Narrating the harm of rape: how rape victims invoke different models of psychological trauma

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Abstract: Psychological trauma has become the main framework for understanding the impact of rape on individual victims. Trauma has traditionally been understood as a mental illness conceptualized in opposition to normality. This dichotomous model of trauma is now in competition with a scale model in which trauma is conceptualized on a scale of normality. In this article, I study these two models of trauma by analyzing victims' narratives of rape. I investigate how trauma emerges in victims' narratives of rape to consider the ways in which the trauma discourse contributes to shaping how victims make sense of, and respond to, experiences of rape. The analysis is based on qualitative interviews with rape victims. I argue that the interviewees primarily talk about trauma on a scale of normality in which they portray trauma as something they can develop if they do not take responsibility for their health. In this way, they can escape trauma and, accordingly, the potential stigmatizing effects of psychiatric labels. At the same time, however, escaping trauma in this manner makes trauma inescapable, as it entails their continued commitment to take responsibility for their health.

Key words: psychological trauma, rape, (ab)normality, DSM

Introduction

In the 1970s, the women's movement directed attention to rape and its consequences to repudiate contemporary trivializing attitudes and responses to rape. Quickly, rape became politicized and the target of social change. In this process, trauma became a means to ensure the acknowledgement of rape victims' suffering because trauma directed attention toward the harm of rape. As early as 1974, Burgess and Holmstrom concluded in a study of rape victims that rape has detrimental health consequences, and the authors delineated the rape trauma syndrome. However, it was not until 1980 that the American Psychiatric Association (APA) decided to include posttraumatic stress disorder (PTSD) as a part of its third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM). PTSD was included in DSM after Vietnam veterans had paved the way for recognition of trauma by contributing to develop knowledge and treatment programs for traumatized veterans and the women's movement had formed an alliance with mental health professionals (Fassin and Rechtman, 2009; Herman, 1997). The trauma framework has since become a dominant way of understanding the impact of rape both inside and outside therapeutic rooms (Gavey and Schmidt, 2011; Egan, 2016; Marecek, 1999).

The medicalization of trauma has contributed to the acknowledgement of the existence and harm of sexual violence by connecting the traumatic event with psychiatric symptoms (Breslau, 2004; Fassin and Rechtman, 2009; Herman, 1997; Kleinman and Desjarlais, 1997). In this way, victims' reactions and behavior can be explained by the trauma framework as a normal reaction to an abnormal situation, rather than the other way around, which is as a pathological reaction to a normal situation (Fassin and Rechtman, 2009). The trauma diagnosis therefore represents an important shift in the ways in which psychology/psychiatry perceives women. According to Marriner (2012), these disciplines have traditionally pathologized female victims of men's violence by diagnosing women with hysteria and

masochism, which has contributed to erasing male culpability. The etiology of the traumatic event has accordingly relocated the cause of distress outside of women (Fassin and Rechtman, 2009). Therefore, the diagnosis of trauma can be distinguished from psychiatric disorders that tend to pathologize women, and it represents a preferred diagnosis for feminist psychologists (Marecek, 1999). However, the medicalization of trauma simultaneously transforms rape into an experience in which expert knowledge is claimed, which, in turn, shapes the ways in which victims understand the causes and consequences of victimization.

Accordingly, the medicalization of trauma has caused concern among some researchers. Psychiatric diagnostic standards, in general, and the trauma diagnosis, in particular, have been argued to contribute to medicalizing social problems, as well as pathologizing and stigmatizing victimized women (Gavey and Schmidt, 2011; Lamb, 1999; Romelli et al., 2016). McGarry and Walklate (2015) therefore question the appropriateness of trauma as a conceptual tool to make sense of victimization. According to Guilfoyle (2013), a psychiatric diagnosis can be considered a knowledge system that creates pre-scripted accounts of what a person is. These accounts privilege expert knowledge and reduce alternative avenues of personhood. The diagnostic system, Guilfoyle continues, therefore pushes people to understand themselves through the diagnostic lens of trauma in order to know the truth about themselves.

The criticism of the diagnosis of trauma outlined above portrays trauma as a mental illness conceptualized in opposition to normality—a dichotomous model in which psychological/psychiatric knowledge and practice define who is within the scope of normality. However, this way of modeling trauma is now in competition with a scale model, which conceptualizes trauma on a scale of normality (Sweet and Decoteau, 2018; Rose, 2001a). The introduction of the scale model represents the shift from medicalization, e.g., the process of making problems medical to emphasize control over them, to biomedicalization,

e.g., the further emphasis of the transformation of medical phenomena by technoscientific means for enhancement or optimization (Clarke and Shim, 2011; Conrad, 2005). The scale model fuses trauma with other health discourses and further appears in non-medical institutions.

In this article, I study these two models of trauma by analyzing victims' narratives of rape. I investigate how trauma emerges in the victims' narratives of rape to consider the ways in which the trauma discourse contributes to shaping how victims make sense of and respond to experiences of rape. The analysis is based on qualitative interviews with rape victims. I argue that the dichotomous model is not particularly apparent in the interviewees' accounts. Only a few interviewees talk about trauma in this manner and accordingly resist or embrace this trauma framework. Most interviewees talk instead about trauma on a scale of normality, in which they portray trauma as something they can develop if they do not take responsibility for their health. In this way, they can escape trauma and thus the potential stigmatizing effects of psychiatric labels. At the same time, however, escaping trauma in this manner makes trauma inescapable, as it entails their continued commitment to taking responsibility for their health.

The two models of trauma appear through the victims' interactions with institutions working with rape. Victims are encouraged to consult these institutions when they disclose rape. The trauma discourse both permeates and connects medical and legal institutions and practices. This is because the development of the trauma diagnosis entailed the development and institutionalization of various interventions and treatment programs. Trauma has also spread to other societal institutions, as psychiatric diagnoses elicit rights to various welfare benefits. Furthermore, trauma has gained the status of proof and is used as legal evidence when the police investigate and the courts adjudicate rape. I therefore begin by describing the institutionalized context before accounting for the two models of trauma.

The institutionalized context

In Norway, the government has aimed at combating rape for the last 10 years by implementing a plan to increase the quality of forensic medical examinations in rape cases, and, further, to encourage all rape victims to undertake a medical examination and report the rape to the police (NOU2008:4). Another important aim has been to strengthen access to psychological treatment and promote cooperation between experts and institutions working with rape victims. These aims have created institutional practices that have contributed to making rape an experience that requires expert knowledge and intervention. In turn, this has transformed rape into a public concern, in which a network of institutions and practices is initiated whenever someone claims to have been raped.

A similar network of medical and legal professionals and expert practices has been described in the US and Canada (Marriner, 2012; Bumiller, 2008; Quinlan, 2017). At the core of this network, Quinlan (2017) contends, is the sexual assault center and the rape kit that draw together various knowledges and coordinate expert efforts that contribute to increasing victims' credibility. According to Marriner (2012), these knowledges reinforce one another so that truth claims of both law and psychology/psychiatry benefit by invoking the other. When victims report a rape to the police or consult a sexual assault center, they become intertwined in this expert network (Quinlan, 2017; Marriner, 2012).

In Norway, the first sexual assault center was established in the capital Oslo in 1986 (Dahl, 1993). According to Dahl (1993), this center was opened in response to the poor treatment accorded to rape victims by public health services. At the time it opened, Dahl initiated a longitudinal study of rape that aimed to identify the nature of the health problems caused by rape. At this time, knowledge of psychological trauma was limited in Norway. The study concluded that nearly half of the participants had developed PTSD a year after the incident. The sexual assault center used to be called the rape crisis center, but it changed its name after

an evaluation of the center suggested that many victims do not consult it if they are raped by someone they know because they associate the concept of rape with a violent rape by a stranger (Fladby, 2004). Today, every county in Norway has a sexual assault center located at a public hospital, usually in relation to the emergency room, which conducts forensic medical examinations. This examination includes the collection of biological samples to test for DNA and toxicology. During the forensic medical examination, documenting physical injuries to prove violence or the lack of consent in rape cases is also common. The assault centers additionally offer medical treatment and psychological evaluation, as well as a short-term psychological follow-up that is free of charge. During the psychological evaluation, the examiner documents the victim's immediate psychological reactions, which will be used in the criminal investigation of the rape case. The short-term psychological follow-up includes an introduction to various self-help strategies. These strategies are published on YouTube[1] and on different websites offering psychological help[2]. In addition, other resources are available online, such as trauma-related apps[3]. The self-help strategies advise on how, for example, to control intrusive thoughts and images, bodily uneasiness, and sleep disturbances. One such strategy for controlling intrusive thoughts and images asks victims to imagine their thoughts and images as appearing on a TV screen. Then, the victims are supposed to imagine that they can stop, play, rewind, or fast-forward the thoughts and images with an imagined remote control. In addition, the victims are supposed to imagine that they can move the images around on the screen. Advice on how to ease bodily uneasiness includes breathing techniques, massage, physical exercise, and controlling the consumption of substances. An example is reducing caffeine, sugar, and nicotine intake. A strategy[4] to cope with anxiety attacks is to exercise in order to induce the bodily physiological reactions that are common

[1] https://www.youtube.com/watch?v=YVExdTPaPSs
[2] https://krisepsykologi.no/ www.kognitiv.no (ABC øvelser) www.krisepsyk.no (SMART)
[3] https://www.ptsd.va.gov/public/materials/apps/index.asp?utm_source=hootsuite&utm_campaign=hootsuite
[4] https://www.kognitiv.no/wp-content/uploads/2014/11/Angst-en-alarmreaksjon-TB-21.06.pdf

during panic attacks, such as increased heartbeat and shortness of breath, and thus learn how these bodily reactions ease off quickly if the victim accepts them rather than tries to fight them. These strategies encourage the victims to take responsibility for their own lives when they do not attend therapeutic sessions.

The sexual assault center offers help to all victims of sexual violence, regardless of whether they choose to report the case to the police. Additionally, the assault center informs their patients about the long-term follow-up treatment available from other institutions, offers referrals to specialists, and assists rape victims with contacting the police and victims' counsel. In Norway, victims of sexual violence have the right to legal representation if they report their case to the police. The counsel will assist the victim and assure the victim's rights when interacting with the police and the legal system. Similarly, other health institutions, the police, and self-help organizations accompany the victims to a sexual assault center if they have not yet consulted one. This means that if a rape victim consults an assault center or any other institution, the victim will accordingly be introduced to a range of experts who will offer treatment and follow-up for a shorter or longer period. This further means that if a rape victim consults the assault center or the police to report the incident rather than to seek therapy, the victim will nevertheless be introduced to therapeutic interventions. In this way, it is the institutions and their experts who introduce the victim to the trauma framework.

The reports from the forensic medical examination and the psychological evaluation conducted at the assault center will be included in the police's investigation of the case, if the case is reported to the police. The reports will further be presented in court as evidence, if the police prosecute the case. Sometimes, the prosecutor will subpoena a professional at the sexual assault center to appear as an expert witness in court and explain the examinations and results. The prosecutor will present the forensic and medical reports in court, regardless of whether DNA evidence, physical injuries, or other forensic evidence is available to be

reported on. In most cases, no forensic evidence is available, which means that the only thing to report on is the potential for trauma-related psychological reactions. For this reason, the initial psychological evaluation from the assault center, as well as the documentation from the long-term psychological follow-up of the victim, becomes important evidence in court.

According to Mulla (2014), rape crisis centers constitute a medico-legal complex in which legal considerations structure the medical examination. This means that the aim of collecting evidence that can prove rape shapes the ways in which the examination is completed. A crucial component is time, which frames the examination as urgent. The urgency is both medical and legal. Biological traces in the evidence collection can deteriorate if not collected in time, and sexually transmitted infections, pregnancy, and physical and psychological traumas threaten the victim's health. This medical urgency contributes to the professionals' readiness to intervene to secure the victims' future health.

Bumiller (2008) and Marriner (2012) have criticized this network of responders because they argue that it constitutes a professional apparatus that rationalizes sexual violence as a treatable problem. Professionals translate sexual violence into symptoms and transform sexual traumas into a disease that has to be managed to avoid a threat to public health. The victims become responsible for coping with their situation by means of therapy and drugs. The focus is on the victim who is rewarded for compliance with treatment programs that aim to transform the victim into a successful survivor. A successful survivor is a victim who is able to demonstrate psychological recovery via expert means (Sweet, 2018). A critical component of survivorhood, according to Sweet (2018), is creating a narrative of psychological transformation, which can be used to access aid. This medical narrative is valuable as currency to gain sympathy and recognition, as well as legal outcomes.

The two models of psychological trauma

The DSM-III is based on a biomedical construction of distress, in which trauma is conceptualized in opposition to normality (Young, 1997). The biomedical model was introduced to add scientific legitimacy to the diagnostic system (Romelli et al., 2016; Young, 1997) because the profession of psychiatry and the previous editions of the DSM had been criticized for lacking a scientific basis (Fassin and Rechtman, 2009; Young, 1997). To give the DSM-III a scientific basis, the APA therefore created a standardized classification system based on the symptoms evident in acts and the bodily conditions intended to be universally recognizable and treatable (Young, 1997). According to Young (1997), the nosology included two main categories: symptoms of pain (distress) and symptoms of impairment in areas of functioning (disability). He explains that the original idea behind the classification system was that the symptoms are tokens of the underlying pathological structures and components of a system of meaning (a syndrome). The concept of psychological trauma—which, metaphorically, means a psychological wound—was created as an analogy to physical injury, which was the original meaning of the term trauma (Hacking, 1994; Young, 1997). In this way, the symptoms express a mental illness, or a psychological wound, which is a binary opposition to normality. The normal constitutes the key organizing concept of medicine, a concept that is both descriptive and evaluative (Hacking, 1995). Classifying humans according to diagnostic criteria always involves values, according to Hacking (1995), even if one attempts to strip the classifications of moral content by biologizing and medicalizing them. For this reason, people might want to embrace or resist these classifications because of their moral connotations. Additionally, people might change their behavior when labeled with a diagnosis, which again contributes to the change in diagnostic classifications.

According to Sweet and Decoteau (2018), the fifth and latest version of the DSM is no longer based on a binary model of normality but on scales of normality. In their article on debates

surrounding the fifth edition of the DSM, Sweet and Decoteau (2018) point to the tensions between those who want to save the normal from increasing psychiatric labeling and those who want to achieve normality via psychiatrization. The critics of the proposed revision were concerned with the expanding scope of psychiatric diagnosis in contemporary life, whereas proponents considered normality to be the end goal of intervention. The first position considers normality as a natural foundation of the self, and the second position considers normality as something achievable through optimization and medicalization. Underneath these positions, Sweet and Decoteau continue, normality is constructed either dichotomously or in terms of spectrums.

Sweet and Decoteau (2018) base the scale model on Rose's (2001a) argument that advances in the life sciences challenge the binary opposition between normality and abnormality, and this variation is the new norm. Within this model, health is conceptualized in terms of susceptibility and optimization. Susceptibility to various health conditions requires people to constantly monitor their health, engage in risk management, take care of themselves, and adjust their lifestyle to improve and promote their health (Rose, 2001a). In a world of susceptibilities, the new norm is to manage uncertainty in the present by attempting to identify and treat predicted future ills (Rose, 2007; Rose, 2001a). It is no longer individual suffering but professional predictions into the future that require medical attention and intervention. Rose (2001b) characterizes the intensification and generalization of health promotion strategies as a will to health. This, he continues, has opened up space for new health promotion professionals, including those he calls somatic experts—not just medical professionals but also alternative therapists and food and fitness experts (Rose, 2001a; Rose, 2007). In this context, Rose explains, people need to shape their life to restore the free autonomous individual who takes responsibility for his/her own life by behaving prudently. In

this way, the scale model is transforming the trauma model into a hybrid field of knowledge, which engages a range of therapeutic and non-therapeutic institutions and practices.

The need to constantly work on the self in order to avoid trauma can be derived from the individual's relationship to the environment. Canguilhem (2012) conceptualizes illness and health as an individual's ability to adapt to his/her environment. He uses the concept of the individual norm, which refers to an individual's relationship to his/her environment. He explains illness as an individual's reduced ability to tolerate a changed environment and health as an individual's ability to transcend the norm. According to Herman (1997), trauma destroys relationships, particularly one's relationships to others, to oneself, and to the community. A traumatic incident can therefore change or narrow an individual's relationship to his/her environment. In order to adapt to the new situation or to transcend it, an individual needs to work on his/her self.

When there is an expectation to work on one's self, the focus is on what one does, rather than on one's symptoms. This focus on doing is also characteristic of self-help groups. Valverde and White-Mair (1999) describe how the self-help organization Alcoholics Anonymous (AA) consists of a set of practices—the 12 steps—rather than a set of ideas. The members of AA work through the steps to recover, but recovery does not mean to be cured; rather, it is to learn to live peacefully with one's dysfunctions. The steps are not a means to an end, and recovery is not an end to be achieved, but instead, it constitutes a *doing*. The steps are a lifelong commitment to oneself and the organization.

In rape cases, professional opinions on how rape is traumatizing contribute to the construction of victims as vulnerable to a future breakdown. Thus, to avoid a breakdown, victims must take responsibility for their health by participating in different interventions offered by psychological professionals and other health promoters. Psychological concepts and insights, such as trauma, are integrated into alternative therapeutic interventions because, as Rose

(1996) has noted, the psy disciplines have been eager to lend their vocabularies and explanations to other professional groups. Professionals working with rape victims accordingly constitute a hybrid field of knowledge that includes legal and psychological professionals and various self-help organizations and alternative experts. The two distinct models of trauma suggest that trauma is no longer simply a syndrome or a sign of pathology but a vulnerability that requires intervention, if a breakdown is to be avoided.

Methods

In this article, I analyze qualitative interviews with women who have experienced sexual violation. I recruited the participants through a youth health center, an organization working with rape victims, and victims' counsel. The health center and the organization advertised my study on their premises (i.e. in offices and meeting rooms and on the inside of bathroom stall doors) and on Facebook. The victims' lawyers asked their clients directly if they wanted to participate. In the advertising letter/poster, I did not mention the word rape but instead asked questions about experiences with sexual victimization: for instance, "Have you been forced to have sex when you did not want to, and did you feel violated afterwards?"; and, "Has anyone had sex with you when you were sleeping or too intoxicated to resist?" I did not mention the word rape in order to avoid excluding women who do not define their experiences as rape; the term rape tends to be interpreted narrowly and is often associated with a violent stranger rape (Gavey, 1999). Anyone who wanted to participate could contact me by phone, text message or e-mail.

I recruited 24 participants for interviews. Twelve of these participants had reported the sexual violation to the police, and six had had their cases prosecuted. Not all 12 women who reported had consulted a hospital-based sexual assault center, but among all the interviewees, 13 had consulted a sexual assault center. Only three interviewees had not consulted any organization or institution in person; instead, they regularly visited such organizations on Facebook. Most

interviewees had been violated by men they knew (friends, acquaintances, ex-boyfriends, dates, and relatives); only three perpetrators had been strangers. The interviewees' age ranged from 18 years to the mid-50s; the majority were in their 20s and had experienced rape within the last three to five years. The most recent rape had happened about three months before the interview, and the oldest had occurred about 27 years before the interview. The only inclusion criteria were being a woman and having a self-defined experience of sexual violation.

The interviews were audio-recorded and transcribed. I started the interviews by asking the interviewees to narrate their sexually victimizing experiences before I asked follow-up questions based on their narratives. I had an interview guide that included the topics I wanted to cover, such as interactions with family, friends, police, the assault center, the court, professionals and non-professionals regarding the rape. I also encouraged them to reflect on different concepts such as rape, victims and health. The interviews lasted from approximately 1½ hours to 4 hours.

Participation in the study was based on informed consent. All participants had to be 16 years or older to give consent for themselves. I conducted the study in line with Norwegian legal requirements and ethical guidelines for research.

My analysis is informed by the poststructural interview analysis approach developed by Carol Bacchi and Jennifer Bonham (2016). This strategy examines what is said in an interview and encourages reflection on how things that are said are considered intelligible, legitimate and truthful. It further scrutinizes what the things said *do* or *produce*. The key term in this analytical approach is problematization: that is, how the things said question what is commonly taken for granted and how the participants problematize the world in which they live. The starting point of this approach is that the things said invoke certain norms and establish ways for people to be. This approach consists of a set of questions to apply to the transcriptions to guide the analysis. For instance, "Precisely what is said in the interview?";

"How was it or is it possible to say those things?"; and "Which 'things said' put into question pervasive ways of thinking? (Bacchi and Bonham, 2016)" With regards to what is said in the interviews, I focus in particular on metaphors, both because the interviewees tend to talk about their health in metaphors and because metaphors can provide important information about the trauma discourse. According to Lakoff and Johnson (1980), our ordinary language and conceptual system are metaphorical in nature, such that metaphor structures not only our language but also our thoughts and actions. Metaphors set meaning in motion because when metaphors are used, something is experienced and understood by means of something else. Lakoff and Johnson call metaphors that address health and emotions "orientational" metaphors because they have a spatial orientation that corresponds with one's bodily or physical posture. For instance, they argue that "happy" is up and "sad" is down because sad people have a drooping posture, whereas happy people have an erect posture. Additionally, "conscious" and "health" are up, and "unconscious" and "sickness" are down because people sleep lying down and are forced to lie down when sick, whereas they stand up when they are awake and healthy.

The dichotomous model: how rape victims resist or embrace the trauma framework

Most of the interviewees (17) in this study include reflections on trauma or mental health in their narratives of rape. Trauma appears as a part of the interviewees' narratives of rape in different ways. Some of these interviewees (6) invoke the dichotomous model, but most of them (11) invoke the scale model. The remaining interviewees (7) do not talk about trauma according to either models.

The interviewees who invoke the dichotomous model clearly distance themselves from the trauma model, or they speak about their experiences within a trauma narrative. These interviewees talk about the trauma model in either/or terms, placing themselves within or outside the trauma framework or the broader category of mental illness.

One interviewee claims that rape has not traumatized her. When I ask her if she has suffered from the incident, she replies as follows:

> Yes, I have. Purely bodily, I did feel pain during the sex and after for several days. And I've suffered in the sense that, I did have, I know that there's some clinical definition of what trauma is, but in the days following the incident, I did feel the way I felt. At the time, I conceptualized it as a kind of trauma. Because I kept experiencing the incident over and over again. I was kind of haunted by these glimpses from that evening. And also, I suffered emotionally because I was very sad. For a long time, I didn't have sex with my girlfriend, and when we did have sex, for a very long time, I couldn't come because I couldn't let go.

Her brief mention of a clinical definition of trauma before stating that she conceptualizes what she feels as trauma indicates that she is making a distinction between an expert opinion and her conceptualization of her immediate reactions to the incident. Even if she conceptualized it as trauma initially, she does not define the incident as traumatizing at the time of the interview. She explains why in the following:

> Let me first say that what I experienced those days afterwards wasn't trauma, and I wasn't traumatized. At that time, it felt like a kind of trauma. But I guess that trauma is something more lasting, and also, you know, what happened those days was just a very strong reaction, over a few days. I guess that trauma would've been that, perhaps, say I couldn't have sex for a long time afterwards. Perhaps if I was afraid or anxious for a long time afterwards, maybe then it could've been trauma.

The duration of symptoms is an important feature of the PTSD diagnosis (Young, 1997), and this interviewee is resisting the trauma category by claiming that her reactions to the incident did not last long. Her resistance can be interpreted as a way of escaping a psychiatric label with potentially stigmatizing connotations. Note, however, that she contradicts herself in the two quotes because she explains why it is and is not trauma in the same manner. This can

indicate limited ways of narrating the harm of rape outside diagnostic categories (Bumiller, 2008; McGarry and Walklate, 2015; Guilfoyle, 2013). However, the interviewee is also using a different argument: she rejects the trauma framework because the term "traumatized" has gained a common sense meaning (Gavey and Schmidt, 2011). The interviewee says, "Maybe because we say it [trauma] when we want to emphasize and exaggerate things, then you're traumatized." Trauma has become a part of our everyday vocabulary—a metaphor for almost anything unpleasant (Fassin and Rechtman, 2009)—and this is why and how this interviewee uses the concept initially. The ways in which the concept of trauma has gained a common sense meaning makes it possible for her to resist the diagnostic framework. Still, she apparently feels the need to explain her immediate emotional reactions.

> I've always been very emotionally extreme, kind of, I can be very, very—kind of ecstatic in one moment and feel hopeless in another. I can react very strongly to things, when normal people will just be annoyed and then forget about it or be sad and then, I don't know. I can be very overwhelmed by feelings, and I can feel them so strongly it feels like I can't be in my own body. (…) I just, I can react strongly, and then in a glimpse, it can pass, and I think that's what happened. It was a very, very strong reaction for a few days, and then I could let go of it again. So, it wasn't trauma, that's my point. So it sort of makes sense that I reacted in that way because that's my personality or pattern of behavior.

To avoid the trauma framework, she explains her initial emotional reaction as a part of her personality because any effusive or excessive emotions can potentially be considered abnormal (Sweet and Decoteau, 2018).

Another interviewee similarly distances herself from psychological categories. "It's not like I'm mentally ill, even if I've had some mental challenges in this process." When I ask her to elaborate on this, she replies as follows:

> Well, I haven't really been depressed or on a sick leave. It's not like I've been floored and unable to work and function. I've basically functioned normally; I've been sad at times, but I don't think I'll call it depression.

In her account, psychological disorders do not fit her understanding of how the rape has affected her life. She is referring both to her feelings and to functionality when making her argument. In other words, she resists the trauma framework by referring to a lack of symptoms of distress and dysfunction. She is not using the concept of trauma, but she is talking about her health in terms of everyday metaphors when she says she has not been floored. This metaphor suggests that she has been on her feet. Metaphorically speaking, to be on one's feet is to be healthy and good—good is up and bad is down, happy is up and sad is down, conscious is up and unconscious is down, and health and life are up, and sickness and death are down (Lakoff and Johnson, 1980). When this interviewee implies that she has been on her feet, she is further implying that she has not had a breakdown. She accordingly constructs the breakdown as a distinction between the normal and the mentally ill, placing herself firmly within the category of the normal. To break down belongs to the mind is a machine metaphor, which refers to mental experiences in which one ceases to function (Lakoff and Johnson, 1980).

A few interviewees, who talk about trauma in dichotomous ways, embrace the trauma discourse. One interviewee, who uses the concept of trauma throughout the interview and speaks of her experiences within a trauma narrative, explains how it is her "emotional life that is hurt by this [incident], not the body." She also talks about pain: "It's strange because a pain that's so strong that you don't want to live anymore is inside you, but it's not bodily pain. If that makes any sense." When she characterizes her emotional life as painful, she invokes trauma metaphors to account for symptoms of distress. Trauma metaphors include wounds, injury, pain, damage. and brokenness, which create an analogy to physical injury (Marecek,

1999; Young, 1997). These metaphors are different from the ordinary orientational metaphors described earlier. This interviewee further applies an image of something broken: “Your whole life is pulverized.” For something to have been pulverized suggests that something has been crushed. This metaphor can be said to belong to the mind is a brittle object metaphor, which refers to psychological strength in which certain experiences can be said to shatter people (Lakoff and Johnson, 1980). By using trauma language in this way, the interviewee has come to understand herself through the diagnostic lens of trauma (Guilfoyle, 2013). Furthermore, to talk about health in dichotomous terms presumes that recovery is an end to be achieved.

The trauma discourse also has specialists that the interviewees might prefer over regular psychiatrists. One interviewee, who was raped 27 years ago and who has been a psychiatric patient for many years, tells me that she was once diagnosed with a personality disorder. She is very upset about this diagnosis, and she has attempted to contest it without succeeding. She says, “Some people like to pathologize their patients and give them medicine, rather than look at the whole picture.” She tells me that she has been trying to be referred to a trauma specialist. When I ask her why she wants to talk to a trauma specialist, she replies, “They don’t look for diagnosis and failings and shortcomings. They rather focus on how you’re doing.” In her account, trauma specialists do not focus on the person but consider a person’s situation (“the whole picture”). For that reason, she wants to consult a trauma specialist rather than psychiatrists, who pathologize her.

As outlined above, some of the interviewees in this study explicitly challenge the appropriateness of the trauma model, whereas others embrace it. When they resist or accept the trauma model, they portray trauma in dichotomous ways. When a few of the interviewees resist the trauma model, this suggests that the trauma discourse does not necessarily fit the way they make sense of how the rape has affected their lives. It can further be an expression

of how they attempt to resist labels with potentially stigmatizing connotations. However, for a few interviewees, the trauma model makes sense or appears as a better option than other psychiatric diagnoses.

The scale model: how rape victims attempt to escape trauma by behaving prudently

The interviewees who invoke the scale model do not resist or embrace trauma, but they talk about trauma or mental illness as something they can develop if they do not pay attention to their health. They compare themselves with other people but do not place themselves in either categories, but on a scale of normality. They do not use diagnostic language, but they talk about what they do to prevent trauma or a breakdown. This way of talking about trauma indicates a general concern regarding health and everyday functioning. They engage in different therapeutic interventions offered by medical and psychological experts, as well as other health promoters. In this context, they place trauma within a general health discourse.

One interviewee explains how, from the start, she decided to take responsibility for her future. "I started to challenge myself shortly after the incident, so I've never been stuck in one place." To be stuck in one place suggests that one is not able to move on, to escape the traumatic experience. One is caught in the trauma, which manifests itself through symptoms. The persistence of symptoms makes the traumatic experience pathological (Kleinman and Desjarlais, 1997). According to the trauma framework, symptoms that ease off with time constitute a normal response to trauma. By challenging herself in terms of forcing herself to do things that scares her, the victim can ease off the symptoms, and she can move on rather than be stuck in the trauma. She elaborates by comparing herself with others:

> I'm a part of this self-help group, and some of the women in that group are in the same spot now as they were immediately after the incident, even 3, 4, and 10 years after. (…)
> That made me think, "I need to rise to my feet. I'm not going to be in the same spot for 10

years." (…)

I don't want to lie down because of one thing [the rape], even if it's a big thing.

By using orientational metaphors in which up is healthy and down means sickness, as described earlier, the victim indicates that she does not want to give up and become sick, but she aims to stay healthy. Furthermore, by comparing herself with others in the self-help group, she can differentiate herself from other raped women who have apparently not succeeded in managing their lives. In this way, by taking responsibility for her future, she can negotiate her position on the scale of normality. Conceptualizing trauma on a scale of normality therefore gives her the opportunity to position herself as more normal compared with others in the self-help group.

Similarly, another interviewee negotiates her position on the scale of normality by comparing herself with a good friend who has been a psychiatric patient for many years. "I'm trying not to become like her. She's very suicidal, very negative. I don't think she has been very solution oriented with her life. I'm more focused on solutions. I want help." She distinguishes herself from her friend by emphasizing how she is managing her situation by being solution oriented and optimistic. She sees herself as taking responsibility for her future. In this manner, she can escape the label of mental illness even if she experiences some mental challenges. However, she has to pay attention to her future to stay on the healthy path.

The future tends to appear in the victims' narratives as fragile. One interviewee, who is describing her health as good at the time of the interview, expresses the following:

> Who knows what it has done to me. If we're talking about trauma [she laughs a bit], that's something that can happen after some time, and then you can trace it back to something you've experienced. So, maybe it hasn't done anything to me now, not yet at least, but that, you know, if I have a breakdown in 12 years [she laughs a bit again], maybe it did affect me after all.

The interviewees picture the future as fragile regardless of how they feel at the present time. This picture can be traced back to experts in the field who have told them that they have to invest in their future. One interviewee attempts to resist this advice, but does not seem able to escape it in her interactions with organizations working with rape victims. She tells me she is doing fine and that she does not think she needs any help from a psychologist, but a self-help organization tells her she must go through certain steps after a rape in order to stay healthy. In the following quote, she is talking about skipping a part of this recovery process.

> I think I skipped that part, or at least that's what they tell me at X [self-help organization], that I've been focusing on the practical stuff, you know, reporting the case to the police. Then when the police dropped the case, I moved on and started to think, 'Now, I'm doing OK! I'm going to focus on what's positive.' So, I've kind of skipped the part where I feel what it feels like, but I don't want to. 'Do I really need to go through it? No, I don't think so.'" So, it might backfire, but then I guess I'll just deal with it when that happens.

The institutional framing of rape victims as vulnerable to trauma prescribes a stage model that anyone who has experienced rape must adapt to in order to avoid the risk of a future breakdown. This model defines a path that all rape victims need to follow to manage their lives. Even if this interviewee is challenging the proposed need for engaging with her emotions, she is still accepting the premise of the model when she says that it might backfire. She is not resisting the trauma model per se but one of the steps she is supposed to go through. This stage model creates an assumption that victimization cannot escape traumatization; either trauma occurs immediately after victimization or has a late onset, if not managed properly. In other words, victimization creates an inescapable vulnerability for future breakdowns. A breakdown indicates that stress, which can be considered both productive and pathological, has not been adapted to and managed properly (Kugelmann, 1992). This future risk of a breakdown needs to be managed by adhering to the prescribed

path. However, this interviewee challenges such a prescribed path when she resists engaging with her emotions.

Another interviewee, on the other hand, takes responsibility for her future by engaging with her emotions. She invokes images of something frightening when she describes the importance of thinking about the rape every once in a while, "to avoid turning it into a ghost or a monster under your bed, kind of thing." A ghost refers to how the rape will haunt her if she does not think about it; similarly, a monster is created under her bed if she hides the rape in her subconsciousness. These metaphors evoke what Gavey and Schmidt (2011) term pop psychological knowledge, which includes simplified psychoanalytical concepts of trauma that are different from trauma metaphors based on the biomedical model described earlier. By thinking about the rape every once in a while, she attempts to take responsibility for not developing trauma in the future.

The constructed threat of a breakdown also creates a fear of emotions.

> It [the incident] has become this thing that I know has affected my life, but I'm not able to connect to my feelings. I know what I felt at that time, but it has become something that I don't dare to think about when I'm alone because then, I don't know what I'll think. So, I don't think about it when I don't talk to people—like I do here [during the interview] or at X [self-help organization]. So, it's kind of this big elephant in the room—only it's in my head.

Fearing her emotions is not only fearing breaking down and suffering the consequences; it is also fearing being unable to manage her emotions on her own. In the above quote, she is assuming that she needs professional assistance to engage with her emotions. The emphasis on trauma as a severe, inescapable condition creates a requirement for professional help to deal with assumed uncontrollable emotions to manage stress productively, avoid breakdowns, and optimize the future. This is an example of how psychological/psychiatric knowledge has constructed the mind as a brittle object that can easily shatter and have uncontrollable

consequences unless managed by professionals. As such, potential trauma requires professional supervision.

However, experts do not necessarily engage with emotions. A common feature regarding the treatment offered by health professionals is an emphasis on trauma symptoms and standardized treatment. One interviewee describes her therapy sessions as follows:

> The main focus was on techniques—what to do when you get those thoughts, and how, you know, get rid of those thoughts. I had to practice those techniques, but it was difficult to do on your own. Because you sit at home and you think, 'What did she say?' Then you look in your book.

The therapy sessions focus on self-help techniques that she can apply when she is alone. In this way, she can continue investing in her future, even when the therapy sessions come to an end. She continues, "We didn't really have much time together, so she didn't really know what had happened, you know, details and stuff. I told her what had happened, but we didn't really dig into it." Working with different techniques is also a way of avoiding to talk about the rape, which can be a relief for either one of them. Turning rape into trauma therefore facilitates treatment without ever talking about rape. According to Hacking (1991), introducing medical models can facilitate professional intervention in relation to issues no one wants to talk about.

When the interviewees talk about trauma as something they can develop if they do not pay attention to their health, they invoke the scale model that requires them to act prudently to take responsibility for their future and thus avoid breakdowns and becoming a liability to others and to society. They engage in various interventions facilitated by different experts and accordingly become entangled in a network of institutions and practices in an attempt to escape trauma. Furthermore, when the interviewees talk about trauma on a scale of normality

rather than in dichotomous terms, they have the opportunity to negotiate their position on the scale to escape the label of abnormality. Still, this model portrays the future as uncertain and the victims as vulnerable to future breakdowns. For this reason, they need to participate in the interventions they are offered to stay on the healthy path. In this way, recovery is a continuous doing rather than a distant end to be achieved.

Entangled in a network of institutions and practices of trauma interventions

The life sciences have contributed to developing knowledge about rape to facilitate recovery and legal redress. This knowledge constitutes a network of institutions and practices that brings together legal, medical, and psychological institutions and experts, as well as alternative experts and self-help organizations (Bumiller, 2008; Marriner, 2012; Quinlan, 2017; Mulla, 2014). This has created a hybrid field of knowledge about trauma in which trauma discourse is fused with alternative knowledge discourses and self-help practices. The trauma discourse shapes the ways in which people understand and conceptualize the impact of crime (McGarry and Walklate, 2015). The victims participating in this study who speak about trauma talk about it in two different ways: as something they resist or embrace (in dichotomous terms) and as something they can develop if they do not pay attention to their health (in terms of a scale). The dichotomous model is less prominent than the scale model, which suggests that traditional psychiatric/psychological discourses are challenged by hybrid health discourses.

Previous research on trauma has focused on and criticized the dichotomous model of trauma. The interviewees in this study who resist the trauma framework do so for the same reasons as already described in other studies—it makes little sense in their understanding of how the rape has affected their lives (Gavey and Schmidt, 2011; McGarry and Walklate, 2015). They reject the framework either because they consider themselves to be without trauma symptoms or because they want to resist psychiatric labels that they consider stigmatizing. Still, a few

embrace the trauma framework because they feel pain from an inner wound and struggle with daily chores. Accordingly, the trauma framework makes sense. Within this dichotomous model of trauma, trauma becomes real through symptoms, and recovery is an end to be achieved. Additionally, women diagnosed with other psychiatric diagnoses may desire to work with trauma specialists to be relieved from other psychiatric diagnoses and to be acknowledged as victims of rape. The medicalization of trauma, in this view, is a desired process not only because of how it can improve victims' mental health but also because it can contribute to acknowledging someone's victim status, although it simultaneously contributes to transforming a victim into a patient.

Most of the interviewees who reflect on trauma and their mental health, on the other hand, talk about it as something they can develop in the future if they do not pay attention to their health. This model portrays trauma on a scale of normality (Rose, 2001a; Sweet and Decoteau, 2018). As rape has become almost synonymous with trauma, the scale model offers victims agency because they can renegotiate their position on a scale of normality and escape trauma by participating in the various interventions offered by experts and institutions. Within this model, trauma becomes real through the threat of an uncertain future, and recovery becomes a continuous doing and not an end to be achieved. This model promises victims that they can escape trauma by investing in their future health. At the same time, the continued commitment to taking responsibility for their future health contributes to the construction of trauma as an inescapable vulnerability for victims of rape. In other words, trauma becomes inescapable through attempts to escape trauma. Rather than trusting their own knowledge of how they feel in the present time, they become entangled in expert discourses that reduce alternative avenues of personhood (Guilfoyle, 2013). Accordingly, both models of trauma create limited options for victims to understand the causes and consequences of victimization outside the purview of these expert discourses. However, some interviewees did not talk about

trauma according to either model, which suggests that some do escape the trauma discourse. In relation to previous criticism of the trauma discourse, this study shows that although an alternative model of trauma can allow victims to escape potentially stigmatizing labels of psychiatric diagnoses, as an expert discourse, it still shapes how victims make sense of victimization.

Marriner (2012) argues that medical knowledge regarding sexual assault permeates courtrooms and tends to be used against victims in family courts, mental health courts, and drug treatment courts. In her account, the expert can be located close to the victim, both inside and outside the courtroom. In Norway, trauma evidence is allowed in rape trials, which means that the expert will be close to the victim to secure evidence. The production of evidence presupposes victims who adopt the trauma discourse and comply with expert interventions. This has to be documented outside the courtroom before it is presented in court. Although expert knowledge in terms of trauma evidence has the potential to benefit victims' legal case, it still contributes to disciplining women, and it offers justice to women who manage to take responsibility for their health. In this way, Mulla's (2014) argument that medico-legal knowledge reshapes the relationship between care and investigation, as well as healing and justice, becomes evident.

Additionally, the trauma discourse reshapes the relationship between health care and crime control. The ways in which the scale model places the responsibility to heal on the victims parallels the responsibility placed on victims to avoid rape. Munro (2017) describes how police campaigns to prevent sexual assault in the UK encourage victims to avoid activities that make them more vulnerable to sexual assault, such as drinking too much or walking home alone at night. In this way, Munro contends that the police use the language of vulnerability to responsibilize and discipline women. This process of responsibilization is part of a new form of crime control that Garland (1996) has characterized as an adaption to failure

in which authorities focus increasingly on the effects of crime, rather than its causes. Within this view, the crime of rape is no longer a problem to be solved, but a problem to be managed. One way to manage rape is to make victims responsible for their own health. The scale model, with its emphasis on managing future health, thus fuses with crime control, such that it is no longer the causes of the crime that need to be treated (the pathological sex offender), but the effects of the crime that need to be managed (potential trauma victim). This study accordingly shows how new norms derived from biomedicine (Rose, 2001a), in the context of trauma, not only challenge the original structure of DSM (Sweet and Decoteau, 2018) but also contribute to a shift in responsibility from professional therapists to individual victims. How victims are responsibilized can further be interpreted as a way of managing the crime of rape.

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