



University for the Common Good

“Silly girls” and “nice young lads”: vilification and vindication in the perceptions of medico-legal practitioners in rape cases

McMillan, Lesley; White, Deborah

Published in:
Feminist Criminology

DOI:
[10.1177/1557085115578163](https://doi.org/10.1177/1557085115578163)

Publication date:
2015

Document Version
Peer reviewed version

[Link to publication in ResearchOnline](#)

Citation for published version (Harvard):
McMillan, L & White, D 2015, “Silly girls” and “nice young lads”: vilification and vindication in the perceptions of medico-legal practitioners in rape cases’, *Feminist Criminology*, vol. 10, no. 3, pp. 279-298.
<https://doi.org/10.1177/1557085115578163>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please view our takedown policy at <https://edshare.gcu.ac.uk/id/eprint/5179> for details of how to contact us.

‘SILLY GIRLS’ AND ‘NICE YOUNG LADS’: VILIFICATION AND VINDICATION IN
THE PERCEPTIONS OF MEDICO-LEGAL PRACTITIONERS IN RAPE CASES

Lesley McMillan

Professor of Sociology and Criminology

Glasgow Caledonian University

Cowcaddens Road

Glasgow

G4 0BA

Tel: +44(0)141 331 8284

Email: Lesley.McMillan@gcu.ac.uk

Deborah White

Associate Professor of Sociology

Trent University

Peterborough, Ontario

FUNDING

This research was supported by the Economic & Social Research Council (RES-061-23-0138-A).

KEY WORDS

rape, sexual assault, criminal justice, forensic evidence, medico-legal

ABSTRACT

In this paper we explore perceptions and presumptions in relation to rape, raped women and rapists, among medico-legal professionals who perform forensic medical examinations in rape cases. We draw upon data from in-depth interviews conducted with Forensic Medical Examiners and Forensic Nurse Practitioners in one area of England. Findings reveal that many of these personnel hold particular views centred broadly on the vilification of victims and the vindication of perpetrators. We conclude that these perceptions and presumptions may hold concerning implications for both victim experiences and evidentiary and judicial outcomes.

AUTOBIOGRAPHICAL STATEMENT

Lesley McMillan is Professor of Criminology and Sociology at Glasgow Caledonian University. Her research interests include violence against women and rape and sexual assault in particular. She conducts research on the criminal justice response to rape and sexual assault, investigative and prosecutorial practices and the use of medico-legal evidence.

Deborah White is an Associate Professor of Sociology at Trent University. Her research interests include the medico-legal responses to sexual assault, the social production of scientific/medical and forensic evidence and expertise, and cultural and gender regulation.

INTRODUCTION

Following years of feminist efforts and campaigns addressing sexual violence and the failure of states to adequately respond, the rape of women is still prevalent across the globe (Htun & Weldon, 2012; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; UNICEF, 1997). Despite some successes resulting in significant legal and procedural reform (McMillan, 2007; Corrigan, 2013) and generally improved institutional processing of rape cases in many jurisdictions, judicial outcomes remain poor with low conviction rates and high levels of case loss (attrition) (Harris & Grace, 1999; Lea, Lanvers & Shaw, 2003; McMillan, 2010; 2011). In trying to account for the lack of justice for raped women, a great deal of research has been conducted on the policies and practices of legal and law enforcement professionals, examining the ways in which these may serve as barriers for those navigating criminal justice systems (see for example Jordan, 2001, 2004; Kelly, Lovett & Regan, 2005; McMillan, 2010; Temkin 1997, 1999; Temkin & Krahe, 2008). It has also been shown that the attitudes and beliefs held by criminal justice personnel can influence women’s post-assault experiences and frequent inclinations to drop out of the process, thereby determining the fate of their cases.

With respect to attrition, the majority of rape cases are lost at the early investigative stages of the justice process (Harris & Grace, 1999; Lea et al., 2003; McMillan, 2010) as a result of victim withdrawal, as well as decisions by police that certain cases are problematic or false. Some research has demonstrated the perpetuation of certain stereotypes among police officers (Temkin, 1997, 1999; Kelly et al. 2005; McMillan; 2010) and “a culture of suspicion” found even in those who are specialists in rape allegations (Kelly et al., 2005, p.51). Lea et al. (2003) reported that whilst many officers were sympathetic to rape victims there was still evidence to suggest that a number held what the authors called ‘traditional

views’ of rape and rape victims and these officers were inclined to more frequently suspect false allegations and/or attempts to seek attention. These findings are particularly notable as sensitive and sympathetic handling of cases is vital to women’s experience of reporting rape and likely to influence whether or not they choose to withdraw from the legal process (Jordan, 2001; Kelly et al., 2005; McMillan & Thomas, 2009; Temkin, 1997; 1999). This underscores the significance of the initial institutional phase for both victim experience and case outcome, and reinforces the need for research into the actors involved at this point.

The Forensic Medical Examination

A key component of the early investigative stage is the forensic medical examination. The purpose of the examination is two-fold: evidence collection from the victim’s body, which may take the form of observation of anogenital and extragenital injuries, collection of swabs and specimens (including semen, sperm, urine and blood); and health care for the victim (Du Mont & White 2007; Mulla, 2011). Medico-legal evidence is used as a means of corroborating a victim’s account of a sexual assault (Du Mont & White 2007). It may be employed to determine the use of force, identity of an assailant, resistance, recent sexual activity, and the inability to consent to such sexual activity due to incapacitation through substance consumption. While practices may vary, the documentation and bodily evidence collected are typically sealed and given to police for possible use by investigators and prosecutors should the case move forward. The common belief is that this evidence can be instrumental in determining judicial outcomes (United States Department of Justice, 2013).

Historically, the forensic medical examination was seen largely as a means of collecting evidence for the justice process, and the care of victims was not a key priority. However, as a result of feminist critique over the last several decades that challenged the response given to rape victims in many locations, the scope and nature of the forensic

medical examination has changed to often incorporate both evidence collection for investigation and prosecution, and the care and medical treatment of the rape complainant (Du Mont & White 2007; Rees, 2010). As such, the role of the forensic medical professional is generally regarded as a dual one. For some this has resulted in a tension arising from the contradiction inherent in simultaneously ‘objectively’ gathering evidence and caring for and supporting the complainant (Du Mont & Parnis, 2000, 2001; Parnis & Du Mont, 2002, 2006; Kelly, Moon, Savage & Bradshaw, 1996; Kelly Moon, Bradshaw & Savage, 1998; Rees, 2010; Savage et al, 1997).

In England, where the research discussed in this paper was carried out, the organisation of forensic medical services has historically been the responsibility of police rather than health care. Traditionally, doctors were contracted by police to carry out examinations which largely prioritised the forensic aspect over the medical or care elements (Pillai & Paul, 2006). Early studies of forensic intervention in England in the 1980s revealed several problems with this approach, including a large number of examinations being conducted in police stations rather than specialist suites or health-care settings, a shortage of female physicians, and the frequently insensitive manner of the attending physician (Corbett, 1987; Women’s National Commission, 1985). Later, Gregory & Lees (1999) and Temkin (1996) highlighted victims’ negative experiences of the forensic examination process, particularly around the insensitivity of male doctors.

In 2002, a joint inspection of Her Majesty’s Crown Prosecution Service Inspectorate and Her Majesty’s Inspectorate of Constabulary revealed that whilst some improvements had been made, problems remained with the availability of female physicians, high variability in training standards with many receiving no formal training, disharmony in the professional relationships between police and physicians, difficulty retaining physicians (especially women), and a ‘less than sensitive’ approach to victims among a minority of physicians,

which led to some victims withdrawing their participation in the investigation (HMCPSI & HMIC, 2002: 23). Their subsequent report (HMCPSI & HMIC, 2007) raised similar concerns around poor availability of physicians and the lack of consistency in how they are employed, varying levels of expertise and services for victims, and a growing trend towards private outsourcing. With respect to training of forensic physicians there has been no consistent approach, and as such standards have been changeable. Whilst the HMCPSI & HMIC report of 2002 recommended training to the level of the Diploma in Medical Jurisprudence, the 2007 follow-up report showed little evidence that this had occurred.

Mary Pillai & Sheila Paul (2006) discussed the variations in service delivery in England in 2005, highlighting the geographical disparity in services offered to victims where some had access to a ‘one-stop shop’ Sexual Assault Referral Centre (SARC) model designed to cater for victims’ forensic, medical and support needs, and others relied on the traditional model of police delivery. SARCs, introduced to address many of the criticisms noted above, were intended to offer victims services such as testing for sexually transmitted infections and pregnancy, antibiotic or HIV prophylaxis, Hepatitis B vaccination, access to counselling and support, and the opportunity to access services without police involvement wherein they could participate in an examination and have samples retrieved and deep frozen whilst they deciding whether to proceed with a complaint to the police (Pillai & Paul, 2006; see also Lovett, Regan & Kelly, 2005). SARC provision, however, was slow to develop across England. By 2005 there were 13 SARC services, and 58 non-SARC services (Pillai & Paul, 2006). With respect to the area in England in which this exploratory study was undertaken, the forensic medical examinations did not take place in the context of a ‘one stop shop’ model of the SARC, but followed the more traditional methods of delivery and were conducted by commissioned doctors (Forensic Medical Examiners, sometimes referred to as

‘police surgeons’) and nurses (Forensic Nurse Practitioners) under the authority of the police, in police suites (Pillai & Paul, 2006).

In contrast to the increasing body of research on police, with very few exceptions (see for example Cowley, Walsh & Horrocks, 2014; Rees, 2010, 2011; Savage, 1997), those involved in forensic medical intervention in rape cases (outside of the North American Sexual Assault Nurse Examiner (SANE) model) have garnered relatively little research attention. Whilst previous studies have highlighted the insensitivity of some forensic physicians and its impact on victims, this has largely been focussed on victim accounts of the process rather than research directly with FMEs on their attitudes and perceptions. This lack of research on forensic medical personnel is surprising given the thorough institutionalisation of the forensic medical examination in many criminal justice systems (Du Mont, White & McGregor, 2009). It is also surprising given that the forensic medical examination is a key point in the post-assault processing of rape cases and could be considered part of the policing stage of the investigation and prosecution of rape and sexual assault, and the point at which most case attrition occurs. In light of how intimate, intense and important the examination is for victims and their cases, and the dual-role undertaken by practitioners, we explore the perceptions and presumptions of medico-legal personnel in this particular delivery context, and consider how they might shape both victim experience and outcomes.

METHOD

We draw upon data from a larger study funded by the Economic & Social Research Council (RES-061-23-0138-A) of the United Kingdom which investigated factors influencing attrition in rape cases. The overall study had a number of research aims, one of which was to determine the extent to which commonly held beliefs about rape may be prevalent in the criminal justice system. Forensic medical personnel were included in this aspect of the

research and this paper details those findings. The research took a case study approach and as such all data for the study was collected in one English county. It was a large mixed methods study and data presented here comes from one facet of the project; in-depth qualitative interviews conducted with Forensic Medical Examiners (FMEs) (physicians) and Forensic Nurse Practitioners (FNPs) (nurses) that were conducted in 2009-10. Ethical approval for the project was granted by the university ethics committee. Details of the overall project are available in McMillan (2010).

Given the project’s overall case study design, criteria for inclusion in the research were all those employed as either an FME or FNP within the county in question who regularly conduct forensic medical examinations of rape complainants. All respondents were employed by the same private provider of forensic medical provision for the police force in question, which included delivery of all forensic medical services. A list of all FMEs (10) and FNPs (19) employed was supplied by the Head Forensic Medical Examiner. Each FME and FNP on the list was contacted via email and asked to participate in an in-depth interview. Excluding those who did not respond, could not participate within the time-frame of the study, or who had not had recent experience with sexual assault cases, our final sample totaled eleven, four FMEs and seven FNPs. All of the FNPs were female, and of the FMEs, three were male and one was female. In terms of experience, the FMEs had been performing the role from between three and eighteen years, and the nurses ranged in experience from between five and seven years.

Interviews took place in private locations in police stations, forensic medical suites, and a private home. They took a semi-structured approach and lasted between approximately one and two hours and each was recorded and transcribed verbatim. Interviews covered a range of topics in line with the broader research aims of the project, including: background; work patterns; the examination; facilities and equipment; forensic evidence; types of cases;

relationship with other criminal justice agents; court; conviction rates; training; and feelings about the work. Taking an inductive approach, data were analysed systematically by both authors who individually read and reread the transcripts and then separately developed analytic themes based on the data. These themes were then compared and discussed and subsequently refined, revised and developed resulting in an overarching conceptual framework centred on the perceptions and presumptions of forensic medical personnel in this setting, in relation to three distinct analytic categories: rape; raped women; rapists. All references in the data to these categories were identified and analysed systematically to establish patterns. The findings below are presented according to these three categories.

FINDINGS

Context

In order to provide context to what we would learn about the perceptions of the forensic medical staff interviewed, we wanted to establish some understanding of their motivations for going into this line of work and a sense of how they perceived the nature of this dual medical and forensic role. We found that among the 11 participants interviewed for this study, almost all had chosen to move into these positions for personal logistical and career reasons. For some, especially the nurse practitioners, a greater degree of autonomy, increased pay and schedule flexibility were the primary attractions. For the forensic medical examiners, it appeared that motivation towards this type of work largely concerned professional development based on expanding experience and skills sets in a new area. This stands in contrast to the care-giving, advocacy-oriented and often feminist ethos embedded in the work conducted by other medico-legal professionals such as some SANEs (see Campbell, Patterson & Lichty, 2005; Du Mont & Parnis, 2003).

With respect to the nature of the dual-role of a forensic medical examiner or nurse practitioner, as discussed above, we found throughout our interviews that while some did note a degree of tension between these two dimensions, they generally perceived their main purpose and top priority to be evidence collection. There were a number of staff who certainly expressed the need for caring attention towards victims and who seemed to have compassion for them in most circumstances, but, the formal evidentiary role was unquestionably considered to be the central purpose of their work. Additionally, unlike the emotional impact reported by others working in sexual assault intervention (McMillan, 2004, 2007; Wasco & Campbell, 2002; Wies & Coy, 2003), only a few indicated that they found this job emotionally challenging. This, however, does not preclude the fact that several expressed an awareness of the difficult nature of the examination process for victims.

Perceptions and Presumptions (1): Rape

There exists a substantial body of social science and feminist literature outlining traditionally pervasive assumptions regarding what a ‘real rape’ is (Estrich, 1987). These beliefs are based on rape scenarios typically played out as violent acts causing physical damage mostly committed by strangers (Du Mont, Miller & Myhr, 2003; Du Mont & White, 2007; Kelly et al., 2005). Whilst generally speaking interviewees recognized the many forms that sexual violence may take, and did typically acknowledge the rarity of unknown assailant assaults, they tended to view those that conformed to the stereotypical interpretation of a ‘legitimate rape’ (stranger based, violent and injurious) as both more serious and clear-cut. For example, one FNP observed in relation to a particular case:

... we couldn’t put a proctoscope in she was so tender, ... so obviously something had happened ... and that was a stranger assault, and I felt she was genuine (FNP1)

Two others similarly commented:

In all the time that I did rape examinations, I think I saw three that were what I would consider real rape allegations, one girl ... was walking home at half past two and she was dragged into an alleyway by a stranger and raped ... it was very traumatic ...

What I mean is that [in these cases] they actually, were going home, were going about their business and were just dragged literally off the road into an alley and raped, they weren't at a party, they weren't drinking alcohol, they weren't with somebody they knew ... (FNP6)

... I remember one ... and she had injuries, and she was very believable ... and [she] came into court, and nice girl, petrified, absolutely petrified, and I thought no they have to [convict], the injuries and everything (FNP2)

Another conveyed her perception of a ‘real case’ of rape in the following way:

Well, not silly girls getting drunk and getting caught by their boyfriends or parents and therefore calling rape ... I've done two victims that were obviously very serious stranger violent rapes... [and one of them] ... where she was dragged into the bushes ... (FNP4)

These beliefs about the circumstances of a ‘real rape’ stand in contrast to the well-documented realities of how most occur. Sexual assaults are overwhelmingly committed by someone known to victims rather than by strangers (Greenfield, 1997; Harris & Grace, 1999; Kelly & Regan, 2003; Koss, 1993; Koss & Heslet, 1992; Lievore, 2004; Tjaden & Thoennes, 2006; Stermac, Du Mont & Dunn, 1998) and even in the project from which this data comes, 89.6% of reported rapes involved a known assailant (McMillan, 2010). Moreover, such

violations are generally carried out primarily through force and threat, and thus typically leave few or no physical markings on a woman’s body (Gray-Eurom et al., 2002; White & McLean 2006; Wiley, Sugar, Fine & Eckhart, 2003, see also Du Mont & White 2007).

Further, despite the fact rape and sexual assault in most regions of the industrialized world are defined as more than just penile penetration of the vagina (see Du Mont & White, 2007), a number of statements made by practitioners and examiners revealed an apparent lack of awareness or acceptance of such legal and formal definitions¹, erroneously reducing rape to penile penetration of the vagina. For example, in response to the interviewer’s question regarding her thoughts on what defines rape, FME1 responded:

It’s any penis entering the vagina where it’s not welcome ... (FME1)

This was echoed by others. One FME, who had reflected that the regular gynaecological training he had received in his medical career was essentially what was required to take on forensic medical examinations, responded to a query about what a normal or ‘ordinary’ rape case would be stating:

vaginal penetration of some sort without an object . . . (FME2)

This kind of interpretation risks both invalidating women’s experience of rape, and as suggested in the following claim by an FME, may alter the extent and nature of evidence collection in a given case:

...sometimes we deal with, not with full rapes just sexual assault, which is different, different nature ... so certain questions you don’t have to ask ...and you also perform less in terms of obtaining evidence (FME4)

In relation to the “minimization or rationalization of sexual violence” that has been identified as one of the many historic and contemporary attitudes towards rape (Edwards, Turchik, Dardis, Reynolds & Gidycz, 2011), there appeared to be a degree of trivialization

and ambiguity regarding sexual violence against women. Indicators of this tendency were interspersed throughout much of the discourse arising in the interviews, such as in this comment:

... everyone has their own idea of what rape is, the law is very precise, but ... you could say it's like a lot of things ... it's in the eye of the beholder isn't it? (FME2)

One FNP seemed to represent the strongest sense of the minimization of rape:

I don't get so upset about the rapes, because rapes and murder I see as human nature, ... I get much more upset by the 9 year olds beating up grandfathers and telling elders to fuck off, because that is a breakdown of society I don't mean that I think rape is like going shopping, but I'm not greatly shocked by rape because it's a failing of human nature since the caves, rape, it's not a new thing, it's not a society thing, it's a bestial thing, that's why it's a commandment, because it's genetic, I think to leap over to the next field and fuck the next chief's wife, and that's not new, I'm not saying that that makes it ok, but it's not kind of oh my god that's terrible, it's like, well things happen ... (FNP4)

Perceptions and Presumptions (2): Raped Women

We found some congruence between FNP and FME perceptions of rape and those they harboured about victims, particularly in terms of the long-held and ubiquitous notions that: a) women lie about rape (see Edwards, et al. 2011; McMillan, 2011; Rees & White, 2012) and, b) women are responsible for their rapes (Comack & Peter, 2005; Randall, 2010; Rees & White, 2012). One of the longest standing fictions is that women are not truthful about rape, whether out of fear or for vengeance (Rees & White, 2012). The cultural mistrust surrounding those who claim rape is firmly embedded. Even the existence of forensic medical examinations and corroborative evidence collection from women's bodies by medical and

scientific ‘experts’ is a test of their veracity (Corrigan, 2013; Parnis & Du Mont, 1999). Such mistrust was evident among the interviewees in this study:

. . . probably about 50% I’d say who have gone out for the evening, who may have had consensual sex, but then either not remembered or thought they’d be in trouble because this isn’t my partner and I need to get out of it . . . I think once they start the ball rolling sometimes they’ve got to save face haven’t they with their partner. . . [and] you think the amount of money it costs to do an examination when it’s just nothing’s going to come of it because it’s all lies (FNP1)

. . .they’ve put themselves in the situation and quite often, . . .got off with this bloke, woke up the next morning, wasn’t her boyfriend, and how can I get round this, I know, I’ll say I was raped. . .I would say probably half. . .[the women] have put themselves [in this] (FNP2)

[seeing a woman] six months after she’s been through a rape process and asking her with hindsight, was it rape, is of no value, because her answer is going to be so contained by her own thoughts and values and ideas, you don’t know what the objective truth is (FME2)

. . .silly little girls that have been caught. . .out by daddy, or caught out by a boyfriend, so I think they were consensual sexual episodes and the rape was a cover . . . I mean it’s all kind of my own conjecture really but I’ve probably done about 100 rape cases and I think maybe 5 of those were real (FNP4)

I think quite a lot of them are, I wouldn't say made up, but they've made a mistake and they may have said [they were raped] (FNP3)

...young women may have had too much to drink, and have found themselves having sex without consent, and then afterwards in the cold light of day oh my god what have I done (FNP5)

...and we need to accept the fact that many of the cases are false allegations, some of them are due to the fact that ... perhaps [the] young person wants to redirect the anger of the family and society from themselves for their behavior they were part of, to another person, because of drinking, because of drugs, and because of being found by other people in such circumstances (FME4)

There is, it would seem, a notable disjuncture between these views and the extant research data that indicate that across many regions roughly two per cent of all claims of sexual violence are false (see Rees & White, 2012). Even the overall project of which this data is part, showed that in the location within which the interviewed practitioners and examiners were working, only 3.9% of rape allegations were established as false (McMillan, 2010; McMillan, 2011).

Beyond this pervasive sense of disbelief of women claiming rape, in those instances in which the FNPs and FMEs did assume that a sexual assault had in fact taken place, there was frequent insinuation that the women themselves could be understood as at least partially culpable in precipitating the violence:

[the women] in society at the moment,...they go out to get drunk in a way that previous generations perhaps didn't, and yet they want all their rights, but they made

themselves more vulnerable . . .[and] the vast majority of cases . . . it’s sort of his word against hers . . . and something’s happened that was fairly unpleasant to the woman and she will have to come to terms with a degree of responsibility because she has had alcohol, but I’m saying to them no no carry on with your social life, don’t let what’s happened and the unpleasantness and what this has left you with stop you from getting on with a normal cheerful life (FME1)

I think it has to start with people taking more responsibility beforehand with the drink and stuff, because . . .you just put yourself in such a vulnerable situation . . .I think education needs to start with the victims (FNP2)

So if my daughter comes home and says oh bastard I got drunk and he took advantage of me, I would probably say well you’d better go and give him a slap, and tell him and tell your friends and learn from the experience, would I tell her to go to the police no . . .because it makes her a victim, instead of being silly and then learning from a mistake, it makes for a victim (FME2)

. . .because you do get a lot of attention if you cry rape . . .but being the kind of person I am I just think you should control your life a bit better (FNP4)

Sometimes they [the victims] have a tendency to minimize their part in the case, perhaps their behavior led to the offence (FME4)

Another FNP more sympathetic towards victims nonetheless appeared to assume that responsibility rested with the victim to control the situation:

How it happened, in the middle of a field, I was drunk, and I was taken to this field, and he had sex with me, that’s all they’d say, and I don’t know, sometimes you just think why did you let them, but people, you can’t stop them sometimes and it was just sort of nice people it happens to, that don’t want to, can’t say no, they’re too worried, frightened to say no, they just sort of want to please the person or whatever but they don’t really want to do it, I don’t know, I don’t understand (FNP 7)

Such interpretations correspond with those pervading the general population (Amnesty International UK, 2005), and popular (e.g. Edwards et al., 2011; Rees & White, 2012) and legal cultures (e.g. Jordan, 2004). Lise Gotell (2007-8) for instance, has theorized the “ideal” victim as she who is responsible for her own safety from sexual assault. These perceptions embody both the more traditional notions about raped women and their behaviours that some would claim as ‘enticing’ (e.g. Du Mont & Parnis, 1999), as well as more contemporary discourses revolving around a woman’s responsibility for actively ensuring her safety. “The ideal is then compared to women who are portrayed as not appreciating the sexual risks inherent in social situations through their own fault, so are seen as behaving stupidly and dangerously. [They] have moved from ‘asking for it’ through [their] behaviour and manner of dress to being viewed as responsible for [their] attacks if [they] have not displayed proper caution” (Derynck, 2009, p.113). More specifically, in terms of alcohol consumption and responsibility, a topic the interviewees referred to frequently, Emily Finch and Vanessa Munro (2007) conducted mock jury studies which revealed that participants believed complainants to be if not fully, then at least partially responsible for being sexually assaulted, a finding reflected in other research (Horvath & Brown, 2007; Maier, 2008; Richardson & Campbell, 1982). Thus, those interviewed in this study did not

diverge widely from the attitudes about victimized women that are held across other dimensions of post-assault case processing and the culture in general.

Whilst it was the case that interviewees did at times express non-judgmental and caring sentiments towards the women to whom they had attended more often than not these also reflected judgments of supposed ‘good character’, as demonstrated by language such as:

demure; she was very together ... competent, very calm (FME1)

that she was 80 odd and ... very stoical lady, [but] ... you don’t want to think that something like that happened (FNP3)

I think one of the first cases I did was like one of the serious ladies, so ... I want to treat them well (FNP4).

Perceptions and Presumptions (3): Rapists

Consistent with the problematic perceptions of both rape and raped women, stereotypical beliefs about rapists often revolve around the notions that men have an uncontrollable sex drive (Burt, 1980; Bohner, Eyssele, Pina, Siebler & Viki, 2009; Moore & Rosenthal, 1992, Richardson, 1996), that allegations of rape may have grave and unfair consequences for men, and a discourse that supports “perpetrator absolution” (Edwards, et al., 2011).

As is evidenced in the excerpts below, some respondents expressed views suggesting that rape is both biologically determined and inevitable, appearing to absolve men of responsibility for their actions:

...there’s something missing when effectively the woman has contributed inadvertently to putting herself in an unsafe situation, and the male sex drive is

something that is, it’s almost a taboo subject to acknowledge that men have a sex drive that has got, you know has led to us all being here really, isn’t it? (FME1)

...but sometimes ...they may be in the middle of having intercourse and suddenly they say no, I mean there is the point of no return with some, with men, there’s nothing they can do about it . . . And some of these girls have made it up and you think they’ve ruined these people’s [men’s] lives (FNP1)

Further, comments made by certain forensic medical staff coincide with their assumption that the claims of many women are false. Some expressed a level of concern about the consequences of a rape allegation for the suspect, one rarely stated in relation to the victim. In particular, an evident theme was the notion that men’s lives would be “ruined” by, at best, mistaken women, and worst, vindictive women:

...and what annoys me about the whole system ... is the fact that the suspect is named, I find that so wrong...because their whole life is ruined whether they’re found guilty or not, they are named and the victim is not named (FNP2)

I’m worried about that somebody might get done for it who isn’t really guilty, now I’m not saying he’s not guilty, I’m not saying that at all, but there’s so much doubt there...and what if he had been sent down and he hadn’t done it or it had been consensual, I mean it ruins his life completely and others as well (FNP6)

Given their scenarios of real rapes and victims, interviewee perceptions of the majority of men, both accused and convicted, were often very sympathetic in nature, depicting them less as true rapists and more as maligned males. Even when respondents

indicated a clear belief in a man’s guilt, they frequently expressed a sense of what we describe as ‘sympathetic vindication’:

[in a case where the man was convicted] you know the whole thing was a total cock up and yet he was the person that got a 7 year sentence for rape, and that’s because his sex drive had overridden whatever else within the relationship, ...I think he thought if he could get it in there and get on with it they would relate better, a horrible cock up, but you know just ghastly, but I don’t think he was a rapist, and yet that’s what he’s labeled as for the rest of his life and the life he’s ruined (FME1)

is it rape in the sense that the vast majority of the country would ever agree, probably not, would a jury convict on that, no they bloody wouldn’t, do you want to put some nice young lad on the sex offender’s register for the rest of his life because he had sex with somebody who fell asleep half way through (FME2)

... but the truth was, he was out for a lads night out, he was horny and he wanted to have sex and he was intoxicated and he behaved irresponsibly and loutishly ... I think he was guilty as hell, I think [he] regretted terribly what he did, genuinely, I think he in the cold light of day being sober, thought Jesus I can’t believe I did that, and I don’t know, how many of us have been near that situation before, I don’t know, I mean obviously not to the point of committing sexual offences, but you know you think of the odd party when you were younger, you think oh my god you know, where you may or may not have been overstepping the mark, or sort of coming close, so did he deserve, the question is, was he guilty, probably ...[but] does he need to go in prison for 10 years and have his entire future wrecked, never become a lawyer, or has he learnt from the mistake, so he gets off, thank god for that ... (FME3)

We noted that the instances in which this sympathetic vindication was expressed generally involved cases of known assailants, this was not necessarily the same expression made for those fitting the stereotypical stranger rapist:

... she didn't know him, she didn't want to have a conversation with him, he was a builder in dirty clothes, he was foreign, she didn't know him, she was very frightened, so all that recorded as to what was happening mentally which I would have thought would be convincing to the jury that this was a situation she did not want to be in, this was not consenting, and that he smelt, he smelt sort of garlicky and unpleasant and sweaty and nasty, and he had sex with her, they found him not guilty. So even the very convincing cases where you know, it doesn't work, because the jury can make the choice (FME1)

Across these interviews with FMEs and FNPs who had indicated having taken on sexual violence forensic examination work largely for personal and professional reasons, there was a striking consistency in their responses to questions pertaining to all three analytic categories. We found that the perceptions and presumptions regarding raped women, rape and rapists, with some exceptions, generally reflected the anti-woman biases and stereotypical understandings of rape that have long permeated criminal justice systems and wider cultures.

CONCLUSION

As part of the broader project focused on establishing those factors that influence rape case attrition, the aim of this paper was to explore one aspect of post-assault institutional intervention; that is the perceptions and presumptions of those who conduct forensic medical examinations. Whilst a notable body of literature exists regarding the nature and impact of

police attitudes on both rape case attrition and victim experience, very little is known about forensic medical personnel in this particular mode of delivery. In underscoring that the assumed standardized forensic medical examination process is in fact highly subjective and variable, what was remarkable was the extent to which, across all three analytic categories – rape, rape victims and rapists - the views of these professionals were largely reflective of rape mythology (Du Mont et al., 2003; Edwards et al., 2011). It was empirically evident that there was a tendency amongst many of these forensic medical examiners and nurses to vilify many of the women who reported rape, and in turn often vindicate those suspected, accused and convicted. Whilst it may not bear directly on such attitudes, it is worthy of note that the FMEs and FNPs in this study also collect forensic medical evidence from suspects. Moreover, not only did their interpretations of what a ‘real rape’ is frequently corresponded with erroneous and stereotypical understandings, they contrasted with the predominant realities presented by the women they saw and documented in the literature.

We posit that the harboring of such perceptions can lead to a ‘culture of mistrust’ within the forensic medical context. Some research conducted in both legal and extra-legal settings has shown the importance to victims of non-judgmental supportive care (Campbell, 2004; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Kelly & Regan, 2003; McMillan & Thomas, 2009; Patterson 2011; Temkin, 1996). Studies undertaken on forensic and health care delivery models and their corresponding discourses such as SANEs and SARCs indicate that this type of care is highly valued and frequently implemented, a reality that contrasts starkly with what was found in this research. For instance, it has been demonstrated that whilst some women have found the forensic medical examination itself difficult, one of the key factors influencing their satisfaction has been the positive role of supportive forensic medical staff. In one study in another jurisdiction, respondents reported personnel being “very understanding” and highlighted the value of being treated non-judgmentally and given

the time and attention their circumstances warranted (Du Mont et al., 2009) (see also Campbell, 2004; Campbell et al., 2005; Lovett, Regan & Kelly, 2005). We are not necessarily arguing that SANE and SARC models are the solution, and would suggest it cannot be assumed that those working in such models necessarily hold more progressive views about rape. We argue that the realities of the types of biases among attending physicians and nurses we have found in our research need to be addressed wherever they manifest, irrespective of the model of delivery.

In light of our findings that suggest a generally less than supportive culture and environment, we put forward a number of possible implications with respect to victim experience and case attrition. Firstly, there is a likely impact for the individual woman, her well-being and future help-seeking and/or disclosure. When criminal justice personnel make judgements about women who are raped, there may be a tendency to convey, either explicitly or implicitly, that they believe their behaviour may have been questionable (Frohmann, 1991, 1997, 1998; Kerstetter, 1990; LaFree, 1989; Spohn, Beichner & Davis-Frenzel, 2001). We suggest that there is potential that such judgments were conveyed to women they examined through word, gesture or tone, and in doing so may have contributed to a culture of mistrust. Given that more positive perceptions can be communicated to, and perceived by, victims as documented in literature (Du Mont et al., 2009; Campbell, 2004; Campbell et al., 2005), we have no reason to expect that more problematic ones are any different. Further, previous research has highlighted that many women have difficulty naming their assaults as rape (Kelly, 1988; McMillan, 2013) and often experience significant feelings of guilt, shame and embarrassment, particularly when disclosing details of the assault (McMillan, 2013), a key aspect of the forensic medical examination. The response of professionals in any context has the power to support women in appropriately naming sexually violent experiences, and to either mitigate or reinforce such feelings. If forensic medical personnel hold problematic

perceptions they may compound the impact of trauma and associated psychological sequelae (Du Mont & White, 2007). Further, McMillan (2013) has argued that poor experiences may make disclosure to helping professionals in, for example, the mental and physical health areas, less likely, especially so for women who are otherwise vulnerable or marginalised and disproportionately represented among those who report rape (McMillan, 2013; Stanko & Williams, 2009).

Secondly, we suggest this culture of mistrust may play a role in the attrition process in two notable ways. Given that a considerable proportion of rape reporters withdraw themselves from the system (Frazier & Haney, 1996; McMillan, 2010; Spohn et al., 2001) and that a negative experience of the criminal justice system influences victim withdrawal (Jordan, 2001; Kelly et al., 2005; Temkin, 1997, 1999), it is reasonable to proffer that problematic beliefs such as those demonstrated by some of the participants in this study, could represent one contributing factor. Further research interviewing women about their experiences of the forensic medical examination and examiners in this and other jurisdictions could be valuable in understanding what may or may not be communicated and any subsequent impact on victim participation.

If there is not sufficient evidence, or evidence of sufficient quality in any given rape case, then the case is likely to be dropped by the police or prosecutors. In this regard, forensic medical personnel play a key role in the evidentiary process and can, through discretionary practices and behaviors, shape evidence in particular ways through what is both collected and documented (Parnis & Du Mont, 2006). It is our contention that if disclosure is problematic for a victim in a milieu of suspicion and skepticism this may limit the details provided with respect to her sexual assault, and in turn affect what evidence is or is not collected for legal processing. This may further lead to inconsistencies in accounts a woman relays to other professionals, such as the police, with whom she may feel more comfortable. It has been

shown that victim inconsistencies can undermine victim credibility, which is often critical in criminal justice decision making and outcomes (McMillan & Thomas, 2009). Moreover, even in the rare instance in which a woman’s case may advance to the point of court, the medical evidence presented (or not) and especially the testimonies to that evidence of forensic medical examiners with such biased assumptions could well contradict and thusly undermine the narrative the victim herself has presented throughout the criminal justice process (see, for example, Parnis & Du Mont, 2006).

The ontology of rape demonstrated by most of the examiners and practitioners interviewed, appeared to play a role in their epistemological practices. This manifested itself with respect to the nature and extent of the evidence they chose to collect. The perceptions of rape and sexual assault held by forensic professionals may circumscribe their evidentiary processes and procedures, thereby shaping outcomes in particular ways. It is clear that in this critical stage of post-assault intervention it is largely the complainants who are vilified and the accused vindicated which may have serious implications for both victim experience and potential case attrition.

The findings of the study are concerning but caution should be advised in extrapolating to the professional body of FMEs and FNPs as a whole. Further research is needed on a wider cohort of this professional group to establish not only particular perceptions and presumptions but the relationship of these to practices and the extent to which they may impact on both victim experience and case outcome. We recognize that efforts to improve this type of intervention are underway in many jurisdictions. In England there has been a commitment from the Home Office and the Department of Health to move to a different model of delivery and establish a Sexual Assault Referral Centre (SARC) in each police force area, which would provide a ‘one stop shop’ and allow victims access to support services beyond the criminal justice process and meet their medical and legal needs (Lovett et

al, 2004). At present there are currently 25% fewer SARCs than the number originally proposed (Cowley, Walsh & Horrocks, 2014). It is also the case that some SARCs are commissioning services from private providers. While the move to SARCs could be positive for victim experience on the whole, we question whether just a different model of delivery is enough if some of the personnel conducting examinations hold these problematic views about rape, raped women and rapists. Further, the findings of the research are also of interest to other jurisdictions where an increased use of private service providers is also underway, for example in some part of the United States. We argue that the perceptions of staff delivering such an intimate and sensitive intervention, which has the capacity to affect the progression of a victim’s case, should be of primary concern irrespective of the model of delivery or the funding structure. We would suggest that all models of delivery incorporate three key elements to ensure this is less likely, i) rigorous personnel selection methods to ensure those recruited to perform examinations hold more progressive views about sexual violence, ii) comprehensive sensitivity training, and iii) regular monitoring of victims’ experience of the examination. Forensic medical examiners, like police, play a significant role as ‘gatekeepers’ to the criminal justice system (Kersetter, 1990; McMillan & Thomas, 2009). It is essential that their biases in evidence collection are minimized and their unconditional support for victims throughout the process optimized.

NOTES

¹ For clarity, the current legal definition of rape in England is penile penetration of the vagina, mouth or anus. Penetration of the vagina, anus or mouth by any part of the body other than a penis, or by an object, is charged as Assault by Penetration (Sexual Offences Act, 2003 (c.42) see http://www.legislation.gov.uk/ukpga/2003/42/pdfs/ukpga_20030042_en.pdf).

REFERENCES

- Amnesty International UK. (2005). *Sexual assault research summary report*. London: Amnesty International United Kingdom.
- Bohner, G., Eyssel, F., Pina, A., Siebler, F., & Viki, G. T. (2009). Rape myth acceptance: Cognitive, affective, and behavioural effects of beliefs that blame the victim and exonerate the perpetrator. In M. A. H. Horvath & J. M. Brown (Eds.), *Rape: Challenging contemporary thinking* (pp. 17-45). Cullompton: Willan.
- Burt, M. (1980). Cultural myths and supports for rape. *Journal of Personality & Social Psychology*, 38(2), 217-30.
- Campbell, R. (2004, November). *The Effectiveness of Sexual Assault Nurse Examiner Programs*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Retrieved 17/06/2014, from: <http://www.vawnet.org>
- Campbell, R., Patterson, D. & Lichty, L.F. (2005). The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: A review of psychological, medical, legal and community outcomes. *Trauma, Violence and Abuse*, 6(4), 313-29.
- Campbell, R., Townsend, S.M., Long, S.M., Kinnison, K.E., Pulley, E.M., S. Bibiana Adames, S.B. and Wasco, S.M. (2005). Organizational characteristics of sexual assault nurse examiner programs: Results from the national survey project. *Journal of Forensic Nursing*, 1(2), 57-65.
- Campbell, R., Wasco, S.M., Ahrens, C.E., Sefl, T. and Barnes, H.E. (2001). Preventing the 'second rape': Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, 16(12), 1239-59.

- Comack, E., and Peter, T. (2005). How the criminal justice system responds to sexual assault survivors: The slippage between 'responsibilization' and 'blaming the victim'. *Canadian Journal of Women and the Law*, 17(2), 283-309.
- Corbett, C. (1987). Victim support services to victims of serious sexual assault. *Police Surgeon*, 32, 6-16.
- Corrigan, R. (2013). *Up against a wall: Rape reform and the failure of success*. New York: New York University Press.
- Cowley, R., Walsh, E. & Horrocks, J. (2014). The role of the sexual assault nurse examiner in England: Nurse experiences and perspectives. *Journal of Forensic Nursing*, 10(2), 77-83.
- Derynck, J. (2009). Lacking context, lacking change: A close look at five recent lower court sexual assault decisions. *Appeal. Review of Current Law & Law Reform*, 14(1), 108-20.
- Du Mont, J., Miller, K. L., & Myhr, T. L. (2003). The role of "real rape" and "real victim" stereotypes in the police reporting practices of sexually assaulted women. *Violence Against Women*, 9(4), 466-486.
- Du Mont, J., & Parnis, D. (2000). Sexual assault and legal resolution: Querying the medical collection of forensic evidence. *Medicine and Law* 19, 779-92.
- Du Mont, J., Parnis, D. (2001). Constructing bodily evidence through sexual assault evidence kits. *Griffith Law Review*, 10, 63-76.
- Du Mont, J. & Parnis, D. (2003) Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses. *Applied Nursing Research*, 16(3), 179-83.
- Du Mont, J., & White, D. (2007). *The uses and impacts of medico-legal evidence in sexual assault cases: A global review*. Geneva: World Health Organization.

- Du Mont, J., White, D. & McGregor, M. (2009). An exploratory study of the medical forensic examination from the perspectives of sexually assaulted women. *Social Science & Medicine*, 68(4), 774-80.
- Edwards, K., Turchik, J., Dardis, C., Reynolds, N. and Gidycz, C. (2011). Rape myths: History, individual and institutional-level presence, and implications for change. *Sex Roles*, 65, 761-73.
- Estrich, S. (1987). *Real rape*. Cambridge: Harvard University Press.
- Finch, E. & Munro, V. (2007). The demon drink and the demonised woman: Socio-sexual stereotype and responsibility attribution in rape trials involving intoxicants. *Social & Legal Studies*, 16(4), 591-614.
- Frankland, J. & Bloor, M. (1999). Some issues arising in the systematic analysis of focus group interviews. In R. Barbour & J. Kitzinger (Eds.), *Developing focus group research: Politics, theory and practice*. London: Sage.
- Frazier, P.A. & Haney, B. (1996). Sexual assault cases in the legal system: Police, prosecutor, and victim perspectives. *Law and Human Behaviour*, 20(6), 607-28.
- Frohmann, L. (1991). Discrediting victims' allegations of sexual assault: Prosecutorial accounts of case rejection. *Social Problems*, 38(2), 213-26.
- Frohmann, L. (1997). Convictability and discordant locales: Reproducing race, class and gender ideologies in prosecutorial decision making. *Law and Society Review*, 31(3), 531-55.
- Frohmann, L. (1998). Constituting power in sexual assault cases: Prosecutorial strategies for victim management. *Social Problems*, 45(3), 393-407.
- Gotell, L. (2009). Rethinking affirmative consent in Canadian sexual assault law: Neoliberal sexual subjects and risky women. *Akron Law Review*, 41(4), 865-98.

- Gary-Eurom, K., Seaberg, D.C., & Wears, R.L. (2002). The prosecution of sexual assault cases: Correlation with forensic evidence. *Annals of Emergency Medicine*, 39(1), 29-46.
- Greenfield, L. (1997) *Sex offences and sex offenders: An analysis of date rape and sexual assault*. US Department of Justice Bureau of Justice Statistics, NCJ-163392.
- Gregory, J. & Lees, S. (1999) *Policing sexual assault*. London: Routledge.
- Harris, J. & Grace, S. (1999). *A question of evidence? Investigating and prosecuting rape in the 1990s, Research Study Number 196*. London: Home Office.
- Horvath, M.A.H. & Brown, J. (2007). Alcohol as drug of choice: Is drug-assisted rape a misnomer? *Psychology, Crime and Law*, 13(5), 417-29.
- HMCPSP and HMIC (2002). *A report on the joint inspection into the investigation and prosecution of cases involving allegations of rape*. London: HMCPSP and HMIC.
- HMCPSP and HMIC (2007). *Without consent: A report on the joint review of the investigation and prosecution of rape offences*. London: HMCPSP and HMIC.
- Htun, M. & Weldon, S. L. (2012). The civic origins of progressive policy change: Combating violence against women in global perspective, 1975-2005. *American Political Science Review*, 106(3), 548-69.
- Jordan, J. (2001). Worlds apart? Women, rape, and the police reporting process. *British Journal of Criminology*. 41(4), 679-706.
- Jordan, J. (2004). Beyond belief? Police, rape and women’s credibility. *Criminal Justice*, 4(1), 29-59.
- Kelly, K., Moon, G., Savage, S.P., & Bradshaw, Y. (1996). Ethics and the police surgeon: compromise or conflict. *Social Science & Medicine*, 42(11), 1569-75.

- Kelly, K., Moon, G., Bradshaw, Y., Savage, & S.P. (1998). Insult to injury? The medical investigation of rape in England and Wales. *Journal of Social Welfare and Family Law*, 20(4), 409-20.
- Kelly, L. (1988). *Surviving sexual violence*. Cambridge: Polity.
- Kelly, L. & Regan, L. (2003). *Rape: Still a forgotten issue*. London: Child and Women Abuse Studies Unit.
- Kelly, L., Lovett, J. & Regan, L. (2005). *A gap or a chasm?: Attrition in reported rape cases, Home Office Research Study 293*. London: Home Office.
- Kerstetter, W.A. (1990). Gateway to justice: Police and prosecutorial response to sexual assaults against women. *Journal of Criminal Law and Criminology*, 81(2), 267-313.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). *Archives of General Psychiatry* 52(12), 1048-60.
- Koss, M.P. (1993). Rape: Scope, impact, interventions and public policy responses. *American Psychologist*, 48(10), 1062-9.
- Koss, M.P. & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine*, 1(1), 53-9.
- LaFree, G. (1989). *Rape and criminal justice: The social construction of sexual assault*. Belmont: Wadsworth.
- Lea, S.J., Lanvers, U. & Shaw, S. (2003). Attrition in rape cases. Developing a profile and identifying relevant factors. *British Journal of Criminology*. 43(3), 583-99.
- Lievore, D. (2004). *Victim credibility in adult sexual assault cases*. Australian Institute of Criminology. Newsletter No. 288. Canberra: Australia.
- Lovett, J., Regan, L. & Kelly, L. (2004). *Sexual Assault Referral Centres: Developing good practice and maximising potentials*. Home Office Research Study 285, London: Home Office.

- Maier, S.L. (2008). ‘I have heard horrible stories...’: Rape victim advocates’ perceptions of the revictimization of rape victims by the police and medical system. *Violence Against Women*. 14(7), 786-808.
- McMillan, L. (2004). "It's about care as much as it's about feminism": Women's personal and political motivations for volunteering in refuges and rape crisis centres.’ *Atlantis: A Women’s Studies Journal*, 26(2), 126-37.
- McMillan, L. (2007). *Feminists organizing against gendered violence*. London: Palgrave
- McMillan, L. (2010). *Understanding attrition in rape cases Economic and Social Research Council end of award report*. RES-061-23-0138-A, Swindon: ESRC.
- McMillan, L. (2011). Sexual violence policy in Europe: Human rights, policies and outcomes in M. Koch, L. McMillan, & B. Peper (Eds.), *Diversity, standardization and social transformation: Gender, ethnicity and inequality in Europe*, (pp. 61-76). Ashgate.
- McMillan, L. (2013). Sexual victimisation: Disclosure, responses and impact, in N. Lombard & L. McMillan, L. (Eds.), *Violence against women: Current theory and practice for working with domestic abuse, sexual violence and exploitation*. *Research Highlights in Social Work Series*. London: Jessica Kingsley.
- McMillan, L. & Thomas, M. (2009). Police interviews of rape victims: Tensions and contradictions, in M. Horvath & J. Brown (Eds), *Rape: Challenging contemporary thinking* (pp. 255-80). Cullompton: Willan Publishing.
- Moore, S., & Rosenthal, D. (1992). The context of adolescent sexuality: Safe sex implications. *Journal of Adolescence*, 15(4), 415-435.
- Mulla, S. (2011). Facing victims: Forensics, visual technologies, and sexual assault examination. *Medical Anthropology*, 30(3), 271-94.

- Parnis, D., & Du Mont, J. (1999). Rape laws and rape processing: The contradictory nature of corroboration. *Canadian Woman Studies*, 19(1 & 2), 74-8.
- Parnis, D. & Du Mont, J. (2002). Examining the standardized application of rape kits: An exploratory study of post-sexual assault professional practices. *Health Care for Women International*, 23(8), 846-53.
- Parnis D. and Du Mont J. (2006). Symbolic power and the institutional response to rape: Uncovering the cultural dynamics of a forensic technology. *Canadian Review of Sociology and Anthropology*, 43(1), 73-93.
- Patterson, D. (2011). The impact of detectives’ manner of questioning on rape victims’ disclosure. *Violence against Women*, 26(18), 3618-639.
- Pillai, M. & Paul, S. (2006) Facilities for complainants of sexual assault throughout the United Kingdom. *Journal of Clinical Forensic Medicine*. 13, 164-71.
- Randall, M. (2010). Sexual assault law, credibility, and ‘ideal victims’: Consent, resistance, and victim-blaming. *Canadian Journal of Women and the Law*, 22(2), 397-434.
- Rees, G. (2010). ‘It is not for me to say whether consent was given or not’: Forensic Medical Examiners’ construction of ‘neutral reports’ in rape cases. *Social and Legal Studies*. 19(3): 371-86.
- Rees, G. (2011) *The role of work of forensic nurse in sexual assault cases: An international comparative approach*. RES-000-22-4084, Swindon: ESRC
- Rees, G., & White, D. (2012). Vindictive but vulnerable: Paradoxical representations of women as demonstrated in internet discourse surrounding an anti-rape technology. *Women’s Studies International Forum*, 35(6), 426-31.
- Richardson, D & Campbell, R. (1982). Alcohol and rape: The effects of alcohol on attributions of blame for rape. *Personality and Social Psychology Bulletin*, 8(3), 468-76.

- Richardson, D. (1996). Contradictions in discourse: Gender, sexuality and HIV/AIDS. In J. Holland & L. Adkins (Eds.), *Sex, sensibility and the gendered body. Explorations in Sociology 46, British Sociological Association*. London: Macmillan.
- Savage, S.P., Moon, G., Kelly, K., & Bradshaw, Y. (1997). Divided loyalties? – The police surgeon and criminal justice. *Policing and Society*, 7(2), 79-98.
- Spohn, C., Beichner, D. & Davis-Frenzel, E. (2001). Prosecutorial explanations for sexual assault case rejection: Guarding the gateway to justice. *Social Problems*, 48(2), 206-35.
- Stanko, E. & Williams, E. (2009). Reviewing rape and rape allegations in London: What are the vulnerabilities of the victims who report to the police?, in M. Horvath, & J. Brown, (Eds.), *Rape: Challenging Contemporary Thinking*, Cullompton: Willan Publishing.
- Stermac, L., Du Mont, J., & Dunn, S. (1998). Violence in known assailant sexual assaults. *Journal of Interpersonal Violence*, 13(3), 398-412.
- Temkin, J. (1996). Doctors, rape and criminal justice. *The Howard Journal of Criminal Justice*, 35(1), 1-20.
- Temkin, J. (1997). Plus ca change: Reporting rape in the 90s. *British Journal of Criminology*, 37(4), 507-28.
- Temkin, J. (1999) Reporting rape in London: A qualitative study. *The Howard Journal of Criminal Justice*, 38(1), 17-41.
- Temkin, J. & Krahe, B. (2008). *Sexual assault and the justice gap: A question of attitude*. Oxford: Hart.
- Tjaden, P. & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey* (Rep. No. NCJ 210346). Washington: U.S. Department of Justice, Office of Justice Programs.

UNICEF. (1997). *The Progress of Nations*. UNICEF.

United States Department of Justice. (2013). *A national protocol for sexual assault medical forensic examinations adults/adolescents [Second Edition]*. Washington: Office of Justice Programs, United States Department of Justice. Retrieved from:
<https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

Wasco, S.M. & Campbell, R. (2002). A multiple case study of rape victim advocates' self-care routines: the influence of organisational context. *American Journal of Community Psychology*, 30(5), 731-60.

Wies, J.R. & Coy, K. (2014). Measuring violence: Vicarious trauma among Sexual Assault Nurse Examiners. *Human Organization*, 72(1), 23-30.

White, C. & McLean, I. (2006) Adolescent complainants of sexual assault: Injury patterns in virgin and non-virgin groups. *Journal of Forensic Medicine*, 13(4), 172-80.

Wiley J, Sugar N, Fine D, & Eckert L. (2003). Legal outcomes of sexual assault. *American Journal of Obstetrics and Gynecology* 188(6), 1638-41.

Women's National Commission (1985). *Violence against women: Report of an ad hoc working group*. London: Cabinet Office.