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Contested suffering: navigating care and making meaning from gendered violence

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CONTESTED SUFFERING: NAVIGATING CARE AND MAKING MEANING FROM GENDERED VIOLENCE

by

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DEDICATION

To all those affected by gendered violence.

To my parents for showing me what it is to care for others.

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I would first like to thank my field site and everyone who helped bring this project to life. I would also like to thank my MACCP program advisors who believed in me and gave me something to aspire to. *Linda,* from the bottom of my heart, thank you for being my self-appointed cheerleader from the start and for providing invaluable comfort when life got in the way. *Lance,* thank you for your countless discussions about various theories, research ideas, and dreams and aspirations. Your encouraging smile helped me believe I had a place in anthropology. More importantly, you are a shining example on how to live life with an open hand. *Bayla,* thank you beyond measure for showing me how to "do" anthropology *and* how to love it. You are truly one of the raddest people I've ever met. I feel more than lucky that you helped shape me as a scholar, activist, and human being.

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To my *friends* who loved and supported me when life made me the worst version of myself – you are appreciated, you are loved, and you have immeasurable value in my life.

Lastly, I would like to thank all the creators of *The Handmaid's Tale* which played in the background on repeat as I wrote…and wrote…and wrote.

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ABSTRACT

Unequal, gendered power relations drive gendered violence, disproportionately affecting vulnerable populations. A paucity of research compares knowledge produced by people who experience gendered violence to their technocratic representations. An analysis of fieldwork data collected virtually through a community-based advocacy program and semi-structured interviews (n=23), shows that survivors and service providers utilize and contest gendered discourses, like constructions of victimhood and survivorship, and policies ostensibly designed to facilitate care in conjoined and distinct ways. I also demonstrate how care systems structure the lives and subjectivities of people who travel through them, producing forms of contested and moralized citizenship. However, people actively resist these forces by creating their own care systems outside the context of managed care. Adopting harm reduction strategies (e.g., affirming people as the primary agents of their care), addressing structural factors underlying gendered violence, and increasing inter-agency communication will create inclusivity and streamline care pathways.

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LIST OF ABBREVIATIONS

AFAB	Assigned female at birth
AMAB	Assigned male at birth
BIPOC	Black, Indigenous, and People of color
CBA	Community-Based Advocates
CBO	Community-based organization
CBT	Cognitive behavioral therapy
CMA	Critical medical anthropology
DCF	Department for Children and Families
DOJ	Department of Justice
LGBTQIA	Lesbian, gay, bisexual, transgender, queer, intersex, asexual
PWUD	People who use drugs
SANE	Sexual assualt nurse exam
SNAP	Supplemental nutrition assistance program
SSP	Syringe service program
UNHRC	United Nations Human Rights Council
VAWA	Violence Against Women Act

INTRODUCTION

a letter. part 1.[1]

X –

Below you'll find a lengthy and elaborate letter. I want to warn you that what I say in this letter can come across as harsh and will probably not be an easy read. The choice is yours. You can either continue reading and hopefully gain an understanding of my perspective, clarified after taking a lot of time to process. Or you can just stop reading right now and save yourself from hearing potentially hurtful things.

If you choose to read this letter, know that this has been months in the making. I've added to it here and there when I've felt compelled to do so or felt inspired by current events. Know that this letter, in its final form, wasn't written out of anger and hate or a desperate grasp for self-actualization, but rather was meant to echo the voices of all the people currently coming forward who've made it clear that we are enough to have had enough.

[1] Schafroth, personal communication, 2018

Why does healing have to be our only goal?
Why can't we be as angry as we feel?

-June Osborne in *The Handmaid's Tale* (episode: "Progress")

.....

I was sitting in my apartment watching *13 Reasons Why* – a television show about a teenage girl who leaves audio tapes for specific people explaining why she committed suicide. I had just graduated from Grinnell College and moved to Washington DC to start a post-baccalaureate fellowship at the National Institute of Mental Health. Was this adult life? Watching Netflix on a Saturday afternoon and not having to read countless articles while I waited for my experiments to finish running? I could get used to this. I was on my fifth or sixth hour of binge watching the series (don't lie, you've been there too). As I'm glancing between my Instagram feed and the television, I notice that the episode is taking a dramatic turn. One of the main characters, Jessica, had been sexually assaulted by a douchey football jock named Bryce. Jessica was adamant that her assault was "no big deal" despite other people hearing the details of it from the recorded tapes. Throughout the episode, the other characters rally around her, even as they subtly try to convince Jessica to report her assault to the police. Everyone appears at her doorstep saying affirming things like "*We're here for you*" or "*We'll stand by you no matter what you choose and no matter what the outcome is*."

"What the fuck…," I think to myself. *"Why didn't I get this type of support?"*

Despite just having moved to a new city and starting a great job, I was not in a good place in my life. In fact, I would probably describe this as the time when I felt the angriest and most resentful I ever had. I burned with an all-consuming rage. This was not

a productive type of anger that creates social progress or benefits society. My anger definitely was not the photogenic kind that would show me in a pink pussy hat with a sign saying some quippy statement like “Fuck the patriarchy!” (although, I do have a shirt with that logo). This was the type of anger that keeps you up at night seething with hatred. This was the type of anger that makes your mood turn a complete 180 for seemingly no reason. This was the type of anger that drags you to the bottomless void of rage. This was the type of anger that demanded to be felt.

Just a year before, I had been sexually assaulted. I had just gone through a really rough breakup with someone who I loved and dated throughout most of my college career. Growing up in a Midwestern town, too, people typically marry your high school sweetheart - so letting this relationship go was a rather painful twist of the knife. With my friends’ encouragement, I tried to put myself out there, as one says. Our college did not have a dating culture, so I was thrown into the unknown territory of our hookup culture. For my friends, it seemed natural and easy to be able to hook up with someone you never met before. Thankfully, though, it was a small campus, so everyone knew everyone to some degree. I gave it a shot – or I at least tried. Most times, however, I (literally) ran away and went back to my dorm. Over time, I started to feel more comfortable with the whole thing. My friends and I got into a good rhythm of which parties to go to, who to talk to, *who not to talk to.* In one night, however, everything changed.

My friends were throwing a party after my college’s annual drag show. This was such a fun time for students! Our semester was ending soon. Hints of a Midwestern spring came in warm breezes, golden sunsets across the cornfields, and smells of

barbecues and freshly tapped kegs. Our classmates and friends performed drag to raise money for our student-led sexual and reproductive health clinic and for the genderqueer student coalition who organized the event. However, at the party, I met a guy, whose name is addressed as "X" in the opening of this chapter, who changed my life more than I ever could have predicted.

Why gendered violence?

As you can probably imagine, my journey from that night in 2016 to now was not a smooth one. After I told some trusted friends what happened, I was quickly met with the *"…and then what happened?*" question, suggesting that my traumatic experience did not give the dramatic flair that would deem it worthy of their attention. Some people also told me that my assault was just a "misunderstanding" caused by "too much" alcohol. I was also presented with a million different options of what I *should* do so that "*it doesn't happen to anyone else*." One option, telling the college administration so I could receive free therapy, proved to be a lie and left me with medical debt. I also heard and was deeply moved by the hundreds of stories from people who unfortunately shared life experiences. It was a tough web to navigate.

The more I felt misunderstood, the more confused and angrier I became. However, I also became curious. How do so many people experience gendered violence, yet it is so poorly addressed in our social and political spheres? Why do so many people continue to say the wrong things or nothing at all? What *are* the right things to say… if there are any? Why do some experiences get more attention than others? *How do people make sense of all the shit that's thrown at them?*

The opening vignette detailing my binge watching of *13 Reasons Why* is an important detail to my story. Seeing all the fictitious characters rally around their friend in support broke me in a way that forced me to start fixing myself. I had finally reached a point where I realized just how much I changed *and how alone I felt*. I was so angry at my friends, who I thought disbelieved me and did not care about me anymore, that I (unknowingly) was cutting them all off. I was terrified of men and refused any form of romance and intimacy. I was so angry at society that I wanted nothing to do with it. This was also around the time during the Trump presidency when Brett Kavanaugh was confirmed as a supreme court justice – echoing the confirmation of Clarence Thomas, another accused perpetrator. So many people, including those close to me, would say things like "*Well, it happened a long time ago so…*" or make the timeless "*Boys will be boys*" argument in defense of Kavanaugh's confirmation. Adding fuel to my fire was all the sexism and sexual harassment I faced at work. Apart from the "everyday" sexism (e.g., being told to smile, white cismen appropriating and getting credit for my ideas, hearing nefarious comments about Asian women), during my first lab hangout, a postdoc asked one of my male co-workers if I was his girlfriend. Five minutes later, another male co-worker groped me. A few weeks later, another postdoc told me that I was going to "waste my breeding years" if I went to graduate school.

Most disturbing to me was that *I was jealous of the villains in my story.* My ex-boyfriend and the person who assaulted me were in committed relationships with other women – and while I can never know for sure, it seemed like they loved and were loved by people whereas I felt like they did not see a purpose in me that did not extend beyond

their own personal pleasure. I was also sad and angry for the people who shared this experience. It was disheartening how many people, ranging from those I loved to those who I barely knew, posted #MeToo on their social media. The weight of all this compelled me to finally seek help and *want* to process and understand everything the best I could. I wanted to act.

In some ways, I have been "working" on my thesis since the day when I was confronted with the uncertainties of how to process my new and unwanted identity of being a sexual assault "victim." This thesis has been a work in progress over the past few years whenever I made efforts to tell a familiar story about what it feels like to experience gendered violence. I have "worked" on it in various diary entries, therapy sessions, activist movements, and intentional conversations I have had over the years with friends and those affected by gendered violence – including the person who assaulted me (which, I have included pieces of the letter I wrote to him throughout this thesis). Thus, I have personal stakes in understanding and retelling the stories about what it is like experiencing sexual and intimate-partner violence where oppression is woven in the social and political fabric of our everyday lives.

What this thesis is and isn't about

First, I want to make it clear that this thesis is not an auto-ethnography or a memoir. I am open about the fact that I have personal experience with gendered violence to be transparent about my motivations to research it and establish my positionality. While each chapter begins with parts of the letter I wrote to the person who assaulted me or letters I have written to myself, I intentionally separate them from my analysis of the

care systems around gendered violence and the people who travel through them. I am not aiming to describe and systematically analyze my personal experience in order to understand the larger cultural experience of gendered violence (Ellis, Adams, and Bochner 2011).

Rather, I aim to build thick descriptions that address the fullness of the lives of people who have experienced gendered violence and those who care for them, highlighting the aspects of their lives that are not defined or categorizable by medical, legal, and social discourse. In addition, while I critique the existing care politics and policies enacted by care systems responding to gendered violence, this is not a sustained attack on the people whose jobs require these providers to enforce them. Even though I center the people who have experienced gendered violence and their experiences seeking care, I do not consider them as points of intervention to improve the care systems or prevent gendered violence. They are not the problem. Their lives do not need sanitizing or translating so they can be deemed worthy of recognition and consideration for academic scholarship. Instead of approaching their experiences as puzzles to be solved by superimposing the theoretical perspectives developed by critical medical anthropology, gender and queer theory, and feminist theory, for example, I asked myself when writing this thesis and ask my readers now to explore people's potential to inform and transform theory and, thereby, its effect on shaping political, material, and intimate realities.

What this thesis *is about* is how and why gendered violence is a pervasive issue in our society and what can be done about it. This involves understanding how care systems responding to gendered violence continue to fail people who have experienced gendered

violence. This also involves complicating and nuancing what we "count" as gendered violence and adopting a humanist perspective to view people as legitimate choice makers in their own lives, especially when these choices oppose what we instinctively consider the "right" course of action. Lastly, and most importantly, this involves facilitating access to those choices and supporting the notion that people do not have to make them alone.

Overall, this thesis interrogates the many assumptions about gendered violence and the people who experience (and commit) it, embedded within the logics and politics of care. In addition, this thesis is about what it feels like to live in bodies that are given multiple and often unstable and malleable identities. These include victim, survivor, at risk, vulnerable, and all the gendered labels often imposed on people (e.g., slut, liar, dramatic, anti-feminist). While my analysis demonstrates how the macrostructural forces within care systems structure the lives of people who have experienced gendered violence, this thesis also addresses how people respond by pushing back against these forces and involving and protecting others during the healing process.

A note on language

In social movements and lay conversations, we typically use the term "survivor." Within my virtual ethnographic field placement at a community-based organization for domestic violence resources, advocates used "survivor" to distinguish their clients from their abusers and to validate the severity and "realness" of people's experiences as they tended to experience heavy amounts of gaslighting on top of the many other forms of abuse. However, as my analyses will explore later, the term "survivor" often did not feel "right" to people. Many expressed that they did not feel worthy of it because "*it could've*

been worse." Others said that to become a survivor you must have been a victim and they strongly reject the latter categorization. Some stated that they still are trying to survive, and that "survivor" implies that they have "gotten over" something, when in reality, it is a lived experience every day of their lives.

Therefore, I typically use person-first language and describe people as "people who have experienced gendered violence." While certainly a long-winded description, I feel that it best captures how people view themselves. However, I prioritize referring to people how they refer to themselves. For example, if people referred to themselves as "survivors" or "victims," I adopt that language when describing their experiences. In addition, I refer to people as "survivors" in reference to how advocates or forensic nurses refer to them, or "victims" when discussing the legal construction of gendered violence. Overall, I aim to avoid broad and static characterizations of people. As one participant named Cara stated "*I'm a conduit, not a container – I experienced it. It happened to me. But it doesn't define me.*"

Overview

In my research, I aim to understand the experiences of receiving and providing care around sexual and intimate partner violence with the intention to shape protocols and healthcare practices responding to those experiences. In addition, I investigate the gendered construction of these experiences and how people navigate and negotiate their care. There is a paucity of research comparing the knowledge produced by survivors (i.e., their meaning making process) to the knowledge constructed by the technocratic assemblage around those experiences, whose criteria are gatekeepers to the various

support systems. This dearth indicates that there have been missed opportunities allowing people to reshape paradigms and to use their experience/s to make sense of the webs of meaning around gendered violence, comprised of their own conceptions, the medicolegal/care systems' construction of gendered violence, and how political and social spheres animate violent realities. At its core, this thesis amplifies people's experiences as constructed and narrated by them to push back on the systemic forces that tend to distort them.

During my data collection and analytical process, I found that no single theory about violence fully captures how it manifests. My analysis not only elucidates the linkages between macrolevel structures and individual suffering, but also how people's social worlds contribute and alleviate the damage caused by gendered violence. Everyone has a role to play in the production of, healing from, and prevention of gendered violence. Therefore, I argue that adopting a dimensional perspective of gendered violence, one that acknowledges the various forms violence takes, suspends our denial of social responsibility and highlights the structures and actors within those structures that give rise to its conditions, outlets, and uses.

In this thesis, I examine how the assemblage of care around gendered violence, comprising the medicolegal system, community-based organizations, and individual providers, functions as a network that configures the *right* kind of suffering, shaping how people make meaning from their experiences of gendered violence. However, there are movers and shakers within this network. People who have experienced gendered violence and service providers utilize and contest gendered discourses - like constructions of

victimhood - and policies ostensibly designed to facilitate care in conjoined and distinct ways. Overall, I argue that gendered violence, constructed by the perpetrator/s and a structurally violent assemblage of care, alters how people view themselves, navigate their social worlds, and conceptualize what it means to "heal." While gendered violence is a heavy topic that should not be romanticized, censored, or sensationalized, people find ways to carry on – just as pain demands to be felt, life demands to be lived.

Chapter 1 provides background literature on gendered violence discourse and the care systems addressing it, including the medicolegal system and community-based organizations. This chapter also outlines the guiding theoretical perspectives stemming from critical medical anthropology and gender and feminist studies on violence and its intersections with gender and sexuality. Lastly, this background chapter explores the social role of the "victim" and "survivor."

Chapter 2 delineates the methodology and data analysis for this research project. Here, I further establish my positionality and demonstrate how my research questions evolved during my preliminary, virtual fieldwork at a community-based organization in Boston, MA. In addition, I outline how I designed this project, including how I adjusted this research project due to the COVID-19 pandemic. I also provide information about my data outcomes and analysis.

Chapter 3 demonstrates how the medicolegal system and community-based organizations posit the subject positions of "victim" and "survivor," while simultaneously prescribing the proper trajectory someone must adhere to in order to demonstrate that they are healed. These care systems use normative forms of gender and gender

performativity to construct these subject positions and trajectory of healing. This chapter also demonstrates how this process fashions lived experiences in participants who did not "fit" the gendered mold. However, this chapter also demonstrates how this is not a fixed process. Individual healthcare providers act as *movers and shakers* within this system to support others in gaining access to care and recognition within these systems. I define movers and shakers as those who intentionally reshape, restructure, and propel a system in a certain direction.

As care systems responding to gendered violence construct care in a gendered way, it is vital to understand how people navigate these systems and negotiate their own identities. These systems and the discourses they employ represent the social and political spaces that construct normative categories, but these spaces also serve as sites to explore how they are also continuously resisted and shaped by those who are excluded or who fall outside the norm. Therefore, chapter 4, shows how people reconcile with these imposed forms of citizenship and why they do not always "fit" someone's life experiences with gendered violence and conceptualizations of themselves. This chapter also demonstrates how the clinical encounters within these systems introduce a "should" paradox, managing how people conceptualize their experiences of gendered violence on a moral plane.

Chapter 5 explores the afterlives of people who received care from formal institutions. In other words, this chapter answers the question of "*what happens next?*" In this chapter, I show how people construct their own care systems in response to institutional failure. People employ technologies of the self/presencing to bring

themselves to the foreground of their own lives, fashioning themselves as institutionally and personally recognizable as mattering. In addition, people who have experienced gendered violence include others in this process, primarily reinforcing a two-gender system. Mainly, people construct “good men” and seek to protect women from gendered violence when creating these care systems. This phenomenon is central to their healing as their own senses of selves are wrapped up in the lives of others.

The concluding chapter offers my insights, derived from my personal experiences and this current research project, about what can be done to address gendered violence in a more impactful and meaningful way. These alternative paths frame gendered violence and the care systems that respond to it as issues of power and structure.

CHAPTER 1: BACKGROUND

One of the most hoary assumptions is the belief that a society will fall apart and its members scatter if they are not threaded like beads on a string of common motives.

-Anthony Wallace in *Culture and Personality*, p. 24

Gendered violence is dimensional

Gendered violence is generally defined as violence directed against someone based on their biological sex and/or gender identity (World Health Organization 2003). More recently, this definition has expanded to capture any type of violence that is rooted in exploiting unequal power relationships between genders. Examples of gendered violence include but are not limited to domestic violence, sexual violence, transmisogynistic violence, and homo/bi/queerphobia.

Despite activism, policy reform, or mandated trainings, gendered violence remains a pressing social issue. Pervasive sexual violence (Masters et al. 2015) occurs in all parts of society regardless of geography or culture (World Health Organization 2003). Researchers and activists debate whether sexual violence should be considered an interpersonal violation or a product of a structural inequality based on genders and sexuality (James 2010b). For example, early anthropological work controversially argued that cultures are either "rape-prone" or seemingly "rape free," with matrilineal societies having a lower incidence of rape (Sanday 1981), suggesting that gendered violence is relationally produced between individuals and through learned masculine gender logics within a specific kinship network. Here, sexual violence is a product of a disrupted cultural configuration of masculinized power.

This “cultural” framework has limitations. First, sexual violence encompasses more than penetrative (i.e., heterosexualized) rape. Second, this culture-centric framework ignores political and economic forces that produce the structural conditions for creating and maintaining gendered violence. Some feminists argue that men [sic] sexually violate women [sic] to evoke fear and shame, subjugating an entire social class, to maintain the patriarchal social order (Brownmiller 1993), or the social system in which [white] cismen hold primary power and predominate in roles in political and economic (e.g., capitalist) structures, social and cultural privilege, and moral authority (Walby 1989).

In addition, state institutions and contemporary forms of power (e.g., military regimes and neo/colonialism) institutionalize gendered violence. For example, gendered violence weaves throughout histories of colonial slavery and imperialism (Scully 1995; Feinstein 2018; Smith and LaDuke 2005), the transformation of slavery into racialized hate crimes and the penal system (A. Y. Davis 2003), and military conquests and regimes (Cain 2014; Min 2003). Thus, no matter the interpretation, sexual violence reflects unequal relational and structural power distributions (Mulla 2014e). Therefore, structurally vulnerable populations (Quesada, Hart, and Bourgois 2011) such as women (cis and trans), Black, Indigenous, and people of color (BIPOC), the LGBTQ+ community, and stigmatized populations are disproportionately affected (World Health Organization 2003; Bent-Goodley 2005; Erez, Adelman, and Gregory 2009; Jones et al. 2009; Mindlin et al. 2012; Razack 1994; Rios 2017).

Gendered violence is dimensional in that it extends beyond "the directly assaultive physical and visible phenomenon with bounded limits" (Bourgois and Schonberg 2009, 16). In other words, macrolevel and structural forces create conditions that foster gendered violence *while also* shaping interpersonal and individual experiences, and the aggregate of these individual acts ultimately legitimizes and reinforces their macrolevel production (i.e., a cyclical process). Therefore, this critical framework provides the most accurate and useful representation of gendered social issues. In other words, examining the social and political systems underlying gendered violence unmasks its structural causes and enhances democratization by building the capacity to mobilize social power against oppressive systems (Singer 1995). In the same vein, limiting the scope of societal issues solely to a microlevel or local context distorts and hides the structural forces and power relations that shape local realities. However, exclusively viewing issues from a macrolevel perspective fails to clarify how different local worlds respond to these forces (Singer 2004, 24), ignoring the tensions between the micro- and macrolevel and intragroup differences (Crenshaw 1991; Lorde 2007). Therefore, I explore how predominant violence paradigms work in conjunction to explain how conditions for gendered violence manifest within the locally situated experience, blurring the (false) separation between the macrolevel and microlevel.

Anthropologists often use structural violence as a theoretical framework to elucidate the systemic production of violence and explain an individual's use of gendered violence in relation to their structural location. Structural violence refers to the linkages between social inequities, social suffering, and power (Galtung 1969a; James 2010b).

"Objectively avoidable" conditions of suffering, like gendered violence, prevent people from reaching their full potential and these conditions of suffering are constructed without a specific actor (Galtung 1969, 168). Here, someone does not act violently because of a predetermined or psychoanalytical gendered script (e.g., a male unconscious drive or desire) (Zakin 2011). Instead, their behavior reflects their structural location. For example, patriarchal capitalist systems that include gendered constructions cast some people as cis-men who are therefore socialized and expected to treat certain others violently to maintain hierarchical order and justify those systems. Cismen then encode protections for only themselves into institutions, continuing the civil and legal subjugation of the majority. Some scholars use this framework to explain why gendered violence is an effective tool for neo/colonialism (Smith and LaDuke 2005; Cain 2014; Dadhania 2018) and why perpetrators of gendered violence are not held accountable in our current "justice" system (Mulla 2014e; Edward and MacLeod 1999). Thus, structural forces disproportionately harm and disadvantage people on the basis of their social location, highlighting an inextricable tie between direct and structural violence.

Structural violence also works synergistically with symbolic forms of violence. Symbolic violence is a Bourdieusian concept to describe power differentials that are unconsciously agreed upon and accepted as the authoritative or common sense ways of being (Durey 2015; Bourgois and Schonberg 2009). In other words, the byproducts of capitalist patriarchal systems (e.g., a shared (mis)understanding that non-male gender identities are objects to be sexually controlled to assert and maintain dominance in political, economic, and social realms) become misrecognized as the normative way of

being, unconsciously reinforcing their structural production. Furthermore, genders and their differentiation are organized into symbolic practices (R. Connell 2020a). For example, some people intentionally act within normative constructs of masculinity (e.g., by drawing upon misogyny and homophobia) to assert dominance over other gender identities (Bedera and Nordmeyer 2020) while others complicitly accept or do not challenge this gender hegemony, even if they do not fit into normative definitions of masculinity (R. Connell 2020a). Therefore, gendered power relations arise in a system of gendered symbols and symbolic practices functioning within societal structures (e.g., families, schools, civic associations, industries). Sexual violence is one strategy to maintain these structures.

The construction of the medicolegal system

Sexual assault intervention is mediated by the relationship between law and medicine in formal emergency room-based programs. Sameena Mulla coined the term *medicolegal system* (Mulla 2014) to highlight the simultaneously distinct and conjoined therapeutic and legal aims of gendered violence intervention that blends the work of medical care and forensic legal investigation into a single intervention. The construction of the medicolegal system exemplifies the intersection of structural and symbolic violence. Efforts combating sexual violence have increasingly become professionalized and institutionalized, comprised of both the distinct and conjoined efforts of medical and juridical spheres (Mulla 2014a; Sutherland et al. 2012; White and Du Mont 2009).

Prior to the current medicolegal system, victims had few post-assault resources since medicalized healthcare systems did not have trained staff nor standardized

treatment protocols to care for them (World Health Organization 2003; W. K. Taylor 2002). This paucity discouraged victims from reporting their assault and/or abuse and offered few protections within the legal system (Du Mont and White 2007). When cases did move forward legally, they often were dismissed because of a lack of forensic evidence or because evidence was improperly collected (Du Mont and Parnis 2000; Du Mont and White 2007). In addition, victims face/d disbelief based on false, patriarchal notions that women [sic] are untrustworthy or too emotionally fragile (i.e., symbolic violence) to be reliable narrators, resulting in an increased demand from medicolegal structures to provide corroborative evidence to support victims' claims (Du Mont and White 2007; White and Du Mont 2009; Acosta 2002). To create better reporting mechanisms and healthcare resources, and in response to carceral feminists' demands for criminalization and "accountability" for perpetrators within the penal system, the medical and legal system became inextricably tied and the standard in gendered violence healthcare. In other words, the legal system depends on the medical system as a reporting system supplying potentially corroborative evidence with which legal actors can attempt to enact the legal consequences of gendered violence, and the medical system depends on the legal system to justify the professionalization and validity of gender violence healthcare.

While under this medicolegal framework, it would appear there are more healthcare resources for people reporting gendered violence on an institutional level, many of these initiatives center more around producing corroborative evidence for legal proceedings (White and Du Mont 2009; Acosta 2002) than centering personal accounts or

providing trauma-responsive care. Within this system, those with specialized training such as forensic nurses, police, or specialized health agents, are the primary producers of corroborative evidence, and therefore credible knowledge. Here, corroborative evidence includes DNA collection, forensic images, and information documented in lengthy, detailed, and formulaic intake forms (Mulla 2014a; 2014d; White and Du Mont 2009; Du Mont and Parnis 2001). The aggregate of the evidence collection process is what Erica James refers to as *trauma portfolios* that establish a victim's worthiness of institutional recognition and care (James 2010a). Moreover, participating in forensic intervention (i.e., providing corroborative evidence *in addition to* providing a personal testimony) is how people must construct their credibility (Epstein 1995) under the medicolegal gaze. Thus, the demand for corroborative forensic evidence underpins a positivist approach in pursuit of medicolegal "truths" (White and Du Mont 2009) predicated on the logic that women's [sic] claims need to be proved and recognized by authorial actors (i.e., those with specialized training as "authorities") to be believed. Moreover, it is important to note that the medicolegal system was built around the *visible* experiences of white, cis-gender women who presented in a way that aligned with society's acceptability standards of the morally legitimate suffering body (Mulla 2014e; Smith and LaDuke 2005; Ticktin 2011). Therefore, the medicolegal system encoded for the exclusion of other people's experiences and identities, resulting in hostile encounters and exacerbated violence (Mulla 2014e).

Medicolegal citizenship

Corroborative evidence, or signifiers of violence, are problematic because they emphasize and perpetuate stereotypic rape imaginaries (Mulla 2014a; Razack 1994), or rape myths based on the structural configuration of a sexed and gendered body. The documentary structures and reading practices by medicolegal agents re/produce stereotypical misrepresentations that white, cis-gender *women* are always victimized in unfamiliar environments by unknown *men* (Mulla 2014a), violence is a singular occurrence in their lives (Mulla 2014b), and that they fought against their attacker resulting in visible, physical injuries (Du Mont, Miller, and Myhr 2003; White and Du Mont 2009; Du Mont and White 2007).

For example, standardized treatment protocols are mostly comprised of gynecological questions and practices, revealing embedded gendered assumptions that a victim is assigned female at birth (AFAB), and therefore can be subjected to invasive medical procedures (Du Mont and White 2007; Mulla 2014a). Medicolegal practices also emphasize that a victim's home is a healing space (Mulla 2014f). This logic negates the possibility that domestic or intimate partner abuse resulted in sexual abuse/assault, reinforcing the false belief that gendered violence is an isolated incident rather than reflecting larger structural issues pervading kinship networks and the uses of gender to legitimize and act within them.

In addition, the demand for forensic images of physical injuries, including micro-injuries (White and Du Mont 2009), divorces the site of assault/abuse from the home and locates it to the victim's body (Mulla 2014f). This practice re/produces notions that a

victim *looks a certain way* and is therefore physically recognizable (i.e., a "real" victim is a physically damaged one). Together, these myths reinforce hegemonic gendering (Rios 2017; Mulla 2014a), or the intentional hierarchization of genders to reinforce patriarchal power (R. W. Connell and Messerschmidt 2005; R. Connell 2020b), and the heteronormative supremacy (i.e., the special rights and privileges granted to cis-gender, heteronormative people) (Stein 2008). They reinforce racism, since women of color are less likely to receive forensic examinations and are treated poorly in medical spaces (Spry 1995; Bent-Goodley 2005; Mulla 2014c). Thus, these myths construct restrictive portrayals of the "ideal and credible victim" (Mulla 2014c; Spry 1995; Du Mont and Parnis 1999; Larcombe 2002).

The product of these rape imaginaries (i.e., the ideal, credible victim) is what I refer to as *medicolegal citizenship*. The medicolegal citizen is formally recognized by the medicolegal system and can access its care and resources. This form of citizenship is a type of *biological citizenship* (Petryna 2010), or forms of belonging, rights, and claims people can make to access resources and care on the basis of biological characteristics. A Foucauldian theory of biopolitics (2003) elucidates how systems of power promote social order and explains how institutions grant some rights and entitlements while denying others. Here, "biopower" regulates the *masses* through the state's categorization, surveillance, and regulation of bodies to optimize economic productivity (Foucault 2003). Biopower is neutral, yet unequally applied (241), as the state promotes a *certain* form of life – or citizenship. In other words, biopower operates through citizenship (i.e., the particular type of body you inhabit) while citizenship is a politically, economically, and

socially configured construct. Power manifests through the categorization of the medicolegal citizen because sexuality bridges the body and the population together where disciplinary power acts at the individual level (i.e., “normal” and “productive” behavior) and regulatory power acts at the collective level (i.e., the acceptable expression of sexuality) (Foucault 2003, 251; Morgan and Roberts 2012, 243). Moreover, Foucault argues that a paradigmatic shift regarding conceptions of the body between the seventeenth and nineteenth century shifted regulatory efforts to sexuality (Foucault 1990). As sexuality discourse got imposed onto populations, it created sexually perverse or proper constructs, ladening sexuality with morality and rationality (Foucault 1990). Thus, these modes of regulation (i.e., biopolitics of intervention) concern the medicolegal system in what it considered permissible or prohibited sexual behavior, offering an explanation why so few are granted full medicolegal citizenship.

Interpersonal uses of violence

Importantly, sexual violence is not purely structural. Limiting the scope to a structural perspective frames sexual violence as a purely agentless phenomenon (James 2010b). In other words, perpetrators of gendered violence would seemingly be absolved of their actions, because their behaviors would be considered products of social structures or unconscious biological drives (i.e., essentialist gender scripts within a psychoanalytical perspective). While social structures and collective scripts heavily influence behavior, only highlighting the structural production of gendered suffering tends to reify the artificial divide between political and civil human rights and concepts of justices within

advocacy discourse (James 2010), prioritizing one over the other rather than examining how macro- and microlevels engage dialectically.

Gendered violence is a tool of oppression that has meaningful and insidious uses among individuals. Sexual violence demonstrates a form of *necropolitical violence* because it uses political *and* social power to subject life to the power of death, dictating how some live and others die by imposing social or civil death (i.e., not accepted by society as fully human and the loss of civil rights due to state intervention, respectively) (Mbembe 2001; Mbembé and Meintjes 2003; James 2010b). Here, acts of violence transgress social taboos and order aiming to exploit, control, and destroy individual and collective bodies and kinship networks. Thus, necropolitics complements biopolitical theory by arguing that violence arises from *the aggregate of individual acts* against non-normative or less socially valuable populations (Butler 2006) while also defining these violent acts as components of larger apparatuses of power (James 2010b, 44). Moreover, necropolitics accounts for modern technologies of violence such as neo/colonialism, neoliberalism, and warfare (James 2010b; Mbembe 2001; Mbembé and Meintjes 2003) that seek to destroy human bodies and kinship networks through violating taboos and social order.

Gendered violence functions as a contemporary form of violence (Brownmiller 1993; Smith and LaDuke 2005; Olujic 1998; James 2010b), or ones not *directly* linked to institutional power. For example, some individual sexed bodies are viewed less than human and are therefore constructed as sites of domination and control (Olujic 1998; Bedera and Nordmeyer 2020). Individual bodies represent social bodies, and violence

against them aims to humiliate the individual while also destroying the reproductive lineage, physically and symbolically, of a population (Olujic 1998; James 2010b). In addition, institutions then use the violation of the individual and social body to employ interventions that legitimize their authority (e.g., surveillance mediated by the forensic exam; carceral culture) that often have raced, class, and gendered implications. Thus, the actions and experiences of individuals and communities are an important piece of the dimensional and cyclical process of gendered violence.

Importantly, the interpersonal usage of gendered violence is on a continuum. If people do not fit the exact criteria of the medicolegal citizen, they can be denied care and recognition by both institutions and the public. There have been numerous instances when survivors of gendered violence have been dismissed by medicolegal actors, like forensic nurses, because their dress, behavior, race and/or class, medical history, gender identity, etc. characterize them as "non-compliant" (Mulla 2014c). While compliance in a medicalized context connotes a myriad of constraints people must operate within, the tendency to dismiss people or inadvertently blame someone for their experience is an act of violence. For example, in 2016, a student at Stanford University named Brock Turner sexually assaulted an unconscious woman named Chanel Miller. There was an overwhelming response of "*what did she expect?*" when the news revealed she had been drinking. Former Judge Aaron Persky even stated, "I mean, I take [Brock Turner] at his word that [she consented], subjectively, that's his version of events," reinforcing misconceptions about mutual consent and failing to question why Brock Turner did not recognize his actions as assault. This logic individualizes blame and resonates with

American ideals of individual responsibility and privatized suffering, reinforcing the (false) beliefs that we are the primary decision-makers of our lives (Singer 2005). However, this logic – drawing from symbolic violence - continues to subordinate and discount our own and others' experiences and does not allow us to interrogate these widely held beliefs. The theory of *civilized oppression* applies here. Civilized oppression is invisible to all but the privileged and accounts for systematic subordination through both interpersonal and institutional processes that are not maliciously intended (Harvey 1999). In addition, instances of civilized oppression are a site where structural and symbolic violence often intersect, especially through health bureaucracy (Ostrach 2017b). Thus, gendered uses of violence exist and are re/produced within structures of care and justice.

Therefore, gendered violence operates within the structural, symbolic, and interpersonal planes, demonstrating its dimensionality. The medicolegal system exemplifies how structural and symbolic violence intersect and interact. The medicolegal system has gained jurisdiction over defining and handling gendered violence, functioning as an institutional arbiter of credible or valid experiences. Capitalist patriarchal systems of gender construction infiltrate this system. In other words, patriarchal notions that women are untrustworthy and too emotional to make accurate claims about their experience/s were unquestioned and institutionalized as the standard practice of caring for gendered violence. Embedded rape myths that construct the medicolegal citizen exemplify the symbolic violence within structures of "care." Moreover, gendered violence exists interpersonally. The gendered body symbolizes the moral and physical

wellbeing of an individual and society (James 2010a). Here, the gendered body is a site for contemporary forms of terror (e.g., colonialism; warfare) and non-maliciously intended acts like victim-blaming (i.e., civil oppression). Therefore, these social structures infuse violence into gender while also infusing gender with violence (James 2010b).

Agency and gender

While these structural and symbolic frameworks are useful when conceptualizing how power works through categorization, discourse, and institutions, we need to expand our thinking. These regulatory forces create subjugated citizens (i.e., people who fall outside the category of the medicolegal citizen) who are deemed unworthy to receive resources by the state and its apparatuses (Martínez 2018). Non-medicolegal citizens are left with limited agency and autonomy (Das 2010; Martínez 2018). However, while faced with constrained choices, people act as social agents who strategically move the system in the direction of their interests, demonstrating subtle and explicit forms of resistance in creative and effective ways (Cox 2015; Das 2010; Petryna 2010; Willen 2010; Ostrach 2017a; Ginsburg 1998).

I aim to highlight agency in my forthcoming analyses to avoid sensationalizing gendered violence and perpetuate a tendency to view experiences through a necrophilic lens – focusing solely on fixed states of suffering and exposure to death. Not discussing individual and collective agency reinforces the belief that people who have experienced gendered violence are *too destroyed* or *too subjugated* to imagine and create new possibilities. We can, and must, discuss possibilities, resistance, and hope as often as we

discuss violence and suffering. People's lives are dynamic, and anthropologists must capture the totality of them lest we hinder the process of "becoming" (see Taylor 2005). Aimee Meredith Cox, in her ethnography *Shapeshifters: Black Girls and the Choreography of Citizenship,* expands our conceptualizations and perceptions of "suffering" by arguing that conscious efforts to commit to the praxis of love and acceptance are central to collective liberation and the reclamation of rights and justice, as such efforts remind us to witness life in all of its dynamic forms.

Witnessing life centers voices rather than suppressing voices – a process often lacking in gendered violence care. The medicolegal system tends to pursue "justice" through criminalization. Consequently, this pursuit constrains an individual because the medicolegal process seeks a certain kind of information from a certain kind of individual. For example, the medicolegal institution demands a clear delineation of events constituting sexual violence, resulting in a singular narrative framework (Mulla 2014b). Medicolegal emplotment, or the configuration of time by creating a coherent whole out of events, reflects an etic perspective. This coherent narrative distorts narratives of inherently incoherent lifeworlds (Mattingly 1994). In addition, this version of emplotment erases the lived suffering of survivors (Kleinman 1988) because medicolegal actors selectively focus on particular elements of survivors' experiences and exclude others. In other words, sexual violence has particular meanings for medicolegal actors who listen in light of their own interests (e.g., to collect medicolegal evidence in a manner that corroborates the victim's verbal account), ignoring other potentially

important aspects, thus risking over-literal interpretations of accounts best understood metaphorically or symbolically in reference to people's life worlds (Kleinman 1988, 52).

Selective interpretation reflects the interests of the medicolegal profession and highly influences and/or constrains people's own interpretation of their experiences (Kleinman 1988, 52). The legal account may reframe and contradict survivors' narratives (Balsamo 1999). Experts also sometimes categorize most of the information survivors tell them during a forensic examination as irrelevant, leaving survivors feeling disbelieved and having to adopt medicolegal frameworks in lieu of their own (Mulla 2014b; 2014c; Jones et al. 2009). This strategy is a critical, yet detrimental, aspect of receiving care for gendered exploitation. For example, previous ethnographic work examining the landscapes of care responding to human trafficking argued that becoming identified as trafficked is vital for accessing resources. However, this is a fixed, or pre-determined, process that hinders how someone rebuilds their personal identity (Nicklas 2017). Thus, there is little leeway for people to voice their own experiences within their own frame of understanding. Rather, they quickly adopt the language and vocabulary made available to them through emplotment efforts (Mulla 2014b, 74).

Moreover, emplotment gives meaning to certain actions (e.g., evidence collection, probing specific questions, constructing a timeline with specific vocabulary) (Mattingly 1998) and places them within a larger therapeutic story that works towards a specific ending (e.g., legal justice) (Mattingly 1998). Medicolegal systems use available resources and texts to set stories in motion (Mattingly 1994; 1998) and people use this to begin making sense of their experience/s. However, there are points of tension that play out in

someone's life outside of a medicolegal context. For medicolegal actors, legal settings are typically the ultimate destination whereas the end goal for the survivor is the return to everyday life (Mulla 2014b). Therefore, it is important to identify the desired ending from medicolegal emplotment and consider whose goal it meets, questioning how people achieve *their* desired ending.

Critical medical anthropology (CMA) offers an appropriate, guiding framework for a multiaxial analysis of suffering and agency. CMA clarifies the extent to which micro-populations resist politico-economic forces and provides frameworks for civically-oriented solutions (Singer 1986; 1995). Thus, the interactive field between the micro and macrolevel (i.e., configurations of power alignments) serves as an action arena of social struggles caused by unequal power distributions (Singer 1995, 86). In developing CMA, Singer (1995) provided the framework of systems-correcting and systems-challenging praxis. The former constitutes minor systemic improvements and working within the system, but with no alterations to the power alignments, while the task of the latter is to unmask the origins of social inequities and mobilize social action to challenge and even permanently change power structures (Singer 1995; Ostrach 2017a).

Importantly, systems-correcting and systems-challenging praxis are not mutually exclusive, in that people can work within a system to obtain what they need in the short-term while simultaneously calling attention to power inequities they experience in order to challenge them (Ostrach 2017a; 2017c). Within this framework, strategies of resistance and agency must be continuous and intersectional to build capacity to dissolve hegemonic systems. In addition, resistance and agency is a continuum of individual and social action.

People can be agentive without experiencing the immediate outcomes of wellbeing or social and political transformation (Martínez 2018). Moreover, agency can take a more palatable form, often referred to as "peaceful" (Epstein 1995), or in more overt and direct ways.

Importantly, people exercise agency within their own gendering. This form of opposition is especially important within gendered violence work as "victim," "survivor," or concepts like the medicolegal citizen are based on gendered assumptions that encode for some people's exclusion. As previously discussed, power over gender and sexuality operates through discourse (Foucault 1990; Butler 1993a). Discourse creates normative gender categories and ways of being with ourselves and with others (i.e., the heteronormative social bond) and is legitimized through societal practices such as marriages (e.g., "*I pronounce you man and wife*"), legal proceedings, medical protocols (Butler 1993). Moreover, sexuality discourse has a history and citational power (Butler 1993). For example, according to Butler (1993), the word "queer" has a homophobic history of a nonnormative identity that is incited upon its usage in discourse. As normative gender categories are spoken into existence, power can operate through them to control and regulate (Foucault 1990; Butler 1993). However, these categories also serve as sites for resistance. In other words, how you act within a determined set of gendered constructs serves as a form of agency. Butler states,

> *What we might call "agency" or "freedom", or "possibility" is always a specific political prerogative that is produced by the gaps opened up in regulatory norms, in the interpolating work of such norms in the process of their self-repetition. Freedom, possibility, agency do not have an abstract or pre-social status but are always negotiated within a matrix of power. (1993, 22).*

Thus, gendered discourse and the gender constructs it produces are not fixed, but rather can be continuously reworked and negotiated to oppose and resist normative gender performativity.

Gendered violence care landscape

Community organizing

While the medicolegal system is the standard healthcare model in gendered violence work, community-based organizations are a crucial element in the healthcare landscape. Community-based organizations and efforts responding to gendered violence emerged in the 1970s. These widespread (white) feminist movements began drastically changing the healthcare landscape (D.-A. Davis 2006; King et al. 2020; Kelly, Burton, and Regan 1996). Specifically in Boston, the Cambridge Women's Center founded the first designated community-based health center in 1971 on International Women's Day by (Cambridge Women's Center 2022). Seeking to create designated care systems and spaces for women's [sic] needs, feminist activists staged a ten-day building takeover of an under-utilized, Harvard-owned building (BARCC 2018; Cambridge Women's Center 2022). This sit-in resulted in a $5,000 donation from Susan Lyman. The organizers used this donation to put a down payment on the facility the Cambridge Women's Center still operates from. Since then, more community-based organizations emerged (Northeastern University n.d.) to address gendered violence. However, these efforts tended to center around femininity and "women's" experiences.

Rather than existing as separate institutions, community-based and medical organizations (i.e., the medicolegal system) operate in a network. However, the services provided and care models differ. For example, it is increasingly common for medicolegal teams to refer people to community-based organizations for prolonged services (e.g., emotional support, legal support, continued medical care) since its model of care is more momentary (i.e., a single visit for a forensic exam) (Mulla 2014b). On the other hand, community-based organizations rely on the medicolegal system to provide resources that are unavailable to them such as PrEP/PEP, a prophylaxis for HIV, forensic exams, or more intensive medical care. In addition, community-based organizations tend to use a harm reduction model. This model grants agency to the people by prioritizing their needs and desires regardless of whether the community advocates believe it is the appropriate course of action, which is typically in contrast with medicolegal efforts. Generally, people are more likely to utilize a community-based organization since these organizations are more grounded in communities' needs, less likely to stigmatize behaviors, and are less likely to involve the penal system (Whitaker et al. 2007).

Community-based organizations also use a different method of healing and education. Medicolegal efforts are designed to only address medically and legally relevant outcomes of gendered violence (e.g., physical injury, STI testing and treatment, emergency contraceptives, evidence collection), whereas community-based efforts tend to address interpersonal dynamics. For example, women [sic] who participated in an intensive self-defense workshop that included a larger structural analysis of gendered violence were less likely to experience sexual assault and were more confident in their

ability to effectively resist assault than similar women [sic] who have not taken such a class (Hollander 2014). Therefore, I also center the efforts from community-based organizations as they are an integral component within care networks that addresses the longitudinal aspects of gendered violence.

While community-based organizations offer a multitude of beneficial, long-term services, they are still intertwined with legal institutions within the state such as the Department for Children and Families (DCF). DCF is the primary institution to report suspected cases of child abuse and neglect. Their mission statement states that they

> "…*work in partnership with families and communities to keep children safe from abuse and neglect. In most cases, DCF is able to provide supports and services to keep children safe with parents or family members. When necessary, DCF provides foster care or finds new permanent families for children through kinship, guardianship or adoption*" (Department for Children and Families 2022).

Often, health providers are told they are mandatory reporters in that they must involve DCF if they suspect a child is being neglected or abused (i.e., if any aspect of a case may reflect and be interpreted as abuse by legal criteria). However, social service bureaucracies like DCF are fraught with internal conflicts and political agendas (L. V. Davis, Hagen, and Early 1994). Like medicolegal actors, social service providers sometimes ignore significant aspects of a given case to make it more manageable for themselves and their structural capacity, frustrating those in abusive relationships and hindering their attempts to leave the relationship (Neale 2018). While only a small subgroup of the participants in this study were parents and encountered DCF, cases involving DCF occupied a significant amount of advocates' time and energy at my primary field site.

Language matters – Victim? Survivor? Neither?

There has been an ongoing debate about what to call someone who has experienced gendered violence. Derived from trafficking discourse, "victim" has long been established within legal settings, and therefore, is a commonly used term in medicolegal systems (Mulla 2014a; Sutherland et al. 2012; White and Du Mont 2009). Research has also shown that people in the United States and Germany believe "victim" is a more appropriate label for someone who has experienced gendered violence (Papendick and Bohner 2017). However, the term "victim" is a contested categorization since there is mixed evidence whether "victim" has a negative impact on people who have experienced gendered violence (Schwark and Bohner 2019). Both qualitative and quantitative research show that victimhood implies a loss of agency (Dunn 2005; McCarthy 1986) and passivity (Leisenring 2006). For example, a quantitative study shows that US undergraduates ascribed less positive attributes and placed marginally greater blame on someone who is labeled as a "rape victim" compared to someone who is labeled as a "survivor" (J. Hockett, Mcgraw, and Saucier 2014).

"Victim" is also a meaningful category in anthropological work. In her ethnography *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention,* Sameena Mulla uses the term "victim" when describing those who have experienced sexual violence because the totality of the care experience denies people claims to their survival (Mulla 2014). Mulla argues that forensic intervention posits the subject position of the victim, an abject and feminized role. Here, the subject position and the social role of victimhood mutually construct each other in that they both are

categorized into hierarchies based on gendered power relations and assumptions embedded within institutional and social practices. However, Mulla demonstrates that victimhood is not passive, but rather victims actively participate in their forensic intervention lest they are deemed non-compliant in medical systems, denying or modifying the post-assault care they receive.

On the contrary, the label of "survivor" is associated with strength, resilience, and a sense of restored agency (Thompson 2000). "Survivor" emerged in feminist discourse in the 1980s as a replacement for "victim," focusing on active coping mechanisms for *survival* (Kelly 2013). More recently, people may reject the imposed label of "victim" because of its negative associations, preferring a self-description as a "survivor," as it implies activity, strength, optimism, and positive coping with a potentially life-threatening experience (Papendick and Bohner 2017; Thompson 2000). In addition, qualitative research shows that women [sic] who embodied or internalized the positive associations of a "survivor" were more likely to proceed with normative care pathways for gendered violence (e.g., legal proceedings) (Patterson and Campbell 2010).

Social perceptions of "survivors" are also gendered. For example, while cis-men in one study rated images portraying women as survivors (e.g., at a self-help group) more positively, they explicitly blamed them more for the assault compared to victim images (e.g., women in a vulnerable position) (Schwark and Bohner 2019). Researchers postulate that men may explicitly blame women more for their assault when depicted as taking an active role in their recovery because these images evoke a violation of expected,

normative gender performance (e.g., women as passive, receptive agents), and thus threatening normative masculine identities.

However, there are limitations to the existing body of research investigating the labels "victim" and "survivor." First, most of the studies above only depict cis-women as victim-survivors of sexual violence. Thus, someone is more likely to ascribe gender stereotypes (e.g., passivity) to a feminized subject because of her perceived gender identity and fulfillment of (or lack of) expected gender roles or behaviors rather than because of having experienced sexual violence. Second, the studies depict "survivorship" and "victimhood" in stereotypical ways. For example, Schwark and Bohner (2019) depict a survivor as either engaging in normative forms of healing like taking part in a support group or being in a vulnerable position, respectively. Such portrayals reinforce monolithic representations of victimhood and survivorship, reinforcing the victim-survivor dichotomy. Third, most existing studies focus on perceptions of people who have experienced gendered violence rather than investigating how people accept or reject these labels in relation to how they view themselves. Fourth, and most pressing, there is a paucity of anthropological work examining how these categories manifest and unfold within someone's social world and how systems that produce, maintain, and control gendered power relations define and use these terms.

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CHAPTER 2: METHODS

"We don't need our agency taken away anymore…that's happened enough."

-Mira, Interview on July 27, 2021

Fieldnotes from October 6th, 2020: It is your typical day - sitting on my yoga ball drinking a very (very) cheap cup of coffee while looking at square boxes, each representing a classmate who I have never met in-person. Rather than listen to dozens of lecture slides, a humanitarian organization presents their new protocols for handling gender-based violence in international disaster settings. The main speaker addresses everyone as "fellow public health officials." As the only anthropologist of the group, I half-heartedly laughed (quickly checking that I muted my microphone) as being the outlier was apparent by the frequent difference of opinions from some of my peers – the primary being that anthropologists are "cultural interpreters" for the "big guns."

The group opens with their mission statement identifying themselves as "*an NGO that uses medicine and science to document and advocate against mass atrocities and severe human rights violations around the world*." Voices drone on for 30 minutes about things that have already been said by hundreds of others (e.g., gender-based violence is bad, we should fix it) – nothing untrue, just not new or necessarily profound. He goes on to say that *"…because we engage in science, we produce 'truths' which carry power*." In complete honesty, I find myself starting to roll my eyes at the casual disregard for the majority of other disciplines and the value of lived experiences as a source of knowledge production. This statement also evoked memories from my time as one of the few women of color NIH fellows where you could find a god complex as easily as you could find a test tube. Trying to perform engagement, but actually thinking about how beautiful my first New England Fall is, I nod and smile, hoping that I have done my due diligence.

My face quickly changes when I hear him say "*It's not the clinician's job to determine if a rape happened. That's a legal decision."*

My mind immediately races with all the "*what the fuck*?" questions I want to ask in response, going against mostly everything from my Midwestern upbringing. I raise my virtual hand and ask why they focus on forensic evidence if research shows that its collection leads to few accounts of justice within a legal framework (Du Mont and Parnis 2000; Edward and MacLeod 1999; Jones et al. 2009; Mulla 2014e; Parnis and Mont 2002). He responded, "*The US tends to focus on DNA, but our organization seeks corroborative evidence* (e.g., physical injuries) *to match the victim's retelling*." Huh…Certainly, there is a lot to unpack there –

> perpetuating rape myths, reinforcing the institutionalized disbelief of victims, making gendered assumptions, to name a few.
>
> Of course, I have more questions. The most pressing one being: *at what point is it the victim's decision?*

Critical questions

Drawing inspiration from Black and intersectional scholars, I argue that sexual violence depends on the synergistic relationships among power apparatuses set in place by the white, cis-patriarchy (Das 2011; hooks 2014; Mohanty 2003; Razack 1994; Mulla 2014e; Crenshaw 1991; D.-A. Davis 2019). We have failed to understand, and therefore, address, the interlocking systems and policies that negatively affect the diverse community of people who have experienced gendered violence. I asked myself many critical questions when designing a study that would seek to explore these experiences. For example, how do I ask about deeply personal experiences when a global pandemic forbade in-person connection? How do I design a study that would not evoke gendered assumptions (i.e., cast people into the lived body of a cis, heterosexual white woman)? How do I even do *this*?

A glimmer of certainty came from setting hard boundaries from the start. From the beginning of my master's program, I aimed to highlight how people contest the forced representations of their partial citizenship (as indexed by their age, race, class and housing status, and constructed sexuality and gender expression based on white feminist logics) (Cox 2015). I also aimed to understand how people negotiate their identities and social locations, specifically in relation to gender, by asserting agency in creative, yet strategic and intentional ways. These contestations and negotiations truly have life or

death consequences for people who have experienced sexual violence as they have often been excluded from the decision and policy-making process. It is a delicate dance representing people as political agents capable of building and creating what the white, cis patriarchy seeks to destroy and dehumanize while also highlighting the institutional failures that create the sociopolitical conditions that give rise to sexual oppression. Thus, my primary research philosophy was to let survivors drive the research process – everything would be their decision.

Original research plan

Community-based organizations are integrated within specific communities and can better assess their needs and provide tangible solutions. In addition, these organizations have the capacity to build long-lasting relationships and often help members navigate other institutions such as hospitals, courts, and DCF. Thus, these organizations served as ideal settings to recruit participants since the integrated nature of community work allowed for a broad system (e.g., hospitals, legal settings) and specific system (e.g., the community organization) analysis, revealing how organizations intersect and interact to shape the experiences of their clients.

Fundamentally, I designed my project to be applied anthropology wherein anthropologists "*use the knowledge, skills, and perspective of their discipline to help solve human problems and facilitate change*" (Chambers 1989, 8). I argue that gendered violence is a social issue in which anthropologists can (and should) collectively participate in creating solutions. One of the core tenets of applied anthropology is centering the people who are supposed to experience the benefits of research within your

project design and implementation (Ashburn et al. 2015; Cernea 1985). Participant observation has been a vital tool for anthropologists to accomplish this goal. Participant observation allows anthropologists to eliminate their own moral judgements, stepping down from academia's ivory tower to cross societal boundaries and enter people's lifeworlds (Ashburn et al. 2015; Bourgois and Schonberg 2009). This approach better captures the nuances and complexities often missed when "doing anthropology" at a distance. Thus, I aimed to represent people who have experienced sexual violence in a way that accurately portrays their lives and the complexities of sexual violence without "sanitizing" the issue nor perpetuating stereotypic misrepresentations. Moreover, applied anthropological methods dovetail with decolonizing qualitative methodologies (Thambinathan and Kinsella 2021) which are especially important to use when studying gendered violence (Smith and LaDuke 2005).

While the COVID-19 pandemic eliminated many possibilities of doing in-person fieldwork (i.e., how participant observation is typically conducted), I was still able to connect virtually with a community-based organization serving survivors of domestic violence. Since September 2020, I have been volunteering with a community-based advocacy organization (pseudonym: CBA) located in Boston, MA. CBA is a successful initiative and partnership of community health centers providing free and confidential domestic violence services for community residents. CBA's client base is primarily structurally vulnerable populations including undocumented women of color, non-native English speakers, people without residency documents, people who use drugs, and LGBTQ folks.

While there was a program manager at CBA, the overall structure was largely egalitarian. Unlike other community-based organizations that other participants worked for and the medicolegal system, the advocates functioned as a team, sharing equal responsibilities and power. In addition, while CBA was housed within a university, the university imposed very little restrictions on CBA's functioning. However, CBA did face the challenges that most publicly funded service organizations do. During the middle of my field work, Massachusetts announced that they would be cutting funding to victim service organizations. This forced CBA to seek external, private funding. These grant applications are still under review.

Throughout my time volunteering with CBA, I reshaped my research questions and approach to best fit the needs of the advocates and the communities they serve. I refer to this approach as a modified version of community-based participatory research since the organization and advocates were not involved in every research decision. However, I frequently conversed with them to get feedback on ideas, research design, and analyses. Applied research, especially when working with marginalized populations, is and should be an iterative process. I consistently reflected and reshaped my project to conduct research grounded in community empowerment. In keeping with this approach, I planned to conduct a qualitative data analysis from fieldwork observations, document analyses, and semi-structured interviews. I also scheduled weekly meetings with the program manager and attended the clinical supervision meetings. I was attentive to the recurring issues the advocates brought up (e.g., the need for funding, working during a

pandemic, what cases required the most group think) and attempted to integrate these areas into my research.

It was striking to see how closely CBA practices mirrored applied anthropology and ethical research practices. I worked with seven advocates during my time at CBA. CBA strategically placed each advocate to fit communities' language needs (e.g., Spanish, Haitian Creole, Portuguese, Vietnamese) throughout Boston. In addition, many of the advocates share similar experiences with their clients such as a shared cultural background, life experiences, or gender identity which helped them foster relationships with their clients as opposed to a more momentary interaction (i.e., relationships typically produced in mainstream institutions). This relationship building allowed advocates to continuously work towards solutions to the issues their clients face. Solutions-based work is another core characteristic of applied anthropology (Ashburn et al. 2015; Chambers 1989). CBA utilized a harm reduction model, a non-judgmental, non-coercive provision of services and resources to people and the communities they live in to reduce the negative outcomes of gendered violence. Here, the primary goal was to not "get someone to *just* leave" an abusive relationship, but to mitigate its negative effects.

The advocates also followed confidentiality practices similar to ethical research. It can be difficult to know how to communicate with people, especially those whom you have never met in person. I followed the advocates' practices. I learned how important it is to never include details about myself and my research unless someone *directly* connected me with their client after debriefing them about my interests and intentions. It was also important that I always communicated with people over the phone, to leave as

little of a documentation trace as possible, unless someone reached out to me via email confirming that they were safe to communicate using other platforms. Thus, connecting with people to talk about their traumatic experiences was extremely difficult during the pandemic, especially because someone's abusive partner or someone connected to the abuser could more easily monitor their whereabouts and to whom they spoke. Therefore, my time volunteering with CBA was invaluable in learning the subtle behaviors or verbal cues someone may use if their safety is in jeopardy while also learning how to respond in these situations.

Using nesting sampling, I aimed to conduct at least ten interviews with a combination of self-identified survivors and advocates that worked with them, recruited through the same sites. I planned to interview advocates in the first stage of data collection since I had already formed relationships with them. In addition, I planned to include the staff members of CBA and partner organizations because most advocates had also experienced gendered violence. I contacted and recruited key informants and other participants based on the relationships built during my service with CBA. I planned on using a mixture of respondent-driven, referral, site-based, and purposive sampling, to recruit participants through CBA and partner organizations. If a participant was willing, I asked them to provide my contact information if they knew of other clients and/or survivors that met eligibility criteria and might be interested in participating (i.e., warm handoffs).

During data collection throughout the summer, I continued my role as an intern at CBA. One of my goals was to continue to engage in reflexive conversations with the

advocates about the progress of my research and ongoing analysis. In addition, as COVID-19 vaccination rates increased, I spent more time at community events and health centers to increase community contact and contextualization.

Adjustments

Additional field sites

I also volunteered with a syringe service program (SSP) that serves people who use drugs (PWUD). I was interested in learning about their experiences of gendered violence more closely. This SSP allowed for in-person volunteering, which allowed me to gain a better sense of how organizations work. I also joined a discussion group of forensic nurses. One forensic nurse saw my recruitment poster and invited me to join their group. We met once a month via zoom. Here, I was primarily concerned with understanding their work from their perspectives, which issues they faced, and how they talk about their patients and their jobs.

Adjusting anthropology

Although my connections with CBA and the SSP were invaluable, I never fully experienced traditional participant observation (i.e., in person fieldwork) and therefore often wondered if I was "actually doing" anthropology. After a lot of time reflecting (i.e., overthinking and grappling with imposter syndrome), I reached the conclusion that "doing anthropology" virtually and during a global pandemic produced benefits and hindrances.

Anthropology produces and reinforces power dynamics and disparities among researchers and the communities from which they draw their research. Typically,

researchers are in positions that are not always afforded to those in their field sites - being affiliated with a university, having access to institutional resources, having (some) financial resources, occupying a socially accepted/respected position (Ashburn et al. 2015). These power dynamics held true in my experience; however, my positionality as a first-generation master's student of color allowed for me to subvert them in subtle ways.

First, master's programs are grossly underfunded. During my time as a student, I worked three jobs, equating to approximately a 20-30 hour work week *in addition* to a full course load, to afford rent and cost of living while still accruing debt. There was little opportunity for additional funding; I applied to numerous "diversity" scholarships at Boston University, but they were mainly granted to PhD students. My lack of financial support made me eligible for Massachusetts's supplemental nutrition assistance program (SNAP – formerly known as food stamps). The paperwork and approval process were prolonged and frustrating, and I commiserated with people in my field site. Second, I shared similar experiences with people who participated in my research. While no experience is the same nor should be pitted against another, a shared understanding facilitated empathy and an underlying sense of connection. However, I *never* disclosed my experiences with my participants unless I was asked. Third, people read me through gendered and racialized scripts that mischaracterize me. Fourth, much like the advocates and survivors I interacted with, I never had the privilege of being "productive" on just one thing. In addition to balancing multiple jobs and doing school, many things in my personal life demanded my attention and energy.

However, it is extremely important not to draw absolute parallels between myself and my participants. While we shared common experiences, there were many things I was not. I was not living in a shelter, using criminalized substances, or currently in an abusive relationship. I understood that I represent/ed an institutional agent whose academic institutions have a chronic history of exploiting entire populations. I fully acknowledge that power differentials lie at the foundation of academic scholarship. Acknowledgment alone is insufficient. Researchers are never neutral agents – politically, economically, socially. As bell hooks eloquently stated:

> *"The choice to work against the grain, to challenge the status quo, often has negative consequences. And that is part of what makes that choice one that is not politically neutral."*

Thus, the choices we as researchers make have material consequences beyond our immediate network. Our behaviors must match our intentions as we also open ourselves to critiques. Therefore, while I was not "doing anthropology" as I had initially set out to do, engaging in these reflexive processes and seeking to actualize productive change anchored me to the field's defining characteristics.

I concluded that I was conducting "deterritorialized ethnography" (Ashburn et al. 2015; Merry 2006). This methodological approach stems from the work of Sally Engle Merry where she traced the development and movement of gendered violence discourse across institutional contexts and international borders (Ashburn et al., 2015, 7). Merry (2006) found that while local contexts produce locally situated forms of knowledge and expressions of gendered violence, there was a general universality across sites as to how people defined and addressed violence (Ashburn et al. 2015, 7). Therefore,

deterritorialized ethnography focuses on a specific issue rather than being bound by time and space. In addition, this approach addresses how information flows across organizations and/or places (Merry 2000). This approach has been a crucial framework because it allows for a wider application of an anthropological lens, recasting and nuancing "obvious" social scripts (e.g., sexual violence is bad) and illuminating what has gone misrecognized in quick "solutions" (e.g., someone should just leave an abusive situation) (Ashburn et al. 2015).

A limitation with deterritorialized ethnography is that the communities or people of interest do not always share cultures, kinship networks, languages, structural systems, etc. (Ashburn et al. 2015). However, *reterritorialization* – or the revitalization or emergence of new ways of existing and areas of investigation - occurs after the destruction of cultures, bodies, spaces, and modes of being caused by colonization, the spread of neoliberalism, and resultant sexual violence (see Smith and LaDuke 2005). These new forms of action and thought have an emergent, common origin that warrant further investigation (Ashburn et al. 2015; Deleuze, Guattari, and Foucault 2009). This phenomenon was incredibly apparent in my interviews. Virtually every participant stated that they more strongly advocated against forms of oppression following their own experiences. In addition, there was an overwhelming sense of kinship and camaraderie among others who have experienced violence. People formed relationships with others who shared experiences. For example, many people participated in this project so that others would not have to endure what they went through. As a participant named Mira

stated, "*I don't know anyone who hasn't experienced* [assault/violence] *… it's a family you shouldn't have had, but you're very happy to have had them now*."

I amended my IRB protocol to include using social media as a recruitment strategy. I expanded my inclusion criteria to include people who have provided or received any type of care or support. I widened this inclusion criterion because I quickly realized that organizations exist in a network. I posted my flyer to a social media group for people in graduate school. People reached out to participate almost immediately. This process was interesting. Although I was almost overwhelmed with responses, a colleague who focuses on the experiences of queer and trans people of color did not receive as much interest - people also reacted to their post with either laughing or angry emojis. People expressed their interest in gendered, specifically feminized, ways. For example, many people titled the email subject line "Violence Against Women Study" or made assumptions that I was only looking at the experiences of cis-women. Despite having wide inclusion criteria, people often made statements like, "*I don't know if* [my experience] *is what you're looking for, but I want to help anyway I can!*" These observations suggest that there is not uniformity in recruitment strategy success, some reterritorialized networks are more easily formed and accessed, and that gendered labor performance (e.g., wanting to help, taking on undue responsibilities) permeates the research process.

Review of outcomes

This study was reviewed and approved through expedited review by the Boston University School of Medicine Institutional Review Board. Participation in the study was

confidential and all interviews were de-identified prior to analysis. Only pseudonyms are used. Participants received a $15 gift card for their participation. All participants verbally consented to participate and have their interviews audio recorded.

Data collection & Participants

I used a mixture of respondent-driven, referral, site-based, and purposive sampling, to recruit participants through CBA and partner organizations. If a participant was willing, I asked them to provide my contact information if they knew of other clients and/or survivors that met eligibility criteria and might be interested in participating (i.e., warm handoffs). I also recruited participants using social media.

People were eligible to participate if they had ever received and/or provided any type of care around gendered violence. There were a range of responses of having provided or received care in community-based organizations, medicolegal settings, and private healthcare (e.g., emotional and behavioral counseling). All participants were >18-years-old and were comfortable being interviewed in English over the phone or via Zoom.

Overall, I conducted 23 in-depth, semi-structured interviews from June-September 2021 (see table 1). Each interview lasted between 30-120 minutes. Fourteen interviews were with self-disclosed survivors (n=14) and eleven interviews were with advocates or service providers (n=11). Three of the ten providers were forensic nurses, and the remaining (n=9) were community health workers. However, these “categories” are not mutually exclusive. Four of the ten providers disclosed that they have also experienced some form of gendered violence. Twenty-one of the interviews were with

people who self-identified as women, one person was nonbinary, and one interview was with a cis-man. In addition, while most people discussed a past experience of assault or experience of abuse, two participants were currently living in a domestic violence shelter and were in contact with an abusive partner.

Table 1. Participant characteristics

Pseudonym	**Pronouns**	**Characteristic**
Ali	She/her	Community-based advocate
Alison	She/her	Experienced gendered violence
Alyssa	She/her	Community-based advocate & experienced gendered violence
Ana	She/her	Community-based advocate
Anna	She/her	Community-based advocate
Ariel	She/her	Experienced gendered violence (living in a shelter & speaking with abuser)
Bailey	She/her	Community-based advocate & experienced gendered violence
Bastet	She/her; they/them	Experienced gendered violence
Celi	She/her	Community-based advocate & experienced gendered violence
Cara	They/she	Experienced gendered violence
Cendy	She/her	Experienced gendered violence (speaking with abuser)
Dotti	She/her	Community-based advocate
Eleanor	She/her	Community-based advocate
Empathy	She/her	Community-based advocate
Joyce	She/her	Forensic nurse
Katie	She/her	Experienced gendered violence
Leila	She/her	Experienced gendered violence
Marcos	He/him	Experienced gendered violence (living in shelter)

Michelle	She/her	Experienced gendered violence
Mira	She/her	Experienced gendered violence
New Yorker	She/her	Experienced gendered violence
Rosie	She/her	Forensic nurse/experienced gendered violence
Zena	She/her	Forensic nurse

It was nerve-wracking to interview people whom I had never met before. I was unsure how to best communicate with people to show that I care, but not to "overperform" and present myself disingenuously. I spent a long time thinking about how to ask people about such personal experiences. I relied heavily on the advocates to help guide me through this process. One of the best pieces of advice an advocate gave to me was that I would eventually say the wrong thing or make someone mad. For example, I frequently used phrases such as "*thank you for sharing that with me*" or "*I'm very sorry that happened to you; that wasn't fair*." While these value-neutral phrases are incredibly important and should be in our trauma-informed vernacular, they can lose meaning as standalone statements, especially if you repeat them. Also, some statements, such as, "*I'm sorry that happened to you*" can come across as pity. I interviewed someone, who called herself New Yorker, who very directly told me never to feel sorry for her and that it is "disgusting" when people say that. Certainly, this does not apply to everyone, but demonstrates how there is no universal "best response." For some, being straightforward with questions worked best. For others, a greater emphasis on validation and frequent checks ins to see how they were feeling worked well. I had to quickly discern which

approach people preferred and better facilitated the conversations. I was present and active during the interview. I was also quick to take responsibility for any mistakes and made it clear at the beginning of the interview that people could push back on any questions, the interview pace, or conversation topics.

Virtual interviews posed challenges. Since I was not traveling anywhere, I often scheduled interviews back-to-back to make my day “more efficient” given that I was already behind schedule with data collection. However, I was both physically and emotionally drained after conducting four, two-hour interviews in a row. I was not retraumatized from hearing others’ experiences, but I could not do much to help someone’s circumstances over Zoom. The process felt very extractive. In addition, it is genuinely frustrating to hear the many injustices people endure and then end a zoom call. Fortunately, CBA held a workshop on vicarious trauma and burnout that was invaluable. I realized that I needed to draw boundaries with myself and to resist “savior or self-congratulatory ethnography." People did not see me as a therapist or community advocate, and it was not my place to impose my support or help without being asked. Of course, I was still more than willing to connect people with resources or assist them as best I could; however, I generally was not providing information they did not already know. I tended to find that people wanted to share their stories with the intention of helping others. For some participants, the interview was an opportunity to practice speaking English. People also participated because they wanted to talk about their experiences with a neutral party as part of their own healing process.

However, I found that conducting virtual interviews helped equalize the inherent power imbalance between researchers and participants. Typically, people conduct interviews at their field site whether that is a health center, someone's home, or a neighborhood. However, conducting interviews virtually allowed others to enter my own space. People saw my bedroom and sometimes commented on how it looked. People got a sense about my own personality by seeing how everything was decorated. People saw me get flustered if I encountered zoom/Wi-Fi issues. Allowing this small glimpse into my own life helped humanize me. In addition, I was also able to connect with people outside of Boston. This increase in connectivity not only facilitated more conversations, but it also helped increase interdisciplinary and multisectoral communication since I connected with people outside of CBA. I also connected with other researchers with similar interests, feeling inspired by others both within and outside of academia.

Qualitative data analysis

Using semi-structured, open-ended questions allowed participants to define their own subjective understandings of their experiences of gendered violence and allowed them to control the course of the interview and which topics we discussed. I primarily used modified grounded theory to capture participants' lived experiences to theorize from the data itself (Houston et al. 2021; Strauss and Corbin 1994). Grounded theory analysis typically focuses on social patterns of action or interaction between and among various actors to discover processes and relationships rather than creating theories about individuals (Strauss and Corbin 1994). Modified grounded theory, however, examines how individuals experience a particular phenomenon, attending to power dynamics to

bridge empirical research and theory in real time (Charmaz 2006; Creswell 2012; Houston et al. 2021). Moreover, modified grounded theory collects and analyzes data in a cyclical pattern rather than linearly.

In line with modified grounded theory methodologies, I inductively coded interview transcripts and fieldwork data. I formulated preliminary codes from my first year of virtual fieldwork with CBA. These overarching themes included topics such as gatekeeping strategies to care (e.g., how are different gender identities addressed and managed in specific care settings), the politics of care (e.g., what are the contests of power existing in these systems), and victim and survivor discourses. These themes guided, but did not restrict, my interviews with survivors and care providers.

To analyze my interview data, I identified emergent themes across transcripts and ethnographic data. After my first three interviews with survivors, I read each transcript for commonalities, while attending to points of divergence and how a participant's identity and social location influenced those differences. This process informed which probes I used during my next interview. Since there was little time between each interview, I was able to remember key points from previous interviews and attended to whether they appeared in later interviews. I then continued to develop a list of common themes as I gathered more interview data. During each interview, especially with survivors as these were very loosely structured, I attended to what people spent the most time talking about and what they organically brought up. I built my analytical memos around those discussion topics. These themes related to the main research interests of experiences within and outside of care settings, person-driven narratives of their

assault/abuse, and conceptualizations of the self. I found that asking participants to choose their own pseudonym at the end of each interview, rather than assigning one post hoc, provided additional, detailed information about the sense of self/selves and its intersection with healing.

All interviews were audiotaped and transcribed verbatim using Otter.ai. and coded using NVivo qualitative analysis software. As I analyzed individual and aggregate data, I recorded analytical memos in NVivo with my interpretations of the data, keeping in line with modified grounded theory by allowing the analysis to emerge in real time. I developed a completed list of themes derived from my data collection process and existing literature on gendered violence healthcare. I then sorted individual participants and experiences into the thematic categories from which I created multiple versions of visual schemas, attempting to create the most streamlined and inclusive logical model. I finalized the schema when every participant had at least one aspect of their experience included.

CHAPTER 3: PRODUCTION SITES OF CONTESTED SUFFERING: VICTIMS TO SURVIVORS

a letter. part 2. [2]

You took something from me – or a part of me. What makes us different, apart from many moral reasons, is your privilege. Your privilege allows you to hide what you did to anyone you choose. Your privilege kept you from hearing people you confided in reply with "*It's just not black and white*," or "*I just don't want to say the wrong things*" and then say nothing - or even now people not wanting to talk because they have more pressing issues or quite frankly are probably sick of hearing me process it aloud.

Your privilege keeps you from telling *anyone* besides your chauvinistic therapist. Unlike what your therapist said – *"if she were my patient, I'd encourage her to explore why she can't* just *get over it"* – it's not a choice. You took that choice from me and don't you ever use those words as a form of comfort. It's demeaning and condescending and fucking wrong. As two people who've never experienced this – to be violated on the most intimate level, to be denied a basic right of compassion– you don't get to decide for me what's the appropriate amount of time to process this.

Because *you don't just get over* this – *you don't just get over* something that made you neutral (at best) towards life – *you don't just get over* something that to this day can make you wish you could erase a significant part of your life every time you saw, read, or heard something related to sexual assault. You get to remain the carefree, detached, egotistical fuckboy. I, however, am bound to the "1 in 5." In that way, I envy you. While other people may see through you, let's get something straight here. I am the one who got broken – you're the one who did the breaking.

[2] Schafroth, personal communication, 2018

"i'll be quiet when
we can say sexual assault
and they
stop screaming liar*"*

-rupi kaur
Home Body, p. 12

……

"*So, I have a really tough case for everyone today*"

Bailey[3] begins our clinical supervision meeting with a referral from her healthcare center that has been giving her difficulties. After providing a general content warning, Bailey proceeds by telling us a complex, as are all, experience of gendered violence. This one between a younger couple.

"*It's hard to know the right course of action, you know?*" – as all the advocates' heads nod emphatically on the Zoom screen.

> *The police are involved. Her health provider is involved. Everyone is involved. This is probably one of the worst cases of domestic violence I've seen. He's strangled her, bit part of her ear off, called her every name in the book. I don't know what to do here. She doesn't seem to think she's a survivor, but I definitely consider her one. I just don't think it's right to force her to work with me if she doesn't want to*.

As I observe the advocates at my fieldwork site discuss how to proceed – talking about what they would do in the situation, asking Bailey *why* the client's healthcare provider referred her to our organization, validating Bailey's feelings that this is a tough situation to navigate – I have flashbacks of my earlier time in working as an outreach educator for a grassroots sexual health organization in college. During my weekly shifts,

[3] All names are pseudonyms

I performed the expected tasks - eagerly answering questions, restocking safer sex supplies, emailing back and forth with the administration to try and receive more funding. However, there were many times when I was in Bailey's position of not quite knowing how to do your job, albeit with less severe consequences. One thing I did not expect was the amount of people who came to discuss their experiences with gendered violence. Fellow students expressed frustration about their experience with Title IX. Others sought post-assault care. No matter the reason people came, the one common thing I heard over and over (and over) was, "*Did it even count?*"

Thus, care providers around gendered violence frequently ask *and* are asked – what counts and for whom?

Defining gendered violence

This question of whether an experience "counts" as gendered violence stems from its contestation and redefinition in social, legal, and political spheres. The Department of Justice (DOJ) previously defined gendered violence, or more specifically rape, as "*The carnal knowledge of a female, forcibly and against her will*," and then in 1927 redefined it as, "*The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim*" – the definition has not changed since ("An Updated Definition of Rape" 2012). Importantly, the DOJ defines domestic violence separately. It was not until the 1970s when legal categories emerged for "rape" or "battering" if perpetrated by a spouse or common-law partner (Hasday 2000). More recently, activist and community-based organizations define gendered violence more broadly to include different forms of

violence like sexual, intimate partner, transmisogynistic, emotional, financial, spiritual, etc. However, despite evolving definitions, some organizations, like the United Nations Human Rights Council (UNHRC), for instance, continue to define gendered violence based on assumptions that victims have a feminine identity and were assigned female at birth (Mulla 2014e). For example, the UNHRC defines gender-based violence as "*any harmful act directed against individuals or groups of individuals based on their gender*, [including sexual violence which takes] *multiple forms and includes rape, sexual abuse, forced pregnancy, forced sterilization, forced abortion, forced prostitution*" ("Sexual and Gender-Based Violence in the Context of Transitional Justice" 2014).

In this chapter, I locate care organizations and the politics that guide their organizational practices as central sites of knowledge production around gendered violence. I argue that these care structures operate through normative constructions of race, class, and gender and sexuality, dictating who is deemed as a real, credible victim, or "morally legitimate sufferer" (Ticktin 2011), reinforcing normative forms of gendered citizenship. Ultimately, this biopolitics of gendered intervention produces a "proper" trajectory of healing in which the *right* kind of victim uses the *right* kind of healing to become the *right* kind of survivor. I also argue that people, including service providers, act as agentive beings, consciously or not, to gain recognition within these systems. However, these enactments of agency have implications that extend beyond the scope of care settings, translating into deeply personal, reimagined subjectivities for the people who experienced gendered violence.

The politics of care

Care systems are not neutral. Many factors, like political agendas and policies, constrain who works at organizations, the type of services they provide, and for whom. One of the first, and most frequent, conversations I had during my time at the community-based advocacy program was, "*what do we do with men?*" The advocates deliberated whether a male-identifying client was "an actual survivor" or pretending to be one to invade in his (female) partner's life. At first, I was rather surprised that we were having this conversation. I, somewhat naively, assumed that anyone of any gender identity would be granted access and treated equally when seeking care services for gendered violence. However, as I became more familiar with the politics of care employed by these care systems, I realized that these conversations reflected widely held logics across organizations. This section shows how two care settings, the medicolegal system and community-based organizations (CBOs), are sites for producing proper victims predicated on normative constructions of race, class, and most presently – (assumed) gender.

The medicolegal system & citizenship

Forensic medical interventions for gendered violence increasingly depend on establishing corroborative evidence to support and prove someone's personal testimony. Corroborative evidence includes DNA collection, forensic images, and information documented in lengthy, detailed, and formulaic intake forms (Mulla 2014a; 2014d; White and Du Mont 2009; Du Mont and Parnis 2001). The product of the evidence collection process is what Erica James refers to as *trauma portfolios* which are an aggregate of

collected data to verify the worthiness of institutional recognition and care (James 2010a). Thus, the demand for corroborative forensic evidence underpins a positivist approach in pursuit of medicolegal "truths" (White and Du Mont 2009). Importantly, this demand is predicated on the logic that women's [sic] claims need to be proven and recognized by authorized/authoritative actors (i.e., those with specialized training) to be believed.

Corroborative evidence, or signifiers of violence, are problematic because they emphasize and perpetuate stereotypic rape imaginaries (Mulla 2014a; Razack 1994), or rape myths, based on the structural and cultural configuration of a sexed and gendered body. The documentary structures and reading practices deployed by medicolegal agents re/produce stereotypical misrepresentations that white, cis-gender *women* are always victimized in unfamiliar environments by *unknown men* (Mulla 2014a), violence is a *singular* occurrence in their lives (Mulla 2014b), and that they *fought* against their attacker, resulting in visible, physical injuries (Du Mont, Miller, and Myhr 2003; White and Du Mont 2009; Du Mont and White 2007). Moreover, it is important to note that the medicolegal system was built around the *visible* experiences of white, cis-gender women of a certain social class (Mulla 2014e; Smith and LaDuke 2005). The demand for forensic images of physical injuries, including micro-injuries (White and Du Mont 2009), divorces the site of assault/abuse from the home and relocates it to the victim's body (Mulla 2014f). This practice re/produces notions that a victim *looks a certain way* and is therefore physically recognizable (i.e., a "real" victim is a physically damaged one).

In her ethnographic research on the forensic intervention for sexual violence, Sameena Mulla (2014) argues that the medicolegal system and forensic practices produce the subject position of a victim. I found that her argument holds true, but there are multiple forms of the victim produced by medicolegal actors. Individual actors are key figures in producing, or controlling, *who* the right victim was. Here, individual care providers function as *trauma brokers* (James 2010a), the creators of the aforementioned trauma portfolios, serving as gatekeepers to care systems that use forms of suffering to supply the demands of the consumers of performed suffering – the care apparatus itself. This apparatus is an assemblage, or network, of care comprised of the medicolegal system, CBOs, and the providers within them. In total, I interviewed three forensic nurses. All expressed rape myths to varying degrees. Interestingly, however, these imaginaries posit different subject positions based on how the forensic actors read their patients' body and behavior. For example, Joyce, the forensic coordinator for a hospital program, and I discussed the forensic intervention processes of sexual and domestic violence – each of which has different evidence collection processes. Joyce stated:

> *There's a lot of overlap between those two. But the big difference is that there's more injury in an interpersonal violence case than there is a sexual assault case… And I think it's violent in a different way. But just interpersonal violence, the person that comes in here has a lot more physical injuries, and I think that there's a lot more emotional and mental injuries because it's been going on for a much longer period of time, versus a sexual assault, you know - typically, it'll be a onetime instance. On average, I would say [sexual assault] is more like, "this happened to me last night." It's not, "I live with this person, and they mentally, physically, and emotionally abused me every day for the last 10 years." But for people to come to the emergency room [for interpersonal violence], they'll have a jaw broken or strangulation marks on their neck, you know like, "I thought he was gonna kill me," they'll have a weapon involved…. I'm just saying it's a lot more violent. Not trying to demean or belittle anything else.*

> *The big difference is that I think when you're taking care of an intimate partner violence case, is that they look crazy. And I'm not trying to say that in a negative way, but it's because they've been abused longer. I mean, there's been head traumas, things like that. There's been instances where their abusers convince them that they're crazy and they're not worth it. It's trauma that's gone on for longer periods of time. So, their stories aren't consistent. It's not because they don't want to cooperate. It's just the effect of the trauma that's been going on for so long.*

Joyce re/produces these imaginaries – sexual assault being a "onetime instance," necessitating injuries (to varying degrees), forging heterosexual kinship – to construct her understandings of gendered violence, differentiating between categories. Here, the intimate partner violence victim endures years of abuse exemplified by their physical injuries and perceived mental status, whereas the sexual violence victim endures only one occurrence of violence and is therefore less physically and mentally altered. While there are multiple and overlapping logics of producing victims of intimate partner and sexual violence based on the same repertoire of myths, the subject positions are created as discrete categories differentiated by how Joyce reads their bodily presentations and behavior. The victim of intimate partner violence will be more visibly recognizable and present in a patterned way – chronic abuse, severe physical injuries, altered behavioral expression.

This logic intersects with compliance standards that are central to gaining recognition and care in the medicolegal system. If people do not actively comply in their victimhood, embracing forensic technologies and demonstrating the potential to heal by following medical orders, they are deemed "non-compliant" (Mulla 2014e). The medicolegal institution demands a clear delineation of events composing sexual violence, resulting in a singular narrative framework (Mulla 2014b). Medicolegal emplotment, or

the making of a configuration in time by creating a coherent whole out of episodic events, distorts the lifeworlds they represent, since these lifeworlds are inherently incoherent (Mattingly 1994). Here, Joyce gestures towards how other institutional actors, like law enforcement, interpret trauma as noncompliance because victims' trauma prevents them from creating a cohesive narrative of events. Based on Joyce's distinction between sexual assault and intimate partner victims, medicolegal practices would at least partially encode for the exclusion of intimate partner victims.

A conversation with another forensic nurse, Zena, reinforced this notion.

Interviewer: *In your program, do you do forensic exams for both intimate partner and sexual violence?*

Zena: *Well, it's really not standardized across the board. Many programs will only do SANE [sexual assault nurse exam] or strangulation exams. And I could talk forever about this, but this really leaves out domestic violence victims. We're one of the few programs who do comprehensive exams that can include both. The programs that only perform strangulation exams just take pictures and do a history; that takes about an hour. Ours take anywhere from two to six.*

Interviewer: *How do you decide which to do?*

Zena: *The person's history dictates what we do. When someone comes in, I ask "What happened to your body?" People will start telling me about the context and everything, but I'm concerned with the medical and evidence collection part. I tell them that they can of course share that information with me after [the exam], but right now I need to know what happened to your body, so I know what to do during the exam. If someone presents as a domestic violence case from injuries and what they told me, I always ask about sexual assault because some people don't know or don't realize they've been assaulted.*

Interviewer: *How does your exam differ for sexual and domestic violence?*

Zena: *The pelvic exam is the difference there.*

Taken together with Joyce's narrative, Zena offers further insight into how the medicolegal system posits different kinds of victims. First, structural constraints

(procedural protocols) can prevent people from receiving forensic exams and healthcare depending on whether they have experienced intimate partner or sexual violence, especially since not all states consider strangulation a felony, despite it increasing the risk of further violence (Glass et al. 2008). Being able to make that distinction depends on how people recognize and label their experiences, which I will discuss later, and how forensic nurses read them. Zena includes people in guiding her during this process by asking them what happened to their body, but selectively listens to the aspects of someone's experience pertinent to evidence collection. Unlike care systems for other forms of gendered violence, like human trafficking, this process was not predetermined nor structured (Nicklas 2017), but was instead improvised in real time. This version of emplotment erases the lived suffering experience of survivors within the therapeutic context (Kleinman 1988).

Second, the focus on *the body* essentializes differences between intimate partner and sexual violence victims through the pelvic exam. All the forensic nurses I spoke to stated that they will not conduct a pelvic exam unless someone indicates that sexual violence occurred, but when there is reason to believe someone was assaulted, they initiate a treatment plan to collect evidence and provide sexual and reproductive medical treatment (e.g., pre-exposure prophylaxis for STIs and HIV, emergency contraception). Standardized pelvic exam protocols are mostly comprised of gynecological questions and practices, revealing embedded gendered assumptions that a victim is assigned female at birth (AFAB), and therefore can be subjected to invasive medical procedures (Du Mont and White 2007; Mulla 2014a).

These forensic examinations are modeled closely on gynecological practice which dictates the separation between the victim as a person and as a pelvis, indicating that the ideal patient sheds *her* personhood to succumb to the transformation into the pelvis (Henslin and Biggs 1971; Mulla 2014), where the medicolegal gaze can enact power (Foucault 1973). Forensic examinations for victims who were assigned male at birth (AMAB) also reflect cultural imaginaries that cast men into the role of perpetrators. Mulla (2014) demonstrates that some medicolegal actors perceived penile swabs, the forensic practice used when the perpetrator was AFAB, as excessive and illogical compared to anal examinations. Penile swabs were not required by forensic documentation practices and were categorized as "miscellaneous," orientating gendered violence against AMAB people towards gender neutrality (Mulla 2014) because of the embedded assumption that cis-women cannot overpower and sexually assault cis-men. Therefore, the gendered practices forensic actors use produce the gendered subject who has been sexually violated, demarcated by penetrative assault by a AMAB perpetrator against a AFAB victim, and whose injuries require more intimate forms of medical/forensic intervention.

Therefore, the product of these rape imaginaries is what I refer to as *victim citizenship*. The victimized citizen is a gendered being formally recognized by the medicolegal system and granted access to its care and resources (see also Mulla 2014e; Nicklas 2017; Harris 2000; Petryna 2010; Das 2010; James 2010b). Foucauldian theory of biopolitics (2003) elucidates how systems of power promote social order and explains how institutions grant some rights and entitlements while denying others. Here,

"biopower" regulates the *masses* through categorization, surveillance, and regulation of bodies (Foucault 2003). Importantly, biopower is neutral, yet unequally applied (241), as the state promotes a *certain* form of life – or citizenship that is a politically, economically, and socially configured construct. As sexuality discourse gets imposed onto populations, it creates proper victims legible to the state and power apparatuses (Foucault 1990). Thus, these modes of regulation – the biopolitics of gendered intervention – employ multiple and overlapping logics to produce victimized citizens (e.g., how nurses perceive patients to improvise and initiate a treatment plan). However, some citizens, like those who have experienced non-sexual gendered violence, are only recognized as partial citizens (see Cox 2015) since there are fewer structural resources that legitimize them within the medicolegal setting.

Virginizing victims

Sexuality, or sexual behavior, complicates whether forensic actors believe a pelvic exam is an appropriate course of therapeutic action. As previously demonstrated, the medicolegal system configures a victim as a passive, feminized being. Simultaneously, medicolegal practices also de-sexualize victims. For example, a participant named Alison states:

> *You know, I understand he was my boyfriend. And I understand that it wasn't just a few days before that that we willingly had sex. And I understand that we had a very, you know, different kind of sex life and all this stuff, I understand. But I also completely understand that I had told [the detectives and forensic nurses], I never wanted to see him again. And I mean, there's no way anybody could convince me that what happened was anything other than rape, and I was like, I'm not gonna let someone can get away with it.*
>
> *He was rough sexually, but again, that was part of our sex life. There were certain things with him and certain fantasies with him that I did with him and*

> *nobody else, you know. And so that's always kind of I guess, played a role in my mind too, is that like ...ugh I didn't tell the detectives this, but he really was the best sexual partner I've ever had. And so then for all this to happen, it just, it just was mind blowing. I just was upfront with [the detectives and forensic nurses] from the beginning. Like, "Okay, listen, I'm not gonna lie. We were just together a few nights ago in a romantic way. And he was my boyfriend on and off, but, but I had broken up with him, and he had gotten his stuff and he had left, he was no longer welcome at my apartment." And so, I had to keep stressing that because I've always been the type where I'm going to anticipate your objections before you even say them.*

Alison continues to share with me that the medicolegal team decided that collecting forensic evidence from a pelvic exam was not deemed an appropriate course of action given that she had sex with the perpetrator a few days prior to the assault. Specifically, the medicolegal team expressed anxieties that any injuries from the rape would not be able to be disambiguated from any injuries incurred during sexual intercourse. In addition, Alison identifies areas of her sex life (e.g., that she enjoyed having sex with the perpetrator while they dated, they engaged in certain sexual fantasies, these fantasies were a private, intimate part of their relationship) that she anticipates complicating and undermining her legal case. Alison suppressed these details about her sexuality and sexual history with the perpetrator based on the internalization of rape myths that would imply that she was responsible for her assault, falsely accusing someone, or would implicate her "responsibility" for the perpetrators' actions.

Mulla (2014) argues that within medicolegal settings, patients are also clients, suggesting the self-consciousness of the economics and social code of healthcare (see Lamphere 2005) in which sex workers are labeled as "repeat customers" (Mulla 2014, 183). Imaginaries tie false reports to "destitute" women seeking healthcare, especially those who are thought to be exploiting healthcare systems following unplanned or bad

sex (Mulla 2014, 183). This logic and the language around "repeat customers" reinforce notions of the "rapeable" and "unrapeable" victim, locating those associated with certain sexualities as unrapeable and denying them access to care and legal protections. While Alison is not a sex worker, nor do I conflate certain forms of sexual expression with sex work, she associates her sexual history and fantasies, one that she believes will be perceived as a taboo, with the logic suggesting that a *right* type of sexuality/sexual behavior aids in the production, or lack thereof, of a "rapeable" victim. Strategically, however, Alison anticipates the use of this logic against her and intentionally crafts her narrative to combat this institutional imaginary by omitting the details of her sexual history with the perpetrator – that she enjoyed having sex with her boyfriend and playing into certain fantasies. In addition, not only are individuals who experience gendered violence cognizant of rape imaginaries, and thus embody them, but the institutional demands around "uncontaminated" (see Mulla 2014), and therefore de-sexualized, evidence prevented Alison from receiving the post-assault care necessary for establishing what *she wanted* – a successful legal case against the perpetrator.

I also found that institutions continue to de-sexualize, or cast victims into specific sexualities, beyond the medicolegal care setting. For example, a participant named Bastet shared with me that she sought out a mental health specialist in supporting LGBTQIA survivors of gendered violence. However, she states,

> *I've heard that she claims to be a LGBTQIA specialist, but she's not really um, because I've heard similar experiences from like other LGBTQIA people that she's not that and other people who identify as asexuals for demisexuals. She said that people like shutdown or that there is asexuality because of you know, trauma, because they experienced sexual assault or something. That's why they're not that into relationships. And I'm like, 'No, it's not that I don't have sexual libido. I do*

> *have sexual libido. I just don't feel sexual attraction at a primary level to every other person that I see or meet. You know, it's not like I look at somebody and am like, 'Oh, he's so hot I really want to do him.' Like, I don't feel that, you know, like, I need to bond with somebody. And I know some people feel that and that's fine. But like, it is not because of trauma. A therapist does not get to decide that. She gets to explore that.*

Bastet identifies as demisexual, or someone who only feels sexually attracted to someone they have an emotional connection with. Here, the therapist medicalizes Bastet's sexuality in a way that reconfigures demisexuality as a trauma response rather than a sexual orientation. Thus, the therapist generalizes that people who have experienced gendered violence become asexual beings as a form of coping or self-protection. While this is certainly a prevalent trauma response, it does not align with Bastet's understanding of her sexuality and how she processed her assault. Therefore, the therapist normalizes a lack of sexuality in gendered violence victims without taking into account Bastet's sexual orientation and relationship with intimacy into her configuration of a victim.

Taken together with Alison's experience, the institutionally legible victims, or those deemed "rapeable," are not sexual beings by their own choosing. Rather, victims are de-sexualized in that care systems significantly limit the extent people are allowed to be sexual before and after their assault and abuse lest they be denied care. For Alison, being *too* sexual, or not engaging in the "acceptable" form of sexual behaviors, prevented her from receiving the type of post-assault care she desired because it interfered with forensic intervention procedures and symbolized taboo behaviors within the realm of medicolegal care. For Bastet, not feeling sexual attraction or intimacy was perceived as a normal part of her victimhood rather than her sexual orientation that existed prior to her assault. While medicolegal practices fixate on the sexual nature of violence to guide

therapeutic interventions (e.g., pelvic exams, penile swabs), they simultaneously craft the subject position of victims as virginal beings who incurred sexual violations.

Community-based organizations

CBOs also produced subject positions of victims but differed from the medicolegal system in that the gatekeeping strategies to care rather than the institutional practices seeking to facilitate care were the sites of knowledge and subject production. As previously mentioned, one of the most frequent conversations in my field site was whether to work with male clients. This is not to say that the advocates never worked with masculine clients – in fact, the program manager and I frequently spoke about hiring a male-identifying advocate. However, there was a significant amount of deliberation discussing whether a male client was a victim or an abuser trying to intrude on a former or current partner.

For example, two advocates I worked with stated that:

> *Abusers will typically try and blame everyone else but themselves. So, when I ask someone to tell me about their experience and they start blaming their partner and all… I'll be like 'who I'm really talking to?'. Survivors, though, will tend to blame themselves because of the abuse and the messages their abuser has told them over the years. So that's one way I can tell the difference*. **(Anna)**

> *That's a part of our assessment when we're trying to figure out who we're working with, right? Because we may get a referral that isn't necessarily the victim. And it's kind of like, paying attention to the way they talk about their abuser. Are they blaming all the time? Or are they kind of internalizing what's going on in their relationship? And a lot of the time, you'll see people who, you know, are, are making excuses for their partners or feeling like they're to blame for what had happened, or where their partner has made them believe that they're to blame for what had happened*. **(Bailey)**

All the advocates at this organization identified as women and held this belief – partially because that is how they were trained and socialized into the role. The supervising counselor would also reiterate this logic whenever someone brought up a question about a male client during staff meetings. Thus, the advocates developed screening strategies, or rather a heuristic, that functioned on gendered assumptions that men who abuse are incapable of internalized shame and stigma. In addition, the hesitancy around working with men – because the overarching assumption was that men were pretending to be abused victims – reproduced gendered constructs that cast cis-women as victims and cis-men as perpetrators. Similarly, the community advocates mirrored medicolegal actors in that they both constructed the subject of the victim as passive who has internalized the brunt of their abuse and/or assault. Bailey brings up the notion of blame that functions on gendered power differentials. Here, Bailey expresses that victims do not place blame nor hold the perpetrator accountable because they misrecognize their abuse and/or assault as a normal/ized part of their relationship. However, this apparent generalization contrasts Alison's experience. Alison states that she was *certain* that her former boyfriend raped her and shared with me that she never blamed herself for his actions. While it *is* common for people who have experienced violence to experience shame and internalize blame, the advocates' strategies, or methods for constructing victims, are based on gendered logics that women [sic] misrecognize patriarchal modes of power directly enacted upon them – which, in Alison's experience, does not hold true.

This gendered logic also appeared in the organization's education tools. They centered the power and control wheel, a common educational tool in domestic violence

advocacy, which argues that an individual's need to exert power and control over another motivates and drives interpersonal gendered violence, which, as a result, legitimizes their own sense of self and identity. The organization "adjusted" the power and control wheel for two AFAB partners and female-identifying partners stating that one woman will "assume the male, abusive role." Thus, these organizational practices suggested an institutional assumption that gendered violence is an inherently masculine phenomenon, producing the perpetrator as embodying masculinity to varying degrees and the victim as a feminized subject. Importantly, since domestic violence advocacy assumes a feminized force of care, then the abused/assaulted victim takes on the role of the most abject feminized subject within this dynamic (see also Mulla 2014).

Problematizing masculinity and locating it within the subject position of the perpetrator was not exclusive to the organization I worked with. I interviewed a former advocate, Ali, who worked at a women's shelter for women and children experiencing domestic violence. Ali told me that their criteria for entry was "fairly open," and that they never denied anyone shelter if they had vacancies, but gender, specifically (perceived) masculinity, was an important component to their work. She described one experience with a trans-person:

> *It was challenging for a lot of reasons that had to do with this individual's own history of trauma, a lot of self-hatred, a lot of like, transphobia towards themselves. They outed themselves as trans. And eventually, folks found out that she was trans. That was where issues started to arise. Before that already, like, she created a lot of conflict in the house because she has a lot of anger. Not that that's not completely reasonable when you've experienced violence, but it just made it really difficult in the house. I would say there were there were days where she was much more femme. But the sort of masculine elements of her came out in anger. And I mean, she had lived a really difficult life. She clearly had a lot of experience getting in physical fights and being really aggressive. And so those*

> *experiences would come out in like, masculine ways, I mean, you know, gender is a construct, but yeah. And then there would be times where she was like, way more femme and way more like, passing and gentler, I think?*

This case example demonstrates that while gender may not be ostensibly foregrounded within the politics of care, it certainly is a predominant factor. Here, the resident's "passing" as feminine facilitated harmony, or conflict-free living, in the shelter since it did not disrupt the feminized social order. In addition, to "pass" as femme, the resident had to fulfill stereotypical gender categories -gentle, non-confrontational, quiet. However, when she expressed past trauma through anger and emotions that others read as masculine, social conflict arose. This case also demonstrates how gender is expected to be fixed across time and space. The "unpredictability" of her masculinized traits that disrupted her femininity posed challenges – including for herself when she felt like she had to express anger in a feminized way. According to Ali, many residents responded with transphobic remarks and sought out the administration to remove her from the shelter. As Goffman (1986) describes in his work on stigma, the "discreditable" seek to live a life partially hidden from others in fear of persecution, presenting their desirable self, which as demonstrated here, is *relationally produced* through gendered discourse. While I certainly do not want to invalidate other residents' triggers or trauma responses from their abuse by male perpetrators, I highlight this case to demonstrate how gender, un/consciously stigmatized, implicitly informs the politics of care beyond just gaining entry or accessing resources.

Therefore, like the medicolegal system, CBOs posit the subject position of the legitimate victim as a feminine being and the role of the perpetrator as inherently

masculine. However, CBOs differ when constructing the victimized citizen through institutional policies or organizational logics that grant, or prevent, access to care and shape experiences within care organizations. Unlike the medicolegal system, CBOs define gender based on the fulfillment of stereotypical, normative roles and behaviors, or gender performativity (Butler 1993a).

Fashioning lived experiences

The politics of care construct modes of normative citizenship that are imposed, to varying degrees, on individuals who must utilize them to gain recognition and care within health networks. Victim citizenship is one of the stages in the "proper" trajectory of gendered violence. I found that people are expected to shed their victimhood and take on a new role of survivorship, which is also deeply gendered and reflects authoritative constructs of race and class. However, I found that there are a range of responses. The "proper" form of survivorship is one that indicates someone is "healed" – a habilitated person who is a "stronger" version of themself. However, when someone does not adhere to normative healing narratives, due to structural constraints or intentional choices, they are the *abject* survivor whose narratives are suppressed and shunned by society. While this trajectory originates from care settings, these modes of citizenship have deeply personal implications for individuals who both utilize and contest them. I will use Marcos's and Cara's experiences to demonstrate how these concepts unfold in their lives.

Marcos

Marcos was one of the few male-identifying clients at the domestic violence advocacy group when I worked there. He is in his mid-twenties, an undocumented

immigrant from the Dominican Republic, and currently living in a shelter. After arriving in Boston, he started a relationship with a cis-woman. When they first started dating, "*everything was a great blessing*." However, she later started accusing him of cheating and threatening to call ICE since he is living without documents. She began sexually abusing him, forcing him to have sex with her multiple times a day and telling him that *"[he's] not a man*" if he was unable to perform or make her orgasm. He left, despite being unable to find a job, but hoped that they could work on the relationship. They eventually got back together when she told him that she was pregnant. Marcos shared that she later revealed that she miscarried because she was upset over him leaving - for which Marcos continues to blame himself. During one fight, she threatened his life and stated that the law would protect her as an American citizen while he is "*just an immigrant piece of shit*." She started physically harming him and Marcos called 911. When the police arrived, they accused him of domestic violence, but eventually took him to the hospital where he was referred to my field site.

> *[The counselors and forensic team] believe that I am not telling the truth, when I tried to enter the shelter - they did not want to accept me, and the police many times did not want to accept my reports, even I still do not know what happened to the case, I just know I'm still walking outside unsure and scared and jobless and homeless*. **(Marcos)**

Marcos's experience of gendered violence is extremely raced and gendered. First, gendered assumptions that men, especially Latinx men, who are chronically hypersexualized (Padilla 2007), cannot be victims of gendered violence prevented him from fully gaining victim citizenship, limiting access to healthcare and shelter. He had a difficult time finding a shelter that would accept him because he lacked the proper legal

documentation (e.g., police reports, restraining orders) to "prove" he was victimized. Until the final fight with the perpetrator, Marcos's fear of deportation and state surveillance prevented him from seeking structural resources, and he had little economic and social capital to provide support. He told me how this institutional dismissal often makes him believe that every demeaning thing his partner said was true. Interestingly, when I asked him about how he felt about being dismissed because he was a man, he said "*It doesn't matter if I'm a man or not, this shouldn't happen to anyone*." This sentiment contrasted every interview I conducted with a self-identifying woman who stated that being a woman, or the gendered component to their experiences, was central to their survivorship and identity. I question whether Marcos's misrecognition of institutionalized sexism reflects that his perceived masculinity was never *visibly* integrated in his care as a victim, but, instead, constructed him as a perpetrator.

Thus, Marcos's documentation status, class, and gender worked synergistically to prevent him from gaining clinical recognition. This finding of partial citizenship, formulated on the basis of gender, parallels other ethnographic work demonstrating that cismen who had been labor trafficked, as opposed to ciswomen who were perceived to have been trafficked for sex, had difficulty gaining recognition in care systems, forcing them to intentionally craft narratives that would grant them access to care and literal citizenship (Nicklas 2017). However, in that study, institutions guided clients on how to do so. This was not apparent at my field site nor in Marcos's story. Rather, it was the perpetrator who attempted to craft her appearance and experience into a victim narrative by intentionally injuring herself to make herself look battered and claiming rights and

entitlements to formal care systems granted by her femininity and residency status. In addition, advocates at CBA were very attentive to *how* male clients crafted their narratives to determine their legitimacy. Had the advocates had any inclination that a male client's experience was scripted, and, therefore, insincere, they likely would have referred them to EMERGE, another CBO that educates perpetrators on domestic violence. Lastly, CBA fully recognized that men *do* experience gendered violence and "counted" them equally compared to women's experiences. However, this only occurred *once a male client was deemed as a legitimate survivor* based on a more intensive deliberation process that varied by the specificities of each case.

Marcos came to CBA well before I joined CBA. Therefore, I cannot attest to how the deliberation process manifested from his case. Overall, he stated that he has only positive experiences with CBA and his advocate, Celi. However, he was well aware that I knew Celi personally and was associated with CBA. He aspires to pursue an education and have his own place to live: "*the only thing I need is to be able to work and fend for myself like every human being, but I can't*."

Cara

Cara is a 27-year-old, who says they fluctuate between being non-binary and ciswomanhood. They experienced two assaults but focused on the one during their college years.

> *I felt like a fucking fraud claiming I was a survivor, you know? Like I wasn't raped this time, but it scared me to death. I knew something was up immediately. When it was…you know… happening… I thought I was going to die, or at least I wanted to. I thought I was being dramatic until he wrapped his hand around my neck. I was like* this is real*! Fast forward months later and I'm still a wreck. I felt like no one understood what I was going through and people dismissed me*

> *because I wasn't raped. This was when the Brock Turner case was going on, so if you weren't being penetrated while unconscious it wasn't real, right? He noticed some of my friends being hostile towards him, so he reached out. He ultimately apologized and that was the only time I felt validated… however, he was a manipulative person – or so my therapist would say. I ended up getting into a relationship with him for a while. I* never *felt comfortable, but I just wanted to feel ... something. My friends were like,* "What the fuck? You're the girl who cried wolf!*" We broke up and I felt so alone – no one understood or believed me. I felt disgusted with myself that I could even [be in a relationship with him]. I felt so repulsed by myself, I thought I had herpes. Like I never had symptoms but was convinced I had it – for like a year! I went to so many doctors just to make sure I was OK. I felt so diseased and herpes I guess just put a name to it.*

First, Cara shows how victim citizenship, predicated on myths necessitating visible injury, mediates people's perceptions of whether gendered violence is "real," dictating whether they had claims to victim citizenship. During the assault, they never questioned whether they were scared and disrespected, but *recognizing* gendered violence required something that would be permissible in a legal proceeding (i.e., wrapping his hands around their neck). In addition, Cara also articulates pervasive myths that cast gendered violence as a purely heterosexualized concept, as indicated by vaginal penetration.

As previously discussed, medicolegal systems *and* CBOs cast perpetrators as men who assault and abuse women, forging a heterosexual relationship. Thus, gendered violence takes place within *compulsory heterosexuality* (Rich 1980) in which patriarchal and heteronormative systems assume and enforce heterosexuality upon women, configuring them as gatekeepers against men's normalized sexually aggressive behavior (Hlavka 2014; Bedera and Nordmeyer 2020). Within institutions, this logic reinforces the *heteronormative supremacy* which assigns special rights and privileges to specific forms of heterosexual expression that is heavily raced and classed (Stein 2008). Importantly, the

imposed, assumed, and protected forms of heterosexuality influenced how people made sense of their experience of gendered violence.

During my conversations with Cara, it was clear that they communicated their experiences through a compulsory heterosexuality framework. For example, Cara shared salient details with me that they remembered in case they wanted to create a legal case against the perpetrator. They were hesitant to proceed because their friends made them feel like this experience "didn't count," and they did not want to falsely accuse someone. These details included the perpetrator being much taller and able to physically overpower them, him being on top of them during the assault, and that they were menstruating and felt embarrassed that the perpetrator would discover their tampon in his attempts to digitally penetrate them. Cara's hesitation around proceeding with legal charges stemmed from their belief that these details would undoubtedly incriminate the perpetrator because they replicated heteronormative power relations. In addition, Cara states in the quote above, "*When it was…you know… happening… I thought I was going to die, or at least I wanted to*." Here, Cara never explicitly refers to their experience as assault, violence, or groping/molestation. Rather, they talk around it describing their experience as "*you know…happening*," drawing upon macro-understandings of heterosexuality to interpret and communicate their experience of gendered violence while also co-constructing common knowledge with me based on their perception of my gender.

Despite otherwise sharing heavy, explicit details about an assault, I found that people with cisgender identities would emotionally prepare me more for instances when there was same-gender assault. For example, people would say things like "*I'm so sorry*

this is gross but…" or "*I know this is disturbing…*" I found it interesting that when the logical social order that portrays gendered violence as a heterosexual occurrence is broken or disrupted, it creates abject experiences of gendered violence that are anticipated to produce feelings of horror, disgust, or perversion (Kristeva 1982; Douglas 1966; Foucault 1990).

Previous research suggests that compounded with fewer structural support mechanisms for queer communities (Todahl et al. 2009), queer people who have experienced gendered violence anticipate homo/bi/queerphobia and are therefore less likely to disclose to authority figures or reporting mechanisms (Davies, Gilston, and Rogers 2012; Javaid 2018; Hlavka 2017). Researchers report that participants express feelings of shame and stigma, specifically around emasculation (Javaid 2018; Hlavka 2017; Davies, Gilston, and Rogers 2012) and "harming" their communities by inadvertently increasing racialized surveillance and perpetuating false hypersexuality tropes (Chmielewski 2017; Meyer 2012), but do not report that queer participants would engage with any form of emotional preparation. This finding suggests that heterosexuality or heteronormative logic guides how people make meaning from their experiences of gendered violence and how they anticipate it will affect others.

It is also interesting how Cara embodied their internalized stigma, convincing them they had herpes. It was a common theme for people to share information about their STI/HIV status with me. People would say, "*…and thank god I didn't have any diseases*" when discussing their post-assault care or mention contracting (usually) HPV when they described notable details of their healthcare experience, suggesting that this aspect of

their biological status was closely tied to their identity as a victim. Embodiment in phenomenological theory conceives the body as the basis of the constitution of the social world and clarifies how the social world contributes to the constitution of the body (Becker 2004; Csordas 1990). Thus, the body is a starting point for analyzing the interplay between the self, culture, and larger systems like medical intervention (Csordas 1990). It was clear that Cara was not labeling those living with herpes as inherently diseased, but rather, they were embodying and articulating their suffering in the only language made available by and legible to care systems. As previously discussed, the medicolegal system biologizes gendered violence through its care practices. Since Cara technically would be unable to receive a SANE exam because nothing "happened" to their body to indicate that they would need a pelvic exam, compounded with their experiences of dismissal and disbelief, they were compelled to refashion themself as a biological citizen – whose biological condition, in this case herpes, would be used to make claims upon care systems (Petryna 2010) – aiming to gain some form of recognition within a system that encoded for the exclusion of their experience.

Importantly for Cara, never fully having victim citizenship meant never feeling like they were a survivor. Cara's experience reflects larger narratives about *survivor citizenship*. Being a survivor indicates a quasi-endpoint in someone's experience. First, someone must be the *right* kind of victim to be granted citizenship. Then, people must indicate some sense of struggle that results in the shedding of their victimhood and rebirth into the valorized *survivor*. The survivor is a habilitated being who is stronger, fiercer, and better than their previous self, advocating against gendered injustices. This is

a linear path and rite of passage (Turner 1969). Deviation from this trajectory results in being deemed an *abject* survivor. For example, Cara started a relationship with the man who assaulted them. As indicated by the "*you're the [person] who cried wolf*" comment, their behavior violated expectations of what someone *should* do – or not do. Cara told me that when they told people this, they often replied with "*What kind of a victim/survivor are you?*" or "*You call yourself a feminist and then do this?"* Cara also heard more damaging statements like, "*You're not a survivor – you weren't raped*." Thus, a survivor is produced from both an institutionally acceptable and definable form of trauma and adhering to the right kind of healing, one not involving the perpetrator or anything that would be perceived as "disempowering."

In addition, a survivor emulates a form of governance established through the application of biopower in which subjects govern themselves and others through their internalized disciplinary power, resulting in the creation of "rational citizens," or those who embody and reproduce state-sanctioned priorities (Morgan and Roberts 2012, 244). Cara states:

> *People didn't start taking me seriously until I was working at a fancy science lab and wearing my pink pussy hat [from the 2017 Women's March]. I wasn't allowed to falter. No one helped when I started using [drugs], smoking, and binge drinking. But then they all told me what a badass I was when I did well - I kept my grades up and kept working. There was a sense of urgency that I recover quickly and be like 'I'm healed!' This was the only time I really clung onto being a woman, too – so I could join the club.*

Healing (and being healed) and empowerment were demarcated by one's ability to *produce* on behalf of institutions and to do so in a timely manner. In addition, healing involves a specific chronology. The predominant model in health and psychological care, which trickles into social worlds, is the medical model which recognizes that something

is broken and needs to be fixed, delineating a clear and linear process in which healing is structured and time limited (Lester 2019). Thus, Cara's relationship with the perpetrator and their substance use were barriers to their performance of *survivorship* indexed by their success in school and participation in the capitalist job market. They became recognizable, although not fully fulfilling the survivor citizenship role, when they participated in normative ways of demonstrating that someone is a productive citizen. This was a gendered process. Cara was celebrated for participating in mainstream feminist movements, like the Women's March after Trump was elected, and for being a "woman" in STEM, engaging in forms of resistance that do not permanently alter power structures, but show acceptable, palatable forms of empowerment (i.e., systems-correcting praxis). Cara personally "clung on" to normative forms of womanhood to gain acceptance and recognition within social spheres to both validate the legitimacy of their assault and how they healed from it.

Therefore, Marcos and Cara illustrate how survivorship is contingent upon recognition as a victim. Marcos's gender, race, and structural location prevented him from accessing resources during his abusive relationship. Cara, partially excluded from full victim citizenship, was compelled to refashion themself, unconsciously or not, as having a diseased biology as that was the only way they knew how to gain recognition. Further, Cara's survivorship status was suspect given that they deviated from authoritative healing narratives that configure the trajectory from victim to survivor as a timely, linear process. They only partially gained recognition when operating in

normative gender and class constructions - adhering to normative womanhood and being an active, productive member of society.

Creating rational citizens was central to my field site's care model and was a common theme across interviews and interactions with advocates. Previous ethnographic work argues that, by their own enactments of agency, people translate themselves into institutional agents (i.e., types of rational citizens) within formalized care systems to improve them (Nicklas 2017). This suggests a collapse between agency and structure – that people are able to act autonomously to improve a structurally violent system from within. However, this specific argument is rather reductive and flat as it does not attend to how these institutions manage someone's ability to participate in public life through social stratification.

As Cara's experience demonstrates, a rational citizen is someone who positively engages with and contributes to existing systems and who does not challenge existing power structures. There are multiple forms of rational citizens depending on someone's location within larger structures. Thus, the centralization of the rational citizen within survivorship narratives functions on a social efficacy model in which the separation and hierarchization of citizens within larger structures remain intact and are reinforced by social processes. For example, care organizations who primarily served people without legal documents and people with lower incomes tracked their clients into lower paying social service jobs. Typically, care organizations only provided certifications for people to become nail technicians, nursing assistants, and maids – all of which are deeply gendered and raced. According to the majority of advocates I interviewed and interacted

with, these certificates were almost always available. Despite many participants wanting to go to community colleges and/or universities, care organizations typically only connected participants with educational services that provided GEDs, limiting the types of job opportunities people qualified for. While Cara was lauded for being a STEM researcher and engaging in feminist movements, their proximal location to these power structures allowed them to assume a form of citizenship that was inaccessible to others. Meanwhile, other institutions created citizens who were legible to normative gendered and racialized constructs.

The unsung lives of advocates

While this chapter has mainly focused on how care systems and the people within them impose forms of citizenship and a normative trajectory of healing, I do not aim to demonize them – to do so would be an egregious misrepresentation of both the structural constraints they operate within and the immense amount of work they do *outside* of work to better themselves, their team of advocates or nurses, and their care systems. For example, during the end of my data collection process, a forensic nurse who saw my recruitment poster reached out to me. She was interested in my research not only because it correlated with her own, but she wanted to learn more about ethnographic methods and an anthropological approach to studying gendered violence (just as it was equally important for me to understand and appreciate a biomedical and forensic approach as well). She invited me to join a discussion group with other forensic nurses who all work incredibly hard to be better at their jobs by doing things like starting journal clubs to keep updated on changing laws and research, engaging with interdisciplinary work to provide

more socially and culturally affirming care, attending conferences without any financial support from their hospitals, and volunteering to train new forensic nurses and law enforcement on compassionate care and to dispel the rape myths that I discussed above (of course, this list does not include the many conversations I selfishly had with them to discuss their work and to "fact check" my understandings of forensic intervention – which also include some of them providing feedback on my thesis drafts). These types of practices extended beyond forensic nurses – virtually every advocate or service provider for gendered violence does more than what their job position expects (and supports).

Instead, I argue that individual care providers are the *movers and shakers* of this care system. While this assemblage of care posits a specific trajectory of identity transformation, it is not impermeable. Individual care providers work within, or create, the tiny cracks and crevices, finding loopholes and workarounds, to provide for their patients. However, these actions do not permanently alter or challenge the power alignments in care systems.

The parts don't always represent the whole

Some research argues that places like forensic intervention settings and community-based programs represent *counter-clinical spaces* (Underman and Sweet 2021), because they are intermediary spaces between social activism and biomedicine, co-opting and hybridizing the two to critique dominant medical settings and modify existing power systems at the meso-level without challenging the forces that undergird them. Thus, despite being informed by social activist movements, professional hierarchies that subjugate forensic nurses and advocates remain.

Virtually every advocate and forensic nurse shared that they were grateful I was conducting research on the experiences providing care for gendered violence, indicating that they feel as though they do not have many structural outlets to vocalize their opinions. One of the main themes from my interviews with them was a perceived disconnect and contention with their organizations' administration. Frequently, advocates made suggestions, wrote grant proposals, and came up with logistical plans to better serve their patients. However, they felt like the administration ignored these efforts. For example, Ali, who was previously mentioned, claims that she and her team would try to get resources so that the staff could employ better safety plans and standardize trainings and organizational procedures. Ali states,

> *[The administration would] be like, 'that's not what we're doing.' And we'd be like 'you're not here - we're here you know, like we're the ones that see all this shit you know, and you're coming over from your little like cubicle.' And so the workers felt really unsafe all the time. Overnight only ever had one staff - that sucked.*
>
> *There was no rulebook for [how we did our jobs and handling conflict] and the turnover made that difficult too because you're always training new people and there was like, a lot of inconsistency in that sense, too. And it's inconsistent for like the women living there like so…*
>
> *And, you know, the admin staff is making like a shit ton of money. So, like, they're all making like six figures. And meanwhile, we're trying to survive, like paying rent in like a shitty place and, you know, barely not being homeless ourselves. Like, it's like brutal, it's like actually brutal. There was a lot of issues around accessibility in terms. And it was really clear that most folks who work in [my city], especially like social service folks, who like aren't making a ton of money, use public transit, and like, don't own cars. People here cannot afford to own cars. Unless, you know, they're really rich. And so, there were a lot of issues around the admin like not caring that, like people use public transit and that we couldn't come to certain shifts at certain times. And like, you can just keep changing the hours, for no reason. And yeah, it was issue after issue, honestly.*

> *I had a time where a person like, straight up called me stupid in front of, like clients and like in front of women who were living there. And I was like, 'okay, cool, like, this is good, like, this is a good, you know, relationship that they're witnessing this. Yeah, this is awesome.'*

Thus, the disconnect between the administration and Ali and her coworkers reinforced economic disparities and prevented the advocates from performing their job as expected by the administration. In Ali's case, this disconnect got so severe that the administration started surveilling their employees and retaliating when they acted against the administration. Ali shared with me,

> *There was so much animosity between the workers and the administration team, there was no trust between them, there was a lot of like rumors that would go around like that they're watching us on the cameras and making sure that like, we're doing certain things... the turnover at the shelter was like, is like nothing I've ever seen at a job in general. Their relief staff went in and out all the time, and like, I'm an example like, I was there for a year. So, you know, I'm one of those people. We did have a union, but it felt like the union.... According to the workers, the union had been, like, infiltrated, too, so like, it was a mess, like honestly, it was a mess.*

> *And there was one person that worked there with me who worked at both [of my jobs], and we would talk a lot, and I did trust her till the end, I still trust her. And then there was also someone at the helpline who had worked in the admin side. They gave me like, some info and like, you know, told me that like, 'Yeah, sometimes they're just watching the cameras.'*

> *There was like an investigation at one. And someone who I still don't know, was on the wrong side of that and like passed all that information on and there's like a big investigation and there's been so much money at that shelter put into, like legal fees and like things to protect the admin. That should be going towards the women and like so much time spent dealing with those conflicts, instead of supporting the women and like, that was just unbelievably frustrating for me. Like it was like, why are we spending time doing this when you know, X person like really needs us today or you know, whatever it was on the day. It was constant and yeah, it impacted everybody I would say...*

Ali clearly had a different set of goals than the administration team. While the administration put forth a lot of effort and resources into monitoring their employees and

protecting themselves against legal charges, Ali's point of frustration was the fact that she was being surveilled *and* that the resources could have been put to better use providing for the shelters' residents. Thus, Ali believed that the organization she worked for had the resources and financial ability to provide for survivors of gendered violence; they just chose not to despite their employees' efforts.

Paths to citizenship

Advocates and forensic nurses are also key actors in helping people navigate the politics of their respective care system. Primarily, advocates and nurses made meso-level adjustments to the politics of care, operating within and against existing power structures. Previous ethnographic work demonstrates that everyone, including direct service providers, knows that the system is flawed (or within capitalist structures that prioritize profits over wellbeing, the system is doing exactly what it is meant to do) and develop "workarounds" to navigate structural barriers (Knight 2015). Here, I saw that advocates and forensic nurses perform these workarounds by creating pathways to citizenship so that people are legible to the politics of care employed by care systems.

Pathways to citizenship can be created through implementing policies. For example, another forensic nurse, Rosie, was newly appointed as the coordinator for the forensic nurse team at her hospital. She quickly sought to address gaps for people to receive care. Recently, strangulation became a felony in her state, so more homicide cases were being tried. However, no one knew about this change and there were few protocols in place to care for strangulation cases. As more cases were being moved into trials, "[*their] charts were going to be scrutinized*." Rosie then put together an entire

literature review showing that if strangulation cases were not treated or properly diagnosed in their forensic unit, they could have fatal outcomes later due to carotid dissection. After reviewing years of forensic charts, she found that very few people ever received proper screening.

> **Rosie:** *It's like [the admin] forgot. So, I told them everything I found an attorney could find.*
>
> **Interviewer**: *So, how'd they respond?*
>
> **Rosie:** *They approved my protocol*.

Thus, Rosie engaged in system-correcting praxis (Singer 1986) by implementing new policies and protocols to match existing ones within the penal system. Rosie also challenged power structures within the institution. First, she independently obtained a grant that created her position and the forensic nurse team. She consistently took on a larger role than her occupational position called for. She created and implemented new policies, trained external organizations, and worked on grant applications, despite having no formal training, to ensure the continuation of the forensic program. Taken together, Rosie pushed her supervisors and hospital administration to recognize and validate her expertise and the value of forensic nursing. As a result, she created a new pathway for previously ignored or unrecognized victims to gain access and entitlements to forensic care.

Joyce, a forensic nurse discussed at the beginning of this chapter, also created a pathway to citizenship through her ethics of care and interactions with patients. Sharing the structural constraints she must work within and how it trickles down into her patients' lives she states,

> *This year at the hospital I can only give people five days' worth [of HIV prophylaxis]. It's a 28-day course, and the meds are like $5,000 to $6,000 without insurance. And yes, we do have like a Victim Compensation Fund, but you have to fork over the money, submit the paperwork and then get reimbursed. And like it all has to be done within like three days. So, I mean, no one's doing that. I'm not traumatized. And I'm not, you know, like, filling out a form to a state agency and making sure I did it correctly in three days when I'm like, fully functional. So, I can't even imagine if you have a traumatized situation going on and you don't even want to think about filling out paperwork. I don't think it's on your high priority list.*
>
> *The Victim Compensation Fund is basically a form that the state says I'm required to ask all the patients, even though they keep saying that all these, you know, forensic exams are free. They're only free if you collect evidence and get the police involved [and are compliant with law enforcement]. And yes, you can be anonymous, but you have the police involved, and you have to collect evidence. So, if you come in and this happened 10 days ago, you're paying for your exam, because I can't collect evidence. So, I mean, that irritates me. And then I submit that form, and then the hospital gets reimbursed $1,000.*
>
> *I mean, a lot of hindrances really make me want to just cry. One is that if you're under 18, and you report that you have sexually assaulted, it's child abuse in [my area] and I, as a mandated reporter, I have to report it. So, I've had, you know, one case in particular, I'll never forget. It was like years ago, but she came in with her friend, and she said she was sexually assaulted. And I'm going through the consent form with her. And she's smart enough to read the consent form and was like, 'What do you mean, you have to report this situation?' So, I explained to her that, you know, less than 18, it's child abuse, and I have to tell the police. She burst into tears and said, 'my parents can't know.' So, I was like, 'Listen, go to a different hospital and tell them what you told me, but you don't tell them your name. Like, I want you to get help and follow up and things like that. I also want to make sure that you don't have any diseases. And you're physically okay, right? So like, I get that you don't want your family to know. But just go somewhere, get checked out, go to Planned Parenthood, go to another hospital. Just don't tell them your name. Because all they're gonna report is that they don't know your name. Please call these advocates. They're free. They're confidential. Like don't tell them your name or how old you are, but you can talk to them, like over the phone.'*

Thus, Joyce is fully aware of the structural constraints she and her patients must navigate *and is frustrated by them.* She demonstrates her knowledge of the policies and uses this knowledge to advocate for her patients within this system. She shares with me that she

makes sure to inform patients that she has to collect evidence and involve law enforcement so that they can receive reimbursement and funds to pay for medical costs like HIV prophylaxis medications. She also communicates later in our conversation that she will always conduct a forensic exam even when there is no physical or medical indication that someone was sexually assaulted (e.g., one patient with dementia told her that her husband raped her, but he passed away several years earlier) so that they do not incur any medical costs for being admitted to the emergency room. Joyce's ethics of care also indicate that she prioritizes people's health and wellbeing as much, if not more than, the hospital's policies allow. By law, she is mandated to report child abuse. In the case she described above, she used her knowledge of the constraints she was in to aid someone in receiving post-assault care by telling them to go to a different hospital or care setting and to not disclose any identifiable information. In this incident, Joyce's hospital already had this intake information, so Joyce instructed her patient on how to receive post-assault care without informing her parents in another setting. Taken together with Rosie, forensic nurses, or more generally, direct service providers, strategically use their knowledge to help people overcome and navigate structural barriers as much as their position within the medical hierarchy allows – and then some.

Conclusion

Reflecting on the question asked by so many of whether their experience of gendered violence "counts" (and for whom) does not provide a clear answer. The politics of care enacted by the medicolegal system and CBOs contest and produce multiple forms of victimhood and survivorship that very few gain access to. These politics, which vary

across settings, rely on normative constructs of gender and sexuality, race, and class that re/produce gendered power relations. In doing so, the multiple and overlapping logics of producing the proper victim and survivor citizen constructs and demands a trajectory that is over reliant on *rightness*. There is a right kind of victimhood that is re/produced by institutional practices predicated on rape myths. There is a right kind of survivorship that structures a linear and speedy recovery pathway to become a moral, productive citizen.

What "counts" as gendered violence is produced through negotiations among institutional interests that, all too often, posit forms of healing less pertinent to survivors than to macrolevel care systems. Thus, people who have experienced gendered violence are in a double bind in which they must "suffer in code" (Dumit 2006) to receive care, legitimizing and justifying the politics that encode for their exclusion. From my study, few, if any, ever successfully progress through each stage due to structural, symbolic, and social constraints.

These politics also infiltrate people's social worlds. Recall that Marcos is an undocumented biocitizen; Cara is a citizen whose loyalty to the assigned biological group is suspect and therefore is subject to exclusion. Slight deviations from the trajectory of healing and its underlying rape myths raise suspicions. Care providers, law enforcement, and the perpetrator call Marcos's "belongingness" within victim and survivor citizenship into question based on his legal status and gender identity. Cara's friends question the legitimacy of their assault and need for recognition. They ask rhetorically "what kind of victim, survivor, *and* feminist" would start a relationship with someone who assaulted them, using Cara's deviation from the victim-survivor trajectory to invalidate their

experiences and question if Cara's assault "counted." Thus, people's social world reinforces the norms produced by the structurally and symbolically violent assemblage of care.

However, the advocates and forensic nurses I worked and communicated with were also fully aware of these constraints and used their knowledge and epistemic power to work around them. They found small areas of intervention that had profound impacts. Even though their subjugated position within this assemblage of care prevented them from challenging or permanently altering this system, they created pathways to citizenship by developing workarounds informed by their expertise and ethics of care.

Thus, interrogating widely held narratives that cast gendered violence through a universalist approach requires us to center the abject citizen, whose multivalent, complex, and non-linear experience serves as a lens to critique these larger assemblages of care that guard the gateways to citizenship.

CHAPTER 4: MORAL MANAGEMENT

a letter. part 3.[4]

My view of myself and my self-worth diminished. **I didn't feel like my actions, and therefore myself, deserved respect from anyone.** I thought I was setting a bad example for my students. I thought my friends thought less of me. I thought that everything I stood for meant nothing. Yes, I should've stopped things before they got started and that's something I hold myself accountable for, but you need to take responsibility, too, of taking advantage just to get laid.

I didn't like the influence you had on my life. I think as I spent more and more time with you, I was losing myself and my integrity – slowly… until there was almost nothing left. I started caring less about school and my research. I was putting less effort in at work. I was telling myself it was okay to get drunk and smoke whenever I wanted because that would solve my problems. It was easy to not care about my commitments. It was easy to party all the time. It was easy to let other guys do whatever they wanted **because I felt like I had lost that right to decide**. All those decisions were easy. Every decision has consequences.

Someone once asked me "Don't you have any respect for yourself?"
My answer then and it still is – how can I?

[4] Schafroth, personal communication, 2018

"These stories aren't worth telling. There's no arc to them, no dramatic climax. There's nothing at stake, not really. You imagine the listener, leaning in, 'And then what happened?'
''Nothing. That's the whole story.'
'Oh,' she says, her mouth in a firm line.
These are little bits of things that happened, or things you think about.
They're light on tension, you know that.
There's no real peril. There's no resolution."

- "Fragments" by Aubrey Hirsch in *Not that Bad*, edited by Roxanne Gay, p. 4

……………………………………………………………………………………………

Cara takes a deep breath in and not so subtly rolls their eyes. "*It was fucking brutal, dude.*" "It" being their experience reporting their assault to their college's Title IX office.

> **Cara:** *I was honestly guilted into doing it. After I managed to leave his dorm … Let me back track. I made up some story about my friend who was blacked out, which was actually true, and that I needed to go take care of her. I texted her boyfriend while it was going on to call me and act like he needed my help. He didn't quite understand the assignment at first, so I had to improvise a bit. Luckily, I guess, the guy I was with seemed drunk so that didn't register. Anyway. I ran back to my friend's house where there was a party still going on. I hadn't realized my shirt was inside out still. I ran into my friend's room where she was passed out and her boyfriend, and my close friend, was lying next to her. I practically jumped into his arms and started sobbing. I was still kind of in shock and I felt like I should cry more but couldn't muster it up fully, so I really tried to turn up the crocodile tears. [My friend] wasn't the most touchy feely, classic Midwestern dude, you know, so he was like, 'Uh… what the hell?!' My crying woke my friend up, although she was still kinda drunk, and I just cried because I couldn't talk… or more like I didn't want to talk…I just wanted to feel protected. I remember burying my head in her pillow so they couldn't see my face. They finally got me to talk and say what happened.*
>
> *I know that they were just trying to comfort me, but it bothered me that the first thing [my friend] said to me was, 'We're going to get help.'*
> *I knew that they were talking about reporting. I immediately told them, 'I don't want to report this. I've been through this before and I know I can handle it.'*
>
> *(Cara starts clicking their pen repeatedly and their cadence changes drastically. They are righteously and justifiably angry. I can't help but look at their posters of*

Angela Davis and Che Guevara in their background and want to put my fist up in solidarity as their pen endures the brunt of their anger.)

Ugh, this is what really pissed me off. [My friend] was like, 'Well, I don't think I'm comfortable with that…'

I think even at the time I was like, 'Uh…some guy just shoved his hands down my pants, choked me, and practically ripped my clothes off, and I'm supposed to care what you're comfortable with?' I'm just sitting there in silence because I don't want to seem bitchy.

She goes, 'I just don't want it to happen to someone else'

My therapist has heard a lot about this, but why is some hypothetical person being prioritized over my actual experiences right now? I immediately felt like a pawn in some fucked game of woke chess.

Interviewer: *Right, I hear you. And your friend seemed to have a lot of faith in the system, too. So, what changed your mind?*

Cara: *Honestly, I just felt like all eyes were on me until I reported it. But I didn't want to. I'm like, these people are going to waste their fucking time, or, at least they'll think that. I wasn't raped or anything. I didn't have any bruises. When I finally went to make my report, it was in some classy building that smelled like Pottery Barn. I had brought my friend Brian [pseudonym] with me because he was the only one who offered to go with me and wasn't seeking clout. The lawyer kept asking me questions and I felt like I kept answering them wrong. I didn't want to tell her that I went home with someone I didn't know. I felt really embarrassed that I had to walk through those details and talk about my tampon in front of Brian – who I knew didn't give a shit, but still. In a way, I like, felt ashamed that I didn't have any bruises around my neck or that this guy didn't rape me. Like I knew all her questions were legally salient, but I was like, 'Bitch, I got nothing.'*

I remember being 15 and being guilted into having sex with…or you know…by my ex and thinking I was pregnant and then accidentally going to some pro-life clinic for a pregnancy test because I was too scared someone I knew would see me buy one at Walgreens and having to tell the worker whose Jesus-eyes were judging me that if I was pregnant, I was going to get an abortion no matter what. I didn't do anything then and that was worse.

This part of Cara's experience outlines the major themes within this chapter – the guilt, the uncertainties, the choiceless choices, the constant comparisons. The previous

chapter argued that forensic intervention and community-based advocacy around gendered violence produce the subject position of the victim and survivor while simultaneously producing a "proper" trajectory of healing in which the *right* kind of victim uses the *right* kind of healing to become the *right* kind of survivor, predicated on normative forms of gender performativity. Thus, victims *should* demonstrate or perform both victimhood and survivorship (or the ability to survive) to gain recognition within a particular care system. This framework aligns with existing research. Previous research has posited hierarchies of victimhood and sexual harm within gendered violence (Hlavka 2017; Meyer 2021; Ricciardelli, Spencer, and Dodge 2021), or a logical ordering of what "counts" as a legitimate experience of violence, in which experiences that closely resemble rape myths, or are accepted by law enforcement (Ricciardelli et al. 2021), occupy the top tier. On the contrary, the bottom tier indexes what I labeled earlier as the *abject survivor*, a person who deviates from the outlined trajectory and who typically is labeled as sexually deviant (Hlavka 2017) and is not perceived as legally or socially innocent (McEvoy and McConnachie 2012).

In this chapter, I expand on this existing hierarchization theory by first exploring how people reconcile, or rather, *resist*, these categories. My analysis demonstrates how individual suffering connects gendered violence to conceptions of selfhood and gender, nuancing understandings of the socially constructed and institutionally imposed categories of "victim" and "survivor." While previous research, including my own, has established that people re/produce hierarchies of sexual violence in ways that align with existing rape myths, people do not place themselves or their experiences within these

hierarchies. In addition, I argue that this phenomenon is driven by a moralized conceptualization of deservingness of care and recognition. This moralized conception of deserving care separates people's actual experiences from the cultural, moralized imaginaries that produce the "worst case scenario." People's experiences receiving care, specifically within the micro-interactions with providers, mediate this process in which these care systems and the institutional actors function as *moral managers*. Returning to Cara's statement of "…*and that was worse*," the "worst" is a pervasive, and often insidious, imaginary that cannibalizes the *actual*.

"I'm not a victim"

Like previous empirical research (Du Mont, Miller, and Myhr 2003; Dunn 2005; J. M. Hockett and Saucier 2015; J. Hockett, Mcgraw, and Saucier 2014; Larcombe 2002; Papendick and Bohner 2017; Schwark and Bohner 2019), I found that all participants who have experienced gendered violence actively reject the label of "victim" because it implies a lost sense of agency. The logic behind their rejection stems from the gendered power relations pervading throughout their assault/abuse and experience/s within care organizations. These power relations subjugate their experiences and identities by fashioning people as passive beings while simultaneously removing the perpetrator's culpability/accountability. For example, a participant, Mira stated:

> *There's no accountability or agency given to the person who raped me, then it's just me being a victim, but not like a victimless crime, but like a crime committed just by air. I hated that, like, I can be a victim of sexual assault, but not the fact that someone raped me.*
>
> *We don't need our agency taken away from us anymore. That's happened enough. So, things that really start like, you know, reaffirming, the quiet work that we do.*

> *If we are putting the perpetrators as the focus, then you could be a victim. But when we don't … I don't think that that's fair.*

Thus, Mira's feelings parallel the construction of a victim within care settings (e.g., a passive being). Like Alison, discussed in the previous chapter, she rejects the conception of victim because it misaligns with how she views herself. She highlights the "quiet work we do," indicating that people are engaged with forms of healing. Mira also rejects the victim label because it diverts attention away from the person who raped her. Meaning, to her, victims exist as isolated, independent entities in which bad things *just happen* to them (i.e., a lack of agency). To Mira, this logic detracts from the perpetrator's intentional and malicious acts. While it is clear that Mira is not suggesting that people are to be blamed for the assault or abuse, Mira highlights that gendered violence does not exist in a social vacuum – there are multiple agents involved in both the hurting and the healing.

While normative gender constructs cast victims into a feminized passive role, people strategically utilize these constructs and gendered power relations to act agentively within a situation of assault and abuse and see their way out of it. For example, Mira navigated her way out of her abusive situation by operating within the same gendered power dynamics that shaped her experience of assault and abuse.

> *I had to kind of play like a psychological game to get out of the situation. Because he had like, I don't want to say he's delusional, I don't know. That's because that's a medical thing. And I obviously can't say that, but he had convinced himself that this was a romantic thing. This is you know, 'just what you do,' even though he had been violent and literally kept me hostage for two days. And the first day, we were at his house, and then the second because I had a dog, or like, because my mom and sister had left and moved to a different place, but they left me with the house and the dog. And so, I was able to kind of use the dog to be like, 'I have to go back,' but then he kept me there. Then, we went to the house, and he didn't*

> *leave me for another day. But he was you know, like, he would say that he was like doing it for my own good. Like, it was very much psychological …there was something going on with him like, 'This is love, or this is how it's supposed to be.' And then I started to try to take that and be like, 'Okay, how can I use this?' I don't know how I did this because looking back I think it saved my life. But I played started playing into it, like really hardcore playing into it, and ended up using it to break up with him being like, 'I'm not worthy of this kind of love. I just love you so much.' He bought it because it played right into his delusion or whatever was going on with him.* **(Mira)**

Thus, the perpetrator here utilized patriarchal and paternalistic modes of controlling and creating situations of abuse. This was Mira's first experience with sexual intercourse. The perpetrator took advantage that she had few frames of reference of what "love" was, infusing violence into the relationship in an attempt to normalize it under the guise of romantic care and intimacy. This paternalistic behavior operates within a banking model of learning in which Mira is told and shown what "proper" love was rather than being an active participant in mutually creating it. Interestingly, however, Mira believes that the perpetrator subjected her to violence because he was clinically delusional rather than, for instance, that he sought to exercise patriarchal power over her. This logic parallels the other ways in which perpetrators, specifically those who are white and cismale, are characterized as suffering from certain forms of mental illness and, by implication, are not responsible in the same ways for their actions as other perpetrators. However, Mira strategically uses these same power dynamics that subjugate her to patriarchal violence and control to escape them. She intentionally portrays herself as desiring this type of "affection" or "love" and undeserving of it.

In addition, Mira exercises agency by using widely held, stereotypical gender norms. Before intentionally playing into the perpetrator's fantasy, she tried leaving the

situation by saying that she had to go take care of a dog. At first glance, this interaction may seem insignificant, but it is rather revealing. The act of everyday caregiving, in this instance for a dog, was believed to be so normalized and routinized within her life that the perpetrator would not be suspicious of it, expect her to return, and not expect her to seek help because he assumed that she misrecognized the abuse for love. Thus, Mira anticipated that she could leave the house without raising suspicion because she would be behaving in a way that aligned with the perpetrator's understanding of her – a gendered being who is submissive and a caretaker.

This strategy mirrors how Cara tried leaving the perpetrator's dorm room. They stated in the opening vignette that they tried telling the perpetrator that they needed to leave to go take care of their friend. At this time, Cara shared with me that they solely identified as a ciswoman and that this was the time in their life when "*[they were] at their most femme*." Therefore, Cara also strategically played into stereotypical gender roles that cast women as caregivers, perceived as an inherent part of their identity and everyday life. It is important to note that in most experiences, people in situations of gendered violence use strategies that are the least likely to worsen the violence. Thus, Cara and Mira both highlight that one strategy utilizes stereotypical gender roles of caregiving and/or emotional labor.

Must be her hormones

Mira highlights another important theme. People who have experienced gendered violence seek to move the system and their lives in the direction of their own interests – something that the subject position and social role of the victim is incapable of doing. As the previous chapter demonstrated, care systems gender the victim. This consequently infuses emotionality into this construct by drawing from feminine stereotypes. Within care systems, specifically medicalized spaces, people perceive women as innately emotional and not in control of their assumed hyper-emotional state. For example, in a study examining perceptions of emotions, participants more frequently judged feminine facial images expressing emotions as "emotional," whereas they more frequently judged masculine images as "having a bad day," meaning participants attributed emotion as an innate state for women and emotion as a transient reaction to a certain context for men (Barrett and Bliss-Moreau 2009).

Scientific theories on genders and sexes construct narratives that characterize the emergent psychological properties of the "female" (i.e., feminized) brain as sensitive and emotional, mirroring social conceptualizations that conflate femininity with emotionality and inferiority. In other words, science borrows popular societal beliefs about gender to develop an explanation of gender difference, especially emphasizing the magnitude of difference, and then uses that explanation to confirm the validity of the dominant gendered paradigm (Shields 2007). In addition, "feminine" emotion is typically portrayed as ineffectual emotionality, a by-product of AFAB physiology, and fulfilling an evolutionary "role" to serve male "needs," while "male" emotion is described as goal-oriented (Shields 2007). The language biomedical researchers use also implies that

ciswomen's assumed susceptibility to stress and predisposition to affective pathologies are due to their lack of testosterone (for an example, see Goel and Bale 2008), essentializing differences in emotionality across genders. Therefore, ciswomen's "healthy bodies" and "normal emotional" states are often defined as disordered and thus serve as the point of intervention or systematic "fixing."

One of the main ways I saw care systems failing people who have experienced gendered violence is that they continue to view them, specifically ciswomen, as solely emotional beings whose primary goal is to unpack and explore their emotional trauma. For example, many participants shared negative experiences with care providers with me. The common thread was that each of these providers only focused on discussing *why* a participant felt (or did not) a certain way, *why* they were upset about something, or *how* they could regain emotional control and happiness. Certainly, stereotypic images of a Freud-like clinician asking, "*And how do you feel about that?*" were frequently mentioned. It was clear that these women did not *just* want to sit around and talk about their feelings all day. When women asked about possibilities of working towards specific solutions and goals (e.g., going back to school or work, dating again, being able to "move on" or "let go" of their assault or abuse) clinicians responded by saying things like "*You don't need to focus on that right now*" or "*Well, tell me why you feel that way*." Such responses frustrated these women. For example, one participant named Michelle stated,

> *I went and started seeing [a former therapist] and I saw her for my last like, year-ish. And like, her therapy techniques were different. She tried a lot of different things with me and it's not like she asked leading questions or pushed me in a certain direction, but the therapy methods weren't great. I never felt like there were any type of solution. Not to be crass with like a cost and reward type of thing. Like I said, it was a great personal cost that I'm talking about [my*

> *assaults]. You know, so like, what is going to become of it, like, where are we going with it?*

Michelle states that discussing her assaults and trauma associated with them came at a personal cost. Michelle wanted an equal exchange or transaction during her clinical encounter. Only talking about her feelings frustrated her because she wanted to gain or work towards something – centering emotionality in the clinical encounter was not the means to her end. Thus, women identified and attempted to reach the goals that they believed would help them "get back to their lives" and were not taken seriously or given opportunities to actualize them within the clinical space.

These encounters were also raced and culturally shaped. However, people pushed against them by attempting to modify the direct interaction. Bastet shared with me another part of her session described in the first chapter,

> *She was like 'There's a [Middle Eastern] word that's used for people who are from Pakistan.' People think Pakistan is in the Middle East, it's in South Asia, [so I thought to myself sarcastically] okay sure let's just stick with that. After talking to me for half an hour only, she said, 'It seems like you're oppressed because of the country you're from.' And I was like, 'Bitch what? he has, he has issues talking about the word [sex]. He can't say the word sex. My ex can't use the word sex or penis; he couldn't talk about penis issues, or sex or vagina. But I'm the one who's oppressed? Like, I can say sex, vagina, I can talk about sex. I don't have issues with that, right? But I'm the one who's oppressed? And like, you do not know what the fuck you're talking about. And I know, I shouldn't be saying this.' And I'm like, 'Bitch, what the fuck? You know what? We're just done with this conversation right this moment, because I just feel like you don't even fucking know. Yeah, if you think I'm oppressed, then you don't fucking have any idea what the fuck you're talking about!'*

Bastet's former therapist configures a representation of Bastet and what she needs based on racial and gender stereotypes – or more accurately, racist logic implying that she is oppressed because she is a Pakistani woman. Bastet resists this representation of herself

and changes the course of the clinical encounter. First, she aims to claim and demonstrate that she is not oppressed by intentionally violating the therapist's expectations. Bastet *explicitly* states that *he*, her former boyfriend, is the one who should be labeled as oppressed because he occupies the epistemic space that the therapist originally creates for Bastet – one in which oppression is defined by a sexually based censorship preventing someone from saying or using sexual discourse. Second, Bastet outwardly questions the therapist's knowledge and credibility as a mental health "expert." More specifically, Bastet tells the therapist that she "*[has no] idea what the fuck [she's] talking about*," subverting pervasive beliefs about how a "good" patient should behave (Jadad, Rizo, and Enkin 2003). Third, Bastet is the one who ends the clinical experience which opposes the typical model of managed care in which the therapeutic actor is the primary driver of the narrative and clinical time making (Mattingly 1994; 1998; Lester 2019). Thus, while the therapist casts Bastet as an oppressed woman, Bastet improvises goals in response – to refute this claim, to challenge the therapist's authoritative knowledge and position, to leave.

This overall pattern differed from Marcos's experience. Marcos was never offered any type of mental health counseling during his forensic examination or experience at the community-based organization. Instead, the community advocate and his current shelter connected him with English learning classes so that he could work towards earning his GED. However, I want to make clear that while I use Marcos as a contrast to the treatment women received that prevented them from working towards their goals, I do not intend to portray Marcos's experience as the standard nor as the ideal treatment. His

experience was deeply gendered as it reflected pervasive beliefs that cast men as unemotional beings. What I *am* arguing is that these clinical encounters produce a bimodal, gendered response in which ciswomen's assumed emotionality serves as the primary point of clinical occupation and intervention and healing, and therefore are not recognized as legitimate goal seekers, while men are only viewed as goal oriented. In addition, this logic perpetuates the notion that emotions and goals are mutually exclusive. Therefore, most of my participants rejected the role and position of the victim because it failed to recognize how they were actively trying to shape their lives in the direction of their own desires and interests.

Playing the part

In addition to a sense of removed agency, people rejected the label of "victim" because they perceived "victims" as manipulative agents who seek attention and take advantage of "the system." Returning to Mira, she states:

> *I thought of myself in a lot of ways as a victim for many years and that is something that while 'Yes, I am,' but I used that as a crutch almost as a way to not deal with things and as a way to get almost actually get attention of being like 'No, but I don't need to work through these things. Because look, I'm a victim - like this happened to me.' And I also realized that that was not helping me at all. It was hurting me a lot more than it was helping.*

Interestingly, when Mira identified as a victim, she was aware of the associations around the construct – that people are expected to not exercise agency, that they are passive beings, that it is used as a strategy to subvert or circumvent normal responsibilities (see Parsons 1975). There was also a point in time when she accepted the notion that she did not have to be an active participant in her own healing, which she later desired as indicated by the quote above. Mira also stated that identifying as a "victim" was a way

for her to get attention. This was a common finding across interviews with ciswomen. Thus, for Mira, a victim is more than just a passive being. Adopting the term functions as a strategic and intentional method to dissociate from residual emotional and physical trauma and to gain recognition from institutional and social systems. This sentiment was also expressed by another participant named Leila. Leila shared with me:

> *Victim is just such a …I don't want to be a victim. I don't want to victimize myself. I- I don't know. I feel like I'm not worthy of "survivor," but I feel like I don't want to be a victim. I don't know where that leaves me. But I am not a fan of it. I don't know what a good substitute would be though, honestly.*
>
> *[My assault is] an event that happened to me. It's like I, like, you know, I go to a concert does not mean that I'm, you know, a crazy fan girl or so, you know, like, yeah, I don't know a good analogy. But in that sense, it's like this was an event that happened, but it doesn't. I just, I hate the idea of it defining who I am. And I have also met people that use it as an excuse to do whatever the hell they want, and then be like, 'Oh, well, I'm a victim.' And it's like, I don't want to downplay what you're going through, but you need to sort it out. You can't just do everything you want. And then say you're a victim, and then let it be kind of thing. So yeah, I think of it as more of an event than a characteristic.*
>
> *Yeah, like I knew a girl who had like an emotionally abusive boyfriend. And then she dated someone who was physically abusive, where he had hit her like, I think three times, which is still three times too many. But she hadn't suffered sexual assault from what I had known, but she had suffered different kinds of assault. And whenever she did something wrong, or like whenever she angered someone, or did something that wasn't right, she would be like, 'Well, you know, it's just, this happened to me, and I just, I don't, you know, this is how I deal with it.' And it's like, I get that. But you can't use this every time you do something wrong. It's not a scapegoat. And I feel like it discredits people, actually, like it sounds horrible saying it… But these were things that had happened to her a long time ago. And I'm not saying that it's not still a part of who she is, in the same way that what happened to me, still is a part of me, but if it's fresh, and you know, you do these things, I will give you leeway, that's fine. But if it's been years, and you're still doing things that are not right, that are wrong, and someone's just trying to confront you about it, own up to it. Don't use this as an excuse.*

Leila first articulates a common pattern across participants – she does not want a singular label or event to define her or her experiences. Second, and most interestingly, is that Leila articulates similar sentiments as Mira in that she expresses that "victims" use their status to escape accountability for various aspects of their lives, which are discrete moral categories of being right or wrong, and that they should work independently on themselves (e.g., "*you* need to sort it out) to heal and cope from their experiences of violence. The notion of processing and healing independently was a pervasive theme across participants. From the previous chapter, Cara's friends shamed them for seeking reconciliation or comfort from the perpetrator, further isolating them from themselves and other social networks. Numerous other participants shared stories with me of how their families and friends held intervention-like gatherings during which they threatened that they would "cut them off" or never speak to them again if they did not leave an abusive relationship. As a result, many participants felt a sense of pride that they "did it" on their own, suggesting that going through the process of leaving an abusive relationship, seeking care, and conforming/ascribing to proper healing models without social support is how this process *should* unfold. Taken together with Leila's statement, people not only apply the sentiment that healing should be independent or self-guided to describe their own meaning making from gendered violence, but also view other people's actions through this same framework.

Similarly, both Leila and Mira highlight how assuming the "victim" role connotes a negatively perceived behavior of attention-seeking and evoking pity, avoiding individual responsibility and accountability. However, given that previous ethnographic

work (Mulla 2014e; D.-A. Davis 2006; Du Mont, Miller, and Myhr 2003), including my own, provides evidence that people experience an immense amount of institutional and social dismissal, it is reasonable that people who have experienced violence would pursue every possibility for validation and support. Thus, it is clear that forms of dismissal become misrecognized and compel people to internalize stigma and shame around gendered violence, influencing how people view themselves *and* others who are read as exploiting victim citizenship.

Moreover, this notion implies that seeking social and institutional support should be strategic and selectively used. For example, Cara mentions in the opening vignette that they chose their friend Brian because they felt like he was the only person who offered to accompany them out of genuine care and not to gain clout. In a separate part of our conversation, Cara shared with me that they went to an "extremely woke" school where proximity or involvement in social activism, or the performance of, served as social and symbolic capital. Cara stated that people only volunteered to support them when it was associated with an institution (e.g., going to the Title IX office to make a statement). Their friends were less enthusiastic to talk with them about their anxieties about herpes, explicitly disagreed with them when they did not want to report their assault, and often disregarded the severity of Cara's experience by pointing them towards the campus's resources despite them having a reputation for being structurally and symbolically violent. Thus, Cara's social network inadvertently told them that their support should only be sought when it directly benefits them.

In addition, Leila mentions her acquaintance who experienced gendered violence and would seemingly use that experience to absolve herself of any responsibility for an alleged wrongdoing. For Leila, whether this behavior is permissible is contingent upon time. She stated that she would give someone "leeway" if they just experienced something traumatic but will rescind that form of understanding after a given amount of time. Thus, healing, or the performance of, involves a specific chronology. I was surprised by how often people ascribed manipulation and "playing the system" to conceptions of victimhood, re/producing beliefs and social anxieties that sufferers drain a system of its political, economic, and moral resources.

When I presented Leila's quotes above to my colleagues, people articulated similar sentiments – that you cannot "*play the victim card*" to absolve yourself of accountability to do "*whatever you want*." To better understand people's perspectives, I asked for specific examples of "victims" taking advantage of a particular system. One person replied that when she was in college, she was disciplined by the college administration for breaking dorm rules. During a disciplinary meeting with the administration, she shared that she mentioned that she had an ongoing Title IX issue. Immediately, the administration expressed sympathy and "let [her] off the hook" for her alcohol incident. She stated that her Title IX case was unrelated to her disciplinary hearing, but the administrators automatically connected the two cases, assuming that her experience with assault caused her to consume alcohol. What I found interesting about this example was that she genuinely believed that she was taking advantage of the system when she did not correct their thinking, ensuring further punishment, as opposed to

viewing her (in)action as a way of exercising agency or strategically navigating a system that prioritizes punishment over other forms of mediation.

What did I survive?

As the previous chapter demonstrated, I found that people are expected to transform into a new role of the survivor. The "proper" form of survivorship is one that indicates someone is "healed" – a habilitated person who is a "stronger" version of themself. However, similar to why people reject the label of a victim, I found that people reject the position of a survivor based on feelings of unworthiness. These feelings of unworthiness stem from micro-interactions, or minute interactions within the larger scheme of the clinical encounter. For example, Leila shared:

> *I don't really see myself as a survivor because I don't really remember it. So how do you survive something that you don't remember? And I mean, I guess the aftermath, the trauma of it, the fact that I was drugged, things like that, but I don't know if I'd really like to...*

When Leila sought healthcare after waking up in an unknown area after leaving a bar with someone, her experience within healthcare made her question the validity of her experiences. The team of forensic nurses provided a sexual assault exam and never maliciously dismissed her, but the micro-interactions, the ostensibly meaningless comments and actions, were the most significant in making meaning from their experiences when people left the medicalized space. Leila describes her experience as:

> *They were just finishing up with someone else, so I mean I had gone pretty early in the day, so it was quite quick. The whole process was long though there were a lot of forms that I had to fill out. The one weird thing that I don't blame them for but at the same time was a little like iffy was well when they had asked me what happened and pretty much you know, I had lost a lot of my memories… I don't know,* they kept telling me how lucky I was *and like and I see where they're coming from because they see the worst of the worst but at the same time it was*

> *just kind of like I don't feel lucky like I know where you're coming from and I know that you're trying to help but that part was a little like iffy but I mean when they see as much as they do in a day it's crazy but I mean … they took me quite quickly, they did the rape kit test, gave me the drugs and then tons of forms for the legal process also. And they were in contact with I think a hospital where they would send the kit and get the results. Mine came back negative but that can happen if they use a condom. So, it doesn't actually say much and then they check my body for like bruises and whatnot. And yeah, I guess that was kind of it. It was very efficient. It was really much like in and out. Um, so that was that.*

Taken together, Leila never assumed the social role of the survivor, or accepted the term in relation to herself, because her experience seeking post-assault care undermined the validity or realness of her assault. Leila never assumed the subject position of the survivor either. While Leila recognizes that the nurse probably just made a statement not intending to cause harm, which is also a form of gendered labor in which women empathize and seek to understand every perspective before reacting (i.e., *a gendered theory of mind*), this comment affected how Leila ultimately configured a representation of herself that was misaligned with her reality.

Leila states multiple times during our interview that she was not in fact "lucky" because she did not remember her assault – she was rather unlucky because she spent years trying to recover her memories about that experience, faced institutional dismissal, and had to navigate a complicated relationship around sex and intimacy. As previously discussed, Leila imposed a structured timeframe for herself and others to "overcome" this victim identity. While she states that she is unsure whether she would have appreciated a less rushed exam, I question whether her speedy exam process mediated the length she felt that she could allow herself to heal afterwards. In other words, her short exam compounded with the "lucky" comment may have influenced the extent to which *she*

believed her assault was valid – a more "real" experience may have necessitated a greater length of time and forgiveness of any perceived misstep during this process.

In addition, Leila interacted with a police officer after she obtained a forensic exam. This interaction reinforced the notion that her experience was not real and therefore was less deserving of institutional attention and resources. She states,

> *And the second I started telling my story, I could just see it in his face that he didn't believe me. And I was just like, trying to tell him [what happened] and he's like, 'Well, did you drink?' and I was like, 'I mean yeah, I had a few drinks but like…' and I tried to explain to him like I've been drinking for a while. It's in my culture, like, yeah, I'm not one to get drunk. I know my limit and I did not reach it; I was nowhere near it. And then one minute I just blacked out. Like that's not even if I was drunk to that extent from blacking out. That's not right. But because I didn't have any proof... He was like, 'Okay, I'll bring it up with a detective.' So, he sent all my information to a detective. But all the inconclusive stuff, plus the negative rape test… They just dropped it. But they never even looked at the cameras [at the bar]. I even tried to get the footage myself, like going to them. I got close, but then they're like, 'Oh, I don't think we can.'*

The police officer never explicitly dismissed Leila like common assumptions about rape culture would have us believe. The police officer never told Leila that she was "*asking for it*" because she was drinking. The police officer never told Leila that she should not have gone to the bar because "*boys will be boys*." The police officer never called Leila a drunk slut. The police officer never explicitly told Leila that he did not believe her. However, each of these statements were deeply felt and expressed through the micro, nonverbal communication during his interaction with Leila.

Leila was attentive and consciously reading his behavior to make meaning from her experience. She states that *"[she] could just see it in his face that he didn't believe [her]."* In addition, Leila was forced to tell the police officer repeatedly that she was not drunk – she learned how to gauge her limit because she had experience drinking alcohol

in a country that has fewer criminalizing laws around consumption. However, the police officer was not convinced as evidenced by Leila's emotional labor trying to get him to believe her. Compounding this interaction, Leila shares that because the corroborative evidence was inconclusive and her rape test was negative, the law enforcement dropped her case. She expresses multiple times during our conversation that the law enforcement did not even try to obtain the security footage from the bar she was at which could "prove" or provide evidence in support of her legal case – doing so would have been the bare minimum and a relatively easy solution to the lack of supporting legal evidence. Thus, she was compelled to take on the responsibility of trying to obtain the security footage despite this being the law enforcement's responsibility. Therefore, Leila's experience exemplifies how institutional dismissal takes form in seemingly "small" interactions with institutional actors, greatly impacting the extent to which people believe in the realness or validity of their experiences of gendered violence. Here, structural and symbolic violence employed by institutional actors weaves their way through the small cracks and crevices within the medicolegal encounter.

"*It could have been worse*"

Therefore, I found that these micro-interactions, along with organizational politics and everyday practices, facilitate attention economies in care systems, casting these systems as *moral managers*, dictating whether, or how, someone assigns value, significance, and labels of "realness" to their *own* experience/s of gendered violence – whether people view themselves as legitimately deserving care. Moreover, the moral management of gendered violence introduces a "should" paradox which argues that

violence and sufferers from it *should* take specific forms, pitting the actual against the imaginary. These clinical interactions and worlds are not just a matter of place as they are of morally imbued interactions and relationships (Kleinman 1988; 1997), forming and infusing moral regimes into the lives of the people that inhabit them. Moral regimes refer to the privileged standards of morality that are used to govern bodies and populations (Morgan and Roberts 2012, 242). For example, while care organizations are *legally obligated* to accept all clients and treat each person equally, care providers un/consciously differentiate their care practices or ethics of care based on their own moral understandings of legitimate experiences of gendered violence (Mishtal 2014).

When theorizing about the attention economies that underlie and uphold moral management, I was intrigued by what experiences and which people produced the most labor, emotional and material, for advocates and nurses. In other words, I was concerned with delineating what demanded the providers' attention and resources. As Cara discussed in the opening vignette, they believed that the Title IX office and the legal advocate were "wasting their time" because, in Cara's mind, their experience was unworthy of institutional attention and subsequent resources since it deviated from stereotypic rape myths, or imaginaries about legitimate suffering. During my fieldwork, I found that advocates spent drastically more time discussing cases that mirrored stereotypic rape myths, allocating their resources towards these cases. This finding makes sense, given that institutional care practices are built around these myths. Thus, in order to receive resources, people often felt like they *should* feel a certain way and *should have* experienced a particular form of gendered violence.

This phenomenon was especially present in nonprofit or publicly funded organizations. For example, after Mira's forensic examination at a Planned Parenthood, they referred her to a publicly funded organization to receive mental health support. However, they informed her that there were only a limited number of available spots. Mira shares with me,

> *So, the woman [at Planned Parenthood] who had given me the number of the psychologist they had said that it would be a very limited program because it was going on like free like a free grant sort of thing and because like there were very specific requirements. Which was really difficult because I had to go through a phone process where I basically had to talk about my trauma again to make sure that it was worthy of getting their help. And I understand that that was the case but that was really hard talking to a faceless person about things you know and not really knowing how to put words on it or to like prove that I was sick enough to get this therapy. Um, but I did that and then was able to. Then they gave me the number of like one place I was able to go. I had like just gotten my driver's license so I was able to like borrow a car once a week to drive 45 minutes or something to my appointment, and luckily there they didn't put it in a system. Like I had to like sign in and they needed my information, but it didn't have to go through my insurance and because I was over 16 but under 18 and I specifically requested for like no parental [contact] you know like that was acceptable because of like the nature of what I was there for so that was allowed. I had like a job at Dunkin Donuts like if I were to need to get an abortion or something I wouldn't have been able to cover it unless it was something that was covered which is also why I went to Planned Parenthood because I've heard they had you know, for low income or no income cases. Also, it's the only thing I knew.*
>
> *[The screening process] was very black and white. I played that. You know, the, the parts that were the most, like physically traumatic, and where I might not have used like, like… I remember that's the first time I used the word kidnapped because I hadn't wanted to before but there I felt like if, if it was up to a random person who had never spoken to where I have to prove that I'm traumatized enough to get free psychology. Like… Yes, he did forcefully keep me there for two days. I feel like I should… so I wanted to use a word that I felt would, you know, would, would fit with that, but at the same time, that was hard, like having to use that or having to like up play it and not having anything in response. I got no feedback, you know, it was just like someone writing it down. Because you have to prove this, like I know, they're probably like, you know, a receptionist or something. They're not the psychologists, this isn't therapy. I got anxiety from like, making calls for like a while afterwards, too, because it was like, you have this*

> *super traumatic thing you're talking about, possibly for one of the first times.* And it's like, if you don't do it, right, you don't get help.

Importantly, Mira attempts to receive care by stating things that were true. The perpetrator kept her in a house for two days, fitting a legal definition of kidnapping. She could not afford post-assault or reproductive care. Mira was traumatized. However, she articulates how having to prove that she deserved care and was worthy of resources forced her to feel like she should frame and view her assault in a way legible to that institution (e.g., using the word kidnapping, expressing the need for anonymity given her age and financial barriers, being "black and white" lest she leave her experience up to interpretation). Thus, Mira highlights that this type of framing is the *right* way to receive care – you must frame and perform your suffering in a certain way that is much more pertinent and meaningful to an institution than to yourself.

This process caused and perpetuated her mental suffering. The hypothetical possibility that she would not be deemed worthy of care based on her own actions caused her to feel like she had performed her suffering (i.e., "play into it") rather than recognizing that she actually experienced it. Here, Mira does not craft a cohesive, strategic story that she believes, or was previously coached to say (see Nicklas 2017), to receive care. Rather, Mira frames specific aspects of her experience of gendered violence in ways that may grant her recognition within the attention and moral economy of care. She highlights the physical trauma and uses legally and medically salient wording to work within a system to obtain what she needs in the short-term. Importantly, however,

this form of systems-correcting praxis works against her, causing detriment to her wellbeing and sense of deservingness.

In addition, Mira's care was predetermined. Because she only had knowledge about Planned Parenthood, likely due to the amount of attention allocated to it in political, and therefore moral, conversations, she *had* to seek emotional services elsewhere with fewer resources. Had she gone to an independent reproductive and sexual health organization, it is possible that the quality and quantity of her care would have improved significantly.

Virtually every participant stated that they "never felt worthy" of being called a survivor, an institutionally meaningful label, suggesting that their experiences never felt valid or institutionally recognized as legitimate forms of suffering. When I asked who would be worthy, they responded by saying something along the lines of "*I just know for me… it could have been worse*." Returning to Leila's experience, she states:

> *Going back to the "I'm lucky" kind of thing, okay. And it's crazy how much that stuck with me because, you know, this woman probably just said it and like, didn't think twice about it, but I thought soooo long about it. And then I just started thinking of all these different stories that I've heard or articles of women who have, or men too, who have suffered crazy sexual assaults that you can't even wish on Satan himself. And for me, those are survivors. If I had remembered and if horrible things that happened, then maybe I would be more open to call myself a survivor, but it feels wrong.*
>
> *But, you know, and, and, as much as I wish that didn't happen to me, don't get me wrong. I feel like I did come out of it a stronger person, someone who's more careful and guarded and I know that women have to be - which is shitty, but I think it was a good lesson because it could have been worse. So like, now I always have pepper spray on me, I'm always you know, if I'm outside, just one earphone in not to, you know, just more cautious in that retrospect. And like, more just, I don't know, accepting of, you know, situations and people. I feel like it just really opened me up a lot. Because I saw people who really stuck through me like for it*

> *so that's my ending. Nothing happened, but I gained from it. Fairy tale. Disney should write me.*

However, I asked for clarification about the experiences she would categorize as having "survived," without naming specific cases, she mentioned very sensationalized forms of sexual assault that media outlets hyperbolize or overuse to encapsulate all forms of gendered violence. In addition, it is clear that one of the most identifiable forms of institutional dismissal, being called "lucky," mediated her relationship with these labels and the value or meaning she assigned to them. Leila also articulates that avoiding the proverbial "worse" granted her partial citizenship to the survivor community (i.e., being a habilitated being). However, this refashioning permeates her moral sense of self in that while "nothing happened," meaning nothing precipitated from her legal case, she refashioned herself into what she believes a strong woman should be – guarded, self-sufficient, able to protect herself. I cannot help but to believe that her interactions with the nurse who called her "lucky" and the police officer who refused to take her seriously restructured how Leila reconstructed herself and her sense of the "right" way of being a woman.

Alison, who was discussed in the first chapter, never questioned whether the perpetrator raped her. She immediately called law enforcement and sought to create a legal case against him. There was not a single point in our conversation when she ever questioned the validity of experiences, but still compared her experience against a hypothetical situation.

> *We used to have a T-shirt project where victims of sexual violence and children and… of course that is you know that and that's another thing too. There's a whole lot of like, you know, 'Hey, at least I was you know, in my mid 20s when*

> *this happened.' You know, at least I knew that it was wrong and I just can't imagine being a child and having to go through this. I think about people who had it so much worse than me and that you know, it makes me so sad for them, but it also makes me feel a little better about what happened you know, like it could have been so much worse. I don't know if that makes sense…*

Mira stated similar sentiments,

> *I compared myself a lot with what I had considered, you know, like a worst-case scenario, like, you know, if it was a stranger, or if it was, like, really violent, or if it was several people, like I went through a lot of scenarios. Like, yeah, it was, you know, if they'd gotten pregnant and had to get an abortion, like all of those things that like… mine could have been worse. So, because it could have been worse, maybe someone else deserved that spot [from a state-funded care center] more than I did.*

Thus, Mira and Alison explicitly state what they view as the "worst case scenario" – a stranger assaulting her, extreme violence, several people involved in her rape, experiencing assault at a certain age. It is a gendered behavioral pattern to downplay your experiences. For example, Mira does not mention in her representation of the "worst case scenario" that her former boyfriend held her hostage, that she felt like her life was in danger (e.g., the perpetrator had ties to the military and owned weapons), or that she too thought that she needed an abortion and seeking one in a conservative area compounded her suffering, contemplating suicide if she was pregnant and could not receive an abortion. Gendered violence, and the care settings around it, are linked to larger structural processes, including local cultural systems of gender and sexuality, for those marginally positioned in relation to patriarchal power. Mira's experience seeking sexual and reproductive health care/post-assault care at a Planned Parenthood in conservative PA was described as:

> *I was ashamed, like so ashamed, you know, like, you know, I felt like, kind of already going in there was a taboo, you know, this is a Planned Parenthood in Pennsylvania. And even though I was very like, you know, I guess I considered myself very open and as already starting like my feminist activism and stuff. But it was just them when it happens to you. It felt so different. Like, was I being dramatic? Would they believe me?*

The forces that constrain care are deeply gendered in that the defunding and stigmatizing of sexual and reproductive health aim to control reproduction, re/produce normative forms of acceptable sexuality, and increase state surveillance of some people with specific gender identities. This political regime reverberated in Mira's experience and caused an acute alteration to her own identity as a feminist and in her experiences with sexual violence. Thus, she had no other option but to entertain imposed normative configurations of womanhood - dramatic, flighty, deceitful.

Mira locates this "worst case scenario" within several rape myths that mutually construct modes of exclusion within healthcare systems and create "exceptional" cases of gendered violence that are deemed worthy of care. Therefore, this pattern creates a double bind in which people do not feel *violated enough* to seek health care and these care settings perpetuate rape exceptionalism. Leila's, Alison's, and Mira's experiences suggest that the institutional practices create hierarchies of deservingness. "Survivor," the one who deserves care, is produced by a moral economy of gendered violence, a defining feature of the biopolitics of gendered intervention that manifest in people's social worlds.

Interestingly, the only people in my study who labeled themselves as survivors, and were therefore deserving of care, were the advocates who had also experienced gendered violence. However, to them, "survivor" served as a meaningful institutional

label to differentiate their clients from abusers. Many of the advocates at my field site and whom I interviewed had experienced gendered violence. One advocate, Celi, who had been in an abusive relationship with her child's father when they were younger shared with me,

> *Like I've been in numerous circumstances where abuse is always present. I've seen pieces of myself in [my clients]. It's because I was homeless as well. I didn't have a place to go in 2010. You know, because I'm a child survivor of domestic violence because I was a child witness, there was a lot of it happening when I was growing up. So, you know, I saw it happen to my mother. But then I was also the target from the ages of eight years old till about I was about 14. So, from 8- 14, I was always at the end of that belt, or I was always at the end of that hand, or kneeling down on rice for hours at a time because that was punishment. And I could go on. But the point is, is that I went through that DV with my family. And so, it was hard. And so, it's why I say I'm a survivor, in many ways, because I lived it - in every shape and form, I lived it.*

From my many conversations with Celi, it was clear that she never recognized nor labeled these experiences as abusive until she started working at the advocacy organization. The topics she associates with her survival of abuse and assault - being housing displaced, experiencing domestic violence as a child as an as intimate partner (i.e., compound trauma), witnessing domestic violence between her parents (i.e., vicarious trauma) – are topics that advocates spent the most time and resources towards. Thus, Celi's occupational position as a domestic violence advocate shaped how she perceived and labeled her own experiences. What she learned to allocate her time and resources to and what is institutionally recognized as deserving of those resources is what Celi ultimately perceives as valid experiences of her own suffering.

This is surviving – living in liminality

One of the main issues with this moral management is that it is an inflexible, fixed model – you are either deserving or you are not. Multiple participants stated that their relationship and acceptance of these labels/categories that underlie this moral economy shifted over time depending on their needs, demonstrating a needed level of flexibility. For example, participants stated that in the moment of their abuse/assault they were victims who lacked agency. However, afterwards, people articulated a variety of situations in which they were agentive beings who attempted to move a system, institutional or social, in the direction of their own interests. Many people expressed how much work they put into their own healing and coping, which they often faced alone or isolated, both intentionally and unintentionally, from supportive networks. One forensic nurse, who also experienced assault, stated:

> *[My forensic team] got invited to teach at the International Association of Forensic Nursing to present on what we've done [at my hospital], which is like huge, but it's in Orlando. So, it would be my first time back to Florida. Which is kind of victorious. You know, it's like, the last time I left Florida, I had just been sexually assaulted and abused for four days. And now I'm returning as the forensic coordinator of six hospitals and talking at an international conference like* that's surviving.

It is important to note that Rosie never referred to herself as a "survivor." Rather, she describes her changed life (as a habilitated subject) as *surviving*, positing an active and ongoing process that does not have a clear endpoint – producing a subject whose needs and institutional demands may change. Her form of survivorship acknowledges and integrates her experience of assault into her reimaged subjectivity and way of being.

Conclusion

> *But with these patients, some of them come at you, you know, because hurt people hurt, right? So, they're not always going to sit there like the Lifetime movies, and*

> *you know, be like, 'Oh, thank you so much for helping me!' Do you know what I mean? And play the victim - they're angry, they're mad*. **(Joyce)**

People's perceptions of the "victim" label are produced in a bimodal fashion. People rejected the label of "victim" because it implies the wrong kind of agency. The first reason they reject this label is because the gendered power dynamic that led to their abuse/assault removes their agency in a situation where they perceive themselves as intentional, present actors. Second, people reject this label because of its connotations of being manipulative and "taking advantage of a system." However, it is possible that the internalization and misrecognition of gendered power relations mediate this process. In other words, what people may view as manipulation or taking advantage of a system may be empowerment or agency to shift power in the opposite direction of its expected enactment within larger systems, or the strategic navigation of the social field (Bourdieu 1985). The exclusivity around *who* can access care in response to gendered violence creates institutional dismissal and structural barriers that people must navigate.

Importantly, expectations about *how* someone should act within these systems and heal from their abuse and/or assault emphasize the role of the individual. Previous ethnographic work has shown those who faced obstacles on their own found that empowering [sic] and felt proud of it, even when practically speaking, it made things harder, whereas people who sought more social support were more able to overcome obstacles but did not have that pride of independence factor (i.e., "the superwoman complex") (Ostrach 2017c). Therefore, the politics of care that configure the social and institutional meaning around "victim" have deeply personal ramifications for how people

make sense of their own and other people's experiences of gendered violence and who *should* be involved during the healing process.

There is a right kind of survivorship that is contingent upon whether someone has been institutionally recognized as a proper victim. In addition, the subject position of a survivor is one that structures a linear and speedy recovery pathway to become a moral, productive citizen. The notion of being a survivor rests on moral economies of deservingness, or the moral management, that compel people to state over and over (and over) – *it could have been worse*. Previous ethnographic work has demonstrated that these reflective, psychological processes serve as moral laboratories, acting as ". . . *a metaphorical realm in which experiments are conducted in all kinds of places and where participants are . . . researchers or experimenters of their own lives*" (Mattingly 2014, 16). However, I argue that these psychological processes are managed by institutions, the actors within them, and how people are treated in clinical spaces. Here, people were not necessarily experimenters of their own lives who explored multiple possibilities on a moral plane but were rather competitors with an institutional and cultural imaginary positing a subjectivity of "the worse-case scenario."

The tendency to downplay their experiences and define the "worst cases" within sensationalized versions of rape myths echo the notion that exceptional cases of rape are the only ones deserving of care, reinforcing gendered patterns of deservingness. For example, women-identifying participants made meaning from their experiences of gendered violence in comparison with pervasive narratives espousing rape myths, resulting in feelings that their experiences did not "measure up" and were less deserving

of care. Previous ethnographic work shows that *certain* forms of suffering become exceptionalized within institutions and care systems, cannibalizing other forms of suffering that are deemed less important (Benton 2015; James 2010b). The exceptional cases of suffering, and in this analysis, rape, create attention economies within institutions that mediate how people who have experienced gendered violence locate themselves within these systems and navigate organizational politics. These sentiments differed from the one cis-male participant who always articulated his experiences of sexual and domestic violence in ways that clearly portrayed his recognition of violence. Moreover, he also never compared his experiences using a framework of deservingness. However, it is important to note that the medicolegal system and CBOs are an inherently feminized space and therefore pose unique barriers to men who must overcome them in different ways compared to women. Second, he was not a native English speaker, so it is possible that our conversations were not as nuanced given both of our language capacities. Thus, more research should be done centering male survivors' perspectives and experiences around seeking care for gendered violence.

CHAPTER 5: VICARIOUS SURVIVORSHIP: I WILL BE SEEN, WE WILL BE OKAY

a letter. part 4.[5]

I understand that my actions from a year ago to now have seemed contradictory. I recognize that. But, that's what I'm realizing the process is – contradiction. However, you don't get to judge me or call me irrational or unreasonable. Throughout this process, as confusing and non-linear as it is, I've begun to patch myself up and put myself back together. **And I make no apologies for how I chose to repair what you broke.**

Part of why I'm so disgusted with you is because **I thoroughly believe that you're not living up to your potential.** You're intentionally cheapening yourself. I've seen what type of person you can be. I think you can be kind, compassionate, sensitive, well-spoken, and intelligent, and deserving of respect, but you don't let yourself be that person. To be honest, as I've opened up to more and more people about what happened, they weren't surprised. Their first reaction was to tell me how they thought you were slimy, they never got good impressions from you, how they think you're incapable of actually liking anyone, how you never treated women with respect. You're known for being one of those guys – that guy who women tell their friends to avoid, that guy who no one thinks is capable of kindness and sincerity, that guy that doesn't cause people to bat an eye when they hear he's assaulted someone. **I'm not going to psychoanalyze you or judge why you are how you are. All that matters is that you can be better. So much better – I've seen it.**

The purpose of this letter was for me to finally be completely honest with you. You needed to hear the effect this has all had on me without me feeling the need to protect your feelings. I've given you a level of respect that you haven't always deserved. It's time for you to return that favor. I don't know what I want from you in return other than a true acknowledgment of the profound consequences of your actions and an actual change in behavior and character. To be perfectly honest, I've had this letter written for months now. I've hesitated to send it because I sincerely don't want to cause emotional pain. **I've also hesitated to send it because I have too much pride to let you think that you're significant enough to occupy my life – I refuse to let myself continue to be victimized by you. I've gained too much self-respect for myself and too much respect for people who've experienced similar things to let the impact of your actions go unsaid.** So as hard as it is for me to say this, how you process this letter isn't my problem.

I'm not looking to involve you in my life and I'm not even looking for a response. **I hope my words will stick with you like your actions have stuck with me so that maybe some other woman down the road doesn't have to fix herself because of you.** I need

[5] Schafroth, personal communication, 2018

to reiterate that this letter isn't written out of spite or with the intention to hurt you. I just think **I could've saved myself a lot of pain if maybe someone was direct with you earlier.** If you're going to take only one thing from this, let it be that **you need to change because this cannot keep happening.**

In all sincerity, I hope your senior year is going a lot better than mine did.

Let's not kid ourselves, rain isn't typically followed by a rainbow of relief, and most death is not a silver-lining type of loss.
Abuse and unforeseen trauma are not lessons to learn but adversities that demand us to find a way to live past them.
They require time.
Time to process.
Time to rest, to lay in bed and stare at the ceiling or watch the show you've seen way too many times.
Time to be, without judgment or fear.

-Hope Weidemann

……

> *[My experience trying to receive care] became this like, very, you know, chew you up and spit you out kind of thing rather than something where you feel you can be safe there. It felt like a very temporary feeling of safety*. **(Mira)**

> *Like I live in a shelter. I'm freaking out. I want to go home but I don't have one. So like, it literally just feels like I'm out of place. I'm like, oh my god, I'm a random puzzle piece that you're just like, what the hell? Where does this puzzle piece go to? Yeah, where did this come from? You know, and that's, that's how I've been feeling*. **(Ariel)**

Thus far, my analysis has primarily focused on how care systems responding to gendered violence fail people – how they chew people up and spit them out, how no one is the right puzzle piece, how safety and feeling safe is ephemeral. Care systems are structurally and symbolically violent assemblages comprised of administrators, individual providers, the policies they enforce, and the ideologies (e.g., rape myths) they re/produce. However, as the previous chapters demonstrated, this is not an impervious system. Individual care providers often operate within these systems, creating and operating within the cracks and crevices of these systems. These actions allow people to gain access to care. Despite these efforts, care systems simultaneously produce gendered beings, specifically feminized subjects, and the proper healing trajectory they must adhere to lest people inhabit an abject subject position. As the fourth chapter

demonstrated, people contest these categories and imposed senses of identity, yet still are confronted with cultural imaginaries about *how they should* feel and *who they should* be. The notion of "should" posits a territory that only the "worst case scenario" can occupy.

An abundance of anthropological research investigates how specific care systems structure the lives of those who encounter them. This area of inquiry captivated me. However, one question that I always sought to answer was – what's next? What happens when people leave these care systems? How do these care systems continue to structure or influence people's lives after being "chewed up and spat out"? How do people respond to and reshape the systems that fail them? Such questions echoed within the conversations I had with people who grappled with their own uncertainties on how to move forward. Care systems, both medicolegal institutions and CBOs, were not always places of healing and re/habilitation – they often worsened the mental and physical trauma caused by gendered violence. People's bodies were used to scrape evidence from, their experiences were questioned and disbelieved, they were told how they should be rather than exploring the possibilities the "could" offered. After people left these semblances of safety and protection, how did they recover – if at all?

People are creative, perseverant, hopeful, and angry. This chapter addresses how people who experienced gendered violence view and reimagine themselves and their futures *outside* the context of managed care. Previous ethnographic work demonstrates that in response to macrostructural and social oppression, people act as *shapeshifters* (Cox 2015). Shapeshifters intentionally carve out spaces for themselves in the world by altering and shifting their ways of existing in response to the forces that seek to diminish

their citizenship. Therefore, by acting as shapeshifters, people produce and uphold versions of themselves that transcend stereotypic and damaging representations of themselves based on their *own* evaluations of themselves and their social worlds.

In this analysis, I expand on this theory by focusing on the afterlives, or the life inhabited after leaving care systems, of individuals who sought formal care for gendered violence. I argue that because care systems fail people who have experienced gendered violence in so many ways and to such a deeply personal degree, people create their own care systems *outside,* but still influenced by, these formal institutions. However, these self-made systems do not necessarily provide the same healthcare services just in a more culturally relevant or grassroots-like way (Prussing 2011). Rather, people creatively build systems to address the areas most targeted (or ignored) by this structurally and symbolically violent assemblage of care. These systems range from an intensive revaluation and reinvention on the self to reworking and reimagining formal support systems to re/creating kinship networks. People do this with purpose. They seek to build a system in which their identities and experiences are fully recognized. These systems are designed to provide support, protection, and safety through the involvement of other people. More specifically, self-identified women intentionally construct the "proper" male who employs the positive uses of masculinity, aiming to "break the cycle" of gendered violence. Similarly, women form an intimate bond with others who have also experienced gendered violence. They attempt to protect others from violence in subtle, yet meaningful, ways that reimagine womanhood. Thus, the infusion of one's healing and sense of self into social systems is what I refer to as *vicarious survivorship,* or the

actualization of healing by viewing yourself through the prospering and protection of others against gendered violence.

Me, Myself, and I

As chapter 3 and 4 demonstrated, care systems espouse and impose a healing narrative that places burden on the individual. People internalize this narrative by feeling like they, and others, are primarily responsible for their own healing. Importantly, care providers would never explicitly tell someone that they should not rely on others. Rather, people's overall experiences within these systems were so negative that they did not have any other choice but to discontinue seeking care. Micro-interactions, or comments made in passing, affected whether someone assigned a negative value to their care experiences (chapter 4). Sometimes, however, discontinuing care was not their choice. For example, Mira lost access to psychological services because the organization ran out of grant money. Taken together, the lack of structural support and poor treatment within these care systems isolate people.

However, people's experiences seeking care, both from formal care systems and from social networks, were never truly about *them.* For instance, the medicolegal system prioritizes evidence collection over the patients' wants and needs (Mulla 2014e). In chapter 3, Zena demonstrated how the *body* is the area of concern. The aspects of their assault/abuse that people find personally significant are completely absent within the medicolegal model of care. While I did not have the opportunity to observe the interactions between community advocates and their clients, the conversations among the advocates generally centered around distinguishing between the perpetrator and the

survivor. However, at my field site, I was included in a group email and text chain where the advocates asked each other if they knew about specific resources they could provide for their clients. These resources mainly centered around Boston's Department of Children and Families (DCF) policies, Boston Public Schools, and childcare. Thus, it was clear that one of the best ways advocates supported their clients was by helping them parent.

While I do not want to argue that quality care does not involve people's families and children, people's main concern was caring for their families and children. Parents made great personal sacrifices to care for their children and families (Carney 2015), such as staying in abusive relationships so that their children knew their fathers. This was directly linked to and mediated by structural care pathways and limited access to structural resources. For example, it was extremely common that the only way parents could provide resources (e.g., food, housing, school) for their children was to stay in an abusive relationship because their partner provided and controlled finances.

Another example is the required involvement of DCF. In domestic violence cases where children are involved, healthcare systems (e.g., hospitals, doctors' offices, mental health providers) immediately involve DCF. Advocates expressed that people were *very* hesitant, and rightfully so, to seek care at the advocacy organization because they feared that DCF would take their children away, especially since the majority of them were not legal citizens. While participating in staff meetings and observing conversations with advocates, it was clear that many people initiated care with CBA but later withdrew when they learned they would need to speak with DCF. People were often in a double bind of

trying to receive formal care for their gendered violence and potentially losing their children. I am not arguing that children and families are not directly targeted or involved in perpetrators' commission of gendered violence. What I am arguing is that community advocates spent more time and labor supporting their clients in "proving" to DCF that they were adequate parents rather than directly addressing the gendered violence itself. These structural constraints located people's experiences with gendered violence in the background.

People's social networks also failed to foreground experiences of gendered violence. For example, when Cara returned to her friend's house after the perpetrator assaulted them, their friends tried comforting them by saying that they were going to get help. As Cara stated in the quote I referenced in chapter 4, "help" was codified language for involving the Title IX office. From the start, Cara did not want to choose this care pathway but ultimately felt guilted into it. Their friends responded to their refusal by saying "*Well, I just don't want it to happen to someone else*." This type of statement not only displaces the responsibility and culpability for perpetrating gendered violence onto the victim (i.e., if Cara did not report, it would be *their* fault if the perpetrator assaulted someone else), but also prioritizes an imaginary victim. In other words, Cara's friends were more concerned with protecting a potential victim rather than honoring Cara's wishes and caring for them how they wanted to be cared for. Therefore, formal care systems and people's social networks fixate on the potential rather than the actual – it is never truly about the victim-survivor.

(Un)Forgettable memories, unforgettable Me

I argue that in response, people would bring their sense of self to the foreground. They did so by directly intervening on the self to validate and make meaning from their experiences outside the context of formal care. While this process took place outside of care systems, their experiences within them influenced which areas of the self people would intervene on or attempt to manage. Previous anthropological work defines this intervention on the self as a *technology of presence* (Lester 2019). Here, a specific type or way of being is grounded and connected to the world, making it perceptible and intelligible to others (Lester 2019).

Based on my analysis, people would employ technologies of presence to become real in ways that are locally and relationally recognizable as mattering but also, and more importantly, *real to their own sense of personhood*. In chapter 4, Leila's forensic nurse said off-handedly that Leila was "lucky" that she did not remember her assault. The police officer assigned to Leila's legal case was even more crass. He continuously asked Leila about her alcohol consumption that night which not only perpetuated false assumptions about blame (i.e., that intoxicated victims are to be blamed for their assault) but also constructed the notion that a legally worthy and recognizable rape is a memorable one. Leila questioned whether not remembering her assault meant that it did not "count." What I found interesting is that these interactions compelled Leila to take extensive measures to try to recover these lost memories. During our conversation, Leila shared what she *did* remember and what she *tried* to remember.

> *I remember leaving with a guy. I remember him trying to kiss me in the Uber and me pushing him away, which also the Uber driver had done nothing about. And*

> *then it's blank. And then I woke up on the side of the street, but I still had most of my belongings. I had lost an ID, which someone else had given to me later who had found it. But I had most of my belongings and I had my clothes on. So, the whole question was, did I actually get raped? Or was it more… you know, he gave up? It's not like I just woke up on a bed naked, it was very much I woke up with everything intact.*
>
> *I just remembered this when thinking about the cop. You know what he said to me? He was like, 'Oh, well, you would know if you were raped.' And I was like, how? [Officer]: 'You guys can feel it.' I was like, I was drugged. I know, that is not how that works. Yeah, that was stupid. But so that's the thing. Like, I mean, why go through the trouble of drugging someone if you're not going to go through with it? But I think I just have, like an inkling of hope, or even, like, as a scientist, I just need to know, like, and I've tried going to a counselor, I've even tried hypnotherapy trying to get my memories back. Nothing.*

She explicitly questions whether the perpetrator raped her. She tries to piece together what *is* perceptible and concrete in her surroundings to infer what happened. She infers that if the perpetrator raped her, there would be missing *material* items - her clothes would be gone, her belongings would be missing, her normal environment would, quite literally, be out of sight. The police officer clearly exacerbated Leila's uncertainty. He stated, "*You guys* [sic] *would know if you were raped… you can feel it*," perpetuating the myth that sexual assaults are so physically painful that you cannot forget them. While Leila looks at her material world to make sense of what happened, she also looks towards her internal sense of being – her memories.

To institutional actors, memories are often contested commodities. During medicolegal exams, victims provide a personal testimony, but this is secondary to the corroborative evidence that cannot "lie" nor "forget" – meaning, quantitative data such as DNA collection, forensic imaging, injury documentation. The more technocratic the medicolegal system became, the less significance the personal testimony held compared

to “objective” forms of evidence. Driving this shift was the ongoing scientific debate as to whether memories were “reliable” measures.

I spent two and a half years conducting neuropsychology research at the National Institute of Mental Health where one of my projects answered questions about the neurobiology of memory. One of the main lessons still burned into my brain today is that, according to memory researchers, memories are *constructed.* In other words, memories are not exact representations or replicas, but are made from various internally (i.e., biological) and externally (i.e., social and/or environmental) driven processes. Thus, researchers configure memories as “fickle,” in that they can be “contaminated” and change over time. Some research shows that that stress decreases memory retrieval (Buchanan and Tranel 2008) and that women with a history of sexual abuse have decreased activation in the hippocampus, the brain region associated with memory (Bremner et al. 1999).

Taken together, the medicolegal system does not place as much value on someone’s recollection of an assault (i.e., personal testimony) because it assumes that memories do not accurately represent past events. These findings are often used against victims in legal settings. For example, victims with traumatic brain injuries (e.g., hippocampal damage) are deemed medically and legally incompetent. Prosecutors will also use this area of research to argue that people are misremembering their assault. Gendered assumptions that women [sic] are inherently more emotional (see chapter 4) also compound this issue (e.g., women are too emotional to tell or remember the “truth”). However, most of this research (Loftus 1996; 2019) arguing against the use of narrative

testimonies in courts typically refer to fallibility of witness testimonies (i.e., what a bystander saw) rather than autobiographical memory (i.e., someone's memory of personal events). Therefore, while someone's memory of their abuse or assault is an important aspect to the medicolegal system, the system tends to place a greater emphasis on corroborative evidence in efforts to be objective and seek out positivist truths.

Here, Leila defines her memories as central elements to reconstruct her assault in ways that are legible to herself and the medicolegal system. While Leila did seek out a forensic exam, she dismissed the negative results of her rape kit (i.e., no foreign DNA was detected) and quickly provided alternative explanations. She states,

> *And [the forensic nurses] were in contact with I think a hospital where they would send the kit and get the results. Mine came back negative but that can happen if they use a condom. So, it doesn't actually say much.*

Compelling Leila to prove that the perpetrator raped her, both to herself and the medicolegal system, were her missing memories. Leila employs technologies of presencing by attempting to materialize the lost memories of her assault. Leila tried retrieving them by going to a mental health counselor, believing that repeatedly talking about her assault would bring these memories to the surface of her consciousness. Leila also sought out a hypnotherapist. When Leila and I first met, we bonded over doing research in STEM – although, unlike her, I gladly departed from that field. Her dry sense of humor, somewhat terse responses, and matter of fact personality reminded me of the countless interactions I had with STEM researchers. I was intrigued by her decision to go to a hypnotherapist. I typically find that people in STEM are hesitant to seek any type of care that is not considered evidence-based. To be considered as evidence-based,

interventions must have been shown to be "effective" in multiple peer-review research studies, employ some kind of quantitative analysis, and have a statistical design that allows researchers to draw causal conclusions (Sackett et al. 1996). Hypnotherapy is often categorized as a "pseudoscience." Even though her mother is a hypnotherapist, Leila states that she "*even"* sought out hypnotherapy, suggesting that this was a "last ditch effort." In her attempts to retrieve her memories of the assault, Leila turns to care systems and practices beyond her typical health-seeking behavior.

Leila's efforts to make her memories perceptible and recognizable compelled her to employ different strategies and involve health systems that she normally would not seek out. At one point in our conversation, Leila stated "*I just needed to know*." The fact that Leila put so much effort into retrieving these memories suggests that, to some extent, she believed they were there, somewhere. When it became clear that her legal case would never be reopened, she wanted to remember for *herself*. *She* wanted and needed to ground her assault to something that she could perceive. Since her memories are not as pertinent to the medicolegal system, Leila created her own care system that foregrounded what matters to her and is tied to her own sense of self – her memories. Recall that formal care systems employ a specific chronology of healing fixed by linear time. Here, Leila implemented her own chronology. She desired for her memories to be accessible for her to revisit. Her care system constructed legitimate suffering as something that the self can relive, recollecting the past and integrating it into the present.

Making truth tellers, expanding life

Lester's term of technologies of presence borrows from Foucault's *techniques of the self*. Foucault characterizes techniques of the self as the procedures, which exist in every institutionalized civilization, that are suggested or prescribed to individuals in order to determine their identity, maintain it, and transform it through self-mastery or self-knowledge (Foucault 1990; 1988; 2017; McLaren 2002). Foucault later modified the definition of the technologies of the self by arguing that individuals construct and transform themselves into their best versions, *with the help of others*, who intervene on people's bodies, thoughts, behavior, and ways of being (Foucault 1988). Thus, these technologies create new possibilities of being.

Recall that in a Foucauldian framework, the individual becomes a subject through the compilation of facts procured by institutions, like medical systems and mental health institutions (Foucault 2017; McLaren 2002). Within these institutions, the confession, or *speaking the truth about oneself*, both produces the subject and allows for subjects to constitute themselves through this type of articulation (Butler 1993b; Foucault 1988). In other words, *truth telling* (i.e., parrhesia) is concerned with the question of how to live. Truth telling is a central technology of the self. The relationships and interactions between care providers and patients produce the subject who embodies institutional norms. However, they also allow the subject to participate in their own self-construction and transformation. Feminist scholarship has applied this theory to its own practices. For example, confession, or truth telling has both a moral and political aspect. Truth telling exists within relations of power because truth tellers require certain political conditions or

structures in place to speak and be heard, per se (McLaren 2002). This section addresses who is considered a legitimate truth teller and how people fashion themselves as one.

Feminists have integrated truth telling theory into narrative therapy. Narrative therapy is a style of therapy that helps people become, and embrace being, an expert in their own lives by crafting and reframing experiences. Current psychologists may also refer to this technique as part of cognitive behavioral therapy (CBT) – a talk therapy in which people identify their thoughts and behaviors, specifically in relation to their environment and relationships. People modify these thoughts and behaviors to better themselves and quality of life. Here, CBT constructs specific cognitive representations as cognitive distortions that can be learned, socially informed, and then altered to fit within society (Waldram 2012).

I turn to a participant named Katie. Katie's cognitive distortion was that it was *her fault* that her ex-boyfriend assaulted her. This distortion would manifest psychologically as intrusive thoughts that prevented her from being intimate with her current boyfriend. Katie's therapist worked with her to undo this distortion, eventually wanting her to be able to talk openly about her assault with her boyfriend. Katie's therapist used a role-playing exercise in which he took on the role of either her cognitive distortion or her boyfriend. She describes the exercise below:

> **Katie:** *We would kind of plan how to talk to my boyfriend about things. [My therapist] would, um, you know, like he would like practice [being him] because I wasn't very good at it. I didn't know what I was supposed to say. We had to do this thing. It's like a common technique, I think, where like, one person is like, your negative thoughts and then one person is kind of like the boss and you like, go back and forth. So, we would do that a lot. Or like, we would do like the role play where like, he would pretend to be like, my boyfriend… not like that! But like me, like telling my boyfriend or like, vice versa. He would kind of pick up on how*

I would tell my boyfriend about what happened. And so, you know, someone else might just come out and be like, 'Yeah, you know, I was assaulted by my boyfriend in high school. This happened.' But like, he knew, like, I wasn't going to do that. So like, he knew that, like, you know, 'She's probably gonna call it a bad experience.'

Interviewer: *Yeah, like really adapting to like how you describe things?*

Katie: *Yeah. And so then, you know, I could like sit there and like, oh, let me type [his response] verbatim.*

Interviewer: *Were these role plays helpful for you?*

Katie: *Yeah, yeah. Sometimes it was... Like, good. But then other times, like, he would be the negative thought, and then I'd have to be bossing it back. Kind of like, 'I could have done more!' [My therapist] would say, '[Katie] you could have done more blah, blah, blah, blah.' And then I would have to be like, 'No, you know, I did this and tried this. And it's not my fault.' I'd have to like boss him back and put him in his place. But like, sometimes that was kind of difficult. And I understand the point. Sometimes, I wouldn't know what to say.*

Interviewer: *Why was it difficult for you?*

Katie: *Because he was really good at it!*

Interviewer: *He was really good at being the boss. He was using my negative thoughts. And then I have to come up with other thoughts to be like, 'No, that's not true.' And sometimes, some of the thoughts I had were true. You know, a few of them I had were, 'You obviously, like, took advantage of me.' But we had to realize that some of the thoughts are true and you can't really do anything about that. So, like, that was kind of difficult too. But, I mean, the exercise was good. It was useful and helpful. But sometimes I felt like, I don't know what I'm supposed to say.*

In Katie's experience, her therapist places emphasis on the confessional, or telling her boyfriend about her assault. From her therapist's perspective this is central to her becoming a healed subject. This therapeutic context multiplies Katie's self into a construct that she must resist and contest. In other words, Katie's therapist takes on the role and personifies Katie's cognitive distortions, or what Katie refers to as her negative

thoughts, and has Katie "boss them back." Her therapist integrates Katie's personal way of framing and speaking about them (e.g., calling her assault a bad experience), closely mirroring Katie's subjectivities. Her therapist attempts to undo her cognitive distortions and have her recognize them as self-destructive. For example, her therapist played the role of her distortion that she could have done more to stop the assault. He also plays the role of her distortions that Katie represents as fundamentally true – that her ex-boyfriend *had* taken advantage of her. Thus, her cognitive distortions, or the points of therapeutic intervention, represent the gendered power relations that subjugate Katie's position within her former relationship and in society. However, this therapeutic technique teaches Katie how to resist them. When the roles switch and Katie plays the part of her distortions, her therapist models how to "push them back," demonstrating how to resist and push back against the sexist logic that Katie was responsible for her assault. Therefore, by taking on the role of Katie's cognitive distortions, and therefore multiplying Katie's sense of self within the therapeutic context, the therapist acts as a mediator of Katie's truth telling – or the way Katie is able to challenge the gendered status quo.

Interestingly, I found that other participants employed similar techniques of the self but did so *outside* the context of formal care and *without* the help from institutional actors. For example, Bastet describes a similar self-employed method.

> *Okay, like, so, this is something that I would do when I was first assaulted when I was like, growing up. I needed a place to hide because I was also experiencing, like, domestic abuse at home. Like, I wasn't experiencing it, but I saw my mom going through it. And so yeah, I just, I needed a place to hide somewhere on Earth. So, I made a place in my mind, and I had imaginary friends. And it was like a whole different dimension. I used to walk in like this specific little location*

> *in my school in like this little circle that I used to just walk in the same spot during like the break. I was always in that world for some reason, you know what I mean?*
>
> *If people bring up things about my childhood, I don't remember things from my childhood. I don't know if it's trauma that blocked it out. I know trauma had blocked out a lot of things in my past, I just don't remember most of my childhood. There was so much chaos in my head that I isolated myself from everyone. I didn't have like friends from like seventh grade to like eleventh grade. I would just walk alone in that specific spot during the break. And even when I would go home, I would just walk, go for walks for like hours, like three or four hours straight, just like walk in like circles or something in a specific spot. And it wasn't like a short walk, but like a long like circular walk with like a similar pattern. I was walking because I just needed to get out the energy. I started untangling like each and every chaotic voice in my head. And I gave each and every voice a single personality and a name. So, they all became like imaginary friends. In my little walks, I would go and consult with them. So, during those consultations, I would just go over like meditations and stuff. Like during this consultation I would ask each one of them their opinions and for some reason they would all have like really weirdly diverse opinions on shit. I feel like they would all be based off of like weird stuff that I would watch sometimes or like read elsewhere. But like through those people I could access that information. Um so yeah that's when one of my imaginary friends was conversing with me and was like 'I just feel like this person does not respect you because they don't respect your body.' Mind blown.*

Here, Bastet's own way of coping and making sense of her abuse mirrors the therapist's CBT technique. Bastet multiplies her sense of self into different friends who each embody their own thoughts and personalities. From a clinical perspective, each of Bastet's friends represents a cognitive distortion in that they are all socially informed and constructed by Bastet's social world (e.g., books that she read or things that she saw in her material world). Interestingly, however, Bastet deviates from the methodology Katie's therapist employs. She allows each of her friends, or forms of self, to formulate their own opinions and perspectives during their consultations. This technique differs

from Katie's experience in that Katie's therapist would emulate the "right" responses to certain cognitive distortions in which Katie would have to replicate.

Here, Bastet just lets her friends speak for themselves with each perspective holding an equal amount of power (i.e., each diverse perspective would get an opportunity to give their own opinion during a consultation). Bastet's technique models a more egalitarian strategy compared to Katie's strategy of pushing back against certain distortions. Similarly, however, both Bastet's and Katie's techniques resisted gendered power relations. One of Bastet's forms of self expressed that they did not believe Bastet's abusive partner respected her because he did not respect her body. This conversation prompted her to re-evaluate the relationship, ultimately breaking up with her former boyfriend. This internal conversation was also the catalyst in Bastet's recognition of and resistance against the abusive relationship between her parents.

Therefore, Bastet created her own care system that resembled the formal therapeutic strategies employed by Katie's therapist. However, this technique was not influenced or aided by an institutional actor. Bastet's multiple selves inhabited the support and presence of "the other" (Foucault 1988) in the self-transformation process. In doing so, Bastet engages in systems-challenging praxis. Bastet seeks to alter the power alignments within formal healthcare systems addressing gendered violence by deeming their technocratic assemblage as futile, bypassing the power placed within these systems and transplanting it within her own system of care in which she is recognized as a morally legitimate being deserving care and respect. Thus, Bastet utilized a technology of

the self by fashioning herself as a truth teller and creating a system that allowed her to wield the power of creating and transforming life.

Diminishing life

Thus far, I have highlighted the ways individuals exercise agency within and outside of formal care systems by employing their senses of self. However, without the proper structural support and access to this support, being agentive can also work against you and can be self-destructive (i.e., oppositional habitus) (Bourgois and Schonberg 2009). I highlight this argument to complicate the association between agency and a positive outcome. This section demonstrates how individual agency, in attempts to create someone's own care system, can be unsustainable and self-damaging without structural and social support reinforcing these efforts.

Bottoms up

After experiencing gendered violence and seeking care, many people used substances to cope. A common belief is that people use substances to either forget their trauma or to regain control (i.e., the notion you can control how much you drink and use drugs). While this certainly may be true, people also used substances because they saw it as a way of expressing that they *do not care* about what happens to their bodies. For example, in chapter one, Cara states that after their assault, they partied with more intensity. When I asked them to elaborate, they said,

> *I reached a point where I just stopped caring because I felt like no one cared for me. So I partied…hard. Even though I went to a really intense school, we partied a ton. Like, even before I was assaulted, I remember getting drunk with my friend for a week straight. It just seemed like a fun thing to do. But like, after I was*

> *assaulted and stuff, I just wanted to get wasted on the weekends. I guess you could sort of say this is self-punishment – like if someone is gonna abuse me, I can just do it myself… But I really just saw it as a way of expressing that I didn't give a fuck anymore. I didn't care if I died from alcohol poisoning or from chain smoking until my lungs collapsed. Sometimes that seemed like a good alternative though. I tried really hard to do all the right things, but nothing good came from it. I was done caring.*

Therefore, Cara does not seem to want to regain control after their assault by either being the one to "harm" their body or by trying to control their mental state through substance use. Rather, Cara expresses how much they *didn't care* anymore. They state that they tried doing the "right things," like making a Title IX report, but they did not experience any benefits from doing so. Their case is "still collecting dust" in the Title IX offices because the college would only pursue it if the perpetrator was a "repeat offender." Cara expressed to their friends that they did not want to report their assault, trying to get them to understand and empathize with them. Cara tried building a support system that would honor and validate these wishes by restating over and over that they did not want to heal by involving the formal mechanisms of care. Despite Cara's efforts, no one obliged. Thus, Cara saw substance use as a way of diminishing their sense of self by being ambivalent towards life. They state that the thought of dying from alcohol poisoning or having their lungs collapse did not bother them. Instead, Cara viewed these options as more desirable alternatives than having to exist in a world where no one perceived them and their desires as valid.

When the casseroles stop coming

Alyssa is a 45-year-old woman who recently divorced her ex-husband who physically and emotionally abused her throughout their relationship. Alyssa and I bonded

over growing up in the Midwest and going to college in a small, rural town. We reminisced about being "Midwestern nice" as we are both still adjusting to living in cities where no one waves or smiles at you on the street. We also reminisced about being a college student in a small, rural town where *everyone* waves and smiles at you. One aspect of small-town life that stuck with Alyssa after graduating was her connection to the Christian church. She shared with me how important the Church became to her. She and her ex-husband, who she described as "very religious," were very active members of their church. Alyssa described how the idea of belonging to a community drew her to establish bonds with the other church members. When her ex-husband emotionally and physically abused her, they sought counseling from their pastor.

However, since the pastor spoke with Alyssa and her ex-husband together, Alyssa expressed that she was never fully comfortable seeking the pastor's support by sharing the details of the domestic abuse because she "*didn't know how much [she] would pay for it when [they] got home*." However, the pastor assigned "accountability" partners to Alyssa and her ex-husband who were other married members. They were meant to provide emotional support and ensure that Alyssa and her ex-husband adhered to the pastor's couples counseling techniques. Alyssa and her ex-husband had very different experiences with these support groups.

> *I had two friends I would meet with every week, and [my ex-husband] had two people he would meet with every week for kind of gender specific accountability. And I leaned hard on those friends. I mean, I really was honest with them. I was transparent with my struggles and how things were really going. And we met every week. And we texted every day. And I mean, I was all about the accountability. [My ex-husband] burned through seven or eight accountability partners, like he couldn't even hold on to his partners, he wouldn't meet with them. Both of my accountability partners operated from a pretty conservative*

> *Christian standpoint of where 'we're trying to save a marriage here,' not like 'we're not trying to get you out.' We're trying to save the marriage. At the same time, they were like, 'I don't feel like you should be meeting with him alone. We don't feel like there's a gender balance there. We don't feel like [the pastor] understands you as a woman, I feel like his wife needs to be there or another woman needs to be there, or we need to be there.' I mean, they repeatedly would say, 'we don't like two men and you in a room together.' Not for safety. Like I wasn't gonna be physically hurt. At the very end of it when we quit counseling, [the pastor] started giving us sex advice that was so like, just odd. I mean, it made me so uncomfortable. It was so triggering for me. And I was like, where is this coming from? Oddly, that wasn't an area where we had struggled. Like we did some assessment with the pastor where it kind of assesses ten different areas, and how well you get along and [identifies] weak spots and places to strengthen your relationship. Sex and finances, which usually are hot buttons for a lot of people - we were really in agreement on that. I mean, we were really solid. So, I was like, let's not mess with a good thing. But it just felt very uncomfortable to be trapped in a room with two men talking about sex in a way that I was like, 'ah, timeout, you're gonna mess things up here.' And I think that was the last time we met with him. That was an awkward and awful ending.*

Even though Alyssa's gender-specific accountability partners were assigned to her, she really sought out comfort and connections with them. Unlike her counseling sessions with the pastor, her accountability partners provided a supportive environment where Alyssa could be honest (i.e., truth tell) about the abuse she experienced in her marriage. Alyssa also referred to her accountability partners as her "friends," while her ex-husband never seemed to create connections with his partners. While her friends operated from a conservative Christian standpoint (i.e., avoiding divorce at all costs), they also tried altering the gendered power relations in Alyssa's counseling sessions. They expressed that Alyssa should not be receiving marriage advice when she is the only woman since they did not believe her ex-husband nor the pastor understood her perspective and the specific challenges she faced. Ultimately, they were right to express these concerns since the pastor later tried giving Alyssa sex advice despite her not asking

for it, making her uncomfortable. The pastor's advice on her sex life triggered past emotional trauma caused by sexual abuse during her childhood. As a result, she left the church.

Later, Alyssa was in the process of divorcing her husband - which proved to be a very drawn-out process spanning across several years. Trying to work, parent, and process her divorce, Alyssa turned to a different church for support. Fearing for her and her children's safety, she met with the pastor and explained that she was trying to leave an abusive relationship. She told her new pastor that she needed and wanted support around her decision to initiate the divorce process. More specifically, she needed support in the form of community to feel safe and protected. While the pastor told her that the church was a safe environment for her, Alyssa felt ostracized. Word had gotten out that Alyssa was a "divorcee." People judged Alyssa for divorcing her ex-husband and made passive aggressive comments about how a "good Christian woman" would never choose to end a marriage. Her ex-husband's abusive behavior was never mentioned. Alyssa mentioned that she had come to church "black and blue" after falling in a parking lot. She said,

> *My jaw was black and blue. I had scabs all up my face and blood all up on my shoulder. I'm in a full immobilizer like, I'm in sunglasses, because I've got a concussion. I can't deal with light and sound. I am a hot mess. I went through an entire church service. Nobody said anything. Nobody followed up privately. Nobody sent a text to say, 'Hey, you look wounded. Do you need anything?' And at that point, I'm like, you know what, I think I'm done with this church community, too. Like y'all are really nice, but you're not providing any support. And I'm sending up an SOS. If I knew someone was in an abusive marriage and they showed up with one whole side of their body black and blue, I would be like, 'What happened? Are you safe? Do you need to stay with me?'*

When I asked if she still attended that church, she replied,

> *I haven't been back since [my injury]. I would say I still believe ...it's not what it used to be, you know. I hope to get back because it used to be a source of strength and guidance and support and comfort. And it's not now you know, and so it's been a huge loss of the marriage. And the fact that he got to walk away with his faith intact is super disappointing. You know, he gets all his friends, people bring him casseroles...*

Thus, Alyssa tried finding different church communities to support her during and after her abusive marriage. At the second church, she tries to make other members understand why she needs their support by telling them about her abusive marriage. However, to the church members, abuse does not seem to justify her "choice" to divorce her ex-husband. They either do not know how or just choose not to support her through her divorce despite being aware of the circumstances leading up to it. The loss of her church community was a personal loss of social support that also fractured her faith. Alyssa stopped and restarted the divorce process multiple times due to life circumstances and often questioned whether it was the right decision.

A self-destructive intervention on the self, an eating disorder, finalized Alyssa's decision to leave the abusive marriage.

> *I just got to a point where I was super depressed and just couldn't see any way out. And I was like, 'Well, death do us part and I sure hope it's soon.' And honestly, I spun myself right into an eating disorder by the last year or two. At the time, what I decided is 'Okay, it's until death do us part. I think I'd like to hasten that. I am not actively suicidal, because I'm not gonna leave my kids with that legacy. But if I did starve myself to death, then it would be like 'Oh, what a surprise. She died of a heart attack at 40.' Like, we had no idea she had heart trouble.' However, this will look tragic and poor, [ex-husband] will be the widower, who you know, the church will rally around him and raise my children for me. And so, when I was losing a ton of weight, and started getting into cardiac symptoms, and started getting significant health symptoms, that's when I was like, 'you're gonna die in this marriage, like this marriage is literally going to kill you. That's a problem.' And so that's probably about when I started to get serious*

> *about if I'm going to survive, I need to leave like ... he's not the type who will kill me.*

Alyssa did not have the structural or social support she desired – a healthy relationship and a church community that supported her. Alyssa viewed her eating disorder as a way of leaving the marriage, slowly killing herself in a way that would appear to have been out of her control (i.e., a heart attack). Thus, because she could not see her way out of her marriage and had little support, Alyssa sought to diminish her life and her personhood by "*[starving herself] to death*." While previous ethnographic work argues that eating disorders are technologies of presencing (Lester 2019), or the ways someone makes themselves recognizable as mattering to others, Alyssa views her eating disorder as a way of diminishing herself to escape an abusive marriage and social neglect. She reaches a point where she does not seek to actualize herself as a recognizable being who matters. Rather, she wants to disappear. However, when Alyssa's eating disorder started manifesting in severe physiological symptoms, Alyssa recognized that she was dying – the marriage was driving her to kill herself. She believed the church would have perceived her death as "tragic," rallying around her ex-husband even though it refused to be there for her. This realization kickstarts Alyssa's need to survive.

When outlining my thesis, I labeled this section as the "doom and gloom" part. I chose to include this section to show that while people work to create their own care systems in response to structural failure, sometimes they are unsuccessful. I used Cara's and Alyssa's experiences to first reiterate the importance of structural and social support. People can act agentively, but it sometimes reaches a point of diminishing returns that

proves to be physically and mentally exhausting. Second, I also highlight their experiences to show how the self still functions as the point of intervention, or destruction, within these self-made care systems. Unlike the preceding section, the specific interventions on the self are meant to diminish life rather than expand it.

Vicarious survivorship

I now transition from how people directly intervene on the self to discuss how people construct the people included in these self-made care systems. In this section, I argue that people employ a strategy I refer to as *vicarious survivorship,* or the actualization of healing by viewing and creating yourself through the prospering and protection of others against gendered violence. In other words, people simultaneously view themselves through other people while also mutually constructing them into beings who will "break the cycle" of gendered violence. This process primarily works through the production of gendered beings *presupposing a two-gender system.*

Making good men

The self-identified women who participated in this study worked towards making good men. Previous ethnographic work demonstrates that [cis]women mutually construct "the real man," teaching them the "proper" and strategic or intentional ways violence should be used, often attending to local cultural standards (Ghannam 2013). For example, an older brother might be violent and controlling towards his younger sisters by surveilling their whereabouts and being verbally and physically aggressive when they break the rules. In Ghannam's ethnography, women interpreted these actions as signs of love and paternal/fraternal care. Similarly, other ethnographic work argues that domestic

violence has a moral logic to re/establish or correct deviations from expected gender norms, re/constructing a "proper" patriarchal dynamic - the husband beats the wife, who, as a mother, is sanctified by the son, but the son is beaten by the father to instill the right sense of masculinity and uphold the father (Bourgois and Schonberg 2009). Therefore, while masculinities change over the lifecourse (Gutmann 2007; E. A. Wentzell 2013; E. Wentzell 2013), in patriarchal societies, violence is interpreted as a central component to how masculinities are constructed, embodied, and expressed (Brownmiller 1993; Bedera and Nordmeyer 2020; Ghannam 2013b).

In line with existing research, I found that self-identified women who have experienced gendered violence believe that masculine violence should be properly and intentionally used. For example, a participant named New Yorker describes how she wanted her father to react when she told him that someone sexually assaulted her.

> *I talked to my father [about my assault], and he says, 'Oh, poor you.' What the fuck? He's my father. He gave me life. He's supposed to protect me. Real fathers would say 'Who is this motherfucker? We're gonna kill him. We're going to shoot him.' But he didn't say any of these things. Or [he also said], 'It's his culture, his chauvinist culture. Man has the right to do this kind of stuff. So it was okay.'*

This is a very clear example of what is expected from men. New Yorker rejects her father's comment of saying "*Oh, poor you*." She views this comment as evoking pity and perceiving her as "weak." Rather, she *wants* her father to get visibly angry and express that anger through violence. In addition, I was struck by the "real fathers" comment followed by "*should…[be violent in response]*." Thus, to New Yorker, real men and real fathers protect their daughters by animating violent realities for other men. Interestingly, in a way, her father's response was violent, just not the right kind of violence that New

Yorker wanted. Her father demonstrated hegemonic masculinity, a masculinity that conforms with dominant ideologies (i.e., patriarchal power) (R. Connell 2020b; R. W. Connell and Messerschmidt 2005), by explaining to New Yorker that men are allowed to sexually assault women because of their supposed cultural rights and entitlements. Therefore, New Yorker's father reinforced and used a form of masculinity that makes gendered violence acceptable by embedding it within its cultural logics.

Self-identified women in this sample produced the role of a "good man" by providing counterexamples. Such women spent more time discussing and spoke with more emotion about the men who failed them - or those who demonstrated *complicit masculinity* (R. W. Connell and Messerschmidt 2005). R.W. Connell and Messerschmidt define complicit masculinity as:

> *Men who received the benefits of patriarchy without enacting a strong version of masculine dominance could be regarded as showing a complicit masculinity. It was in relation to this group, and to compliance among heterosexual women, that the concept of hegemony was most powerful. Hegemony did not mean violence, although it could be supported by force; it meant ascendancy achieved through culture, institutions, and persuasion* (2005: Pg. 822).

These authors further discuss how we must question "*how men conform to an ideal and turn themselves into complicit or resistant types, without anyone ever managing to exactly embody that ideal*" (as cited in Wetherell and Edley 1999, 337). For example, Alison, whose experience was described in the previous chapters told me about a mutual friend who really "*let [her] down*."

> *I was really hurt by one of our friends. Chris [pseudonym] could have really probably helped my case more but instead of [helping me by telling the detectives the truth] he just said '[The perpetrator] looked sick and then he left.' I think [the perpetrator] had even said something to Chris like 'I did something to Alison.'*

> *I always felt that maybe, you know, if Chris said more like, 'Well, he did come in, he did say he had done something horrible that Alison' that it could've really helped me. And he didn't tell them the way [the perpetrator] looked or that he looked unhinged or anything. And I've always thought that if Chris had said a little bit more, that maybe, you know, more [legally] might have happened. And I remember this person I'm telling you about… he sent me a friend request on Facebook, like six years ago. And I thought, huh, and I messaged him, and I said, 'Chris, I know we were really good friends at one time back in the 90s. I just want you to know that …' and I told him everything. I said, you know, 'When you were questioned, why didn't you tell [the police officers]? And so, I told him, I said, 'You know, when the detectives questioned you about [the perpetrator] raping me back in the late 90s, you could have said something. You could have said exactly what you knew, and you didn't.' And he didn't respond to me for about a month. And then he did and you could just tell he could feel it [my pain]. In his words, he really had no idea what to say, you know, he was like, 'I'm really sorry, I don't remember what happened.' I'm like, 'Okay, well, you might not remember it,' but at the time I kind of had to really explain to him again what had happened. And so, you know, that really did bother me, because I do think he was at least somebody saying, 'Well, he did come into work, but he looked bad. And he was saying he had done something horrible to Alison.' That could have been something.*

Thus, while Chris was never directly physically violent towards Alison, his failure to tell the detectives what he knew about the perpetrator (i.e., that the perpetrator told him that he assaulted Alison and that something was "off" the morning after he assaulted her) deeply wounded her. Chris did nothing – that is the point. He was complicit and yet, never enacted a sense of dominance. By failing to tell the detectives that he knew that the perpetrator assaulted Alison, he protected his "fellow man," upholding patriarchal assemblages of power. However, Alison saw an opportunity to mold him to be a better man - or to at least recognize his past failings. When Chris added Alison on Facebook, she did not have to respond and interact with him at all. Despite it being years after Alison's assault, Alison outwardly tells Chris that he could have done more to help her. When Chris does not seem to remember, Alison is persistent. She walks him through

everything that transpired, explaining that when their mutual friend raped her, Chris let her down by staying silent. Alison later shared that this conversation had a profound emotional impact on him. He apologized – and Alison believed him to be sincere. Thus, Alison constructed a type of masculinity by correcting its complicit form. This type of masculinity does not center violence, but acknowledges that men are able to reevaluate and change their behavior.

Self-identified women in this sample also constructed good men by providing spaces for them to demonstrate care and kindness. In other words, women recognized and validated that there are positive uses of masculinity, decentering violence from its construction. For example, Alison states,

> *I guess there was always a little part of me that kind of had wanted one of my guy friends or my brother to go kick his ass, you know. Although, to be honest, he probably was a mentally unhinged person. And he was dangerous. And so, I would not have wanted that now. But at the time, I mean, I had some incredible guy friends who came and they helped me pack up everything and they helped me move out. And they really just hung out with me that summer. And it was nice to have a good group of guys and girlfriends. So, I had a terrific support system*.

The sentiment of wanting men to protect women after their assault/abuse was a common theme during my interviews and fieldwork. For some, like New Yorker for instance, this protection manifested as wanting men to be violent towards other men. However, Alison highlights how she felt safe and supported by her male friends showing kindness. They helped her moved out of her apartment (i.e., where the perpetrator raped her), they hung out frequently during the summer, and they protected her through the everyday acts of kindness.

Another participant named Michelle provides a similar example. Michelle was in an abusive relationship where her ex-boyfriend raped her multiple times a day. When her friends and family grew frustrated that Michelle would not "just leave" the relationship [sic], they ostracized her hoping that Michelle would choose them over her ex-boyfriend. However, one of the few people that "*stuck by [her] side*" was her father. Initially, she felt uncomfortable sharing and talking with her father about the details of her abusive relationship and rapes. She shared one conversation they had in which she felt heard and supported.

> *My dad came into my room and he was trying to be nice about it. Of everyone, he was the kindest. He said, 'Your mom says that I need to understand that you're like a battered woman. But I don't even know what that means. What is this? What does that mean? How were you battered?' And then my mother, you know, said things like 'I need to understand, you know, you need to tell me, you need to tell me details, so I understand how best to help you' and different things like that. So, you know, oftentimes, I felt like some people wanted to know for their own sake. But it's not really right, you know, it's not helping me find the solution.*

Here, Michelle describes her father as being the kindest person to try and support her. Comparing the questions he asked Michelle to her mom's, he asked her more open questions about her abusive relationship, allowing Michelle to drive the narrative. On the contrary, Michelle's mother asks her direct questions – or rather, *tells* Michelle that she needs to disclose the details of her abusive relationship so that she can "help" her (i.e., leave the relationship). Michelle states that these types of questions, or demands, were self-serving so that people could be emotionally prepared to hear about Michelle's relationship rather than support her through it. Thus, her father provided an environment that is not demanding. He sought to understand her experiences with violence rather than emulating them by forcing her to disclose things she does not want to.

However, I also saw Marcos (see chapter 3) attempt to maintain this type of masculinity, one that centers kindness and a sense of equality, when the perpetrator attempted to violently manage it. Unlike some other participants, Marcos quickly launched into discussing the personal dynamics between himself and the perpetrator rather than his experiences receiving care. He stated,

> *Everything started when I met her. Everything was very good for me; it was a great blessing to have met her because I personally was going through a very bad situation emotionally because of things that had happened in my life before arriving in the city of Boston.*
>
> *I had a part time job, and she had a job. After meeting and having some time seeing each other, we decided to find a place to move in together and share the expenses and help each other. Everything was perfect, that I assure you. I worked. She also worked. Sometimes I came home and cooked and we ate together. We washed our clothes together; we did everything together. Together helping each other, we both paid the house expenses. She put more money than I did in the expenses because she had more income than mine, but I helped as much as I could. And, I also had to help myself. My mother, who lives in the Dominican Republic, I had to send her some money also to help her with some debts that she has because she had to go into debt to be able to pay my ransom when I was kidnapped in Mexico, but that's another story.*
>
> *Everything started to get different when she started to have an aggressive attitude for no reason. She fought over nonsense things and sometimes she yelled at me. I didn't understand why she had such a bipolar mood change. Then I realized that she was taking medication that helped control an addiction, say heroin, and some other prohibited substances.*
>
> *But I decided to stay and support her. Within me, I had the hope that I could help her to overcome that part of her life.*
>
> *I was really a good person with a noble heart, and I was very in love with her - I admit it.*

While "perpetrator" tends to have masculine connotations, the female perpetrator's behavior here is typical for sexual predators in that she incrementally pushed boundaries to exercise control over Marcos (see Mulla 2014, 163). In addition, Marcos's reaction to

her abusive behavior is similar to other participants (e.g., Mira), in that he initially attributes her abuse to a loss of agency (i.e., from her substance use).

Marcos later shares with me that the perpetrator became incredibly controlling – yelling at him to do household chores, forcing him to contribute a disproportionate amount of finances towards their living expenses, and sexually abusing him while stating that he "isn't a man" if he cannot sexually perform. Prior to this, Marcos expressed a sense of pride that everything in their relationship was *equal and together*. However, the perpetrator violated this sense of equality, especially around finances and physical labor, aiming to control Marcos. In doing so, the perpetrator reinforced normative gender roles that place an undue burden to provide economically while simultaneously reinforcing raced, sexual scripts that hypersexualize Latinx men. Together, this abuse continues to subjugate Marcos in a chronic state of dependency, as his lack of documentation hinders his social and personal mobility. This (false) sense of security is compounded by his mother's lack of finances due to his kidnapping. He did not volunteer details about this during the interview as he perceives this as a separate issue from his abusive relationship (i.e., *that's another story)*.

Throughout this process, Marcos maintains his representation of himself as a good man. Central to this conceptualization was his active, willing, and equal participation in the everyday aspects of their relationship. In addition, Marcos centers notions of understanding and support – even when doing so was detrimental to his wellbeing. He states at the end of the quote that "*I was really a good person with a noble heart, and I*

was very in love with her I admit it." Thus, Marcos locates his decision to stay in the relationship within intimate narratives of caring for the perpetrator.

Marcos is currently living in an all-male shelter. Initially, one shelter (not associated with CBA) attempted to deport him to the Dominican Republic since he does not have legal residency documents. However, Marcos was able to provide adequate documents showing that he had a restraining order against the perpetrator, which granted him access to a shelter in the Boston-area. It seemed like he received these during his emergency room visit – although, it was unclear from our conversation, and privacy laws (and my own research ethics) prohibit the CBA advocate from sharing this information with me. When I asked him to elaborate on his experiences in the shelter, he stated,

> *In [that] shelter [other residents] broke my lock on my locker and they stole all my belongings and some evidence I had of the case. I made the report to the main office, and they transferred me to [another]. The only problem is that most of the people in the shelter are addicts* [sic] *and disrespectful people who try to pick fights and stuff and I'm really not that kind of person. I'm trying to get my life back but it's too difficult, I can't even study at the shelter because there are always people yelling or talking, you know, I don't have space or privacy. I really feel like I'm in a prison without having committed no crime.*

Here, Marcos de-centers notions of violence (e.g., fighting) from his own representation of himself. He also demonstrates institutional compliance in that he relies on reporting mechanisms (e.g., the shelter management center, the police, the medicolegal system), despite these not working towards his own interests and the symbolic (and literal) associations with the prison and immigration system.

He also recognizes and appreciates the institutional support that Celi, his CBA advocate, provides.

> *The counseling helped me a lot to vent in the moments that I felt the most bad, and the emotional help that I received from Celi when she listens to all my words and I tell her how I feel and my concerns. [I] really appreciate her very much.* **(Marcos)**

As discussed in chapter 3, Marcos is seemingly unconcerned with the gendered power relations within his previous relationship and in his experiences receiving care. When Celi first referred him to participate in this study, she expressed that he really wanted to participate. He later shared with me,

> *I just hope that all this helps to ensure that no other person goes through the same situation that I am going through, I hope that no one in the world has to go through a situation like this. I hope I can be of great help to people who are going through this situation, whether they are men, women or children. I hope no one goes through things like that.*
>
> *Excuse me for expressing how I feel, I just hope that the story is useful to you and that you help many people with your work.*

It is clear that Marcos genuinely wants to help others and views institutional care pathways as a valid way to do so. Despite having negative experiences in them, he finds value in Celi's work, continues to rely and depend on formal care systems (although, this is structurally managed), and believes that participating in a research study on gendered violence will create a lasting, positive impact. While he sustains his conceptualizations of the positive forms of masculinity, he also posits notions of what a good client is.

Taken together, there are positive and negative uses of masculinity. The negative uses, of course, result in violence that subjugates others to establish patriarchal power or gain access to it. While some women want men to intentionally use these negative forms of masculinity, the self-identified women in this study place greater value on the positive forms that construct men as caring, supportive beings. In doing so, they reimagine and

reconceptualize masculinities to engender masculine ways of being that are not predicated on violence.

Making women, protecting women

The majority of participants witnessed gendered violence growing up. Their mothers were abused by their fathers emotionally, verbally, physically, and sexually. In domestic violence advocacy, this is referred to as compound trauma or intergenerational trauma where people experience multiple forms of violence across their lifespan. In these cases, it was quite interesting to see the roles mothers played in shaping their daughters, specifically with regards to intimacy and relationships with men. There was a range of strategies women employed to ensure that their daughters would not experience gendered violence as they had. For example, Bastet's mother was explicit with her advice.

> *My mom always said to me growing up – her voice was in my head constantly, like a ringing that said, 'A man who hits you once will hit you again.' For some reason, that just constantly kept ringing in my head.*

Bastet's father frequently abused his wife. Her mother tells Bastet that "*A man who hits you once will hit you again.*" While Bastet states that she frequently heard her mom say this, she made it a point to remind Bastet of this message whenever she was dating someone. What I find interesting is that Bastet's mom is attempting to pass down gendered knowledge constructed from her own experiences of violence to protect Bastet from experiencing it herself. While the message may read as "men who are violent will always be violent," the subtext conveys a more nuanced message. Bastet's mother tries to tell her that if a man hits her, she needs to leave the relationship immediately lest she subject herself to a violent future. Bastet can control her future.

Other mothers would teach their daughters similar lessons but in more complex ways. To demonstrate this, I turn back to Celi. Recall that Celi is a community advocate at my field site. She was one of the first people I connected with there. Her vivacious personality and genuine care for others radiated across my Zoom screen and we quickly bonded. Celi experienced gendered violence throughout most of her life. She describes her childhood as a rather traumatic one. Her father was physically and emotionally abusive to her and her mother. He was controlling and manipulative and would physically abuse her if she challenged his authority. When Celi was a teenager, she started dating the father of her daughter. Unfortunately, he was also extremely abusive. Celi became pregnant when she was a teenager which sparked conflict between herself and her parents. She described her parents as being "devout Catholics." In other words, to them, being a good daughter meant that Celi would never have sex before marriage let alone become a pregnant as a teenager. Despite her parents holding traditional Catholic values, her mother encouraged her to get an abortion when her ex-boyfriend told her parents that Celi was pregnant before she had the chance to. When I asked how she felt about this response, Celi stated,

> *You know, my mom was frantic in a way because I think she was trying to protect me before my dad [became violent] because my dad was the one who ultimately told me to get out of the house. But I think she was trying to protect the whole blow up of what my dad would do. So that's why she was saying, 'You can get abortion, we can fix this. Everything will be fine. Don't worry about it. Just listen to me.' I kept saying no, like, 'I'm not comfortable. I don't want to do this.' It's like, I knew better. Don't abort because in the first seven days, [the fetus] already ha[s] a heartbeat [sic]. So. It's like, I didn't feel comfortable. Me personally, I'm not even talking values. I'm just talking me, right, So I'm not comfortable going through an abortion when I already knew that I was pregnant. And I knew what I was doing so it's not like an orthodox thing of where it's like, 'Well, he raped you' It's like, no, he didn't, I knew what I was doing. I knew what happened. It*

> *was an oops moment, I wasn't trying to get pregnant, it just happened. And so, you know, for me, I just didn't believe in that*
>
> *That's what triggered my dad to say, 'Well, then you know what she's leaving. She doesn't [get an abortion], then she's leaving. She's getting the hell out of the house. This is not my daughter. This is not who I raised. So, she's leaving.' So I remember leaving my home with my dad being very angry, very loud, very just forthcoming telling me every terrible word you can say under the sun. And I can still remember my mom, like being upset, crying, you know, feeling torn, because she can't really fight back my dad, but then she doesn't want to see me leave. I remember that happening when I was 19.*

Even though Celi did not want to get an abortion and did not see it as the right choice for her, her mother tried to instruct her to get one, trying to convince Celi to subvert the gendered constructions she grew up with. While forced abortion is a form of gendered violence, Celi's mother encouraged her as a form of protection against her father's forthcoming anger and violence. Having experienced her father's violence firsthand, Celi's mother anticipates her husband's violence and seeks to protect her daughter despite it going against Celi's wishes and moral code. Unfortunately, however, Celi's father forces her to leave her home when she chooses to stay pregnant. Even though he also wanted Celi to get an abortion, this was because he perceived Celi's pregnancy as a poor reflection on him as a man and as a father who was able to control his daughter's sexuality. He also lashed out when Celi resisted his power to control her (i.e., telling her to leave when she told him that she was not going to get an abortion). Therefore, her mother's actions were facilitated by the instinct to protect rather than the need to control.

Celi then moved into her ex-boyfriend's house where she continued to experience violence. Her ex-boyfriend was physically abusive towards her. Celi shared a conversation she had with his mother when she was living at their house.

> *I remember his mom, she passed away already, but his mom actually told me 'If you don't anger my son, and if you just kind of just be… you know, don't disrespect him, don't anger him, don't make him mad. Things will be okay for you.' She didn't say to stay in line, but I think that's what she was emulating to me. Like, just keep it straight.*

This woman also experienced chronic domestic violence. Here, she tried to make Celi adhere to patriarchal logics – do not anger men, do not disrespect them, know your place and you will be "fine." Thus, the perpetrator's mother attempted to configure Celi into someone who adhered to gender norms of being passive and not challenging patriarchal power. While her instructions are controlling and reinforce hegemonic gendering, I also see her trying to protect Celi from violence by sharing ways *she* protected herself from gendered violence. Celi described her ex-boyfriend's mother as very quiet and meek. Thus, it is possible that the perpetrator's mother played into feminine gender roles as a survival strategy in her own situation of gendered violence.

Even though Celi was not welcomed at her home, she left her ex-boyfriend's house after he continued to abuse her while she was pregnant.

> *The last time that he had ever put his hands on me, I was about eight months pregnant, and he did punch me. And he punched me specifically in the stomach. And I remember dropping to my knees and feeling pain. But it was the next day after where I told him 'Don't ever, ever touch me again, because I need to give birth to our child. I will report you if you ever hit me ever again in this way.' It's a shame to admit, but it is something that I speak my truth. Yes, I was hit when I was pregnant with my daughter, you know, there are times that I felt scared that maybe she had passed because I wouldn't feel her moving in my stomach.*
> *I think I scared him at that point because he refused to do that. But the verbal abuse and manipulation continued but the physical piece ended after I told him that, because I was scared for my life. I took a risk to even say that to him. But I just felt like I can't keep taking punches. I can't keep taking these things, especially in pregnancy, I started to fear it for my own daughter. I didn't know what was going to happen with her. And so, I couldn't take it. I took a risk.*

Celi felt empowered in her role as a mother to protect her own daughter from abuse. What compelled Celi to leave the relationship and his home was her fear that his physical abuse would cause a stillbirth. At a great personal cost and risk, Celi told the perpetrator that she would report him to the police if he ever hit her "*in [that] way*" again (i.e., hit her in a way that would potentially hurt the fetus). Thus, Celi sought to protect her own daughter by completely removing them from the perpetrator's abusive household. During my many conversations with Celi, it is clear how much she loves her job as a domestic violence advocate and how much she loves her clients. One of her biggest points of pride is that Celi feels like she is raising her daughter in a healthy environment and teaching her how to preemptively recognize abusive behavior, protecting her daughter without forcing her to adhere to gender norms or having her witness her mother being abused. She wants to empower her daughter with the skills and knowledge to have healthy relationships. She wants her daughter to have the childhood she never experienced.

Similarly, virtually every participant shared with me how they were trying to protect others from gendered violence. While many people stated that their own experiences with abuse or assault drastically changed them, they want to do everything they can to ensure that no one will ever experience what they did. For some people, like Celi, this meant committing to a career to serve other survivors of gendered violence. For many others, this meant having an active role in political and feminist spheres to advocate for policy changes around gendered violence. Many of the people I spoke to told me how they became more engaged in feminist activism, seeking to address gendered violence at its root causes and in its everyday forms. For example, Leila helped

establish an organization that provides free pepper spray, whistles, and other self-defense measures to people. Many others are a part of activist organizations that challenge patriarchal power in our political system and workspaces by actively protesting or forming other ways of resistance. Others led or are a part of support groups. No matter how people engaged with activism around gendered violence, one thing was abundantly clear – people deeply cared for others and wanted to protect them at all costs.

Conclusion

This chapter has argued that people are active agents in their own healing outside the context of managed care for gendered violence. While formal care systems tend to push someone's sense of self to the background, people actively bring their sense of being to the foreground so that they are recognized as mattering within their own care systems. These care systems employed specific technologies of the self and ways of presencing that included multiplying their sense of self to expand life, or, in situations of structural and social failure, to diminish life.

In addition, people also sought to include and involve others in their care systems. This process primarily worked through the making of good men and the protection of women, reinforcing and recreating a two-gender system. Care systems like the medicolegal system and CBOs, form unintentional communities (Goffman 1961), that do not consist of individuals voluntarily assembled to pursue common goals, generating, promoting, and enforcing moral and political codes that help pursue a good life. No one chooses to experience gendered violence.

However, people *do* create a world that is built for people to thrive in. At the heart of these self-made care systems, people wanted and needed to witness the protection and prospering of others – what I refer to as *vicarious survivorship*, or the actualization of healing by viewing yourself through the prospering and protection of others against gendered violence. People's newly formed social bonds transcended the physical sense of being. Rather, people sought not only to build protective social networks, but also to construct a world built from their own trauma.

Here, notions of moral legitimacy function on theories of "hope" (Mattingly 2010). Mattingly argues that "hope" involves the practice of creating, or trying to create, lives worthy of living amidst bitter realities of suffering (pg. 6). Hope is paradoxical as the active construction of positive possibilities also serve as a reminder of suffering. My analysis demonstrates how gender is layered onto this theory. Within people's acts of vicarious survivorship – how they live more violence-free, prosperous lives through other people – is the reinforcement of the gender binary. This same binary underpins the structurally violent assemblage of care, gatekeeping services and exacerbating trauma. Therefore, the emergent forms of legitimacy and moralization of beings echo gendered institutional practices.

Overall, people healed and experienced life beyond formal care systems by creating alternative realities in which others would never experience the gendered violence they did. They saw and lived their own healing through others.

CONCLUSION: ALTERNATIVE REALITIES

a letter to myself.[6]

I'm relishing in a period of gratitude. I feel like everything is starting to make sense and come together as it should. I love my field and my research. I feel like the people I'm meeting serve a purpose in my life – and I hope my being gives back to their lives, too. My friends are my greatest inspiration and my deepest sense of comfort.

I am surprisingly optimistic about the future if this is my present. I feel myself expanding and changing in ways I wouldn't have expected.

I'm still angry and have resentment, but it's far less consuming and doesn't compare to the excitement, drive, and love I have for myself. A few years ago, I truly felt like I had nothing to live for or that nothing was waiting for me. The pain was intolerable.

Now is different. Or at the very least, this moment and place in time serve as a reminder that it becomes tolerable. Things can change. People have a lot to offer. I can open myself up to possibilities.

I hope this trajectory continues.

[6] Schafroth, diary entry, October 24, 2020

In a way, I feel like, well, it can only go up from here,
because I reached the depth of where I could go.

-Anna Marie Tendler

From the outset, I have argued that care systems responding to gendered violence are structurally violent assemblages that alter how people conceptualize their experiences of gendered violence, what it means to heal from them, and their senses of self. This assemblage does not reflect the intentions of individual care providers, who find ways to move and shake the system, but, instead, reflect the macrolevel processes that manage and inform cultural imaginaries of gendered violence. Such imaginaries force people who have experienced gendered violence to compete on a moral plane for recognition, care, and a sense of validation and realness of their experiences. These structural forces fracture, but do not break, people's lifeforce as they create their own care systems built around the protection and prospering of others.

Limitations

One limitation was my choice to include medicolegal perspectives rather than solely focusing on community-based organizations. While I have argued that medicolegal institutions and community-based organizations exist in a network, I only conducted virtual and in-person fieldwork at community-based organizations. Three interviews were with forensic nurses, which is significantly less than the number of interviews conducted with community-based advocates. This lack of variability may have embedded bias in my data by limiting perspectives. Similarly, I did not conduct any participant observation that

captured provider-patient interactions. I was only able to attend to how people spoke about their experiences receiving and providing care for gendered violence.

Second, while deterritorialized ethnography produces data unbounded by geographically tied ideologies, it also poses challenges. For example, I had disproportionate samples across sites, types of care people provided and received, and cultural backgrounds. In addition, because of the exploratory nature of my interviews with survivors, I may have threatened reliability because I was not always asking questions using the language and frameworks available to participants. While this variability in my participants' experiences provided rich, qualitative data, the lack of a shared context/ethnographic site (and my ability to participate in and observed this context) created a paucity of equally in-depth ethnographic data to contextualize and ground these experiences in local cultural systems of violence, gender, and healthcare.

A third limitation in my study design is that the sense-making process is a retroactive analysis where I risked distorting, sanitizing, or misrepresenting someone's experiences. However, I attempted to mitigate these threats by including direct quotes and fieldnotes. Similarly, I primarily used referral-based sampling at CBA and other community-based organizations. It was possible that advocates referred people to participate who they thought would be a "good participant" or "has an interesting story to tell." A "good participant" would likely be one who complies with institutional demands. It was also possible these referred participants were the ones who had positive experiences at my virtual field site, potentially skewing my analysis of these systems and how people experience them.

I consider the limited time for data collection and analysis a significant, if not the primary, limitation to this study. Due to delays in receiving IRB approval to recruit participants using social media, the timeframe for data collection and analysis was even more compressed. In addition, structural constraints prevented me from being able to solely focus on this project during the time that *was* available. I *needed* to work three jobs to barely get by. These financial circumstances almost forced me to leave this program. I had a rather unfortunate encounter with a bat at the beginning of my data collection process – resulting in a medical bill (one of four) that initially was over $17,000. There was little to no financial support from my academic institution.

Concluding remarks

It may appear from the linear progression embedded in the letters to my assailant and to myself that reaching the point where I am able (and want to) dedicate a career to researching gendered violence has been a clear, character-building journey. It has not. If I had a choice to "redo" that night when I met "X," I would certainly stay home. I would never have chosen this path for myself. I am not a better or stronger person because I was assaulted. I merely adapted.

In many ways, I did not choose to research gendered violence for myself, even though understanding and retelling the stories of gendered violence have great personal significance. This project was not part of my healing process nor was I retraumatized while bringing this project to fruition. When I left STEM, I wanted to choose a career that had personal and political significance - I wanted it to be more than about me.

Unexpectedly, I saw my own experiences echoed in the voices of those who were gracious enough to participate in this study.

I do not know a single person who is not affected by gendered violence. Whether someone has experienced it directly, knows somebody who has, or maybe has even committed gendered violence, it acts like a boulder thrown into a pond, creating tidal waves for ripples.

What can we do, then, to animate violence-free realities?

I hesitate providing various websites, names of large organizations, and hotline numbers. I tend to find that people (including myself in a former life) will often just repost them on their social media, perpetuating performative activism under the guise of "*raising awareness*" or "*starting a dialogue*." The large organizations like the Rape, Abuse & Incest National Network or the National Domestic Violence Hotline are also easily accessible via Google. In addition, people who experience gendered violence experience constant referrals. They are referred off to the next organization, the next provider, the next friend, aimlessly traveling through structural and social networks with no clear destination. Therefore, I suggest several interventions that can help us move forward. Certainly, this is not an exhaustive list nor a step-by-step guide, but I offer some tangible next steps.

An inherently political issue

First, we must recognize that gendered violence is an inherently political issue. Our political and economic policies exacerbate and create the conditions that give rise to gendered violence. Far too often, gendered violence is framed as an interpersonal issue

driven by sexual desire rather than, for instance, seeking to assert and maintain structural power that is supported by our current political structure. In addition, the political and economic forces that mutually construct the conditions giving rise to gendered violence are felt differently depending on someone's social and political location.

For example, since the beginning of the COVID-19 pandemic, there has been a horrifying surge of gendered violence as indicated by a drastic increase in hotline phone calls, higher rates of intimate partner homicide, and increased gendered violence related medical visits. The mandated stay-at-home order and decreased capacity for alternative housing have trapped survivors at home with abusers. Additionally, abusers use the stay-at-home order to increase their surveillance and control over survivors, limiting their connections with the outside world.

The majority of people who came to my field site at the community-based advocacy center were people without legal documents who were especially vulnerable. Abusers use their lack of legal status as a tool of manipulation and control. For example, it is very common for abusers to threaten to report people to immigration authorities, such as ICE, if they attempt to seek help, leave the relationship, or report their abuse. Additionally, it is very difficult for undocumented immigrants to have a stable income to acquire housing, food, and other resources because most jobs require proof of citizenship. Abusers will also prevent their partners from seeking employment by making them feel "stupid" or "unworthy" for their limited language abilities. Often, survivors must rely on their abusers for money, housing, food, and other needed resources, making the cost of leaving the relationship or reporting their abuse that much more severe. Therefore, the

instilled fear of deportation and separation from their families in conjunction with the pervasive amount of control abusers exercise over them leaves undocumented survivors with few options.

The anti-immigration rhetoric and ideologies espoused by prominent political figures worsened this problem. The Trump administration's use of anti-immigration rhetoric embedded xenophobia and racism into policy. Undocumented immigrants used to be able to obtain asylum by establishing credible fear by stating that they would face domestic violence in their country of origin. However, in 2018, the justice department defended a Trump administrative decision that overturned this asylum protection. Meaning, fearing domestic violence was no longer a sanctioned way to seek safety, leaving thousands without protection. There are still rigid restrictions for those who fear domestic violence in their home countries, and it is extremely difficult to prove this within a legal framework. Although there have been sweeping lawsuits seeking to reserve this policy, final decisions have yet to be rendered.

In addition, undocumented survivors were protected under the Violence Against Women's Act (VAWA). VAWA sought to improve legal and community responses to gendered violence, allowing survivors access to services and resources. This legislation allowed undocumented survivors, who might not have been eligible for immigration benefits, to gain permanent residency if they were in an abusive relationship with a US citizen or permanent resident. The legislation expired in February 2019. While the House approved its reauthorization in March 2021, the bill remains untouched by the Senate and is still inactive. This standstill is due to new provisions closing the "Boyfriend loophole"

and “Stalker loophole.” Current federal law does not prohibit former or current abusers or people who have committed misdemeanor stalking from having firearms, despite evidence that dating partners cause intimate partner homicide and gun-related injuries. The proposed revisions would prevent these abusers from obtaining and keeping their firearms. Opposing Republicans, such as Sen. Joni Ernst (R-IA), Sen. John Cornyn (R-TX), or Sen Mitch McConnell (R-KY), argue that these provisions infringe on Second Amendment rights and are “too partisan.” Additionally, NRA funding and VAWA’s recently added protections for Indigenous people and the LGBTQ+ community also likely influence the opposition’s decision.

Therefore, the policies we support, and oppose, and the assumptions or logics embedded within them matter a great deal. When evaluating a specific policy, I encourage us all to interrogate the specifics of it such as who it reaches, who it does not reach, who it actively and passively harms and how. I also encourage us all to examine the political and economic factors and policies that are *associated* with gendered violence. A policy does not have to directly address gendered violence to affect it. For example, anti-immigration laws, criminalizing policies against substance use, funding for housing and healthcare, *all* intersect and influence someone’s experience with gendered violence by affecting whether someone is comfortable (and able) to seek healthcare/support, has access to resources, and the quality of care they receive within those systems.

Education and structure

One common theme I heard across participants and across field sites was the importance of education about gendered violence and healthy relationships. Typically, education about gendered violence takes the form of trainings. For example, workplaces and schools require people to undergo sexual harassment and assault trainings. These trainings frame gendered violence as a preventable issue and assume that gendered violence exists because people lack the knowledge on how to intervene in situations that potentially lead to sexual assault (i.e., active bystanderism) and how to utilize reporting systems (Salazar et al. 2014; Orchowski et al. 2020; Kleinsasser et al. 2015; Coker et al. 2011). These trainings also function under the assumptions that there is a simultaneous training for care providers or administrators on how to handle misconduct/assault/abuse cases, that people will intervene in situations, and that these trainings will increase usage of existing reporting systems. However, previous research evaluating the efficacy of these trainings has shown mixed results. Trainings generally increase active bystander actions (Salazar et al. 2014; Coker et al. 2011; Kleinsasser et al. 2015). However, qualitative studies reveal that nonwhite racial groups and male-identifying students are less likely to engage in active bystanderism (Hammock et al. 2020; Hoxmeier, O'Connor, and McMahon 2018), suggesting that trainings do not resonate with all students nor fully account for power relations that perpetuate the cultural imaginary that casts men of color as sexual predators.

While I agree that trainings are a start, they are insufficient as standalone solutions. First, most trainings are not designed in a way that allows people who have

committed gendered violence to recognize their problematic behavior. Very few people take a sexual misconduct training and think "*Oh, that's me*." One reason why this misrecognition exists is because these trainings perpetuate the victim/abuser dichotomy. This is a phenomenon in which people rely on exclusive constructions of victimhood and gendered predation to support and uphold a favorable self-image and emphasize the difference between these two groups. Therefore, while I am not arguing for the dismissal of all educational tools, I am arguing that any sort of educational tool should center arguments of power. For example, instead of presenting cases where gendered violence looks a certain way, and therefore requires the "right" course of action, trainings should equip people with the knowledge about power and control and their intersections with gender, race, and class. If we center our discussions on gendered violence around power and how it is socially patterned, then we will begin to nuance our understandings and responses to gendered violence.

In a similar vein, our educational tools should *de*-center reporting mechanisms. While this information should be accessible, traditional reporting mechanisms are structurally and symbolically violent. Thus, if someone believes that reporting their abuse or assault is the only option they have to receive care, they are really stuck between a rock and a hard place if they do not want to involve legal authorities, the police, or school administrators. In addition, financial barriers also prevent people from seeking out these traditional reporting mechanisms. While forensic exams are free, the medical care associated with it (e.g., STI and HIV prophylaxis medications) is not. People can get reimbursed through the Victims Compensation Funds, but they must involve law

enforcement, which is structurally violent towards people without legal documents, people who use drugs, and BIPOC communities. In addition, you have to be deemed "compliant" to receive these funds, which is a gendered and raced concept. Therefore, education tools should also provide people with other options to receive care. These include community-based organizations and independent health clinics that provide free or low-cost care. Importantly, these types of organizations demand and deserve more financial support to continue providing services.

Rethinking the "gender" in gendered violence

As the previous chapters argue, gender, its construction and perception, is an extremely powerful construct to the care systems around gendered violence. Gender has significant material and social consequences within the realm of gendered violence care. I argue that we must stop framing gendered violence as a woman's issue. I certainly do not want to argue that women (cis and trans) do not require or deserve care nor say that they do not experience gendered violence. I am arguing that the reduction of gendered violence to "women's issues" distracts from larger racial, class, and health system issues that go far beyond the women who experience gendered violence. This logic replicates the "divide and conquer" strategy of managing identity politics. In addition, this logic reinforces the gatekeeping strategies care systems use, making it very difficult for men (cis and trans), non-binary, and genderqueer folks to receive adequate and affirming care.

I also recommend that we widen our vocabulary and language when discussing gendered violence. Interrogating widely held narratives that cast gendered violence through a universalist approach requires us to center the abject citizen, whose

multivalent, complex, and non-linear experience serves as a lens to critique these larger assemblages of care that guard the gateways to citizenship and care. Organizations and those who interact with people who have experienced gendered violence should adopt different terms given the complex meanings associated with "victim" and "survivor" that complicate the ways people use them to refer to themselves and others.

Therefore, we also must actively work to dispel the rape myths. This task also requires us to continuously push back against cultural imaginaries about gendered violence by dispelling pervasive rape myths within institutional and social spheres, attending to the complexities of gendered violence and the people who experience it. First, this includes formulating medical and forensic practices that are not confined by AFAB/AMAB anatomy. Second, this includes eliminating policies that restrict who is eligible to receive care by providing more structural and financial support to organizations. Third, this includes using gender inclusive language when discussing gendered violence. Collectively, we must dismantle the (gendered) moral economies that reinforce harmful narratives of deservingness by expanding organizational practices to attend to other forms of gendered violence beyond penetrative rape. We can do this by not asking the "…*and then what happened?*" questions when people open up about their experiences with violence. We can also do this by not creating and supporting the structures within our care system that pits forms of suffering up against each other. In addition, we can dismantle the "*it could have been worse*" narrative by creating the spaces for people to process their experiences openly and safely without judgment. Doing

so requires us to validate and give attention to all experiences of gendered violence, not just the exceptional cases.

Rethinking empowerment

Most of our empowerment narratives center the individual. However, what if, in addition to empowering individuals, we were to also provide a sense of community and collective forms of support? It is an overly romanticized notion that a righteous few must stand up against an unjust evil. We can build community. This thesis demonstrates how individual care providers work within the system, allowing people to gain access to care they would not have been able to receive. They are what I refer to as the movers and shakers of the care system. However, they need support, too. One of the simplest, yet powerful, strategies my field site used was creating a space for advocates to support each other. We regularly met each week to "check in" with each other. Everyone was allowed space to talk about their anxieties, personal stressors or barriers, difficult cases at work, and successes in their professional and personal lives. People asked and gave advice and support. It was a space where everyone, for at least that hour and a half, felt heard and cared for by each other. What if organizations created similar spaces? Forensic nurses and community advocates do not always have to do their job by themselves. Hopefully, the empowerment and support of individual care providers will then manifest in our healthcare policies and ethical practices.

If there is one thing to take away from this thesis is that *we all play a role in the production of, healing from, and prevention of gendered violence*. I cannot emphasize enough the importance of social support in processing and healing from gendered

violence. No one is absolved from their social responsibility to care for each other. This responsibility also requires us to recognize that change is possible. A quote from the remarkable bell hooks encapsulates this notion:

> *Once you do away with the idea of people as fixed, static entities, then you see that people can change, and there is hope*

Our current care systems and social discourse prioritize punishment over progress. Far too often, I only see people engage with social issues to avoid consequences. For example, I was speaking with one of my friends and her husband. Her husband told a story about one of his coworkers "*slapping [his wife] on the ass*" and then telling her to "*shut up*" when she objected. This story was followed up with "*Can you imagine if I did that to [my wife]? She'd yell at me and leave me.*" This sentiment is far too familiar. The idea of sexually assaulting someone and being verbally aggressive was not perceived as morally wrong. Rather, the fear of consequences or being labeled as a bad person (e.g., perpetrator, abuser, predator) kept him from entertaining this idea. Thus, we must stop acting out of the fear of being punished and instead act with sincere intentions to *do better*.

Fear of punishment also reverberates in the lives of people who experience gendered violence. For example, Mira feared seeking post-assault care because she lived in a conservative area and Planned Parenthood was highly stigmatized. Marcos feared deportation and institutional dismissal. Cara feared asking for help because they thought their college would punish them for their substance use rather than support them in processing their assault. Other participants feared that their parents would find out about their assault due to mandatory reporting and punish them for having sex. So many people

I interacted with fear seeking support for gendered violence because they are worried they will lose custody of their children. First, we must work in our social and political worlds to destigmatize gendered violence. We also have to realize that care systems for gendered violence are not stand-alone institutions – they are deeply connected to other systems like reproductive healthcare, DCF, and carceral institutions. Therefore, I also encourage us to recognize and dismantle the criminalizing pathways built into our care systems. Looking to community-based efforts that de-center surveillance is a start.

An alternative reality

What if we were to suspend our denial of social responsibility? What if we were to acknowledge that we are all actors, somehow in some form, in "the system" we so quickly critique? Far too often, I hear "*it's not my responsibility to...*" If caring for a fellow person and humanizing them is not our responsibility, then what is? Imagine if we were to complicate our conceptions of gendered violence that uphold the false dichotomy between the victim and the victimizer. Imagine if we were to dismantle normative, patriarchal logics while also creating new systems founded on critical connections across ideological boundaries. Imagine if we were to let go of the shame, stigma, and self-hatred instilled in us by capitalist, patriarchal power and recognize that we are social creatures who need others. Imagine if we were to stop blaming ourselves and others and point our fingers at the structures that seek to destroy life. If we were to recognize the power in community and our part in vitalizing the world around us, we just might start.

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