The truth told by the body:

Swiss medicolegal responses to intimate partner violence from a gender perspective

Abstract

This paper offers new insights on the practical consequences of a gender-neutral framing of Intimate Partner Violence in a specific institutional context, showing how it results in differentiated recognition of victims of IPV. Through an ethnographic case study conducted in a medicolegal centre in French-speaking Switzerland, I show how the focus has shifted from a problem defined as a form of violence against women to a gender-neutral representation of a familial problem of 'domestic violence' in which neither perpetrators nor victims are named. This outcome is linked to political decision making at the cantonal level that privileges a gender-neutral reading of IPV, which is no longer conceived in terms of male violence perpetrated against women. The paper foregrounds the specific ways in which the support provided to victims of IPV by a public health institution have been impacted by and contributed to this changing agenda. Its findings show that by certifying physical forms of violence, while excluding psychological violence, medicolegal expert knowledge ultimately legitimises some victims while excluding others from receiving its support.

Keywords: intimate partner violence, medicolegal responses, gender perspective, physical/psychological violence, violence against women

Introduction:

In recent decades, various legal, social, and public policies have sought to address violence against women (VAW) (Hearn & McKie, 2009). Studies conducted within different European settings have shown that the institutionalisation and professionalisation of public action to counter different types of VAW lead to its depoliticisation (e.g. Romito, 2008). Specifically, the gendered nature of VAW in its various manifestations, ranging from intimate partner violence (IPV)[1] to sexual violence in public spaces is obscured by dissociating its definition and framing from early feminist problematisations of VAW (Bacchi, 2009). For example, in the French context, Lieber (2003) has shown that the public policies to address women's safety in public spaces marked a shift away from the feminist

conceptualisation of women's experiences of violence and their sense of security within the public space. Ultimately, after institutionalisation these public policies were formulated in gender-neutral ways that did not specifically address women's issues (Lieber, 2003, p. 84). Research on IPV has shown that it is increasingly framed as the non-gendered outcomes of individual and interactional problems within families (Römkens, 2016; Withaeckx, 2013) or as incidental manifestations of temper loss (Stark, 2013).

This framing of IPV as loss of temper/control contradicts a gender-based understanding of IPV as violence aimed at control (Johnson, 1995; Stark, 2007). The 'losing control' paradigm emphasises violent acts and incidents, while obscuring their meaning, consequences, and functions of instilling gendered relations of domination within the intimate sphere. Feminist studies have critically examined this focus on physically violent acts, demonstrating that victims of IPV rarely experience just one form of abuse (DeKeseredy, Schwartz, Fagen, & Hall, 2006) and that psychological violence is as damaging as physical violence, if not more so (Adams, Sullivan, Bybee, & Greeson, 2008). Defined as 'a pattern of coercive behaviour exerting power and control in an intimate relationship through intimidating, threatening, harmful or harassing behaviour' (Hearn, 2013, p. 159), IPV needs to be understood accordingly as material, bodily and psychologically damaging processes over time (Hearn, 2013, p. 159). Although it can also occur in gay and lesbian relationships, the phenomenon was initially problematised by feminist movements in the 1970s as mostly a gendered form of violence exerted by men against their female partners, and as a tool of social control and part of a continuum of violence against women (Hanmer & Itzin, 2001). IPV assumes numerous forms that encompass emotional and psychological abuse, such as tormenting, humiliating, denigrating, insulting, blaming, and isolating a victim by denying her social contacts and treating her as mentally ill (Piispa, 2002; Walby & Allen, 2004). They also encompass economic violence, which includes depriving individuals of access to money and forbidding or forcing them to work as well as intimidation, obsessional stalking, spying and monitoring, and suicide threats. All of these behaviours are forms of IPV that may or may not include physical aggression but can be side-lined if the focus is only on specific violent incidents and episodes (Gloor & Meier, 2012, p. 11).

More importantly, the hierarchisation of some acts of violence over others – with physical and provable violence assuming centrality over psychological abuse – has

contributed to IPV's dissociation from a gender-sensitive and feminist framing (Romito, 2008). This process occurs when the perpetrators' violent acts and the victims' defending acts are positioned at the same level, giving credence to the claim that IPV is gender symmetrical, affecting men and women alike (Dobash, Dobash, Wilson, & Daly, 1992). This conception of IPV counters the commonsensical view that physical violence puts men at an advantage against women because they are allegedly stronger and features in debates centring on victimisation surveys conducted in the 1990s. By counting only the physical acts of violence, these surveys produced controversial gender symmetrical results and undermined the gender-sensitive framing of IPV as a form of gender-specific violence against women. Consequently, feminist researchers, notably Dobash et al. (1992) famously demonstrated that a focus on physical violence within the surveys eclipsed the actors' interpretations, motivations, and intentions, thereby omitting the contexts of the overall relationship and the violence and its specific detrimental consequences on women. They showed how conceptualising IPV exclusively as physically violent acts ultimately precludes its differentiation from 'conflict between two men in a bar'. This gender-blind conceptualisation 'obscures all that is distinctive about violence against wives which occurs in a particular context of perceived entitlement and institutionalized [gender-based] power asymmetry' (Dobash et al., 1992, p. 83). Consequently, researchers have argued for linking coercive control of women and IPV in general to broader gendered power relations, postulating that ending IPV and establishing gender equality can only be achieved in conjunction (Stark, 2013).

Adding to this literature that examines current policies on IPV from a gender perspective, this paper presents a case study of a medicolegal centre within a public hospital in Switzerland. It argues that Swiss institutional responses to IPV in the canton under study have followed a similar depoliticisation logic that is apparent in the choice of terminology used to talk about the problem, in the public targeted by the institution under study, and in what is silenced or at least marginalised in the process. It highlights the dominance of a forensic institutional logic within this institution – sometimes despite its agents' reservations – in the prioritisation of physical violence over psychological and less visible types of violence. Moreover, it shows how the bruised body (Fassin & D'Halluin, 2005) plays a critical role in the services offered to victims of IPV. This study provides new

insights about the practical consequences of a gender-neutral framing of IPV in a specific institutional context, revealing how it leads to differentiated recognition of victims of IPV.

I begin by outlining some contextual elements relating to the medical centre's origin and the rationale for its establishment before analysing its work. I specifically explore the implications of foregrounding physical acts of violence as the basis for providing victims of IPV with medicolegal certificates and assess the significance of this documentation of visible traces of physical violence on victims' bodies for IPV certification. In the following section, I present different examples extracted from my ethnographic and interview data that elucidate the significance of such practices and the consequent exclusion of some IPV cases from the ambit of practices at the Centre. In the final section, I discuss the implications of excluding non-provable and intangible psychological violence from the sphere of public action against IPV. Whereas the discourse and mission of the medicolegal centre (and those of the police and social agencies, as I show elsewhere; Khazaei, 2019) entail recognition of psychological violence, in practice, they prioritise physical violence when assessing danger and formulating measures to protect victims. This practice stems from their specific institutional logic and may not be shared by the individual agents themselves. However, by focusing on situational physical violence and neglecting manifestations of systematic coercive control exerted by perpetrators on victims, the sphere of public action elides a wide range of situations and cases that entail this type of VAW.

Some methodological clarifications

The empirical data on which this article is based was gathered during six months of ethnographic fieldwork conducted in 2015 with nurses and forensic physicians from the medicolegal centre under study. This fieldwork was part of a wider research project in which I investigated Swiss institutional responses to IPV cases from three principal perspectives – medical, social, and police – through an extended ethnographic study. Ethnography is a particularly appropriate methodology for examining processes and mechanisms (O'Reilly, 2005). Extending beyond a comparative approach, my study entailed an integrated analysis of three institutional field sites. By studying them in relation to each other, I was able to retrace the path of a victim within and across these institutions and to grasp and develop a transversal understanding of how IPV is de-gendered. Because

of the space limitation, here I focus on the medicolegal centre, while emphasising that my findings are based on the overall picture that emerged from my analysis of all three key sites of public action against IPV in the Swiss canton under study (Khazaei, 2019).

Notably, my analysis focuses on the intermediate level, which extends beyond individuals and their personal opinions and actions. In this case study, nurses and forensic physicians are investigated as state agents whose work is framed and defined by legislation, regulations, and specific institutional objectives but also by a professional logic and 'ethos' (Fassin et al., 2015). My primary interest lies in reconstructing the institutional logic and patterned practices at the supra-individual level and not in the beliefs of individual professionals. The case studies and empirical material presented here are not isolated and anecdotal; they were selected because they clearly illustrate the main patterns of institutional discourses and practices.

Data were mainly collected through participant observation during patients' consultations with a nurse or a forensic physician, observations of related brainstorming sessions between nurses and physicians, and formal expert interviews conducted with all of the observed professionals (seven nurses and three forensic physicians). I analysed the verbatim transcribed data gathered from observations, talks, and interviews and applied a grounded theory approach, entailing open and axial coding (Boeije, 2010) using the Atlas.Ti software programme.

A changing agenda

The World Health Organization's framing of IPV as a public health issue within an international VAW initiative in 2000 prompted the launch of policies specifically targeting IPV against women during the following decade in Switzerland and in the canton under study. Despite the prominent role of Feminists in the 'discovery', visibilisation, and conceptualisation of the problem, over time and in the process of institutionalising IPV as a public problem in the Swiss context, the focus gradually shifted from a definition of the problem as a form of VAW to a gender-neutral representation of a familial problem, termed 'domestic violence' in which neither perpetrators nor victims are named (Lieber & Roca i Escoda, 2015, p. 5; Khazaei, 2019). This semantic shift from VAW to domestic violence signified the reconstruction of social reality, concealing the fact that men are the perpetrators and women the victims in more than 90% of IPV cases (Lieber, 2003).

Moreover, instead of talking about men and women, or perpetrators and victims, the discussion now centres on couples, children, and the elderly (Lieber 2003). This process of redirecting the focus from VAW to de-politicised and de-gendered public policies for tackling domestic/family violence was also apparent at the medical centre that constituted one of my fieldwork sites.

The need for a specialised medical centre was mostly expressed by medical professionals from the hospital's emergency unit who had treated the injuries of evidently battered women (Hofner & Viens Python, 2014). In their responses recorded in an exploratory survey conducted in the canton in the early 2000s, they noted that they had little time, lacked the expertise to discuss the women's situation with them, and were unaware of which institutions could support these women (Hofner & Viens Python, 2014). Therefore, a facility was created within the hospital staffed by competent personnel – mainly volunteer physicians and nurses – who could take charge of the patients sent from the emergency unit, listen to their stories, and dispense information (a founding member of the medicolegal centre, interviewed on 11 March 2013).

The facility was, however, underfunded and overly dependent on the work of volunteers. Then in 2004, the forensic department of the cantonal hospital joined the project, highlighting a particular need for a medicolegal centre in the fight against intimate partner violence conjugal violence (Hofner, Viens Python, 2014). With the forensic department's economic support, it became possible to operate a full-fledged service within the hospital run by paid professionals instead of volunteers. But the Centre was not directly under the forensic department and was staffed mainly by nurses. This new model specified that the Centre specialised in the medicine of violence, that is, the specific use of medicine or medicolegal expertise in relation to violence.

Although the service's original aim was to take care of female victims of IPV and to support them by providing them with information, the newly opened medicolegal centre's ultimate objective was to receive all victims of interpersonal violence. When I interviewed the Centre's current director – a forensic physician – she stated that it was not acceptable to open a centre in a public hospital that would accept only one section of the population.

> When we opened the centre in 2006, we decided on a consultation service for interpersonal violence that included male and female victims of familial or community violence in the sense of the WHO typology. We refused to make a

distinction. Conjugal violence against women is an issue that should be addressed specifically, but when we launch a consultation service within the hospital, we should make it available to all adult victims of interpersonal violence. (Clara, interviewed on 14 January 2016)

Thus, despite its original intention, the Centre did not cater exclusively to female victims of IPV, who now account for just one-third of the consultations. The director specified that the inclusion of all adult victims of interpersonal violence would help 'to put an end to the men–women opposition. We could say that our resources are for both, not only for women' (Clara, interviewed on 14 January 2016).

The recent research agenda of the medicolegal centre mirrors this orientation through the inclusion of men who are victims of IPV or children exposed to domestic abuse, thus reflecting contemporary concerns within the canton under investigation. The brochure depicted in Figure 1, which was widely distributed within the canton, was designed by the Cantonal Office of Gender Equality (COGE) and illustrates this shift away from framing IPV as a specific type of violence inflicted on women by specifically targeting male victims of IPV. I asked the Centre's director to explain how and why the decision was made to conduct research on male victims of IPV, given that most victims of IPV who come there are women and the majority of male patients are victims of other types of interpersonal violence. She responded as follows:

It was the same question of communication; the need to say that our resources are for both men and women. Caring only about women fuels the fire. [...] During conferences, when we talk about IPV, the question, "and what about men?" is always raised. So this responds to a real need. (Clara, interviewed on 14 January 2016)

In addition to this changing agenda and targeted public, which dissociated the Centre's framework from the feminist one, the foregrounding of forensic expertise at the Centre adds another layer of complexity in the recognition of victims of IPV as mainly victims of a form of gender-based VAW. The next section will delve into the work of the Centre and its institutional forensic logic to substantiate the above argument.

The medicolegal certification of IPV

At the time of my fieldwork, the medicolegal centre had a relatively small team of professional staff comprising six nurses – all female – as well as three forensic physicians (one of whom was male) and two secretaries. The Centre's presentation brochure and website reveal that its two main objectives are to receive and support victims by listening attentively to their experience of violent events, and to issue medicolegal certificates attesting to violence endured. The Centre offered medicolegal consultations to anyone who was directed there from the emergency unit or to anyone who asked for an appointment as a victim of any type of interpersonal violence.

The first part of a consultation focused on eliciting the necessary information from the patient to issue a medicolegal certificate. This initial stage was followed by a planned break, during which the professionals could discuss the case and identify missing details that needed to be asked. They also reflected on where they could direct the patient afterwards to receive support.

Following that break, the nurse or forensic physician who had conducted the consultation undertook an examination of the patient's body. The patient would be asked to take off their clothes, keeping on their underwear. With the help of rulers and bevels of various sizes, the expert would measure the injuries and scars, placing a ruler next to them and taking pictures with a professional camera adjusted to take very clear and contrasted pictures that revealed any bruise or haematoma. During the examination of the patients' bodily injuries, the bruises discovered were generally described – as the following excerpt illustrates – to be subsequently added to the certificate.

> Nape: at the upper right of the neck, at the edge of the scalp, a linear reddish skin abrasion, obliquely situated down and inward, measuring 5 x 0.2 cm, in relation to the above-mentioned facts, according to the declared words of the person concerned. (Field notes taken during an audio-recorded examination, 27 February 2016)

Specifically, in IPV cases the professionals asked the patients to recount their story of their relationship with the perpetrator (termed the 'author' of violence) from the beginning. They asked them to describe the context of their relationship, the violence, the forms it took, and how and why it began up to the present. Subsequently, they were asked

to describe in detail the last incident that brought them to the Centre. For some of the patients, the hospital was the first institution that they contacted, and these consultations also marked the first occasions when they opened up and recounted their experiences of violence, resulting in long consultations lasting nearly three hours.

Having attended some very long IPV consultations, I expected the final certificate to be very long too, reflecting all the different types of violence that the women described during their interviews. Consequently, when I saw a medicolegal certificate for the first time, I was surprised by its brevity. There was only one paragraph dedicated to previous episodes of violence, the context, and the story of the couple's life. It also included a few lines about the health situation of the concerned person. Most of the certificate comprised a long and detailed description about the last incident of violence, including the physical injuries presented in forensic language. The length of the final medicolegal certificate indicated that there was no proportionality between the time spent assessing an issue during the consultation and the corresponding space for recording it in the final document. Women could speak at length about their life experiences, their relationships with their partners, and the psychological and economic violence they had endured during the consultation, but these topics would amount to merely a few lines in the medicolegal certificate. By contrast, marks and traces of physical violence could be described extensively in the certificate, which depicted pictures of injuries, bruises, and cuts adjacent to rulers that indicated their size.

Although the Centre acknowledged all dimensions of IPV in its official mission (including psychological, economic, and sexual violence and their impacts on victims' health), the fact that hardly any space in the certificate was devoted to portraying these dimensions of violence was indicative of the centrality of the physical dimension of IPV in the Centre's work.

Forensic physicians' concurrent requests to nurses to leave out a lot of contextual, psychological, and emotional details from their reports often prompted debates that reflected the tension between the supporting role of the Centre and its forensics-oriented approach, which is explored in detail in the following section. Some professionals were concerned that this practice could weaken the cases of victims with no evident physical traces, those who did not go promptly to the hospital, or those who took out sufficient time for the wounds to heal before deciding to speak out. Given the recurrence of this issue

in the health professionals' discussions, I incorporated it in interviews with them. Jeanne, who was one of the Centre's longest serving nurses, provided the following perspective:

> I think what is more difficult for me is the psychological violence, and yet these are the aspects that are less recognised. Though one feels sorry more easily for a woman who has a black eye or has got her arm broken, the psychological violence is more fearsome. [...] It scares me more and is more insidious. And, well, it goes hand in hand with intimate partner violence. (Jeanne, interviewed on 23 November 2015)

The nurse was explaining her discomfort at having to omit the psychological violence, denigration, or other pressures imposed on victims by perpetrators, which featured often in IPV cases. She continued:

> If they arrive with some injuries, I mean, I am even somehow relieved! When you see a person, who has real traces on her body, you see she has been held by arms etc. I tell myself: "Yes, I can relate to that, it speaks to me." At least I can prepare a beautiful certificate! Conversely, faced with a woman who tells me: "No, no, he never lays a hand on me, but he threatens me, puts pressure on me, denigrates me, but I do not have even one scar to show you"; it is much more complicated. We do not make any medicolegal certificates for such cases. (Jeanne, interviewed on 23 November 2015)

Such observations revealed a tension between the victims' accounts of the psychological dimensions of their partners' violence that went 'hand in hand' with IPV, as Jeanne put it, and the forensic directives guiding the work of the medicolegal centre. 'A beautiful certificate' in a forensic sense documented traces of physical violence; consequently, certificates could be issued only for women whose bodies displayed such traces.

The emphasis on the physical dimension of violence and on traces found on a victim's body is related to the standard use of forensic documentation at the Centre. Forensic practices emerged to link the reality of violence to observable traces left on the body, dead or alive (Porret, 2010). Judicial and police assessments of victims' claims of being subjected to violence rely on the expertise produced by forensic experts (Juston,

2016). Police and judicial organs accord much greater credibility to medicolegal certificates compared with normal medical certificates because they are considered more 'objective' and 'free of subjectivity', as forensic physicians can measure and document traces even without hearing victims' stories whose words would not suffice within judicial reasoning (Perona, 2017). The detailed sequence of incidents and the use of conditional clauses in the certificates' content are aimed at minimising affects and emotions and signify to the judicial organs that the certificate's content is completely neutral (Fassin & D'Halluin, 2005). For example, in the case at hand, the professionals sought to detach from the victim's declarations. A statement asserting that the Centre took no responsibility for the identity of the patient was inserted and was reinforced by other phrases that preceded the account of the violent incident. They included, for example, 'on [a given date] and at [a specified time], an individual who declared to be called [complete name] and to be born on [date of birth] was examined at the centre' or 'based on the declarations of Mr or Ms […] it seems', or 'it looks like'.

Notwithstanding the Centre's close adherence to the standards of forensic documentation, the bottom of each page contained the following sentence: 'This document is a medical observation report and is not to be considered forensic expertise.' This statement was somewhat unexpected, considering that the Centre's official position affirmed its added value and unique ability to offer medicolegal support to victims of violence. In fact, the professionals insisted on differentiating themselves from their counterparts in the hospital's forensic department, who provided official forensic expertise declaring whether or not a victim's story was corroborated by the injuries observed on her body. Such expertise could be viewed by magistrates as 'proof' supporting victim's claims, in contrast to the medicolegal certificates issued by the Centre. The next section clarifies this point and its consequences.

Conflicting missions and entailed tensions

Why then did the Centre's practices closely adhere to the principles of forensic medicine, overlooking forms of violence other than physical ones, without granting their certificate the status of expertise? This decision could be considered a double bind, as the Centre's certificates only applied to victims of physical violence, while being short of

forensic weight to provide proof even for these selected victims in their judicial battles. I asked Albert, one of the forensic physicians, to explain this decision.

> We only describe. We provide a description and not a forensic interpretation. We have only a part of the information (the version of the patient who is in front of us and not the other protagonist's version). That is why we specify "based on the declarations of" the victim; I mean the person who comes to us. We provide a description. We may add the observations done in the emergency ward of the hospital, but that's it. It is solely about presenting a photographic snapshot of the injuries at a precise moment, both in the written description and in the photos. (Albert, interviewed on 29 January 2016)

The fact that they did not interpret meant that they did not take position on the plausibility of the violence or the veracity of the patient's account of the violent incident. The explanation of this forensic physician echoed what I had been told by the Centre's director and other nurses in response to the same question, articulating the institutional discourse. Their practice of 'describing' and not 'interpreting' thus contrasted with purely forensic practice. Albert explained to me that a key difference between the two approaches is that forensic expertise is requested from the forensic department (and not the Centre) by judicial police or subsequently by the magistrates in the court to determine the veracity of a complaint and the gravity of the assault. This expertise is used by the judicial police to make a decision on whether to pursue the assault, and it is used by the magistrates to decide on acquittal or conviction. Therefore, a series of precise questions are asked, and a forensic expert is expected to take position and give their account of the facts. However, the staff of the medicolegal centre insisted that they did not evaluate the veracity of the victim's claims and produced the medicolegal certificate at the patients' request.

Consequently, a dilemma was apparent regarding the Centre's stated mission of supporting victims – which should include recognition of all forms of violence – and providing them with medicolegal certificates that was based on forensic exigency and claimed to be 'neutral' and 'objective'. This dilemma manifested in the issuance of certificates that covered only physical violence, excluding many other forms of violence. As previously mentioned, this dilemma was sometimes a source of tension among

professionals themselves because some were concerned about the potential negative impacts of their certificates for a victim undergoing a judicial battle. Another example of this tension concerned the question of the victim's alcohol consumption on the day of the incident. Some nurses feared that specifying the percentage of alcohol in the victim's blood at the time of the violence could discredit her declarations in an eventual judicial battle. However, the Centre's director insisted that this was required forensic information and that they could not make arbitrary decisions on information included in the certificate to favour victims. This argument was in line with the forensic claim to neutrality and the fact that they refused to take any sides, which contravenes the Centre's purported identity as a supporting institution for victims rather than a purely forensic department.

These tensions can also be viewed as arising from the convergence of a forensic perspective and the nature of nurses' work, which is to provide care. On the one hand, the nurses tried to listen attentively and to record and certify the violent experiences of their patients. The following statement made by Isabelle clearly defines the roles of nurses and the Centre: 'We are caregivers, and we stay caregivers'. On the other hand, the method of questioning and investigating every detail could highlight certain perceived inconsistencies that would become more conspicuous during the judicial processing of the case.

Finally, despite the professionals' compassion and understanding of the atmosphere of control and psychological pressure on the victims, the initial decision to establish a medicolegal centre for IPV led to the Centre's work being confined within medicolegal boundaries. At the same time their certificates' significance was limited as they were not considered proof to verify victims' statements for the court. Furthermore, this limitation was not inconsequential for the treatment of women, whose stories could not be backed up by evidence of physical violence. The following ethnographic extract from one consultation that I observed is quoted at length as it elucidates one such consequence, revealing a prominent theme within my broader analysis.

Finally, despite the professionals' compassion and understanding of the atmosphere of control and psychological pressure on the victims, they followed the forensic logic. It must be noted however that this choice is the Centre's own. It is not at the request of the judicial apparatus. When the judicial apparatus needs a forensic expertise, it requests the hospital's Forensic department to provide it. Therefore, this decision undermines the Centre's mission to provide support and listening to victims. It excludes

their experiences of violence which do not entail physical traces without providing any significant advantage in court. Furthermore, this limitation was not inconsequential for the treatment of women, whose stories could not be backed up by evidence of physical violence. The following ethnographic extract from one consultation that I observed is quoted at length as it elucidates one such consequence, revealing a prominent theme within my broader analysis.

Limits of the system

In March 2015, a young woman in her early twenties had an IPV consultation with Anastasia, one of the forensic physicians. A few days earlier, she had endured severe physical violence inflicted on her by her ex–partner, against whom she had previously pressed charges three times. She explained that on the previous Tuesday morning, she was going to the train station when she encountered him on the street. She was scared when he approached her and threatened to disfigure her someday, and she called the police. He left before they arrived. As he was not present and had not committed any physically violent act, the police officers did not pursue the matter. However, they asked her to call them immediately if she saw him.

After the police officers had departed, she had just taken a few steps when the man reappeared and resumed the threats, finally pushing her against a wall. Using his left hand to block her movement, he punched her three times in the head, covering her nose and mouth with his hand so that she could not breathe for a few seconds. He then grabbed her head, pulling her down with both hands and kneeing her so violently that she felt the upper row of her teeth break.

> At that moment I started to scream, and he let go of me and left. I was bleeding everywhere, and I was scared, I shouted and there was a lady who arrived and called the police, who called an ambulance. They went to fetch him at his address this time, and he has been arrested.

When Anastasia asked her, what had happened after her previous complaints, she made the following statement: ‘He denied all in court and gave an opposite account of everything to the extent that the judge did not know whom to believe anymore, and it would lead nowhere, so I withdrew the complaints.’

During the usual brainstorming break held in the middle of the consultation, Carla, the chief forensic physician, asked Anastasia whether the woman wanted to press charges. Anastasia answered: ‘Yes, she has already done it, three times up to now; she has regularly called the police!’ Then Carla looked back at me and said regretfully, ‘here we see the limits of the system. We needed to wait until her head got smashed before reacting’. The last physical incident that brought this woman to the centre was severe and visible enough to be acknowledged under the category of police action that entailed arresting the perpetrator and the Centre’s issuance of a certificate for her. Yet, the previous incidents – such as the assaulter’s implicit threat when he displayed a knife on her moving day – did not induce any recognition of the danger she was in. I do not know if this woman had come to the Centre for those previous events, but as Jeanne’s quotation specified previously, in those cases the Centre would not have provided any medicolegal certificate either. Consequently, in the absence of any physical and provable traces of violence, this victim’s claim could not be legitimised by the police nor the Centre. In the case of physical assault, the victim’s report elicited a response, whereas when she previously reported threats and psychological violence, there was no response.

Similar situations that I encountered during my fieldwork confirmed that the above-mentioned incident was not exceptional. The death threats made against the victims and their intimidation and stalking by the perpetrators that illustrated the dimension of control and the abuse of power that continued even after separation were usually side-lined. The reason was that various institutions, including the medicolegal centre, the police and the court, treated IPV as mainly involving physical acts and prioritise the materiality of visible traces of violence on the victim’s body over the psychological violence reported by the victim.

These incidents – and many more that I witnessed during my fieldwork – made it clear that the risk of a serious assault or of psychological harm that could not be demonstrated easily and materially proved were less decisive factors in the recognition of victims’ claims. Consequently, a wide variety of behaviours, entailing psychological pressure and control were excluded, even though these acts involve specific forms of gendered power relations and violence that are characteristic of IPV (Johnson, 1995; Stark, 2007).

Conclusion

This ethnographic study has shown how the medicolegal centre was impacted by but also contributed to a narrow understanding of IPV in its practices, despite its professionals' reservations or discomfort at times. The Centre's ambiguous treatment of non-physical forms of violence, coupled with a clear focus on physical acts of violence, entail consequences with regards to victims of violence. Specifically, this approach contributes to the delegitimisation of the claims of those victims who cannot show physical traces while only partially legitimising those with bodily injuries because it does not provide proof. The objectification of a violated body through measurements of injuries inflicted on it enters into the political domain of legitimisation, wherein decisions are made on granting state protection to victims. Prevailing suspicion, whereby the veracity of victims' claims is systematically questioned and must be assessed in an 'objective' and 'neutral' manner applying a forensic logic leads to selections that foreground and legitimise the truth told by the body.

Clearly, this (de)legitimisation issue exceeds the responsibility of the Centre. The focus on material proofs is coherent with the general mission of both the police and the court, two generalist institutions which tackle broader issues and are not expert in IPV. However, I argue that an institution designated as expert of IPV in the canton should not disregard this expertise and follow police or judicial perspective at the expense of supporting all victims of IPV. By taking a stand and acknowledging other forms of violence in their certificates the medicolegal centre could play a role in recognition of the specificity of IPV as more than merely physical violence. Including psychological violence in the certificate would not be enough for countering the gender-blind framing of IPV at the cantonal level. However, by narrowing its mission to forensic examinations of injuries, which is a service that is anyhow available elsewhere in the hospital in response to judicial requirements, the Centre contributes practically to an incidental and act-based reading of IPV cases. By listening to victims recounting their experiences of violence for hours but keeping only physical acts in their final certificates, the Centre's practices participate in confining the understanding of IPV to incidental and isolated instances of physical violence. The invisible control component of violence is, however, an essential characteristic of IPV, considered as a form of gendered violence, entailing male dominance over women in the intimate sphere, which reflects the structural and gendered social positions of intimate

partners. Given this narrow understanding, the treatment of IPV ultimately resembles that of other forms of interpersonal gender-neutral violence, such as street fights. Through its ethnographic investigation that extends beyond evaluations of professionals' responses to IPV cases, this study has revealed the unintended consequences and practical outcomes of the institutional logics in place, whereby victims are deprived of adequate help.

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[1] Linking IPV to VAW throughout this article is not to dismiss the experiences of violence in gay and lesbian relationships and beyond that of cisgender men and women. The data from the ethnographic fieldwork on which the analysis in this article is based did not allow me to position myself towards the treatment of other cases beyond heterosexual relationships as those are the only ones I encountered.