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'Every bone of my body:' Domestic violence and the diagnostic body

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ABSTRACT

Diagnostic categories for domestic violence have shifted over time, transforming from a disorder of psychological passivity and acute injury into a chronic and somatically invasive condition. This paper links these changing diagnoses to constructions of the abused body and to victim-blaming narratives. Based on an analysis of medical journal articles, this research identifies two logics that undergird domestic violence diagnoses, the body, and victim-blaming: 1) the logic of injury (1970s–1980s); and 2) the logic of health (late 1980s–present). The logic of injury is associated with overt victim-blaming, a temporally bounded and injured body, and psychological passivity. Once the feminist anti-violence movement gained mainstream credibility, however, the logic of injury fell out of favor as an explanation for domestic violence. What surfaced next was the logic of health, which is associated with chronic diagnoses and what the author calls a temporally extended body. The temporally extended body is flexible and layered, linking up past, present, and future states of disordered embodiment. The author suggests that, rather than ushering in hope and possibility via the logic of health's somatic flexibility, this abused body creates spaces into which new forms of blame and self-responsibility can take shape.

1. Introduction

That preoccupation with the future increasingly pervades our experiences of the present is a central claim of many theorists dealing with biomedicalization. We are made up of potentialities, constituted by our engagement with what is novel about the future. As Adams et al. (2009) point out, this temporal combustion pulls us in two directions at once: to know oneself is to know about one's future, and yet the future is quintessentially unknowable. Reflecting this dual orientation, one of the central features of biomedicalization literature is a tension between both the expansion of hope and of governance, between novel modes of flexibility and increasing self-responsibilization (Galvin, 2002; Orr, 2010; Pitts-Taylor, 2010; Rose, 2007). The expansion of possible futures via technologies and biomedicine may yield unexpected configurations, transforming what is normative. Or, we may become subject to further regulation, investing normative standards with new power.

The aim of this paper is to explore this tension at the level of the body, using the case of changing biomedical constructions of domestic violence. I will explore how diagnosis is used to capture domestic violence in particular ways, to label and make sense of the abused bodies that biomedicine must diagnose. I will also show how diagnoses shape the possibilities of the abused body, its present and future "health," its temporal movements through biomedical pathologies. Tracking constructions of the abused body through biomedical literature from the 1970s (the early years of medical attention to domestic violence) through the present, I attend to the ways in which the boundaries of the abused body are reconfigured in line with cultural shifts in victim-blaming narratives *and* in diagnostic categories. Here, I define victim-blaming as the widespread cultural discourse and practice that holds victims of violence and oppression responsible for their own victimization. In this analysis, I will link together: modes of victim-blaming, the construction of bodies, and shifts in diagnoses. The construction of the abused body here is not *just* reliant on biomedicine; rather, biomedical diagnoses and victim-blaming tropes are entangled (Murphy, 2012).

First, I will review literature on diagnosis and the biomedical body, in which I take up this tension between increasing flexibility (Clarke et al., 2010; Rose, 2007) and the ushering in of new forms of blame (Pitts-Taylor, 2010). Next, using data from peer-reviewed health journals, I will demonstrate the important role that diagnosis plays in defining domestic violence. Variably diagnosed as a disorder of pathological passivity, as a set of acute injuries, and as a chronic disease, I will argue that a profound transformation in diagnostic categories has taken place since the 1980s. I follow these diagnoses through health literature to reveal how they construct the abused body, both relying on and reinventing victim-blaming

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narratives. Ultimately, I argue that the chronic framework amplifies victim pathologies via *temporal extensions of the body*, which locate abuse inside the body, making the victim's future increasingly subject to her past abuse.

2. Theoretical background

While medicalization is concerned with a broad process of redefinition from social to medical problems (Conrad, 2007), studies of diagnosis focus on the construction of medical *knowledge* (Brown, 1995). Analyses of diagnoses call attention to biomedical epistemologies and the reification of particular cultural dynamics (Jutel, 2011b). For example, Jackie Orr tells the story of how panic disorder filled the gap left by hysteria in twentieth century diagnostic classifications (2006). Doctors did not deem women less "hysterical," but rather, the diagnostic language that captured this pathology changed. The sociology of diagnosis gives us the tools to examine how problems are "captured" by biomedical discourse, how they are made to "speak" about pathologies and treatments (Orr, 2006, p. 21). Because biomedicine has a great deal of cultural legitimacy to define what bodies are and do (Rose, 2013; Turner, 1996), diagnostic categories act as pronouncements of what is "real," making it appear that diagnoses describe nature itself (Jutel, 2011a).

The terms of diagnosis, however, do not remain stable over time. Notably, scholars have documented a shift from processes of medicalization to those of biomedicalization. Biomedicalization does not exert control *over* something, but rather, fundamentally *transforms* the way we understand our lives (Clarke et al., 2010). "Life itself" (Rose, 2007) is to be intervened upon with medical tools and promises of a "better self." Biomedicine's authority to define life is not limited to discrete control over diseases; instead, biomedical discourse reshapes the way we envision our bodies and our selves, always open to "enhancement."

With the rise of biomedicalization over the past fifty years (Clarke et al., 2003) comes the increasing equation of personhood with "good health" and proper embodiment. According to Nikolas Rose, "Personhood itself becomes increasingly somatic … To live well today is to live in the light of biomedicine" (2013, p. 7). Our bodies are diffusely regulated through regimes of "good health" via the normalizing discourses of biomedicine (Decoteau, 2013). Under conditions of biomedicalization, "The body is no longer viewed as relatively static, immutable, and the focus of control, but instead as flexible, capable of being reconfigured and transformed" (Clarke et al., 2010, p. 78). Rather than fixed objects of biomedical knowledge, bodies become actors that play malleable roles in patients' futures.

While some scholars view this biomedicalization of possible futures as opening up a field of hope (e.g. Rose, 2007), other scholars question the neoliberal mandates to self-monitor that are contained within biomedicalization discourses (e.g. Pitts-Taylor, 2010; Galvin, 2002; Mamo and Fosket, 2009). For example, in her discussion of neuronal plasticity, Victoria Pitts-Taylor argues that scholars have exaggerated the postmodern potential of plasticity (2010). Though plasticity does free the brain from biological determinism, plasticity also invests the subject with unparalleled responsibility to *live* his or her brain "correctly." According to Pitts-Taylor, "… popular discourse on plasticity firmly situates the subject in a normative, neoliberal ethic of personal self-care and responsibility linked to modifying the body" (2010, p. 639). With flexibility comes a mandate to be a "better" self, a more productive citizen, and a more rigorous health consumer. According to Rose Galvin, neoliberal risk discourses amplify concern about the health of the body while also amplifying the *blame* attributed to people "at risk" (2002). As health risk is increasingly inscribed in somatic selves, it becomes nearly impossible to delink biomedical discourse from the pervasive cultural blame doled out for "bad" embodiment.

Other scholars view the uncertainty that comes with biomedicalization in more optimistic terms. As Rose suggests, "… risk calculations offer no clear-cut algorithm … Contemporary biopolitics thus operates in practices of uncertainty and *possibility*" (2007, p. 52, emphasis added). One's future health is always subject to change; thus, future modes of embodiment are uncertain and perhaps open to, "… tactics for contestation, or new forms of curiosity" (Adams et al., 2009, p. 250). It is as if the boundaries of the body are opened up by their unpredictability. Indeed, Jasbir Puar has argued that this type of dispersion of bodily boundaries may yield challenges to normative conventions (2007, p. 221). The implication here is that when the boundaries of the body become unhinged from here-and-now certainty, unforeseeable (and often progressive) possibilities abound.

On the one hand, flexible bodies usher in neoliberal forms of blame. The risk that is part of this flexibility provokes dis-ease and uncertainty among patients, many of whom are constantly in a state of being almost-ill (Fosket, 2004; Shostak, 2010), or as Timmermans and Buchbinder call them, "patients-in-waiting" (2010). On the other hand, many scholars argue that flexibility will open up novel possibilities for bodies and selves. These analyses, however, often fail to identify the flexible biomedical body as a *normative* body. If we consider inequalities across race, gender, and sexuality, it becomes less clear for *whose futures* the biomedical body, in all its pliability, can really provide hope. For example, in her work on HIV, Claire Decoteau shows how the flexible futures opened up by biopolitics depend on one's *ability* to embody norms, to sync oneself with Western ontologies of the body (2013). When the biomedical body is unattainable, insecurity is ramped up in patient's lives (Decoteau, 2013). This point is critical for understanding the biomedicalization of domestic violence victims, who carry a heavily gendered stigma with them, typified in victim-blaming narratives.

What *is* clear is that temporality has become a central feature of biomedicalized bodies, especially since the expansion of chronic illness after World War II (Armstrong, 1988; Clarke et al., 2003, 2010). Adams et al. (2009) suggest that we are living in a state of "anticipatory modes" in which, "… the future is inhabited in the present" (p. 249). This constant anxiety about the future actually reconstitutes who we are in the present. And as Armstrong contends, "… emphasis on a population constantly 'at risk,' chronic illness, prevention, health promotion, anticipatory care, early diagnosis, and so on, have functioned to celebrate the existence of a *temporal trajectory* to almost all illness" (1988, p. 219, emphasis added). Temporality pervades the epistemology and practice of biomedicine. But as Armstrong goes on to explain, the rise of risk frames is generally meant to "protect the future" of patients (1988). Therefore, biomedical extension into the future of health implies *optimization*. However, in the case of domestic violence, I will argue that, rather than functioning to optimize health, the temporal extensions of the abused body function to extend and deepen pathology. For battered women, the future is already jeopardized, already in a state of perpetual and yawning disaster.

Using this frame of temporality, I will make two claims on this set of literature. First, I will argue for an understanding of the ways in which diagnosis compels particular forms of embodiment. Following Berg and Harterink, I understand the embodiment of the patient as a discursive biomedical production (2004, p. 14). Shifting diagnoses construct the modes of embodiment available to patients. Second, I will argue for a reconceptualization of the biomedicalized body as what I call a *temporally extended body*, a body that is extended into the future while remaining suffused with the past. The body here is "splayed" (Puar, 2007) across multiple registers: past abuse, current presentation in a biomedical setting, and