturned in 2019, and on one of the days that I revisited my standard Google search for the associated coverage, suddenly none of the previous articles came up. I was not previously aware that people can submit a "right to be forgotten" request to Google if their criminal convictions are unspent. When I eventually found the relevant material again, I made sure to save it directly to my computer. Unsurprisingly though, this means that Gabbai does not want to be associated with this material, and my naming him could be read as unethical as a result. In doing so, I do not subscribe to the idea of "once a perpetrator, always a perpetrator". I instead intend to recognise the harm caused by both the violence and the legal system, as well as the possibility for change. This approach is informed by abolitionist politics (Lamble 2021). However, linguistically, given the already lengthy ways in which I refer to people who have experienced sexual violence discussed in 1B of chapter 1, I variously use words such as "assailant" in this write up for brevity, although I do not intend to ascribe a sense of permanence in doing so.

Finally, there is scope for error in the documentation of the case law materials. Judgments from the civil courts are recorded and transcribed, although it is less clear whether judgments from the Court of Appeal are recorded before being "handed down" in transcript form. In one such judgment, it refers to a woman's diagnosis of 'Dialectic Behaviour Disorder', which is not an existing diagnostic category (R v Adams 2019, [9]). This could indicate the judge's mistake, which would be an interesting insight into the judiciary's poor understanding of mental health, but it could equally be a mistake in the transcript. As such, it is difficult to interpret, and I focus on the surrounding information. However, it is also a pertinent reminder of two things: the law's logics are largely opaque, and judgments are not veridical insights into the courtroom space nor individuals' testimonies.

Table 2. Policy Documents and Analysis

Title	Pages	Analysis type	Year
CPS Guidance on pre-trial therapy	23	Analysed	2022
CPS Guidance on Rape and Serious Sexual Offences (2021 version)	219	Analysed	2021
CPS Guidance on Rape and Serious Sexual Offences (2020 version)	211	Analysed	2020
CPS Guidance on pre-trial therapy	25	Analysed	2020
CPS Psychological Evidence Toolkit	37	Analysed	2019
HM Government Rape Review Progress Update	35	Consulted	2022
HM Government Tackling Violence Against Women and Girls	85	Consulted	2021
HM Government Responses to consultation Convicting Rapists Protecting Victims	43	Consulted	2007

3. Methodological Strategies for Interview data

A. Recruitment

Interview participants were recruited between June and December of 2021, during the COVID-19 pandemic. Participants were therefore recruited through online communities, and interviews were conducted remotely (either recorded over the phone, Zoom, or Microsoft Teams): phone interviews were offered in case participants did not have a private space to access the internet during the pandemic. Recruitment proceeded through two forums that are accessible for people who identify with experience of abuse, mental health, or both: The Violence Abuse and Mental Health Network (VAMHN) newsletter (n=1), and the National Survivors User Network (NSUN) e-bulletin (n=8). These forums are explicitly intended for individuals with "lived experience" of psychiatric diagnoses, and their content often speaks to the associated harms of mental health services. As such, they represented fruitful sites for the centring of neurodivergence in this project. However, this also meant that a few participants were explicitly critical of psychiatry (Ellen, Megan, Sarah). While I happen to align with a critical view of psychiatry, this is important to note here, and will be discussed further in section 2D of chapter 5.

Participant details are provided in table 3, which were either accrued through the interview itself, or in the debrief session, when I asked participants if they would like to volunteer some basic demographic information. Of the nine participants, eight used 'she/her' pronouns and identified as heterosexual, while one identified as gay and used 'he/him' pronouns. A variety of psychiatric categories were identified with or designated (depression, eating disorders, anxiety, Borderline Personality Disorder, PTSD, Bipolar, psychosis), although six out of nine participants identified with PTSD in some form. Three participants identified with psychiatric diagnoses before their experience of sexual violence (Megan, Ellen, Harib), while six either obtained or found meaning in them afterwards. Two participants identified as black, one as Pakistani, and one as Spanish, while the rest identified as white, where disclosed. Individuals ranged in age from 23 to 55, and all participants chose their own pseudonyms. Two participants did not disclose their ethnicity (Elaine, Sarah), as they both felt this was not "relevant" to their experience.

This is important to acknowledge, as well as the valid point that sexual violence is a somewhat universal facet of gendered harms.

Table 3. Descriptive information about participants

Pseudonym	Age	Age at first adult exp of sexual violence	Identification with Psychiatric categories	"Mad" before sexual violence?	Race identified with	Sexuality	Pronouns
Elaine	Undisclosed	"Early twenties"	Depression, Suicidality	No	Undisclosed	Straight	She/her
Sarah	54	"About 20"	Depression, Psychosis, Anxiety, BPD, C-PTSD, Self-Harm	No	Undisclosed	Straight	She/her
Maya	23	18	PTSD, Depression	No	Black	Straight	She/her
Megan	52	Unclear – twenties onwards	Depression, PTSD, Eating Disorder	Yes	Spanish	Straight	She/her
Beverley	55	19	Bipolar II	No	Black	Straight	She/her
Alice 1	24	18	C-PTSD	No	White	Straight	She/her
Ellen	42	Unclear – thirties onwards	Depression, Anxiety, C-PTSD, Bulimia, Suicidality	Yes	White	Straight	She/her

Alice 2	53	Unclear – thirties onwards	PTSD	No	White	Straight	She/her
Harib	44	“About 21/22”	Anxiety, Bipolar, Depression	Yes	Pakistani	Gay	He/him

The recruitment process was conducted through self-referrals in response to recruitment materials posted in forums, which contained my contact details. Interested participants then emailed me for more information. These materials called for participants who met the intentionally broad inclusion criteria (over 18; experienced sexual violence post age 16; self-identify with psychiatric diagnoses either before or after assault; in touch with a support service). The condition that participants be over 18 was dictated by university ethics procedures, although my requirement that they had experienced sexual violence since the age of 16 additionally reflects my focus on adulthood sexual violence.

Both the inclusion criteria and recruitment materials were designed to provide potential participants with a sense of control over the research process. As sexual violence is a violation of a person's autonomy, and those who access mental healthcare may be deemed to lack capacity over their own decisions, it was important to me to provide potential participants with a sense of autonomy and choice over taking part regardless of diagnosis, rather than assuming (and reinscribing) an inherent vulnerability (Downes, Kelly, and Westmarland 2014; Clough 2014). In the study advert I referred broadly to "experiences of mental health or neurodivergence" to recognise participants' own autonomous assessment of their experiences, rather than adhering to legalised or psychiatric definitions and diagnoses externally imposed upon them (Hengehold 2000). Similarly, rather than mention "rape", I referred to "sexual violence (any unwanted sexual experience)". This was in recognition of an established literature on the heterogeneity of sexual violence experiences (Gavey 2005).

Being mindful of providing participants with control over the interview process was built into my ethical approach at every stage of the research process. Each time that I interacted with participants, I would remind them that participation is optional, while aiming to be as transparent as possible about the interview process. This approach to ethics is again informed by feminist scholarship on violence, and acknowledges the dynamic and ongoing potential harm of the research encounter (Clark and Walker 2011; Mulla and Hlavka 2011).

After participants self-referred, initial assessments were conducted to ensure that participants met the inclusion criteria; to provide them with information about the

research process; to establish informed capacity to consent; and to establish rapport before conducting interviews online. I contacted potentially interested participants to conduct an initial assessment using their platform of choosing (initial assessments were not recorded). Each time we met participants were sent a one-off link for a Teams/Zoom call. Each meeting used a different unique joining ID for enhanced security, and contact details were stored in a password-protected file.

This enhanced security was particularly important. Establishing privacy at each meeting was complicated on account of the COVID-19 pandemic, as conducting interviews online runs the potential for intrusions on either end. An interview with two sexual violence researchers operating in Uganda, Sylvia Namakula and Agnes Grace Nabachwa, proved particularly useful here. They suggested agreeing on a 'diversion topic' (Namakula and Nabachwa 2020) with participants, so that if either of us experienced our privacy as compromised, we could switch to a topic of their choosing. This was particularly important in the event that participants were in ongoing abusive relationships with partners whom they lived with. Each time I contacted participants I confirmed who I was speaking with, that it was safe to do so, and that our conversation could not be overheard.

The requirement that participants be in touch with a formalised support service was implemented as a measure to ensure their safety and capacity to participate. As anthropologist Sameena Mulla and her colleague Heather Hlavka have noted, the 'risk does not end in the moment the research encounter ends' (Mulla and Hlavka 2011, 1521). I therefore ensured participants consented to me contacting their cited support service, to seek confirmation that they were being adequately supported to take part. This measure was conducted in service of autonomy and safety: I wanted participants to be able to provide me with the details of someone they trusted, but in addition, someone who could provide psychological support in the event of their distress. I had initially planned to recruit through the feminist gendered violence service that I used to volunteer for, but again, this was not possible in the circumstances of the COVID-19 pandemic. It was a requirement of the university ethics procedures that an external person would need to confirm participants' capacity to take part, as recruiting through online forums meant that individuals themselves reached out to obtain more information about my study, rather than being pre-recommended by a support service which itself conducts

assessments of safety. Negotiating this condition of participation was complicated, and while at times my contacting a support service was appreciated, at other times it was tokenistic or potentially harmful. I will discuss this further in section 3D.

B. Interview Topic Guide

Interview practice was informed by feminist work on conducting interviews with people who have experienced violence, which emphasise the importance of providing compassion, reassurance and belief to participants' disclosures (Campbell, Goodman-Williams, and Javorka 2019; Downes, Kelly, and Westmarland 2014); and emphasising participants' choice and control (Campbell et al. 2009). To provide participants with a sense of "narrative control", the topic guide was additionally informed by literature on narrative interview methods. Tom Wengraf's work on narrative interview methods tangentially informed the interview design, in how he operationalises research questions for qualitative research in general (Wengraf 2001, 54–59), and I additionally included a single embedded narrative interview question (Wengraf 2001, 113), inviting participants to "tell their story", in order to access data on how they narrated and made sense of experiences of sexual violence (see appendix 2).

I offered individuals the opportunity to read through the topic guide before interview in service of transparency. This is standard practice to mitigate the potential distress caused by interviews on difficult subjects such as sexual violence (Campbell, Goodman-Williams, and Javorka 2019). I started the interview by asking participants to tell me about themselves generally; this was an open question, intended to allow participants to begin the interview on their own terms. After this, the topic guide moved straight onto asking some lead-in questions about sexual violence and mental health, to mitigate any anxiety participants might experience in anticipating these topics (Campbell, Goodman-Williams, and Javorka 2019). The questions were intentionally open, to encourage participants to negotiate the interview in as much detail as they felt comfortable with (Campbell, Goodman-Williams, and Javorka 2019). As seen in the topic guide (appendix 2), I spent time working up to answering the embedded narrative interview question, which invited participants to "tell their story".

However, my practice diverged from traditional narrative interviews being conducted with 'no interruptions' (Wengraf 2001, 119), on account of the principles taken forward from feminist literature emphasising reassurance, belief, and choice. At times I had to therefore intervene in narratives with supportive responses, or with an offer of a break (Downes, Kelly, and Westmarland 2014). During the interview, I provided breaks every fifteen minutes, as well as at any point that I sensed participants were experiencing difficulty. At these points I would also remind people that we can change the topic, that answers to all questions are optional, or that we could pause or discontinue the interview if necessary (Campbell, Goodman-Williams, and Javorka 2019).

Interviews were recorded and transcribed verbatim by myself, and stored in password protected files. Participants were also given the opportunity to feedback on my emerging interpretations, and to edit the transcripts themselves. I will briefly discuss this further in section 3D. I felt cash incentives and vouchers were the most appropriate renumeration in the context of violence research, as they cannot easily be traced. This was an important consideration in the context of potential ongoing abusive relationships (Fontes 2004), and they do not jeopardise individuals' potential reception of benefit payments (Bell and Pahl 2018), which several participants were in receipt of. I therefore chose to renumerate participants with a £50 voucher for anywhere of their choosing, provided I could purchase it online, due to the limitations of the COVID-19 context.

C. Data Analysis

All transcripts were input into NVivo 14 for analysis, and were first analysed using similar procedures to the discursive analysis of case law described above. Yet in conceptualising interview data as a discursive practice which is articulatory, and hence a moment of meaning-making for participants, the prompts yield slightly distinct results. Although interview data revealed examples of testimonial violence experienced by participants, they are not a site of that violence, and attending to their articulations additionally highlights positive sites of discursive meaning, in rendering their experiences legitimate. The discursive construction of "legitimate trauma" in the interview data therefore looks extremely different to that established in the case law.

Again, it will be illustrative to work through this as an example. In the discursive analysis of interview data, the discursive construction of "legitimate trauma" was considered an alternative or oppositional discourse, in contrast to the biomedical one established in the analysis of the law. Some themes of this discursive construction included dissociation, somatic language, and distress as fluid and recurrent, rather than a one-off traumatic event. My analysis is that the function of this discursive construction legitimates experiences of sexual violence, particularly the somatic language, and enabled participants to negotiate their ongoing distress. This is read as disruptive to biomedical discourses, as it exceeds and challenges those associated discursive constructions of trauma. For example, the subject produced by biomedical psy discourses in professional literatures on sexual trauma is constructed as either broken, or on the way to a breakdown, in need of expert intervention (Gavey and Schmidt 2011; Laugerud 2019; Spurgas 2021). In articulating their experiences as fluid, recurrent, and ongoing, participants resist and disrupt this categorisation.

To attend to the final prompts suggested by Ussher and Perz, here concerning speech and subjectivity, interview materials were additionally subjected to a second conceptual reading to better get at participants' embodied experiences. I will first explain what this meant intellectually, before outlining how this analysis was conducted in practice. This reading was specifically conducted according to Toril Moi's reading of phenomenology in general, and Simone de Beauvoir's work in particular (Moi 1999). On Moi's conception of embodied experience, or what she calls 'the body as a situation' (Moi 1999, 81), participants are considered always embodied, and subjectivity is then not conceived of as an "inner world", but rather participants' situated ways of being in the world, and their interactions with the often prejudicial effect of ideas about identity. As Moi writes, this means that there 'can be no "identity" divorced from the world the subject is experiencing' (Moi 1999, 91), and 'we are continuously making something of what the world continually makes of us' (Moi 1999, 117).

Moi's distinctions are additionally important to this project's assessment of norms and stereotypes. Like other feminist theorists, I wanted to surface how experiences of identity are not naturalised on bodyminds, but how people interact with social norms and stereotypes (Moi 1999; Young 1980; Butler 1992; Alcoff 2000). In Moi's work, she is

primarily analysing embodied and situated experiences of gender, but notes that our embodied experience includes 'our experience of all kinds of situations (race, class, nationality, etc)' (Moi 1999, 91). She contends that embodied experience then interacts with societal norms and stereotypes concerning these categorisations of identity, and takes these norms and stereotypes to be entirely socially constructed categories, or "myths". As such, she asserts that to speak of a *generalised* identity 'is to impose a reifying or objectifying closure on our steadily changing and fluctuating experience of ourselves in the world' (Moi 1999, 81–82); we are not just concatenations of identity categories. While identity is here an important facet of individuals' embodied experiences and subjectivity, like Moi, I analyse the norms and stereotypes surrounding them, as well as their embodied material and social effects. This is important, as this project critiques the specific norms and stereotypes surrounding sexual violence and trauma in general, and psychiatric diagnoses in particular: especially in terms of who they give voice to, and who they exclude. Diagnoses are social and identity categories, and in Judith Butler's words, 'identity categories are never merely descriptive, but always normative, and as such, exclusionary' (Butler 1992, 15–16). Analysing embodied experience as a dynamic situation is to consider the fact of having a specific kind of bodymind, and the meaning that bodymind has for that individual in ways that are socially and culturally saturated.

Attending to participants' embodied experiences of speaking about sexual violence additionally reveals the ways in which norms and stereotypes about identity interact with judgment, and hence, provides a more detailed answer to my question concerning how discursive constructions affect or constrain opportunities for speech. Leigh Gilmore suggests that the ways in which judgment is added to testimony takes a specific form in contemporary society: 'namely, that stigmatized aspects of identity will be added to witnesses as weight their words cannot bear' (Gilmore 2017, 6). Stereotypes and norms come into play in the telling and hearing of sexual violence, as knowledge is instantiated in both institutions and agents who "just see" interlocutors in a certain light, according to these norms and stereotypes (Fricker 2007, 76).

Both Gilmore and Fricker theorise how judgments impact embodied experience, and in particular, Fricker's work highlights how prejudicial identity stereotypes are not only operational in the courtroom, but can track individuals' embodied experiences of

different contexts (Fricker 2007, 27). The "injustice" of judgments in our social and material lives can incur additional practical and embodied harms, in barring individuals access to legal redress, or healthcare, for example, as we will see in chapter 6. Attending to participants' embodied experiences of speaking about sexual violence both centres their situated experiences, and highlights the far-reaching impact of judgments in relation to stereotypical ideas about sexual violence and mental health. It establishes connections between legal discourse, judgment, and individuals' testimonies. This second conceptual reading then specifically attends to the interviews as not just articulatory practices themselves, but to participants' embodied experiences of speaking about sexual violence.

The importance of centring embodied experiences of neurodivergence is additionally central to both feminist and critical disability studies (Johnson 2021; Price 2015; Mollow 2006; Spurgas 2021). Johnson draws on phenomenological and embodied experiences to re-examine feminist condemnations of the psychiatric diagnosis of borderline personality disorder (BPD). She writes that

> While the primary calls for action among feminist scholars are to rename BPD or abolish the framework that supports this diagnosis, asserting that it unnecessarily medicalizes women's emotions, trauma reactions, and attachment difficulties, a small contingent asserts that wholly critical views of this diagnosis risk invalidating women who experience physical and mental distress currently organized as BPD (Johnson 2021, 636).

She shows how crip theorist Margaret Price evades both a medicalised psychiatric diagnosis and feminist reductions of these labels to tools of social control, by using phenomenological language to describe the "unbearable mental pain" of inhabiting the category. In invoking the category without subordinating herself to the diagnosis, Price's turn to phenomenology brings her embodied experience forward, and surfaces the role of norms surrounding identity. For example, while she '[does not] appreciate being labelled by the psychiatric profession' (Price 2015, 277), she is aware that this label, along with being white, affords her access to therapeutic spaces, for example. By firmly foregrounding bodyminds, and the situated and embodied viewpoints of specific lives,

the ways in which feminist discourse have harmed or shaped these experiences come into sharp focus.

Practically, the phenomenological reading was conducted once I had constructed the thematic framework and conducted the discursive analysis in NVivo. Then I specifically analysed the data in relation to speech and embodied experience. To do this, I first traced the embodied narrative contexts of individuals' decisions to speak about sexual violence (or not). This meant tracking specific locations of sexual violence testimony, including the criminal justice system, and educational contexts, for example. Then, I scrutinised individuals' embodied experiences. First, this meant attending to which aspects of the discursive participants found meaningful and valuable. Second, this examined all the kinds of "situations" that Moi describes, and how participants made meaning from these – for example, in connecting their experiences to their age or race. The interaction between these two aspects of the data then constitutes the phenomenological reading itself, as the entirely socially constructed stereotypes and "myths" associated with various aspects of participants' identities came to bear on the adjudication of their testimonies. In this examination of embodied experience, I reveal both which aspects of the discursive were sites of meaning-making or harm, and the situated experiences and harm of "testimonial injustice" itself. In bringing Fricker's work to bear on this analysis, I expose the specific ways in which participants' felt their testimonies or realities were undermined (Fricker 2007). Subjectivity is dynamic, not a unified or stable entity, nor is it "fixed" by discourse at any given time. It is conceptualised as encompassing participants' dynamic and ongoing interactions with available subject positions and identity norms and stereotypes over time and in different contexts. As such, my analysis of subjectivity is necessarily incomplete, and shaped by the inter-subjective dynamics of the research encounter.

D. *Ethical Challenges and Limitations*

Under this framing, my interactions with materials, participants, and my reflections thereafter, are all shaped through discourse in ways that I was not, and am not, necessarily conscious of. As Judith Butler's reading of Foucault suggests, 'power pervades the very conceptual apparatus that seeks to negotiate its terms, including the subject

position of the critic' (Butler 1992, 6). Practically, this meant that I kept a reflexivity diary, in an effort to identify at least some of the ways in which my encounters with materials and participants were shaped or constrained. Especially in light of the "testimonial injustice" participants experienced, it was important to implement effortful considerations to counter any prejudicial or silencing effects in the research encounters.

The reflexivity diary that I kept during the research process was informed by feminist literature that suggests that interrogating personal experiences of the research encounter can deepen analysis, and illuminate wider social and cultural dynamics. The prompts for the diary were designed using the work of Christine Bold (Bold 2012, 106). Bold re-orders the reflexivity prompts suggested Valerie Yow, which explicitly attend to the role of identity in the research process (see figure 1; Yow 2006). Given the theoretical framing of this project, as well as ongoing issues of representation and exclusion within feminist work, these were important sites for interrogation. This is a vital component of a critical analysis, as the imperative for researchers to be "reflexive" is fundamentally interpersonal, and relies on consideration of my interactions with interview participants, rather than merely reflecting on or enumerating a list of my identifications (Pillow 2003b, 177; Murray 2020). The prompts were intended to draw out how my experiences played out in the interviews, and in subsequent analysis, rather than merely operate in a confessional or tokenistic way.

Figure 1. Bold's reflexivity prompts (Bold 2012, 106)

1. Why am I doing the project in the first place?
2. How does my ideology affect this process? What group outside the process am I identifying with?

The answers to these should be in your mind from the start.

3. What am I feeling about this narrator?
4. What similarities and differences impinge on this interpersonal situation?

Awareness of these during the interview may help maintain an open mind.

5. In selecting topics and questions, what alternative might I have taken? Why didn't I choose these?
6. What other possible interpretations are there? Why did I reject them?

These questions may come forward when analysing the data.

7. What are the effects on me as I go about this research? How are my reactions impinging on the research?

This final question might include the cumulative effects of different interviews of time.

(adapted from Yow, 2006: 228, my italics)

The first ethical problem that I encountered while collecting interview data pertained to my requirement that participants be in touch with a support service. Two of my earliest assessments were conducted with people with different combinations of personality disorder diagnoses, C-PTSD, Autism, and ADHD. Neither had access to a formal support service. One of these women had additionally been regularly denied support when seeking it from formal mental health services on account of the personality disorder diagnosis. My requirement that she had access to support was then experienced by her as an accusation, as though the lack of support service was her fault, for lack of trying. After one of these assessments, I wrote in my reflexivity diary that

> She accused me of being another white middle-class person who assumes that everyone can buy a therapist, and quite rightly said that the requirement that individuals have a support service should be made clearer in the materials for advertising the study.

My reading of the research participant's response is that several things are going on here. First, there is an expression of understandable exasperation at the structural problems with service provision in the UK: an important point and critique of existing systems that is largely not captured by my project. Second, she is also right to criticise my recruitment materials, in which I had not clearly defined what I meant by a support service, which was not limited to a 'therapist'. My ethical approach was challenged by this participant, and it was a challenge that I agreed with. Subsequently, I rewrote my study flier to include a separate bullet point about the support service requirement, as well as a definition ('support worker, mental health professional, sexual violence professional, GP, or peer support service'), and I revised my resource list to include peer support services that I could assist with referrals for, in light of her difficulties with access to formal support services. This edit was made in response to a legitimate challenge, and to try and emphasise that a support service did not have to be limited to one that was costly. However, this is also an example of the complexity of these decisions. Even if I had been able to conduct my interview as planned through the feminist sexual violence service I used to work for, its virtue of being "feminist" does not necessarily mean that it would have been trusted by potential participants, or even helpful.

The second ethical challenge that I encountered with interview practice was in my decision to renumerate participants for their time. I chose to renumerate participants with a £50 voucher for anywhere of their choosing, which was intended as an amount that was not so big as to constitute coercion to participate, while also acknowledging the value and emotional toll of participation (Downes, Kelly, and Westmarland 2014). One of my participants was a full-time carer for his Mum, and so I additionally renumerated him for the cost of obtaining care externally to facilitate his participation, as other feminist researchers have taken childcare into consideration in their research practice (Oakley 1981).

However, there are debates around how to approach renumeration with "vulnerable" participants (Davies 2015; Downes, Kelly, and Westmarland 2014), and one of my participants, Alice 2, told me that it felt like a re-inscription of the abuse she had experienced, as her abusive ex-husband would regularly buy her "gifts" after an abusive event or period; she told me that she would be giving it away. Alice 2 raises an important

consideration, particularly in relation to mental health research. Amongst the research community of "survivors" of the mental health system, it is generally suggested that participation in mental health research from people with "lived experience" should be compensated appropriately (Wallcraft, Read, and Sweeney 2003). Researchers engaging with the idea that payment may mirror abusive experiences have similarly felt that a "gift", in the form of a voucher, would be better than nothing (Coy 2006). This was not the case for Alice 2, which partly reveals that everyone experiences research differently, and that the measures I implemented were imperfect ones in this complex context. The importance of Alice 2's critique is then levelled at the idea that there is one standard or "benevolent" practice in either mental health or violence research, and emphasises the need for research that responds to participants in a dynamic and ethical manner (Clark and Walker 2011; Mulla and Hlavka 2011).

The third ethical challenge I encountered was with how I had designed the topic guide, as my emphasis on reassurance had a potentially limiting influence on both the data and the resultant analytic strategies. For example, Beverley regularly used the phrase "d'you get it?" in her interview. This phrase could potentially have many different meanings, and could be a marker of Beverley's emotional discomfort, or a response to speaking about difficult topics. The difficulty of interpreting it is partly found in a limitation of conducting interviews remotely. Only two participants (Sarah, Ellen) elected to have their cameras on for interviews, and attending to "embodied experience" is limited by this method of data collection. However, when I went back to examine at which points Beverley had used this phrase, it became clear that it was exclusively when she was discussing either her experience of the category of Bipolar, or her experiences of violence. While this could indicate emotional difficulty, it could also suggest that Beverley perceived me as not understanding her experience of mental health or sexual violence. Under a phenomenological and discursive framing, there is inevitably a gap in understanding here, but during the interview, sensing discomfort, I thought that the best response to these moments was to provide validating and reassuring responses, rather than to ask further questions. McKenzie-Mohr and Lafrance suggest that phrases such as this are usually key moments for communication, understanding, and clarification (McKenzie-Mohr and Lafrance 2011, 61). In not following up and clarifying at these moments, the interview encounter may have tempered Beverley's testimony and experiences of

precisely the topics at hand. Feminist interview methods often include conflicts between practices of care and strategies for obtaining information, and surfacing these is important for interrogating the limitations of our knowledge production (Thwaites 2017).

The decision to invite participants to feedback on my interpretations, or read through and alter their transcripts, was intended to both foster their autonomy, and honour their own interpretations and embodied experiences. However, given the remote nature of the interviews, it was difficult to establish ongoing research relationships with participants, and while some responded positively to my emerging interpretations, the engagement has been relatively sparse. In addition, I choose not to surface any edits participants made to their transcripts, as this was conducted in service of them being able to author the narrative, which as we will see in chapter 6, was not always their experience.

The interview sample size is additionally small; the data I collected is dominated by both women, and diagnoses such as PTSD, depression, and anxiety. This was perhaps influenced by my requirement that participants be in touch with a support service, but also reflects some of the discursive frameworks surrounding sexual violence, and who is able to speak about it. It was clear that this was also affected by other individual and structural factors: for example, one person was unable to take part as they were sectioned while I was collecting data. The sample size was additionally affected by my own safety and capacity as a researcher, as the period of the COVID-19 pandemic was challenging in many ways, and limiting the number of interviews was necessary for managing my own distress (Campbell 2002). While the discursive analysis of interview data is therefore highly situated, it can tell us about how discursive constructions of sexual violence and mental health permeate 'the web of everyday existence' (Foucault 1977, 183) for these highly situated individuals in its rich analysis of their specific embodied situations.

Conclusion

In this chapter, I have outlined how this project was conducted, and the justification for its (re)conceptualisation, in light of the COVID-19 pandemic. In part 1, I outlined my theoretical orientation, which reflects a critical feminist and Foucault-informed

understanding of discourse, power, subjectivity, and embodied experience. This means that this project focuses on the discursive, and is supplemented with phenomenological methods and tools. In part 2, I specifically detailed my approach to discursive analysis, and the ways in which this varied for the different materials, to answer the research questions at hand. This led to a broad appraisal of the policy and legal landscape, as outlined in sections 2A and 2C (Phipps 2010).

In part 3, I explained my specific approach to accessing individuals to participate in this research (3A), as well as the approach to the interview itself, which is informed by feminist principles and narrative methods (3B). The nature of my research questions additionally led to an analytical strategy for interview materials that drew on feminist phenomenological literature, to attend to participants' embodied experiences (3C). Both this, and my ethical practice more generally, were implemented in an effort to centre participants and their own assessments of their experience and reality, as well as their autonomy and control over the research process. Under this framing, both participants' subjectivities and my access to them are necessarily dynamic and incomplete. Within all of these decisions lie complex ethical considerations and challenges, which I have integrated into the discussion herein. Legal texts and interviews demonstrate distinctive aspects of our social and material worlds. In bringing them together for discursive analysis here, we can garner insights into both legal discursive constructions and embodied experiences of speaking about sexual violence at the nexus of mental health.

3. The Words May Change But the Melody Lingers On

Introduction

In this chapter, I explicate my critical appraisal of Anglo-American feminist literature, to provide some theoretical backdrop for the interrelations between feminist, legal, and psy discourse on the topic of sexual violence and mental health. I argue that Anglo-American feminist narratives of sexual violence and mental health remain exclusionary and informed by psychiatric professional discourses, which continues to implement narrow parameters around sexual violence testimony: 'the words may change but the melody lingers on' (Rush 1996). This phrase, and the title of this chapter, are taken from an article of the same name by feminist social worker Florence Rush. Rush was an incisive voice in the field of sexual violence, feminism, and the psy disciplines in the US, and it is through several observations from her work that I have structured part 1 of this chapter.

The introduction to this chapter is the longest of any in this thesis, and this has been deemed necessary to set up the contemporary context, the justification for its approach, and the associated intervention into this literature. In this introduction, I summarise the shape of this review, as well as how the materials were accrued. Then, I explicate a case study example from my readings of Government policy documents to introduce the contemporary landscape in full, and to demonstrate the messy and interconnected relationships between feminism, the law, and the psy disciplines. I use this case study to introduce in full Florence Rush's three narrative episodes that structure part 1 of this chapter. The three episodes are: The Freudian Cover-Up (1A); Today I'm a Feminist, Tomorrow I'm a Therapist (1B); and The Discovery of Trauma: "A Mark On the Brain" (1C). While all three narrative episodes that I describe coexist to an extent, I suggest that each episode largely replaced the former. I draw out the narrative shape of feminist reasoning within the field, as well as their historical oversights and blind spots (Shepherd 2008; Cvetkovich 2003; Hemmings 2011). My intention is to, in Toril Moi's words, 'provide a diagnosis of the theoretical pictures that hold us captive, not in order to refute them, but to make us aware of other options' (Moi 1999, 119).

In section 1C, I draw on the insights of Clare Hemmings to demonstrate that these three episodes coalesce to produce a broadly chronological narrative arc of "progress": transforming feminist discourse from the historic denial preceding the 1970s in section 1A to the successful "discovery" of sexual violence in the category of trauma in section 1C. Hemmings' work is useful here, as this narrative arc invites us to forget the feminist past and embrace the present category of trauma. Instead, following Hemmings' invitation to refuse an uncritical acceptance of the present, we can see with clarity that the discovery of trauma is where new norms were delineated for the experience and articulation of sexual violence. Part 2 of this chapter is then concerned with critiquing these new "norms" that the discovery of trauma has generated in relation to psychiatric diagnoses. To do this, I draw on insights from both critical race and critical disability theory in section 2A, which demonstrate that the category of trauma in general, and psychiatric diagnoses in particular, vary in their accessibility. In section 2B, I address the role of "normal" trauma and PTSD in the legal realm, and introduce the medico-legal history of "malingerers" and the law's anxieties surrounding mental health and the "contamination" of traumatic memories. Finally, in section 2C, I turn to examine what being "normal" really means at the nexus of sexual violence and mental health, as well as its consequences for speaking about sexual violence from psychiatric diagnoses. The aim of this chapter is to demonstrate that feminist scholarship has been focused on demonstrating that people who have experienced sexual violence are "not sick" (hysterical), but "traumatised". In this understandable bid for legitimacy, this scholarship has contributed to the construction of new "norms" surrounding sexual violence and mental health, and these raise specific problems for people who identify with psychiatric diagnoses.

It is useful for me to briefly summarise the reason for structuring part 1 of this chapter using Florence Rush's work. The period between the 1970s and 90s saw a plethora of feminist scholarship and activism engaging with the psy disciplines on the subject of sexual violence (Pache 2022; Bourke 2012; Sweet 2021). There are various ways and times in which feminist work has denounced, debated, and endorsed psy expertise between the 1970s and the present UK context. Rush's commentaries on feminist engagements with the psy disciplines were made during this period, and she had a finger on the pulse for the particular consequences of feminist work in relation to sexual

violence. Her assertion that 'the words may change but the melody lingers on' is particularly significant, as her contention is that the new category of "trauma" for understanding sexual violence carries many of the same problems that feminists were directly trying to resist. This is a similar argument to that which I am making here. In addition, Rush's work is exceptional in this literature, in that it engages with the nexus of the relationship between sexual violence and psychiatric diagnoses, where most scholars focus on either one or the other. It is for this reason that I structure each narrative episode with observations from Rush's work.

Before I continue, I will summarise the methodological approach taken to this chapter, for clarity. This is a critical review of secondary feminist literature published between 1963 and 2021, although I focused on the proliferation of feminist engagements with the psy disciplines between 1970 and 1992. I obtained texts in an exploratory fashion, and materials include prominent and foundational Anglo-American feminist sexual violence texts (e.g. Brownmiller 1975; 1999; Griffin 1971; Kelly 1988), as well as those specifically discussing the psy disciplines or psychiatric categories (e.g. Herman 1992; Chesler [1972] 2018; Ussher 1991; Millett 1970; Firestone 1970; Burgess and Holmstrom 1979; 1974). Focusing exclusively on scholarship from the UK and the US constitutes only a partial examination of feminist literature on sexual violence in the Anglophone world, and focusing on the most prominent texts necessarily results in omissions, particularly in relation to race (Davis 1981; Davis [1981] 2019). However, American feminist theory has been strongly influential over British feminist conceptions of trauma and sexual violence politics (Crook 2018; Serisier 2018), and examining foundational and oft-cited texts is here important for revealing some of the oversights in feminist engagements with the psy disciplines. Important critiques have been made of this "mainstream" feminist literature in relation to race (Phipps 2020), but less attention has been given to the particularities of psychiatric diagnoses, and this is the contents of my intervention. Finally, throughout this critical appraisal, and particularly in the second half of this chapter, I draw from insights from critical feminist scholarship to critique the identified "norms" (e.g. Sweet and Decoteau 2018; Laugerud 2019; Davis 1981; Davis [1981] 2019; Stefan 1994; Serisier 2018; Phipps 2020; Harrington 2010; Sweet 2021; Pache 2022; Haaken 1999; 1998; 2010; 1996; Crook 2018), as well as critical race and disability theory (AlAmmar

2023; Goozee 2021; Spurgas 2021; Johnson 2021; Carter 2021; Hartman 1997; Deer 2015; Wanzo 2009).

Sexual Violence: A Public Mental Health Problem

To contextualise this chapter, I start with a case study from my reading of Government policy documents, to illustrate some of the problems with the current discursive landscape. More attention than ever is being paid to the psychological dimensions of gendered violence by Government policies. British Feminist researchers working on mental health at King's College London declared in 2017 that violence against women is now a 'public mental health problem' (Oram, Khalifeh, and Howard 2017, 159).[6] Government policy soon followed this sentiment, as in the UK Government's 2021 strategy for tackling violence against women and girls, the 'detrimental effect on mental health' (HM Government 2021, 20) is cited as the primary consequence of gendered violence. In the 2022 rape review progress update (HM Government 2022), the Government details a case study of the impact of sexual violence on Faiza,[7] who was able to access support for her subsequent 'self-harm', 'trauma', and 'intrusive suicidal thoughts' (HM Government 2022, 10). The psychological support Faiza was able to access came from her Independent Sexual Violence Advisor (ISVA). Government funding for ISVAs was one of the key policy responses to the realisation that prosecutorial success was dwindling in 2006, and their role is to support people who have experienced sexual violence through the criminal justice system (McGlynn 2010). The case study concludes by saying that Faiza's 'voice was heard throughout' her experience of engaging with the criminal justice system (HM Government 2022, 11), and that the ISVA coordinated with a variety of 'other professionals […] to support Faiza's recovery' (HM Government 2022, 10). Faiza's experience was effectively articulated and 'heard' by the Criminal Justice System, and subsequently, she was supported towards "recovery".

Faiza's experience illustrates the here arguably successful feminist mobilisation around the psy disciplines in relation to sexual violence testimony. Before feminist mobilisation

[6] This assertion is arguably particularly influential coming from this research group, which is located on-site at the Maudsley Hospital: the birthplace of British psychiatry (Angel 2003).
[7] Not her real name.

around trauma and psychiatric diagnoses, the social assumption was that sexual violence was "abnormal" (Bourke 2012), and so too were the people who were testifying to it: they were either "mad" or "bad", and their testimony untrue (Stefan 1994; Alcoff and Gray 1993). US legal and (dis)ability scholar Susan Stefan articulates this when she writes that

> In order to maintain the fiction that violence against women is itself aberrational, women who suffer and fear that violence must themselves be painted as aberrational. This serves the dual purpose of silencing them and discouraging other women from coming forward (Stefan 1994, 1306).

Declaring sexual violence a "public mental health problem" then challenged this dominant paradigm to redefine sexual violence as both ubiquitous, and psychologically harmful. Tanya Serisier has shown that this process created a new genre for stories of sexual violence by 'providing a new discursive framework for making the experience and its articulation politically meaningful' (Serisier 2018, 8).

However, within the story of redefining sexual violence as a "public mental health problem", in society and policy alike, are several interconnected stories about the relationship between feminism, the law, and the psy disciplines. For example, returning to the case study of Faiza detailed in the rape review progress update, despite her 'voice being heard throughout' her engagement with the Criminal Justice System, her case was met with a 'No Further Action' decision from the Police. A closer look at Faiza's story also reveals that she is additionally described as 'neurodivergent' and had diagnoses of depression and anxiety before her experience of sexual violence. The presence of mental health diagnoses significantly affects Police decisions to prosecute and charge suspects in England and Wales (Hohl and Stanko 2015; Ellison et al. 2015). Despite the conclusion of the case study, Faiza's voice did not even make it to the courtroom. Faiza's case is illustrative here of some of the problems with feminist scholarship concerning the relationship between sexual violence and mental health. Despite the narrative that trauma, or mental health diagnoses, are "normal" in the wake of sexual violence, these new norms both delineate new narrative demands for sexual violence testimony, and necessarily lead to exclusions: particularly for people who identify with psychiatric diagnoses before assault. To understand these shifts in feminist discourse, and the

associated struggle for the legitimacy of sexual violence testimony, it is important to place them within their wider context of debates surrounding psychiatric diagnoses more generally.

To do this, I first describe what Rush called *The Freudian Cover Up* - the feminist argument that the psy disciplines were complicit in silencing sexual violence testimony by designating claims of sexual violence as expressions of 'madness' or 'fantasy' (Rush [1977] 1996). Rush instead contributed to a burgeoning literature that defined sexual violence as an ordinary event in the lives of women (Harrington 2010, 105), as well as its manifestation in the form of "madness" or psychiatric categories. These scholars built on various anti-psychiatry analyses conceptualising both madness and violence as oppression (Chesler [1972] 2018; Ussher 1991; Laing 1960; Szasz 1962), and began to conceive of both sexual violence and the psy disciplines as techniques of social control (Harrington 2010). This narrative worked to emphasise the ubiquity of sexual violence, and was influential to changes in legislation in the US (Naples 2003, 1154). In the UK, these legislative debates have been especially concerned with notions of trauma and PTSD, as we will see in the next chapter (Ormerod 2006; Ellison 2005; Criminal Justice System 2007; Ward 2009; Crown Prosecution Service 2021a). This period additionally saw the establishment of women's experiences as central to the production of new understandings of sexual violence, as well as to instantiate themselves as the experts of these new truths (Serisier 2018, 11); Rush recounted her own experience of sexual violence within this literature, for example (Rush 1980).

This is part of the second episode I narrate, *Today I'm a Feminist, Tomorrow I'm a Therapist*, a paraphrasing of Rush's observation that I will explain at the outset of 1B (Rush 1996, 311). I demonstrate how this opportunity for new claims of expertise led to debates within feminism around whether placing psychology at the centre of sexual violence politics was productive either politically or therapeutically (or neither). For example, Rush was shocked at how far sexual violence had become medicalised by the time she wrote about how *The Words May Change But The Melody Lingers On* in 1996, asking

> why is it that originally militant and politically active rape crisis centres, which also offered counselling and emotional support, lost funding unless they relinquished their politics and offered only therapy for women subjected to rape, incest, and other forms of sexual abuse? (Rush 1996, 311).

Rush's question is still pertinent today, as Faiza's case shows. ISVAs are regularly now instantiated within feminist rape crisis centre, while funded by the Government. However, the ISVA's primary role in Faiza's case was in providing emotional and psychological support, rather than affecting wider societal change or even a successful criminal conviction. For Rush, and others, defining sexual violence as a "public mental health problem" was depoliticising (e.g. Armstrong 1994; Bumiller 2008).

This leads me to the third and final episode that I narrate within feminist engagement with the psy disciplines, which is about the "discovery" of trauma, represented by Rush as 'a mark on the brain' (Rush 1996, 311). To illuminate the appeal of this psychopathological understanding of trauma for feminism, I draw on insights concerning social categories of the "norm", and whether sexual trauma is "normal" because it is ubiquitous, or "normal" because it is not a mental "illness" (Sweet 2021; Pache 2022). This discussion focuses on feminist scholarship examining the psychiatric diagnoses of PTSD, Multiple Personality Disorder, and Borderline Personality Disorder – I engage with other diagnoses, but find these particularly illustrative of the narrative episodes that I intend to reveal here. This is particularly because within feminist debates, these three diagnoses have strong relationships to the history of "hysteria", and the associated stereotypes surrounding femininity and pathology that operate within the psy disciplines. The discussion is additionally focused on the consequences of these narrative episodes and ensuing debates on speech. This reflects my research questions, which are oriented around how people who identify with psychiatric diagnoses experience and *speak* about sexual violence, and the discursive scaffolding surrounding the legitimacy of sexual violence testimony more broadly.

1. Florence Rush's Three Narrative Episodes

A. The Freudian Cover-Up

The first significant point of feminist engagement with the psy disciplines concerns observations about the "psy"lencing of sexual violence which rose to prominence during the 1970s, building on the anti-psychiatry literature that came before it. British critical psychiatrist R D Laing is often credited with the idea that '"mad" behaviour was understandable in the context of a person's life' (Ussher 1991, 147); a legitimate expression of oppression and hardship rather than a biological "mental illness", and thus in need of social and political solutions rather than individualised medical ones. Feminist writers noted that Laing's analysis, published in 1960, failed to properly consider the role of gender within this configuration. US psychologist Phyllis Chesler first built on Laing's analysis in 1972 with her foundational text, *Women and Madness* (Chesler [1972] 2018), and a similar work was later written by British psychologist Jane Ussher in 1991 (Ussher 1991). They argued that conceptions of "madness" are additionally gendered, and indeed, misogynistic, tracing this back to mythological ideas about women. One of the most illustrative examples provided by this literature is the notion of the "hysteric". Etymologically deriving from the Greek "hustera" meaning womb, the diagnosis is analysed as embodying a legitimate and understandable response to patriarchy and distressing life events, as well as a means of discounting women's speech – "she's hysterical". On this account, "madness" is established as a normal response to patriarchy, as well as a means of silencing women's testimony, and thus a barrier to social or political change.

It was ultimately Sigmund Freud, and through him psychoanalysis, that came to exemplify this "psy"lencing of sexual violence amongst feminist scholars. Rush originally delivered her paper entitled *The Freudian Cover-Up* in 1977, arguing that Freud's contributions to the psy disciplines colluded with perpetrators to cover up the ubiquity and harm of sexual violence. While illustrative here of this first narrative episode, Rush's assertion was predated by several other feminist texts. Kate Millet went as far as to say that Freud was 'beyond question the strongest individual counterrevolutionary force in the ideology of sexual politics' (Millett 1970, 178), and that 'it is not enough to find feminism evil – it must be diagnosed as an illness, a pathology' (Millett 1970, 207). These works became influential in the sexual violence literature (Harrington 2010), and the

same sentiment was additionally central for prominent writers such as Susan Griffin and Susan Brownmiller (Griffin 1971; Brownmiller 1975), who began to analyse sexual violence as a tool of psychological control, and a means by which 'all men keep all women in a state of fear' (Brownmiller 1975, 204). As such, they also positioned the psy disciplines as a means of "covering up" the extent and prevalence of sexual violence, and Freud was rendered the source of this denial. Brownmiller was particularly and vehemently against Freud, going as far as saying that 'Men have always raped women, but it wasn't until the advent of Sigmund Freud and his followers that the male ideology of rape began to rely on the tenet that rape was something women desired' (Brownmiller 1975, 315). In order to understand this condemnation of Freud, it is important to unpack some of the components of this narrative: how the psy disciplines were considered a tool of social control, and the debates around psychiatric diagnoses and sexual violence that coalesced around the release of the third edition of the Diagnostic and Statistical Manual (DSM) for psychiatric diagnoses in 1980.

In the 1960s and 70s, Feminists were increasingly noting the role of the psy disciplines in prescribing a respectable femininity – measured by women's ability to act "responsibly" as woman, wife, or mother; the psy disciplines were viewed as a *tool* of the patriarchy. In *The Feminine Mystique* (1963), Friedan suggested that the passivity of American femininity was a form of psychological brainwashing, akin to that experienced by prisoners of war (Friedan 1963). While Friedan's argument was about society at large, soon anti-sexual violence feminists were analysing psychological experts as, in sociologist Carol Harrington's assessment, 'agents of mass indoctrination in female subordination and male impunity' (Harrington 2010, 106). The psycho-pathologisation of women was argued to serve the dual purpose of prescribing an acceptable and compliant femininity. As American feminist Mary Daly wrote in 1979, 'the patient patiently re-learns her history, which is reversed and rehearsed for the therapist's records' (Daly 1979, 287). Daly analysed women as being 'mind-raped' (Daly 1979, 287) by the therapeutic professions. Whether through designating someone as "mad" and "hysterical", or through the process of treatment itself, sexual violence testimony itself is here either denied, or even rewritten as symptomatology: women's stories are omitted through psy "expertise".

These works intersected with anti-psychiatry scholars such as Lucy Johnstone, who was arguing that women who were being designated "mad" were in fact not sick (Johnstone 1989), and that the psy disciplines were colluding with perpetrators to "cover up" the extent and harm of sexual violence. Rush describes this as a "psychiatric conspiracy". As women increasingly approached her to tell their stories, she observed that many of them described what she called 'the psychiatric conspiracy of avoidance or distortion of the sexual abuse problem' (Rush [1977] 1996, 272). Feminists resisted the idea that "madness" is caused internally – for example, through genetics or biology – and reconceptualised behaviour known clinically as psychiatric diagnoses or symptoms as culturally and socially instantiated. Feminists were resisting biologically deterministic explanations for women's behaviours in general. For example, Judith Herman's psychoanalytically trained mother, Helen Lewis, published a book in 1976 called *The Psychic War in Men and Women* (Lewis 1976). In it, she argued that 'anatomy contains no inherent prescription for women's social inferiority' (quoted in Herman 2013, 531), and instead, that it was patriarchal societies, and ideals of masculinity and femininity, that were psychologically harmful.

Feminist resistance to notions of "madness" was additionally occurring in a context where emphasis was being placed on the biogenetic origins of psychiatric diagnoses, particularly in the years following the introduction of the third edition of the DSM for psychiatric diagnoses in 1980 (Angel 2003; Harrington 2010; Spurgas 2020). In the late 1970s, the task force appointed to revise the DSM were committed to several principles that ran counter to the previous editions of the manual. These included a distinct emphasis on the biological aspects of mental health, and a distinction between "normal" people and the "sick" (Angel 2012). Cultural theorist Katherine Angel has suggested that under this new conception, 'Disorders were discrete, and operationalized by sets of symptom criteria' (Angel 2012, 8). In their attempts to resist this categorisation, feminists were instead placing emphasis on the environmental causes of diagnoses, and particularly insisted on understanding them in relation to widespread sexual violence.

In feminist writing, feeling states and attendant psychiatric diagnoses were being reconceptualised as legitimate and understandable responses to sexual violence, rather than the consequence of women's biology. An illustrative example of this

reconceptualization can be found in the slightly later, and foundational, work of Judith Herman in *Trauma and Recovery* (1992). Herman's work is particularly notable here, as her firmly feminist input was influential in the resultant psychiatric diagnoses produced in the 3rd edition of the DSM (Herman 1992). In *Trauma and Recovery*, Herman was particularly outraged by categories of "personality disorders", as the very language locates the problem in individuals' personalities, rather than experiences of trauma or sexual violence. She argued that the diagnoses of Multiple Personality Disorder and Borderline Personality Disorder were contemporary "hysteria" diagnoses.[8] Taking the example of Borderline Personality Disorder, other feminists both have and continue to argue that this diagnosis acts as a proxy for diagnosing trauma or sexual violence, while othering (and silencing) those who receive it, given both the conceptualisation of its cause as internal (personality), and its stigma within the psy disciplines (Shaw and Proctor 2005; Ussher 1991, 136–37; Chesler [1972] 2018; Bumiller 2008, 91). As such, this diagnosis is analysed as a socially constructed tool for societal control: a means of pathologising and silencing sexual violence.

The focus on the psy disciplines as a tool of social control, and the illustrative example of "hysteria" to capture both the trauma of sexual violence, and the extent of its "psy"lencing, illuminates the feminist condemnation of Freud. There is a story told about Freud that neatly explains each of these problems, and it has been regularly repeated by foundational texts in the field (Herman 1992; Ussher 1991; Daly 1979; Mason 1994).[9] The story goes something like this: in Freud's early work with "hysterics'" he initially, and commendably, bore witness to stories of sexual assault, abuse, and incest during the course of his therapeutic investigations. In 1896, he published *The Aetiology of Hysteria,* a report of eighteen case studies, in which he radically claimed that at the bottom of every case of hysteria there was one or more instances of childhood sexual abuse (Freud 1896, 203). Yet, as Herman and psychologist Lisa Hirschman noted (Herman 2023, 6; Herman and Hirschman 1976), Freud reflected on 'the realization of the unexpected frequency of hysteria [to determine that] it was hardly credible that perverted acts against children

[8] It should be briefly noted that Herman felt it was her own 'passionate embrace of feminism' that influenced her mother's work cited above; and distinguishes her mother's 'conventional' assessments of 'gender roles' from her own as a 'radical feminist' (J. L. Herman 2013, 530).
[9] Mason's work is not a "foundational" text, but is significant in the next chapter, on account of her contributions to law and policy.

were so general' (Freud 1954, 215). Instead, he determined that women's experiences of sexual violence were fulfilling unconscious desires and fantasies. The turning point is often considered his last "hysterical" patient named Dora; in 1985 there was an entire essay collection published under the title *In Dora's Case: Freud-Hysteria-Feminism* (Bernheimer and Kahane 1985). It is this case that marked the moment when the psychoanalytic focus on fantasy led Freud to finally conclude that his patients' accounts of sexual violence were false. As he is quoted by Herman, 'I was at last obliged to recognise that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up' (Freud 1925, 34). This story offers a clear message: Freud underwent a transformation from benevolence to evil, from bearing witness to individual stories of sexual violence, all the way to a societal "cover up". Given that he could not face up to the ubiquity of sexual violence amongst his clients, a new blanket of silence was thus laid across the problem of sexual violence. This story serves the feminist imperative of emphasising the therapeutic and political value of speaking out about sexual violence on a mass scale; provided there is a receptive witness.

Further, Freud's articulation of accounts of sexual violence as "fantasies which my patients had made up" provides a neat explanation for the "mad/bad" configuration that is often established by feminist analyses. Whether false allegations were considered to be made intentionally (bad) or not (mad), they had been historically associated with a feminised subjectivity. Over the course of the twentieth century, false rape allegations were increasingly viewed in medico-legal circles as both prevalent, and a form of psychopathological "gender-related lying" (e.g. Kanin 1994; cf Ellison 2009; cf Quilter 2015). This was occurring in the context of the increasing role of the psy disciplines in policing British state liability in relation to legal and welfare policy, and the consequent assessment of "real" versus "malingering" claims of trauma (Smith 2011). After the first world war, the British government attempted (unsuccessfully) to convince psychiatrists to assess whether veterans were suffering from real war neuroses, or were "malingering", in order to limit the amount of pension awards being given to veterans for psychiatric injury (Smith 2011, 13). This is particularly notable, as "malingering" constitutes a psychiatric category in contemporary classification systems used in both the US and the UK (World Health Organization 2022, QC30; American Psychiatric Association 2022, V65.2). It is specifically described as the feigning of illness in service of an outcome, one

of which is “compensation or personal injury damages” (World Health Organization 2022, QC30). Prejudicial stereotypes about women, irrationality, and financial gain were the target of this feminist scholarship, and condemning Freuds work provided an appropriate narrative with which to do this.

Feminist critiques of this landscape were also beginning to highlight the role of social control in the creation and maintenance of “normal” and “deviant” sexual identities (Segal 1994; Rubin 1984; Ussher 1991; Butler 1990), and indeed the entrenched association of femininity with the latter (Firestone 1970; Millett 1970). The psy disciplines were considered an arbiter of “normal” and “deviant” femininity (Johnstone 1989; Ussher 1991), and indeed “normal” and “deviant” sexuality (Weston 2017; Merck 1992; Ussher 1991). The disavowal of Freud explained how and why people who had experienced sexual violence were either adjudicated as “mad”, subject to fantasy, or “bad”, due to the deliberate fabrication of accusation, as it was particularly feminised. Further, a rejection of psychoanalysis aligned feminists with concomitant shifts in medicine, psychiatry, and the law, all of which were increasingly rejecting psychoanalysis in favour of a somatic and taxonomic psychiatry (Spurgas 2020; Angel 2003; Smith 2011).

This account gives the psy disciplines a figurehead, and a villain. This summation of Freud’s work is a story told for a particular purpose: it demonstrates how the “evil” patriarchal forefathers denied women’s experiences of sexual trauma. As such, these critiques of Freud, and hence psychoanalysis, echoed core messages in feminist politics. They demonstrate the widespread societal denial of sexual violence, and that responses to sexual violence deemed psychopathological were instead ubiquitous and understandable in context, rather than indicative of a pathological feminine subjectivity. Therefore there is a shift in the narrative here. Although the wider feminist narrative may have begun with the notion that Freud was a product of his time, and that he got various things about women and sexual violence wrong (e.g. Millett 1970; Firestone 1970), he became cast as a patriarchal enemy, and the source of the “psy”lencing of sexual violence.

This narrative of the psy disciplines as a feminist enemy established several interrelated messages. The first was the fact that women being designated as “mad” were actually responding to their environments in a normal way; they were not “sick”. Kathie Sarachild,

an American feminist often considered one of the originators of consciousness-raising, wrote in 1970 that 'when we had hysterical fits, when we took things "too" personally, we [were] […] responding with our feelings *correctly* to a given situation of injustice' (Sarachild 1970, 78). Consequently, this narrative highlights that psychiatric diagnoses were complicit in patriarchal abuse as they were denying and silencing women's experiences, as well as the prevalence of sexual violence – whether through biogenetic explanations for mental health problems, or psy theories and treatments themselves. The final thing established by this narrative was to inaugurate two competing sides: women versus men, good versus evil, and feminism versus the psy disciplines. The psy disciplines are painted as an enemy of feminism itself: Firestone went on to write that psy 'theory… was used to wipe up the feminist revolt' (Firestone 1970, 70), and Rush that 'psychology is used not to help, but to trap and ensnare the female' (Rush 1996, 272). The figure of Freud becomes symbolic in these texts as embodying the opposition, as well as all of these narrative consequences.

It is important to clarify that Freud was symbolic, rather than wholly disavowed, as Rush even had to explain later that she wasn't blaming him (Rush 1996). She writes that

> I never intended to either praise or bury the man. I hoped to present him as yet another tool by which he has been employed to sustain the subordination of women and children (Rush 1996, 304).

Rush felt the need to make this statement as many of her contemporaneous feminist writers valued aspects of Freud's theorising, of psychoanalysis, or of the psy disciplines more generally. By this time, feminist politics had already appropriated some psychological concepts, such as the liberatory potential of therapy, and the associated value of speech. As such, an outright rejection of the psy disciplines was not on the cards.

Other scholars have demonstrated that the feminist challenge and attendant narratives are a somewhat reductive reading of Freud's work (Bourke 2012; Sweet 2021; Haaken 1996). British psychoanalyst Juliet Mitchell and US sociologist Nancy Chodorow have attempted to reanimate the utility of his work for feminist politics, for example (Mitchell 2000; Chodorow 1978; Mitchell [1974] 2000, 61–63). However, I am less concerned with

representations of Freud's ideas in terms of historical accuracy or theoretical utility, and more interested in how they resonated for feminists at a particular moment in time and why. One of the most important things established by feminist narratives is to contest the notion of psy expertise and psychological "fact", and to reveal that psy professionals such as Freud are storytellers too: storytellers with the power to affect material consequences for speech and subjectivity. Critical race theorist Rebecca Wanzo writes that

> Medical storytellers are often not constructed as storytellers at all because research, statistics, and experiments are represented as reasonable discourse and facts […] The artificial binaries between sentimental and real, emotion and fact, and experience and evidence demonstrate how an individual narrating a personal story of pain can be relegated to a space outside of knowledge about her own body or history (Wanzo 2009, 146).

The feminist work outlined above contests the practice of taking a psychiatric "history", and argues that this suppresses and rewrites women's understandings of their own experiences of sexual violence and mental health.

Yet there was also disagreement between feminists about the psy disciplines. Janice Haaken has since suggested that it was psychology that was the "bad object" of the women's movement (Haaken 2010, 69). What she meant by this was that while often dismissed as an enemy, feminist anti-violence work has appropriated several aspects of psy knowledge. The rendering of the psy disciplines as an outright *enemy* of the movement then fails to capture parallel developments in the exchange of ideas between feminism and the psy disciplines. For example, the aforementioned anti-psychiatrist and feminist Lucy Johnstone (page 70) has since developed an anti "illness" model of psychology, which is being increasingly implemented in mental health services in the UK (e.g. NHS Foundation Trust 2020). The model is organised around encouraging clinicians to ask "what happened to you" instead of "what is wrong with you" (Johnstone and Boyle 2020). While writers such as Louise Armstrong and Kristin Bumiller argued that the psy disciplines co-opted feminism (Armstrong 1994; Bumiller 2008), as US Sociologist Paige Sweet has suggested, 'the truth is fuzzier' (Sweet 2021, 56). The very practice of consciousness-raising was at once political and therapeutic, and generated a new body of

feminist "expertise" on the psychology of sexual violence; in feminist debates, the role of the psy disciplines in "speaking out" about sexual violence was newly up for debate.

B. *Today I'm a Feminist, Tomorrow I'm a Therapist*

This section is a paraphrasing of Rush's recounting of Louise Armstrong's work, who was a prolific feminist writer on the subject of sexual violence and the psy disciplines. Rush writes of Armstrong that

> When asked what she was writing, she answered that her subject was [sexual violence]. The response [in 1978] was, 'Oh, you must be a feminist'. Now, when asked the same question and the same answer is given, the response is, 'Oh, you must be a therapist' (Rush 1996, 311)

This extract is here useful for exposing the entanglement of feminism and the psy disciplines between the 1970s and the 1990s. The rendering of the psy disciplines as an enemy of feminism and a depoliticising force obscures the more active role that feminism played in the rise of psychological expertise on sexual violence. Analysing the US context, Sweet suggests that feminist anti-violence work was not co-opted by the psy disciplines and the associated therapeutic state, but rather, actively participated in its creation, thus muddying the waters of the "good versus evil" story told here (Sweet 2021). The same is true of the UK, for although British feminism positioned itself as an antagonist towards the psy disciplines, particularly regarding conventional (biomedical) psychiatry (Thomson 2006), the notion of consciousness raising had also already appropriated some psychological ideas, such as the notion that speaking about sexual violence had therapeutic utility (Harrington 2010). While some continued to suggest that the psy disciplines were pathologising and depoliticising, others began to see value in them for both understanding experiences of sexual violence, and how to politicise these. These disagreements constitute the second narrative prominent in these works – the debate about the utility of the psy disciplines, and whether they had a feminist future.

On the one hand, some continued to emphasise that the focus on the psychological would be depoliticising, and lead to the 'separation of the realm of mental health from the rest

of our social and political lives' (Jeffreys 1987, 143). On the other hand, some argued that therapeutic interventions could be a means of personal transformation, and even, political impetus. Extracts from Chesler's book, *Women and Madness*, were published in the British feminist activist publication Spare Rib in 1973, ahead of the book's UK release, and the review concluded that 'Beyond our bodies and our conditioning, we have minds. We can break patterns. Once our situation […] is understood, we can go on to – what? At least, sanity' (Morrell 1974, 40). Understanding women's psychology offered new transformative potential to influence their environment – to 'break patterns', and better understand and advocate for their own accounts of their realities.

This shift followed the activism of the 1960s in which freedom and emancipation was connected to a reclamation of psychology (e.g. Laing 1967). For example, Friedan's description of enforced femininity as psychological torture already hinted that freedom could be achieved by reclaiming women's mental health through psychological knowledge (Friedan 1963). Analysing the psy disciplines as oppressive was therefore embroiled in notions of psychological freedom. In Carol Harrington's words,

> The [women's movement] described their oppression as a psychological matter, arguing that their very self understandings had been formed from the point of view of their oppressor. The political projects of these movements thus focused upon cultural expression and individual self-transformation (Harrington 2010, 111).

Notions of "madness" imposed a version of reality upon women, but feminist understandings of women's minds could enable alternative understandings of their "situation", and to reconceptualise "madness" as "sanity". British Historian Sarah Crook has previously conducted an analysis of British feminist activist periodicals through the lens of mental health. Amongst her findings was a concerted shift in British feminism towards the position that 'the psychological was political' (Crook 2018, 1164). However, the form that this emancipatory psychological knowledge should take was similarly up for debate – whether feminism provided "alternative" knowledge to psy expertise, or whether a feminist mental health paradigm could be valuable either therapeutically or politically.

The practice of consciousness-raising was perhaps initially intended as a site of alternative knowledge to psy expertise. Again, in Harrington's words, 'Feminist consciousness raising groups [were] meant to provide a public space where victims could speak their truth in opposition to the established wisdom of the experts' (Harrington 2010, 106). However, increasingly the appeal of a "feminist" understanding of mental health became embroiled in their engagements with the psy disciplines. Shulamith Firestone wrote in 1970 that 'Freud was merely a diagnostician for what Feminism purports to cure' (Firestone 1970, 44). Firestone's argument was fundamentally that Freud had made valuable observations, but had wrongly attributed them to the feminised individual psyche rather than socio-political conditions made visible by feminist analyses. Perhaps a "feminist" version of psychology could be possible, one that did not merely diagnose sexual violence, but could "cure" it.

New understandings of "feminist" practices in the field of mental health contributed to the construction of feminist expertise on the psychology of sexual violence. Frances Seton wrote an article recounting her experience of therapy in the British activist publication Spare Rib in 1976, arguing that it was supplementary to the personal and political value of consciousness-raising. She directed her defence of therapy towards the anti-psychiatry faction within feminism (Thomson 2006) and argued that her experience of therapy both assuaged her distress, and made her 'more profoundly and constructively political' (Seton 1976, 32). She describes a 'new understanding of the political importance of psychology', and how in her ability 'to understand the workings of the psyche and how to use the tools of therapy, [she] can […] apply it to the larger social sphere' (Seton 1976, 32). The first Women's Therapy Centre was founded in the UK in the same year, and after over a decade of practice, they published a collection of essays about their experience. In the introduction, psychotherapists Sheila Ernst and Marie Maguire write about the newfound importance of the psy disciplines to feminist praxis, as they learnt that 'this distress might have a life and logic of its own even though its roots lay in the violence and oppression women experience within society' (Ernst and Maguire 1987, 8).

Speaking out about experiences of sexual violence was also central to the construction of this new feminist expertise. Disclosing personal narratives of sexual violence had already

become a cornerstone of the literature (Harrington 2010), and these were often published alongside "expert" feminist psy interpretation. Herman and Hirschman published their paper *Father-Daughter Incest* in 1976, which devotes extensive space to the words of people who had experienced sexual violence, but is presented alongside their own analysis of power and control (Herman and Hirschman 1976). Similar works were also emerging about adulthood experiences of sexual violence in the sociological literature (e.g. Russell 1974). The demarcations between "experts" and "victims" was increasingly blurred, as well as the role of "speaking out" within this (e.g. Rush 1980). For example, Jill Saward, who was raped in her home in London in 1986, told her story with the help of a ghost writer in the book *Rape: My Story* (Saward and Green 1990), and then went on to consult with victim support and the police as an "expert" by experience (Harrington 2010). As Carol Harrington notes, these developments 'did not dismiss the necessity of expert interpretations of women's stories; rather [they] replaced existing psychological expertise with feminist expertise' (Harrington 2010, 107). The most important political message established by this body of work was that it cemented speech as a valuable weapon for breaking the glass ceiling – it was imbued with both personal and political impetus, and the psy disciplines were newly central to its transformative potential.

This period saw a concerted shift towards a rise in ostensibly "feminist" approaches to sexual violence and mental health, which even influenced mainstream psychiatric developments. Before the 1970s in the UK, psy-medical research and practice was rarely concerned with the psychology of people testifying to sexual violence (Bourke 2012). From the 1970s onwards, however, trauma research on sexual violence proliferated, and was firmly rooted within the psy tradition, although often with a feminist emphasis on testimony and experience. In 1974, Ann Burgess and Lynda Holmstrom, American psychiatric nurse and sociologist, respectively, conducted a landmark study of the specific psychological effects of rape, which they termed "rape trauma syndrome" (Burgess and Holmstrom 1974); this was followed by Herman's work on sexual violence submitted for publication the following year (Herman and Hirschman 1976).[10] Then 1980 marked the introduction of post-traumatic stress disorder (PTSD) into the third edition

[10] This detail of when the paper was submitted is here briefly illustrative of how quickly this scholarship proliferated, and is mentioned in her latest book (Herman 2023, 6).

of the American psychiatric diagnostic manual (American Psychiatric Association 1980). This development was influenced by feminist mental health practitioners such as Herman, and also included explicit mention of sexual violence as one of its causes, which made it the first diagnosis to make explicit reference to aetiology and the environment (Bourke 2012; Herman 1992). While the notion that focusing on the psychological could depoliticise the anti-violence movement's driving political force is still very much a concern within feminism today (Gavey 2005; Gavey and Schmidt 2011; Raitt and Zeedyk 1997; Sweet 2021; Egan 2019), this period saw a rise in "feminist" approaches to mental health, and their political and therapeutic utility.

C. The Discovery of Trauma: "A Mark On the Brain"

The narratives presented above were generally concerned with establishing the legitimacy and seriousness of sexual violence. As Rose Corrigan has articulated, 'it is important to understand the anti-rape movement as a product of the struggle for women's liberation' (Corrigan 2013, 4). Understandings of trauma then provided a particularly neat solution to this message, as it spoke to the unique harm caused by sexual violence, as well as its ubiquity. In the "discovery" of trauma, feminists were presented with a language to both explain the psychological experience of sexual violence, and to instantiate it in the social sphere (Herman 1992). These three narrative episodes thus form a general linear narrative arc, or what political scholar Clare Hemmings would call, a 'political grammar' of *progress*. Hemmings demonstrates that the stories feminism tells about its recent past are undergirded by one of three narrative arcs. She writes that 'the story of its past is consistently told as a series of interlocking narratives of *progress*, *loss*, and *return* that oversimplify this complex history' (Hemmings 2011, 3, emphasis mine). Hemmings' use of the term "political grammar" expresses the ways in which political ideas and practices are constructed and signalled within feminist discourse, which makes it significant for this project. In her exemplary analysis of the narrative arc of progress in feminist discourse, she suggests that it has two key features: it is clearly a "positive" story, and it is a narrative with a clear chronology, taking us from the past, specifically before the 1970s, to the post 1990s feminism, the 'complex feminist present' (Hemmings 2011, 35). The discovery of "trauma" is seen to unearth both the extent and harm of sexual

violence, a positive stepping stone and a progression from *the Freudian Cover-Up* before the 1970s on the path to women's liberation. I will therefore put Hemmings' narrative arc of progress to task in the next two parts of this section.

Mobilising around trauma was more palatable to law and policymakers than a generalised "feminist" discourse, on account of the associated neurobiological scholarship that could "observe" and "verify" it. Rush recounts a presentation at a conference in Maryland by a group of psychologists who describe the harm of violence and abuse as a neurobiologically instantiated 'mark on the brain' (Rush 1996, 311). In this section, I will lay out the appeal of trauma to feminism. First, in terms of neurobiological understandings of trauma and dissociation (a "mark on the brain"), and second, in emphasising its unique and ubiquitous psychological harm, which explains the aforementioned assertion on page 64 that sexual violence is a "public mental health problem". However, despite the initial resistance to the psy disciplines and the risks associated with pathologising sexual violence, there is a paradox at the heart of contemporary feminist messages about psychiatric categories and sexual violence. Although people who have experienced sexual violence are represented as "not mad", their "normal" responses are understood through the lens of psychiatric diagnoses, and are hence, "abnormal".

Trauma, Dissociation, and Pathological Memory

Trauma as a psychiatric category offered a scientific explanation for women's "normal" responses to sexual violence, demonstrating that their testimony was legitimate; they were "not mad". Yet being fundamentally a psychiatric category, within this definition lies the idea that traumatic memories are encoded pathologically, differently from normal memories, and are then stored in the unconscious as vivid snapshots subsequently re-experienced as flashbacks (Brison 2002). This notion of traumatic memory as buried in the unconscious has been strongly influenced by theorising within the psy disciplines on the related concept of "dissociation". Throughout the twentieth century, dissociation in relation to "madness", and indeed trauma, were notably explored by Pierre Janet and Carl Jung in Europe (Longden, Madill, and Waterman 2012; Bourke 2012; Leys 2000); and William James, Morton Prince and Ernest Hilgard in the US (Longden, Madill, and

Waterman 2012). The idea of a pathological dissociation provides a particularly "rational" view of the unconscious as structured and ordered (Haaken 1996). In general, the idea is that trauma caused by an external force could induce vertical "splits" in consciousness, separating unconscious and conscious operations (Haaken 1996). The notion of "dissociation" as a "split" in conscious and unconscious operations is considered a normal response to gendered violence; British feminist Liz Kelly and her colleagues, for example, have emphasised the 'splitting/dissociation which is so often a response to abuse' (Kelly, Burton, and Regan 1996, 93).

On this view, traumatic memories are preserved in the unconscious as a "reality imprint", to be unearthed by therapeutic excavation or indeed legal fact-finding; the traumatic memory perfectly preserved in the unconscious, inaccessible apart from in flashbacks and dreams (van der Hart and Dorahy 2009; Haaken 1996). Traumatic memories are not just considered to be buried in the unconscious, but also *engraved* as a "mark on the brain". This was particularly informed by an extensive neurobiological literature accruing around trauma theory, particularly pioneered by Bessel van der Kolk (van der Hart, Bolt, and van der Kolk 2005; van der Kolk 1994; 1984; 1987; Roth et al. 1997), who is a friend of Herman's (Herman 2023, 8). In *Trauma and Recovery,* Judith Herman elaborates this particularly neurobiological conception of trauma, when she writes that

> A wide array of animal experiments show that when high levels of adrenaline and other stress hormones are circulating, memory traces are deeply imprinted. The same traumatic engraving of memory may occur in human beings. The psychiatrist Bessel van der Kolk speculates that in states of high sympathetic nervous system arousal, the linguistic encoding of memory is inactivated […] Just as traumatic memories are unlike ordinary memories, traumatic dreams are unlike ordinary dreams […] traumatised people relive the trauma (J. Herman 2015, 38–39)

As such, feminist accounts of "dissociation" and pathological memory, in tandem with neurobiological evidence, offered the potential to challenge societal (and legal) denial with hard evidence: the memory is "imprinted" and "engraved" deep in the individual (and societal) unconscious. It is described as a self-evident reality, and "proof" of the

violence that was previously hidden. In addition, the neurobiological literature appealed to feminist practice more generally, which emphasises the importance of trauma as an embodied experience – the introduction of animal studies also contributed to understandings of responses to sexual violence including "fight" or "flight".

The concepts of dissociation and traumatic memory are also intimately tied to autobiographical memory and speech. This harks back to the previous narrative episode, and the therapeutic rationale that "speaking out" could help to make women 'experts of their own lives' (Schechter 1982, 109), by enabling them to construct a personal history of their own, in contrast to that prescribed by the psy disciplines. If traumatic memories are encoded differently from "normal" memories, then their reintegration into "normal" autobiographical memory, and reconstructing a coherent narrative of the self, has both therapeutic and political potential (Brison 2002, 49).

To illuminate these two features of "trauma" as a psychiatric category, and their theoretical consequences for speech, it is useful to draw on feminist philosopher Susan Brison's work on the trauma of sexual violence. Brison contends that some constructions of trauma represent the traumatic memory as a "snapshot", a veridical account of "what happened". However, this privileged epistemological status can only be preserved if the traumatic memory is not accessed, which is in conflict with the second assumption within this account: that the trauma can be cured by speaking about it. Brison writes of traumatic memory that

> It's accurate because untouched (like an unretouched photo), not worked over or thought about with the distorting categories of cognition. This apparently gives it privileged epistemological status as the bearer of truth – as that which, for ethical and political reasons, must be preserved. This observation, however, comes at the cost of ongoing pathology, and is in conflict with the survivor's goal of psychic recovery (Brison 2002, 70).

The notion that talking about sexual violence will lead to a "psychic recovery" is still very much the case in contemporary psychological models of trauma treatment. For example, British psychologists Anke Ehlers and David Clark, in what is perhaps the most influential

paper on cognitive behavioural therapy for PTSD, suggest that the 'trauma memory needs to be elaborated and integrated into the context of the individual's preceding and subsequent experience in order to reduce intrusive reexperiencing' (Ehlers and Clark 2000, 335). The idea is that the pathological traumatic memories can thus be integrated into people's narrative memory, and therefore elaborated in a coherent manner.

Trauma and dissociation as definitions were then appealing to feminists in that they could explain previously inexplicable behaviours; the silence surrounding sexual violence; and for emphasising the therapeutic value of speech. It explained to feminists why traumatised narratives are often fragmented and incoherent. Yet it also fulfilled the promise of liberatory and transformational potential: treatment could enable the formation of coherence, and thus provide both therapeutic and political value. Speech was not optional, but essential for both recovery and political change (Herman 1992). For example, Liz Kelly explicitly states that forgetting about sexual violence is merely a 'short-term "holding strategy"', and that the trauma 'has to be dealt with at some later point' (Kelly 1988, 222). Therapy, remembering, and then talking about experiences of sexual violence were newly central, constructing a strong imperative to talk about sexual violence; feminist politics was bound up with therapeutic epistemologies and interventions (Sweet 2021).

On the flipside, the notion of traumatic memories as "snapshots" that are 'not worked over' (Brison 2002, 70) on account of them being *unspoken* raises questions about how sexual violence testimony may be received and adjudicated. Where Freud's discovery of sexual trauma became a symbol of "falsity", of patriarchal forces of oppression, the discovery of sexual trauma is represented as both a "fact" and the "truth". Feminist writers such as Susan Brownmiller, Liz Kelly, and Susan Griffin repeatedly talked about the discovery of sexual violence as a "truth" or "fact" that they attribute to feminist organising and associated consciousness raising in the 1970s (Brownmiller 1975; Griffin 1971; Kelly 1988). Focusing on Kelly's work briefly, on account of her UK location, she noted that where Freud's '"truth" resulted in countless women's and girls' truth being redefined as fantasy' (Kelly 1988, 169), the 1970s was the decade which revealed a 'knowledge explosion' (Kelly 1988, 61). Along with her colleagues, she wrote in 1996 that

> We have become accustomed to discussion of the 1970s and 1980s as the decades in which sexual violence was discovered: unearthed from layers of historical disbelief and denial (Kelly, Burton, and Regan 1996, 88).

Just as trauma can be retrieved from the depths of the unconscious as a veridical snapshot, so can it be "unearthed" from the veil of silence within society. The language of "fact" and "truth" is important for feminists engaging with the law, as the association between "trauma" and "truth" has an extensive medico-legal history. In criminal law, legal commentators have previously called for psychiatric evaluations of people testifying to sexual violence throughout the twentieth century to interrogate the "truth" of sexual violence (Ellison 2009). The "discovery" of trauma from the unconscious therefore also became a psychiatric definition which was legible to the law as a "mark on the brain" – the traumatic truth.

Further, in Kelly's representation of the 'knowledge explosion' which 'unearthed' sexual violence from historical denial, we are invited to share in the *enthusiasm* of the political grammar of this progress (Hemmings 2011, 36). It represents a clear chronological contrast between the denial preceding the 1970s, to the "discovery" of trauma that is well-established by the 1990s (Kelly, Burton, and Regan 1996, 88). Hemmings argues that this positive affect has two effects: we are invited to therefore leave the previous feminist past behind, and the emphasis on "newness" invites us to approach the present with appropriate excitement (Hemmings 2011, 56). I suggest that this political grammar has resulted in a general lack of scrutiny within feminist work according to psychiatric diagnoses. The observation that feminism has neglected attention to experiences of psychiatric diagnoses is not new, and on page 15 I alluded to Johnson's assertion that within feminism, 'neurodivergence is submerged into undifferentiated discussions of women's mistreatment in patriarchal social and medical contexts' (Johnson 2021, 636).[11] Before I segue fully into the second half of this chapter, to put these critiques of the new norms established by the trauma paradigm to task, it is worth initially explaining the residual confusion within the diagnostic category of PTSD, and whether it is the traumatic event, or its aftermath, that is "abnormal".

[11] Johnson's concern with "neurodivergence" is here specifically concerned with the experience of distress currently organised as Borderline Personality Disorder.

Trauma as Uniquely and Ubiquitously Harmful

Closer interrogation of the history of the diagnosis of PTSD reveals ongoing conflicts in terms of which features are considered "normal" or "abnormal": whether it is a response to an event that is exceptionally harmful, or an exceptional event (and hence rare). This harks back to the Turner judgment reproduced in section 1 of the introduction to this thesis, and the question of whether the nexus of sexual violence and psychiatric diagnoses is abnormal because it exceeds 'the stresses and strains of life' (R v Turner 1975b, 74). It represents a debate over time about the extent of violence in women's lives, and whether sexual violence is indeed a ubiquitous structural and political issue, or "aberrational" (Stefan 1994). In the first set of diagnostic criteria for PTSD, the definition of a traumatic stressor in the 1980 edition of the DSM states that it 'would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences' (American Psychiatric Association 1980, 236). As noted briefly on page 80, the manual explicitly mentions 'rape', which instantiated this diagnosis as the result of an external traumatic event – a result of women's environments rather than their biology and individual psyches. However, a 1987 revision changed the definition of trauma from 'a recognizable stressor that would evoke significant symptoms of distress in almost anyone', to being 'outside the range of usual experience' (American Psychiatric Association 1987). This revision was condemned in Herman's *Trauma and Recovery*, as she argued that instead of being 'outside the range of usual experience', sexual violence is 'so common a part of women's lives that they can hardly be described as outside the range of ordinary experience' (Herman 1992, 33).

Herman's analysis echoes arguments such as those of Griffin and Brownmiller – that sexual violence was harmful and ubiquitous, and a means by which 'all men keep all women in a state of fear' (Brownmiller 1975, 204). Trauma explained previously inexplicable experiences associated with "madness", such as flashbacks and dissociation (Herman 1992), and the special category of "complex" trauma was subsequently developed to emphasise both the unique harm caused by sexual violence, as well as the gendered nature of its occurrence (Herman 1992; 2015). The harm of sexual violence was conceptualised as uniquely traumatic; its socio-political origin as a form of 'political

violence or even gendered terrorism' (Spurgas 2021, 1). The cause of sexual violence is here located in a dysfunctional society, and its harmful effects especially grievous.

Feminists had even started mobilising around psychiatric categories beyond trauma diagnoses, as a means of emphasising the extent of the harm caused by sexual and gendered violence. American activist Susan Schecter was supposedly against the medicalisation of sexual violence, but when speaking to health care providers during the 1990s she suggested that '37% [of abused women] have a diagnosis of depression, 10% psychotic episode, 16% alcoholism, 47% PTSD, and 46% anxiety' (Sweet 2021, 112). Increasingly, it seems that diagnoses across the board are considered "normal" responses to sexual violence. Although people who have experienced sexual violence are represented as "not mad", the associated distress is often considered pathological – whether through understandings of trauma and dissociative memory, or diagnoses in general; there is increasing acceptance of the fact that people value identification with psychiatric categories and its associated support. For example, Brison's compelling philosophical analysis of sexual violence which included her own experiences, reveals the relief she felt at accruing a psychiatric diagnosis, the problem not only hers alone to manage (Brison 2002).

However, emphasising the extent of the psychological harm of sexual violence has almost generated an equivalence between definitions of the traumatic event, and its associated pathology. The absence of one negates the other, such that if someone is not acting "traumatised", then their experience of sexual violence may be called into question itself (Gavey and Schmidt 2011). Critical feminist psychologist Stephanie Pache has noted of the Anglo-American anti-violence movement that medicalised categories discerning what is considered "normal" can be defined in two different ways. She writes that

> Biology, psychology, and medicine contribute greatly to the definition of […] sanctioned behaviors, creating categories of normalcy, which encompassed both what is statistically frequent, i.e., "standard," and what is considered not pathological, i.e., "healthy" (Pache 2022, 3–4).

Although psychiatric definitions of trauma emphasise its "standard" ubiquity, they paradoxically represent it as an "illness". As established throughout the course of this chapter, this paradox is an understandable one in the context of feminist efforts to insist upon the unique harm and prevalence of sexual violence. The trauma model did achieve the feminist imperative of establishing the statistical frequency, or "standard", in Pache's formulation, of sexual violence in the lives of women to an extent. For example, the 2022 edition of the international diagnostic classification system (ICD-11) states that PTSD is 'more common among females' (World Health Organization 2022, 6B40). In Janice Haaken's words, trauma '"democratizes" mental suffering by emphasizing commonalities in human responses to overwhelming events' (Haaken 1996, 1079).

While this has successfully highlighted the extent of the harm caused by sexual violence, organising around psychopathology, which fundamentally entails psychiatric designations of "abnormal" psychology, can potentially function to discredit sexual violence testimony. Further, psychiatric definitions are themselves complicated by norms and stereotypes. Despite Herman's efforts to redefine trauma as normal and ubiquitous, the latest international diagnostic manual articulates the essential diagnostic criteria for post-traumatic stress disorder as: 'Exposure to an event or situation […] of an extremely threatening or horrific nature' (World Health Organization 2022, 6B40). Sexual violence continues to be defined in severe terms as 'extremely threatening', which in turn is likely to play into stereotypes about "real rape" as being perpetrated by a stranger in a violent attack: a minority of sexually violence experiences.

The feminist narrative discovery of a "mark on the brain" constitutes the final narrative episode in a political grammar of progress. It follows the sequence that Hemmings suggests in its progression from a pre-1970s society of denial and "psy"lencing, to the post 1990s feminist "present" (Hemmings 2011, 35). I will here remind the reader of a particularly triumphant quote produced in the introductory chapter of this thesis (page 10) from a 1993 conference for therapists working with those who had experienced sexual violence: 'The world has split open. Women have broken the silence' (Haaken 1999, 13). This quotation demonstrates Hemmings' chronological trajectory, and its resultant and triumphant arrival at the positive and exciting future. However, it is my contention that while 'the words may change […] the melody lingers on' (Rush 1996), as

many of the problems of legitimacy associated with stereotypical ideas about women and "madness" remain. As Hemmings suggests, we cannot leave the past behind and embrace this feminist future without critique (Hemmings 2011). In establishing trauma as the norm, a new "truth", this in turn entails specific narrative demands that are not necessarily accessible across psychiatric diagnoses. The title of this chapter additionally demonstrates that these critiques are not new, as Rush was making them in the 1990s. Similarly, feminist psychologist Jeanne Marecek contended that, 'far from countering the medicalized idiom of conventional psychiatry, [trauma] has merely replaced one idiom with another' (Marecek 1999, 165). Feminist mobilisation around trauma and psychiatric diagnoses can act as a *double-edged sword*. While helpful in some instances, at the same time it can individualize, decontextualize and depoliticize experiences (McKenzie-Mohr and Lafrance 2011, emphasis mine).

2. New Norms and The Double-Edged Sword

In this second half of this chapter, I turn to appraise and identify these critiques of the category of trauma in terms of who it potentially excludes, particularly in relation to psychopathology. I reveal that understandings of sexual violence and trauma in feminist scholarship are constructed around a psychologically "normal" subject. Individuals are conceived of as psychologically "normal" before sexual violence, and trauma is additionally the "normal" response thereafter. Drawing on critical race literature, and critical disability scholarship, I illuminate the exclusionary nature of psychiatric diagnoses and "trauma", what this means in the legal realm, and then I turn my attention to what being "normal" really means in this context.

A. "Normal" Trauma

In chapter 2, I mentioned Judith Butler's assertion that 'identity categories are never merely descriptive, but always normative, and as such, exclusionary' (Butler 1992, 15–16). Accordingly, in this section, I follow Butler's invitation and turn my critical attention to the formation of "trauma", "rape trauma syndrome" or PTSD as not just diagnostic categories, but identity categories. The exclusions that I discuss here are primarily informed by critical race theory, as well as some critiques from critical disability theory.

Some of these are more general observations of the feminist anti-sexual violence scholarship, and others are specific observations of psychiatric categories, as well as their potential consequences for people who identified with psychiatric diagnoses before sexual violence.

The first definition of PTSD occurred when psychiatry was trying to define a standardized nosology for the first time, such that the diagnostic criteria could theoretically be used "objectively" by behaviourists and Freudians alike (Harrington 2010; Angel 2003). Yet the first, and hence foundational, studies on psychological responses to sexual violence were *exclusionary*, they used white middle-class samples (Sutherland and Scherl 1970; Burgess and Holmstrom 1974). Herman and Hirschman describe their white sample as 'quite ordinary' (Herman and Hirschman 1976, 742). This resulted in particularly classed "symptoms" becoming associated with its psychological effects, such as moving, changing jobs, and purchasing new security devices (Stefan 1994). Further, many of these symptoms could literally not be exhibited by someone who was being contained in mental health services, which raises questions about the accessibility of trauma diagnoses.

There is an imperative to "speak" and "recover" from trauma within the entanglement of feminism and the psy disciplines outlined in the first half of this chapter. This is evident in Liz Kelly's notion that trauma must be 'dealt with' (Kelly 1988, 222) at some point, and Brison's work on the therapeutic value of recovering a narrative, and a story, after sexual violence (Brison 2002, 60). Yet either "speaking" or "recovering" are not accessible for everyone, or even necessarily desirable, particularly in relation to experiences of psychiatric diagnosis. US scholars such as historian Ruth Leys and anthropologist Sameena Mulla have written about how the concept of traumatic remembering is both culturally and racially contingent, and how for many, *forgetting* in fact represents a more effective and valuable strategy; trauma is not necessarily narratable (Mulla 2016; Leys 2000). Further, critical disability scholar Alyson Spurgas has criticised the concept of "recovery" for being defined in terms of feeling a return to "safety" (Spurgas 2021), a feeling which is not available to everyone – particularly those who experience additional racial marginalisation, or who continue to experience mental distress in ways which are currently organised around psychiatric categories (Johnson 2021).

This reflects more general racial exclusions within the feminist work that I have outlined above.[12] For example, Angela Davis has written important critiques of the work of Susan Brownmiller and Shulamith Firestone for some of their actively racist assumptions: Brownmiller perpetuates the myth of the black male rapist, and Firestone presents a puzzling analysis of a racial "oedipal" complex to a similar end (Davis 1981; Davis [1981] 2019). In her book, *Women, Race & Class,* Davis extends this analysis to demonstrate that black women are often represented as "unrapeable". This is partly on account of how white men are assumed to 'possess an incontestable right of access to black women's bodies' (Davis [1981] 2019, 158); and partly because black women are perceived as unruly, immoral and promiscuous. Critical theorists Saidiya Hartman and Sarah Deer have produced similar analyses concerning how sexual violence against black and indigenous women is deemed permissible (Deer 2015; Hartman 1997; 2019; 2018). These racialised dynamics justify sexual violence against women of colour, and contribute to a construction of white women as the ones who are fundamentally both woundable and rapeable, which affects who is afforded legitimate sexual violence testimony (Phipps 2020; Serisier 2018). Conceptualisations of sexual trauma are enshrined in notions of white fragility and woundability (Davis 1981; Phipps 2019; Hartman 1997), and the genre of sexual trauma and "speaking out" was largely created by and for white women (Serisier 2018)

Those who do not conform to the definition of "normal" trauma may be denied associated psychological support and legal legitimacy, and the definition itself was constructed around a highly particular experience of white middle-class women. Legal scholar Clare McGlynn and colleagues have termed this a 'one size fits all' conceptualisation (McGlynn et al. 2020, 5), such that individuals' experiences must conform to standards of trauma as operationalised within the medical framework. They write that

[12] Although there is not the available space in this project to offer many of the compelling critiques of the feminist work that I have presented in this review, I want to additionally acknowledge the present current of transphobia in British feminism. Mary Daly's (1979) book is often considered one of the foundational scholarly works of trans-exclusive radical feminism, and Liz Kelly has been similarly criticised on these grounds.

> Where a victim-survivor's complex and lived experience sits outside the paradigmatic medicalised narrative of trauma, they are not only left without the language with which to articulate their experiences, but they are also likely to receive less practical support and assistance, and potentially suffer further harm due to not having their experience adequately validated and recognised by others (McGlynn et al. 2020, 5).

People's experiences do not necessarily map neatly onto trauma symptoms and categories, and other diagnoses may not be experienced as validating in the wake of sexual violence, or may prevent people from accessing meaningful support. Psychiatric diagnoses are not objectively knowable, and are approached with different opportunities for treatment and support. Dissociation and its associated treatments are more often identified in white middle-class women, while black women are more likely to be medicated (Nazroo, Bhui, and Rhodes 2020; Spurgas 2021). Sexual trauma as a normative category can be exclusionary, and fails to capture the structural and political factors that may contribute to which accounts of sexual violence are deemed legitimate.

Critics have noted that the psychiatric category of trauma is itself exclusionary. Some critiques are more persuasive than others for the purposes of this project. Stefan suggests that Burgess and Holmstrom's first and foundational study on "rape trauma" details an initial sample that excluded a category of women with intellectual (dis)abilities or who were 'mentally ill' (Stefan 1994, 1292). Burgess and Holmstrom document one example where

> The 28-year-old single woman was brought to the emergency ward at 2:30 a.m. […] 'I was standing outside the Club when a car pulled up with four men in it. They pulled me into a car.... Two of the men raped me and then they dumped me out. Someone passing by stopped and brought me in here' (Burgess and Holmstrom 1979, 12–13).

This woman is clearly documented as saying that she has been 'raped', and yet was excluded from the formation of the category of "rape trauma". While certainly an egregious oversight, it is difficult to tell from Burgess and Holmstrom's book whether the

women they excluded identify with psychiatric diagnoses or intellectual (dis)abilities. This woman is further documented as saying 'A psychiatrist told me I was trying to destroy myself' (Burgess and Holmstrom 1979, 13), which is suggestive of mental distress at the very least, but in general, I am not particularly compelled by Stefan's critique specifically in relation to mental "illness".

However, several other contemporary analyses are more powerful for the purposes of this project. Important critiques have been made of the notion of trauma as a "mark on the brain", and of the diagnostic categories of trauma and PTSD, in relation to their exclusions, and their reliance on a single discrete trigger. Literary trauma theorist Layla AlAmmar took to X (formerly Twitter) in 2023 to critique Bessel van der Kolk's influential book, *The Body Keeps The Score*, for having a 'Eurocentric focus where to be traumatized, you have to be a member of the dominant group' (AlAmmar 2023). Similarly, political scholar Hannah Goozee has criticised the categories of trauma and PTSD for representing a highly individualised and 'event-based psychiatry' (Goozee 2021, 110). Focusing on individual and discrete events obscures the wider socio-political conditions of individuals' experiences. Like AlAmmar, Goozee suggests that 'contemporary approaches to trauma are constrained by an exclusive, Eurocentric psychiatry' (Goozee 2021, 102).

We can usefully extend Goozee's observations that constructions of trauma reflect an individualised and 'event-based psychiatry' (Goozee 2021, 110). This focus on discrete traumatic events is reflected in the associated symptom profile of "trauma" in feminist scholarly discourse, and in psychiatric definitions. Dissociation is produced by a psychic "split" in response to a singular violent event (Liz Kelly, Burton, and Regan 1996). The symptoms of "flashbacks" and "dissociation" are additionally temporally specific, and tied to this single event, in that they are considered to place people "right back in" the traumatic experience. Spurgas has persuasively demonstrated that dissociation has become the *'sine qua non* of trauma and has been treated as necessary for trauma to register as legible and legitimate' (Spurgas 2021, 2, emphasis original). They argue that the rhetoric of dissociation itself is produced within a white and middle-class register, on account of how the traumatic event is represented as an abnormal and "horrific" act against an underserving victim, which is itself reflected in the psychiatric definition of traumatic events as 'extremely threatening or horrific' nature' (World Health

Organization 2022, 6B40). Spurgas notes that, for many people, experiences of trauma do not occur in this sudden and surprising way, amenable to the individualised (and successful) treatment and recovery that Goozee describes (Goozee 2021, 110). They are instead embroiled in wider embodied experiences of precarity or violence, which are impacted by different situations of race, class, gender, and psychiatric diagnoses. Spurgas raises important points surrounding the narrow conception of trauma and its associated legitimacy, as well as the potential consequences of this for those who identify with psychiatric diagnoses.

Feminist theorising about trauma has additional consequences specifically in relation to people who identified with psychiatric diagnoses before assault can attain legitimacy. Carter has also suggested that understandings of trauma are specifically constructed around the idea that the person was psychologically "normal" before an assault. Carter terms this an assumption of 'bodymind stability' (Carter 2021, 6), as it is through this construction that embodiment can be understood as disrupted and traumatised. This notion of coherent and continuous bodymind stability is theorised as culturally impossible (Carter 2021), and I suggest that it is particularly irrelevant to those who found meaning in psychiatric diagnoses before their assaults. These are narrow parameters surrounding trauma's legitimacy, and they are particularly exclusionary in relation to psychiatric diagnoses.

To recap: people of colour were excluded from the construction of sexual trauma, and this has contemporary resonances in the racial discrepancies in psychiatric diagnoses (Nazroo, Bhui, and Rhodes 2020; Spurgas 2021). Further, understandings of trauma are focused on the imperative to remember and process traumatic memories, and a Eurocentric and "event-based" Psychiatry that focuses on discrete events and the associated dissociative "split". This is additionally exclusionary, and reveals ideas about being psychologically "normal" before sexual violence, and suddenly damaged afterwards. This is not everyone's experience, and nor can treatment always incur a return to "safety". This adds additional dimensions to the discursive scaffolding dictating who is afforded legitimate sexual violence testimony.

B. The Legal "Standard"

Feminist engagement with understandings of trauma as a psychiatric category necessarily raises the spectre of the medico-legal history pertaining to malingerers, and a different meaning of the word "standard" then arises: the legal standard. This section will briefly address the relationship between the discovery of trauma and the law. As mentioned on page 72, the history of PTSD is intimately tied to the diagnostic category of "malingerers", and British legislative responsibility for providing compensation for traumatic events (Smith 2011, 13). In Pache's words, 'The issue of responsibility has been at the heart of the two-century long debates on the mental effects of traumatic events' (Pache 2022, 15). For while the notion of trauma "democratised" experiences of suffering in that more people had a language with which to articulate their experiences, the law was then tasked with finding a way to curtail its responsibility in relation to compensation – it had to demarcate a distinction between which kinds of trauma are everyday "normal" experiences, and which are "normal" and deserving of legal redress. In 2001, British psychiatrist and activist Derek Summerfield published an article in the British Medical Journal arguing that the category of PTSD had essentially gone too far, and that people were claiming to suffer from this diagnosis on grounds that were not legitimate (Summerfield 2001). He cites a 'growing list of commonplace events' (Summerfield 2001, 96), including sexual harassment, that were being wrongly medicalised in his view, and that as a result, people were making legal claims for compensation on the basis of this diagnosis which they didn't deserve. Their trauma was not deemed legitimate, they were in fact "malingerers". So because sexual harassment may be 'commonplace' and hence normal, on Summerfield's account, it does not meet the threshold for true, pathological, and legitimate sexual violence. Legal scholar Deirdre Smith has suggested that as a direct result of contributions like Summerfield's, 'the very real psychological impact of horrific events is often minimized and claims of psychological injuries continue to be regarded with suspicion' (Smith 2011, 65). The very presence of a diagnosis of PTSD may lead to legal scepticism.

The story of the "discovery" of sexual trauma has created normative expectations, and its emphasis on "truth" necessarily reanimates the opposite side of the binary – falsity. The reality of rendering all trauma stories as "true" is that it makes it much easier to generate

counter claims – the extremity of the narrative, cast in terms of good against evil, truth against falsity, generates a vulnerable position for sexual violence testimony. Brison writes that 'if victims' stories are accepted as unassailable, unjustified reverse-victimization claims can be harder to contradict' (Brison 2002, 34). Scepticism of sexual violence testimony is particularly rife in the legal context, which is often traced back to the assertion of a seventeenth century jurist Lord Matthew Hale. Hale suggested that rape is 'an accusation easily to be made and hard to be proved, and harder to be defended by the party accused' (Hale 1736, 635–36). As Wendy Larcombe has argued, it is the inverse of Lord Hale's statement that is and has always been true: 'rape is an extremely difficult allegation to make and a relatively easy one to defend' (Larcombe 2002b, 97). Socio-legal scholarship in Canada and Australia has consistently evidenced this claim (Larcombe 2002a; 2002b; Young 1998), and that the mere presence of a "victim's" mental health evidence swings trials in favour of the defendant (Gotell 2002).

Further, Gavey has expressed concern that recognition of the injustice of sexual violence has become too closely tied with the "proof" of, and liability for, psychological damage (Gavey 2005). Legal understandings of violence privilege an "injury model", that overemphasises the production of an injury, even if psychological, as proof (Sweet 2021, 183). Notions of proof are embroiled in understandings of certainty and fact, and so continue to enact a high legal standard for "proof" of violence. Experiences that meet popular understandings of exceptional "real rape" (Estrich 1987), and are characterised by both a person who is "normal" before the assault and subsequently traumatised (Gavey and Schmidt 2011), are more likely to garner legal legitimacy. Further, mental health evidence produced in a therapeutic context is unlikely to meet this criterion of "proof" of violence, as the narratives constructed in therapy are produced under distinct discursive frameworks from the law, and to different ends. Memories of sexual violence can be true in two different ways – as an accurate account of "what happened", or as testimony that corresponds to an internal representation (Haaken 1996); people may be judged as sincerely, but falsely, believing they were raped (Serisier 2015). As such, in therapy, narratives can be dynamic and changeable as people evolve in understanding their experiences, rather than accessing a veridical snapshot preserved in their unconscious. This lies in contrast to narratives constructed for legal proceedings as "proof", or even the feminist representation of experiences of sexual violence as a "truth"

as via both, sexual violence testimony must be articulated in the expected (traumatised) way.

Organising around the law has then reanimated binaries between normal and abnormal, truth and falsity, but this also reflects the psychiatric definitions, which continue to cast sexual violence as aberrational. The fact that the 2022 international diagnostic classification system defines traumatic events as those of an 'extremely threatening or horrific nature' (World Health Organization 2022, 6B40) additionally assumes that sexual violence is extreme. It further states that the event is likely 'to cause pervasive distress in almost anyone' (World Health Organization 2022, 6B40). Definitions of trauma are culturally determined, and while sexual violence is considered distressing for 'almost anyone', this is not always how it is experienced, and the absence of diagnosis may be conflated with the absence of violence. This is again a psychiatric standard that does not adhere uniformly in relation to embodied experiences of diagnoses. For example, mad activist and scholar Flick Grey identifies with the diagnosis of Borderline Personality Disorder, and in a compelling piece written for the UK's radical mental health magazine, *Asylum*, she notes how the extreme definition of sexual trauma obscured her own experience (Grey 2017). She argues that this narrative has created a cultural expectation that sexual violence is always the most traumatic thing that can happen to a person, explaining that for her, a fraught relationship with her mother was much more traumatic than her experiences of sexual violence – particularly because there was no cultural script for how to articulate it. The feminist conception of trauma inadvertently produces a definition of the violence itself as abnormal, as well as its associated psychopathology (Haaken 1996), and this equivalence is not necessarily how it is experienced by people who identify with psychiatric categories.

The new category of trauma has legal consequences for how and when people can access mental health services. Representing trauma as a veridical "discovery", a "true" "snapshot" to be retrieved from denial and the unconscious, is an account of the psychology of sexual violence which seemed particularly compatible with the law. While this emphasis is understandable, endorsement of dissociation and trauma as the new feminist "truth" has generated a particularly high standard of "proof", which renders it vulnerable to legal counter claims of "contamination" and "falsity". As evidenced by the

old 2002 legal policy, fears of memory contamination have previously restricted people's access to therapy pre-trial (Crown Prosecution Service 2002). This was intended to mitigate the prospect of therapeutic records being used to establish inconsistencies or impugn credibility at trial, but resulted in a serious limitation around the psychological support people could receive before court. Notions of dissociation and pathological unconscious memories as structured have therefore paradoxically prevented people from getting meaningful mental health support if they want to pursue criminal justice: trauma is here considered pathologically unspeakable. Whether this medico-legal understanding of sexual violence was actually practised between the 2002 guidance and the subsequent policy overhaul in 2019 is the task of the following chapter.

C. The Figure of "Normal"

In this chapter, the figure of "normal" has appeared in multiple different ways. First, in the feminist narrative episodes, in the assertion that women's responses to sexual violence were "normal", they were not "sick". This then became somewhat complicated by the discovery of trauma, for while these responses are still conceptualised as "normal", they are, at least for some, instantiated in the realm of psychopathology. Further, critical race and disability scholarship demonstrates that understandings of sexual violence represent individuals as "normal" before assaults, read: white, middle-class, and sane. Then, in the law, understandings of "normal" sexual violence are influenced by psychiatric commentators and definitions: Summerfield contends that we are unnecessarily medicalising "normal" experiences, and Flick Grey's experience exposes that legal and psychiatric definitions of "normal" sexual violence are constructed in particularly extreme terms, as with stereotypes concerning "real rape" (Estrich 1987).

Before I conclude the coverage of this chapter, I want to turn my attention to what being psychologically "normal" here really means, as there are important insights in this literature that pertain to the nexus of sexual violence and mental health. The established normal/abnormal distinction so far presents several problems in relation to psychiatric diagnoses. On the one hand, psychiatric categories can grant legitimacy to people who have experienced sexual violence (Marecek 1999), but on the other, this paradigm

renders sexual violence itself inextricable from the medical and psychological, and thus potentially a problem to be "treated" and "cured" (Bumiller 2008; Armstrong 1994; Raitt and Zeedyk 1997). Feminist understandings of trauma are constructed around someone who is psychologically "normal" before an assault, which fails to capture those who identified with psychiatric diagnoses beforehand. However, feminist emphasis on trauma being "normal" has been an understandable response to the enduring influence of prejudicial stereotypes about people being either "mad" or "bad", particularly in the eyes of the law.

This issue is itself embroiled in wider debates around psychiatric diagnoses more generally, and their complicated relationships to identity, pathology, and legitimacy. Norwegian Sociologist Solveig Laugerud has conducted important work at the nexus of sexual violence and trauma here, but she builds on the theorising of Paige Sweet and Claire Decoteau (Sweet and Decoteau 2018), which it is first worth summarising before explicating Laugerud's insights (Laugerud 2019). In a comprehensive analysis of debates surrounding the fifth edition of the Diagnostic and Statistical Manual (DSM-5), Sweet and Decoteau found some surprising agreement between psychiatrists and anti-psychiatrists alike. For example, both agreed that diagnoses such as "depression" were normal responses to life events such as grief. Depression is presented as an example of how the (normal) human condition is overly and unnecessarily medicalised; this reveals a binary conception of "normal" in which individuals are actually "healthy", not "ill". Such arguments are akin to Summerfield's in section 2A above, in which he considers sexual harassment to be an overly medicalised, and "normal", experience (Summerfield 2001). In contrast, the figure of "normal" in diagnoses such as "autism" is conceptualised quite differently. Interventions and support for people who identify with autism are actively encouraged, and "normal" is instead 'the end goal of a set of interventions, a future horizon' (Sweet and Decoteau 2018, 117). In the case of depression, psychiatry is presented as a potential threat; and for autism, it is useful for the optimisation of health and support. They found that these debates were further complicated by the fact that psychiatric labels can constitute an identity category. Some people identify with psychiatric diagnoses such that "recovery" is not desirable, as it would mean the loss of a sense of identity; an identity which is tied to the acquisition of supportive resources.

This reveals the aforementioned complicated relationships between pathology, legitimacy, and identity; particularly in relation to sexual violence and trauma. Laugerud's work is illustrative here, as she draws heavily on Sweet and Decoteau's theorising about the two different ways to conceptualise "normal": in binary terms, or on a spectrum, a 'future horizon' (Sweet and Decoteau 2018, 117). Laugerud investigated how people who have experienced sexual violence invoke different discursive constructions of trauma to speak about their experience – her focus on testimony makes her work especially relevant for this project. Laugerud suggests the first discursive construction is informed by psychiatric expert discourses, such that trauma is understood as pathological (Brison 2002), a mental "illness" (Laugerud 2019). Historian Joanna Bourke demonstrates that on this conception, the original Greek meaning of "trauma" as a bodily injury is retained, and individuals' psychological "wound" is expressed as a mental "illness", in binary opposition to a normal or healthy person (Bourke 2012). Bourke demonstrates that this conception of trauma replaced the previous medical paradigm of individuals being rendered "insensible", a form of incapacitation (Bourke 2012). In Laugerud's study, a few embraced this dichotomous discursive construction and its associated metaphors of wounds, injuries, pain, damage and brokenness to understand and legitimise their experiences. However, Laugerud found that the majority of her participants articulated their experiences of sexual trauma on a scale of normality: an eventual traumatic "breakdown" could be avoided by optimising and managing their health. Accordingly, Laugerud's participants could 'escape the stigmatizing effect of psychiatric labels' (Laugerud 2019, 1), by avoiding describing their trauma in pathological terms.

In Laugerud's work, each of these discursive constructions expresses a notion of trauma as *legitimate*, but one is *pathological*, and the other is firmly within the realm of health: they are not "sick". Laugerud suggests that the second discursive construction is here fused with professional health discourses that appear in non-medical institutions, such as self-help organisations and therapeutic interventions (Laugerud 2019, 5). The figures of "breakdowns" and "illness" then appear differently in each, as the first embraces or includes breakdowns and mental (dis)abilities; while the second requires individuals to negotiate their "health" such that breakdowns can be avoided. Laugerud's participants engaged in interventions because they did 'not want to give up and become sick'

(Laugerud 2019, 13), whereas in my work, as will be demonstrated in chapter 5, people identified with psychiatric categories in one way or another: they *were* “sick”. Laugerud does not specify which of her interviewees identified with psychiatric diagnoses, but given that all of my participants did, it is perhaps unsurprising that all of them engaged with discursive constructions of their experiences as pathological. Understanding these complicated relationships between sexual violence testimony, psychiatric diagnoses, and legitimacy, is the remaining task of this thesis.

Conclusion

In part 1 of this chapter, I demonstrated that feminism’s engagement with the psy disciplines has been messy and at times contradictory in relation to sexual violence and “madness”. These contradictions have resulted in a slightly confused landscape, and a lack of clarity over feminist positions on trauma and psychiatric categories. The lack of a unified feminist psychology has resulted in a kind of feminist-psy-legal hybridised understanding of sexual trauma, and consequently, the category of sexual trauma is normative and exclusionary. This was the focus of the part 2 of this chapter, in which I establish discrepancies in who is considered woundable, and hence who’s trauma is deemed legitimate; particularly along experiences of race and psychiatric diagnosis. The political nature of psychiatric categories, and the fact that their designation is influenced by experiences of race and class, are also generally absent from the representation of trauma as a self-evident truth amongst women.

The three episodes narrated in part 1 here produce an overarching narrative culminating in the discovery of trauma. This demonstrates a political grammar of “progress” that I call into question in terms of the norms that it has established, and how far it has facilitated sexual violence testimony (Hemmings 2011). The political grammar details the feminist victory in establishing that responses to sexual violence exhibited as symptoms of “madness” are in fact normal trauma responses. Inexplicable experiences and behaviours associated with “dissociation” or other psychiatric diagnoses are also normal, and the discovery of trauma enabled the great “unearthing” of the “truth” of sexual trauma by “speaking out’”: from the depths of societal silence, and individual consciousness. While the language of trauma can speak to both its unique harm and ubiquity, the category of

sexual trauma is inherently exclusionary, and defining sexual violence in psychopathological terms has complicated conceptions of what is "normal" and "abnormal". Both of these consequences are helpfully summarised by Spurgas, who it is worth quoting here at length. Spurgas writes that

> Even as we have moved toward thinking of gendered and sexual violence and their traumatic aftermaths as political and structural (and as psychologists have gotten better at accounting for these types of violence and their effects), we still too often operate within a reductive logic regarding femininity that is ultimately unjust insofar as legitimate trauma becomes relegated to a certain demographic, and only that type of trauma experience is legible as suffering. Further problematic is that, under this prevailing logic, the type of feminine suffering that is most clearly legible is that which follows from violence is framed as "exceptional" (as opposed to the suffering of those who are not victims of "stranger rape," incest, or abuse "at home"). Most often, survivors (even under Herman's improved formulation) are imagined to be white and wealthy or middle-class – and their treatment is targeted as such (Spurgas 2021, 3).

Spurgas notes here the problems with legitimacy, and who's stories of sexual violence are taken seriously, particularly in the eyes of law, in relation to enduring stereotypes about "real rape" being exceptional (Estrich 1987), and disparities in race and wealth.

To make sense of the contemporary situation, it is important to understand that anti-sexual violence mobilisation around both the law, and the psy disciplines, was a product of the struggle for the legitimacy of sexual violence testimony. There is a distinct lack of engagement in the sexual violence literature with different psychiatric categories, and how this complicates understandings of trauma. While some have drawn out the "double-edged" implications of the trauma paradigm for sexual violence testimony (Gavey and Schmidt 2011), less critical attention has been given to the increasing definition of sexual violence as a "public mental health problem". In section 2C of this chapter I discussed how the figure of "normal" relates to sexual violence, psychiatric diagnoses, legitimacy, and identity. Laugerud's study of sexual violence and mental health provides initial insight here into how psychiatric labelling or identities may complicate the narrative demands

of sexual violence testimony, as her participants sought to distance themselves from notions of pathology and "sickness" in articulating their experiences (Laugerud 2019). This suggests that asserting an identification with psychiatric diagnoses may compromise the legitimacy of individuals' testimony: both inside and outside of the courtroom. Further, as Sweet and Decoteau show, people may identify with psychiatric diagnoses in different ways (Sweet and Decoteau 2018). In Johnson's neurodivergent intervention into feminism she suggests that people may identify with psychiatric diagnoses 'wholly, partly, ambivalently, or strategically' (Johnson 2021, 635). Revealing these nuances, and the associated prejudicial stereotypes about "sickness" and "madness" is the remaining task of this thesis. While sexual violence is here considered "normal" trauma when expressed through symptoms such as dissociation, I have shown that this may raise the spectre of medico-legal psychological scrutiny in the eyes of the law, to which I now turn.

4. Normal Trauma and Abnormal Diagnosis in Law and Policy

Introduction

This chapter explicates two discursive constructions identified in my analysis of case law in England and Wales: "legitimate trauma" and "abnormal" psychology. These judgments therefore reveal a binary model of "normal" and "abnormal" mental health in relation to sexual violence, as theorised by Sweet, Decoteau, and Laugerud in the previous chapter (Sweet and Decoteau 2018; Laugerud 2019). These cases betray a legal conception of the individuals testifying to sexual violence as, at least potentially, psychologically "abnormal". This chapter is divided into three parts. In part 1, I produce my explication of "legitimate trauma". I show that this construction requires corroborative evidence: either medical and psychiatric, or witnesses to individual "distress". Within this, the judgments indicate that the "freeze" response to sexual violence serves as particularly powerful corroborative evidence (section 1A). Rather than simply reflecting the original Greek meaning of trauma as a physical "injury", as in Laugerud's work (Laugerud 2019), I argue in section 1A that this reflects and reproduces the 19th century medico-legal notion that rape victims are rendered "insensible" by sexual violence identified by Bourke (Bourke 2012). Bourke has shown that this notion of "insensibility", a kind of incapacitation, actually facilitates sexual violence testimony, contrary to the feminist notion that medico-legal ideas (e.g. hysteria) silence experiences of sexual violence (Bourke 2012). The same was true in these cases. In section 1B, I also show that "legitimate trauma" is premised on individuals being "normal" before the assaults and "abnormal" thereafter, which echoes the discussion in the previous chapter in section 2A. Here "normal" is standing in for: productive at work, and psychologically healthy. Further, the equivalence of the traumatic event and the traumatic aftermath can additionally introduce scepticism into judgments, with the absence of one erasing the other. Once I have detailed these features, I will demonstrate the requirement that "legitimate" sexual violence testimony be corroborated in section 1C.

In part 2 of this chapter, I detail the construction of "abnormal" psychology. In section 2A I describe how, in some instances, this constructs individuals as "malingerers":

specifically, the medico-legal category that labels individuals as lying for financial gain. In section 2B, the focus is on whether people are manipulative or attention-seeking, which draws from stereotypes about feminine irrationality and pathology. Within this section, I provide a lengthy account of one particular case (R v Gabbai 2019), as it produced the most extensive discussion and reproduction of mental health evidence, and is particularly illustrative of its prejudicial effect. This case additionally demonstrates the binary opposite to the "insensible" bodymind: the "sensible" bodymind, that either invited violence or failed to effectively resist it. To demonstrate this point within the legislative framework of the SOA (2003) and a "reasonable" belief in consent, I compare Gabbai to a "successful" case of "legitimate trauma", and contrast the two bodyminds produced in the materials: one sensible, one insensible. Then, in section 2C, I provide an example in which a woman's testimony is deemed unreliable, not because she was manipulative, but because she was mistaken ("mad"), although her account was corroborated, and hence ultimately an example of "legitimate trauma".

In part 3 of this chapter, I contextualise some of the consequences of these constructions on sexual violence testimony, and associated understandings of trauma, memory, and speech. I argue that the law constructs legitimate sexual trauma as preferably unspoken before a trial. Any prior disclosures, or mental health evidence, raised the spectre of "abnormal" psychology, which could contaminate memory, testimony, or both. In section 3A, I explain the law's anxieties about memory contamination with reference to Janice Haaken's work on repression, before demonstrating this through the analysis of case law materials. In section 3B, I bring in key findings from the analysis of legal policies and my doctrinal readings of case law on capacity to bolster the arguments presented, and to demonstrate these claims in their wider legal context. This section demonstrates that the law operationalises a "state-based" approach to memories of sexual violence in relation to mental health, such that a "traumatic" state affords individuals with veridical access to traumatic memories, and an "abnormal" state compromises reliability in the same way as a cataract on vision. These two findings are strongly indicative of the literature outlined in section 1C of the previous chapter, which suggests that "dissociation", and pathological memory, are particularly strong markers of the legitimacy of sexual violence testimony (Brison 2002; Spurgas 2021; Haaken 1996; Carter 2021).

To introduce this chapter, and some of the perils of the “double-edged sword” of medicalising sexual violence in the legal sphere, it is useful to summarise the extant case law and CPS policy concerning the relevance of mental health evidence to sexual violence trials. Evidence of PTSD is now admissible in England and Wales under certain conditions, on account of how it provides ‘evidence of psychological injury in exactly the same way as any doctor might give evidence of physical injury consistent with a particular allegation’ (R v Adam Eden 2011, [14]; Crown Prosecution Service 2019; 2021b). Note the emphasis on “injury” as “proof”. As discussed in section 2B of chapter 3, this is to be expected in legal contexts (Gavey 2005; Sweet 2021).The cited case here concerned sexual abuse of a child, but is pertinent in its effect on precedent, and also because it can still be argued that evidence of such an “injury” was accrued elsewhere. The appellant’s case was that ‘the symptoms are [not] necessarily related to a history of child sex abuse, merely that the symptoms are consistent with some long term repeated events’ (R v Adam Eden 2011, [13]). For this reason, expert evidence of PTSD is only admissible in “general” rather than pertaining to a particular individual. Yet the appellant’s position also reveals that within the discursive operations of the law, there is space for disbelief: that someone may have PTSD, but be misattributing the causal event of that PTSD. Serisier has previously articulated this problem, in writing that

> To label a narrator as sincere but mad as opposed to a liar does not offer a greater legitimation of their narrative or the self that it constructs, and leaves the ethics question surrounding belief unresolved (Serisier 2015, 82).

The law in England and Wales makes space for disbelief, which may be especially pertinent where the idea of PTSD or “madness” is introduced, and the person constructed as being an innocent victim of their own confusion, their own “mind” (Haaken 1998). While this prospect has been interrogated in relation to childhood sexual abuse (Haaken 1998; Powell, Hlavka, and Mulla 2017; Lewis 2006), to which this case relates, less attention has been afforded to the particular dynamics in adult cases.

Further, CPS policies indicate a sceptical legal view of mental health evidence, as in the most recent CPS guidance on psychological evidence in sexual violence cases, criminal justice professionals are advised to consider ‘the evidential value of a diagnosis of PTSD’

(Crown Prosecution Service 2019, 24), while advocating an 'understanding of pre-existing mental ill-health' and cautioning that 'corroboration must be actively sought and inconsistencies or lies must be dealt with rather than wished away' (Crown Prosecution Service 2019, 23). Corroboration directions remain at the judge's discretion (R v Makanjuola (supra), R v Easton, 1995), but convictions are supposed to be possible in England and Wales without corroboration. However, this language in CPS policy is strongly suggestive of the outdated twentieth century notion of encouraging psychiatric evaluations of sexual violence testimony (Ellison 2009), encouraging prosecutors to seek either evidence of 'corroboration' or 'mental ill-health [...] inconsistencies or lies'. This scepticism is evidenced in this chapter through my analysis of legal judgments, and I specifically return to my analysis of CPS policies in the section on traumatic memory before concluding this chapter.

1. Legitimate trauma

The materials for analysis were presented in table 1 of the methodology chapter (pages 33 and 34). In this section I detail the construction of cases in which trauma was legitimated: here, in the resultant judicial treatment. Even though evidence of PTSD as "psychological injury" was deemed admissible in criminal trials in 2011, no subsequent cases were identified in which this was the case. Instead, there appeared to be an association between cases of "legitimate trauma" and the timing of the Government's original consultation on the admissibility of expert evidence on "trauma", with four (R v Allison 2006; Lawson v Executor of the Estate of Dawes (Deceased) 2006; R v Soroya 2006; R v Boulton 2007) out of the six successful cases occurring between 2006 and 2007 (exceptions: R v Smith 2002; London Borough of Haringey v FZO 2020).

A. Freeze or Flight

On the same day that the consultation on the admissibility of sexual trauma evidence was opened to the public in 2006 (Home Office and Office for Criminal Justice Reform 2006), the Court of Appeal sat to adjudicate the appeal of a psychiatrist, Christopher Allison, who had been convicted for multiple counts of rape and sexual assault against his patients. Allison appealed against his conviction largely on the basis that his wife had since found

a letter from one of the people he assaulted expressing sorrow at his professional suspension after the allegations came to light, and that this behaviour was "implausible" from a woman who claimed to have been raped. It was also argued that this woman returning to therapy with him after the first sexual assault was "abnormal" behaviour for someone who had experienced sexual violence. This, coupled with Allison's own psychiatric notes describing her as 'whorish' (R v Allison 2006, [22]), and his account of how she 'had submitted to sex willingly' (R v Allison 2006, [21]), was clearly intended to rewrite this woman's account of sexual trauma into one of objective consensual sex.

In the dismissal of Allison's appeal, the judge reiterated the woman's own descriptions of her trauma, in her use of the language of "freezing". Her voice is re-animated in the judgment to describe 'how your body just stays there and you are furious with your body because you can't just get up and go' (R v Allison 2006, [6]). In other cases from around this time, individuals' testimony is similarly reproduced to demonstrate the experience of "freezing": in one judgment, it states that the woman 'repeatedly told him to stop, but that she felt like "a rag doll" and was unable to move a muscle in her body or offer any resistance' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [42]). Judith Herman's (1992) foundational conception of the "freeze" response to sexual violence similarly quoted people feeling like a 'rag doll' (Herman 1992, 42), and this language was gaining traction in medical jurisprudence around the time of Allison's appeal. In 2007, Fiona Mason, a forensic psychiatrist who had authored training materials on sexual trauma for judges that were being used in 2008 (R v D 2008, [9]) co-authored an article published in the British Medical Journal detailing the health consequences of sexual violence, including being 'paralysed with fear and powerless to fight back' (Welch and Mason, 2007). Mason's influence over legal practice is enduring, as she also co-wrote the most recent guidance on psychological evidence (Crown Prosecution Service 2019).

These cases reveal the utility of the language of "freezing" for legitimising individuals' experiences and accounts of sexual violence in the courtroom. However, the "freeze" response is especially palatable to the judiciary on account of it being physically instantiated. In legalised understandings of gendered violence, there is an overemphasis on physical and bodily "injuries" (Bourke 2012; Sweet 2021, 183). For example, in Naveed Soroya's case, a young Polish woman had arrived in the UK without a work

permit, and needed a way to make money while she waited to accrue one. She responded to an advert in a Polish newspaper for cleaning work, which is how she met Soroya, who was subsequently convicted of raping her when she went to collect her first round of wages. In the appellate judgment, it states that ‘She was not physically injured or threatened and needed to explain why she had put up no obvious resistance’ (R v Soroya 2006, [6]). In the original trial, the reason for her lack of ‘obvious resistance’ was attributed to a diagnosis of a “conversion disorder” adduced by the prosecution, which meant that she ‘might be abnormally passive in the face of stressful circumstances’ (R v Soroya 2006, [7]). Although no longer a psychiatric category in the international diagnostic manual, a “conversion disorder” was previously categorised under “dissociative disorders”, ‘being associated closely in time with traumatic events’ (World Health Organization 1992, F44.4). In the 2013 edition of the DSM, it also states that ‘conversion disorder is often associated with dissociative symptoms’ (American Psychiatric Association 2013, 320). Of particular note here, is the judiciary’s weighing up of whether she had ‘put up no obvious resistance’ because she was ‘abnormally passive’. The conclusion was to the effect that she was ‘not able to fight back as she froze due to psychiatric illness’ (R v Soroya 2006, [14]). Accordingly, it was decided that she was not able to enact ‘resistance’ due to a trauma-induced ‘illness’.

This distinction is remarkably reminiscent of the British medico-legal notion of “insensibility”. As briefly mention in section 2C of chapter 3 in my discussion of Laugerud’s work, Bourke has demonstrated that before the language of trauma was applied to sexual violence in the UK, people were considered to be rendered physically “insensible” and incapacitated in psychiatric and legal texts (Bourke 2012). Bourke additionally shows that articulating experiences of sexual violence in relation to being “insensible” actually served to *legitimate* individual experiences and testimonies of sexual violence, rather than the contemporary conception that hysteria induces silencing. She writes that ‘the “sensible” body was seductive and either invited abuse or would have been able to repulse any attack. The “insensible” rape victim testified to “true” violation’ (Bourke 2012, 33). This notion is equally evident in Soroya’s case, as the woman’s lack of ‘obvious resistance’ (R v Soroya 2006, [6]) is explained through the idea that she was ‘abnormally passive’ (R v Soroya 2006, [7]), and ‘froze due to psychiatric illness’ (R v Soroya 2006, [14]). The language of the “freeze” response does remarkably similar work

to the 19th century notion of insensibility. This is also evident in the other "freezing" descriptions being particularly physical and bodily, and framed around an ability to "resist" or not: 'not able to fight back' (R v Soroya 2006, [14]); 'unable to move a muscle in her body or offer any resistance' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [42]); 'you can't just get up and go' (R v Allison 2006, [6]). The frozen bodymind testifies to "true" violation, in the same way that the insensible one did before it: resistance is here medically, or psychiatrically, impossible.

The "freeze" response is much more prevalent in the materials than the associated notions of "fight" or "flight" in the popular imaginary. There is one example of a "flight" response being documented in the materials, albeit not in relation to the sexual violence itself, but ongoing risks from an abuser. In a 2007 appeal against his conviction, Malcolm Boulton's lawyer argued that his trial judge had erred in permitting one woman's evidence to be read out in court due to her being absent 'through fear' (R v Boulton 2007, [2]). She had taken 'steps to conceal her whereabouts' (R v Boulton 2007, [33]), such that she 'could not be traced' (R v Boulton 2007, [36]) for participation in the original trial. This appeal was also dismissed, suggesting a judicial understanding of the legitimate fears of repercussions from abusers. This time in the Court of Appeal, the woman's testimony from an evidentiary hearing is quoted to justify her absence through fear, where she is noted as saying 'I am not averse to duty, your Honour I am just averse to martyrdom' (R v Boulton 2007, [34]). Her decision to avoid participation in the trial is on account of her fear for her life – 'martyrdom'.

While these cases are important in demonstrating how physically instantiated "flight" or "freeze" responses to trauma may be indicative of legitimacy, they additionally reveal a legal construction of the problem of sexual violence being located within women's minds, rather than instantiated in the social sphere. In the Boulton appeal, the residing judge stated that the woman's 'reference to "martyrdom" shows clearly her state of mind' (R v Boulton 2007, [35]). This woman had been subject to multiple attacks and death threats from her abuser intended to prevent her from testifying in court, and the judicial positioning of this fear as a "state of mind", rather than a legitimate fear of repeated threats on her life, speaks to the increasing medicalisation of sexual violence as a problem located within a "state of mind": a problem to be treated and cured.

The Allison judgment also sees the problem of sexual violence as placed firmly in the woman's "state of mind". The judgment reproduces her testimony to explain why she returned to therapy with her assailant, where it is reiterated that 'He was… he had become to me – this is horrible – almost a god-like figure after these months in therapy' (R v Allison 2006, [8]). Similar extracts of her testimony are reproduced in the judgment, as she goes on to say that 'I didn't question, I didn't challenge. I still stupidly believed, even after this was happening, that he knew what was good for me. I really believed that' (R v Allison 2006, [8]). These words all express important aspects of the power dynamic between Allison and this woman, of her experience, and of Allison's justification for his abuse, which was that he 'thought it might have' (R v Allison 2006, [22]) helped her therapeutically. However, the conclusion of the judgment, and the reason for dismissing Allison's appeal, is articulated as the fact that she clearly 'put the appellant on a pedestal' (R v Allison 2006, [44]). Here it is her mistake placing Allison on a pedestal, rather than Allison using and abusing his power over his patients as a psychiatrist. Both the antecedents and harms of sexual violence are instantiated in a "state of mind".

B. Normal Before and Abnormal After

In both criminal and civil cases, the judgments draw attention to the contrast in individuals' lives before and after their assaults, and how they were normal before, but psychologically damaged afterwards. The effect of sexual violence is adjudicated as 'devastating' (R v Soroya 2006, [44]) or as individuals being 'indelibly marked psychologically' (London Borough of Haringey v FZO 2020, [88]). In particular, these effects are framed in terms of their impact on individuals' productivity and work, which is represented as a fall from grace. In one civil case, a woman claimed against her assailant posthumously, who had multiply imprisoned and raped her. In the judgment, it states that she 'had previously been enthusiastic and ambitious' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [29]) before the assault, which led to a 'personality change' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [28]). In their elaboration, the judgment states that a 'significant factor' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [28]) of this change was that she did not return to work, which was

especially unfortunate because she had been a ‘rare talent’ (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [29]).

In another civil case from 2020, and the only case involving a person testifying to sexual violence who was a man, he had been multiply sexually assaulted by his sports teacher at school, well into his adulthood. In the judgment, he is described by a former colleague as ‘innovative and gifted’ (London Borough of Haringey v FZO 2020, [27]) before his breakdown in 2011, when ‘there was no dispute that this breakdown did indeed occur nor that the Respondent was no longer able to work because of it’ (London Borough of Haringey v FZO 2020, [34]). There is no denying that these were potentially veridical accounts of the lived experiences the judgments describe, but this construction additionally speaks to wider considerations about sexual violence in the popular imaginary, and what a “normal” sexual violence story looks like. This finding is notable, as it extends the discussion of Spurgas’ and Carter’s observations about being “normal” before sexual violence discussed in section 2A of chapter 3. Both theorists flesh out their understanding of what it means to be “normal” before sexual violence using Lauren Berlant’s conception of the “good life”. Although there is not space here to do the particularities of Berlant’s insights justice, in sum, the “good life” signals an unattainable but inherently attractive ideal, particularly marked by productivity and prosperity. In her PhD thesis, Carter suggests that trauma is understood in the popular imaginary as ‘an interruption in the “good life”’ (Carter 2019, 204).[13] If the “good life” is a marker of promise and prosperity, the same is true here in the descriptions of these people as ‘gifted’ (London Borough of Haringey v FZO 2020, [27]) or ‘talent[ed]’ (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [29]).

However, Spurgas and Carter’s theorising on the “norms” surrounding trauma and sexual trauma can be broken down in these judgments further, as this is currently standing in for two other factors that come to bear on the legitimacy of sexual violence testimony (Spurgas 2021; Carter 2021). Namely, the equivalence of the traumatic event with the aftermath, and the assumption that people are not just “productive” before sexual

[13] I realise that it may be unconventional to cite another scholar’s PhD thesis, but the work is exemplary, and in any case, this is merely the best quotation for making broader points made in the two published articles.

violence, but psychologically "normal": I will detail these both in turn over the remainder of this section. Firstly, the construction of legitimate trauma in these materials reveals an expectation that sexual violence will necessarily result in a 'personality change' or a psychiatric 'breakdown'. This language is indicative of professional psy discourses, in which trauma is represented as a ticking '"time bomb" metaphor' (Gavey and Schmidt 2011, 444), leading to an eventual breakdown brought on by a particular and discrete trigger. This expectation can cause an equivalence between the traumatic event and the traumatic aftermath in the judgments analysed, which is not everyone's experience of sexual violence, and plays into stereotypes about "real rape". For example, in one civil from 2006, there was a question raised as to whether this woman had "invented" what happened, and whether she was "dramatic". In the judgment's dismissal of this sentiment, it states that 'it has to be said that what happened to her over the relevant period was, by most people's standards, dramatic' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [79]). Here, both the sexual violence and its aftermath are conceptualised as exceptional, in understanding them as "dramatic".

Similarly, in the case of London Borough of Haringey v FZO (2020), the case at appeal was that 'the sexual activity perpetrated was not violent in nature, but rather non-forceful and sympathetic in character, which would negate any form of PTSD, complex or otherwise' (London Borough of Haringey v FZO 2020, [158]). This man was first assaulted at the age of 13, and the notion that he had a 'sympathetic' relationship with his sports teacher is neither convincing nor legal. However, the idea that this 'sympathetic' relationship would 'negate any form of PTSD' represents a slippage in the language of trauma: if the sexual violence is not perceived as traumatic, despite being a crime, then the associated distress is seen to be eradicated too. The equivalence of the traumatic event and the psychological injury is evident here, such that the absence of one negates the other (Gavey and Schmidt 2011; Harrington 2010). In this case, it potentially also speaks to a sexuality dimension, as while a "normal" sexually traumatised person may be seen as "feminised" in medico-legal circles, the conversely "pathological" understanding of homosexual men could be considered particularly complicit or responsible for the abuse they experienced (Spurgas 2021; 2020; Javaid 2015). This man is represented as having a consensual and 'sympathetic' sexual relationship with his sports teacher, which suggests not just that he invited the abuse but participated in it.

Secondly, part of the disagreement on the legitimacy of the trauma in this case came from conflicting reports from expert psychiatrists. These expert evaluations are often presented as objective or rational, which again obscures what they construct, and the assumption that people are psychologically "normal" before sexual violence. In one of the other civil cases, two women were claiming against the police for their mishandling of the John Worboys case – the prolific taxi driver rapist convicted in 2009. In the judgment, one of the women is deemed of 'good character' (DSD & Anor v The Commissioner of Police for the Metropolis 2014a, [69]) by the expert psychiatrist. He additionally states that 'she was a normal and confident young woman before the assaults' (DSD & Anor v The Commissioner of Police for the Metropolis 2014a, [71]). As commentators such as Spurgas have demonstrated, the notions of being of "good character", and "normal and confident" are particularly embroiled in ideas about class. The limited demographic information in case law materials make it difficult to adduce the specificities of class, but the subsequent damage of the sexual violence is again articulated in terms of productivity, but as specifically 'damag[ing] her performance at university' (DSD & Anor v The Commissioner of Police for the Metropolis 2014a, [70]), reflecting a high level of education, if not necessarily a class dimension.

Further, the judgment explicitly connects her being 'normal and confident before the assaults' to the fact that 'she would not have developed mental health problems had it not been for the assaults' (DSD & Anor v The Commissioner of Police for the Metropolis 2014a, [71]). The assuredness that she would not have 'developed mental health problems' could be partly connected to an assessment of class or material privilege, but it certainly reflects that she was considered not just "normal", but specifically, psychologically "normal" before the assault. In tandem with discursive constructions of sexual violence destabilising people's physical autonomy by rendering them insensible, this re-animates Carter's work concerning "bodymind stability". It is assumed that people have 'bodymind stability' (Carter 2021, 6) before experiences of violence, and that the sudden interruption to the "good life" is what renders individuals traumatised. While these facets are theorised as culturally impossible, they are also, I suggest, particularly unattainable for people who identified with psychiatric categories before experiences of

sexual violence. The judgment that individuals would not have 'developed mental health problems' outside of sexual violence reflects both cultural and psychological privilege.

C. Corroboration

While these aspects of how each individual case is discursively constructed reflect wider considerations surrounding the legitimacy of sexual violence testimony, it is important to emphasise the very active role that psychiatric evaluations play in these cases. Every case involved some degree of psychiatric assessment, as the mere presence of mental health evidence raised the spectre of "abnormality". Here, the individuals testifying to sexual violence are seen as psychologically "abnormal", and required corroboration to be believed. All "successful" cases, bar the one concerning a psychiatrist himself (R v Allison 2006), were corroborated by medical or psychiatric evidence, or both (R v Soroya 2006; London Borough of Haringey v FZO 2020; DSD & Anor v The Commissioner of Police for the Metropolis 2014a; R v Smith 2002; Lawson v Executor of the Estate of Dawes (Deceased) 2006).

In what is again a particularly stark example, the Polish woman in Naveed Soroya's case underwent two psychiatric evaluations before the trial: the psychiatrist enlisted by the defence suggested that she was 'nice, believable' (R v Soroya 2006, [17]), and the one employed by the prosecution that there was 'nothing in the [psychiatric] history or psychiatric examination […] to suggest the complainant would have any psychiatric or psychological reason for giving an unreliable account to the police' (R v Soroya 2006, [18]). At the time, this evidence would have ordinarily been considered unduly prejudicial to the defendant, as it speaks to her credibility specifically: the prosecution is not allowed to call expert witnesses to bolster the credibility of its own witnesses (Rumney and Taylor 2002; R v Robinson 1994). While therefore an exceptional judgment, it demonstrates the power of persuasion of psychiatric evaluations, particularly when delivered by experts. The "truth" of her disclosure necessarily fell to the psychiatric assessments to gauge that she was 'nice, believable' (R v Soroya 2006, [17]), and the judgment consequently concludes that she was 'not manipulative' (R v Soroya 2006, [38]). Having to explicitly surface this conclusion reveals the underlying alternative, or

hypothesis, that had to be disproved: that she was psychologically “abnormal”, and hence, unreliable.

The abolition of the requirement that judges issue a warning of convicting on the basis of a woman’s uncorroborated testimony in sexual offence trials is heralded as another success of feminist legal reform in the English context (McGlynn 2010). However, this success is here limited by which individuals’ accounts are deemed reliable without corroboration, and how mental health evidence figures in determining the truth or falsity of an account of sexual violence – particularly as judges still retain discretion as to whether to make a corroboration warning in sexual violence trials (Leahy 2014). Interestingly, the corroboration rule remains largely implemented in Scotland, although in 2023 a ‘seismic’ (Brooks 2023) case has just altered this rule, such that evidence of “distress”, when witnessed by a third party, can now be used as corroborative proof of sexual violence (His Majesty’s Advocate v CRB 2023). Lay witness testimony to distress also proved useful in testifying to individuals’ trauma in these materials. In the posthumous civil case, a previous employer describes the woman as ‘deeply upset’ (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [30]) following the sexual violence; and in R v Smith, the woman subjected to sexual violence immediately ran to her neighbours’ house, who’s testimony spoke to her ‘being in a terrible state, shaking and crying, and she said that the complainant had told her that she had been raped’ (R v Smith 2002, [7]). I do not doubt that these were veridical accounts from these witnesses, as well as the very real experiences of the people who had experienced sexual violence. However, the power of evidence of “emotional distress” is here notable. Sameena Mulla, along with her colleagues Amber Powell and Heather Hlavka, have conducted research of trials in the US that similarly showed the power of performing emotional distress in the “normal” way (Powell, Hlavka, and Mulla 2017). Corroborative evidence from witnesses came under the umbrella of trauma when it spoke to either individuals’ psychological or medical state, or their broadly defined emotional “distress”.

The requirement that these individuals be corroborated, and the associated psychological scrutiny they were subjected to, in Wendy Larcombe’s words, ‘reveal as much about judges and the law as they reveal about women’ (Larcombe 2002b, 107). Larcombe argues, of the Australian context, that the story of the “false rape complainant” arguably

tells us more about the law and the judiciary than the story of rape convictions for this reason. Here, similarly, judgments do not reveal an "objective" and "rational" assessment of women's testimonies, but one that is heavily entrenched in the stereotypes and norms surrounding the psychology of sexual violence. To make this point more fully, I now turn to the other side of the binary: "abnormal" psychology.

2. "Abnormal" Psychology

On the other side of the binary legal treatment of the relationship between mental health and sexual violence lies the "abnormal" bodymind. In some cases, this was indicative of "malingering", while in others, the "true" insensible bodymind is replaced by a "false" and sensible one. In this section I will first explicate some examples of "malingerers", before moving on to discuss those who were considered "manipulative", and specifically, I detail the R v Gabbai (2019) case to make my point about insensibility, before describing an instance adjudicated as "madness", rather than general "badness".

A. Malingerers

The assumption that the people testifying in these cases were "abnormal" is evident in the fact that weighing up the two narratives – disordered and unreliable or legitimately traumatised – appeared in all cases. In several cases, this demarcation was specifically conducted in relation to ideas about "malingering": people "faking" trauma for financial gain. In the posthumous Case X from 2006, it is noted that the woman who had been subjected to sexual violence had 'sold her story to a newspaper' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [124]). The psychiatrist evaluating her on behalf of the defence had not known this information at his original report in 2002, in which he 'concluded that the diagnostic criteria for PTSD were indeed fulfilled' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [116]). Upon discovering that she had sold her story, however, he decided that he was

> Strongly of the opinion that someone genuinely suffering from this disorder simply could not have drawn herself to public attention in this way, and it is quite

inconsistent with the "avoidance" which is a central feature of PTSD (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [82]).

Her PTSD is here given to be not "genuine", and hence: factitious. Further, the judgment continues: 'It is also relevant here, however, as an example of self-dramatising' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [82]). The judgment states a belief 'that she does tend to dramatise events' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [79]), and notes 'her tendency to gild the lily' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [84]), as well as a question of whether 'she is a "drama queen" and prone to exaggeration' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [79]). The notion of a "drama queen" is steeped in stereotypes about feminine irrationality, and exaggerating or manipulating the facts. However, the judgment is not interested in whether she "exaggerated" events, but whether they are entirely invented. Instead, the fact that she accrued '£16,000' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [80]) for selling the news story within a week of her assailant's death is given by the judgment to be 'more significant' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [80]) than her "self-dramatising" in this series of events. This speaks specifically to a construction of "malingering", as it is explicitly the financial gain that is considered significant in the judgment, rather than her 'tendency to gild the lily' (Lawson v Executor of the Estate of Dawes (Deceased) 2006, [84]).

In another example of a case which draws from ideas about "malingering", there is considerable overlap with this construction and ideas about personality disorders. In the judgment concerning the man and his sports teacher, much of the discussion centred around the conflicting assessments of two expert psychiatrists, and whether he was deemed to suffer from 'emotionally unstable personality disorder' or 'complex PTSD' (London Borough of Haringey v FZO 2020, [177]). This reflects the fact that it is solely along this binary that these judgments operate. Concern was expressed that this man's diagnoses only changed to trauma-related categories after he disclosed the abuse, the suggestion explicitly that he had persuaded the clinicians at his private healthcare institution 'to change their diagnosis from personality disorder to trauma in order that the health insurer would meet his claim' (London Borough of Haringey v FZO 2020, [85]). This latter aspect specifically draws on ideas about personality disorders being

‘manipulative’ (persuading the clinicians to change the diagnosis), and ideas about “malingerers” unjustly seeking financial gain – here in the form of health insurance for the psychiatric care he received after his breakdown.

One expert psychiatrist additionally felt that complex-PTSD ‘is essentially another way of describing a personality disorder’, and that complex-PTSD has ‘a considerable degree of overlap with emotionally unstable or borderline personality disorder’ (London Borough of Haringey v FZO 2020, [46]). This is an important and interesting detail, as it reflects the feminist efforts to redefine certain personality disorders, including emotionally unstable (previously borderline) personality disorder, as legitimate responses to trauma (Herman 1992; Shaw and Proctor 2005; Chesler [1972] 2018; Bumiller 2008). In addition, it reflects the resistance to this conceptualisation in medicalised circles. Rather than the psychiatrist considering these personality disorder diagnoses within the category of “trauma”, instead, the reverse is true, as he suggests that complex-PTSD is ‘essentially […] a personality disorder’, which comes with all the attendant stereotypes of being manipulative or malingering, as above. The appellate judgment states that the view of this psychiatrist ‘was that CPTSD does not appear in standard diagnostic texts and that it is an inapposite diagnosis in the present case because the abuse was not perceived as "traumatic" by the Respondent, either at the time or for years afterwards’ (London Borough of Haringey v FZO 2020, [46]). This is a fairly recent judgment, and reflects both the lack of medical acceptance of complex-PTSD (although at the time it was not ‘in standard diagnostic texts’), and the psychiatrist’s perception that this experience was not “traumatic”, and in fact, that ‘the abuse did not make more than a minor contribution to the claimant’s mental health’ (London Borough of Haringey v FZO 2020, [88]). The idea that this man was “malingering” and seeking financial gain here bleeds into the medico-legal conception of personality disorders and manipulation.

B. Manipulation, Attention-Seeking

In several cases, it was suggested that the people testifying to sexual violence were manipulative or attention-seeking. In a recent case in Wales, one woman testifying to sexual violence was deemed ‘manipulative and capable of influencing others’ (R v Adams 2019, [13]), and it was argued that a consensual ‘relationship’ (R v Adams 2019, [9]) had

begun when she was 13, and her assailant was 40. In this case, it is plausible that she was also forced to contend with a personality disorder diagnosis, although either a typo in the transcript or a mistake in the judgment has called it 'Dialectic Behaviour Disorder' (R v Adams 2019, [9]). This case is comparable to London Borough of Haringey v FZO (2020), as both experiences of abuse started when the individuals were very young, and their assailants in relative positions of power over them, and both were likely contending with potential personality disorder diagnoses. In the face of these stark power dynamics, this narrative of manipulation is used in these judgments to negate the traumatic event itself, transforming it into an account of consensual sex that has been misrepresented by unreliable narrators. In the Welsh case, this narrative was ultimately successful, the reasons for which I will discuss later in this chapter in the effects of the legal construction of "abnormal" psychology in relation to speech.

In R v Gabbai (2019), the judgment similarly constructs a woman testifying to sexual violence as manipulative and attention-seeking, on account of a history of "false" rape allegations: all documented in her mental health records, through her interactions with therapeutic professionals. In this judgment, the appeal was successful, and the conviction overturned. Edward Gabbai had initially been convicted for sexual violence against multiple people in 2018. Part of the basis for his appeal in 2019, and the one that was ultimately successful, entailed accessing "fresh evidence" in the form of extensive psychiatric notes pertaining to one of the women he had assaulted, all accrued before she had even met Gabbai in December of 2016. This woman had experienced multiple instances of sexual violence before meeting Gabbai, and these had been documented in various different ways by mental health professionals over the years.

In 2014, this woman had seen a university counsellor and discussed an experience of sexual violence, and the notes written by the counsellor are reiterated in the judgement, which states that 'after discussion of her history of mental health problems and drug-taking, the notes record "see Thought Sheet… I took him back to my flat. I didn't say no to begin with. Lying. Attention-seeker."' (R v Gabbai 2019, [38]). The presentation of the latter half of these notes in both quotation marks and the first person is interpreted by the judgment as suggesting that 'The implication of the last phrases is, or may be, that they were self-descriptions' (R v Gabbai 2019, [38]). Given the limitations of analysing

judgments, and especially their reproduction of notes from years earlier, it is impossible to know whether this was the case or not. The first extracts in quotation marks – 'I took him back to my flat. I didn't say no to begin with' – could equally be adjudicated as a presentation of trauma that includes self-blame. Either way, the question in the judgment was not whether this prior experience induced legitimate trauma, but whether she had a propensity towards being "lying, attention-seeker", and whether this was a self-description.

The question of whether she was "lying" was combined with the fresh evidence suggesting that she had doubted other past experiences of sexual violence in therapeutic contexts. The additional "fresh" counselling notes for admission were all produced in 2016, prior to her meeting Gabbai. Again, the limitations of judgment materials make it difficult to interpret the use of quotation marks in the reproduction of these records, but the judgment details the following examples. On the 12th of October 2016 she had an hour-long call with a counsellor, which is documented as

> Raped three times. 'I put myself in dangerous situations'
> 1. 18 years taken from a bar. I only said no half-way through.
> 2. A guy forced himself on me.
> 3. In Spain. Maybe wasn't rape (R v Gabbai 2019, [39]).

On the 19th of October, in her pre-admission notes to this service she is documented as 'Has suffered three rapes. Putting herself in dangerous situations (i.e. voluntarily)' (R v Gabbai 2019, [40]). After a counselling session post-admission, on the 21st of October, the notes say that she 'touched on whether the sexual acting out was more a symptom of her self-hatred. A form of self-harm' (R v Gabbai 2019, [41]). Then on the 1st of November 2016, a psychiatrist notes that she 'tells me that she is always putting herself in danger, found it hard to say no, but there were lots of other times she didn't [say no] when she wanted to say no' (R v Gabbai 2019, [42]). The judgment concludes that 'In our view, this evidence was of a striking nature, and relevant as suggestive of previous false accounts. The evidence that the complainant had doubted her own past suggestions of rape, and was "Lying. Attention seeker" should have been admitted' (R v Gabbai 2019, [59]).

This conclusion is important for several reasons. Firstly, the discussion of this woman's 'sexual […] self-harm' (R v Gabbai 2019, [41]) speaks to the opposite side of the construction discussed earlier around women's bodyminds being rendered "insensible". Where an "insensible" bodymind testifies to true violation, this woman's "sensible" bodymind 'was seductive and either invited abuse or would have been able to repulse any attack' (Bourke 2012, 33). She is the one who puts 'herself in danger' and invites abuse, and fails to resist the attacks because 'she found it hard to say no'. This notion of the "sensible" bodymind either inviting abuse or being able to resist it, is particularly prominent in contemporary legal and policy discourses (Stringer 2013; Phipps 2010). Lise Gotell, writing of the Canadian legal context, has suggested that legal understandings of "consent" are embroiled in wider stereotypes about respectable (and hence resistant) femininity. She writes that 'sex outside, sex that is risky, sex that defies standards of responsibility, respectability and sexual safekeeping, marks the complainant herself as a deviant' (Gotell 2008a, 887). In R v Gabbai (2019), this woman is adjudicated at failing in this effective "sexual safekeeping", on account of her 'self-harm', which instead diminishes her consent in the same way that Gotell describes.

Secondly, the totality of this evidence being 'suggestive of previous false accounts' is a stretch in general, but in the specific legislative context of England and Wales, it becomes specifically relevant to proceedings to establish Gabbai's *reasonable* belief in consent, according to the legislative framework surrounding the SOA (2003). The judgment states that 'Her own description of her earlier behaviour might indicate how she behaved with the appellant, in such a way as to affect his reasonable belief in her consent' (R v Gabbai 2019, [50]). This case can be contrasted with the aforementioned R v Soroya (2006), in which it was argued by the appellant that he had a reasonable belief in consent because 'she froze due to psychiatric illness' (R v Soroya 2006, [14]). Soroya's appeal was unsuccessful precisely *because* she froze, because a diagnosis of a "conversion disorder" was admitted to testify to that effect, and because it was not at all possible that she invited the abuse, unlike the woman's "sensible" bodymind in Gabbai's case.

Finally, the conclusion of Gabbai's case is important because the judgment overturns his conviction on this basis of a reasonable belief in consent, despite video evidence to the contrary. A transcript of a video Gabbai filmed of this assault on his phone is presented

in the judgment, which was both graphic and distressing for me to read, as well as to reproduce here.[14] The judgement takes a different stance: 'We have looked with care at the video. On a straightforward viewing it appears, at least arguably, entirely consistent with role-play' (R v Gabbai 2019, [30]). The judgment hones in on a particular part of the transcript concerning one of the claims at appeal, which was that while the vaginal penetration was consensual, the anal penetration was 'unintentional' (R v Gabbai 2019, [13]) on Gabbai's account. The judge suggests that the video is 'important, as it shows, on a plain viewing, a giving of explicit consent by the woman a few seconds after the allegedly anal penetration: "Do you want me to stop? No"' (R v Gabbai 2019, [30]). Yet, providing just a few more lines of the video transcript presents a quite different and sinister picture:

> (*Gabbai inserts penis*)
> [woman]: Ouch, ouch, ouch. Please, don't. No, please, no. Ouch (*crying*).
> Please, don't, please, don't
> Gabbai: Do you want me to stop?
> [woman]: (*shakes head*)
> Gabbai: Say it clearly, say it clearly
> [woman]: No (R v Gabbai 2019, [15]).

The judgment wilfully eradicates the woman's distress ('crying') and explicit non-consent 'please, don't' in favour of rewriting her account into 'a giving of explicit consent' that is 'entirely consistent with role-play'. Linguistic scholar Susan Ehrlich has noted that video evidence is particularly persuasive to juries (Ehrlich 2018), but it was additionally noted by the judge's summing up in the original trial that the jury had 'not had the benefit of any expert evidence in this case' (R v Gabbai 2018, 8). While again, it is impossible to say from these materials which pieces of evidence were compelling for the jury at the original trial, the mental health evidence became crucial for the judiciary: so crucial that Gabbai is adjudicated as having a *reasonable* belief in consent while a woman is clearly recorded as 'crying'. Gabbai's case is therefore a particularly illustrative example of the power of mental health evidence, particularly within the legislative framework of the SOA (2003)

[14] I say this chiefly to forewarn the reader.

in England and Wales, to render a bodymind "sensible" and hence culpable, for the violence they were subjected to.

C. *Unreliable*

In other cases, the "abnormal" state of mind of individuals is rendered not manipulative, but just plain mad. In the introduction to this chapter, I noted Serisier's assertion that labelling someone as "mad" instead of a "liar" does not offer a greater legitimation of their narrative, nor explain why they were not believed. The cited 'ethics question surrounding belief' (Serisier 2015, 82) is again explained in the relevant case through the power of corroborative evidence. In Allen Smith's appeal in 2002, it is written that

> The fact of suffering from a severe borderline personality with associated histrionic and dependent features does not by itself necessarily discredit a person's reliability in all matters… I am sure the complainant should be considered as being capable of giving reliable evidence when she is relatively well, on mental or general subjects. It is more doubtful whether she is capable of doing so accurately when sexual matters are involved (R v Smith 2002, [21]).

In a psychiatric report in the judgment it was 'said that the woman's disorder would involve a failure of normal perception in relation to emotional rather than factual matters… if corroborated, her account of a sexual incident would be credible' (R v Smith 2002, [29]). Such assessments are transparently damning, as both paint this woman as *incapable* of narrating *any* experience of sexual violence reliably, without corroboration. The psychiatric reports are clear: this woman is simply unable to reliably narrate experiences of sexual violence as these are 'emotional rather than factual'. While she is able to give 'reliable evidence […] on mental or general subjects', she is not a reliable narrator 'when sexual matters are involved'. However, her account was indeed corroborated by both extensive physical medical evidence, including an ectopic pregnancy resulting from the violence, and a witness, Peter Dawson, who had been with Smith later on that evening when he expressed his fear of being caught: 'I hope she doesn't shout rape' (R v Smith 2002, [9]). The assumption of "abnormal" psychology is present in

each of the cases that were analysed here, an assumption that could be overturned by medical evidence, or evidence of "insensibility".

3. Traumatic Memory and Testimony

The rendering of this woman as unable to reliably narrate "sexual matters" raises the question of the effects of these two discursive constructions for sexual violence testimony. I will here remind the reader of the discussion in the previous chapter, in the section on trauma as a psychiatric definition, of Susan Brison's observation that amongst certain trauma theorists there is a conception of traumatic memory as pathological – encoded "wrongly", inaccessible to consciousness apart from in flashbacks and dreams (Brison 2002, 70). Linda Alcoff and Laura Gray-Rosendale (1993) have additionally noted the conception of "normal" sexual trauma as untouched "raw experience" in need of expert verification (Alcoff and Gray 1993). On this account, the traumatic memory is pathological – encoded "wrongly", inaccessible to consciousness apart from in flashbacks and dreams. This is additionally reflective of the "event-based Psychiatry", and Spurgas' and Carter's insights that the sudden psychic "split" of dissociation has become a marker of legitimate trauma (Goozee 2021; Spurgas 2021; Carter 2021). Within trauma theory, "dissociation" is considered to induce vertical splits in consciousness, and the memory is considered successfully "preserved" when it is not worked over through cognition, or even speaking about it. While "dissociation" can "prove" sexual violence, the spectre of legal anxieties about memory contamination discussed in section 2B of chapter 3 is re-animated by the presence of mental health evidence.

A. Repression and Contamination

Janice Haaken has noted that the converse of "dissociation" can be found in Freud's work on "repression", which has contributed to understandings of "horizontal" splits in consciousness (Haaken 1998; 1996). Ideas about repression have contributed to suspicion of sexual violence claims, on account of the literature examining the problems of memory reconstruction and therapeutic suggestion. The idea is that each time an unconscious memory is accessed for elaboration, it runs the risk of introducing erroneous

details, including those implanted by therapists themselves; the false memories then run parallel (hence, horizontally) to the true ones, thus muddying the waters of memory retrieval. Although the literature on "false" memories generally concerns childhood sexual abuse, the idea that accessing or articulating a memory may introduce error has additionally been applied to adult witnesses to emphasise 'the malleability of memory and its vulnerability to social influences' (Haaken 1999, 51). Elizabeth Loftus, one of the leading researchers in this field, perhaps most famously testified to this potential for falsity in adults during Harvey Weinstein's trial (Associated Press in New York 2020). Both dissociation and repression then retain an idea of the "true" traumatic memory being successfully preserved in the unconscious as an almost independent artefact, and it becomes contaminated or altered by our interaction with it. Understandings of dissociation and repression are fundamentally tied to contemporary psychological theories about memory reconstruction, which renders the initial disclosure of sexual violence a more persuasive form of "proof", than stories that have been told before.

These two models of memory, and their associated consequences for sexual violence testimony, are evident in my analysis of the case law materials. The contrast of these two discursive constructions, and their implications in terms of speech, are again exemplified in comparing the appellate cases of Edward Gabbai and Naveed Soroya. In each case, part of the appeal was concerned with accessing extensive previous mental health records, with a particular intention to establish the women concerned as prone to making false allegations. The woman in Gabbai's case had spoken about her previous experiences of sexual assault with several mental health professionals. In contrast, in Soroya's case, the woman had mentioned a prior experience of sexual assault during her police interview about Soroya. After Soroya's conviction, extensive investigations were conducted to find records pertaining to this assault, intending to demonstrate its "falsity" (R v Soroya 2006, [25]). At appeal, it was established that there was no mention of this assault in the woman's prior medical records (R v Soroya 2006, [41]). The judgment states that the fact that she was 'reluctant to confide in […] others does not begin to demonstrate falsity' (R v Soroya 2006, [34]).

In fact, the judgment is wholly sympathetic to the lack of disclosure, as 'she had a huge problem with memory' on account of the "conversion disorder", and 'she was reserved

and it was not in her nature to tell others' (R v Soroya 2006, [34]). The very category of a "conversion disorder" is "dissociative", and a 'reluctance to confide' is here received as understandable. The memory of this experience was considered successfully "preserved", or falling victim to the 'huge' problems with traumatic memory evidenced by both the woman's diagnosis, and her insensible bodymind. In contrast, the woman in Gabbai's case had potentially introduced error, self-blame, and by extension: falsity into her memories of sexual violence by talking about them, which compromised her reliability as a witness. In addition, the preference for "first disclosures" as "proof" is similarly evident in the case of the man groomed by his sports teacher. His first disclosure coincided with his psychological breakdown, and when disclosed to his treating mental health facility, was immediately reported to the police (London Borough of Haringey v FZO 2020). In both this case and Soroya's, the accounts of the sexual violence produced for trial were only the second time that they had been documented speaking about it, and thus the memory had been successfully "preserved" from contamination.

B. State-Based Memory Retrieval

While the focus in this chapter has been on my analysis of case law, it is worth briefly turning to the analysis of CPS policies to illustrate these two understandings of memory in full, as well as some of the associated institutional logics. The policy analysis demonstrates a distinct "state-based" understanding of mental health and memories of sexual violence, and betrays the legal suspicion of people testifying to sexual violence, as discussed in section 2B of chapter 3. The notion of preserving and immediately documenting these initial, pure, forms of disclosure was much more emphatic in the 2020 draft of the CPS guidance on pre-trial therapy published ahead of public consultation. Therapists were repeatedly reminded to respond to any new disclosures by 'encourag[ing] the victim to report the offence to the police as soon as possible' (Crown Prosecution Service 2020, 6); and fostering 'trust' with people was retooled in service of this: 'it is only when a victim develops a sense of trust that they will more fully disclose what has happened' (Crown Prosecution Service 2020, 10). These disclosures were also required to be 'fully documented', in case of a therapist being called as a 'First Disclosure Witness' (Crown Prosecution Service 2020). Further, the CPS's focus on, or anxieties about, weaknesses in prosecutorial evidence was clear in this document (Temkin and

Krahé 2008). While the draft explicitly noted that traumatised people may provide accounts of their experience that include *inconsistencies* and gaps in memory, later in the guidance, 'inconsistent accounts' is provided as one of two examples of therapeutic evidence likely to be subject to disclosure in a criminal case. When the guidance goes on to discuss the danger of false memories of sexual violence, it states that caution towards falsity is advisable where someone has a history of any 'hallucinations, delusions, or other altered states' (Crown Prosecution Service 2020, 11), or simply where 'they have not taken a critical attitude to the thoughts and images that have come to mind but simply assumed them to correspond to true events' (Crown Prosecution Service 2020, 11).

After this policy was published, it was subject to a public consultation, which I responded to along with my supervisors, suggesting that it was unduly and prejudicially focused on "fact-finding" (Yapp et al. 2020). Although the CPS did not publish the responses to this consultation, the Government's Victims' Commissioner Vera Baird released her response to the consultation, which expressed a similar sentiment to ours. She suggested that therapy is focused on 'feelings and emotional responses to trauma rather than facts or rehearsing the details of a traumatic incident' (Baird 2020). Presumably in light of the responses to the consultation (including ours), the 2022 document removed the content explicitly around psychological scrutiny and "fact-finding", but it is notable here in establishing the law's wider suspicion of sexual violence testimony, in addition to demonstrating a *state-based* model of trauma, psychiatric diagnoses, and memory.

This draft document also exposes the institutional logic of the CPS, and while the newer version has since removed this content so explicitly, the law's view of traumatic memory as pathological, encoded differently and therefore existing in a different state, is evident in the enduring document on procuring "psychological evidence" at trials. This document was co-authored by psychiatrist Fiona Mason, who was cited in section 1A of this chapter on account of her writing on trauma, and her influence over both legal practice and CPS policies. In the guidance, it is stated that when someone who has experienced sexual violence is participating in a trial, they 'may act or feel as if they were being traumatised all over again. This high state of arousal may facilitate memory retrieval and therefore should not necessarily be avoided (Crown Prosecution Service 2019, 23)'. The notion that the 'high state of arousal may facilitate memory retrieval' is particularly suggestive of the

idea that traumatic memories have 'privileged epistemological status' as an 'accurate' snapshot of events (Brison 2002, 70). Further, this superior access to 'memory retrieval' comes explicitly with the suggestion that the courts should put individuals in a state such that they 'feel as if they were being traumatised'. While such a policy was legally designed to access the best possible evidence from people who have experienced sexual violence, it additionally assumes that they would prioritise a conviction over literally 'being traumatised all over again'. The document is littered with feminist-inspired language – to 'empower' the 'survivor' to take 'control' – and yet it articulates a practice that it acknowledges as harmful. The resounding message is that individuals must preserve their memories before trial, and prepare to be re-traumatised. In the aforementioned case in which a woman fled before the trial 'through fear', it was argued at the appeal that she should 'submit to the trauma of giving evidence' (R v Boulton 2007, [13]). This additionally expresses the sentiment that participation in legal proceedings as not only traumatic, but a compulsory "duty" (R v Boulton 2007, [34]).

The legal materials invoke a state-based model of memory retrieval – if in a state of trauma, the memory becomes accessible in its perfectly preserved form. Further, the inverse of this betrays a legal conception of the pathological mind as having a direct, and harmful, bearing on perception and memory. The judgment in R v Smith that a woman was unreliable on 'sexual matters' on account of her diagnosis cited a case from 1965, in which the ability of someone with a mental health problem to accurately perceive events was compared to that of a cataract on vision: 'it must be allowable to call medical evidence of mental illness which makes a witness incapable of giving reliable evidence, whether through the existence of delusions or otherwise' (R v Toohey 1965, 162). The applicability of the Toohey case to sexual violence trials was ultimately dismissed as outdated in a case concerning sexual abuse of a child in 2014, in which it was suggested that the question of witness reliability is for a jury to decide, rather than a doctor (R v H 2014). However, this understanding of mental health remains evident in recent case law. Psychopathology having a direct bearing on individuals' ability to perceive events, in the way of a cataract on vision, betrays a particularly state-based, and sceptical, view of mental health.

In the appellate case in Cardiff concerning the woman wrongly deemed to have 'Dialectic Behaviour Disorder, a condition which is characterised by taking extreme positions' (R v Adams 2019, [9]), it is suggested that her manipulative nature extends to her ability to perceive and remember events. The case at the appeal was that that the "disordered" woman 'was now, many years after the event, viewing her past relationship with him through that *prism* in a distorted way' (R v Adams 2019, [9], emphasis mine). The idea that someone's psychiatric diagnosis functions as a 'prism' of distortion is directly comparable to the language in Toohey; a cataract on vision and an inability to correctly access a veridical pathological memory. As a reminder to the reader, this "relationship" had begun when she was 13, and her assailant, Donald Adams, was 40. They had met as they were both members of a brass band. Adams had been initially convicted of multiply sexually assaulting this woman while she was between the ages of 13 and 17, which eventually culminated in a pregnancy; and he was additionally convicted of assaulting another member of the brass band, a young man, who was of a similar age. The two people Adams assaulted had kept in touch since they were younger, and eventually met up in 2016 to discuss their experiences. Fears of collusion and the prospect of the initial jury having used each accusation to corroborate each other culminated in the conviction being posthumously quashed. As well as being deemed an unreliable narrator of events, the young woman was also adjudicated as 'manipulative and capable of influencing others to support her allegations' (R v Adams 2019, [13]). In understandably seeking out someone with a similar experience of sexual violence, and talking to an old friend, this woman's 'Disorder' is seen to contaminate not just her own memory and testimony, but the other person's as well. Prior disclosures of sexual violence are damning, and the legalised notion of psychopathology functioning as a state-based 'prism' through which events are perceived and remembered is clear: whether through the veridical insight of trauma, or the distortion of abnormality.

As a final reflection before concluding, it is additionally worth discussing the case law surrounding "capacity" to consent in relation to psychiatric diagnoses. This case was excluded from the discursive analysis, as the woman had a diagnosis of an intellectual (dis)ability, but it is briefly notable as it is one of the most influential cases underwriting capacity. In this case, the woman was deemed 'unable to communicate' consent (*Sexual Offences Act* 2003, s 30(2)(b)). She had spent several stints in mental health institutions,

and had been categorised as having schizo-affective disorder, emotionally unstable personality disorder, an IQ of less than 75, and harmful alcohol use (R v C 2009). I present these in a list, as in the judgment, because again, it is not clear which of these diagnoses is considered relevant to proceedings. In 2006, she visited a mental health resource centre and was seen by a consultant forensic psychiatrist. The psychiatrist observed that she left the interview 'in a distressed and agitated state' (R v C 2009, [18]), and then she met the defendant in the car park and told him she wanted to leave as she believed people were after her. He offered to help, and took her to a friend's house where he gave her crack, and then asked her to give him a 'blow job' (R v C 2009, [18]). 'Her evidence was that she was really panicky and afraid' (R v C 2009, [18]), saying 'these crack heads… they do worse to you' (R v C 2009, [18]); 'she did not want to die' (R v C 2009, [18]), and was later found, 'lying on the bed in a foetal position' (R v C 2009, [18]).

The issue in question was whether this woman was unable to refuse, or 'unable to communicate' consent by way of a 'mental disorder impeding choice', and whether the defendant could have been reasonably expected to know that; the charge related to section 30 of the Sexual Offences Act dealing with specific offences against people with a 'mental disorder' (*Sexual Offences Act* 2003, s 30). Whether the defendant could have been reasonably expected to know the woman's inability to consent is again reflective of sexual violence being legally defined by an increased psychological scrutiny of people testifying to sexual violence (du Toit 2009; Dowds 2022). The defendant was initially convicted, then acquitted at appeal, then the conviction restored by the House of Lords. The final judgment exercises extensive discussion of the legislative history of the capacity to consent, including the old "status-based" model, where people with a particular characteristic (like a psychiatric diagnosis) are deemed to lack the capacity to make decisions, they are adjudicated as "defective". Instead, the judgement clarified that a person's capacity to consent is person and circumstance specific, as the psychiatrist's observation that she was 'distressed' evidenced that 'her capacity was likely to be affected by her relapsed mental state' (R v C 2009, [19]) on the day in question. This again demonstrates the corroborative role of "distress", but in heralding capacity to consent as person and circumstance specific, the judiciary have inherently introduced increased psychological scrutiny of the person testifying to sexual violence. They adjudicate whether *this* person's psychology in *this* circumstance is constitutive of consent or sexual

violence. While the evaluation of consent was heralded as person and situation specific in R v C (Rees 2010), the rendering of this woman as a "defective" narrators of their own experiences is fundamentally now "state-based". This argument has been made elsewhere by British social justice scholar Beverly Clough, who suggests that legal approaches to capacity to consent to sex are highly individualised (Clough 2014). This context bolsters the arguments being made here about the "state-based" adjudication of people with psychiatric diagnoses.

The totality of these findings reflect the socio-legal scholarship of other jurisdictions. Alison Young, writing of the Australian context, has demonstrated how the discursive operations of a trial eradicate sexual violence testimony almost entirely, calling it '*the wordless song of the rape victim'* (Young 1998). I cannot make a similar claim, as I was not analysing individuals' testimonies directly, but the consequences of the discursive construction of sexual violence and mental health on speech. These findings therefore echo those of Young, to demonstrate the far-reaching effects of legal judgments. The notion that prior disclosures were here damning, and the preference that experiences of sexual violence be either immediately reported or unspoken, suggests that *the wordless song of the rape victim* continues beyond the courtroom, and even to therapeutic contexts. Although the CPS' 2002 pre-trial policy discussed in the introduction of this thesis (page 8) has been supposedly replaced, its logic and effects are largely here unchanged. This reflects the persistence of institutionalised legal logics (Hengehold 2000), despite the changed contents of the associated policies. Also in the introduction, I presented the legislative concerns that mental health evidence could compromise the defendant's right to a "fair trial". However, here, as Lise Gotell established in Canada, and Wendy Larcombe in Australia, on a discursive analysis, the opposite is true (Gotell 2002; Larcombe 2002b).

Conclusion

While the language of trauma has arguably improved understandings of experiences of sexual violence, in the legal materials, it is soberingly restrictive to sexual violence testimony. The two available discursive constructions identified here can be demarcated along a stark normal/abnormal binary. In all judgments in which mental health evidence was discussed, there was an implicit assumption that the people testifying to sexual

violence were psychologically "abnormal", in need of corroboration. This is the effect of the "double-edged sword" that occurs when the effects of sexual violence are placed firmly within the realm of psychopathology, which re-animates the spectre of "madness", and generates specific norms for sexual violence testimony.

In part 1, the embodied language of "freezing" was particularly palatable to the judiciary as a site of "proof" for sexual violence, which in section 1A, is interpreted as akin to the 19th century medico-legal category of an "insensible" bodymind. Then, as now, this language enabled individuals to garner legitimacy. Legitimate trauma in relation to sexual violence was additionally evidenced through being "normal" before assaults, and with experiences of violence resulting in an eventual "breakdown" in section 1B. Being largely constructed through medical or psychiatric evidence, presented as ostensibly "objective", this construction obfuscates its specificity: that the sexually traumatised subject is living a productive "good" life before sexual violence, and that they are psychologically normal, or even perhaps materially middle-class. This construction additionally betrays a legal suspicion of the "mind", as it preferred trauma to be unspoken before a trial, and this was evidenced through a physically incapacitated bodymind and corroboration, as discussed in section 1C. This finding therefore accords with the supposedly outdated 2002 legal policy requiring that people do not discuss experiences of sexual violence in therapy before trial: it was damning when they had. This additionally demonstrates the corroborative power of physical evidence and witnesses to "distress" in experiences of sexual violence, although such evidence was here *required*.

In part 2, discursive constructions of "abnormal" psychology constructed a manipulative and attention-seeking subject in search of financial redress, which draws from both understandings of psychiatric diagnoses such as "malingering" (section 2A), and stereotypes about a feminised irrationality, pathology, and malice (section 2B). In section 2C, I demonstrated that this can even function to render some people unable to testify to sexual violence. In addition, prior disclosures of sexual violence evidenced by medical records or even other witnesses proved particularly damning for individuals' legitimacy. Prior disclosures of sexual violence are adjudicated as potentially introducing "falsity" into witness accounts. In part 3, I suggest that this reflects and reproduces understandings of "dissociation" and "repression" in relation to sexual violence

testimony, and their influence over "false" claims of sexual violence in adulthood as well as in childhood. The pathological and traumatised bodymind of people who have experienced sexual violence emerges here as a site of its "proof" – both in feminist understandings and the legal context. And just as highlighted in the previous chapter, engaging with the dichotomies of truth and falsity, and normal/abnormal psychology, has unfortunately entrenched strong restrictions on the legitimacy of sexual violence testimony.

5. Sick, But Not Too Sick

Introduction

In this chapter I explicate the discursive constructions identified in interview materials. In the introduction, I will summarise the findings and their conceptualisation, as well as my justification for choosing the word "sick". Part 1 of the chapter is concerned with establishing the complex ways in which participants sought to establish their "legitimacy" in the context of powerful norms and stereotypes. Their identification with psychiatric categories sharpened the "double-edged sword", and this required participants to establish that they were "not sick", or at least not *so* sick that they are innately pathological or non-credible. In contrast to Laugerud's study discussed in section 2C of chapter 3, my participants found their experiences carved out in sharper discursive relief: the legitimacy of their experience viscerally validated as legitimate by the notion of trauma as a "scar" (Gavey and Schmidt 2011) but forced to contend with the double-edged implications of consequently being "sick". Participants sought to instantiate their experience as normal and understandable in their violent context, with associated "normal" diagnoses including depression, anxiety and PTSD. Participants were universally aware that their speech could be categorised as mad or untrue, and positioned their experience in opposition to labels and diagnoses associated with irrationality or non-credibility. Yet given that trauma responses are defined in pathological terms, proving legitimacy was also connected to establishing that they were sick *enough*.

The majority of the discussion in this chapter is found in part 2, which is then concerned with fleshing out how participants spoke about their experiences at the nexus of sexual violence and mental health, and some of the ways in which this was disruptive to constructions of trauma identified in the previous chapter. Given the phenomenological orientation of this study, and the rich variation in individuals' embodied experiences and testimonies, part 2 is a lengthy appraisal of various nuanced articulations. However, this is intentional, in an effort to surface participants' voices in a historic feminist context within which they have been overlooked (Johnson 2021), and in doing so, constitutes a

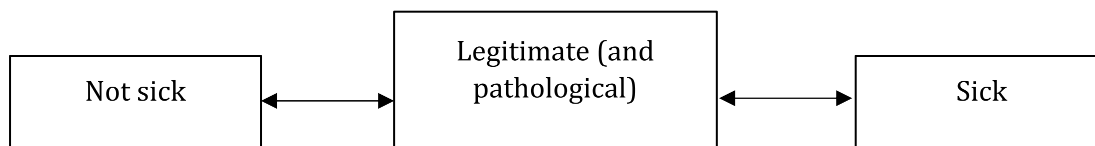
specific intervention intended to disrupt, exceed, and reconfigure the category of trauma itself (Spurgas 2021; Carter 2021).

In section 2A, I discuss the utility of the language of "dissociation" and "flashbacks" for participants, which was ultimately made meaningful through somatic and physically instantiated language, as discussed in section 2B. In section 2C, I note how the somatic language visibilised participants' experiences of sexual violence, which was not necessarily desirable, but made them tangible, and hence available for useful somatic interventions (section 2F). In some cases, this language additionally left participants feeling an enduring sense of permanence, as though they had "failed to recover" (section 2G). This chapter picks up on some of the insights from critical sexual violence, trauma and disability studies discussed in section 2C of chapter 3 (Goozee 2021; Spurgas 2021; Carter 2021; Laugerud 2019), although solely to contextualise the insights that participants articulate themselves. For example, the notion that sexual violence leads to a single and eventual "breakdown", which is reflective of both the legal materials, and a Western event-based Psychiatry, did not necessarily track onto participants' experiences. Instead, in section 2D I discuss how they spoke about experiences of violence and associated distress as socially-instantiated, fluid and recurring, and were articulate about different ways to continue negotiating this distress, or even safety (section 2I). I discuss how participants did not necessarily choose to "remember" sexual violence, but to forget (section 2E), and how speaking about symptoms was often easier than talking about violence (section 2H).

To flesh out these findings, this chapter describes and characterises two separate discursive constructions within the data, which exist on a spectrum with each other (see figure 2). First, participants had to prove that their responses to sexual violence were legitimate expressions of pathology, and that they were not so "sick" as to be undeserving of treatment. The two outer boxes represent external forces that exert a constraining pressure on the middle, and consequently, narrowing the parameters of legitimate sexual violence testimony where psychiatric diagnoses are concerned. Second, there is a discursive construction that captures and represents participants' embodied experiences as pathological, and hence legitimate, the central box in figure 2. This construction is

particularly enriched by the phenomenological tools employed in this analysis, and attending to participants' specific embodied experiences.

Figure 2. Visual representation of the "double-edged sword" of trauma and pathology.



This chapter details a restrictive discursive landscape at the nexus of sexual violence and mental health, the "double-edged sword". This phrase was in fact used by one of my participants, Harib, to describe the delicate balancing act at play in speaking out: 'it's like a double-edged sword, because it was like if I go and tell someone I'm still not going to get believed'. The particular dynamics at play in silencing and disbelief are dealt with in the next chapter. However, of significance here is the role of diagnoses in identity and legitimacy. Identifying with psychiatric categories, and the associated medicalised and somatic language, were important sites of meaning-making for participants, and attending to this is the task of this chapter.

Finally, I have chosen the term "sick" to conceptualise the discursive constructions identified in this chapter, on account of some insights provided by critical disability theorists Corinne Lajoie and Emily Douglas. These two philosophers edited a special issue for *Puncta, a Journal of Critical Phenomenology*. The special issue was entitled, *A Crip Queer Dialogue on Sickness,* and in their introduction to it, they demonstrate that there is a tradition in phenomenological analyses to distinguish between "disease" as a medical category, and "illness" as it is lived and experienced. They suggest that this dyad fails to capture the structural and political conditions of these categories, as well as the structures that make us "sick": 'the ways in which experiences of bodily difference are framed by systems of power, exploitation, and oppression' (Lajoie and Douglas 2020, 6). Individual experiences of psychiatric diagnoses, and their consequences, vary widely in

relation to race, class, and sanism and ableism. I hope to draw out some of these dynamics in the next two chapters.

1. Sick, But Not Too Sick

In this section, I describe the discursive construction in which participants asserted that their experience was *normal*, and that they were both ‘not sick’ (McRuer 2017), and sick enough, to be taken seriously. Most prominently, the diagnoses people felt were normal trauma responses pertained to the various forms of PTSD. However, other psychiatric categories considered understandable and attributable to violence included depression and anxiety (Sarah, Alice 1, Alice 2, Ellen). This reflects Sweet and Decoteau’s suggestion that diagnoses such as depression are a “normal” part of life (Sweet and Decoteau 2018). These responses being normal and understandable also enabled people to instantiate their experience and support-seeking in contrast to paradigms that designate them as a strictly psychiatric “problem” to be fixed. Ellen described how the trauma paradigm enabled her to access specialist support, which she found more validating than typical psychiatric approaches which are ‘one-dimensional’ (Ellen), on account of it being at least partly socially instantiated. Ellen had been sexually assaulted by a stranger in her adult life, at her local pub. She said that

> once I then was able to view my experiences through a trauma lens and talk about it in that way it has opened doors from a health profession perspective to individuals that have been more beneficial to me finding my own peace, rather than looking at it through a psychiatric, kind of, you know, medical, brain function, perspective

Laugerud similarly established that people valued access to the specialist support afforded by a generalised “trauma” paradigm in relation to sexual violence (Laugerud 2019). Here it is additionally useful for Ellen in terms of granting herself legitimacy, as she views her ‘experiences through a trauma lens’, rather than a ‘medical, brain function, perspective’. As such, this paradigm places her distress in its social context, rather than being inherent to her ‘brain’.

However, these findings contrast Laugerud's work discussed on page 100 in which her participants were presented with two different discursive constructions for narrating sexual violence: trauma as binary pathology, and trauma as a spectrum of health optimisation (Laugerud 2019). In instantiating their experiences as legitimate, while retaining identification with psychiatric diagnoses, this led to complex and "double-edged" discursive effects. While within this discursive terrain people could instantiate their experience as normal and understandable, this was inevitably partly premised on an abnormal "other" associated with madness. This notion of abnormality was often externally designated - whether people merely anticipated being labelled as mad (or bad), or whether they actually were. Participants talked about being classified as 'mental' (Megan), a 'nutcase' (Ellen), 'mad' (Sarah), 'hysterical' (Maya), 'crazy' (Beverley), and even 'bat shit crazy' (Alice 2). Within this discursive construction, people sought to establish their own experiences as pathological, but normal and understandable, in contrast to notions of abnormality and "madness".

For example, Megan tried to instantiate her experience as pathological in the correct way, although she had to resist receptions of her testimony as either "mad" or "bad". The first sexual assault she experienced was when she was seeking crisis support for her mental health at a hospital, where no one was available to see her, and as a result, the hospital called the police to remove her. When the police arrived, she refused to leave, and then one of the policemen sexually assaulted her. In response to this, she 'defended' herself and became 'a bit violent', which the police responded to with extreme violence and 'nearly choke[d] her' – he knelt on her back until she couldn't breathe. Some time later, Megan ended up on a mixed mental health ward. Here she was multiply sexually assaulted by a nurse, and these instances were witnessed by other staff members. On the second occasion, the police again arrived on the scene, and she described their approach as like 'a good policeman and a bad one'. She said,

> So the bad one came to me and looked at me, and then said 'Well, he said you attacked him', and I said, 'What?', and I said 'Excuse me, could you read how many medication I had taken that day?', I wasn't able, I was so spaced out, I wasn't able to hurt anyone. He said 'Well you know, you attacked a policeman before', or something you know they had the record, 'That's why you're here'

Before Megan is able to give an account of this experience, her speech is automatically invalidated by the police man by her prior experience of being assaulted by the police, as well as being accused of a proclivity to violence due to, in essence, the notion of being either "mad" or "bad" – 'That's why you're here'. In the police narrative, her supposed prior violence and "bad" behaviour rendered her both responsible for additional experiences of violence and in need of psychiatric incarceration because she is "mad".

In order to resist being designated as "sick", Megan instantiated her experience as a "normal" trauma response by drawing on the pathological language of dissociation, which additionally allowed her to emphasise her veracity: dissociation is a marker of legitimacy (Spurgas 2021). She said she 'Never attack[s] anyone unless I feel under threat', and how she responds to these threats by becoming 'very dissociated and kind of spaced out very distressed', while still retaining a clear memory of what happened. She says

> … of course if you're on a mental ward they think you're inventing everything, but I never lose touch with reality at all. I get dissociated but I, I remember everything you know? Doesn't matter how upset or whatever. Er, so of course they tried to think 'ah she probably'… but I've never been psychotic, I'm not a psychotic person, I'm not a liar either.

Megan is emphasising that she is not 'mental', not 'psychotic', not a 'liar', and instead enlists the notion of pathological dissociation as being both a response to feeling 'under threat', and like a "snapshot" – 'I remember everything you know'. This is again indicative of the notion that dissociative memories are pathological, buried in the unconscious as a "truth" to be unearthed. At various other times she impresses upon me that she is not 'schizophrenic' or 'psychotic', and so 'I don't lose touch of reality I know exactly what happens'. She explicitly said that she sometimes refuses to disclose that she is 'mentally unwell' on account of an awareness of this reception. Dissociation is here represented as a normal and understandable response to prior trauma, in contrast to those who are really sick (and hence, unreliable). Constructing "norms" for idealised subjects and bodyminds are inevitably premised on an "other" – normal trauma versus abnormal behaviours (Sweet and Decoteau 2018; McRuer 2017).

Sarah was sexually assaulted by a friend in 1987 when she was 20, and her experience is here illustrative of which diagnoses are validating, and which come in tandem with harmful treatment from mental health staff. When I asked Sarah whether her diagnosis of PTSD had been helpful for talking about sexual violence, she said yes, and went on to say 'And I think also, the depression and anxiety… You know, I'm depressed because this violent event took place'. All of these diagnoses are represented by Sarah as normal and understandable in the context of violence – 'I'm depressed because this violent event took place'. Sarah's assertion that these diagnoses were normal and understandable was connected to other ways in which she had felt "othered" by psychiatric labelling, and designated as "abnormal". Sarah had come to expect the worst of medical professionals' responses to (and labelling of) her self-harm, as she said that 'people who have self-harm, we have bad press'. She spoke of how good her first ever psychiatric liaison nurse was, because 'he saw the whole person not just the self-harm'. This was contrasted with several experiences of medical professionals blaming her for her self-harm since, and in some cases denying care. Here she describes some of these experiences

> I've had the refusal to… refusing to give me anaesthetic for the suturing, and only recently, I don't know, it was about five or six months ago, a nurse, two doctors said that I needed suturing and a more senior doctor said 'Don't bother'
>
> You know I've been in hospitals… in the A&E department and being told 'There's a really poorly person sitting next door to you', the clear inference is that you're not [….] you've done it yourself. You know I've had it all said, I don't think there's anything that they could say that would surprise me, from 'Attention seeking', when actually it is seeking attention, we all do that, that's what we do as human beings.

Being labelled as someone who is not deserving of care, and even treatment, is reflective of biomedical understandings of "cause" and "effect", which ultimately serve to render Sarah the "problem": 'you've done it yourself', rather than a legitimate 'poorly person' in need of medical attention. The designation of Sarah as 'attention seeking' is additionally problematic due to how it renders her as responsible for her own distress, and in this

sense, not *pathological enough* to be deserving of treatment. Yet on the flipside, this designation led to Sarah accruing the psychiatric label of 'borderline personality disorder', which she felt rendered her *too pathological,* and beyond help. Although some people find value in this diagnosis, for Sarah, it felt as though it was a lazy and vague label administered in the face of her self-harm, and to justify a lack of care. She said

> I just feel that sometimes when people see self-harm, consultants, it's all too easy for them to go down the borderline personality disorder diagnosis and not do a thorough formulation of what the illness is

Instead, and with the help of a new psychologist, she reconceptualised this diagnosis as PTSD. This is reflective of feminist work that has long suggested that the label of 'borderline personality disorder' serves to discount and eradicate legitimate experiences of trauma among feminised people, and is a modern 'hysteria' diagnosis (Shaw and Proctor 2005; Herman 1992; Chesler [1972] 2018). Sarah said that

> more recently, about three years ago, I've been under the care of a psychologist, and he's of the opinion that I haven't got borderline personality disorder, he thinks I've got post-traumatic stress disorder which I agree with, which would fit in with my experiences when I was younger, about the sexual violence and also some childhood trauma

> it is a horrible diagnosis and I feel for anybody who has got it as a diagnosis and I'm lucky… I'm fortunate – I'm articulate, I'm intelligent, I can fight my corner. Whereas all too often, and it's all too often women who have that diagnosis, they're not in a position to be able to say 'Excuse me but that's not right'

She went on to say that she noticed such a 'difference in staff attitude' after accruing the borderline label, and how there should be more 'compassion and understanding' for people who inhabit the diagnosis, as scholars have indeed argued (Johnson 2021). Understanding the consequences of the label, the associated blame, as well as the eradication of her traumatic experiences, she distances herself from borderline personality disorder – it is 'not right'. Instead, and according with an understanding of

trauma as "normal", she instantiates her preferred diagnoses as understandable in the context of 'sexual violence and also some childhood trauma'. Sarah's experience of a "normal" response to sexual violence includes three different diagnoses, in contrast to diagnoses of so-called "severe mental illness" (e.g. personality disorders) which are written off as abnormal and often, beyond treatment. However, in order to be conceived as legitimately traumatised, Sarah must prove both that she is not so pathological that she is undeserving of 'compassion', and that she is pathological enough to be traumatised, rather than simply another woman being 'attention-seeking' for no good reason.

Alternatively, walking this fine discursive line was sometimes impossible, with people feeling as though they had been designated as simultaneously too pathological, and not pathological enough. Maya felt that her testimony was rendered simultaneously not traumatised (pathological) enough, and too pathological. This time, not by a psychiatric institution, but by a feminist-inspired sexual violence service. Maya was 23 when we spoke, and her assault occurred when she was 18 during her first year of university by someone known to her. Maya had sought therapeutic support multiple times after her experience of sexual violence. One of these efforts saw Maya seek support from a counsellor in a local Rape Crisis Centre. She felt that this counsellor made several assumptions about her relating to her race. She recounted her experience of these assumptions, saying that the counsellor had assumed 'oh you're a black woman you must have like trouble with your family, and I'm like no my family is actually really supportive'. Here Maya does not meet the counsellor's expectations of the black "family", which could have reflected a view of the black family as conservative, or a set of racialised assumptions about blackness and pathology. Either way, this meant that Maya's experience of counselling was that she was not performing her trauma in the expected way. Maya describes:

> I don't think she meant to make it a hostile environment, but also just thinking like, OK, you say you're going through this… you had this traumatic event like show me that you're traumatised, almost, like I almost felt that pressure. Or like she'd show me like these weird posters, and she'd be like, yeah, so most people like there was… I don't know if I could find it, it's like a spider diagram of like poor mental health symptoms, and she like showed it to me, and there's like 20 things round this spider

> diagram, and she's like most people can relate to having one or two, or like maybe three or four if you're doing really badly. And I was like, why can I relate to everything on this thing [laughs] I was like, have I lost it? Like am I feeling mentally unwell and I've just got no grasp of anything?

Maya felt that by not complying with the counsellor's reading of the "black family", she had failed to show that she was 'traumatised' enough in the expected way ('show me that you're traumatised'), which required a notably different performance than for the white participants, who did not discuss contending with assumptions about their family. Equally, while this 'spider diagram' was perhaps intended for Maya to gain a better understanding of her experience, instead, she felt it rendered her outside the counsellor's legibility for 'doing really badly' and being 'mentally unwell' or having 'no grasp of anything'. In being perceived as not either 'traumatised' enough, and too 'unwell', she felt that her experience could not be properly understood and registered.

2. Legitimate Trauma

In this section, and the main task of this chapter, I stay with how participants characterised their experiences, in order to delve deeper into what the embodied experience of "sick, but not too sick" was like. Participants enlisted the terms 'dissociation' and 'flashbacks' to explain their experiences, but in general, descriptions of somatic and embodied distress were more tangible to make their experiences of violence "knowable". However, physical and embodied descriptions incurred narrative consequences – either visibilising the violence and making the need to "prove" it more pronounced; or leaving participants with a sense of permanence, of how the 'damage has been so long-lasting' (Elaine). Participants instead used medicalised language to find a way out of speaking about sexual violence, and found value in aspects of their diagnoses which afforded them with a sense of ongoing protection from future sexual violence.

A. Dissociation and flashbacks

Discussions of symptoms in the aftermath of sexual violence were generally articulated by participants using the neurobiological language of 'dissociation' and 'flashbacks'

(Megan, Sarah, Alice 1, Alice 2). However, while these concepts were represented as consequential of sexual violence, they were often suggestive of interactions with psy "experts", such as individuals' counsellors. While this language was useful for explaining participants' experiences, their meaning was somewhat elusive and 'confusing' (Alice 1). For example, Alice 1 was 24 when we spoke, and had been sexually abused throughout her childhood and adulthood by the same person, ending at age 18. She had received a diagnosis of PTSD when she was 22, although she identified with complex-PTSD more strongly. When describing and summarising her mental health experiences, she elaborated on what she meant by 'flashbacks'. She said

> I mean I call them flashbacks again I've spoken to this with my therapist that, it's probably a mix of… again we're not really sure, but it's like a… when I, I think it, it could be more dissociation

Here she says that 'we're not really sure', and she goes on to say that she doesn't 'really know why', that it is 'very confusing' and that she herself is 'still not really sure yet'. Alice 2 had also been in an abusive relationship, this time between the ages of 40 and 45; her then husband abused her in myriad ways during that time, which included psychological abuse, and sexual and physical violence. She was 53 when we spoke, and she also mentioned 'dissociation' and 'flashbacks', as well as other knowledge that she had obtained from a psy expert, during an interaction with her counsellor. She recounted the conversation, and said that

> She was telling me how the brain rewires after trauma, and all this, that I didn't really know, and I was thinking well this is going to be long term then, and this explains sometimes why I, I don't process things the same as the majority

Alice 2 says that she doesn't 'really know much about [dissociation]', and goes on to say 'I was thinking of asking my counsellor about some of these things because I feel like I don't know much about what I'm living with'. Alice 2's descriptions of the trauma of sexual violence as naturalised in 'the brain' through medical 'rewir[ing]' generate a sense of bewilderment and alienation from herself – she doesn't 'know much about what [she's] living with'. This sense of alienation from herself then also paves the way for the

epistemic authority of mental health professionals to shape this narrative – the 'counsellor was telling [her]', and she 'was thinking of asking [her] counsellor' to explain more. I do not mean to suggest here that these dynamics necessarily rewrite Alice 2's experiences, but rather that it is reflective of the authority of the language of dissociation within professional understandings of trauma (Spurgas 2021).

While dissociation was useful as an explanatory concept, participants could not 'get to grips' with dissociation (Sarah) because it was 'very confusing' (Alice 1), or they 'don't really know […] what [they're] living with' (Alice 2). The utility of this language provided by interactions with psy experts appeared to be only made meaningful for participants when expressed in somatic and embodied terms. The above extracts are here illustrative of an important distinction: while descriptions of 'flashbacks' and 'dissociation' were somewhat vague, somatic and physically instantiated language enabled participants to make meaning from expert understandings of trauma. In these extracts, Alice 1 experienced 'flashbacks' and 'dissociation' as largely intangible concepts, Alice 2 made them tangible by describing their presence in her 'brain'.[15] This echoes section 1C of my appraisal of feminist scholarship, and the associated neurobiological literature establishing trauma as a "mark on the brain". What is useful for Alice 2 in knowing that her 'brain rewires' is that her bodymind is now physically altered and "dis-abled": the effects are 'long term then', because she does not 'process things the same as the majority'. Discussions of symptoms were then useful insofar as they were demonstrative of pathology and abnormality, as Alice 2 distinguishes herself from the 'majority'. They enabled descriptions of previously inexplicable behaviour, but the experiential utility of the language of dissociation and flashbacks is brought to the fore by participants' descriptions as physically instantiated and somatic.

B. *Somatic Suffering: Rendering Violence Knowable*

Sweet, writing of how people articulate the invisibility of gaslighting in the wake of abuse, writes that 'Survivors use evidence of somatic suffering to render their experiences of gaslighting *visible* and *knowable*, to produce bodies that have been 'dis-abled' by abuse'

[15] Alice 1 similarly makes these concepts meaningful in somatic and physically instantiated terms, which I will discuss on page 152.

(Sweet 2021, 225; emphasis mine). The women she interviewed rendered their experiences of psychological abuse real by narrating embodied harm. The somatic was similarly prominent in my data to render experiences of sexual violence both “visible and knowable”. I will start with how this language rendered participants’ experiences “knowable”, and hence legitimate and real, either to themselves or others. In order to legitimise their experiences, participants compared their experiences to historically legitimate forms of violence, such as losing limbs (Beverley, Alice 3), bruising and physical violence (Alice 2, Megan, Elaine), or having been in a war (Alice 3, Ellen). Some participants enlisted the language of physically instantiated somatic symptoms such as a ‘scar’ (Gavey and Schmidt 2011), as in the original Greek meaning of “trauma” as injury (Beverley, Alice 1, Sarah). The bodymind emerges in these descriptions as a site of physical “proof” of “what happened”, to render their experiences recognisable in the same way that physical violence is adjudicated. This is particularly notable for this project, for while I critique the legal reliance on evidence of “injury” or “insensibility” as physically or somatically instantiated, this is additionally an important site of meaning for participants’ embodied experiences.

For example, while Alice 1 was not ‘sure’ about flashbacks and dissociation, she too went on to describe her PTSD in physically instantiated terms, as something that is ‘in [her] brain’. She said that

> it did help to like solidify in my mind what happened to me was really bad, the fact that I’ve got PTSD and that helped me to realise it was bad and that I needed to do something, it wasn’t just, you know, something I could just push away because, you know, it’s in my brain

Here PTSD is represented as understandable in context of what happened being ‘really bad’, but also a pathological reality that she could not ‘just push away’, because ‘it’s in [her] brain’. This language similarly acknowledges the role of neurobiological understandings of trauma in establishing legitimacy, as discussed in chapter 3 in section 1C about trauma as a “mark on the brain”.

This language here additionally enabled Alice 1 to render the violence knowable and legitimate to herself – it 'helped [her] to realise it was bad'. She felt as though she had previously been 'underplaying how badly [she] was struggling', thinking that 'it's just not that big of a deal', and that she 'blamed' herself for being 'anxious' and 'depressed'. When I asked her what had changed since that time, she cited her PTSD diagnosis, saying that

> I think it was when I had the diagnosis really, yeah, when I really realised… Because obviously again I was like comparing it to like physical violence and then, you know with like physical violence you're going to have like a bruise or a scar or something, and then you realise actually with what I've got, you know I've also got like long-term issues from now

The value of Alice 1's diagnosis is here useful for rendering her experience of violence legitimate and knowable to herself. She elaborated that her description of a scar was 'like a mental scar'; 'a physical scar I guess I've got on my brain'. Instantiating the violence (and the diagnosis) in this way was helpful for validating her experience in an equivalent way to 'physical violence'. Rendering her experiences of violence knowable also enabled Alice 1 to access support: she 'needed to do something' to manage her 'long-term issues'. She had previously 'blamed' herself for being 'anxious' and 'depressed' on account of it not being a 'big deal': here, she is enlisting the normal and everyday meanings of "anxiety" and "depression" as not being severe enough to meet the criteria for pathology. Instead, accepting her diagnosis as pathological allowed her to acknowledge that both the experiences of violence and its aftermath were not normal, and were in fact pathological in need of support and intervention: 'I needed to do something'. Instantiating the trauma 'in [her] brain' made it both tangible and real, which enabled her to grant herself legitimacy.

For others, the somatic language was not required to make the violence knowable to themselves, but to emphasise the "proof" of "what happened": either to me in the interview itself, or to other potential audiences. For example, Beverley also talked about how sexual violence can 'leave a scar'. Beverley was 55 when we spoke, identified with the category of Bipolar, and her experience of sexual violence occurred when she was 19. Her assailant was an ex-boyfriend, and she had recently broken up with him as she had

met someone else. The new boyfriend went on to become the father of her daughter, and was the only person she disclosed the assault to before our interview; he didn't believe her. When I asked her to further describe what she meant by the word "scar", she said

> Well it's a… it's, it's just a, it's just a scar, it's like if a person's been stabbed or something in a way, except it's an emotional scar, it will always be there. It's like… you know, it's not something anybody ever asked like I say if anybody would ever say have you been raped I would say yes I've been raped because it's something that has happened. It's a… it's like… because it's such a… you just have no control over this thing because somebody just takes control and because it's so violating it's against your personal body it's not something you've given somebody permission to do, it's just such… it's just something that will always be there that this happened to you, that somebody has done this to you against your will.

Beverley's description here demonstrates the value of the physically instantiated and somatic language for making the violence legible in a similar way to someone who has 'been stabbed'; it is both as grievous and apparent as physical scars. Although a "scar" could be accrued through an unfortunate accident, Beverley's comparison to a "stabbing" is significant, as it is represented as a violation. It is a 'scar' because 'it's something that happened' that you have 'no control over' as it's 'violating' your 'personal body'; this comparison thus also demonstrates that Beverley was not at all responsible for what happened, as she had 'no control over' it. At the same time, it serves as proof of that violence, because 'it will always be there'. She is talking about the violence that she experienced in factual terms, and as self-evident proof of "what happened".

Beverley's use of the words 'stabbing' and 'scar' were used to make the violence knowable to me, and I wondered whether, like Alice 1, it was also a way of proving to herself 'how bad' it was that she had been 'violat[ed]'. She talked about her frustrations that the 'onus is always on the woman' to prove the violence. However, when I asked her if she felt she had to prove the violence to herself, she said 'No because of what he said'. For after the assault, her assailant walked her home, and they passed some policemen in the street, at which point Beverley recounted: 'I always remember him saying to me, "You can go and tell them if you want, you can go and tell them", yeah! And of course, you know, I couldn't'.

The language of a scar enabled Beverley to make the violence she had experienced legible to me in no uncertain terms – 'it will always be there', 'this happened' – as well as her frustrations that the 'onus' is always on the rape victim to prove "what happened". However, this was not needed to prove the fact of the violence to herself.

In Sweet's analysis of women who had experienced domestic abuse, the physical and somatic symptoms that her participants reported to render their experiences real were generally bodily, including effects such as irritable bowel syndrome (IBS) and asthma (Sweet 2021, 250). These symptoms are often written off by clinicians as "psychosomatic", rather than real expressions of affective pain and distress. Both Maya and Alice 1 spoke about experiences of IBS to articulate the disabling effects of sexual violence. For example, Alice 1 enumerated various 'physical issues that people aren't aware of', including teeth-grinding, fatigue, asthma, IBS, fatigue, to explain how 'tiring' and 'hard it is really'. Like the impact of sexual violence on her mental health, all of the symptoms Alice 1 describes are largely *invisible* in that while they made her experience of sexual violence knowable to her and actually debilitating, but not visible to others.

C. Somatic Suffering: Rendering Violence Visible

Descriptions of ways in which "bodies"[16] were marked by violence were enlisted less often in service of "proof" of violence, but instead were used to render experiences of violence visible. The somatic language used to visibilise experiences of violence was largely centred around the "body", rather than the "mind". This was used to establish the harms of sexual violence, and visibilised what was ultimately invisible. To first take a very literal example of this distinction, Alice 2 repeatedly referred to PTSD as 'an invisible debilitation'. She talked about the 'unseen minority that are veterans of this gender war'. For her, a symbolic way of visibilising this "war" was by getting a physical tattoo of poppies: 'that's why I've got my poppies, because I felt like it was a war'; 'the tattoo, shows the invisible debilitation'. This was a particularly tangible expression of the invisibility of the harms of sexual (and in Alice 2's case domestic) violence; the 'invisible debilitation'

[16] Although I use the term "bodymind" for political reasons, to use it here would not be to honour participants' embodied experiences, which often clearly enacted a distinction between the "mind" and the "body".

of PTSD. It is briefly worth noting that Alice 2 re-defined PTSD as both a 'debilitation' and 'anti-social', rather than an 'illness', to explain her prior behaviour: 'I used to curl up in a ball in public spaces, that's anti-social isn't it, and I used to scream if anyone touched me, that's anti-social'. This can be read as disruptive to medicalised designations of trauma, as it instantiates the "problem" clearly in the social sphere: her behaviours are socially considered a problem ('anti-social'), and what is invisible about her PTSD is the actions of her ex-husband that caused it ('debilitation'). However, it is also an expression of how PTSD, dissociation, and flashbacks were largely *intangible* for participants, and required instantiating on a physical body – here through tattoos.

However, for some, bodily visibility was not always desirable. For Alice 1, when describing her experiences of 'dissociation' and 'flashbacks', the embodied experience of these visibilised her experiences in a way that felt beyond her control, such that 'other people can see it'. She said that

> I start kind of acting like I'm being abused, you know, someone like is abusing me, so in, but like I'm not aware of myself doing that so often I can be like gasping or like looking down, or like, kind of, just looking really terrified whereas to me in my brain like I'm not even realising that I'm acting like that? But other people can see it
>
> I guess my body, well obviously my mind, my mind thinks that there's a threat and then my body reacts in that way but maybe there's not… yeah. A… yeah… I don't, like in my conscious mind I don't, I know that there's not and I know that, you know I'm not about to be abused or anything like that, I'm not in danger but in my subconscious mind I think I… it's still… like a lot of things are very triggering so… yeah, it makes sense that I think my body is still trying to protect me a bit and acting in that same way

These descriptions are strongly informed by neurobiological understandings of trauma, including concepts such as fight or flight mode – 'it makes sense that I think my body is still trying to protect me a bit'. This echoes discussions within feminist scholarship about how dissociation places individuals right back "in" the traumatic event (section 2A,

chapter 3). Alice 1's division between the "mind" and the "body" is additionally significant, as while the PTSD in her 'brain' made the violence knowable to herself, her bodily response was 'subconscious' which made it visible to other people: 'other people can see it'. Unlike Alice 2, this visibility was not intentional, and compromised Alice 1's mastery over her distress. When I initially analysed this extract, I read Alice 1's description as 'unconscious', rather than 'subconscious'. The description of 'subconscious' is in line with ideas of 'dissociation' in professional psy and trauma discourse, with the traumatic memory as a pathological truth buried beneath ("sub"-consciously), and the body "going back" to 'protect' from 'threat'. Alice 1's experience here then adheres to the paradigmatic experience of sexual trauma and dissociation (Spurgas 2021).

She then elaborates her description of dissociation as 'I think it is a lot of dissociation that I'm kind of zoning out and going back to that place'. The explanatory power of dissociation and flashbacks is found in their temporal specificity, as well as what they visibly *do* in the present to her embodied self – Alice 1 experiences this as transporting her back to the event, and her 'body' or 'face' then betray her experiences of violence 'subsconsious[ly]', which made them discernible. She said that she was not 'aware' of herself doing it, but that 'other people can see it'; there is perhaps also a sense in which "dissociation" feels like reliving the violence for Alice 1, in that it felt specifically out of her control. While Alice 2 obtained a tattoo to intentionally visibilise her experience, the visibility of Alice 1's bodily reactions was undesirable, particularly because it made her feel the pressure to speak about her experiences more acutely. She said that

> all I kind of want to do is not show that, you know, I don't want to show that around people

> it's hard to kind of meet someone and be like 'Hi, by the way I have PTSD this is why I'm like this' like it takes… you kind of want to get to know someone before you go deep into like your life experiences

Here PTSD is explanatory ('this is why I'm like this'), but it additionally makes her experiences of violence visible, through how it affects her physical face and body. She said

that at times she can look 'very scared', and that perhaps people wonder 'is she scared of me?', which then required that she explain. It made her feel as though she had to go 'deep' into her experiences with people that she did not feel comfortable with. Embodying PTSD was uncomfortable for Alice 1 because she did not want to 'show' her experiences, nor feel the pressure to disclose and speak about them.

Similarly, although Beverley used the language of a 'scar' to instantiate her experience as equivalent to a physical injury, she too distinguished experiences of sexual violence from other physical illnesses or (dis)abilities, again on account of the demands associated with rendering that experience visible. In discussing the importance of speaking about sexual violence, Beverley said

> I don't think it's spoken about enough. I think you do… I think it's very hard for a woman to talk about. It's the hardest thing, it is. Even, even, do you know what I mean, losing a limb or whatever, cancer, anything is better than saying that you got raped because it's just so personal.

In this extract, the narrative of responsibility is less salient than in Beverley's discussion of a 'scar' as the result of a 'stabbing', as both the descriptions of 'losing' a limb and cancer are not necessarily evocative of an external responsible party. She went on to say 'it's such a personal, personal, personal thing, for somebody to invade your body against your will'. Beverley is drawing out a distinction between physical ailments (cancer; losing a limb), and sexual violence, with her use of the word 'personal'. She connected this 'personal' nature of rape with having to 'justify and then prove' what happened, as well as an enduring sense of shame: 'it's not the woman's fault or feels ashamed or something… so I think we should talk about it yeah'. While the embodied effects of sexual violence made visible the extent of participants' suffering, this was undesirable when it came with the associated pressure 'to justify and then prove' (Beverley) what happened. Externalising the effects on Beverley's 'personal body' came with understandable trepidation in this discursive landscape, and Alice 1 wanted 'to not show that', particularly with those that she was not comfortable with. Rendering sexual violence visible and knowable are then here distinct.

D. The Timebomb Metaphor Revisited

Every participant apart from Megan talked about wanting to carry on "as normal". People wanted to 'block' (Elaine, Beverley), 'push off' (Alice 2), and 'contain' (Ellen) the violence, by putting it 'out' (Beverley) of their heads. Several people made reference to a physical box to contain the experience of violence (Beverley, Sarah, Harib), including 'Pandora's box' (Sarah), as well as simply putting a 'lid', or a 'lock' on the violence to 'drum it down' (Harib). These metaphors all evoke the idea of something unwieldy or uncontrollable that has to be contained. In addition, everyone used these metaphors of containing in relation to mitigating a single or eventual "breakdown". Here, therefore group these descriptions under the heading of the "timebomb metaphor" which I will briefly contextualise with reference to the literature. As briefly alluded to in section 1B of the previous chapter (page 113), this metaphor conveys a notion of trauma as a ticking timebomb that could lead to an eventual "breakdown"; instead, people tried to 'block', 'contain', 'box' and 'lock' up the experience. In this section, I show how participants positioned their bodyminds in relation to the idea of a "breakdown", and how these articulations can be read as expanding, and disruptive of, medicalised understandings of sexual trauma.

The timebomb metaphor reflects how feminist and psy scholarly discourse constructs trauma as something to be "dealt with", and that while "carrying on" or "forgetting the violence" may be seen as a temporary 'coping strategy' (Liz Kelly, Burton, and Regan 1996, 85), it must be addressed at some point. The notion of "carrying on" is represented in much feminist and psy discourse as harmful (Gavey and Schmidt 2011; Laugerud 2019), as it is an expression of repression or avoidance, rather than dealing with the problem. This is articulated by Nicola Gavey and Joanna Schmidt, who write that

> Within psy discourse more generally, traumas or "issues" have to be "dealt with"; if they are not, if a woman has "subdued her feelings" or is "not ready" (FG2 P2) for instance, or has "blocked it out" (FG2 P3), "bottled it up" (FG7 P2), "bur[ied] it" (FG4 P3), or "shelve[d] things" (FG3 P2), then as the "time bomb" metaphor suggests, her defense against future pain and suffering brought about by "triggers" of various kinds is vulnerable indeed, and the consequences are problematic, signaling "trouble ahead" (FG4 P4) (Gavey and Schmidt 2011, 444)

The timebomb metaphor is thus an example of expert and professional discourses on trauma that render the traumatised person as a fragile bodymind in need of expert management, otherwise doomed to explode (Armstrong 1994, 97). Participants similarly spoke of 'mental breakdown' (Beverley), a 'psychotic break' (Alice 2), and how traumatic experiences 'trigger' (Sarah) such effects. This represents trauma as leading to an eventual breakdown, in which the trauma must be treated and "dealt with" in order to recover. Under expert psy and feminist discourses on sexual violence, the timebomb metaphor represents the mind as a machine (Laugerud 2019; Lakoff and Johnsen 1980), in need of necessary maintenance: to address the "problem" rather than avoid it. On this account, attempts to contain the trauma are seen as problematic and temporary coping strategies, whereas participants' narratives were generally disruptive to the traditional "timebomb" metaphor, and hence notions of "recovery" and "cure", in several different ways.

One description that initially appeared to adhere to the ticking timebomb metaphor was provided by Sarah. Sarah described her experience as a 'box' that had 'to come open', which implies that experiences of trauma must eventually be dealt with to mitigate their damage. It was in 1994 that she first came under mental health services, which was seven years after her experience of sexual violence. In discussing the experience, she went on to say

> it felt a bit like I'd put my experience and what happened into a Pandora's box and shut the lid, and in 1994 I became pregnant with a planned pregnancy but I lost the baby at about 12 weeks, a miscarriage, and that kind of triggered Pandora's box […] And for the lid to come open. It was almost as if there was so much stuff going on that something had to give.

This description of the box as 'Pandora's box', which contained all of the evils of the world, could be considered within the biomedical register of trauma – as 'horrifying events' that must be eventually "triggered" for the feminised subject to effectively deal with her feelings. However, Sarah disrupts the timebomb metaphor in two ways. Firstly, she disrupts the popular idea that sexual violence is a discrete event which is uniquely and

supremely traumatic, understanding sexual trauma instead as socially and culturally determined (Gavey and Schmidt 2011; Carter 2021; Spurgas 2021). She includes other events that are less widely accepted as traumatic in the popular imaginary, such as a 'miscarriage', in the description of her experience. It was not that sexual violence led to an eventual and unique breakdown, but that there was 'so much stuff going on' that the box burst open. Secondly, 'the lid [coming] open' was not experienced by Sarah as a bad thing. In her words, it revealed that she was 'poorly', and 'gave [her] tools basically to manage that overwhelming sense of distress'. Sarah's use of the word 'poorly' here is disruptive in itself to linear narratives of "cure" and "recovery", as it is described in terms of her use of ongoing 'manage[ment]' using her 'tools'. The word 'poorly' also does similar work to the word "sick", in that Sarah brings attention to the multiple structural inequalities that make us 'poorly', as she felt that her PTSD diagnosis 'frames' several different experiences, including multiple difficult miscarriages, and 'childhood trauma'. She disrupts the notion that sexual violence is a discrete and isolated event that needs to be "dealt with".

Rather than representing this process as a linear narrative in which a single terrible crisis and "breakdown" occurs, several participants instead expressed both gratitude for ruptures as and when these arose, with ongoing negotiations of their distress as fluid and recurrent. Spurgas has suggested that medicalised notions of sexual trauma construct it as a discrete event that is temporally specific, and hence accessible through "dissociation" and "flashbacks", and amenable to a medical "cure" (Spurgas 2021). She theorises a more expansive version of the category of sexual trauma, which captures and embraces a non-linear notion of 'falling apart' (Spurgas 2021). Carter makes a similar argument of the category of trauma more generally (Carter 2021), and these observations are particularly pertinent here in order to appraise the rich variation of bodyminds that here exceed and reconfigure "trauma" as a category.

For Sarah, her "breakdown" allowed her to access support to manage the 'overwhelming sense of distress that [she] was feeling', and for Ellen, the sexual violence was a 'catalyst for change', and what led her to access the support she wanted and decide 'to live'. Both Sarah and Ellen saw their ongoing distress as fluid in its recurrence, rather than something to be addressed, treated, and cured. Ellen's notion of the "timebomb" of her

sexual violence led to what she described as ‘unravelling’. When I asked her to describe what she meant by this, she said

> all this emotion that I just hadn’t felt, or I’d felt but managed to find a way to contain it, you know, just sort of put it back in its box and all that sort of thing. You know, I couldn’t contain it anymore

She variously referred to this moment as an ‘avalanche’ and ‘complete yeah collapse’, and how she identified as a ‘phoenix’ ‘rising from the ashes’. While at first glance this looks like the familiar notion of repression leading to a single “breakdown” in need of expert management, Ellen found ways to constantly (re)negotiate these ‘unravellings’, rather than breaking down, being treated, and then recovered. She said

> there’s been many mini unravellings in between that, and you know, sort of, and I still, as I say I feel everything and I allow myself to feel it and I get overwhelmed most days but with great gratitude for being here

She negotiated her ongoing distress through multiple ‘unravellings’ and still feeling ‘overwhelmed most days’, rather than manoeuvring towards an eventual state of “recovery” and “cure”. This is again quite the departure from Laugerud’ study, in which her participants ‘stay on the healthy path’ towards a future horizon (Laugerud 2019, 15), as Ellen’s articulations are constantly recurring and being renegotiated.

Further, she consistently subverted psy knowledge to access ongoing support in a way that worked for her. She said she was ‘thankful for the labels’ she had received, but just because she ‘need[s] to use them in order to access help’. She referred to her complex PTSD diagnosis as ‘a key in a lock to open doors to get help so that I can stay well’. In this sense, Ellen’s account is disruptive to the psy model of trauma as an isolated incident to be dealt with. Psy metaphors represent people as ‘stuck’ in the past, or in denial because they have ‘pushed things down’. These orientational metaphors being backward and downwards suggest ideas of repression and denial, as well as a lack of progress (Laugerud 2019). This also reflects Ellen’s identification with complex PTSD as “strategic” (Johnson 2021), to ‘open doors’ and ‘access help’. For when she said ‘I’m thankful for the

labels', she went on: 'but I also don't believe in them'. They were useful for her negotiation and orientation through services, and for also negotiating a constant or ongoing state of rebuilding, 'solid brick by solid brick' in her words. 'Unravelling', 'avalanche', 'collapse', and the idea of the 'phoenix' all provide Ellen with a sense of agency over her ongoing distress, as well as an understanding that this process may be fluid and recurrent.

Sarah's understanding of her distress was similarly fluid in its recurrence. In order to manage and understand her self-harm, Sarah found it useful to consider her experience in 'waves […] because they will crash out, that overwhelming emotion'. She also found this language particularly resonated due to living by the sea, and the significance of the ocean in her life. Her distress was no longer something to "recover from" or be "overcome", but, as for Ellen, fluid and recurrent. Sarah's distress both during that first stint in mental health services almost 30 years ago, and since, was instead conceptualised as something that she preferred to manage herself through "poaching" (Johnson 2021) psychiatric knowledge. This idea of 'thieving' or 'poaching' a psychiatric label has been described by Johnson, who builds on queer theorist José Esteban Muñoz's ideas about 'disidentification' (Muñoz 1999) to describe ways in which people neither straightforwardly accept or reject a psychiatric category, but rather work both with and against a category or label: using it without subordinating oneself to it (Johnson 2021). Sarah articulated ways in which she was able to "poach" and retool the accrued labelling concerning her 'self-harm'. She valued the support of a psychiatric liaison nurse during her first crisis who had had specialist training in self-harm. She said that

> He didn't focus on the self-harm, he focused on my mental health needs and looking at coping strategies and other ways of managing it so he gave me tools basically to manage that overwhelming sense of distress that I was feeling

She repeatedly talked about self-harm as a coping strategy in this way, saying that 'I don't agree that it's a behaviour, it's a coping strategy'. The distinction between a 'behaviour' and a 'coping strategy' is important for Sarah to emphasise that it is one legitimate expression of her distress, rather than a "problem" to be entirely addressed by medical professionals, or an expression of a naturalised and innate biological pathology. Here, she makes what Johnson calls 'invocations of medical terminology that differ qualitatively

from being subjected to diagnostic terms as devices of medical authority' (Johnson 2021, 642). She works within the label of 'self-harm' to reconceptualise it to make meaning for herself, and in doing so works against the designation of her as a medical object of scrutiny; a problem to be addressed. In fact, she preferred to negotiate the bodily management of her self-harm in her own space. In describing the different forms her self-harm can take, she said that

> I'm in lots of pain as I said earlier, and sometimes I self-harm just because I want to experience a different type of pain, and then there's the impulse self-harm where something's happened, things are overwhelming, and it's like [clicks] I need release like that […] [my GP] prescribes sterile strips and dressings so that as much as possible I can manage my self-harm myself.

Sarah "poached" and repurposed psy knowledge to manage her 'self-harm' her own way; learning and navigating ways of managing her ongoing distress herself were important, and represents a disidentification from psychiatric modes and treatments because she can 'manage' her distress 'herself'. Both Ellen and Sarah found ways to engage with psy expertise that were both strategic and subversive to the timebomb metaphor. In centring their experiences of being 'overwhelmed most days' (Ellen), novel ways of conceptualising the pain and distress of sexual violence are exposed that exceed the medical categories they inhabit. In centring experiences of inhabiting psychiatric categories, we can complicate feminist representations of the undifferentiated ways in which women are mistreated and misrepresented by expert psy and sexual violence discourses. This allows us, in Johnson's words, to turn '*with tenderness* towards those who are – or who have histories of – unravelling' (Johnson 2021, 637; emphasis hers).

While Sarah and Ellen's experiences here are particularly disruptive to psychiatric ideas, it should be noted that they both expressed quite explicit anti-psychiatric sentiments, as did Megan, who as above, had been specifically sexually harmed on a mental health ward. Earlier, I noted that Ellen's identification with C-PTSD was 'strategic', which is another reference to Johnson's work which I quoted in the conclusion of chapter 3. Johnsons suggests that people may identify with psychiatric diagnoses either 'wholly, partially, ambivalently, or strategically' (Johnson 2021, 635). While on my theoretical orientation

I cannot say with certainty how participants identified, the reading of Ellen and Sarah as 'strategic' is informed by their embodied experiences of negotiating services, and in their ability to circumvent or refuse medicalised interventions. In contrast, others seemed to carry more 'ambivalent' sentiments towards their diagnoses and experiences of sexual violence, or an intense frustration at the lack of recognition for their experiences.

E. Forgetting

In section 2A of chapter 3, I noted that some people may "forget" experiences of violence, rather than necessarily be compelled to narrate them (Mulla 2016; Leys 2000). Beverley's experience was complicated and more ambivalent, as she seemed to realise during our interview that she had often forgotten about her experience of sexual violence. In this sense, her story was also disruptive to the traditional timebomb account, as her decision to 'bury' the violent experience had resulted in her forgetting her experience for long periods. For Beverley, forgetting was not a temporary "coping strategy" leading to an eventual breakdown, but almost an intentional decision. After her daughter's father 'didn't believe' her, she decided not to talk about this experience, and to "block it out" instead. She talked about how she 'just wanted to bury it, you know [daughter's father's name] didn't believe me […] I just felt this sense of shame about it, so I wanted to bury it'. So his initial reaction of disbelief made her feel 'shame', and led to a desire to 'block it away', 'forget about it', and 'bury it'. This decision to 'block' out the experience was an intentional choice, as she '*wanted* to bury it' (emphasis mine), and this was connected to a refusal to 'carry' and 'bear' (Beverley's words) the violence, nor its effects: 'I didn't want it to… muck me up, in that, I just didn't want to be carrying it and bearing it so I just put it as… as notched it down to experience, put it in a box, just left it at that'. She said she could 'see a whole heap of trouble coming from this so [she] just wanted to bury it'.

In the "timebomb" metaphor, the assumption is that to "block" or "bury" the violence may lead to future problems, which Beverley described in terms of both 'trouble coming', and how it could 'muck [her] up'. Beverley felt a sense of ambivalence around her experience of sexual violence, particularly in the context of many other experiences of abuse that seemed more significant. Yet she also sought to acknowledge the significance of this event, and to understand why she had forgotten about it for so long. She spent a lot of

time during the interview wondering why that was, why it didn't 'get' her in the same way as some of her other abusive experiences. She said

> I think it might have got me, I think it might have affected me so much more as I said I don't think I had a lot of time to focus on it because I was in a relationship, d'you get it, and he didn't really believe me, and we just kind of forgot about it

Beverley is here aware of the notion that trauma can 'get' you down the line, but her experience is instead one of an almost casual forgetting ('we just kind of forgot'), at least in part a deliberate choice due to encountering disbelief. She partly attributed this ability to 'contain' her experience of sexual violence to both its temporal isolation in comparison to her experiences of abusive relationships, and to its comparative insignificance in her life: 'I'm going to write a book one day my story's really crazy'. She said

> because so much other shit happened after that, it just kind of got pushed to, oh well, I mean tell you the truth sometimes I forget, forget about it. For long periods of my life I think I've forgotten about it.

> it's harder to put domestic violence or abuse and that into boxes, this was just one incident, so that's why it was easier… it's easy to put into a box, and it literally was one incident, I went there, it happened, so it was easy for me to put it into a box innit, it's quite easy, to it… it was quite easy you know, after… especially after I'd told my daughter's Dad, he didn't believe me that was it I just put it into a box and I never really went there again.

Beverley is here explaining how it came to be the case that she did and could 'block' out the violent experience, particularly in comparison to her other experiences of violence or abuse: being a temporally isolated 'incident' made it 'easier' to 'put into a box', as well as the fact that 'so much other shit happened'. Contrary to the single "event-based" model of trauma in Psychiatry discussed in section 2A of chapter 3, Beverley's isolated experience of sexual violence was far easier to forget in contrast to the more intensive and consistent experiences of 'domestic violence', among other things (Goozee 2021; Spurgas 2021; Carter 2021).

During the interview, she continued to think through why or how she had largely forgotten and buried this experience, which led her to muse that ‘they say children do that with childhood trauma don’t they, they bury things’. Here she is referencing elusive expert discourses of trauma (‘they say’): it is elusive insofar as it is vague, and additionally conveys a sense of epistemic authority in terms of who knows about ‘childhood trauma’. Notably, Beverley described growing up in a very violent household, and therefore had lived expertise of ‘childhood trauma’, but rather than trusting her own experience, here she surfaces a version of psy expert discourse about how one should ‘deal’ with things that have been ‘bur[ied]'. When I asked if she’d like to talk about the sexual violence with someone, she said

> I’d have to ring up some rape, rape support line or something and talk about it. Yeah but it was when I was 19, so and I don't, I don't know, just add it to the list I'll get to it eventually [laughs] kind of thing. Clearing out all the things in my past, I’ll get down there eventually I suppose, but… right now it’s just, you know, you know

The metaphor of ‘clearing out all the things in my past’ renders the idea of talking about sexual violence as almost chore-like, something on her to-do ‘list’ that she’ll ‘get to’ ‘eventually’. Beverley’s account is here then disruptive to the idea that sexual violence is essentially and extremely traumatic. Trauma is not inherent to an event but socially and culturally determined (Kafer 2013; Carter 2021; Spurgas 2021), and sexual violence is a ‘culturally-recognised trauma’ (Grey 2017) often represented as the most “horrific” thing a person can experience. Beverley disrupted this discursive construction, as sexual violence was lower on her ‘list’ than her other difficult life experiences. Several participants named other experiences as more traumatic than sexual violence, such as physical (dis)abilities, experiences of violence, racism, or miscarriages (Sarah, Ellen, Beverley, Harib, Megan, Alice 2, Maya). They talked about ‘putting trauma in terms of sort of priority’ (Ellen), and how ‘it was bad, but then I’ve seen bad things’ (Beverley). In contrast to the medicalised idea that sexual violence is a timebomb to be addressed, participants instead diverged from and disrupted this discursive construction.

However, Beverley's allusion to the need to tidy the mess from her past retains a conception of memory as unruly, as well as a need to be 'clearing it out'. Ironically, both "clearing out" or "tidying" traumatic memories, and avoiding or repressing them, are represented as problematic by expert psy discourses. Haaken has noted that leading false memory researchers such as Elizabeth Loftus describe memory as a process that requires 'sweeping, dusting, tidying things up' (Haaken 1998, 51): Loftus's warning is that when we participate in this domestic (and feminised) maintenance of the mind, we can alter its contents and hence introduce falsity. So feminised people are compelled by expert psy discourses on trauma and memory to both "deal" with experiences of violence, but to avoid "tidying" or "repressing" the memory of it in doing so, if one is to retain its "truth". This is one of the ways in which psychiatric diagnosis complicates the narrative demands of sexual violence testimony. Beverley's response to this can thus be seen as adaptive in context: rather than walk the tight rope of 'clearing out' her experiences without rendering them untruthful, 'for long periods of [her] life' she has 'forgotten about it'.

Maya, the only other black woman I interviewed, also referenced "forgetting" during our interaction. However, for Maya, this experience was notably different from Beverley's, as it was not so much reflective of ambivalence as a desperate and necessary choice. This is here reflective of how race further restricts the "double-edged sword" of sexual violence testimony, and "forgetting" being not necessarily an "adaptive" or "empowering" choice, but the only available option. Maya expressed a frustration that her experience of trying to "forget" invisibilised her distress, which was partly an intentional decision after her extensive failed attempts to garner recognition for her experiences. As will be shown in the next chapter, Maya faced an extensive and sophisticated network of denial for her experiences. The dynamics of the testimonial injustice Maya experienced was particularly racialised, involving several actors including her assailant, her university, psy-feminist experts, and even her peers. This culminated in her having to drop out of University and enrol elsewhere. She expressed a desire for a new start at her second university, and an opportunity to 'keep it about appearance' rather than be the person with 'mental health problems'. She says

> because I was getting support from, like this local sexual violence organisation where like they were like we can refer you to the one in your new city and I was like no, no

> no. I'm just gonna go to uni, forget about it, and then spent all of first year like trying to forget about it and then spent like… I don't know, I think like they were very much interlinked like trying to understand that, like maybe the reason like, um, I wanted to stay out and like party till like 6:00 or 7:00 AM was the fact that like I slept terribly anyway and like had all these nightmares, and like spoke to my doctor about like PTSD after the event, like I had like such vivid nightmares for like 2-3 years

She talked extensively about how her experience of going out and 'partying' was here received as 'normalised', even 'glamourised', and some of the things 'society praises'. This 'praise' was felt in the context of university life, and the glamorised or idealised idea of a rebellious youth. In trying to 'forget' about her experience and participate in the social demands of university, this invisibilised her distress. Her decisions to 'stay out' and not sleep were partly informed by the fact that she 'slept terribly anyway', but the reality of her PTSD was thus obscured by trying to assimilate and forget about it. Participants' experiences of "boxing" up the "timebomb" of sexual violence were generally valuable for negotiating their ongoing distress, but Maya here expresses frustration at the requirement to do so, which was largely connected to the imperceptibility of her experience and the associated lack of recognition and support for it.

F. *Intervening on the Somatic*

In contrast to the invisibility of Maya's experience, articulating sexual violence in somatic and physical terms produced bodyminds that had been "dis-abled", and as such, could be intervened upon. Somatic language was particularly useful for people to intervene on their experiences, either through physical interventions, or eye movement desensitisation and reprocessing (EMDR), a largely somatic intervention that does not require talking about "what happened". This supports professional anti-sexual violence discourses, in which somatic interventions are perceived as 'liberating for clients, since they don't just have to "tell stories"' (Sweet 2021, 107). Just as Alice 1 and Beverley expressed hesitation about talking about sexual violence on account of having to "prove" it, somatic language and their associated interventions were preferred over and above talking about sexual violence. Participants preferred to 'talk around' the abuse, saying 'I've got this symptom' (Alice 1), especially when these symptoms were somatic and

hence felt more straightforward for people to intervene on. Speaking about sexual violence was valued for potentially facilitating political change, and protecting others from sexual violence in the future, but it did not necessarily have therapeutic value. Laugerud, drawing on Ian Hacking, argues that introducing medical models can facilitate professional intervention in issues that no one wants to talk about (Laugerud 2019; Hacking 1991). Working with psychological techniques becomes a way of avoiding or refusing to talk about sexual violence.

For Elaine, the language of the physical and the somatic was initially helpful for her to intervene on, and manage, her distress. Elaine's experience of sexual violence occurred in her early twenties, when a friend whom she trusted invited her round to his house one day, where he then raped her. She said that her 'mental health was fine until the episode of sexual violence', and that 'it's never been quite right ever since. Er mainly, mainly depressive symptoms, some anxiety, but mainly recurrent depressive symptoms'. For Elaine, her experience of inhabiting the psychiatric category of depression is specifically and explicitly connected to her experience of sexual violence. In the initial aftermath of the attack, Elaine said that her experience

> led to um, me having a severe headache, and by that I mean a constant headache, unremitting, which went on for many, many months, um, literally there was no relief from the headache it was a very bad stress headache which meant I couldn't concentrate, I couldn't even write, um, and that in the end made me develop severe depression.

The two main ways that she felt and understood her experience of violence were through a severe stress headache, and equally severe depression. She was clear that the cited 'stress' and 'headache' was causing her depression. She continues from the prior extract as follows:

> just to be conscious was unbearable so I was deeply suicidal, I didn't act on it because, you know, I knew that this would just be…, you know, this was a product of the headache and the stress, um, and you know, and I hoped the headache would recede

> and therefore the depression and everything else would recede, and in the end that's what happened

This causative chain was important for Elaine as evidenced here – she didn't act on her suicidal ideation because she knew it was 'a product of the headache and the stress', and accordingly, when the headache receded the depression went along with it. For Elaine, conceiving of the distress in somatic terms also gave her some control over how to relieve it. She went on to explain that this was because 'a stress headache is muscular, it's the muscles in the scalp, and I think that regular exercise, you know, it was what really helped make me feel better'. In both her experience of suicidal ideation, and the relief from it, the stress headache was the central causative aspect – in enacting a physical intervention by exercising her body, this enabled her to 'feel better'.

Elaine additionally expressed a preference for not talking about sexual violence in favour of the somatic. When I asked if she had spoken about her experience of sexual violence in any therapeutic contexts, she said 'I think when psychiatric histories are being taken it has been noted down, I don't think I've ever talked about it with anyone no one's seemed particularly interested'. Given that Elaine's experience of her depression was so intimately linked with her experience of sexual violence, I found this surprising, but she explicitly said that she did not want to talk about it with mental health professionals, and that she felt that

> The therapy may not be helpful to me or going through it with a therapist may not be helpful to me. Um, and I've always been, never quite confident that people would actually understand either […] how it affected me

She felt that people would neither 'understand' her experience, nor how it 'affected' her. In our initial assessment, Elaine told me that she valued talking about her experience with me insofar as she wanted others to not have her experience. Yet in the interview itself it became clear that outside of that, she did not want to speak about sexual violence. When I asked for clarity whether Elaine would prefer the opportunity to talk about sexual violence, she said that

> to be honest […] it seems so long ago […] and the damage has been so long-lasting […] and I don't see how it can help. It can't undo, it can't really undo the damage, because the damage has been so enduring and sustained

Elaine's overwhelming experience was that the damage of sexual violence had already been done, and that talking about it did not have therapeutic value: 'it can't really undo the damage'. Elaine conceptualised her experience in physical and somatic terms, which at least initially produced a bodymind that she could intervene on and allowed her depression to 'recede'. She did continue to feel an 'enduring and sustained' sense of 'damage', which is a consequence of the physical and somatic language which I will discuss in due course. However, here I am concerned with her sentiment that talking about her experience of sexual violence with a 'therapist' would not be helpful, especially on account of how people may not 'understand'. While speaking about sexual violence had potential political value for Elaine, personally, it did not, and conceptualising her distress in terms of the somatic supported her take-up of physical interventions instead.

Eye Movement Desensitisation and Rewiring (EMDR) is a trauma intervention that is intended to provide a way of lessening the stress associated with traumatic memories that does not require speaking about it. EMDR is increasingly popular in anti-violence services for being a fundamentally somatic intervention, in which people picture traumatic events or their sequalae while focusing on an external stimulus such as an oscillating finger (Sweet 2021, 343–44; Shapiro 2018). This intervention thus supposedly relieves the need for speaking about sexual violence. Like Elaine, participants expressed a preference for interventions in which they did not have to discuss "what happened". Alice 2 recounted her experience of EMDR, and said that it was 'brilliant'. However, when I asked if it had helped her to talk about her experience of sexual violence, she answered with a resounding 'no'. She went on to say that

> No yeah just made it easier to cope with or… it just stopped the flashbacks so I could like get out and go out in busy places, and you know, like if there was a firework like that would give me the flashback

For Alice 2, EMDR was valuable for enabling her to assimilate into everyday life again in a way that was less *visibly* distressing, and that it stopped her 'jump[ing]' at stimuli such as a 'firework', or how she 'used to curl up in a ball in public spaces'. For Alice 2, the EMDR relieved these somatic and embodied experiences that were uncomfortably visible, because they additionally made her vulnerable ('curl up') and exposed. EMDR was valued for assuaging Alice 2's visible distress, but not for enabling her to talk about it. Both Elaine and Alice 2's reticence for talking about sexual violence seemed to partly reflect a fear that their audience would not 'understand', rather than solely an aversion to speaking about violence itself. In fact, Alice 2 expressed a distinct distain for having to narrate 'what happened', and how if people ask her 'what did he do' then her 'brain starts to wobble', even after the EMDR. Like Elaine, her knowledge of the response she could receive threatened her embodied integrity ('wobble'), and this was felt as intrusive. She thus retains a conception of her PTSD as pathological, given the instability of a 'wobbl[y]" "brain', but found it easier to 'cope' by reducing the visibility of her experience through EMDR, although it did not make it easier to speak about sexual violence. Somatic interventions are here valued for assuaging distress, not for facilitating speech or speaking out, as in the feminist representation of therapy as potentially political.

Sarah similarly preferred EMDR over the "talking cure", and felt that the latter did not have personal or political potential for her. Sarah identified with the categories of PTSD, anxiety, depression, and psychosis when we spoke. She found the language of PTSD, dissociation, and flashbacks, and eventually EMDR useful for "rewiring" her brain. She says

> I used to have quite regular flashback… flashbacks even, in relation to the incident that I've told you and some childhood stuff, but I count myself really lucky. I've had some EMDR, and I've had really intensive EMDR to be perfectly honest and that's really helped. And, I don't' understand it, the scientific part of my brain thinks how on earth can, you know, tapping on your hands or doing that [gestures with finger] with your hands help. And I was really cynical about whether it would work, the psychologist's called Zafar, and he was, 'What have you got to lose', and I, I do, I literally feel that my brain's been rewired to the correct circuit that it should be

> […] that's how it feels to me, that things have been put back in place how they should be

This notion of the brain being 'rewired to the correct circuit' is again neurobiological and somatic, and strongly influenced by psy discourses about trauma. According to American Psychologist Francine Shapiro, the founder of EMDR, the idea is that the traumatic memory has been stored 'dysfunctionally in the brain' (Shapiro 2018, 16), until it is, as Sarah says, 'put back in place'. While this mechanism was again not particularly useful for Sarah's understanding ('I don't understand it'), the intervention was helpful for relieving her distress.

She compared EMDR to her first stint in mental health services (1994-1997), where she had to talk about "what happened". When reflecting on this, she said 'I'm not convinced talking about it was that beneficial, certainly compared to the EMDR. The EMDR, for me, has been much more useful'. For Sarah, EMDR was preferred over the "talking cure", which was not 'beneficial'. However, in contrast to Alice 2, the EMDR enabled her to talk about the sexual violence in a way that she couldn't previously. At the end of the interview when reflecting on her experience of our interaction, she talked about how the EMDR had helped her be able to talk about the experience of sexual violence with me. She said 'it just feels different doing it now, after the EMDR, it feels… more settled. As if I've put it to bed, to rest'. As an intervention, Sarah valued this EMDR for its "rewiring" impact over and above talking therapy, although its ability to relieve her distress additionally enabled her to talk about it. She lamented that if she had had EMDR sooner then she 'could have spoken about it' and 'had those difficult conversations with [her] husband', preventing the breakdown of their marriage. Sarah did not feel that talking about sexual violence had a therapeutic benefit, but in contrast to Elaine and Alice 2, she valued somatic interventions for enabling her to talk about it subsequently.

Alice 1 was in the process of accessing EMDR when we spoke, and she disclosed to me after the interview that she was not convinced it was useful. In the single instance she mentions it during our recorded interview, she said that it requires that she goes 'into it a lot more, about what actually happened and stuff". Although it is somewhat unclear, from this extract it appears that Alice 1 was required to *talk* about what happened during

EMDR, which she too distinctly wanted to avoid. Alice 1's interview was the first in which I decided not to ask the embedded narrative interview question around her experience of violence. After the interview, I told her that I didn't ask this question, and my reflexivity diary reads as follows

> I disclosed that I had actually decided not to ask that question, and she said that she was grateful for this. She said she wanted to talk about it, but that it took a long time for her to feel comfortable with someone discussing it.

Instead, Alice 1 expressed a preference for talking about symptoms and responses, rather than necessarily going 'into' what happened, which enabled her to 'talk around' experiences of violence

> I can talk about it and… To some extent, obviously not maybe go really into it but I can talk around it

> I'm lucky to have a few really close friends, um, but, that I can talk to about it with, but kind of more just in like a…. maybe not the abuse itself, like I wouldn't just casually bring up… but I just mean like, kind of, just like talking generally just like oh, I have this symptom, or like I, I'm kind of, I don't know, trying this different thing now to help me and things like that that

Whether or not Alice 1 was required to talk about "what happened" during her EMDR sessions, she too felt that this did not necessarily have therapeutic value, and instead expressed a preference for 'talking generally' about symptoms and interventions. Medicalising experiences that no one wants to talk about can enable people to access support by absolving them of talking about sexual violence. Alice 1 instead prefers to 'talk around' the abuse with reference to 'this symptom' or 'this different thing'. Discussing symptoms was here preferable to talking about the lived experiences and events of sexual violence. Further, contrary to the feminist message identified in section 1C of chapter 3 that sexual violence must be 'dealt with' (Kelly 1988, 222) and "narrated" (Brison 2002), talking about experiences of sexual violence was not generally experienced as carrying therapeutic value (see page 83). Instead, somatic interventions were preferred, and often,

to assuage distress and relieve participants from the narrative demands of sexual violence testimony. That is not to say that there is not value in speaking about trauma, but that experiences of sexual violence exceed this narrow and limited conception.

It is important to note that there were disparities in how participants were able to negotiate diagnoses, and associated services, in relation to race. In arguing for the increased recognition of a political framing of mental (dis)ability, critical disability scholar Alison Kafer reminds us to attend to Jim Swan's questions about healthcare and social justice: 'How good is the care? Who has access to it? For how long? Do they have choices? Who pays for it?' (Kafer 2013, 19). These questions are pertinent here – medical representations, discourses, and interventions reflect ideological constructions of normalcy. Participants accordingly revealed discrepancies in who is diagnosed as legitimately traumatised, as well as the resultant differences in access to discursive time and space in mental health settings, and consequential support. It is important that the three participants who had received treatment for dissociation and flashbacks (EMDR) were white (Sarah, Alice 1, Alice 2), with diagnoses of PTSD or C-PTSD; these symptoms are primarily identified in white middle-class subjects (Spurgas 2021). Similarly, the only participant who felt that talking about sexual violence had therapeutic value was Ellen, who was also white and identified with C-PTSD. Sarah describes her experience of services as allowing her 'time to dissociate', she says that

> EMDR […] used to take a good 40 to 60 minutes. So the way that we got round it was that he booked me in for an hour and a half, so that I had time to disassociate, time for him to bring me back, and time for the EMDR. Yeah… and I count myself as lucky that he was able to do that and give me that extra time, I count myself as lucky that he saw me for about eighteen months, two years, and he's going to see me again… You know, there's lots of mental health services that haven't got capacity for that level of support

She explicitly notes that this is a question of service 'capacity' and that she is 'lucky' to access psychological support that will accommodate 'time to dissociate'. Spurgas has previously suggested that having the 'time to dissociate' is not something that everyone is afforded (Spurgas 2021). Here it is additionally accommodated with the provision of

extra therapeutic time, which is highly unusual within the context of UK statutory mental health services.

Disparities in care are particularly racialised, and sexual and gendered violence against people of colour is often excused (Kaba 2019; Day and Gill 2020; Day and McBean 2022); their disproportionate experiences of trauma rarely identified and appropriately supported (Spurgas 2021). Beverley, a black woman, was accordingly not afforded the "time to dissociate" due to differences in services; treatments offered in accordance with her diagnosis; and financial reasons. She wanted 'proper Freudian therapy' for her childhood, but such psychoanalytic treatments are largely not provided by the UK National Health Service (NHS). Yet Beverley's access to therapy was further limited by her diagnosis and her financial situation. She said that due to 'being Bipolar': 'they don't offer [proper Freudian therapy] and I haven't got the money to pay for that kind of therapy'. Of her experience of sexual violence itself, she said 'who am I to tell it to? My GP? Who's going to want to hear?'. She expresses the limited services that she has access to, as well as the interpersonal limits of the discursive space available to her in medical or therapeutic contexts – 'who's going to want to hear?'. Her experience of her 'treatment' was that she would occasionally and briefly meet with a psychiatrist, 'then they just write you a prescription for whatever meds and that's it. That's a psychiatrist, they don't give you psychological on the NHS'. Rather than being afforded access to somatic treatments such as EMDR, or being afforded 'time to dissociate', she was medicated – again, dissociation and its associated treatments are more often identified in white middle-class women, and black women are more likely to be medicated (Nazroo, Bhui, and Rhodes 2020; Spurgas 2021). The combination of Beverley's financial position, and the nature of her diagnosis, which may have been partly connected to her experience of race and diagnostic practices, meant that talking therapy was not available to her.

G. Permanence

A problem with this somatic language is its implied permanence, which led to painful experiences for several participants. Again, as Sweet argues, because 'trauma relies on neurobiological theories of the body and brain, suffering is made somatic and permanent' (Sweet 2021, 164). While the physical and somatic language initially enabled Elaine to

relieve her distress, the flipside of this was that the recurrence of her depression and suicidal thoughts led her to feel as though she was 'failing in a trajectory of recovery' (Sweet 2021, 136). She said that had come across the term 'resilience' through her increasing involvement in mental health research as a long-term patient. While I had here interjected to say that I was not sure the term was useful on the basis that I feel it implies that some people are inherently fragile, and that failure to recover is consequently seen as a failure of will. She disagreed with me, and said

> I like it [...] it makes me think of being strong, being able to endure and hold on, I mean, I think I have a lot of physical, this comes from the runner in me, I think I have stamina I think I have physical resilience, um so I like that. I wish I had, you know, mental and emotional resilience.

While Elaine's experience of depression was initially one that she felt she could overcome, at least partly through her own intervention – by exercising – her longstanding physical resilience was not one that she felt ultimately translated to her 'mental and emotional resilience'. She went on to say that 'I wish I could have proven to myself that I was a stronger person, more resilient'. Contrasting her physical strength and ability to intervene on her health with her lack of 'emotional resilience' leaves Elaine with a sense of weakness, as though she had "failed" to stay strong after her initial recovery. Elaine identified with the diagnosis of depression very strongly – 'that is the overwhelming effect' – which was perhaps part of why it felt somehow inherent to the physical constitution of her bodymind, as a lack of 'resilience'.

Further, while much of the literature on sexual violence suggests that people blame themselves for "what happened", Elaine instead blamed herself for her failure to recover. She stated of the assault in plain terms, 'he was responsible, so I do blame him for doing it, but I haven't held onto negative feelings'. But when it came to her mental health, she said

> I do blame myself for not recovering better. I've always blamed myself for not recovering better, I always wondered if, you know, the attack exposed some kind

> of inner weakness within myself, the fact that one thing, you know, could in effect trigger so much damage to myself.

Elaine's emphasis on the physical and somatic, as well as the associated traits of strength and weakness, and her responsibility for those traits, eventually led to her blaming herself for 'not recovering better'. While she locates the cause of sexual violence in its socially instantiated context ('he was responsible'), she also locates the pain of her experience as exposing an 'inner weakness' – and thus her distress feels as though it is her fault, while the traumatic event itself was not. The notion of it 'exposing' this weakness also implies that it was there all along, and the disparity between her 'physical resilience' and her 'inner weakness' was painful because it rendered her distress inevitable, and something that she could not control or have autonomy over anymore.

Another way in which the trauma of sexual violence is often conceptualised is in terms of how it impacts people's ability to trust men, as well as their intimate relationships. When I asked how Elaine conceptualised her mental health in relation to sexual violence, she said that it impacted her 'trust, and the recurrent depressive disorder'. In relation to trust, she said that she had 'never been able to have a proper physical relationship because of that one attack' and that she had 'never been able to trust men' in relationships. The fact that this had such an 'overwhelming effect' and 'devastating impact' on Elaine's life made her feel, in her words, inadequate:

> part of me feels inadequate that one thing, which you know didn't, didn't really, you know, injure me physically, you know, has had, you know, such a lasting impact, I feel, that makes me inadequate

Her enduring (and permanent) inability to return to a state of trusting men, along with the 'recurrent depressive disorder' made her feel like a failure in several distinct ways. Here this is also partly due to a failure to comply with the expectations and ideals of heteronormative relationships. In feeling unable to do this she felt 'inadequate', especially because she no longer had somatic symptoms (or injuries) to show for it. This is also notable insofar as it reflects a "failure to recover". Notions of recovering from trauma are often expressed as a 'return to safety' (Spurgas 2021), and an ongoing concern with

sexual safety may be considered indicative of an "adjustment disorder", a "maladaptive" response to sexual violence (Stefan 1994). In this sense, Elaine's enduring hesitance around trust and intimacy is also experienced as a "failure to recover".

The somatic language therefore had somewhat paradoxical effects, for Elaine initially found somatic language useful for emphasising the transient nature of her experience rather than its permanence, in her knowledge that both the headache and the depression would recede. Alice 1 was one of the youngest participants, and had experienced abuse and violence more recently than Elaine, and she similarly valued her understanding of symptoms for their promise of relief. While she also cited her 'long-term issues from now on', she felt as though she was negotiating her health towards "recovery", rather than being permanently 'scar[red]', and found the language of psychological symptoms useful within this. She said that

> I'm, I'm not as anxious as I used to be and not as depressed as I used to be. Yeah, just a lot of the symptoms that I do have even though they are still quite severe they're just I guess less severe [laughs]. I mean that gives me hope because for a long time it again felt like I… I remember like when I first realised I had PTSD I was like how am I ever going to get better, I don't know I just, because it just, yeah, so it's given me some hope that I know that I can get better, so. Yeah, it makes me feel positive knowing that, even though it's just long

For Alice 1, there is a hope that she can 'get better', and her symptoms 'less severe', even if it is 'long'. The language of a 'scar' was earlier useful for Alice 1 to recognise and validate her own experiences of "what happened", but the language of symptoms and PTSD enabled her to articulate a sense of future hope and recovery. Contrastingly, Elaine's descriptions do not allude to the future at all; perhaps as she felt that she identified as a 'patient'. Alice 1's articulations of discrete medicalised outcomes ('anxious', 'depressed', 'PTSD') enable her to conceptualise her future in terms of prospects of recovery and cure; these outcomes are available for intervention, and thus made concrete. Despite this optimism, there was still a sense in which this language still implied permanence for Alice 1. Earlier she described it as 'in [her] brain', and reflecting of her life experience with PTSD to date, she said that 'in my memory it's something I've always had to some extent'.

Again, this is because Alice 1 identified strongly with the category of PTSD, as it carried explanatory power about who she was: 'in my memory it's something I've always had to some extent'. This highlights a "double-edged" feature of the somatic language, for while both here and in the legal materials, it enabled people to garner legitimacy and even useful interventions, it can lead to an enduring sense of inevitability of this damage: for Alice 1 she has always 'had' PTSD, while for Elaine, the violence 'exposed' her 'inner weakness'.

H. Victim or Patient

Negotiating the implied permanence of this somatic language was transparently uncomfortable and painful, and like Alice 1, participants favoured negotiating ongoing 'long-term issues' with their mental health over identifying with labels such as "victim" or "survivor". This was partly to do with fears about telling people, as above, and partly because the permanence of psychiatric categories provided them with tools with which to negotiate their lives and ongoing safety, rather than feeling the permanence of the violence itself. For example, Alice 2 talked extensively about getting 'beyond' the categories of victim and survivor; she said 'I am beyond the abuse now' and 'I'm not that person now'. She sought to leave the violence, and the associated speaking positions of victim and survivor, in the past. In contrast, she was talking about walking her dog on the beach the week before we spoke, and how she just kept 'scanning it to see if there's any potential danger'. Of this, she said that 'I think that that is PTSD because I don't think that's a normal reaction, so I don't think I'm ever going to get beyond that'. She said that she 'thought [she] was cured of it' but that it had since 'flared up again recently', so 'it's just always going to be there'. She connected this to her aforementioned comment about 'how the brain rewires after trauma', and how she processes things differently, meaning: pathologically. While here the violence Alice 2 experienced is firmly placed in the past, the continuing presence of PTSD is both explanatory, and it also gives her a sense of control over 'any potential danger' in the future. This is also strongly suggestive of the typical traumatic narrative, and how your "body keeps the score" (van der Kolk 2014), which enables protection from future violence.

Elaine similarly preferred to engage with her experiences when conceptualised in somatic and psy terms, rather than in relation to sexual violence. I asked if she had ever looked at sexual violence resources, to which she answered 'no'. She elaborated that

> I've always felt that to dwell on it won't help […] or to read about sexual violence won't help me, um, I don't really want, you know, to read something which will lead to me reliving, you know, that traumatic experience [….] I try to distance myself from it as much as I can

Elaine sought to 'distance [herself]' from the experience of sexual violence, perhaps in part because of the affective permanence of the damage that she experienced. Instead, she found unlikely relief in an autobiography of an American psychologist who identifies with the category of bipolar – Kay Redfield Jamison's *An Unquiet Mind;* I say "unlikely" because Elaine did not identify with the category. Elaine says

> Um, and it was about her experiences of bipolar disorder, now I'm not, I don't have bipolar, I've never been diagnosed with it et cetera, et cetera, but she describes, in her… this kind of biography, how when the lithium dose wasn't quite right it would really, make, you know, it would, it meant thinking was very hard for her, and that kind of resonated with my experience of not being able to think because of the wretched headache. Um, and so, and I was reading, I read that as I was, the headache was beginning to dissipate, I think that was in the October, and it really helped me to, to come out of the headache, you know, just feeling that, you know, I could empathise with someone else's experience.

Elaine found that this account 'resonated' with her inability to think, regardless of the fact that she does not identify with the same psychiatric category, and had not taken lithium. While there is recognition within sexual violence literature of its embodied and somatic effects, Elaine found more solace in information in literature on lived experience of psychiatric categories than in potential sexual violence resources. This seemed partly because she could not 'undo' the sexual violence, but could find comfort in knowing that the headache would 'dissipate' and her depression would 'recede' with it: recovery is a future prospect. Conceptualising her distress in relation to the headache, and

‘distanc[ing] herself’ from the ‘traumatic experience’ as much as possible, allowed Elaine to conceive of the distress as temporary and treatable – even if that conception was temporary itself.

For Alice 1, while her diagnosis showed her proof of ‘how bad’ her experience of sexual violence was, this was not straightforward, and represented internal struggles with the severity, pathology, and legitimacy of her experience. She said that ‘I wasn’t like punched in the face, you know?’ In elaborating on the utility of her diagnosis she said

> You know, so that kind of helps to make you realise, yeah, how bad it is, how serious it is, even though you kind of, I still, I think there’s just a desire in me to wish that it wasn’t that serious?
>
> Sometimes I’m still like not realising how bad that is, I think it’s still, yeah… processing like how bad that is when you… I think in my mind I just don’t want it, I just wish it wasn’t that bad, wish like ah, okay I was just touched like that, I wish it didn’t affect me, I wish I didn’t have PTSD, I wish I could just move on from it. You know? I don’t know. It’s just a frustrating thing. Sometimes in my mind I just wish it wasn’t that bad, and I could just… but, the fact that I have PTSD, it shows how bad that is, what’s happened to me

This is an uncomfortable embodied experience for Alice because the PTSD remains a site of proof of ‘what’s happened to [her]’, but she wished things it ‘wasn’t that serious’. She said ‘I was *just* touched like that’ (emphasis mine), which is here represented as less serious than being ‘punched’. This feature of the discursive construction represents an equivalence between the traumatic event and its aftermath for Alice 1: accepting the abnormality, and at times permanence, of her diagnosis meant accepting the abnormality of the violence, which was complicated and painful.

I. Recovery and Safety

However, participants’ ongoing identification with psychiatric diagnoses were valuable in their utility for negotiating sexual safety. An “adjustment disorder” is conceptualised

as a "maladaptive" response to sexual violence on account of maintaining an ongoing fear of violence, as this fear is seen as having an abnormal preoccupation with the risk of sexual violence, and failure to "readjust" to normal life (Stefan 1994). An adjustment disorder is defined by the World Health Organisation as a 'maladaptive response' to a stressful life event (World Health Organization 2022, F43). Women's fears of a ubiquitous form of violence are here represented as pathological reactions to be overcome, in order to return to healthy heterosex. Yet several participants disrupted this idea, as they instead valued aspects of the categories they identified with for helping them to have a better awareness of ongoing (un)safety. In contrast to Elaine, who felt as though she had failed to recover a sense of trust and safety around men, several participants were thankful for this newfound awareness of how to negotiate their safety.

The three women who spoke most extensively to this were Ellen, Beverley, and Sarah, which was perhaps related to feeling a general sense of precarity or unsafety. Ellen and Beverley both talked about being in financial precarity, and Sarah and Beverley both talked about their responsibilities as mothers to protect their children from potential danger. Ellen was grateful that 'there's just this added layer now of self-protection which I'm very thankful for'. Beverley described the effect of sexual violence in relationship to trust: 'tell you what it left me, it left me always doubting men's true morals', but this was considered valuable, and something that she was 'good at'. She went on to talk about this in relation to her experience of Bipolar, and how it afforded her with adaptive skills in relation to sexual violence. When I asked whether she would have liked to talk about the violence at the time, she said 'I think so', and specifically related this to the consequences it has had on her relationships. She said

> I really don't let men get too close to me, emotionally, d'you get it… And I'm, I'm quite alright with that. I'm quite… I don't know if that's a part of Bipolar as well, I don't know I'm quite alright for them just to see *a* side of me, and not all sides of me, and to know all parts of me. Um. Because there's many parts. When you're Bipolar you, you can play many parts, there are many different parts to your pers… not personality, it's like, you, you can be a very good actress, you know, you can show people just what they want to see, in a way. It's got nothing to do with what you're feeling you can present a very good façade. And I think over the years I've got quite good at that.

Beverley started her answer to this question with 'I think so', and ended with 'Maybe. Maybe it would. I don't know'. While she starts off talking about how it could have changed her relationship to men, she ends up convincing herself that this new orientation to men in intimate relationships is valuable: 'I'm quite alright with that', 'I've got quite good at that'. This feature of Beverley's life and experience is helpful for negotiating her safety: dividing her sense of self into 'sides' or 'parts' is protective and useful. In contrast to psychiatric definitions that define a newfound fear of rape as aberrational and a failure to recover (Stefan 1994), here it is particularly valuable. It is important here that she distinguishes playing 'many parts' from her 'personality', as again, this demonstrates a refusal to be defined by her Bipolar or for it to be located as some internal reality, but rather a feature of how she negotiates the world.

While Beverley found this aspect of her diagnosis helpful, she expressed difficulties with her 'hypermania', particularly in relation to its associated 'hypersexuality'. She said that when in these phases of her life she would do a lot of online dating and casual sex, and now looking 'back […] Especially what I've been through, I could be, you know, getting in a car with some rapist'. While 'hypersexuality' was therefore helpful to understanding her behaviour, it made her feel as though she had not effectively managed her risk of violence during periods of hypermania. This reflects the societal conception, and the finding in chapter 4, that certain bodyminds "invite" abuse (Gotell 2008b; Bourke 2012). Beverley also elaborated on this being an ordinary and daily aspect of negotiating her life, rather than an aberration. In talking about how society needs to discuss sexual violence a lot more, she said 'as a woman I think you tend to just… it's not accepted but it's just like… I don't know it's, it's… I don't know it's a weird thing it's there for every woman'. She described sexual violence as a 'secret hidden thing', which was exactly her experience of it. Further, the description of it being 'accepted' and 'there for every woman', which as a consequence means that you 'can't go certain places' expresses Beverley's frustration that she is responsible for navigating her own risk of violence.

Like Elaine, Sarah was also active in mental health research and practice, and her particular passion was for changing perceptions of self-harm using her lived experience. Sarah's experience of sexual violence was at times enmeshed with professional trauma

discourses, and at times disruptive to them. Like Elaine, she discussed the impact of the event on her ability to trust and be intimate with men. When lamenting the loss of her husband who had since left her, she said ‘it had a massive impact on our sex life, in all areas of our life’, and elaborated ‘the anxiety that I sometimes, well often feel, around men, about whether you can trust them’. However, this anxiety was helpful to Sarah for how she understood and managed her distress in relation to safety. When elaborating on how her anxiety diagnosis was validating in the wake of sexual violence, and her newfound experience of dating, she said

> there’s somebody who wants to meet me for coffee, just to see how we get on, and we’re getting on really well online, and my friend Jane, who I went out with this morning, we’ve already said about that I’ll be texting when I… I’m meeting him in a kind of like public café, about how I’ll be texting to say that I’m safe when I’m leaving et cetera, and that’s all around the anxieties that I have. Um… I haven’t been explicit to Jane about what happened when I was 20, because it was a long time ago, and I do feel that largely I’ve moved on, but certain things mean that I have to ensure that I can ensure my safety as much as possible, and this is one of them, meeting… he’s called [name], um, because it, maybe it’s because I’m more aware of safety because of what happened to me, maybe it’s because I’m more mature

The utility of her ongoing identification with the category of ‘anxiety’ is useful for Sarah to ‘ensure [her] safety’, and her experience of sexual violence alerted her to this state of (un)safety. She refers to herself as ‘naïve’ before the assault, and ‘more aware of safety’ here.

Conclusion

This chapter has examined how participants characterised their experiences at the nexus of sexual violence and mental health. Identifying with psychiatric diagnoses here both enables the garnering of legitimacy through somatic language, as well as valuable interventions, while additionally complicating the narrative demands of sexual violence testimony: sick, but not too sick. These echo findings of research with people who have

experienced domestic and sexual violence (Marecek 1999; Brison 2002; Sweet 2021). As discussed in part 1, those diagnoses considered "normal" and legitimate responses to sexual violence included PTSD, depression, and anxiety.

In part 2, there were diverse ways in which participants understood and articulated their experiences. The discursive construction of participants' experiences as pathological and legitimate was valued by participants for rendering their experience knowable, largely through the use of somatic and physically instantiated language (sections 2A and 2B). This language also rendered their experience visible or permanent, which led to difficulties (sections 2C and 2G). For example, given the 'invisible debilitation' (Alice 2) of psychiatric categories, the imperative to "speak out" about sexual violence came with further demands to externalise and prove what happened (section 2H). Participants articulated experiences that exceed and disrupt both the hybrid psy-feminist and legal understandings of "trauma" identified in chapters 3 and 4, as well as wider cultural understandings of sexual violence and psychiatric diagnoses. Rather than conceptualising "recovery" as a feeling of a 'return to safety' (Spurgas 2021, 12), several participants valued aspects of their ongoing identification with psychiatric categories for helping them to negotiate an enduring sense of (un)safety (section 2I). Participants also found ways to negotiate their distress as fluid and recurrent, rather than a single and ultimate "breakdown", and at times even forgot the violence, rather than walking the double-edge of narrating it (sections 2D and 2E).

Further, this chapter has established important differences in how participants identified, as well as how they were perceived, which additionally complicates this landscape. In relation to how people identified with psychiatric diagnoses, some were able to negotiate their distress strategically, by "poaching" and negotiating psychiatric knowledge without necessarily subordinating themselves to it. Alice 2 even reconfigured the category of PTSD to make it socially instantiated, refusing to be the designated problem. However, others felt that their diagnoses were part of their long-term identity as a 'patient' (Elaine), which led to feeling an enduring and permanent damage; a failure to "recover". All of the participants who were afforded access to trauma diagnoses and associated treatment (EMDR) were additionally white women, while the two black women (Maya and Beverley) both struggled for legitimacy and a receptive audience in

therapeutic settings, and instead either wanted, or tried, to “forget”. It is the reception of these testimonies to which I now turn in the next chapter, to both characterise the testimonial environment in which participants were operating, the harms it caused, and to trace the various ways in which this was then negotiated.

6. From Sexual Violence Testimony to Testimonial Injustice

Introduction

In this chapter, I first distinguish the aims here from the previous chapter, before summarising the shape of this chapter and the utility of Miranda Fricker's concept of "testimonial injustice" for its purposes. After summarising the utility of Fricker's work, I will put the concept of testimonial injustice to task to explain the particular and unique harm of the silencing that participants experienced. In part 1, I first present the utility of Fricker's work in full, before providing some examples of how prejudicial stereotypes about psychiatric diagnoses intersected with conceptions of femininity, race, and class, to produce these distinctive silencing effects in section 1A. Then, in sections 1A and 1B, I use Fricker's theorising to show how institutions participate in testimonial injustice: whether as individual institutional agents, or in more diffuse structural ways, as in Harib's description of a generalised culture of homophobia at his school. Throughout this discussion I weave in examples of what Fricker terms the "practical" harms of testimonial injustice: its knock-on effects as to whether individuals could access support, justice, and even the financial repercussions. In part 2 of this chapter, I move to explicating the particularly epistemic and painful harms of testimonial injustice. Here I summarise Fricker's contention about how testimonial injustice has the capacity to distort individuals' reality and their very personhood. In section 2A, I provide some examples of this harm, and the pain and distress that it caused. Finally, before concluding, I discuss in section 2B how different participants responded to their experience of the dwindling prospect of accountability, which was particularly marked by race. Before concluding, I provide a tentative example of how the nexus of sexual violence and mental health might be usefully reconceptualised in collective and relational terms, rather than individual pathology. This chapter reveals the individually specific ways in which participants encountered silencing, and the particular and unique harms and injustice this incurs. It is the aim of this chapter to demonstrate that the injustice of prejudicial ideas about sexual violence and mental health extends beyond the courtroom.

In the previous chapter, my focus was on how experiences of trauma, psychiatric diagnoses, and sexual violence were discursively constructed by participants, and some of the ways in which this impacted their embodied experiences in negotiating legitimacy and distress. Here, I extend this analysis to examine the specific processes by which participants' testimony was rendered "non-credible". I trace how participants negotiated embodied experiences of speaking about sexual violence, and the specific ways in which they encountered disbelief. To do this, I introduce Miranda Fricker's notion of "testimonial injustice" (Fricker 2007), which highlights how prejudicial identity stereotypes can be mobilised along power relations to silence or event distort individuals' testimony. This chapter builds on other sexual violence scholarship which addresses the conditions under which sexual violence testimony is dismissed (Serisier 2018; Powell, Hlavka, and Mulla 2017; Alcoff and Gray 1993), although my intervention is specifically addressed to how identification with psychiatric diagnoses complicates this discursive landscape.

Fricker's work carries three key insights here. First, she demonstrates that testimonial injustice can become "systematic" when it carries further injustices as it tracks a subject through their embodied experiences: limiting individuals' access to legal redress or healthcare, for example. In this sense, the concept of testimonial injustice illuminates some more of the phenomenological aspects of participants' experiences: how they are oriented through space in relation to stereotypes and norms, and how they consequently orient their testimony. Second, in her Foucault-informed theorising of active and passive forms of power, she shows how prejudicial identity stereotypes can function to discredit people in *actual* or *potential* terms – their silencing effect does not even necessarily have to be explicit for it to work. Institutions such as the law have an important part to play in representing and reproducing these stereotypes, as seen in chapter four. Finally, Fricker notes that a unique harm caused by testimonial injustice occurs when prejudicial identity stereotypes *distort* subject formation, in how they constitute, or cause, subjects.

1. Testimonial injustice

Fricker introduces her conceptualisation of "testimonial injustice" using the compelling example of Tom Robinson, a character in the book, *To Kill a Mockingbird.* Robinson is a

young black man charged with raping a white girl called Mayella Ewell. Fricker suggests that it is obvious to the reader that Robinson is innocent, and yet at his trial, there is a 'straightforward struggle between the power of evidence and the power of racial prejudice' (Fricker 2007, 23), with the latter eventually winning out in the judgment of the all-white jury. As the power of mental health "evidence" versus mental health "prejudice" is a central concern of this project, Fricker's work carries a useful framing for these concerns. Tom Robinson becomes a fairly central case in Fricker's discussion, as the racial prejudice operating in the trial incurs additional injustices – Robinson is convicted, but then also ultimately killed, supposedly for trying to escape the prison (Fricker 2007, 26).

Fricker uses this case to build her central argument and conceptualisation of "testimonial injustice", which is when a prejudice on the part of the listener causes them to accord a speaker with diminished credibility. She suggests three key features of the kind of "testimonial injustice" that Tom Robinson experienced. These are that it occurs along dynamics of power and control; uses identity-based stereotypes to diminish credibility; and that this has a special and unique harm in undermining a person's reality. Fricker fleshes out several other components to her theory of relevance here. She argues that a unique and systematic "injustice" occurs when testimonial injustice produces further injustices according to prejudicial stereotypes, such as limiting a person's access to criminal justice, or healthcare. Again, Robinson is illustrative here, as the testimonial injustice he experienced denied him both practical "justice", and eventually, his life. Powell, Hlavka and Mulla have demonstrated how prejudicial stereotypes about race and gender were mobilised in the courtroom against children who had experienced sexual assault in the US, thus limiting their access to "justice" in the traditional sense (Powell, Hlavka, and Mulla 2017). Given my examination of how participants negotiated their embodied experience of speaking about sexual violence in different contexts, Fricker's attention to how testimonial injustice can limit a person's testimony in legal or medical settings is also important.

Further, Fricker notes that for these prejudicial stereotypes to have a silencing effect, they need currency in the popular imaginary, and the very existence of stereotypes can even have silencing effects without being explicit. People who have experienced sexual

violence and psychiatric labelling operate under popular stereotypes about constructed social identities (McKenzie-Mohr and Lafrance 2011; Fricker 2007; Gavey and Schmidt 2011), and these stereotypes have the power to inhibit speech before it is even actualised. Fricker attributes this to a distinction between "active" and "passive" power, which it useful to briefly explain. Fricker theorises power as a capacity that persists even when it is not being realised, which is akin to Foucault's articulation of power as diffuse and 'net-like' (Fricker 2007, 10): people can act as if under surveillance, even when they are not (Foucault 1977, 195–231). She suggests that 'identity power is active or passive, it depends very directly on imaginative social co-ordination: both parties must share in the relevant collective conceptions [...] where such conceptions amount to stereotypes' (Fricker 2007, 15).

A shared awareness of a stereotype on the part of the speaker and the hearer is sufficient to silence, and perhaps this can be clarified with reference to one of my participants, as Elaine actually used the term 'testimonial injustice' in the first initial assessment that I conducted. The session was not recorded, but afterwards I noted that she had described how people are afraid to disclose, or disregarded when they do, because they are considered innately unreliable. Fricker's work on this concept illuminates a particular feature of the silencing my participants encountered, which is identifiable in Elaine's description (as it was relayed by me at the time). In Elaine's distinction between people who are afraid to disclose, and those who are disregarded when they do, she exposes silencing processes that have either "active" or "passive" power: they are either "disregarded" or "afraid to disclose" in the first place. The operations of power do not have to be actively enforced or even explicit to achieve their silencing effect (Fricker 2007, 15). Fricker's work then shows that prejudicial stereotypes about certain identities, whether explicit or not, can set certain speakers up as non-credible; and these stereotypes follow people through their decisions to speak about sexual violence in different institutional spaces through diffuse operations of power. I will now explicate several examples of how participants felt set up to be "non-credible" through prejudicial identity categories, before elaborating some of the dynamics through which these operate according to Fricker's conception of "testimonial injustice".

A. *Stereotypes and Testimonial Injustice: 'Nutcase', 'pervert', 'black woman'*

Participants discussed the ways in which they were set up to be irrational or non-credible, which included either active or passive interactions with prejudicial identity categories including being mad ('nutcase'), gay (a 'pervert'), and a 'black woman'. For example, Ellen was drugged and assaulted by a stranger in her local pub. She decided to disclose her experience of sexual violence to her employers, in part to explain her inability to go back to work. At the time, she was working for a small cancer support charity. When Ellen had applied for this job, she had been open about what she termed her 'lived experience' of various physical and mental health conditions, particularly because she believed this added value to her work. However, when she told them about the sexual violence, she said that

> I really felt like they didn't believe me. I really, and I've, that's the only time in my life that I've ever just… you know, just, this, compl… it just felt, and I am very intuitive, I walk into a room and I feel stuff, and I just felt like I wasn't believed, and I do believe that that is partly because I'd been so honest about my own sort of challenges with my mental and physical health

Here Ellen says that she 'wasn't believed' which is partly attributed to her honesty about 'challenges with [her] mental and physical health'. Ellen felt as though she was here perceived as either irrational or non-credible on account of her diagnoses. In Fricker's work on testimonial injustice, she notes how stereotypes do not have to be accepted as 'true' for their impact on credibility to be effective (Fricker 2007, 15). Ellen saw her 'lived experience' of mental health challenges as an asset to her work, rather than having a diminishing effect on credibility. On account of the 'imaginative social co-ordination' (Fricker 2007, 15) involved in this interaction, Ellen really 'felt' the disbelief on behalf of her colleagues, which is here an example of the 'active' power of testimonial injustice.

The testimonial injustice Ellen experienced here also impacted her access to other discursive spaces, on account of how she felt her testimony could *potentially* be received. In the same passage, she goes on to talk about how she could be seen and her consequent ability to testify to sexual violence. Given that her experience of violence also occurred in

a pub in her local community, she was reticent to involve anyone she knew in a criminal investigation. She said that she 'didn't want my local community being involved in a rape investigation where I was already in the process of being the resident, sort of, whatever, well I was going to say nutcase'. Here she is expressing how she is positioned by her community ('resident [...] nutcase'), a perception which sets her up as irrational and mad, before she could even decide to speak about sexual violence, or at least seek criminal justice reparations. She talked about how the notion of "speaking out" was 'too mammoth' for her. She went on to lament 'the judgment upon those of us who are, who talk about what's happened to us, especially when you have a diagnosis of, you know, mental ill health'. Ellen's experience of the potential reception of her story, coming from the 'resident [...] nutcase', prevented her from talking about sexual violence, and here even being able to access criminal justice, due to her awareness of how her testimony could be received and scrutinised, as well the actual disbelief she encountered. It is notable here that Ellen had received psychiatric diagnoses before her assault, and that members of her community were aware of this: she knew that she was known as the 'resident [...] nutcase'.

Maya similarly felt that she was unable to access criminal justice because of her positioning, or (in her words) 'social power', as a 'black woman'. Maya discussed the criminal justice system as inaccessible to her on account of its perception of black people being inherently perceived as offenders, in contrast to the social positioning of her assailant. She said that

> I was assaulted by a white male, who like in most situations will have more social power than me, or like social capital, is it... whatever you call it. So like, and I'm a black woman. Black people are always assumed to like be committing the crime, not being the victim, like subconsciously, so like the justice system wasn't made for someone like me to get justice, like relative justice, from someone like him

She felt it impossible that she, as 'a black woman', could be perceived as a 'victim', and instead more likely that she would be perceived as 'committing the crime' due to 'subconscious' prejudicial ideas about 'black people' in general. Here she is expressing the power of stereotypes about 'black people', particularly in terms of how they are

perpetuated by the power of institutions such as the 'justice' system. Legal processes often resort to stereotypes to discredit people, especially black people, in relation to sexual violence (Ellison 2009; Powell, Hlavka, and Mulla 2017; Smith 2018). In Fricker's discussion of Robinson in the courtroom, his testimony is 'so distorted by prejudicial racial stereotype that they cannot, in that courtroom context, perceive Tom Robinson as anything but a lying Negro' (Fricker 2007, 36). This illustrates general racial prejudices in the eyes of the law, and intersects with extensive writing from critical race theorists on how black people are received in legal contexts, specifically in relation to sexual violence (Davis 1981; Davis [1981] 2019; Crenshaw 1989; 1990; 1992).

In Maya's case, the enduring power and circulation of these prejudicial ideas about her being 'black', 'aggressive' and hence potentially an "offender", was sufficient to limit the legitimacy of her testimony. This demonstrates the far-reaching testimonial effects of the power of legal prejudices, as it incurred specific practical harms for Maya. The harm of mobilising such stereotypes becomes 'systematic' according to Fricker when it follows subjects through their embodied experiences of institutional spaces – legal, educational, medical – such that it produces further injustices (Fricker 2007, 27). It is not just that Maya and Ellen experience testimonial injustice in the sense that they are set up as having diminished credibility on account of prejudicial ideas about 'black people' (Maya) or 'mental-ill health' (Ellen), but they experience additional and broader injustices in being deprived of access to discursive space in legal settings. For Maya, this leaves her without recourse to the position of "victim", as underlying assumptions about race serve to produce a testimonial environment in which she feels she is more recognisable as an "offender".

While Maya felt potentially recast as the "offender" within legal circles, Harib felt that if he spoke about his experiences of sexual violence, then he would be perceived as a 'pervert'. Harib identified as gay, and his experiences of sexual violence had all been perpetrated by men. Harib had not spoken about his experiences of sexual violence, and nor was the silencing he experienced explicit, but was instead discussed in relation to prejudicial ideas about homosexuality that were circulating at the time. Harib described three instances of sexual assault; two when he was younger, and one as an adult. He talked about the prospect of being designated as non-credible chiefly in an educational

context. This was discussed in relation to an assault that occurred at school when he was a teenager. Although I focus on experiences of violence adulthood in this study, and his age at the time of this event was unclear, it remains instructive here as an example of how Harib still felt that he would be perceived today. He talked about the impossibility of speaking about sexual violence when he said that

> it's like a double-edged sword, because it was like if I go and tell someone I'm still not going to get believed, and if someone sees it he's still going to be like you've done this rather than it's been done to you

> this is the worst part of being gay, if somebody would have walked in, he would easily be able to make a big drama, and say, look he's a puff, he's a pervert, he just tried to touch my parts, and I had no leg to stand on

The 'double-edged sword' of sexual violence here demonstrates how Harib felt that his testimony could recast him as the offending party: 'you've done this rather than it's been done to you'. Further, Harib felt that even if someone had witnessed his assault, this would still be the case: 'if someone sees it', 'if someone would have walked in [...] I had no leg to stand on'. Although in the first passage Harib is clearly discussing a historical incident, there is an enduring resonance for Harib: 'this is the worst part of being gay'. Harib felt that his inability to obtain legitimacy was attributed to his sexuality being perceived as a 'pervert'. On account of his assailant being perceived as "heterosexual", and him as 'a puff', he felt that this left him no recourse to talking about sexual violence, as he would always be recast as the offender, rather than the victim. This speaks to wider constructions of masculinity and sexuality, such that men are perceived as perpetually receptive to sexual contact (Javaid 2015). Yet it is also speaks to notions of certain bodyminds "inviting" abuse on account of sexual, or just feminised, stereotypes (Gotell 2008b; Bourke 2012). There is an enduring power in prejudicial identity stereotypes to potentially reverse the victim offender relationship, and to obstruct individuals' access to an audience with whom to speak about sexual violence.

Further, both Harib and Ellen felt as though they had been targeted by assailants *because* of these restrictions on their testimony, thus assuring their silence. Ellen felt she was

‘more likely […] to be a victim’ and deliberately targeted on account of her “madness”, as her assailants were armed with ‘knowledge of my mental fragility shall we say, emotional fragility’. Harib similarly felt that he was targeted as an adult on account of his assailant’s assumption that he could not be out as gay, on account of being ‘Asian and Pakistani’. When he was 20/21, he met an Iranian ‘chap’ on a bus; they chatted, and Harib mentioned that he was gay. The man then invited him back to his home, where he tried to sexually assault him, although Harib managed to escape. Harib felt as though he had been deliberately targeted on account of assumptions his assailant made about his sexuality in relation to his community. He said that he must have ‘noticed I'm Asian and Pakistani, he probably thought I'm not out to anyone, so he probably thought even if he had raped me I'm not going to go out there and tell anyone’. He said that

> I had put myself in a vulnerable position, because he comes from a culture where it's against the law to be gay, so he's probably used to coming from a country where he's abused young gay boys or gay men, and they've not said anything because it's against the law, and secondly, they’re scared that they’re going to be outed

Harib is transparently making several assumptions of his own here about his assailant, as he suggests that his assailant had previously targeted ‘boys’ and ‘men’ who were afraid of being ‘outed’ in countries where homosexuality was illegal, and extends this to his own ‘vulnerable position’. However, there is a sense in which his assessment of the posited silencing effect had become self-fulfilling, as his feeling that the assailant thought that he wouldn’t be ‘going to go out there and tell anyone’ became eventually true, which was at least partly connected to the cited ‘double-edged sword’. Sexual violence here coalesces with social and structural inequalities to produce some bodyminds as inherently less credible, or experienced as such, and therefore more desirable as targets. For Ellen this was explicitly connected to being perceived as “mad”, while for Harib, he expressed complex cultures of oppression that inevitably rendered his sexuality as “deviant” and his testimony void.

B. Institutions: Self-Protective

The potency of identity stereotypes is compounded by the processes of power relations that elevate one account over another, particularly as they can operate in diffuse ways within institutions, rather than necessarily through individual actors. Even where there was no particular agent exercising this power, Harib felt excluded from the very possibility of speaking about his experiences of sexual violence, and in Fricker's words, his 'exclusion marks an operation of social power' (Fricker 2007, 10). Prejudicial identity categories interacted with institutional cultures, and power relations, to dictate how certain people's testimony will be received. In Harib's discussion of the impossibility of speaking about sexual violence, he attributed this to the cultural and institutional context in which he was operating. Harib grew up under the legislative framework of section 28 of the Local Government Act (*Local Government Act* 1988), which outlawed discussions of queerness in schools until 2003 in England and Wales. He said that 'I grew up in the early 90s late 80s, where homophobia was very visible'; when I suggested that 'section 28' must have been explicitly challenging, he agreed, saying that 'I grew up at a time when it wasn't safe to be out, or it was very difficult to be out'. He specifically connected this oppression to institutional cultures that contributed to the silencing of queer people, and active encouragement of homophobia, when he said of this time that

> teachers and people in powerful positions did not discourage homophobia, if anything they encouraged it, either by staying silent, or actually agreeing with the homophobic person

This culture of 'silen[ce]', and even the 'encourage[ment]' of homophobia by institutions contributed to an oppressive environment for Harib, but it additionally and specifically affected his ability to talk about sexual violence. When I asked whether he was reticent to talk about sexual violence on account of his mental health diagnoses, he said that instead, 'I didn't talk about it because, remember it happened at the time when LGBT was not something easy to be out about, and you had to pretend you were heterosexual'. The impossibility of talking about sexual violence is here connected to visible homophobia and heteronormativity. Cultural norms are powerful in their ability to encourage people to assimilate into the dominant social order (Muñoz 1999), here, to heteronormativity, as Harib felt he had to 'act straight'; he said of this time that 'you had to pretend you were heterosexual'. The complicity of schools in contributing to this environment, and the role

of ‘teachers’, contributed to Harib’s sense that disclosing the sexual violence that was happening to him at school was impossible. This marks a diffuse operation of social power, for the silencing was not necessarily perpetrated by a particular agent, but socially disseminated (Fricker 2007, 10). Harib also cites the wider implications of this environment, and the processes of power relations which elevate one account over another. Where homophobia is actively encouraged, and ‘pretend’ heterosexuality compulsory, Harib’s experience was impossible to visibilise, and homophobic violence was then both permissible and actually evident in the section 28 legislation.

Participants additionally described experiences in which institutional agents were complicit in testimonial injustice. They were evasive of accountability, which compounded individuals’ injustices; this reveals the practical harms of testimonial injustice, which bar individuals from resources such as criminal justice (Fricker 2007, 46). For example, Elaine was reticent to disclose sexual violence because ‘people can frame things as they choose to’. She eventually reported her assailant to the police as her assailant continued to harass her when she was out cycling. She said that they did not reference her mental health, but she had ‘mentioned’ her depression in ‘the context of things’. Whether or not they referenced her mental health, their reception of her story undermined her capacity as a knower (Fricker 2007, 49). When I asked Elaine what she meant by ‘testimonial injustice’ in our interview, she said that

> I felt when I went to the police they didn’t quite take me seriously. Um, they have a phrase, ‘I’m not disbelieving you’, they say, [laughs], they don’t, you know, they don’t say outright ‘we don’t believe you’, they say ‘we’re not disbelieving you’ and you’re thinking ‘hmm you don’t believe me do you’, er so, I found that very dismissive, um, you know, I felt, they felt… I felt they felt I was wasting their time because I was reporting something to them which they couldn’t do anything with, um, and so yeah. Um, that felt like testimonial injustice yeah.

Although Elaine ‘wasn’t surprised’ by this response from the police, due to ‘reading things in papers’, it had several important consequences. The shift from police saying ‘we don’t believe you’ to ‘we’re not disbelieving you’ is significant. A statement of non-disbelief resonates in the contemporary context where emphasis is placed on technical compliance

with protocols around the treatment of sexual violence cases. As such, it is institutionally self-protective. They did not actively 'disbelieve' her, and could document the case as such, but the effect of their response for Elaine is specifically that she does not feel believed ('you don't believe me'), and nor does her testimony then carry any practical impetus – 'they couldn't do anything'. They do not necessarily participate in the 'disbelief', but the effect is that her testimony is treated with a diminished credibility, and hence additional practical injustices.

Another example of institutions functioning in self-protective ways, was in Megan's experience of psychiatric records as a site for authoring an alternative account. When Megan was assaulted by the mental health practitioner on the ward, he faced no professional repercussions, even after she had met other people whom he had assaulted as well. After he assaulted her on the second occasion, Megan encountered a nurse who asked her to tell him everything that happened. In recounting this episode she said to the nurse: 'please someone help me this is what happened to me exactly and I feel I am in danger, because the guy hasn't been dismissed, nobody has listened to me, um, you know, I have a witness'. He documented her story, and asked her to sign it, before he encouraged her to call the police. Megan's explicit feeling of being 'in danger', and her gratitude at someone finally 'listen[ing]', was clear. Nothing came of the police investigation, and her assailant continued to work on the ward while Megan was on it. She left the ward and had to return a year later, when she was assured by a senior member of staff that her assailant had been moved to a different ward: notably, not terminated. While her experiences had been acknowledged within the context of that encounter and in her earlier interactions with the sympathetic nurse, the institutional response was devoid of meaningful accountability. She voiced her exasperation at this situation, and the structures that produced it

> It's only one side of the story, it's only one side of the story and it's the professional, the mental health staff, and they, they, they help each other, they are friends and they help each other

On account of the power inherent in psychiatric institutions, her assailant and his 'friends' (the institution) were allowed control of the narrative; the 'only […] side of the story' that

was legible. She lamented how 'there's no justice for someone that has no power', and that 'nobody listens to you because they listen to other side of the story, people with wealth, people with reputation'. Megan therefore explicitly discusses the institutional processes and 'power' dynamics which elevate 'one side' over another, particularly on account of her social location: 'no power'.

In addition, Megan notes the enduring effects of these dynamics, as it is not just that the professional story is elevated over hers, but it is the authoritative story in its documentation. Despite the detailed record taken by the nurse of her own account, the story told in her medical records is the one that she describes as being there 'forever'. She had been able to access her psychiatric records since, and said

> my medical records, me mental records, and so the things are… my goodness me, just, it's just the truth is not there. Talk to me, talk to me, or talk to who knows what happens, who was there, you know? No is just one side of the story, is just one […] and if they write it then it's there forever

Mental health professionals have the power to 'write it then it's there forever', and they literally rewrote Megan's 'truth' without 'talk[ing] to [her]'. Megan did not elaborate what this 'truth' was, but the term is potent here, as that is the way in which mental health records are represented in the eyes of the law, as seen in chapter four. British Criminology scholar Natasha Mulvihill has recently analysed a paradigmatic case of doctor abuse to demonstrate the authority of powerful professionals in authoring a self-protective "script" that rewrites the "victim" as non-credible (Mulvihill 2022). Similar sentiments were identified in the review of feminist scholarship described in chapter 3, in which it was suggested that individuals can be "mind-raped" by psychiatric institutions (Daly 1979; Chesler [1972] 2018; Ussher 1991; Armstrong 1994). Psychiatric and legal institutions can protect themselves through documentary practices and paper trails. Ellen also spoke about how in psychiatric records, 'it's there for life'. The power of mental health institutions eradicated Megan's own "truth".

C. Institutions: Distorting the Script

Elaine and Megan's experiences demonstrate that actions conducted by institutional agents can culminate in testimonial injustice, but Megan's experience demonstrates that they can also participate in processes of rewriting, or distorting, the narrative: 'identity power at once constructs and *distorts*' (Fricker 2007, 55). One of the most extensive experiences of institutions becoming involved in the "distorting" of participants' embodied experiences and testimony was articulated by Maya, which is worth explicating at length. The actions of institutional agents at Maya's university colluded with her assailant to produce a different account in which prejudicial and racialised stereotypes about black women were deployed to render her hypersexual, and hence responsible, for the violence she experienced. As quoted in section 2A of chapter 3, this echoes Angela Davis' assertion that white men 'possess an incontestable right of access to black women's bodies' (Davis [1981] 2019, 158).

Maya was assaulted during her first year of university, after being on a night out with a friend. On this particular night she was 'very drunk', and while out they bumped into a group of their 'guy friends'. One of the guys had said he was 'not drunk', as he had too little money for drinks, and he subsequently decided to go home because he didn't want to be around 'everyone being drunk'. He and Maya decided to share a taxi home, and she passed out in the taxi only to arrive at his flat – Maya thought this wasn't necessarily out of the ordinary, as he also lived with the friend that she had been with earlier that night, and they often stayed at each other's flats after a night at the club. She decided to sleep there and ended up taking his bed. Given the disparity in their levels of intoxication, this situation was primed for him to write a different version of events, as Maya had no memory of what happened (Serisier 2018). This was also premeditated, starting that very night. Maya said

> I woke up and he was on the floor so I just assumed that all night he was on my floor, but like some of my clothes were off, and also interestingly, like I found out after, was the girl who we always go out together. She was like calling me and she said someone was like cutting your phone off and like we'd always like… We'd always text each other like, even if like she went home with someone or whatever like, we'd always saying what was going on so I can only assume like he had my phone… And he was like turning my phone off, and then she was texting him like 'Where is she', like and

> he was like oh she's come back to mine, and she was like OK, like, I don't know why she left me but OK

He deliberately tried to rewrite his assault from the beginning into one of consensual sex ('she's come back to mine'), by 'cutting [her] phone off' and preventing her friend from assuring her safety. When she then realised that her phone had died, she asked to borrow his to check the bus times to get home. When she did, he had left a group messaging chat open in which he had been texting friends about having sex with her, calling it 'gross', and her a 'slag'.

Her assailant was the first to use the term "rape", which served to pre-empt Maya's testimony and write a different account: first interpersonally through a peer, and later through the accountability procedures at the university itself. Maya found this out as she later bumped into someone who knew him, who relayed to her: '"Oh you're the girl [name] says has accused him of rape", and I'd like never said that or anything, like I didn't even like know what language to use about this whole event'. In naming it as 'rape' for her, he first designates this as a violent experience for Maya, and then distorts her into a false accuser before she had even put this 'language' to the 'event'. When she found out that he was using this language, this was when she initially went to the university to seek some accountability. She said

> then I went to the uni, and then my uni was like, oh don't go through internal misconduct procedures, call the Police, which I think there's a lot to be said on that, especially given like the whole Sarah Everard thing, and also, telling like a person of colour to go to the Police for a traumatic event, and I was like, yeah that's questionable. It also very much seemed like the uni wanted nothing to do with it.

Both the university and her assailant evade accountability for her experience – he by rewriting it as a (false) accusation of rape, and the agents of the institution by 'want[ing] nothing to do with it', and suggesting that she 'call the Police' instead.

Of this experience she says that 'I just felt like when I was told to go to the Police, like, I was just being pushed in a way that I would never gotten like a like fair outcome anyway,

it was like just don't make it our problem'. In its refusal of accountability (not 'our problem'), the university institution was complicit in the rewriting of the script and compounded Maya's experience of injustice. Sarah Everard was a white woman who was raped and murdered by a policeman in London in 2021; her experience was met with understandable outcry, as well as criticisms about how media representation and public sympathy is more readily afforded to white women (e.g. Dodd and Rawlinson 2021). In referencing Sarah Everard, she notes that the university encouraging her to contact the police was not just avoidant but actively harmful, given the risks for women in general, and in particular for, 'a person of colour to go to the Police for a traumatic event'. Maya was right to be sceptical. She went to the police and found that they were 'compassionate', but that the investigation was not 'thorough', and when nothing came from it 'I literally just felt like I had no option, but to drop out of University', and enrol at a new one. For Maya this also meant that she 'took another like 15,000 pounds of debt and all those other things'; their complicity in the violence incurred additional financial consequences, and practical harms (Fricker 2007, 46), for Maya. Yet Maya actually returned to her first University three years after the assault to insist on pursuing the internal misconduct procedures. This was when she provides a stark example of how the university assisted her assailant in his counter-story, and are hence complicit in their rewriting of it. She said that

> the internal investigation even though they sent it to me like under like encrypted whatever, I like, saved all of it because some of it was really wild… Like they got his friend to write a statement about how, like, he was a virgin and he felt like this whole situation was really special, and how he was going to ask me out. And I'm like you were not going to ask out this girl you were calling a slag… [Laughs] And like, it's like, and like… Like, this is just not realistic, and they were saying how he was like so shy and excited, and that he really liked me, and I was like… I read all the stuff he was saying about me, he did not like me, like what the hell is this, and then like, he also had to write things from his perspective, and went along a similar theme, and I wanna say he did something like… And that I came on to him, and like I started twerking on him in the uni club, and I was like I don't twerk… like this so fucking racist as well

The university's complicity in her assailant's version of events is here clear. They 'got his friend' to write statements which represent him as a 'virgin' who was 'shy and excited', while she was 'twerking on him'. By drawing on hypersexual stereotypes about race and gender, Maya is then reconstructed through understandings of a racialised and gendered voracious sexuality. As Patricia Hill Collins has noted, black woman may be portrayed in terms of being 'jezebels', as hypersexual or aggressive (Collins 1990). By protecting themselves from being properly accountable, the university are not only complicit in the violence Maya experienced, but participate in this form of epistemic violence, twisting both the story and her reality, and colluding with the assailant (Powell, Hlavka, and Mulla 2017).

While at the university where she was assaulted, Maya additionally faced extensive denial from her peers, leaving her without recourse to support. This further illuminates how the testimonial injustice Maya experienced was structural and systematic, and excluded her from communities that were essential to her identity, such as women, and black people. She was not only unable to access "trustful conversation" from her peers, but the extent of this injustice, and the associated losses of these communities, damaged her 'self-acknowledged affiliation to a group identity' (Fricker 2007, 53). Being excluded from communities of social identity, Fricker argues, carries unique harms. After the assault, her assailant continued to make insulting, racialised, and derogatory comments about her both in a group WhatsApp chat and to individual peers. The best friend with whom she had been out continued to relay things that he was saying about Maya without 'compassion', and other friends were in the group chat and remained silent. She says

> the guy who was like… who assaulted me, like spoke about me before he said all these things about like having jungle fever and obviously all these really like fetishising things, and then, but there were so many people that I knew in this group chat, and no one would ever like stand up for me, and then I also felt like it was significant that like there was a black man in this group chat who didn't stand up for me.

> I think like what's a really big shame to me is like we always talk about allies, but sometimes, like the people literally within your own group won't show you compassion, like other… like she was also African. So like other black people didn't

> show me compassion, other women didn't show me compassion, like it does feel very lonely and everyone likes to think like no, we'd all do better

The extent of the 'fetishising' way in which her account was distorted then reached her peer group, and alienated her from avenues for support. Neither 'other black people' nor 'other women' showed her 'compassion'. Losing these communities led Maya to 'feel very lonely', and eventually to her leaving university: her feelings of loneliness then add another dimension to the more practical harms that she experienced in moving universities and incurring more debt. Her gendered and racial identities were an important part of Maya's personhood, and in being excluded from those communities, this was prejudicial not just to her capacity as someone to "know" her own life, but in essential attributes of her social identity, which was here especially egregious and painful. In Fricker's words, 'Keeping one's dignity in the face of such a double assault on one's personhood can take great courage, especially if the assault is persistent and systematic' (Fricker 2007, 54).

To elaborate this sense in which Maya's word was devalued, she additionally cited an experience of a peer discussion about the need for consent classes at her new university institution, in which she recounting a girl saying that she knew 'how to not get raped, I just say no'. When Maya elaborates this experience she says, almost as if speaking to the girl herself, that

> you obviously see yourself as like a woman who's valued by society, like your words mean something you can't imagine like a situation where like people don't care about what you have to say, but also like when you would also be defenceless for yourself. So I think all of that made me think like, I don't know like do you really wanna go to uni and be that person who like has all these like, mental health problems

The extent of the injustice Maya encountered is here contrasted with this other person's words, as for Maya, she had not been 'valued by society', her words didn't 'mean something' and she was 'defenceless' – both when she was assaulted and in the extensive testimonial injustice thereafter. She felt her words did not count, and her assailant even

named the experience as ‘rape’ before she had. The “problem” had effectively been left with her, rather than instantiated in any societal accountability, and she did not want to embody this problem by being the person with ‘mental health problems’. Operations of identity power can be evidenced both in institutional actors in the distortion of scripts, and the more diffuse operations of power relations through which Maya’s testimony was here undermined. The fundamental lasting effect of this testimonial injustice for Maya is that her words are not ‘valued by society’, and she had been degraded in her very capacity as a knower and a speaker.

Fricker additionally writes of how testimonial injustice can incur an intellectual blow to self-confidence. A similar harm was expressed by Alice 2 in her workplace: at the time, she had been a secondary school teacher. When Alice 2 told her superiors at work that she had PTSD, they told her that she ‘hadn’t been in a war so you can’t have it […] and could be making it up’. In doing so, the effect is that they deny that her traumatic experiences entitle her to the category of PTSD (not ‘a war’), and simultaneously suggest that the source of the trauma is in her head: ‘could be making it up’. Her disclosure of PTSD is non-credible, which absolves her employers of taking any action to support her. Quite the opposite, as after that, ‘no one would speak to [her]’ at work, and she was ultimately dismissed from her job. The result of this for Alice 2 was that she subsequently felt as though she was gaslighting her employers, rather than the other way around. She said

> I feel like I'm just gaslighting people saying I've got [PTSD], because… I think it's because of the people I worked with saying you haven't been in a war and stuff like that, that was really damaging to me, and maybe it shouldn't have been, but it really was, and the this headmaster, he said I've had a friend with PTSD and he went into war and you haven't been in a war, then the deputy head at another point says we don't even know if you've got it you could be making it up

Alice 2’s perception of her reality, and her experience of PTSD, is instead rendered as ‘gaslighting’: she feels she is the one threatening others’ grip on reality, rather than the other way around.

To flesh out this example further, it is useful to bring in some context on gaslighting. The term "gaslighting" is derived from George Cukor's 1944 film *Gaslight*, in which a woman's husband initiates an insidious tactic of trying to undermine her sense of reality and make her feel "crazy"; his primary method is to brighten or dim the gaslights and then to insist that she is imagining it. It has since gained currency in the popular imaginary for describing the coercive control and mind manipulation tactics employed in abusive relationships. Sweet has effectively theorised gaslighting as a sociological concept (Sweet 2019; Sweet 2021), and suggests that it functions in a related way to testimonial injustice, in that it 'is the result of structural and cultural conditions that set certain people up to be *irrational* and *non-credible*' (Sweet 2021, 219, emphasis mine). Sweet has asserted that one of the most extreme consequences of gaslighting is to 'confuse and distort her reality such that she must accept his imposed reality in place of her own' (Sweet 2021, 219). Here, a similar effect can be observed, as the blow to Alice 2's confidence is such that she acutely *feels* their 'imposed reality', that she is the one doing the gaslighting, rather than the other way around. Alice 2's epistemic authority as a speaker in general is undermined by the responses of her colleagues, but it also had professional consequences: she had lost her job, as well as her confidence. These events had both epistemic and practical consequences, which constitutes 'a wrongful epistemic humiliation of considerable personal and professional consequence' (Fricker 2007, 51).

When I asked her if she valued speaking about sexual violence in our interview, she ultimately felt that this was inaccessible to her. In her reflections on sexual violence testimony, she said 'It's stigmatising, and I feel like I've done it to myself […] it's like a boomerang, I go out and talk about it and then it boomerangs back on me, and I think it's sort of self-sabotage'. This description as 'self-sabotage' suggests that Alice 2 felt that she herself was creating this problem, or at least that the mere act of speaking about sexual violence from a psychiatric diagnosis would produce this 'boomerang' effect: forcing her to contend with prejudicial stereotypes and to effectively counter them. The description of a 'boomerang' is evocative of several orientational metaphors: she remains in the same place, stuck in a loop of circularity. In trying to testify to sexual violence and its debilitating effects, her experience is such that her testimony circles back to her, eventually causing more damage ('self-sabotage').

To understand Alice 2's experiences of this 'boomerang' further, it is important to contextualise her experiences of speaking about sexual and domestic violence in various other public forums. I will elaborate three of Alice 2's specific experiences here in detail. She was ultimately either excluded from them, or ignored, for failing to tell her story in the narrative form of "what happened". The boomerang is 'self-sabotage' because she does not garner legitimacy from her audience. She was invited to speak in parliament at an event about the Istanbul Convention, the Council of Europe's legal standard for combatting violence against women and girls, which was ratified by the UK in 2022. While Alice 2 spoke at this event, she felt that all they wanted was an answer to the question: 'what did he do to you', and that in refusing to do give one, she was subsequently 'dropped because [she] didn't give them currency'. She said that 'they always want these poster girls for domestic abuse', and that in her refusal to be reduced to "what happened" to her, she failed to comply with the narrative demands of an idealised version of sexual violence testimony. She did not meet the "idealised" 'poster girl' version of someone who has experienced sexual violence, and was hence 'dropped', taken down from her political platform, for not providing 'currency' in the form of a valorised stereotype.

Alice 2 expressed frustration at the imperative to tell one's story as a "trick" in the individualised register of public forums reflects both the public appetite for stories of individual crisis (Armstrong 1994; Berlant 2011; Wanzo 2009) and what Leah Lakshmi Piepzna Samarasinha calls the 'survivor industrial complex' (Piepzna-Samarasinha 2018, 229). These are well established ways in which the narrative demands of sexual violence testimony shape the testimonial environment in which people are operating (Bumiller 2008; Serisier 2018). Alice 2's use of the term 'currency' above was notable, as she was frustrated by other trauma 'survivors' who had made 'lucrative career[s]' out of their public appearances. The two women she discussed had experienced physical domestic abuse, and had either visible scars or (dis)abilities as a result; this is reflective of Sweet's observation that 'institutions tend to prioritize visible, physical injuries' (Sweet 2021, 183). The imperative to show and externalise her own "scars", or speak about "what happened", was demanding due to the requirement to "prove" the disabling effects of her experience, and notably both more demanding and carrying less 'currency' than the women who embodied self-evident disabling effects of abuse. Physical (dis)abilities are more legible as suffering than psychological ones (Carter 2019).

Finally, she had also tried to speak about her experience at an academic conference about "madness". The conference sought perspectives from lived experience, although Alice 2 was not compensated for this: 'they've got these survivors here, they can't be bothered to pay them'. At the conference, Alice 2 talked about her conceptualisation of 'victim-survivor-beyond', which she thought would be particularly interesting to the academics attending. Instead, she said her speech was entirely 'ignored', and that everyone instead directed their questions to the woman who had cancer and wanted to be a doctor. When clarifying what she meant by 'victim-survivor-beyond' at this conference, Alice 2 said that: 'no one asked me any questions so that's what I mean about beyond, I want to get beyond that'. She sought to get beyond the demand to speak about "what happened", and the associated platforming of these "idealised" or stereotypical ideas about stories of sexual violence. Yet in being unable to do so, the language of a 'boomerang' effectively captures her stasis: staying in the same place, unable to make the world move with her.

2. **Negotiating Testimonial Injustice**

Fricker suggests that the most egregious harm of testimonial injustice is that in degrading someone's capacity as a knower, they are symbolically degraded as a human: the harm of testimonial injustice is that it is fundamentally dehumanising (Fricker 2007, 44). Fricker writes that

> To understand just how profoundly the experience of persistent testimonial injustice might penetrate a person's psychology, and just how debilitating it might be in circumstances where psychological resistance would be a social achievement that is more or less out of the subject's reach [...] the prejudice operating against a speaker may have a self-fulfilling power (Fricker 2007, 55).

The debilitating nature of testimonial injustice lies partly in how it excludes people from trustful conversation and epistemic communities, and Fricker suggests that prejudicial stereotypes can therefore affect how a subject is constituted (what she counts as socially) or is caused to resemble (what she comes to be). Fricker distinguishes this power of prejudicial stereotypes from a Foucaultian conception of power as productive, as these

stereotypes do not simply produce subjects, but *distort* who they really are. These concepts are useful here, as participants were universally aware that their testimony was considered less valuable than others, and that the task of "proving" it would be 'a social achievement that is more or less out of the subject's reach' (Fricker 2007, 55). In some cases, how individuals' testimony was received as less valuable actually *caused* them to feel less valuable; in others, the comparative lack of space for their narratives, and their knowledge of what they "count as socially", affected how they oriented their testimony (how they were *constituted*).

A. Distress and Harm

Although many participants felt that their diagnoses legitimated or reflected the sexual harms they had experienced, they additionally described ways in which the processes of testimonial injustice were affectively distressing and harmful. When I asked Elaine how the 'testimonial injustice' she experienced made her feel, she said 'it made me feel devalued. It made me feel as though, what, you know, that what had been done to me didn't really matter it didn't really count [...] it almost gave it a permission'; later she added that it made her feel 'worthless'. She elaborated that it

> made me more susceptible to recurrent depressive symptoms [...] damaged or stopped or retarded my self-esteem from recovering, and your sense of self influences how you see yourself how you feel about things and the world [...] so I think because my self-esteem never really recovered and part of that, you know, was the unhelpful reception from the police, I think that, you know, made me, predisposed me to have further depressive disorder symptoms

The 'testimonial injustice' itself literally impacted Elaine's sense of herself, which 'never really recovered'. In this sense, there is an extent to which the devaluing of her testimony actually *caused* her to feel 'devalued', and to impact her confidence in the form of 'self-esteem'. The 'unhelpful reception from the police' undermined her sense of self and how she subsequently felt about the world. As she says, it gave what happened a permission which made her feel devalued such that she 'never really recovered'. Fricker suggests that (prejudicial) 'identity power at once constructs and *distorts* who the subject really is'

(Fricker 2007, 55, emphasis original). I cannot help but feel Elaine's pain here in being devalued, and while I cannot lay claim to "who she really is", what is clear is that the harms Elaine experienced were not limited to the violence itself, but this subsequent experience of *testimonial* violence.

In Harib's elaboration of his difficulties with 'anxiety' and 'depression' growing up, he cited 'the oppression' as one of the chief factors. Fricker notes that oppression can be explicitly repressive or 'a silent by-product' (Fricker 2007, 58) of prejudice. Harib specifically cited the impossibility of his testimony, and its associated silence, as a factor in this mental distress. He said that

> You know being gay is one thing, OK, there might be struggles around being accepted, and all the rest of it, but then facing sexual violence and not being able to come out about it […] And that was what probably created more anxiety and depression in myself, because whichever way you look at it […] it's like I was to blame, because that's how… but you know the same time I'm a victim, because if I tell someone I'm still going to be taken the piss out of, if I didn't tell somebody, I'm going to suffer in silence

His articulation of how he is both 'to blame' and to 'suffer in silence' encapsulates the affective pain due to his lack of recourse to sexual violence speech: it was prohibited before he could even start. He describes 'sexual violence' as something that he was not 'able to come out about' – the use of the language of "coming out" thus rendering it hidden and "abnormal", akin to popular discourses on homosexuality – and how this led to 'more anxiety and depression'. The lack of discursive space available to him affected how he was *constituted,* as he knew his testimony would not count, thus assuring his silence. He elaborated that because he could not talk about it, he had to be a 'counsellor for [himself]' to try and make sense of it. He described how 'that then even traumatises you more', because he could not 'offload' the experience and it was 'happening all in one person'. Both the "problem" and "harm" of sexual violence are therefore rendered entirely Harib's to deal with on account of the impossibility of talking about it. For if he spoke about it he was 'going to be taken the piss out of', which he connected to an external perception of him as somehow either complicit in or responsible for his experiences of violence on account of his sexuality ('I was to blame'). Even though Harib had not spoken about his

experience, he perceived that speaking about sexual violence was ultimately impossible. This demonstrates how prejudicial identity categories can actually constitute subjects, determining what they 'count as' socially (Fricker 2007, 55). Harib knew that there was no discursive space for his experiences of sexual violence, on account of prejudicial ideas about homosexuality, and thus he was left to deal with it entirely internally.

B. Reconceptualising Justice

Due to the harms of testimonial injustice, people were left to negotiate this oppressive testimonial environment in adaptive ways. These decisions were particularly marked by race, and participants' awareness of what their speech counted as, as well as the 'mammoth' (Ellen) task of proving it, led to realistic compromises of "justice", and directing their energies elsewhere. When faced with a lack of accountability, people are tasked with finding novel ways of negotiating experiences of justice (Mulla 2016). For some participants, they felt that the most important part of speaking about sexual violence was in the hope that other people were not subjected to the same violence that they had been (Megan, Beverley, Elaine, Harib). This expression of "justice" could be made possible by engaging with the criminal justice system, but it additionally reflects the broader notion that sexual violence testimony carries political impetus and the possibility for change.

In particular, the two black women, Maya and Beverley, articulated forms of justice that acknowledged both the limits and impossibility of obtaining traditional forms of "justice" or accountability. These were not expressions of the possibility for change, but practical compromises in the face of unjust, biased, and racist institutional procedures: their awareness of the prejudicial reception of black people in criminal justice settings led them to reconceptualise other "fair" forms of redress. It is important that the lack of accountability, discursive recognition, or traditional notions of "justice" were particularly salient for Beverley and Maya. Beverley said that as a black person, she knew that criminal justice was not a realistic prospect, and instead approached her boyfriend to achieve a different notion of justice – she wanted him to beat up her assailant. She said, 'as a black person as well. I suppose, and he was black, we were all black, I suppose you wouldn't be going to the pol[ice] yeah, justice to me would have been him beating him

up'. In Mulla's words, writing of sexual violence and justice, Beverley was here hoping for a 'different notion of justice' (Mulla 2016, 291). She knew that criminal justice was inaccessible to her, both because she was black, and because her assailant would be treated more punitively on account of the fact that 'he was black' as well. Instead, obtaining accountability and recognition from her boyfriend in the form of "beating him up" was the form of justice that Beverley was looking for. However, as I mentioned on page 160 he failed to believe her, which meant that this alternative form of accountability was similarly lost for Beverley.

Maya had made many unsuccessful attempts to seek justice and legitimacy: from the police, her university, and even her peers. Her university failed to provide her with formal accountability in the form of any repercussions for her assailant, but eventually they issued her with a formal apology and a small amount of financial compensation. With this gesture, Maya made this accountability meaningful – she intended to frame the apology, and with the compensation she said

> I bought some pillows because of five years of nightmares and terrible sleeping. And I was like, I'm gonna get myself these boujie pillows, and it's symbolic. […] I don't know I just felt like I had to do a lot of advocating for myself, and also kind of understanding like, what is the most fair outcome I can get from this?

Maya reconceptualised her notion of accountability into one that was attainable, and that recognised the extent of the testimonial injustice and mental distress that she had experienced. The apology was made meaningful and significant in framing it, partly as it was the only time Maya had encountered accountability in her pursuit of justice, or even a receptive audience – 'I had to do a lot of advocating for myself'. As Maya's prospects for accountability diminished, she had to negotiate her own notion of justice, and to provide herself with 'the most fair outcome' in that context – some comfortable pillows to assuage and symbolise years of how she 'slept terribly anyway and had like had all these nightmares', and how that had been 'invisible' on account of the extensive and repeated denial of a reception. She enacts a reconceptualising of accountability, in the context of realising the limits and scope of justice or 'compassion' from those around her. Although both Maya and Beverley therefore described novel and somewhat attainable forms of

justice, I do not mean to suggest that this was innovative and empowering, but rather, these were pragmatic responses to a highly restrictive and prejudicial environment. Further, Maya and Beverley were realistic about their racialised reception in criminal justice settings rather than surprised, and enacted responses to them within the confines of their environment.

However, the testimonial injustice participants experienced did not always stop them from engaging with criminal justice settings: Maya herself had made persistent attempts to garner accountability before accepting her university's response as 'the most fair outcome'. Megan was the only participant who continued to value reporting her experiences in criminal justice contexts, although she was aware of how it would be received. Megan's response to the extensive socio-political denial that she faced was to emphasise her own veracity. She insisted on being a good witness, and went to extra lengths to document factual and often written accounts of "what happened" for her subsequent experiences of violence. Her awareness of her potential reception as someone 'on a mental ward' who is 'inventing everything' led to a strong emphasis on veracity and reporting. She says that

> Even though, all my experience that I have, incidents or whatever, I just go and talk to the police, talk to someone, and say this has happened to me, in case it happens to someone else, you know? Doesn't matter if I look ridiculous, or they, they look at me funny, or whatever, I say, I don't care, the only thing I want is to write my statement, this is me, this has happened at that time of the day

Megan here enacts the knowledge that her diagnoses, or even her behaviour, could 'look ridiculous' or 'funny', but that it 'doesn't matter' as long as she has done her duty of protecting others: 'in case it happens to someone else'. She is expressing an awareness that the police may undermine her reality, and impose their own perception of her as 'ridiculous' or 'funny', but instead continues her search in pursuit of testimonial justice: an environment in which her testimony can be heard without prejudice, and which affirms her credibility (Fricker 2007).

This contrasts with Maya's experience, and her increasing awareness that it was too exhausting to prove the legitimacy of her testimony under the restrictive narrative parameters that were complicated by psychiatric diagnosis and race. For example, the reader will recall the discussion of Maya's experience of a counsellor at a rape crisis centre discussed in chapter 5 on page 143 in which Maya could not establish that she was either traumatised enough, or that she was not "too sick". Maya consequently reconceptualised her approach to not only justice, but to support-seeking as 'the most fair outcome' she could access in context. After her extensive attempts to garner accountability and justice Maya asked herself 'what is the most fair outcome I can get from this? And also like, is the most fair outcome just looking after yourself?' As a response to a testimonial environment devoid of 'fair outcome[s]', Maya went on to say that 'I can still be passionate about these issues in a way which isn't detrimental to myself'. Again, partly on account of an awareness of the limits of any possible accountability, Maya suggests that the 'most fair outcome' for her could be 'just looking after yourself'. Maya's expectations of recognition and support changed, as well as her approach to both. She said

> I think like for the past five years it's been like so consuming like I went through this thing and it was so unfair, like can anyone else see like how unjust this was. Like my dad was being like you're so obsessed with like what you think justice is, like I literally fixated on that, and like, rather than like, it's not that black and white, like how can I look after myself and feel better and get the support I needed. And I think had I been able to like unpack… I think part of unpacking that is understanding what is going on and sometimes that needs a name, but I don't think… I think that's just the start of it and I think I was afraid of that just becoming the end of it.

Maya's shift towards looking after herself, to 'feel better' and get 'support' rather than pursue 'what [she] think[s] justice is' was directly in response to how 'unfair' her negotiation of those accountability procedures were. Her experience of justice was not 'black and white', but 'unjust' and 'unfair', and her 'fixation' on this inaccessible outcome was 'detrimental to [herself]', particularly as the prospects of justice diminished. She is realistic about the limits of her testimony, as well as the exhausting nature of it 'consuming' her without recognition. She shifts her attention from being 'obsessed' with

justice, to 'unpacking' what was 'going on' for her and to 'get the support [she] needed'. In Maya's articulation of her fear that giving her experience a 'name' could become 'the end of it', when it is 'just the start', is perhaps reflective of her desire to live a life that is not defined by sexual violence, and hence permanently being a victim or survivor, or even a dutiful witness. While Megan felt both compelled to speak about her experiences with the police, Maya's energies here were already spent.

Further, in order to enact this shift, Maya reconceptualised the harms she had experienced on account of something her counsellor said. Maya recounts:

> "this has all been a traumatic experience for you, like, university has been a traumatic experience for you" and I think that was literally like my third year of uni and I actually realised, like, someone had said to me what the issue was, and I feel like the support I've seeked after that has been about addressing that

In line with the extant critiques of the "event-based" psychiatric model of trauma discussed in section 2A of chapter 3, Maya's 'traumatic experience' was not limited to the discrete event of sexual violence, but included the many additional harms associated with her experience of injustice. Instead, she finds solace in an understanding of her distress which accommodates a number of different harms caused by different aspects, actors and institutions involved in her experience – the university authoring a different script, the racism, the social ostracization, isolation and lack of solidarity and the lack of accountability from either her university or the criminal justice system. Further, in allowing herself to diverge from the narrow conception of sexual violence as in and of itself inherently traumatic, Maya gives herself permission to seek support for 'what the issue was', which is not isolated to a specific event or timepoint. This turn to forms of "trustful conversation", connection, and solidarity, constitutes a site of fairness and justice (Fricker 2007). This shift is somewhat reminiscent of Mulla's work, to facilitate 'the direction of one's energies, if only for a while, into the labors of the self" (Mulla 2016, 299).

Ellen similarly spoke of enacting a shift towards directing her energies inwards, and the subsequent affective relief of this. She said that 'I'm just doing Ellen, authentically Ellen,

present in everything I do, present in all my messiness, non-apologetic for it, and just taking one day at a time'. This "presence" in taking 'one day at a time' is notably again disruptive to linear conceptions of "recovery" oriented towards the future (Laugerud 2019), and Ellen's descriptions of doing 'authentically Ellen' also speak to the promise of political and relational models of trauma that emphasise community building across experiences of what she describes as 'messiness'. Ellen specifically described these relational aspects of mental distress and trauma when I asked whether she valued speaking about sexual violence, she said that

> Relationships, and I do believe that that kind of is where it starts, and again that's just through my own means and my own very limited experience, but I know that that has been so fundamental is… relationships have been so fundamental to me being able to talk about stuff, being able to find my way to navigate services, to find peace

Here it is 'relationships' that were not only 'fundamental' in enabling her to 'find peace', but also that specifically enabled her to 'navigate services' in the strategic ways described in section 2D of the previous chapter. This is community building in action, and specifically, a "crip" community building in action, if knowledge is being shared across people who identify with psychiatric diagnoses. However, while I am suggesting that there are kernels of political promise in what Ellen articulates, Maya is an example here of how not everyone is admitted to "trustful conversation", and even Ellen was highly selective about where these energies were spent. She specifically connected this shift towards directing her energies inwards to a dissonance in the discursive reception of her stories, when she said that

> I have to keep reminding myself all I'm doing is being authentic, and I try to be as kind and as, as, I suppose, aware of other people in that as well. And I'm learning to kind of navigate that because it's all very well owning your own story but then if you whack someone around the face with it…

While Ellen felt 'relationships' were 'fundamental', and did value this shift towards being 'authentic' and 'kind' to herself, she also directly connects this to limitations of the

discursive framework for sexual violence – while she could 'own' her story, telling people was experienced as to 'whack someone around the face with it'. The presence of norms and stereotypes surrounding sexual violence testimony dictate strong limitations on where people can tell their 'story'.

However, Ellen provides glimpses of alternative options: of aiming not to feel "cured", but to feel "different". I briefly noted in section 2D of the previous chapter (page 156) that, in Spurgas' critique of dissociation, she posits can alternative option, in 'collectively and mutually validating ways of living, forms of life, that shatter the directive to be silent' (Spurgas 2021, 12). Ellen is perhaps a tentative example of such an option, 'present' in her 'messiness', 'one day at a time' and 'non-apologetic'. She additionally 'own[s]' her own story, and in pursuing trusted relationships, she does indeed 'shatter the directive to be silent' (Spurgas 2021, 12), while remaining aware of the limitations surrounding her testimony. In her description of being 'authentic', she is additionally embracing feeling "different", and 'owning' her 'messiness'. Carter has suggested that forging new models of trauma requires that they be both political and relational (Carter 2021). I suggest that Ellen has already gone some way towards doing that. In forging coalitions of trauma across trusted 'relationships', and in her 'non-apologetic' refusal to be silent or "recovered", she re-calibrates her priorities from feeling "cured", to embracing feeling "different".

Conclusion

In this chapter I have traced the important ways in which testimonial injustice operates to either prevent or distort participants' testimonies and embodied experiences. By drawing on the theorising of Fricker, I have shown how these prejudicial stereotypes do not have to be explicit, but participants merely had to be aware that they exist, in order for their unjust effect to be actualised (section 1A). In addition, prejudicial stereotypes were operationalised at the institutional level, whether through diffuse operations of power, or the actions of specific institutional agents (sections 1B and 1C). This chapter additionally demonstrates connections between both the injustices and prejudicial stereotypes that are operationalised by the judiciary, and those that manifest in everyday life. Despite Maya's relentless advocating for herself, for example, she found that

traditional justice, and even interpersonal accountability, was unavailable to her. In some cases, institutionalised testimonial injustice manifested in 'not disbelieving' participants (Elaine), and in the cases of Maya and Megan, outright collusion in authoring an authoritative, and alternative, script (sections 1B and 1C). The effects of testimonial injustice are extraordinarily affectively painful, and incur additional and 'systematic' (Fricker 2007, 27) injustices insofar as they limited participants' access to healthcare, justice, or even a sense of community trust and identity (section 1C). Both sexual violence and its harms are dehumanising, and the trauma does not end with a discrete experience of violence (section 2A). Participants reconceptualised their notions of "justice" so that they could access a "fair outcome" in the face of so much injustice and unfairness, which speaks to both the limitations of "justice" and accountability, and understandings of "trauma" themselves (section 2B).

This demonstrates that the narrative demands for sexual violence testimony are particularly challenging for those who identify with psychiatric diagnoses, as well as uniquely harmful. On the final page of Fricker's book, she suggests that her theorising 'points to the possibility of a different sort of treatment, one more directly concerned with institutional conduct' (Fricker 2007, 177). The specific ways in which institutions participated in testimonial injustice can be considered important learning points, and sites for addressing the effects of stereotypes and norms surrounding sexual violence. The importance of a socio-legal intervention into understanding the relationship between sexual violence and psychiatric diagnoses lies in exposing these points, and the fact that the associated "injustice" is not limited to the operationalisation of the law in the courtroom.

7. Conclusion

This thesis examined the discursive construction of sexual violence and mental health, and its discursive effects on sexual violence testimony. It contributes to an established literature that calls for a rethinking of sexual trauma beyond the dissociative and psychopathological (Haaken 1996; Spurgas 2021; Carter 2021; Sweet 2021). One of the core demands of a political and relational model of trauma is one that takes seriously the fact that psychiatric categories are political: they are related to medical constructions, and designations, of bodymind "normalcy" (Kafer 2013; Carter 2021). As several other feminist scholars have observed, there are additional norms that come to bear on the hearing, and silencing, of sexual violence testimony (Serisier 2018; Phipps 2019; Spurgas 2021; Alcoff and Gray 1993). This thesis contributes novel findings to these literatures. I have demonstrated how psychiatric diagnoses complicate the narrative demands of sexual violence testimony in harmful "double-edged" ways, both inside and outside of the courtroom. I discuss the contributions of this project in part 1 of this chapter, and suggestions for future research in part 2.

In chapter 3, I introduced three at times overlapping, and slightly contradictory, episodes within feminist scholarship on sexual violence, trauma, and psychiatric categories. These three episodes coalesce to produce an overarching political grammar of "progress", culminating in the discovery of trauma. Inexplicable experiences and behaviours associated with "dissociation" are considered normal responses to sexual violence, and the discovery of trauma enabled the great "unearthing" of the "truth" of sexual violence: from the depths of societal, and individual, consciousness. I demonstrated that when we introduce critiques from critical race and disability theory, the category of sexual trauma is exposed as exclusionary, and particularly constructed around white middle-class women who were psychologically "normal" before sexual violence.

In chapter 4, I turned to examine how the relationship between sexual violence and mental health is discursively constructed in legal materials in England and Wales. Legal understandings of trauma and psychiatric categories were contingent on a "state-based" theory of mind. In the legal guidance on psychological evidence, legal professionals are encouraged to place people who have experienced sexual violence 'into a state of trauma'

to facilitate memory retrieval, while the effect of psychiatric categories on reliability was compared to a distorted 'prism' (R v Adams 2019), such that people could only speak about 'factual' rather than 'emotional' (sexual) matters (R v Smith 2002). Feminist and psy discourses on sexual violence are complicit in this state of affairs: the notion of traumatic memories being encoded pathologically, buried in the unconscious separate from conscious operations, has contributed to institutionalised norms for understanding trauma: accessible only through symptoms connected to the temporally isolated event, such as dissociation, flashbacks, and nightmares. This notion of dissociative memories rendered sexual violence unspeakable before a trial due to ongoing concerns about memory contamination (repression); "successful" cases demonstrated that people had kept quiet before assaults. Similarly, it became clear that for trauma to be legitimated by the law, people had to be additionally "pure" and "good" before assaults, and psychologically damaged afterwards (Lawson v Executor of the Estate of Dawes (Deceased) 2006; DSD & Anor v The Commissioner of Police for the Metropolis 2014a; DSD & Anor v The Commissioner of Police for the Metropolis 2014b; R v Allison 2006).

In contrast, those who had disclosed assaults previously, or sought mental health support, were deemed either illegitimate or unreliable narrators. Memories of sexual violence are unnarratable in the eyes of the law, lest they risk contamination. It was here that the political promise of trauma and PTSD as veridical "proof" of sexual violence was seriously curtailed. As the diagnosis of PTSD requires the identification of a prior traumatic event, introducing "proof" of trauma into proceedings was difficult if not impossible, due to legal anxieties about it unduly biasing the defendant's right to a fair trial. Further, the very suggestion of traumatic psychopathology led to suspicion, and a dichotomous adjudication of whether someone was legitimately traumatised (normal), or psychopathological (abnormal) (Lawson v Executor of the Estate of Dawes (Deceased) 2006). Adjudications of (ab)normality are transparently stark in the law, due to the ongoing power of precedent (R v Turner 1975a). This led to a variety of different forms of psychological scepticism, including assessments of the violence as "normal", such that this 'would negate any form of PTSD' (London Borough of Haringey v FZO 2020). Further, as demonstrated in section 2A of chapter 3, the "threat" of sexual violence is conceptualised as one that is posed to psychologically *normal people:* any engagement with mental health support or psychiatric categories before the assault risked further

attacks on credibility, especially if people had experienced sexual violence previously (R v Gabbai 2019).

These two chapters established several things. The introduction of mental health evidence, whether of "trauma" or prior contact with therapeutic services, re-introduced a corroboration requirement into sexual violence cases, and necessarily resulted in psychological scrutiny under the assumption of (ab)normality and pathology. The feminist political promise of characterising sexual trauma as dissociative, in need of remembering and narrating, is here in conflict with legal adjudication that reanimates anxieties about repression and contamination. Both feminist engagements with the psy disciplines, and the law, are powerful forces in shaping the meaning of the relationship between sexual violence and mental health.

In chapters 5 and 6, I turned to examine how this experience was discursively constructed by interview participants. In chapter 5, I fleshed out the "double-edged sword" of trying to negotiate speaking about sexual violence in relation to psychiatric diagnoses. Participants similarly sought to establish that they were "not sick" (hysterical), as they were aware of the prejudicial ideas associated with how their testimony might be received. However, they all felt that they identified with psychiatric diagnoses in some way, and that they are simultaneously "sick" (distressed). This meant that speaking about sexual violence was an extraordinarily difficult and painful balancing act. Participants' testimony was constrained by norms and stereotypes, but their articulations were additionally often disruptive to discursive constructions of "trauma" identified in previous chapters. Instead, participants found meaning in a particularly somatic language to render their experiences real: both visible and knowable. Participants also found ways to negotiate and manage their ongoing distress, and psychiatric diagnoses, while refusing to be subordinated to them.

In chapter 6, I traced the forms of the "testimonial injustice" people encountered to demonstrate the far-reaching harms of the stereotypes and norms surrounding sexual violence and mental health, and how people oriented their testimonies and energies in response to these dynamics. Participants were both practically excluded from traditional forms of "justice", and epistemically harmed by the operations of testimonial injustice

that they experienced. Participants were universally aware of the unspeakable double jeopardy in which they were operating: speaking out about sexual violence from a position of psychiatric diagnosis is like a 'boomerang' (Alice 2): it has nowhere to land.

I showed how people chose to navigate this incredibly restrictive testimonial environment: contrary to the political promise of discovering trauma, people turned away in pain from the speech imperative, and instead chose to negotiate their own conceptualisations of justice as their prospects of accountability diminished. In turning away from the narrative demands fostered by anti-sexual violence politics, and sharpened by identification with psychiatric diagnoses, the participant narratives presented here can be read as a critique of the given frameworks, and the failings, or outright collusion, of a variety of institutions in the injustice of sexual violence. The language of psychopathology was even valuable for enabling this turn away from the demand to speak about sexual violence, enabling people to 'talk around' (Alice 1) their experiences by referring to categories and symptoms instead. Participants additionally found new ways to articulate their experiences that were disruptive to feminist, psy, and legal understandings of trauma, as it refuted temporally isolated events and symptoms such as flashbacks and dissociation in favour of a fluid and recurrent account of how to negotiate the world. I suggest that within these articulations lie political promise of a community and relational understanding of sexual violence and its associated distress.

Analysing the relationship between sexual violence and psychiatric diagnoses, I have argued, is important, for two reasons. Firstly, in the lack of attention to neurodivergence in feminist scholarship, this enacts a form of Fricker's testimonial injustice. It wrongfully denies people who identify with psychiatric diagnoses their capacity as an informant of feminist knowledge (Johnson 2021); homogenises variations in the embodied experience of sexual violence (Fricker 2007, 134); and bars "mad" people from participating in the very formation of knowledge on sexual violence. This injustice additionally extends to the relative neglect of mental health in associated changes to sexual violence legislation, and in the updated and currently implemented CPS policies.

I term this a crisis of the knowledge paradigm of sexual trauma itself, to make a distinction I identified in the first book that I read over the course of my PhD: Samantha

Ashenden's *Governing Childhood Sexual Abuse* (Ashenden 2004). In it, Ashenden suggests that there are two kinds of epistemic crises that happen in relation to sexual violence: crises of execution, in which sound bodies of knowledge are exercised badly, and crises of the knowledge paradigms themselves. In the time it has taken to write this thesis, a plethora of legal policy has been published that was intended to foster better treatment of people who have experienced sexual violence in general, and better conduct in terms of disclosing mental health evidence in particular. These policies thus contend that there is a lack of clarity around legal rules and practices when disclosing mental health evidence in sexual trials, one that can be resolved through proper scientific rigour. Law, policy, and the efforts to reform both on mental health evidence, have transparently conceptualised the problem as a crisis of execution, where good knowledge about trauma and psychiatric diagnoses is being used or regulated badly. However, as has been evidenced throughout the analysis here, we are not facing a crisis of execution, but a crisis of the trauma paradigm itself: sexual trauma is not an objective or verifiable scientific fact, but a political construction of normalcy with harmful effects and affects (Carter 2021). In addressing these oversights, this thesis therefore makes several important contributions.

1. Contributions

The first contribution this project makes is to the legal literature, and the associated efforts to reform the law surrounding sexual violence and mental health: this thesis therefore additionally has practical implications and recommendations. I have demonstrated that the prejudicial effect of mental health evidence is extremely powerful, on account of enduring norms surrounding trauma, and stereotypes about "madness". In supplementing the legal analysis with an analysis of policy documents, I additionally expose the legal understanding of mental health in sexual violence cases in clear view, as well as some of the institutional logics that sustain it. The far-reaching effects of stereotypes about "trauma" and "madness" required that accounts of sexual violence testimony were corroborated in the cases identified, to counter this prejudicial effect. This specifically raises questions around the value of mental health evidence to people who have experienced sexual violence *at all*, as it is my contention that this will always

lead to psychological scrutiny, and as such, raise the spectre of the "corroboration requirement".

Recommending a practical solution to this problem is extremely difficult, but two examples of Australian legislation are briefly instructive here. In Tasmania, there is a rule of evidence which provides that counselling records may not be admitted in sexual offence cases without the consent of the person testifying to sexual violence. Yet this exemption is narrow: it only applies to communications that take place after the alleged offence, and only where the counselling records speak to harm arising from that offence (Law Commission 2023, 100; *Evidence Act* 2001, s 127B (1) and (3) to (5)). This very specific set of conditions did not arise in any of the cases analysed herein. Instead, feminist organisations in England and Wales are campaigning for legislative reform that accords with the model being used in New South Wales, Australia (Rape Crisis England & Wales, Centre for Women's Justice, and End Violence Against Women 2022). This would see the introduction of a multi-stage application process for the admissibility of mental health evidence, and the document concerned must have significant probative value not already established by the case. However, as noted by Jennifer Temkin over twenty years ago, this model would still operate according to the judge's discretion as to what will be considered of "relevant" probative value (Temkin 2002, 142). As in the case of R v Gabbai (2019), I suggest that this will often be the case.

However, the second contribution of this thesis lends newfound impetus to the suggested reforms, as it pertains to the particular injustices that stereotypes about "madness" incur both epistemically and practically. This contribution provides evidence of specific harms incurred at the nexus of sexual violence and mental health, and in bringing the concept of "testimonial injustice" to bear on this problem, we are also offered a potential solution to the judicial discretion in the reforms currently being proposed. Fricker additionally fleshes out the virtue of "testimonial justice", an ethical and epistemological corrective on the part of the hearer: an effortful choice to counter prejudice (Fricker 2007, 86). She notes that jurors are actively encouraged to reflect on potential prejudices, as well as their specific positionality in relation to the case. For example, she observes that the egregious harm caused to Tom Robinson is incurred not just because he is black, but because the jurors are white (Fricker 2007, 91). This reflexive critical awareness is then

precisely the kind of effortful work that is demanded of jurors, and equally, of the judiciary. It is therefore my recommendation that the proposed reforms in England and Wales be implemented in tandem with training for judges and prosecutors on the potentially prejudicial effect of mental health evidence, as identified here.

I suggest that judicial training *must* include perspectives from the social sciences, rather than just psychiatrists, to testify to the potential pitfalls and rape "myths" that are specifically associated with mental health. This thesis has at times mentioned the significant role of psychiatrist Fiona Mason in this field, in authoring training materials for judges (R v D 2008, [9]), as well as the current guidance for prosecutors on psychological evidence. However, enlisting psychiatrists for guidance will inevitably fail to speak of stereotypes concerning mental health, as they are not critical of the paradigm itself. For example, in the current CPS guidance on Rape and Serious Sexual Offences, it includes an "annex" document that addresses individual rape myths in turn (Crown Prosecution Service 2021c). While some mention psychological responses to sexual violence associated with "trauma", none address the specific dynamics associated with stereotypes about "madness". Implementing findings from the social sciences, such as those offered here, is essential if we are to get even a little closer to the kinds of just institutional treatment that Fricker envisions.

The third and final contribution of this thesis is then made as an intervention into feminist, psy, and legal understandings of trauma, psychiatric diagnoses, and sexual violence. In centring neurodivergence, and bringing critical disability theory into dialogue with these fields, I revealed the ways in which participants disrupted and expanded the category of sexual trauma in novel and important ways. This finding lends empirical impetus to critical disability theorists' suggestion that we need to forge new alternative and collective understandings of trauma (Spurgas 2021; Carter 2021; Kafer 2013), and that the medicalised and dissociative model is no longer tenable. The urgency of this call is additionally found in the harmful ways in which the norms and stereotypes surrounding trauma and mental health were enacted – by professionals in rape crisis centres, and in mental health services. This contribution then also has practical implications, in its suggestion that both therapeutic and legal professionals attend to

these prejudicial errors and harms, and to the complex relationship between sexual violence and neurodivergence.

2. Future research

Additional research into the relationship between mental health evidence and sexual violence in England and Wales would be useful for two reasons. Firstly, both the conversations within the literature that I examined and with those I interviewed were dominated by discussions of PTSD. More research into the nuances in how other diagnoses are experienced and understood in relation to sexual violence would help to enrich these findings and these discussions. Secondly, while I reviewed feminist scholarship, how these conversations have played out in activism and campaigns for legal reform could provide insight into the challenges involved in their implementation. For example, in a recent meeting with the non-profit organisation *Rape Crisis England and Wales* in which I shared my research findings, the organisation mentioned that they wanted to call for more extreme legal reform, but had organised around the New South Wales model as they felt it had a higher chance of passing into law. A closer assessment of the processes surrounding legal reform, and the feminist campaigns organised around it, would provide further insight into the challenges inherent in this process.

Similarly, future research using the methodology of trial observations would be invaluable for examining how mental health evidence is used in practice, particularly if the proposed reforms are implemented. This is the form of research that I had intended to provide, but the COVID-19 pandemic dictated otherwise. Conducting trial observations is particularly challenging in England and Wales, both emotionally and practically, as researchers are not allowed to verbally record trial proceedings, and instead are tasked with making verbatim notes. However, this work would provide important insights into how either the current legal rules, or the proposed reforms, operate in practice. This would shed light on how the operations of a trial draw on stereotypes about mental health, rather than focusing on how they emerge in the case law and associated judgments from the judiciary.

In that vein, while I touch on how people negotiated “traditional” forms of justice in this thesis, this was not the specific focus of this project. Some scholarship has been recently published on this topic, including an intervention from Herman (Herman 2023). However, more work examining how people who identify with psychiatric categories negotiate and conceptualise experiences of “justice”, or the lack thereof, after sexual violence is particularly pertinent in the context of increasing efforts to conceptualise it as a social justice issue, rather than a medical one. Similarly, while this project has gone some way to documenting the ways in which institutions participated in testimonial injustice – either as agents or in their diffuse operations of power – future research that specifically examines documentary practices of internal accountability procedures would be invaluable for interrogating these dynamics further. There is also a concerted lack of work that has been conducted in this area, with scholars occasionally resorting to single case studies to examine these processes (Mulvihill 2022).

Conclusion

This project offers a novel approach to some of the extant problems with sexual violence testimony in general, and medically-informed understandings of trauma and mental health in particular. In illuminating both the particular “injustices” incurred at the nexus of sexual violence and mental health, and the political promise of engaging with the embodied experience of neurodivergence, this work has gone some way to forging the possibility of a more equitable framework for feminist politics. A more thoughtful engagement with neurodivergence can challenge problematic ideas about sexual violence and mental health. We need to move away from the idea that we want to “eradicate” and “cure” mental health “problems”, and learn to attend to how we can live with them and foster care for those who experience distress currently organised in this way (Kafer 2013). In listening and attending to those experiences, we find new ways of conceptualising the relationship between sexual violence and mental health, as well as novel strategies for negotiating our distress that are collective and nourishing. A deeper engagement with neurodivergence will lead to more inclusive feminist knowledge on sexual violence, and more equitable accounts of what justice might look like in this context.

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Appendix 1

Bailii search strategy

Bailii search terms: (("rape" OR "sexual assault" OR "indecent assault" OR "rape" OR "sexual offence" OR "sexual offences") AND "complainant" AND ("psychiatric" OR "mental health" OR "psychological" "post-traumatic stress disorder" OR "post traumatic stress disorder" OR "rape trauma syndrome")) OR (("rape" OR "sexual assault" OR "indecent assault" OR "rape" OR "sexual offence" OR "sexual offences") AND "complainant" AND ("therapy" OR "therapist"))

Jurisdiction: England and Wales, relevance >=5%

Results: 58

Cases included: 6

JustisOne search terms: "rape" OR "sexual assault" OR "sexual coercion" OR "sexual offences" AND "psychiatric evidence" OR "psychological evidence" OR "counselling notes" AND "evidence"

Categories: “sexual offences” AND “evidence”

Dates: 2001-present

Results: 5

Included: 0

LexisOne search terms: ("rape" OR "sexual assault" OR "sexual coercion" OR "sexual offences") AND ("psychiatric evidence" OR "psychological evidence") [keywords]

Source name: judgments

Results: 187

Included: 1

WestLaw search terms: "rape" OR "sexual assault" OR "sexual coercion" & "psychiatr!" OR "psychol!" OR "mental health" OR "mental disorder" [subject/keyword] [cases]

Dates: 2001-present

Results: 38

Included: 2

Appendix 2

Annotated Interview Topic Guide

Pre-contact

- Check if consent form returned.
- Check if would like to see questions in advance.
- Check if someone present for interview.
- Fill in reflexivity prompts.
- Record interview date.
- Make sure colleague available for debrief.
- Use preferred contact details.
- Reminders:
    - Note times for breaks.
    - As much or as little detail as you want, can skip questions.
    - Make notes of linguistic terms that they use to come back to.

Theoretical Questions

1. How do participants understand their psy experiences in relation to sexual violence?
2. What are participants' experiences of experiencing sexual violence and talking about it in relation to mental health/neurodivergence?
3. How does neurodivergence or psychiatric diagnosis impact on speaking about sexual violence?
4. Are **psy understandings of sexual violence** politically and personally valuable?

Interview

Initial

- Confirm who I am speaking to.
- Confirm it is safe (private) to speak.

Introduction

- Focus on participant wellbeing and safety.
- Confidentiality, anonymity, and safeguarding.
- Recording, length, breaks (chat/verbal), pace, questions voluntary.
    - One sided conversation (my limited disclosures).
    - Some questions may seem obvious, trying to understand your POV.
- Remuneration.
- Consent: explaining that they can withdraw at any time (and will still receive the e-voucher), as well as skip questions, take breaks, or pause the interview.
- Explain the consent question around data sharing (and explain they can change their mind).
- If any capacity issues are raised, make excuses and conclude the interview.
- Check whether they have any questions.
- Check they are happy to continue.
- Choose diversion topic and ask if there is anyone they want me to contact if they become distressed.
- Breaks – record time for next break.
- **Encourage to get a cup of tea, water, cigarettes.**
- Explain will take notes.
- Emphasise can go at own pace!
- START RECORDING.

Background

- Just to start, can you tell me a bit about yourself (e.g. how old you are, where you're staying)

Experience of event

- Can you tell me a bit about your general experience of mental health/diagnoses? (How old, what kind, how accrued)
- Did the incident of sexual violence have an effect on your mental health?
- Have you thought about it in mental health terms? Is this helpful?

Experience of speaking about event

- Have you spoken about this experience previously?
    - Can probe feminist/justice/mental health contexts if these come up.
- Did you talk about the effects on your mental health?
    - If so, how did people respond?
    - Can probe feminist/justice/mental health contexts if these come up.
- (If you have not told anyone, how have you found the effect of that on your mental health?)
- **Narrative Interview Question:** Would you like to tell me your story?
    - Impacts?
    - How did you come to understand this experience?
- Do you find it helpful talking about the effect of what happened on your mental health?

Value of psy understandings of sexual violence

- Do you find that any mental health experiences/diagnoses make it more difficult for you to talk about what happened?
- Do you find that any mental health experiences/diagnoses validate or help you understand what happened?
- Do you think it is important that survivors talk about the effects on mind/behaviour?
- Do you think about your experience in mental health terms? Is this helpful?

Any other impacts

- In the last few minutes, is there anything else you want to mention that hasn't been covered?

Conclusion

- Thank participant for their time.
- STOP RECORDING.
- Ask how they found it and if they would like me to contact anyone.
- **Pseudonym**, identity info (age, pronouns, sexuality, ethnicity, where you live).

- Go through future contact with consent form – explain that the research process is slow.
- Go through support services.
- Safe to send resources?
- Advice to remove digital footprint: delete emails, phone contact, hide interview data from Teams, discuss safe times and formats for future contact.
- Feedback?
- Thank again and reiterate that all information is confidential and private.