Introduction

Sexual Violence in the City

I’m in a hurry, and luckily, I see a taxicab parked at the curb less than a block away. A few steps closer and I recognize the driver. When I signal to him, he waves in acknowledgment and pulls the car forward so I don’t have to take the last few steps in the summer heat. “Where you headed . . . hospital?” And when I say yes, and direct him downtown, he sighs, “It’s never good news when you are headed to the hospital.”

It was the summer of 2002 in Baltimore, and I was a rape crisis advocate volunteering for a local rape crisis center. I completed my training for this in February 2002, and at that time I bought my first cell phone. I was on call four or five times a week, taking as many eight-hour shifts as I could. The calls would come at all hours, and sometimes, even if I was not on the schedule, I, or another of the advocates, might be called if there wasn’t enough coverage or there were multiple cases and additional rape crisis advocates were needed.

Though cell phone–equipped and therefore reachable, I was without a car. All of the other advocates drove. “No problem,” I would say. I lived near a large hotel so there were usually taxis out front. The hospitals where we worked were no more than a 20-minute drive away, and once the volunteer coordinator called us, we had 45 minutes to reach the emergency room. It had been a busy summer; I was getting a call at least every other shift. The lore at the rape crisis center was that the overnight shift had the most activity, but I didn’t sign up for that shift because cabs are harder to come by in the middle of the night, and I was not keen to explore the city in the darkness. Still, there didn’t seem to be a particular witching hour: 6 a.m., 12 noon, 5 p.m., or 9 p.m.—the calls
came. I would grab my bag and rush to one of four hospitals, wondering what I would encounter there.

In the hospital, I looked for the “ASA,” or “alleged sexual assault victim,” as the police, hospital personnel, and forensic nurse examiners referred to her (and, less frequently, him). I met my first forensic nurse examiner during my training as an advocate, and was immediately curious about the profession. The role of the forensic nurse examiner, a specially trained registered nurse, is to both care for and collect evidence from victims of violence. If I was unable to locate the forensic nurse examiner to buzz me into the back, I knew the codes to the emergency room doors and frequently just let myself in. I then checked the giant white board, which would tell me where the victim was—the letters “ASA” scribbled next to her name. The rape crisis center had cautioned us to reject this moniker; as rape crisis advocates, we did not have to qualify our clients as “allegedly” victimized. We, unlike the law enforcement personnel who saw them during the course of rape crisis intervention, were free to believe them and to aid their recovery to the best of our abilities. I and the other rape crisis advocates frequently wondered why nurses continued to adopt this moniker since their other patients weren’t treated as if they “allegedly” had stomach pains or any other health complaints.

When meeting a patient, I introduced myself, offered information about the rape crisis center, and then stayed for as long as the patient wanted me to stay. At times, this was only a few minutes, but as often as not patients asked me to accompany them during the forensic examination. There, I held their hands, offered what comfort I could, and did my best to promote the interests of the victim by helping her to communicate her needs and desires to the forensic nurse examiner. As the months passed, I prided myself for the ease with which the forensic nurse examiners now regarded me, though initially they had been wary. For better or for worse, I had become part of the team.

By 2004, I had a driver’s license and a much beloved blue 1988 Volvo 240DL station wagon. I drove myself to the hospitals, but I missed bantering with the taxi drivers and the resulting calm of friendly chitchat. In the summers, I missed the air conditioning; the Volvo’s cooling system had long ago given up and was not worth fixing. I hated hospital parking lots and the extra step of validating my parking ticket before
I left. And on my way home, again, I missed chatting with taxi drivers and the way their talk helped me shake off the thrumming emergency room air. I learned to quickly return to what I was doing before the phone rang. I learned to program my cell phone so that it rang differently when it was the rape crisis center calling. I also learned that no matter how whimsical or gentle my ring tone selection, I always felt a slight jolt when the calls came.

By 2005, I was feeling odd about my city. Emergency room geography lessons began filtering my view. Steps from my home, there was the pay phone where just last week two men abducted a young man at knifepoint, drove him to a forest just north of the city, and assaulted and abandoned him there. In a well-frequented stretch of bars and clubs near the waterfront, there was a popular dance club where there had been at least two suspected cases of Rohipnol drugging. I went there once—it was a lot of fun but I avoided it in the future. A woman was kidnapped during lunch hour from the parking lot of a mall that was a favorite downtown tourist destination. Her hands were still bound by sheets when she was brought to the hospital three days later. The mall housed one of my favorite retail stores but I stopped shopping there because the manager raped one of the employees, and if the employee still worked there, I wanted to give her space. The woman who ran up to my car window to sell me my morning paper arrived in the emergency room one day. We laughed and joked at the hospital, but when she saw me drive up a week later, she looked away and I didn't stop to buy the paper. A taxicab dispatcher reported an assault by one of the drivers. When I began warily eyeing any and all taxicab drivers to see if their descriptions matched the dispatcher's assailant, I stopped missing the comfort of those brightly colored taxicabs.

Baltimore—lovingly called “Small-timore” by some joking residents—is a modestly sized city. It was simply a matter of time before some of the dots connected and my work at the hospital began to seep into my daily life. My occasional unease was comparable to the occasional bouts of hypochondria experienced by medical students as they were taught new pathologies and symptoms. Awareness of the violence around me made me no more or less prone to its spell. When I wrapped up the fieldwork on which this book is based, I reflected on my experiences, concluding that while many familiar places and personalities had
figured in my investigation of sexual violence, the most striking and frequent characteristic of the violence I had witnessed was that it was almost always between intimates. The myth of the threatening stranger rapist had proved to be just that, a myth, and victims more often than not named a friend, family member, co-worker, or neighbor as attacker.

In these opening pages, some of the basic elements of a “typical” sexual assault intervention come through. Each case is a surprise for the professionals who respond to it, interrupting some other activity. As a rape crisis advocate, I experienced the unpredictability of sexual assault intervention first hand, taking calls as needed, never knowing when I would be making a trip to the emergency room. Forensic nurses, police detectives, and rape crisis advocates could be called upon at any time and under any set of circumstances. None of us knew when we might be called or what violent events had set the intervention in motion. For rape crisis advocates and forensic nurses alike, the shift work was not a full-time pursuit but rather a secondary addition to one’s day-to-day routine. Like the forensic nurses and police detectives, my role as a rape crisis advocate was highly dependent on a delicate network of technology and my participation was contingent on key tools such as cell phones and automobiles. Indeed, a malfunctioning pager once crippled the entire patient advocacy operation over the course of several months. The technologies upon which forensic practitioners rely varied in their sophistication, but none of the stakeholders in the sexual assault intervention were able to carry out their charges without one technology or another.

This book examines the rapidly changing world of sexual assault forensic intervention, particularly as it is mediated by the relationship between law and medicine in formal emergency room–based programs. It traces the complex of care that emerges from the interpenetration of legal and therapeutic practices. Ultimately, it argues that blending the work of care and forensic investigation into a single intervention shapes how victims of violence understand their own suffering, recovery, and access to justice—in short, what it means to be a “victim.” Because of the institutional protocols governing forensic intervention, even the most well-intentioned forensic nurses tend to focus on collecting evidence, often at the expense of caring for their patients. Institutional forces frequently cast the psychological or even
physical trauma of victims as a secondary priority in the emergency that requires forensic nurses to race the clock to preserve rapidly deteriorating biological evidence. The reality is that most of the evidence they do collect never reaches the courtroom, while many studies have found that at present, when cases do reach the courtroom, forensic evidence does little to increase the likelihood of a guilty verdict. The impact of the forensic intervention, then, is largely on the victims themselves, and on how they come to understand what has happened to them. These interventions weigh heavily on victims of violence, as they serve as the medium through which experiences of victimization and recovery are cultivated. Many studies have documented the tendency of formal interventions to introduce more suffering into victims’ lives even as they attempt to care for the victim, a phenomenon referred to as re-victimization or “the second rape” (Campbell 2001b; Madigan and Gamble 1991). At both the federal and local levels, rape crisis management is one way in which the state responds to the immediate aftermath of violence (Corrigan 2013b). In Baltimore, Maryland, a forensic nurse examiner typically has the dual responsibilities of treatment and evidence collection, a fairly typical model of sexual assault intervention in the United States. Institutional imaginaries of sexual violence are configured as “medico-legal”; the term highlights the simultaneously distinct and conjoined therapeutic and juridical aims of intervention. Forensic training manuals, textbooks, and policy documents routinely frame sexual assault interventions as such (Crowley 1999; Office on Violence Against Women 2004; Olshaker et al. 2006). The intervention casts the sufferer of rape as both a victim within the legal context and a patient within the medical world. Distinct, incongruent, and divergent configurations of space and time mark the nexus of clinic-courtroom, reshaping the relationship of care to investigation, and healing to justice. The on-call nature of forensic practice, which I also experienced as a rape crisis advocate, is characterized by a responsive set of institutional protocols. The report of rape itself activates the technological resources and institutional nexus in which a sexual assault intervention will be staged and engages the professional expertise of police detectives, forensic nurses, and other emergency room personnel. Because many of the experts who are mobilized all work on shifts, picking up “on-call” hours between other tasks or jobs, it also means that sexual
assault intervention is often secondary to the careers and daily lives of many of the personnel who respond to these calls.

There is a lively and deeply insightful literature that takes up the politics of naming in victimization studies (Alcoff and Gray 1993; Lamb 1999; Mardorossian 2002). Many feminist scholars argue that the term “victim” is pejorative and ought to be replaced by “survivor,” allowing women the opportunity to transcend the disempowered subject position of the victim and move on. I deliberated for some time over what term I would use to describe the men and women I met in the emergency room. As the reader has no doubt already noticed, I chose to use the term “victim,” though sometimes I interchange this with the term “patient.” I made this choice because I think it is the most accurate given the particular setting in which I conducted research. Legal institutions locate and constitute victims, not survivors, and the forensic intervention, with its therapeutic components, also casts this victim as a patient. In fact, these institutional nodes often deny victims and patients their claims to survival. On the rare occasion I do use “survivor” when referring to a particular individual, it is because in this case the victim referred to him- or herself as a survivor, and is claiming the status of survivor. I also understand victimhood from within an ethnographic context, and hence, describe how victims are not passive, but rather, take on active and participatory roles in the forensic intervention. As they participate in the process of framing themselves as victims, men and women position themselves within the medico-legal nexus. For those who do not actively participate in the sexual assault intervention, there is a risk of being branded non-compliant by the medical and legal staff.

While many studies have rigorously analyzed one particular space, the courtroom (Taslitz 1999), as the most prominent site figuring within sexual assault cases, this book draws attention to the events and processes that must take place as a precondition to prosecution. Very few sexual assault cases reach the level of adjudication, as the strict criteria for prosecution are rarely met. For example, of the Midwestern cases examined by Campbell et al. between 1999 and 2005, 43% of cases were not referred to prosecutors by police for a myriad of reasons, while 15% were referred but not “warranted” (deemed to have significant legal merit) by the prosecutor. Of the 42% that were warranted, 13%
were subsequently dropped or resulted in acquittal, while 29% resulted in guilty pleas or convictions. In the Baltimore emergency room in which I conducted research, logbooks for the years 2002 to 2004 indicate more than 300 sexual assault forensic examinations conducted each year; 2002 and 2003 figures are confirmed by the local rape crisis center’s records of emergency room companions dispatched to attend rape victims in the hospital. The Maryland State Police give totals of 179, 208, and 182 rape cases respectively for each year. During this period, forensic examinations could only be conducted with permission from a police detective or a state’s attorney; thus, the lower number of cases reported by the police reflects that at least one-third of cases were “unfounded” (deemed to have inadequate legal merit) following the forensic examination. In 2010, media scrutiny and intervention by local and federal government uncovered several factors contributing to police under-reporting of sexual assault in Baltimore.

Whatever stage of legal disposition to which a case progresses, it is still meaningful and meaning-making for those who participate in its pre-trial phases. This book, therefore, focuses on the emergency room, and adjoining sites, such as the police department, rape crisis center, state’s attorney’s office, and homes of victims as spaces where important legal, medical, and life interventions are made prior to the stage of adjudication. While cases may not reach prosecution, upon reporting they are all subject to a combination of forensic investigation and medical intervention. Drawing on historical material, detailed ethnographic research, documentary artifacts, and interview transcripts, this book interrogates the ways in which medical and legal aspects of the sexual assault intervention are alternately distinguished and conflated. At times, it is individual personnel who may conflate their juridical and medical priorities. At other times, it is the protocols themselves. This volume examines the institutional boundaries of medical and legal practice by focusing on how time operates within both medical and legal registers, ultimately demonstrating that the forensic is not a simple amalgamation of medical and legal components, but a unique mode unto itself. Time, and the way it operates, marking the intervention as urgent and setting various potential future horizons, is a running theme throughout this book as many of the technologies brought to bear are about shaping time, arresting time, and recording time at
different junctures of the sexual assault intervention. The forensic, this book asserts, has its own temporal rhythms. Time, expertise, technology, routines, and protocols are all features of the institutional structure that regulates and conscripts the actors who abide within them, whether they are forensic nurses, rape crisis advocates, police and crime lab officials, or prosecutors. By attending to the way individual actors deliver care and justice in the setting of the sexual assault intervention, this book draws attention to how institutional structures can perpetuate cycles of injustice, particularly when the needs of sexual assault complainants intersect with the needs of the criminal justice system. With a detailed and focused ethnographic description, this book brings awareness to the complex dynamics that are unfolding in the course of sexual assault intervention, with the goal of empowering readers to entertain creative and constructive change to the dynamics of sexual assault forensic intervention, whether through policy reform, therapeutic protocols, criminal justice procedures, or as ethnographers of legal and clinical practice.

One of the key institutional features of forensic intervention is its temporal configuration, which focuses primarily on anticipation of the trial. As a privileged site and destination in the idealized sexual assault intervention, the courtroom is present in the emergency room not simply as a space, but as an agency that structures the examination. As anthropologists renew their interest in the role of things as social actors, we have learned to take seriously not only the human denizens of the social milieu, but the non-human (Bennett 2010; Latour 2005; Law and Hassard 1999); in this case, the courtroom is but one of many actants breathing life into the form that suffering, healing, and justice may take. Because the question of consent is at the center of the legal definition of rape, one of the ways in which time takes on prominence throughout the forensic intervention is the perpetual figuring of the courtroom as the inevitable point of arrival; it is within the courtroom that the state bears the burden of convincing a jury that a victim’s consent was not offered. While the case under question may not, in fact, reach the courtroom, the courtroom asserts itself throughout the medical intervention. Technological interventions shape the sexual assault victim as a legal and medical subject and produce proof of or against consent. The location of the sexual assault intervention within the
emergency room reveals the urgency with which sexual violence is met, and that urgency resonates within both legal and medical logics. Legal urgency is inherent in the challenge of collecting (organic) evidence that is rapidly disappearing or deteriorating while the medical emergency centers on the immediacy of treating the sexual assault victim for physical and psychological trauma, sexually transmitted infection, and potential pregnancy. Here, it is the vital materiality of life itself, in the form of rapidly deteriorating DNA, which demands urgency. Even as forensic nurses aim to act urgently and effectively through an efficient examination rubric, sexual assault victims draw on a range of experiences and relations in making sense of the experience of sexual assault and its aftermath. At present, because so few cases progress to the trial stage (Spohn and Horney 1992; McMillan 2010), we must focus on the intervention itself as the institutional engagement that has the largest impact on victims, their understanding of the process that lies ahead, and their sense of their experience of suffering. Doing so allows us to develop a more ethically responsible and nuanced approach to sexual assault intervention, one that balances the needs of sexual assault victims in relation to the challenges they will face in their recoveries, challenges that go beyond the limited horizon of a potential trial. It also introduces important considerations for thinking about the paths that professionals in the field of sexual assault intervention need to weigh in seeking to develop their expertise and deepen their understanding of what it means to be effective when working with sexual assault victims. What is just another day on the job for a forensic nurse is often a life-changing event for the sexual assault victims with whom they work.

Interrogating Sexual Assault Interventions: Defining the Research Question

The decision to focus my research on emergency room interventions into sexual assault grew out of years of reading about sexual violence in the United States. As a young woman, I had begun to research sexual violence, first reading such classics as Brownmiller’s *Against Our Will*, and Estrich’s *Real Rape*, in response to the spate of disclosures of victimization that were so common in my social world. Friends, teachers, co-workers, relatives, and mentors began to disclose experiences
of sexual violence. “I was raped.” “This happened to me.” “I was once attacked.” The disclosures came from all quarters and were conveyed by speakers sharing their grief, rage, pride, and shame. Concerned—and embarrassed—that I did not know how to respond properly, I tried to learn how to support those whose lives had been touched by sexual violence. As I read over the years, I began to take note of some common features in the available literature. In general, scholarly engagements with rape were often fractured. For example, a psychologist or criminologist might focus on victims or perpetrators. Rarely would both appear within the same framework. Studies that included victims’ perspectives or testimonies seemed to share a lot with the sexual victimization self-help literature. A particular uniformity manifested in the common testimonial narratives. Rape narratives seemed to belong to a genre of their own—the tone, narrative features, and quality of the voices did not always reflect the diverse experiences comprising stories of sexual violence. Rape narratives are linked by the act of violence itself. Most narratives inevitably begin with a description of the violent act. The narrator’s tone rings with a particular incredulity, while also creating a dire sense of inevitability of the impending rape attack. The anticipatory structure gives way to unavoidable violence. The narratives are written with the benefit of hindsight and the victims know how the stories will end. Narrators also describe the force used to isolate and immobilize them, their protestations, fear, and physical pain. Rape’s aftermath always includes utter transformation and discontinuity, though as readers we are dependent on the author to identify these discontinuities, as we know very little about a victim’s life prior to the event of rape. Typically, narrators communicate their frustration with the inability of their community of friends, relatives, and colleagues to truly understand the nature of their suffering. Finally, victims depict the insensitivities and failures of law enforcement and medical personnel when they report rape to the police.

This last feature, repeated by scores of rape victims, drew my attention to the issue of rape investigation and prosecution as harrowing ordeals for the victim. My curiosity settled around how rape as a legal category could impose on a victim’s suffering by overtaking her access to and expectation of care. When I first accompanied victims during police questioning, I noticed that police scrutiny played a large part in
eliciting various details from the victims. These questions were often repeated in the course of questioning, often by different personnel. Thus, it was not uncommon for a uniformed officer, a police detective, and a forensic nurse examiner to ask a victim the same question within a short time span. All three aim to establish an investigative time line, and to identify evidence of a crime having taken place. In the United States, the legal definition of rape rests primarily on lack of consent and the threat and/or use of force, and this definition is always particular to the criminal statutes of the specific state in which the crime took place. The investigative time line, the legal definitions, and eventually, cultural myths about sexual violence produce the rape narrative, and account for the narratives’ typical features. The interventions of legal personnel teach many rape victims what matters about rape and what people want to hear. While criticisms of medical and law enforcement personnel and their shortcomings in supporting sexual assault victims are frequently examined in social science literature, the overwhelming institutional stamp on the rape narrative has been largely undercriticized until very recently. The challenge in this book is to demonstrate the intricate means by which sexual violence is defined within a very particular institutional matrix characterized by intertwined projects of juridical and medical intervention.

Historically, Baltimore is like many densely populated urban centers in that the evolution of sexual assault response followed a familiar sequence. After the women’s rights movement drew national attention to the issue of sexual violence in the early 1970s (Brownmiller 1975; Griffin 1979), the first sexual assault forensic nursing program opened its doors in Memphis, Tennessee in 1976 (Taylor 2002: S91), the second in Minneapolis in 1977 (Ledray 1999), and the third in Amarillo, Texas in 1979 (Antognoli-Toland 1985). Prior to the advent of more centralized sexual assault intervention programs, states, or even single jurisdictions within a state, would each generate their own medico-legal evidentiary examination, often glossed as a rape kit, and victims could go to any hospital emergency room where the gynecological resident or emergency room physician would conduct evidence collection procedures per the guidelines included with the rape kit (Taylor 2002). Nurses were frequently present, sometimes reading instructions to the doctors who conducted the interventions with the nurse chaperones giving them
step-by-step direction. This model did not require any specific expertise on either the nurses’ or doctors’ parts, but rather just a basic skill set and an ability to follow directions. The lack of specialized competence was itself often devastating for victims, who expected to find themselves in capable hands (Winkler 2002). After victims, medical professionals, and law enforcement all expressed great dissatisfaction with these types of programs, a national movement began to emphasize efficient treatment and efficacious evidence collection. Having witnessed sexual assault interventions in their role as chaperones, nurses were among the loudest critics of the haphazard response and treatment rape victims received in the healthcare system. Nurses were pioneers at the national level, establishing formal training programs, suggesting best practice standards, embarking on more scientific study of forensic practice, and forming a professional association to focus on the skills requisite for effective sexual assault response—the International Association of Forensic Nurses (henceforth, IAFN). The IAFN eventually developed protocols for sexual assault evidence exams, established training and certification standards, founded a peer-reviewed journal of forensic nursing, and also expanded its scope to include forensic nurses working in fields beyond sexual assault response. Experienced nurses may now elect to be tested and receive credentials as FNEs or Forensic Nurse Examiners. As a nationwide movement gained ground, nurses at the local level frequently pioneered the introduction of forensic nursing programs based on their knowledge of the growing field and their dissatisfaction with existing arrangements (Ledray 2001). Under the older systems, advocates, and medical and legal personnel worried that victims were receiving poor care, while evidence was being badly collected and preserved. Thus, between the late 1970s and the present day, a shift ensued in which nurses began to receive training to specifically manage all aspects of victim care. In Maryland, nurses participate in an IAFN-organized course as the IAFN is headquartered in Maryland. The State Board of Nursing also participates in credentialing FNEs. In some jurisdictions, as in Baltimore, a single hospital or clinic claimed responsibility for hiring nurses trained in forensic intervention, and for conducting sexual assault interventions. At City Hospital, nurses had been assisting gynecology residents with forensic examinations for many years. Dissatisfied with the long waiting periods and general lack of
compassion from the doctors, who seemed very disinclined to conduct the examinations and even more leery of testifying in court, the nurses at City Hospital heard that nurses in nearby Virginia had completed forensic training and were conducting exams on their own. By 1994, the nurses of City Hospital had established their own program after completing their training and had spread the word throughout the city that all sexual assault victims could be sent to their emergency room–based program. The proliferation of training programs and licensing in forensic expertise for nurses corresponded with this call for greater quality of care and higher standards of expertise in sexual assault intervention, though standards for certification and training forensic nurses remain very diverse and vary from state to state, as do the rape kits in use across the country. The International Association of Forensic Nurses reports that there are currently about 590 sexual assault nurse examiner programs in the United States and its territories.

According to Baltimore’s current protocol, all victims report to or are transferred to City Hospital, presently the only hospital in the city designated to conduct forensic exams. In the field of forensic nursing, it is notoriously difficult to recruit, train, and fully staff a program so that sexual assault response is available 24 hours a day, 7 days a week, all throughout the calendar year. As noted earlier, sexual assault response is carried out on an on-call basis; thus forensic nurses sign up for a certain number of on-call hours every month, in addition to their primary employment obligations. They are minimally compensated for being on-call, and only receive a regular wage if called in. This puts administrators in a position of constantly covering abandoned shifts when nurses are offered extra shifts through their primary employers, who are more reliable sources of additional income. The pressure of staffing shortages may guarantee that some administrators are willing to keep nurses on the call rotation whose skills may not be up to muster simply because there is no one else to replace them. Often, it is a single nurse administrator who is the last line of defense, filling empty shifts to guarantee that no call goes unanswered and no victim goes unserved. Because of the daunting staffing challenges, many large population centers have transitioned toward a pattern in which only one or two hospitals will have thriving sexual assault nurse examiner programs so that the pools of on-call forensic nurses will be large enough to address the
local need. While most jurisdictions in the United States rely on the cooperation of forensic nurses, police officers, and detectives in sexual assault interventions, Baltimore exemplifies this by bringing together the various actors in the common space of the emergency room. Until 2009, a police detective from the Sex Offense Unit interviewed the victim and then determined whether to authorize the collection of evidence, after which the hospital staff paged the on-call forensic nurse examiner. A rape crisis advocate from an independent rape crisis center might also be called to accompany and counsel the victim. Thus, from the outset, the victim would find him- or herself at the confluence of several different institutional processes. While some police, FNEs, and advocates may think they are playing very distinct roles in the sexual assault intervention, the victim may not perceive them to be carrying out distinct functions, or even working for different institutions, particularly because everyone is attending the victim within the same institutional space of the hospital. What’s more, as we will see, some police, FNEs, and advocates adopt a cooperative relationship in which they work toward many of the same goals, further fusing into a single entity from the perspective of the victim. As of 2009, compliance with federal law dictates that police can no longer decide when a forensic evidence collection should be undertaken—victims may choose for themselves and they may do so before deciding whether to file a report with the police. While it remains to be seen what long-term impact these new policies will have, many programs, including the one studied in this book, report the immediate effect is the increase in the number of sexual assault victims participating in sexual assault forensic examinations, while scholarship demonstrates very little change in the outcomes of court cases.

These policies unfold at the nexus of two distinctly gendered professional spheres—policing and nursing. As arguably the most feminized of any profession, nursing exemplifies the care work associated with women in the public and domestic spheres (Reverby 1987; Sandelowski 2000). With the exception of nurse practitioners, the typical registered nurse works under the supervision of a medical doctor. The forensic nurse examiners at City Hospital, for example, could only dispense medications under the standing orders of one of the two physicians who provided program oversight. While the nursing profession is
93% female and 7% male, sworn officers in local police departments are about 88% male with a 12% female minority (Health Resources and Services Administration 2010; Langton 2010). While some forensic nurses do become interested in a forensic practice out of a desire to assist victims of violence, nurses also cite other professional reasons for coming to the field of forensic nursing. For many, the field is exciting and the association of working with law enforcement carries great attraction. The training, which is relatively short and does not require graduate education, allows nurses to practice as FNEs with relative independence. While the doctors and nurse administrator may review their charts, the nurse works one on one with her patient and will typically only consult a doctor or another nurse at her own discretion, or participate in peer review with other nurses. As FNEs, nurses’ expertise can be acknowledged in its own right.

If the police are most closely aligned with the masculine authority of the state, while the nurses exemplify a feminized force of care, the sexual assault victim occupies the most abject feminized subject position. The flux of gender and power catches all three actors within a relational dynamic in which the FNE, seeking to have her expertise acknowledged, often identifies and allies herself with the police force while appropriating the masculine power of policing. The nurse simultaneously distances herself from the close association with the feminized victim by producing a clinical competence that is professional while not appearing overly empathetic or caring. The FNEs posit that this cool clinical demeanor is a necessity if they are to reliably participate in the criminal justice procedure. Thus, the care they offer victims is often encumbered by its juridical focus.

By focusing on the institutionally constituted subjects of nurses, police detectives, advocates, and victims, this book investigates the agency of institutions at a micro-level. Attending to the interplay between these gendered subjects in the demarcated space and time of the victim-cum-patient’s emergency room stay, it demonstrates how multiple and competing imaginaries animate the intervention. It shows how institutional interventions sometimes preclude the consideration of sexual violence within a broader social framework. While the book demonstrates again and again that victims narrate sexual violence within broad contexts, drawing attention to conditions of living, such
as race, poverty, work, family life, or the induction of families into foster-care services, these narratives were often subsumed by particular procedures of medical and legal care. Ultimately, this volume draws out institutional investments in notions of appropriately marked bodies and the configuration of sexually violated subjects as constituted by a forensic intervention that is both medical and legal in its modality. It argues that the ethical consequences of sexual assault intervention are borne almost solely by the sexual assault survivor, and brings into view those ways in which different stakeholders in the sexual assault intervention, including FNEs, prosecutors, police, policy experts, and legislators, might challenge the institutional structure to reduce or eliminate such burdens.

Anthropological and Sociological Conversations about Sexual Violence

This work is anthropological in that it is ethnographic, with all of the excesses and surplus that are characteristic of a descriptive enterprise. It is important that some of the narratives, stories, and fragments within these pages do not lend themselves to any one analysis in an easy or simplistic way. Human life is too complex and varied to be easily reduced, and thus the most effective ethnographies recognize these complexities by leaving some things unanalyzed. From time to time, I present details for which I have no definitive analysis, but I hope that readers are empowered to ask their own questions about these interventions and their impact. I approach this material with as much insight as I can bring to bear on it, and thus, this project is a part of many different anthropological conversations. Correspondingly, I have consulted many literatures in crafting my approach to the study. Reading carried me through the many facets of my work, including framing my research question, developing a methodology, carrying out research, sifting through and organizing my data, analyzing my findings, and producing a text. In addition to the rape narrative literature, I looked at a more broadly defined set of literatures on sexual violence, which led me to more specific readings on institutional structures, legal anthropology, clinical practice, and the state. In this section, I discuss only my engagement with the research explicitly focused on sexual violence and
how it opened up other literatures and avenues of thought. Where relevant, those subsequent literatures are dealt with in particular chapters.

With its focus on social problems of industrialized urban-centered populations, sociology has taken a systematic approach to the study of sexual assault and sexual violence, particularly since the feminist turn of the 1970s (Rose 1977). Much of this literature has a social constructionist perspective (Chasteen 2001), following the evolving cultural and social construction of “rape” over the past three decades. Significant attention has focused on the proliferation of rape myths, those folk fantasies about rape that persist in the popular imagination no matter how many times they are shown to be unsubstantiated (Andrias 1992; Du Mont and Parnis 1999). These myths, many authors argue, are rampant within police units and other locations within the criminal justice system. Institutional ethnography has also attended to the institutional responses to sexual assault, showing how different actors coordinate their responses in the interests of intervening in sexual violence (Martin 2005).

Sexual assault nurse examiner programs have comprised one of the main professional and institutional innovations in response to the call for better services for sexual assault victims. White and Du Mont’ have conducted research evaluating the efficacies of sexual assault nurse examiner programs, rape kit technology, legal institutional responses, and forensic evidence (Du Mont and Parnis 2000, 2001, 2003; Du Mont, White and McGregor 2009; Parnis and Du Mont 1999, 2002, 2006; White and Du Mont 2009). The World Health Organization report that they authored suggests that medico-legal evidence has a minor impact on prosecutorial outcomes (Du Mont and White 2007). This finding is echoed in more recent work (Sommers and Baskin 2011). At the same time, a continuing theme in the sociological and criminological literature demonstrates the impact—including psychological—of forensic intervention on the victims who participate in these interventions (White and Du Mont 2009; Du Mont et al. 2009). This careful and rigorous sociological research has continued to shed light on the evolving question of sexual assault forensic intervention, and has opened the door for more qualitative inquiries into medico-legal sexual assault intervention as it is practiced in different geographic and historical settings (Rees 2010, 2011; Crozier and Rees 2011).
Though anthropology has not, historically, been as outspoken on the topic of sexual assault, the discipline frames sexual assault from a different perspective than sociology. Sexual assault has been treated mainly in broad contexts of structural and sectarian violence, and the range of institutions implicated in making sexual assault socially meaningful extends beyond medical and legal institutions. One of the most broad-sweeping and sustained perspectives on violence against women and gender-based violence in anthropology is offered by Sally Engle Merry (Merry 2009). Merry conducted ethnographic research at a number of sites including urban centers in the United States (Merry 2001a, 2001b). Taking a broad view of culture (Merry 2012), Merry has tracked institutional influences as well as the ability of legislative and policy reforms to recast legal subjects through criminal jurisdiction but also through human rights discourses (Merry and Shimin 2011). Her work illustrates the location from which anthropologists are poised to observe, analyze, and critique the intersection of institution, law, and culture as it affects women and men who are victims of gendered violence. Merry’s work not only offers a number of theoretical frameworks for analyzing gendered violence, but also helpfully models many different ethnographic methodologies for situating the anthropologist in the field, including attention to historical genealogy in gaining understanding of the anthropological subject (Merry 2003). This historical turn can be noted in some of the other anthropological texts referenced here. Overall, Merry’s work boldly suggests how the field might be constituted when anthropologists research violence against women and girls, by positioning the anthropologist at the intersection of law, regulation, institution, history, and culture.

Another long-established voice in the anthropology of sexual assault is Peggy Reeves Sanday. She has addressed the problem of rape in at least three different ways. A comparative study of the configuration of male and female power among 95 Indonesian tribal groups demonstrated great variation in the occurrence of sexual violence in different communities. Sanday then sought to identify what factors contributed to the formation of “rape-prone” versus “rape-free” societies (Sanday 1981). She concluded that a correlation existed between matriarchal governance and lower incidence of rape. She then turned her attention to sexual violence in the United States, focusing on sexual violence
in university settings. Building on her prior research, Sanday studied patriarchal power, which she argued was exemplified by the phenomena of fraternities and Greek life on U.S. campuses (Sanday 1990). While her most recent book also grew out of another campus rape case, this time she examined American legal history and turned most of her analysis to the subject of the trial, tying her historical insights to the examination of a set of 1990 cases involving several St. John's College students (Sanday 1996). I found this particular progression in Sanday’s research to be extremely helpful in my own deliberations about where to enter into the anthropological study of sexual violence. I read her second study as arguing, if implicitly, that the experience of sexual violence in the lives of the young women she interviewed was primarily filtered through the institution of the university and processes of adjudication. Subsequently, her third study depicted the suffering of another young student, but this time by attributing her sexual suffering to the intersections of the legal and university systems while historicizing the legal technologies available for intervention. Clearly, legal and educational institutional contexts are key sites of shaping juridical and cultural attitudes toward rape. The prison is another site through which cultural imaginaries of perpetration and victimization are articulated. In his anthropological research on mandatory sex offender treatment programs in prisons, James Waldram points to the institutional and disciplinary contexts in which the subject position of “sex offender” is produced. He argues that the treatment profile posits a moral subject who must be habilitated, rather than, for example, an offender who carries out rapes because of patriarchal privilege (Waldram 2012). If the subject position of offender is institutionally constituted, how might the subject position of “victim” be produced within the same institutional contexts?

The autobiographical ethnographies of anthropologists Cathy Winkler and Micaela di Leonardo began to draw in other institutional and social currents that shaped their experiences. For di Leonardo, race was one of the forces cultivating the imaginary by which her case was perceived. Attacked by an African American perpetrator, di Leonardo found herself in the position of dispelling the historically deep popular stereotype that “black on white rape” was the norm (Di Leonardo 1992: 30). Di Leonardo narrates her interactions with the police, including
their deployment of particular imaginaries of racial identity and crime statistics. The question of race and crime is a sensitive one, and I was aware, as I did my research, that the statewide coalition of rape crisis centers was conducting a survey-based study on African American women's experiences of the sexual assault intervention (Weist et al. 2009). Rather than turn my scrutiny to the African American experience, I drew on di Leonardo's criticism to think about institutional imaginaries, including the “racialization” of particular problems or bodies. In this book, the racialization of the patient's body plays out within the context of a medico-legal examination heavily informed by nurses’ experience in their local professional practices with a largely African American patient population that they associate with particular health issues.

While Winkler begins with the rape attack and then details the horrific circumstances of her own medico-legal examination, a great deal of her study focuses on her interactions with the legal system. Winkler attributes much of what she calls her re-victimization to her entanglements with law enforcement and prosecutors. She also brought her eventual loss of livelihood to bear on her suffering (2002). She is impressively adept in conducting phenomenological analyses of the rape attack, tying her ability to narrate rape to her sensory experiences (Winkler 1994; Winkler and Hancke 1995). She contextualized her phenomenological approach within a broader anthropology of violence and established the tenuous nature of knowledge about violence as it contaminated particular ontological modalities with “suspicious” sensuous ways of knowing. In short, traumatic experiences by their very nature elude description by the narrator who, trauma theorists hold, may not have the language to describe an experience that must remain “unclaimed” (Caruth 1996). As knowledge and memory become unreliable, victims may turn to their sensory knowledge, the sensations of the body, to communicate their experiences with others. In Winkler’s experience, law enforcement rejected her sensuous knowledge. I read Winkler as critiquing the precise moment in which a victim’s knowledge of self is invalidated by the formal processes of forging justice; this book seeks to explore these moments in the encounters between FNEs and sexual assault victims.

While Winkler experienced the invalidating of her sensual self-knowledge at the hands of the law court, my field research in the
emergency room suggested that particular forms of sensuous knowledge were privileged within forensic practice. Forensic nurses were expert in folding the fleshy materiality of the raped body into acceptable forms of evidence that could then be apprehended within and by the court of law. Susan Ehrlich and Greg Matoesian, both noted sociolinguists, treat the linguistic practices of the rape trial with sensitivity and detail, drawing attention to the forms of speech that mark criminal rape trials in an adversarial justice system (Ehrlich 2001; Matoesian 1993). Ehrlich's observation of the dearth of any evidence apart from victim testimony in the two trials she studied motivated me to focus on rape interventions prior to the trial stage as the processes by which material evidence collection occurred were unlikely to make an impact beyond the space of the forensic encounter. Pratiksha Baxi has written about Indian practices of medico-legal sexual assault intervention from an anthropological perspective, suggesting that localized understandings of the sexed (female) body become institutionalized through these practices (Baxi 2005). She suggests that clinical evidentiary procedures produce a raped body that is normalized for the Indian law court, without regard to whether these clinical procedures are grounded in evidence-based practices. In the juridical world, there is no objective knowledge and all expertise is subject to the standards of the court of law, admitted only after being vetted by the court. That doctors and nurses are influenced by their own cultural mores is not a revelation to a medical anthropologist, but Baxi's fine-grained research tracked the specific ways in which forensic practices become standardized, and motivated me to identify these moments among the FNEs with whom I worked.

For linguistic anthropologist Shonna Trinch, the law court also produces the domestic violence and rape victim's voice through an administratively mediated form of listening to domestic violence complaints and rendering the complaints actionable by legal forms of writing (2003: 225–68). These practices are shaped by the formal modes of argument that govern law courts, particularly with respect to rape cases (Matoesian 1993). My emergency room–based research would have to take into account both the places and particulars of the use of touch and the forms of recordkeeping and representation by which evidence was noted and preserved in anticipation of a case's arrival in the court of law.
The court of law exists as part of a complex interplay between various legal sites and techniques that intersect to produce a sexually violated subject. Anthropologist Veena Das has turned her attention to the production of the gendered sexually violated subject, arguing that judicial verification results in a woman’s speech being “pitted against her body” (2002: 261). Her work draws attention to the tensions between victim subjectivity and judicial verification, a tension that this book explores by questioning the assumption of the ability of forensic practice to produce a unified body and narrative, and the discrepancies that might arise and be subjected to erasure or rewriting in the course of the forensic examination. Das also analyzes sexual violence at length in her work on gendered violence during the partition of India and Pakistan, interrogating the role of the state in responding to sexual assault (1995, 1996a, 1996b, 2000). Das demonstrates that honor, shame, and family are reconfigured through formally sanctioned state institutions. Survival and suffering are ongoing projects here, and Das’s anthropological inquiry poses the question of life “after” violence again and again. What does it mean to survive? What does it mean to choose to re-reinhabit the scene of devastation (Das 2006a)? This book attends to the re-inhabiting of the everyday by remaining attuned to the ideas of recovery, healing, and restoration that abound within the sexual assault intervention. Within the sexual assault forensic examination, the circulating imaginations of justice and the successful future varied depending on which actor’s perspective one explored. Nurses, victims, advocates, and police detectives often had very different notions of what forms justice and healing might take, and these notions were not stable, coinciding at times, and departing from one another at others. For the victim, the nurse, police, and advocate also represented the state’s interests and resources brought to bear on the crisis of sexual assault.

The task I set myself, then, was to think of the institutional investments in healing and justice as deeply tied to several factors. I would have to focus on the state’s stake in sexual assault by following the legislation, resources, and sanctions invested in sexual violence. I would have to be attentive to the micro-procedures of forensic practice, and the training of the sensory faculties that constituted forensic expertise. I would also have to look at the technological and representational mediation of evidence—how was evidence produced? In addition, I would
have to think about the temporalities at work in the context of forensic practice. My engagement with institutions had shifted to an engagement with instituting. Most critically, I would have to draw out the ways in which victims’ understandings of their own experiences of sexual assault and intervention were constituted by the institutional processes in which they participated.

On Methods

I conducted research between January 2002 and December 2006. I began as a rape crisis advocate working in the local rape intervention program. Early on, I decided that I would frame my research by getting involved. From the outset, I abandoned any notion of being a fly on the wall, as this was neither ethical nor desirable in this research setting, committing, instead, to situated knowledge (Haraway 1988). This would help me attain a thorough understanding of how the intervention functioned from within the intervention itself. All stages of my research and writing were carried out with oversight and review from the Johns Hopkins University’s Homewood Institutional Review Board and the Marquette University Office of Research Compliance. I chose to become a rape crisis advocate in part to receive the training and learn what stakes I would come to have as a rape crisis advocate. Hospitals are often places full of students. To many of the medical personnel with whom I worked, having an anthropologist in the emergency room was equivalent to having a resident present. Within the cramped confines of the small examination room in which the forensic examination was completed, my presence would be very obtrusive if I was simply to be an observer. As a rape crisis advocate, I hoped to give something back to the community with whom I worked. I contacted the local rape crisis center and shared my research plans and met with the director before being accepted into the rape crisis advocate program. She was supportive of my research goals and held me to the same standards as other rape crisis advocates. With the right training, I was also able to interact with sexual assault victims in what I hoped was a sensitive and ethical manner. I underwent training and supervision, and abided by the rape crisis center’s confidentiality clauses. Rape crisis advocates are free to speak and write about their experiences as long as they do not reveal
victims’ identifying information. In addition, I agreed not to take any
tools or ask directed questions during the sexual assault interventions,
as the rape crisis center and forensic nursing program did not want me
to create an account that might contradict the forensic record. Instead,
I wrote my field notes immediately after leaving the hospital. Whether
such precautions were necessary or not, I did not want to be in the posi-
tion of having my research compromise a legal case. Of course, when
I began my work, I did not know how few cases advanced to the trial
stage. The anxiety my recordkeeping raised retrospectively demon-
strates the deeply anticipatory focus of rape crisis intervention among
the participating institutional actors.

In the examination room, I focused not only on the interpersonal
relationships among hospital and legal personnel and victims, but also
on their use and adoption of forensic technologies. The hospital gave
way to numerous sites through which a victim’s particularly gendered,
sexed, and vulnerable body could be given institutional life. Long after
the physical evidence of sexual assault had ceased to exist, technologi-
cally crafted bureaucratic evidentiary bodies were made to stand in for
the victim’s sexually violated body. Technology had a place in creating
these types of assemblages and assigning them places within the biogra-
phy of particular subjects and the phenomenal world of their relation-
ships. For example, I observed that victims’ bodies were photographed
and documented such that they may stand as separate and distinct
from the future healed body of the “victim.” The recording of evidence
as schematic drawing, photographs, and written narrative condensed
and encoded rich sensorial encounters between practitioners and vic-
tims involving pain, odors, and bodily discharges. These evidentiary
records served to construct a body in legal discourse that was able to
withstand the passing of time and accrual of duration throughout the
juridical process. In the emergency room, I was able to observe the
unique administrative features through which a victimized body was
fixed in such a way that sexual violation was made legible to a court of
law, perhaps at the cost of the victim’s own recognition of self.

As a rape crisis advocate, I observed workplace practices, and con-
ducted rape crisis interventions as part of my investigation of the web of
relationships created in the institutional environment that had arisen in
response to sexual violence. The relationships formed through my work as a rape crisis advocate were valuable for analyzing how others, including forensic nurse examiners, police officers, and victims themselves, were cast in relation to my role as one of many care providers for victims. Though sexual assault cases are a matter of public record with the condition of victim confidentiality, I did not take consent for granted. All research participants took part in the project based on informed consent, and were allowed to withdraw at any time. I took appropriate measures to protect the anonymity of all participants. Field data took the form of recorded and transcribed interviews, as well as field notes, which I was careful to keep secured. Methodologically, I focused on a number of adjacent sites and constituents, including: (1) the emergency room as a space of practice, (2) victims, (3) forensic nurses, (4) detectives and attorneys, and (5) the documents through which their practices are recorded and the technologies used in pursuit of evidence. The emergency room was my primary research site simply because it was here that a sexual assault victim entered the hospital, and interacted with many differently affiliated personnel, all of whom could relate to him or her from different institutional perspectives. Attrition rates are very high following the reporting of a rape complaint; the forensic intervention most typically comprises the victim’s only contact with the medico-legal system. Through close observation of interactions during the brief time the victim was in the emergency room, I could identify how specific institutional agendas shaped the process. I concentrated on the way forensic nurses managed what they deemed the contradictory demands of collecting evidence with providing care. I also tracked the uses of various forensic technologies in the examination. I observed 44 examinations during the research period. Following the examinations, I often conducted interviews with forensic nurses, asking them to reflect on: (1) the manner in which they explained their role to the victim, (2) whether they felt they fulfilled the victim’s expectations, (3) their relationships with particular detectives and attorneys, (4) their sense of the legal strength of the collected evidence, and (5) their general sense of satisfaction or frustration with the case. In the emergency room, I also observed detectives as they worked with victims and forensic nurse examiners. I paid close attention to what types of questions
and concerns manifested in detectives’ interactions with sexual assault victims.

In August 2004, following my stint as a rape crisis advocate, I suspended my participation in rape crisis interventions and relocated to the administrative offices of the sexual assault forensic nurse examiner program. In addition to observing forensic nurses carrying out their administrative labors, I gained access to documents I was free to use within the hospital, for example, forensic documentation protocols, and also self-studies the forensic nursing program had undertaken. I was able to use and compile data about these documents when I visited the administrative offices within the emergency room. I have excluded any and all health records from my data in order to protect the privacy of patients. I collected and analyzed the differing types of paperwork and blank forms created for institutional use, as well as the genres of bureaucratic writing used to record the legal case at different stages. These forms and genres are available to document any and all sexually violated bodies, regardless of sex, race, or circumstance. I examined the circulation of texts by following the various forms used as official documentation of the violation and its legal standing, noting protocols, the channels through which paperwork were exchanged, and where they were eventually deposited. I sought to trace how paperwork linked different subjects, spaces, and practices. By collecting these documents, I also compiled an archive that tracked changes and formed wells of institutional memory within administrative procedures.

During this period I also conducted interviews with rape crisis advocates, activists, individual forensic nurse examiners, and select police detectives, crime lab technicians, state’s attorneys, and public defenders. I attended and observed monthly staff meetings of the forensic nurse examiners at the hospital, and forensic nurse training sessions, and interviewed forensic nurses in other states by phone to gain a comparative insight. In addition, I attended grand jury orientations each time a new grand jury was seated and received sexual assault training by a member of the forensic nursing staff.

From May to December 2005, I implemented the last module of my research project, recruiting sexual assault victims to interview on a bi-weekly basis. Both the nursing program and the Human Subjects Review Board preferred that these victims were not recruited from
among those that I had observed in the emergency room. In fact, they requested that I avoid following up with any of the victims whom I had personally attended as a rape crisis advocate. Again, this concern stemmed largely from the perception that I might become a target of a subpoena in a potential adjudication. A relatively small number of victims responded to my flyer posted in the emergency room. Four of them enrolled in my study and agreed to meet with me on a regular basis. I interviewed each one extensively over a six-month period. I conducted sequential iterative in-depth open-ended interviews with the individuals in this group. Sexual assault cases take six months to one year to go to trial in Baltimore, and I often discussed the potential outcomes of cases with victims. Either law enforcement or the victim might elect to terminate the legal process. Otherwise, the case could end in a trial, or a plea bargain, usually in response to a preponderance of collected evidence. This last outcome was often considered the most “successful” by forensic examiners as it circumvented the courtroom altogether. From the nurses’ perspectives, the public did not have to shoulder court costs while victims were not subjected to the ordeal of trial. What’s more, the nurse did not have to take time off from work to testify. As institutional structures constructed victims’ narratives in such strict terms, I maintained an open-ended format during my interviews so that victims could reflect on the various factors affecting their lives while building their own narrative. Almost all of my interviews were recorded using a digital recorder with permission of the research participant. A research assistant transcribed these recordings. I then edited transcripts for content, erasing all identifying characteristics. By January 2006, I had collected dozens of documents, training manuals, forensic text books, advocacy newsletters, case law notations, and news articles. In addition, I had three thick notebooks full of field notes, as well as hundreds of transcribed pages from the interviews I conducted. A complex rendering of how sexual assault interventions touched many lives emerged from the diverse evidence I collected.

In organizing the materials I had collected and subjecting them to analysis, I used several different approaches. I often searched for repeated phrases or sentiments or frequently occurring questions and coded my notes and transcripts for these themes. Alternately, I scrutinized moments in which tensions arose in encounters between sexual
assault victims and forensic nurse examiners identifying all actors, human and non-human, and the attendant structures contributing to the conflict. In part, this was because I refused to take ethical failures for granted. I sought to generate the categories for analysis primarily from victims’ and nurses’ concerns rather than to take on categories that were ready-made within preexisting literatures.

In addition, I sought to achieve a mode of writing in which the style of rendering reflected the ways in which information and narratives were organized in the course of the forensic intervention. Thus, there is relatively less discourse in the resulting book as compared with a traditional anthropological monograph. Rather, descriptions are offered as they were encountered, in fragments and pieces, with attention to the tone, quality, and inflection with which they were delivered in the telling. These fragments align to reveal the complex workings of the institutional array that organizes the sexual assault intervention. What has emerged is a book in which each chapter focuses on a critical node in which actors, things, and circumstances collide and generate a particular effect or impact on victims and their experiences of sexual assault intervention.

Chapter Descriptions

Each chapter of this book draws on diverse selections from my field research in order to depict a different aspect of how sexual assault intervention becomes a complex lived reality experienced by sexual assault victims. Moving the site of analysis from things to processes to emotions, the book captures how it is that sexual assault intervention is imagined, experienced, and felt. The first chapter begins with a focus on DNA as it takes center stage in forensic intervention, arguing that it, along with the victim, becomes the “patient” in the emergency intervention. Numerous studies have demonstrated that DNA rarely figures in the legal resolution of sexual assault, although it is often the focus of the sexual assault intervention. This book begins by focusing on the single substance that is synonymous with the latest technological advancements in forensic intervention. Chapter 1 argues that victims, nurses, and even perpetrators imagine DNA as a legitimizing feature of victim narratives as well as material validation of the experience of
sexual victimization. First, victims often attempt to preserve, transport, and surrender any forensic evidence prior to their contact with law enforcement, demonstrating a keen awareness of the significance of DNA findings. Tales of perpetrators forcing victims to participate in the destruction of potential DNA evidence are rampant within victim narratives. Thus, it is evident that the association of DNA with establishing juridical truth has circulated among both victims and perpetrators. The realities around the discovery and use of DNA in rape cases, however, fall far short of these expectations. While DNA does not, in fact, play a great role in case disposition, nurses reinforce the primacy of DNA evidence in the intense scrutiny and time allocated to the process of collecting DNA in the course of the forensic examination. The examination takes on pedagogical qualities as victims are expected to demonstrate bodily discipline in yielding to the examination practices so that perpetrator DNA can be successfully recovered. Focusing on victim participation in recovering DNA as a form of patient compliance challenges the notion that the ideal victim is utterly passive, as she is expected to be an active stakeholder in the forensic examination process. In the time allocated to the search for DNA, perpetrators are imagined to have expressive, lugubrious bodies, while the ideal victim is curatorial in her approach to facilitating the search for and preservation of DNA evidence. Like a museum curator who orchestrates the encounter between exhibit and public, the victim guides the police and nurse to the evidence on and in her body, evidence that she has often taken pains to preserve.

Chapter 2 describes the ways in which time is worked by the forensic intervention, and how institutional temporality diverges from the ways in which victims narrate their experiences in time. While the search for DNA gives the sexual assault intervention its urgency, there are multiple modes of time operating within the space of the sexual assault intervention. Chapter 2 looks closely at the diverse ways in which time saturates the sexual assault intervention. The problem of documenting medico-legal evidence is frequently a problem of time; by the time a case goes to trial, the victim's wounds, psychological and physical, may have healed. During their examination, forensic nurses capture these wounds through technological intervention, fixing them in time. This manipulation of time in order to overcome the problem of time's
forward march is carried out within a particular investigative context in which the victim’s narrative is clearly demarcated as having a beginning and an end. This time line of victimization, determined by formal criteria derived from legal statutes, contains within it those elements that are relevant to proving whether a crime has been committed. These elements include indicators of motive, force, and lack of consent. Once the time line is determined, nurses work to produce evidence that populates the time line in dense increments. This process takes the form of a forensic interview, and in the course of this interview, victims struggle to describe the event of victimization through their own meaningful frameworks. Victims’ narratives of suffering do not have the same start- and end-points as the forensic narrative. The forensic interview becomes a series of interruptions in which victims tell their stories and forensic nurses stop them with questions in order to craft a forensic narrative. This struggle over the most meaningful way of telling about sexual assault is largely driven by the different anticipatory structures in which the participants are enmeshed. For the nurses, it is the court of law that is the ultimate point of arrival, and for the victims, it is a return to the everyday that forms the future horizon.

Chapter 3 shows how truth-seeking criteria are instilled in forensic nurse examiners. It argues that forensic nurse examiners rely on criteria abiding within institutional structures and drawing on legal frameworks. These modes of reasoning and evaluating evidence are particularly marked when nurses are challenged by intense emotion. This chapter turns to how the sexual assault forensic examination, with its focus on violence resulting in bodily and genital injury and the recovery of organic substances, is an intimate and challenging encounter; sexual assault intervention requires generous resources in managing emotional distress, and it is not simply the victim who is vulnerable in the course of intervention. Nurses must have strategies to conduct themselves appropriately, even when the case under investigation tests the limits of their comfort. Drawing on scholarship around emotional labor, disgust, and training, this chapter looks at the pedagogical techniques through which affective expertise is inculcated into forensic nursing staff. It shows that emotional mastery is taught through ostensive lessons, rather than overt instruction, by drawing on three areas of ethnographic research that highlight nurses’ strategies and the moments
in which their motivations become opaque to victims: (1) observations of nurses conducting forensic examinations; (2) interviews with nurses about their personal intervention style; and (3) observations of forensic nurse training programs. Through these sources, the chapter reveals the spectrum of facial expressions, gestures, and utterances that make up the affective expertise of forensic nurse examiners, and how this affective register orients the forensic nurse toward the question of truth. The cases in this chapter illustrate how, time and again, nurses respond to situations that they find personally alarming by mobilizing criteria of credulity. In essence, trainers teach them to put aside their emotional responses and adopt legal criteria. Rather than sort through their complex feelings, nurses become practiced at deferring their emotional responses by focusing on the credibility of the case they are building. This training has a strong impact on nurses’ “bedside manner” and accounts for the cool, clinical affect that confuses and, at times, dismays sexual assault victims seeking a kind word or a more warm and supportive demeanor.

Chapter 4 begins with the case of emergency contraception, a therapeutic technique, to probe the relationship between sexual violence and reproductive violence. A forensic nurse examiner’s orientation to victims’ future possibilities and potentialities is heavily framed by legal criteria, while victims draw on very complicated relationships and histories of violence, and frequently structure their own narratives around issues of livelihood. While nurses are struggling with their own complex emotions, victims struggle with a range of issues and concerns of their own. Like the struggle over the “time” of the narrative, this is in contrast with the information and themes elicited and recorded by the forensic nurse as she constructs a forensic narrative of the victim’s experience of assault. Reproductive and productive concerns are frequently victims’ primary worries. Many of the victims are economically vulnerable, and managing the threat of pregnancy and securing work were common concerns in reclaiming control over one’s body and life. Thus, it was typical for victims to accept the emergency contraception offered by the nurses. In addition to concerns about reproductive health, victims continually articulated their worries about sexual assault related to their ability to make a living, and discussed the return to work and the securing of income as a sign of healing. This was a major theme
for the victim population I worked with, but one that was frequently ignored or subverted in the medico-legal intervention. Victims were literally interrupted and asked to provide other details unrelated to their concerns about livelihood in order to propel the forensic interview forward. If participating in prosecution interfered with the ability to work, the women with whom I worked frequently chose to petition the state’s attorney to withdraw charges. Without the resources to guarantee their economic security, victims had to weigh their own participation in the prosecution against their other interests.

Chapter 5 takes the example of photography as a legal technology, showing how the medical and legal are materially linked through forensic photography. In particular, photography is used to deal with and erase the problem of duration. High-quality images are achieved by balancing victims’ needs with the court’s demands, and the visual artifacts that emerge are uniquely forensic rather than a simple amalgamation of medical and legal components. Effective forensic photography is heavily dependent on victims’ active participation. The chapter shows that forensic photography, while anchored in both obstetric and criminological photographic traditions, is not a simple combination of both, but rather unique in that they take pains to break the photographic plane with the victim’s gaze. This defies obstetric conventions in which the viewer never sees the patient’s face, let alone meets her gaze. The intersection of gazes during the forensic examination itself functions such that the victim can communicate her pain to the forensic nurse. Other visual conventions overcome the healing of wounds over time by capturing forensic findings so that they are fixed in time and therefore accessible for viewing by the jury long after they have healed. Thus, while the photos are purportedly for documenting wounds, they actually serve to document affect. Examining the visual component of sexual assault intervention illustrates the ways in which technology impacts interactions between nurses and victims, and also defines forensics as something more than the knitting together of distinct legal and therapeutic components.

Chapter 6 turns from visual documentation to focus on other forms of documentation and paperwork. While sexual assault forensic protocols produce visual images, these images are contextualized by other forms of documentation that serve as a repository of institutional
memory and imagination of sexual assault. These documents transmute individual cases by subjecting them to a process of aggregation that retains and reproduces gendered stereotypes about rape that individual nurses and doctors are typically sensitized to and seek to avoid. Chapter 6 also analyzes the ways in which technologies of documentation sustain particular gendered imaginations of victim and perpetrator. While nurses may be well trained and oriented toward sexual assault as a form of violence that impacts men and women, the paperwork they use has built into it gendered assumptions that cast women in the role of victim and men in the role of perpetrator. The writing and reading practices associated with documenting examinations, and the audit practices for reviewing forensic documentation, also reveal the gendered assumptions with which the documents are encountered by practitioners. These documentary structures and reading practices reproduce stereotypical understandings of sexual assault rather than affording victims the opportunity to disclose and document their unique experiences of victimization. As a result, nurses’ own sensitivity to the unique elements of each victim’s experiences is erased while documentary requirements sustain and institutionalize stereotypical accounts of perpetrator and victim behavior and identity.

Chapter 7 analyzes the way forensic medicine configures the home as both harmful and healing. The techniques of forensic intervention are not limited to reshaping the image of the victim and her wounded body in the forensic photograph or documentation, but rather extend even to reworking the victim’s sense of her home and her family, and the process through which this transformation of home is achieved is at the center of the chapter. Sexual violence most often involves a victim and a perpetrator who know one another, often through the same kinship network. While statistics bear out this pattern, forensic protocols view home as both the place of risk and the place of healing. Even as a perpetrator from within the kinship network is frequently named as the party to be investigated within the forensic documentation, as the case progresses and nurses prepare to discharge the victim, the victim is frequently commended back into the care of the family members who are suspected of creating or contributing to the conditions of victimization in the first place. Within the course of the forensic examination, forensic nurses achieve this effect through a micro-localization of the
crime scene to the victim’s body rather than locating the crime at a set of geographic coordinates. By insisting that “the body is the scene of the crime,” nurses can divorce home as the site of the attack from home as the site of return and healing. Tracking the complicated family negotiations that emerge among members of a victim’s kinship network as the forensic intervention unfolds, this chapter demonstrates the family’s awareness of itself as a potential source of comfort and healing, as well as betrayal and harming.

Chapter 8 looks at the idea of patient compliance as it migrates from nursing practice and medical intervention into forensic intervention. While it is tempting to condemn law for its co-optation of medical procedures, medicine is deeply implicated in shaping legal sensibilities within the sexual assault forensic examination. This chapter looks at how forensic nurses draw heavily on their nursing practice in their work with sexual assault victims. As most Baltimore nurses who become forensic examiners are largely from emergency medicine backgrounds, sensibilities formed within emergency medicine practices often inform their forensic practice. In particular, nurses mobilize ideas about patient compliance in their forensic practice. Understanding patient compliance as a recent invention of modern medicine (Greene 2004), the chapter shows how patient compliance emerges to account for uncertainty in the forensic intervention. Generally referring to the expectation that patients will follow medical orders, patient compliance is often called into question when treatment regimens fail. Thus, nurses are skeptical of victims who show signs of drug use or reveal an HIV-positive status in the course of the medico-legal intervention, as these statuses are stigmatized as indicators of risky behavior. Victims’ complaints about pain may be ignored or deflected in these contexts as nurses identify pain complaints as drug-seeking behavior. HIV-positive status puts patients outside of the purview of prophylactic therapies, and with medical and health status always legally discoverable, a patient with an existing history of a sexually transmitted infection could potentially be seen as less credible to the jury. In addition to illegal pharmaceuticals, victims with complicated diagnoses and unusual prescription medication scripts may further be suspected of non-compliance, thus compromising credibility. While forensic intervention purports to speak to the facts of the case, it has
become a new way of telling old stories about victim credibility in the court of law.

Overall, these chapters enumerate a number of themes, which are discussed in the conclusion. First and foremost, the ethnography paints a picture of a newly emergent professional field—that of forensic nursing. Each chapter highlights a different aspect of the proficiencies and capabilities comprising the skill set of forensic nurse examiners. Altogether, this book depicts the richly layered conception of expertise produced throughout the stages of sexual assault intervention, fostering insight into where experts, and victims, too, might offer meaningful and creative resistance to the structures that encumber the delivery of care for sexual assault complainants. An understanding of forensic expertise suggests the underlying imaginary of the rupture of sexual assault, and the state’s place in repairing this injury. Thus, sexual assault emerges as a temporally bounded, highly specific, legally defined sequence of events that are characterized by a densely populated time line. The forensic nurse produces material evidence with which to inhabit the time line.

Additionally, the nurse and police investigators together aid the victim in producing the narrative features that will provide the descriptive force of the time line for purposes of prosecution. In the emergency room, the technological resources wielded in the name of evidence collection and therapeutic intervention drive the criteria defining consent. The sexual assault victim is constituted as a particular legal subject through his or her intersection with the appropriate technological intervention. She must make her body available to forensic scrutiny without complaint. Even as the forensic nurse examiner investigates the sexually violated body, she manages the victim’s potentialities and possibilities. The cooperative victim and the compliant patient intersect within this institutional matrix.

This book provides many descriptions of circumstances of sexual violence as told to me by different men and women. Their pain and concern encompass a wide range of experiences—the common feature binding these accounts is their unfolding within and intersection with forensic intervention rather than grounding the analysis within the moment of violence itself. In taking this approach, the book raises doubts as to the neatness of the category of “rape” and invites readers to the conversation rather than paralyzing discussion by producing a
tone of horror. In many ways, the legal system materializes a rape allegation and significantly shapes the experience of victims as they seek to make sense of the violence that has intruded in their everyday lives. Increasingly, the law operates by deploying therapeutic technologies with trained medical personnel within hospital settings.

Forensic nurse examiners, police investigators, crime lab technicians, attorneys, and rape crisis advocates strive to institute uniformity with the legal and therapeutic regime through which the intervention is staged. Victims thoughtfully fold sexual violence into a range of events, trajectories, and concerns, framing its significance through diverse engagements with life, love, mourning, and oppression. At times, these map easily onto the frameworks instituted by the legal and medical goals of sexual assault intervention. Inevitably, their accounts and experiences encompass surpluses, excesses, and uncertainties that do not lend themselves to medico-legal definition. The pages of this book capture these realities as victims give voice to them, showing where they are woven into the institutional fabric of legal and medical intervention, and where those narratives, often painfully and singularly autobiographical, move away from the institutional grain, confounding the “one size fits all” model of care offered in the forensic intervention. I hope that this ethnography captures the multitudinous reality of sexual assault, the actors that shape that reality, and the disruptive tremors that impact and unsettle victims’ lives in a myriad of ways. Gathering this information, attentively parsing through it, and listening the way only an ethnographer can, we might begin to imagine a way to challenge existing models and introduce more ethically informed modalities of intervention that better serve the needs of victims, nurses, prosecutors, rape crisis advocates, and even the state.