A Feminist Poststructural Discourse Analysis of "Secondary Trauma" within a Sexual Assault Program

by

Raegan Elizabeth Plett

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

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Abstract

This thesis presents a critical reading of secondary trauma research and literature within the context of violence against women, as well as interviews with sexual assault counselors. A feminist poststructural discourse analysis is used to discuss how trauma and secondary/vicarious trauma discourse are inherently victim-blaming and maintain women's oppression. Dominant phallocentric discourses permeate secondary trauma discourse, falling into three overarching categories—normalization, gendered political will, and medicalization/pathologization—are identified and linked to their maintenance of women's oppression as they shift responsibility for violence against women from society as a whole onto women. An analysis of female counsellor's narratives for discourse in operation within a sexual assault response program is presented. Finally, discussion of the need for awareness, choice, and action is presented within current social work practice and policy-making, including a proposal for the direction of future research.

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Introduction

Secondary trauma, also known as vicarious trauma, compassion fatigue, burnout, secondary traumatic stress disorder, and empathic strain among other terms, is a relatively new area of concern in social work. Currently, secondary trauma is a popular topic of discussion, research, and theorizing in social service systems, as well as within academic institutions. I will use the term secondary trauma to capture the official discourse of secondary trauma, including compassion fatigue, empathic strain, et cetera, as we find them talked about in the research and literature. Female social service providers who work with women who have experienced violence make up the community of women that I make reference to throughout this thesis. According to secondary trauma literature, these counsellors, supports, advocates, helpers, crisis workers, therapists, et cetera (I will use these terms interchangeably) are at great risk of developing secondary traumatic stress disorder, otherwise known as vicarious trauma. Much of the research and existing literature on secondary trauma is focused on these affected counsellors/support people and the traumatic content that they are exposed to through their work. Secondary trauma in the counsellor looks a lot like the trauma that the victims or firsthand traumatized individuals experience. Many, if not all, of these victims of secondary trauma fall into specific categorization criteria (though not all are formally diagnosed) for Posttraumatic Stress Disorder (PTSD, see APA, 2000). Throughout this thesis, I will use the term "trauma" as the label constructed referring to the symptoms and impacts following a "traumatic event." Unlike other authors who have used this term to refer to the event (rape, sexual assault, child abuse) itself. As I explored and read the literature and research on secondary trauma from my location as feminist

critical researcher and advocate for women who have experienced sexual and physical violence, I developed numerous concerns regarding the implications of this body of literature. My argument in this thesis is that the constructed and socially legitimized language and knowledge used to speak of trauma and secondary trauma furthers, rather than relieves, the oppression of women. I demonstrate this by using discourse analysis to deconstruct academic texts that describe, diagnose, and attempt to treat secondary trauma. Discourses are multiple, but vary in their authority (Gavey, 1989). I am interested in what discourses are centred and prioritized, making them the dominant discourses.

> The dominant discourses appear "natural," denying their own partiality and gaining their authority by appealing to common sense. These discourses which support and perpetuate existing power relations, tend to constitute the subjectivity of most people most of the time (in a given place and time). (Gavey, 1989, p. 464).

Secondly, I interviewed sexual assault counsellors in order to understand discourse in operation in the community and, more specifically, in a program that has feminist foundations.

Although the main purpose of this thesis is to establish a critical standpoint in regard to the way that we think and talk about vicarious trauma by using feminist poststructural discourse analysis, I also attempted to provide a more general overview of violence against women; I discuss its prevalence and society's lack of effective and ameliorative response to violence against women. For example, I begin with a discussion of the normalization of violence against women because my specific viewpoint on this issue is a fundamental theme that runs throughout my thesis. This viewpoint greatly

informs my subsequent reading of secondary trauma texts, and frames my concern regarding the intent and goal of rape and sexual assault services currently offered to women, and are the systems within which the women I have interviewed work.

As a sexual assault counsellor myself, not only am I concerned about the prevalence and devastating effects of violence against women, I have become extremely curious about the high rate of burnout among sexual assault workers, namely the impact on the helpers. This curiousity drove my research in the direction of vicarious trauma. I was increasingly uncomfortable, however, with the research and literature that I was reading on the subject. I felt that it was strangely divorced from the systemic issue of violence against women represented in its discipline with the use of language, labels, constructs, knowledge, and power. Further, in talking to sexual assault workers, the adoption of trauma language and knowledge increased my concern for how violence against women was being addressed or simply maintained, and its impacts treated.

Thus began my journey and my struggle with the language and power that secondary trauma discourse enacts in a sexual assault program. When I use the term language, I am referring to the discursive practice in which we communicate meaning and knowledge. All language is located in discourse (Gavey, 1989; Weedon, 1997). This thesis is my attempt at renegotiating responsibility. In it I partake in a discourse of social service and professional responsibility by showing how violence against women is maintained, accepted, and even promoted through the dominant discourses that allocate responsibility to individual women, even by those who claim to fight against it. Furthermore, I analyze how discourses constitute victim and therapist subjectivities, and govern the behaviours and relationship between counsellor and victim.

In Chapter 1 of the thesis I provide statistics to demonstrate the prevalence of violence against women and its traumatic effects. I examine the messages that women receive about violence, as well as the normalization of violence against women. In Chapter 1, I also critically contextualize sexual assault services by discussing the ways in which many feminist and independent social service agencies have become depoliticized and unable to carry out their mandates due to the pressure to conform to governmental standards, which are decidedly non-feminist. To conclude Chapter 1, I briefly introduce the concept of secondary trauma in the context of sexual assault violence services. I argue that the ways in which secondary trauma (vicarious trauma, empathic strain, burnout, compassion fatigue) is diagnosed, talked about, and treated have powerful discursive effects that contribute to rather than alleviate women's oppression by labelling their responses to working with violence against women ill and in need of treatment. I argue that the discourses of PTSD and secondary trauma effectively and subtly blame women for the violence they experience under the guise of "healing."

In Chapter 2, I explain the epistemological and methodological strategies I used to explore the subtleties of secondary trauma discourse. I chose to use a feminist poststructural discourse analysis methodology because it provided the foundation for the analytical lens I was primarily interested in. Also in Chapter 2, I explain my perspective as it pertains to the use of power and knowledge, the construction of language and power/knowledge, as well as subjectivity. I introduce discourse analysis and walk through my research methods. Here, I also outline the unique evaluation and assessment criteria I adhered to in my research.

In Chapter 3 of this thesis I continue to present the social context within which this research takes place through exploring literature and research about vicarious trauma. This information informs my understanding of what constitutes secondary trauma dominant discourse. I analyze the literature and research from a critical feminist poststructural perspective to uncover the hegemonic discourses that inform it. I present background information on vicarious trauma and secondary trauma, symptomology, and diagnosis. I analyze and discuss the subtle nature of phallocentric discourses that inform the trauma and secondary trauma disciplines, which I argue fall into three overarching categories: normalization, gendered political will, and pathologization. I specify and identify numerous popular and well-established discourses that maintain women's oppression and shift responsibility for violence against women from society as a whole onto women. In short, I interrogate discourses that blame the victim.

The first discourse I identify in the literature is the *normalization* of secondary trauma. I also identify four embedded gendered discourses that implicate societal assumptions: *woman as weaker*, woman as *responsible*, the *therapist as dangerous*, and the *invisible perpetrator*. I explore related discourses regarding the *removal of the man,* and the *client as infectious*. Finally, I demonstrate how the literature and research I examine contributes to medicalizing and pathologizing both in service delivery and in impact. To conclude Chapter 3, I give examples of contradictions and inconsistencies within the secondary trauma literature and research.

In Chapter 4, I present my discourse analysis of the interviews with four sexual assault counsellors. I demonstrate how main discourses predominated the counsellors' language. First, I present the gendered and pathologizing *client as infectious* discourse,

including how the client is constructed and segregated from other women and society. As well, I present how the construction of client as infectious works to maintain male privilege in segregating the client out as the problem (scapegoat) and the one who needs treatment, through the use of rape myth discourse and the construction of a real victim. I analyze the construction and regulation of victim/client subject positions. I also note counter-discourses and points of resistance to the dominant professional and trauma discourses.

Secondly, I show how therapist subjectivity is constructed in the discourse and the struggle set up for women to construct acceptable and safe subjectivities. As well, I present the internalized disciplinary techniques that circumscribe counsellor subjectivities and police behaviours and emotions (Chambon, 1999; Chambon & Wang, 1999). I present how the therapist is divided out as dangerous, disciplined to be silent and not talk about work outside of the agency, and how she is divided within herself, as a woman in the community and a professional. Throughout my analysis of the interviews, I present examples of counter-discourse and resistance to dominant discourse that construct the *therapist as dangerous*.

In my conclusion, Chapter 5, I discuss the results of my analysis and suggest ways to make a difference. I discuss how we might begin to increase our resistance to dominant discourses, and by extension, both men's and women's experiences and subjectivities. We must take responsibility for how we employ discourse and take seriously our roles as active agents of change. I argue that we must question how discourse is operating and what discourses we are deploying by learning to recognize discourse and its impacts. Finally, I discuss implications for practice, including our need for community-building,

accountability, and reflexivity, in order to internalize and understand personal and social responsibility for change. I conclude this thesis with suggestions for future critical research directions on the issue of the far-reaching impacts of violence against women and its relationship to secondary trauma.

Chapter 1: Setting the Stage: Violence against Women and the Social Service System Response

Violence against Women and its Resulting "Trauma"

Prevalence

The threat of violence is a daily reality for women. The statistics on violence against women are staggeringly high. In fact, due to its high rate violence against women is considered to be a *normal* part of daily life for all women (Profitt, 2000b). Normalcy connotes and reflects our society's values. When something is called normal, it dissuades the need for criticism, attention, concern, or intervention. Normal is perceived and assumed to be natural, good, and acceptable for all citizens (Chambon & Wang, 1999). The term normal is reserved for that which society has determined to be correct, healthy, standard, and acceptable; *abnormal*, on the other hand, is for all that is other, peripheral, undesirable. The active normalization constructs the "standard for judgement and against which to distinguish the pathological. Normalization implies the development of form of knowledge that set standards and ideals for human thought and human conduct and against which individuals are assessed, measured, and judged" (Chambon & Wang, 1999). However, as I will show, normalizing discourses can have devastating and far-reaching impacts that result in the depoliticization and the approval of violence against women.

For example, "abnormal brain function," "abnormal eating patterns," and "abnormal sexual urges" are all concepts that are easily conveyed and understood. The words that are used to convey normal and abnormal clearly construct abnormal as

undesirable. However, in the case of violence against women, normal is terrifying, but its normalization signifies social apathy towards the issue.

Normalization of violence against women is supported by statistics. The numbers are extremely high, with 51% of all Canadian women reporting that they have experienced at least one incident of sexual or physical violence (Statistics Canada, 1993). That is more than one out of every two women. Close to 60% of these women have survived more than one incident of violence (Statistics Canada, 1993). A rape is reported in the United States (US) every six minutes (Zoucha-Jensen & Coyne, 1998). According to US Department of Justice (2007), every 2 minutes someone in the US is sexually assaulted. Furthermore, the US government estimates suggest that "for every rape reported to police, 3 to 10 rapes are not reported" (Zoucha-Jensen & Coyne, 1995). One in five women (20%) will be raped in her lifetime (Koss, 1993) and one in four (25%) women is sexually abused as a child (Rowan & Foy, 1993).

In 2000, women made up the vast majority of victims of sexual assault (86%) and other types of sexual offences (78%) (Statistics Canada, 2001). Eighty percent (80%) of sexual assaults occur at home; 49% occur in broad daylight (Sexual Assault Care Centre, 1999). In cases reported to police, 80% of sexual assault survivors knew their abusers. About 10% were assaulted by a friend and 41% were assaulted by an acquaintance, 28% were assaulted by a family member, while the remaining 20% were assaulted by a stranger (Statistics Canada, 2003). Victimization surveys show that less than 10% of women who are sexually assaulted report the assault to the police (Federal/Provincial/ Territorial Ministers Responsible for the Status of Women, 2002). It is estimated that over 80% of women who are sexually assaulted do not report due to humiliation or fear

of re-victimization in the legal process. For women of colour that fear is heightened by racism (Ontario Women's Directorate, 2002). Frontline organizations confirmed that racist and sexist attitudes toward Aboriginal women continue to make them especially vulnerable to sexual assaults in Canadian cities (Amnesty International, 2004).

More than one out of every two (54%) girls under the age of 16 have experienced some form of unwanted sexual attention, one in four (24%) of these girls have experienced sexual assault, and almost one in five (17%) have experienced incest (Holmes & Silverman, 1992). In a Toronto survey, young women identified assault as their highest safety concern. Since women are most vulnerable to sexual assault, harassment, and other forms of gendered abuse, their concern is consistent with their experiences (City of Toronto, 2002).

In a Canadian study, one in four (25%) of all female post-secondary students in 1993 had been physically and/or sexually assaulted by a male date or boyfriend. One in five male students (20%) surveyed said that forced intercourse was acceptable, "if he [the perpetrator] spends money on her," "if he is stoned or drunk," or "if they had been dating for a long time" (Johnson, 1996). Eighty-three percent (83%) of women with disabilities (over four out of every five) will be sexually assaulted during their lifetime (Stimpson & Best, 1991).

The prevalence of violence against women is staggeringly high, and therefore, it is no wonder that our society simply considers it *normal*. However, I also believe that these statistics are conservative, due to several reasons including the stigma of reporting, the fear of being labelled a victim, threats by the perpetrator for telling, the lack of understanding (by both men and women) of women's rights (e.g., what constitutes sexual

assault). Many women make an active choice not to tell in order to forget or deny the assault, or they are in utter disbelief that anything positive or helpful will come out of the telling (Herman, 1997; Koss, 1998; Profitt, 2000b; Russell, 1998). Generally, women avoid being seen as victims (Kelly, 1988), and many women find it difficult to name their experiences of forced sex as rape (Koss & Harvey, 1991). As well, victim's experience are historically and culturally contingent, cued from the "intersecting and conflicting discourses through which the world is understood and shaped" (Mardorossian, 2002, p.747), so she may not even define her experience as violence against her or oppressive.

In my work with women who have been sexually assaulted, I have come across many women who do not feel that they have the right to say "no" to unwanted touching, contact, sexual advances, nor do they feel that they can say "no" at any time. Many women have felt that if they smile, kiss, go out on a date, wear "revealing" clothing, drink too much, think someone is attractive, et cetera, they are responsible for inviting the "normal" violent response of being touched, physically abused or raped. These beliefs about their behaviours as cause or condition for violence are reinforced by societal rape myths (Meyer, 2000). Many women and men believe that women are responsible and that men have the right (Burt, 1998; Donnerstein & Linz, 1998). These beliefs place women in danger to such a high degree that there is no other word for it but *normal*. That is, at least in a society that does not really want to deal with a problem, where the result of shifting the value of female may interfere with the comfort and privilege or entitlement of the male (Wriggins, 1998).

So, why are we not talking about rape, and why are we talking about trauma? Especially those concerned with critical research, social justice, anti-oppression, and even

feminism? Carine Mardorossian (2002) criticizes feminist focus of the last decade, stating that rape has become taboo in feminist theory and analysis . Further, she questions our indifference as feminist scholars in a time when the body is so high on the priority list for theory. She argues that "such indifference is all the more remarkable since gendered crime such as rape and domestic violence show no sign of abating" (Mardorossian, 2002, p. 744). On the contrary, according to Mardorossian (2002) rape and domestic violence are the only crimes whose "rates have increased. The rate of other violence crimes has decrease by 7 % compared to 1998 and has reached an all-time low since [US] authorities started keeping track of crime rates in 1973" (p.744). Supporting this sentiment, Marion Foley (1996) highlights the irony in the "public and political silence around rape" as the number of "reported rape grows, and evidence is emerging that it is actually harder to get a conviction now than it was 10 years ago. The number of convictions has remained constant over that period whilst reported rapes have increased four-fold" (Foley, 1996, p. 173).

To call violence against women *normal*—the standard, typical, usual (Canadian Oxford Dictionary, 2004)—devalues the experience of women who consequently must navigate and live in a society where it is normal for them to feel unsafe, in danger, and ultimately responsible for the violence they experience.

The Effects of Normalization

Labelling violence against women *normal* represents and facilitates an abdication of responsibility; this labelling results in the omission of violence as cause in women's experience. It implies that society has no responsibility for the fact that half the population lives in fear. Violence against women simply becomes "reality" and "the way

it is." This sets a precarious stage for the woman victim who is expected to know how to prevent or stop violence since it is such a *normal* part of our experience. As a result, prevention strategies are focused on women and have been the focus of research and literature (Zoucha-Jensen & Coyne, 1998). Terry Gillespie (1996) states that, while "the issue of gender is acknowledged with regard to the predominantly female victims of rape and sexual assault [...] the issue of the male perpetration of sexual violence is virtually ignored" (p. 152).

For example, the City of Winnipeg's Police Service Web site includes a section called *Crime Prevention and Personal Safety*. This section, which specifically addresses women, provides a list of preventative measures that women can take to protect themselves from being sexually assaulted (The City of Winnipeg, 2006). The Web site has four major headings: *Protecting yourself from sexual assault*; *If you are attacked*; *Sexual assault and drug misuse*; *If you become a victim of a sexual assault* (The City of Winnipeg, 2006). Interestingly, and with the consequence of valuing women's comfort and personal safety below men's, there is no reference to the aggressor (at least 95% of whom are men according to statistics reported by Klinic, 2007). Not only does the Web site not address the perpetrators of these crimes, it fails to suggest measures that men can take to avoid committing violent crimes against women. The Web site does nothing to encourage perpetrators to admit to violence they have committed against another person, and/or explain the consequences for committing violence against women. Indeed, if you visit this Web site, you will *not* find the following information: *How NOT to become a rapist: You are the only one with the choice; What happens when you attack; Drugging your victim;* and *If you become a rapist*. Unfortunately, even if there were such headings

as listed above, there is little publicly accessible information to substantiate them. This does not mean that the information is not attainable or possible, it is simply not a priority and not valuable and accessible discourse in our society.

The implications are clear: women are responsible for their own safety and care, and men are not responsible. Because men are not even addressed, they are effectively removed—within the literature and information on sexual violence the perpetrator does not appear, is not confronted, and is rarely even mentioned. Even feminist authors have remained focused on the impacts of violence (raising awareness of impacts and responses) and healing the woman who has experienced violence (Brown, 2004; Haaken, 1996; Haaken, 1998; Haaken, 1999; Lamb, 1999b; Lerman & Porter, 1990). This focus on women, and away from men, has been criticized by Bonnie Burstow who states that feminist research and therapy is primarily enacted by White, middle-class, heterosexual, non-victimized women, who use the medical language of mental health and psychiatry therefore perpetuating patriarchal, racist, sexist, and classist social practices (Burstow, 1992). As well, Carine Mardorossian (2002) argues that the focus of research, even feminist research, has been on the impacts of rape and women's oppression (abuse, domestic violence, et cetera) and the construction of "trauma." She states that "popular discourse is more than ever invested in transforming this social problem into a personal transaction, while psychologists, psychiatrist, and sociologists continue to study the issue of male violence—by studying women" (Mardorossian, 2002, p. 753)

Instead, our society teaches women to act in ways to prevent assault and violence with its many programs, books, classes, self-defence courses, awareness-raising, and service systems. This is an overt acknowledgement of the value society places on women

because the imbedded message to women is: violence *is* happening and will *continue* to happen—deal with it yourself. Therefore, prevention is about not letting violence happen to *you*, and our society tells women that we can affect whether we will be victims or not. The message is that every woman is responsible for her own experience of, or lack of, violence. If, as statistics report, it happens to one in two women, half of women are guilty of not securing their own safety. In effect, all women are guilty.

As women, we receive the message that we must be hypervigilant and constantly aware of our surroundings. As women, we are taught that it is normal behaviour to always park our cars in well-lit parking lots; walk in packs with our keys at the ready to either enable a fast escape in our vehicles, or to use as a weapon. We are told that it is irresponsible to not check the inside of our cars before entering them. We are told to ensure that we lock all doors and windows immediately upon entering our homes and vehicles. We must, we are told, be aware of not only the people in our environment, but also the possible escape routes and exits. The list of rules is endless. These rules for responsible living go as far as to include hours of the day we *should* be out, what we *should* wear, how we *should* walk, who we *should* talk to, how we *should* drink (never take our eyes off our glass), and how we *should* go to the bathroom (never alone).

Interestingly, the symptoms of many mental disorders include the very behaviours (and the attitudes that accompany them) that we as women are told to adopt in order to keep ourselves safe (Burstow, 1992; Burstow, 2003; Haaken, 1996). For example, these hypervigilant behaviours can be easily construed as paranoid, repetitive, obsessive, which have been identified as symptoms of disorder. A few of the potential diagnoses, which may ensue after displaying the above-mentioned behaviours include delusional disorder,

agoraphobia, obsessive-compulsive disorder, acute stress disorder, posttraumatic stress disorder, generalized anxiety disorder, phobias, and paranoid personality disorder (APA, 2000). In short, attention to danger and threat is simultaneously necessary and considered a "negative" coping behaviour. Enacting this kind of heightened awareness is seen as necessary and responsible, but it is, at the same time, labelled as having a "trauma lens." Women are therefore in an absolutely impossible and contradictory situation. I continue my exploration of this phenomenon in the section on pathologization and in my analysis of the secondary trauma discourses in the research text in Chapter 3.

Presumably, society recognizes that women are in danger, and decides that something needs to be done under the guise of promised personal risk reduction. However, no amount of prevention measures solely focused on women will lower the statistics of violence. The prevalence of violence will not be altered by books written on how to protect ourselves as women, self-defence courses offered in communities and universities, or police, and community Web sites providing information on how to protect ourselves.

Who is a Victim?

Society deals with the problem of violence against women by addressing the potential victim, namely all women (Burstow, 1992). Both men and women maintain this victim-focus. It contributes to our understanding and knowledge of who the victim is by constructing victim subjectivity and outlining for us the characteristics of the victim. For example, in the media we are provided with images over and over again on numerous crime shows, movies, and in other scenes of sexual violence against women of the supposed typical characteristics of a victim. Scenes are set, behavioural and physical

characteristics are depicted again and again constructing what a victim looks and acts like, what she wears, drinks, and how she puts herself in danger's way (Rambo Ronai, 1999). The popular media is saturated with the dos and don'ts of becoming a victim (Mardorossian, 2002). What we alter is our idea of who occupies the victim subjectivity: who gets violated and who does not. These subjectivities become very clear in media messages and depictions. Mardorossian (2002) discusses how media depicts women as "real" and "fake" victims. These messages construct and perpetuate a particular victim subjectivity, which women are measured against and determined to be – or not be - *real victims* when violence occurs. For example, real victims usually include young, beautiful, virginal women and do not include street-involved, elderly, or disabled women. Marian Meyers (1995) lays out, through analyzing newspaper words and pictures, how real victims must be white and of a certain class. Mardorossian (2002) states that "film industry and/or feminist criticism reproduces the 'ideology of rape' by depicting women as powerless and subordinated to the will of men" (p. 746). When the victim is represented in film, documentary, or media that stage rape she is often represented as suffering in terms of "pathos and horror" (Mardorossian, 2002, p. 746), as well she is usually beautiful (Mardorossian , 2002; see Alcoff & Gray, 1993; Johnson, 1995; Meijer, 1993; Mills, 1995; Walters, 1995). Some subjectivities are valued/valorized, some are devalued—we are responding to the subjectivities created by/in the discourse. "Real" victims are to a certain extent occupiers of a valorised subjectivity, so long as they look and behave within the accepted and valued victim subjectivity, including that they do not blame men in general (become man-haters, over-generalize) and they fix themselves and return to normal (i.e., middle-class, heterosexual and White, in behaviour if not skin

colour). Nicola Gavey (1999) also discusses the definitions and hegemonic constructions within sexual violence that contribute to women not seeing themselves as victims (this also impacts the prevalence rates that we have available to us).

I am constantly struggling to become more open-minded and critical, and I am constantly asking how to affect change. Since working within the sexual assault field, I have seen that women of all social locations are raped and experience violence. The dominant construction of a type of woman who gets raped is a myth. Erin Graham (2006) challenges the construct of a *type* of woman who experiences oppression, violence, rape, and exploitation ("is prostituted") as she speaks about her personal experiences working as a mental health advocate in a downtown Vancouver women's centre. For women on the frontlines, a type of woman who gets raped is challenged, even though this real victim subjectivity is promoted and prioritized. However, I have at times caught myself thinking, after hearing stories from women who have been sexually assaulted: *What were you doing? Why did you do that? Are you surprised that something happened to you? You should know better.* Where does that *should* come from? Unfortunately, that *should* is an internalized reaction, and I have learned it well. It is that *should* that I struggle to be aware of, reflect on, and challenge in my life and work. The challenge is to find a way of thinking *other* than what I have readily available in my social and discursive environment, which is my source for knowledge gathering and identity formation. As a conditioned individual of our society, I have internalized victim subjectivities, which include language, knowledge, and beliefs about what a victim looks like, how they behave, and who they are. I believe that awareness and choosing to respond and deconstruct these constructed knowledges that segregate out a *kind/type* of woman who

gets raped is an integral task for affecting change. This approach is supported and prioritized in the work of feminist authors, Gavey (1999), Haaken (1996, 1998, 1999), Lamb, (1999b), Marecek (1999), and Rambo Ronai (1999). As I have already established, all women are potential victims by virtue of their gender.

Effects: "Trauma," "PTSD," and "Rape Trauma Syndrome"

Normalization has also kept the trauma that results from sexual assault unacknowledged and unrecognized by societal systems (such as the mental health field). The patriarchal values subtly supported by normalizing discourse are revealed by the fact that it was not until men experienced trauma due to wars (shell shock and combat neurosis) that society recognized the existence and seriousness of personal effects experienced due to stressful and life-threatening events (Herman, 1997). Following the Vietnam War, the medical diagnosis of Posttraumatic Stress Disorder (PTSD) was an official recognition of the effects of trauma. This further prioritized and legitimized men's aversive experiences and was for the first time included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980 (APA, 1980). However, the original definition of PTSD states that the traumatic experience must be unique and fall "outside the range of usual human experience" (American Psychiatric Association, 1987, p. 250). Under this definition, women who experience violence are overlooked and their trauma denied because their experience is not unique (Brown, 1991; Haaken, 1996; Mardorossian, 2002). Rather, it is typical—normal.

Concerned feminists worked to illuminate and unmask hidden violence by men and elicit a response from society using consciousness-raising (Burstow, 2003; Haaken, 1996; Herman, 1997; Mardorossian, 2002). The original definition of PTSD did not

include women who had experienced rape, but the definition of PTSD was eventually made more inclusive so that it would encompass rape and sexual assault victims. However, war veterans continue to be the most publicly-recognized sufferers of PTSD; long-term psychiatric illness was formally observed in World War I veterans but did not appear to enter the public consciousness until the aftermath of the Vietnam War (Herman, 1997). Thus, the definition of PTSD, which followed as a response to veterans' experience, was once more based on the standardized male experience (Burstow, 1992; Fish, 2004).

Paula Caplan (1999) discusses bias in the research on sex and gender that has to a significant extgent defined and constructed psychological "truths" about men and women (Caplan & Caplan, 1999). This text critically examines some of these "truths" and explains why and how they have been misleading, including depicted differences and impacts in relational abilities, verbal, spatial, and math skills, aggression, mother-blame, and hormones. This gender bias in health care is demonstrated and supported by the work of Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970). The premise of their study, which has been widely accepted and has received strong support, is that clinical judgments about the characteristics of healthy individuals differ depending upon the gender of the person evaluated. Their second hypothesis is that behaviours judged as healthy for men would not be judged healthy for women. This was also confirmed in their findings. By analyzing the differences in descriptions of behaviours, Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel concluded that a "double standard of health exists for men and women, that is, the general standard of health is actually applied only to men, while healthy women are perceived as less healthy by adult

standards" (1970, p. 5). Susan Hekman (1999) discusses the differences between women and men as women occupying a location of "other," therefore woman is always defined relative and peripherally to men who are central. She states that women are perpetually located as "second-class citizens" (Hekman, 1999, p. 5). Laura Brown (1991) argues that "normal" experience is based on male experience.

The push for a trauma diagnosis came out of war veterans' difficulties receiving economic compensation since there was no psychiatric diagnosis available by which veterans could claim compensation (Herman, 1997). Therefore, it was not simply due to the empathic recognition of the need for acknowledgement of the male war veteran experiences, but rather, due to economic and financial pressure by the veteran community. Due to this pressure on the US government over the last two decades, PTSD is now one of several psychiatric diagnoses for which a veteran can receive compensation, such as a war veteran indemnity pension, in the US (Mezey & Robbins, 2001).

The construction of PTSD as legitimate, with it becoming central, recognized, and a condition in need of treatment, is, according to some feminist writers, a clear example of our society's main goals—financial gain and upholding patriarchy (see, for example, Becker, 2004; Burstow, 1992; Kelly, 1989). Jan Fook (2000) talks about how certain viewpoints and experiences are mainstreamed by being positioned as "legitimate". Fook (2000) goes on to state that the professionalization of women's professions such as teaching, nursing and social work can be analyzed as a process of masculinisation. In practice then, the professionalization of social work (from the private to the public domain) is the process of prioritizing and legitimizing masculine (patriarchal)

experiences and "truths," in that "women's work" is transferred to the public professional setting in order to gain acceptance. Mardorossian (2002) provides an example of how funding pays for certain discourses to be centred, due that the ideals of those who provide funding for research and institutions—often White, patriarchal, conservative males. Stacy Hammons (2004) and Dorothy Smith (1990) explain how discourse, through practices of language, distribution of knowledge, and policing of behaviour, is made "legitimate." Many feminist writers note that the dominance of patriarchal discourse is damaging to women in its practice and impact. For example, Bonnie Burstow (1992) asserts that psychiatric knowledge positions those in the category "woman" as already problematic and in need of psychiatric "treatment." She states that women are constantly positioned in need of fixing because they do not conform to the expectations of patriarchal capitalism, noting that women are diagnosed with mental illness twice as often as men (Burstow, 1992).

Individual focus on the woman and the trauma distracts from the greater issue of societal violence towards women. Janice Ristock (2002), in her interviews with lesbian survivors of domestic abuse, chose to focus on "responses to violence" rather than the effects (short- and long-term) of abuse. Concentrating on effects of abuse reflects its psychological consequences, which holds focus on the individual—the traumatized woman. Ristock (2002) uses PTSD as an example to show how the 'psy' disciplines (including psychology, psychiatry, and social work) label women who experience flashbacks and hypervigilance. Ristock (2002) goes on to argue that the label PTSD ignores the subjective experiences of women who have experienced violence and does not take into account the complexity of its *effects* on the daily lives of women. I will use

the term 'psy' throughout this thesis to refer to discourses from the disciplines of psychology, medicine, psychiatry, criminology, and social work. I also incorporate Parton's (1999, p.107) point regarding what Foucault (1977) termed the 'psy' complex, that these "new disciplines legitimated new knowledge claims and forms of social regulation that subverted the classical order of political rule based on sovereignty and right".

The label PTSD does not inform us about the varied and multiple ways that women engage in coping, resisting, and surviving (see Burstow, 2003; Haaken, 1996; Lamb, 1999b; Marecek, 1999). Ristock (2002) claims that this focus on the effects of violence locates the trauma outside of the victim, she quotes Sharon Lamb who states, "if we accept these assumptions, we are then very close to seeing women who have been victimized as 'damaged goods,' thereby reinforcing female passivity" (cited in Ristock, 2002, p. 80). I argue that the PTSD label pathologizes the woman and labels her ill, placing the trauma deep within her. I argue that trauma is constructed as pathological, in dominant discourse, and it is born in and spread by her body, due to an innate female weakness. At the same time, I agree with Burstow (1992, 2003) that the process of diagnosing her and labelling her "traumatized," objectifies and dehumanizes her, thereby naming her "goods" (damaged). Lamb argues that, "being victimized has become equivalent to having a chronic mental illness," (Lamb, 1999b, p. 108).

Thus, Ristock (2002) purposefully chose to look at the impact of violence within a larger social context, focusing on how victimized women speak about their personal struggles of attempting to live as survivors of violence. With this intent and social contextual gaze, sexual abuse (violence experienced by women) can be seen as a complex

social problem that continues to have multiple impacts on women instead of simply being a mental health issue (Ristock, 2002).

Although many researchers have attempted to better understand the experiences of women who have been sexually assaulted and raped, their research and its resulting literature are firmly grounded within the medical/pathologizing/illness model that informs and makes up the foundation of the social services field. Burgess and Holmstrom (1974) interviewed women who had been raped, and their research introduces the concept of Rape Trauma Syndrome (RTS), which is meant to describe and categorize some of the patterns of response and reactions they found in victims (for a critique of their work see Foley, 1994 and Kelly, 1988). Burgess and Holmstrom (1974) commented that some of the victims' symptoms reflected what had been previously found in combat victims (Herman, 1997). According to this body of work, RTS as a result of sexual assault can lead to PTSD but is not as widely understood or recognized by service providers or the general public as PTSD (Burgess & Holmstrom, 1974). Rape Trauma Syndrome refers to the acute phase and long-term reorganization process that occurs as a result of rape or attempted rape (Clancy, 2001). Another term that has been used to acknowledge the specific effects of rape and sexual assault is rape-related posttraumatic stress disorder (RRPTSD).

Though medicalizing women's experiences of rape should not be our end goal, it (regrettably) seems to be a way of getting some attention paid towards women's experience—and "trauma" is, perhaps, a more friendly and acceptable term than historical labels including "hysterical," "mad," or "bad" (Burstow, 1992) The lack of acknowledgement and understanding of trauma, not simply due to a nameless stressor but

as a by-product of violence and threat against women, results in the silencing of women's experiences of violence. Women are now walking around with their stories removed from them, simply diagnosed (e.g., PTSD) and pathologized based on symptoms that they exhibit (e.g., hyperviligance, sleep disturbances, depression). The medicalization of rape is "a process whereby a social and political issue is redefined as an individual problem requiring treatment" (Foley, 1996, p. 172). Through trauma discourse, women's behaviour, not men's, and her responses to rape, rather than men's enactment of it, is the problem to be fixed (Foley, 1996).

> This medical model of rape involves patching women up without acknowledging the condition which cause and condone rape. The sexual politics of male violence is negated through the use of gender neutral language which goes to considerable lengths to avoid recognizing that rapists are men. (Foley, 1996, p. 172)

Further to this, the women who do hear other women's stories of violence are now *also* diagnosed and pathologized as a result of their contact with "traumatized" women. The silencing of the women who have a story to tell about men's violence, through identifying her as ill, is not a new power play by the dominant patriarchal society. Historically, women have been labelled "hysterical," a term that still exists to describe "irrational," "overreacting," and "overemotional" women—many women have been institutionalized due to their severe "hysteria." Trauma symptoms in women are also attributed to personality disorders and some psychoses (Haaken, 1996). Notably, most, if not all, of these women have experienced violence and experience persistent and

continuous oppression (Burstow, 1992; Chesler, 1972; Haaken, 1996). Davis (1999) also describes the psychiatrization of PTSD.

Since PTSD became a concern of the mental health system women have made some progress in being acknowledged and treated in their experience of trauma. Women who have experienced violence or assault are cited as the most likely (80%) to develop PTSD along with concentration camp and torture survivors (Breslau, Davis, & Andreski, 1991). This understanding and acknowledgement of PTSD situates the victims of sexual assault, and thereby prescribes an understanding for both themselves and those who come in contact with them. In a society that seems to value and currently prioritizes standardized services, categorization of illness, and standardized, efficient, and lowest cost treatment of problems, "PTSD" contributes to these practices by allowing those who are treating the traumatized individual to have a better understanding of the problem. However, the *problem* has now become the *trauma*, not the act of violence perpetrated against the woman. Marian Foley (1996) puts treatment in the context of the medical model and the medicalization of rape, questioning the language of "treatment," "fixed" and "recovered," what these look like in the woman and who has the authority to assess and judge her recovery.

Unfortunately, instead of societal acknowledgement and action regarding violence against women, there is a trend of further pathologizing—though the labels have changed slightly, from women as "hysterical," to women having "PTSD," and I suggest, more currently, women as "borderline personality" and "paranoid schizophrenic," among many other potential diagnoses. Along with the pathologizing comes victim-blaming and institutionalizing of women—servicing the *symptoms* of violence against women and its

resulting *disorders* (Caplan & Cosgrove, 2004; Penfold & Walker, 1983). This structural and societal acceptance of violence against women is evident in hegemonic discourses (gendered, normalizing, pathologizing), which construct knowledge, shift and maintain power away from women to tell their stories of hurt, and limit women's voices being heard, felt, and affecting change (Profitt, 2000b). Women's stories of hurt and violence are often untold because women do not want to speak them and others do not want to hear them (Herman, 1997). Undoubtedly, the effects of violence against women are enormous. They have implications for both the victims/survivors themselves, as well as for the family, friends, and helpers that love and support the victims.

The societal messages and experiences of violation do not solely impact those who experience firsthand violence. The messages are there for all women and men regarding society's value of women and how we can be treated and who/what women should be (violence and the potential of sexual violence is normal). As a result, women cannot embrace the subjectivity fully of woman as it is so prominently and dominantly constructed by our Euro-Western society—at least we cannot do so and be considered whole and valuable. The dominant society's valuing and discourse for women's subjectivity places all women in a social location of lesser, weak, and not fully capable. Women are seen as responsible, needing to heal from, or be treated for PTSD, vicarious trauma, and secondary traumatic stress disorder.

In summary, recognition and understanding of the victim has not necessarily been beneficial for women or decreased their risk of violence or assault. Conversely, women experience greater bias in diagnoses (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Chesler, 1972; Penfold & Walker, 1983); their experience of violence leads

to their pathologization, potential institutionalization, and treatment. Women are the scapegoat for both their own victimization and male violence. Penfold and Walker recount a woman's statement in a Vancouver study, which puts it succinctly, "I feel that, essentially, when a doctor prescribes a pill for me, it's to put *him* out of *my* misery" (1983, p. 191). Prevention and abolishment of male violence that all women experience is ignored by our social systems and services, and women are simply instead seen as symptomatic and disordered. These women who are traumatized, symptomatic, disordered are then viewed as eligible for treatment within our various social programs, including sexual assault services. Society's values are revealed in its choice and action to treat women in their hurt and survival responses to their risk and experience of violence, over treating the endemic violence perpetuated by men.

Sexual Assault Services

Symptom-Based Services

Research that looks critically at service providers, policies, and the systems that maintain them is increasingly required. Our society has come to depend on service providers to manage and solve problems. For example, if I have a cough, I visit a doctor to treat *the cough:* symptom, diagnosis, solution. Unfortunately, the cough is only a symptom of a more serious cause, which is often and easily overlooked. At least it can be overlooked if the symptoms disappear and are kept in-check. The deeper-rooted cause, which is the real issue, can continue to infect and destroy the body silently since we focus primarily on the various symptoms we encounter. My cough may be caused by a more serious infection or condition. However, unless time and energy is taken to consider and treat the root cause

of my cough, it is easy to efficiently and economically "treat" my cough with a lozenge or tea. Though, it may return, worsen in symptoms, or quite easily infect others if uncured.

In the same way, when a problem enters the *service* system it is cut from the context of society, and the *problem* (or the symptom) is serviced. Thus, society divorces itself from responsibility for the cause. The problem-solution language so prevalent within social service agencies reifies the belief and constructs the *reality* of the *problem as personal*. This language supports the isolation, pathologization, and subsequent depoliticization of social issues. Thus, we treat problems (symptoms) and ignore the causes. In this system, an individual is perceived and treated as a number of symptoms rather than an individual responding to an act of violence, which has greatly affected all aspects of their self, identity, and life. In the case of violence against women, *trauma* (PTSD) is considered to be the problem, as is *secondary trauma*, which can develop in the helpers and the supporters of the traumatized individuals. In addition, the numbers that are so great (of women affected by violence, rape, sexual assault) have allowed society to consider this issue *normal*, and now the disordering of the helpers is becoming *normalized*, and a natural result of victim contact. Unfortunately, what is overlooked is that when violence and the potential for personal violence are seen as normal, *all* women are not safe, and cannot live feeling completely safe. As they are unable to keep themselves safe, they come quickly to understand that others in society will not help keep them safe. Sadly, if violence does occur and a woman becomes symptomatic she is simply labelled traumatized, she is pathologized, and considered disordered because she cannot cope with a *normal* event. The medicalizing of rape judges women's responses,

survival techniques, and coping mechanisms through the lens of psychiatry, mental health, and pathology discourse (Foley, 1996). Women's behaviours are scrutinized and reframed as symptoms of their disorders.

Feminist Agency Philosophy

Sexual assault services were started by women for women with the goal of eradicating violence against women through social awareness and activism (Burstow, 1992; Profitt, 2000b; Weedon, 1997). Feminist agencies claim to operate from a set of values and a philosophy that is different from mainstream social and health services. The following quote by Smith and Douglas (1990) locates and differentiates feminist therapy and social analysis from the dominant society that oppresses women:

> A feminist social analysis, the contextual underpinning of all feminist therapy, explains all behavior as it is developed and displayed within a *society that systematically denies and actively challenges the right of women to make their own decisions, honor their own feelings, and choose their own actions, that is, to exercise power within themselves.* Without this social context, a woman's inability to assert her individual rights in a hostile environment, her disempowerment, is seen as an individual matter and ascribed to her personal failure. Such a nonfeminist analysis blames the victim for her inability to overcome the social oppressions that inhibit her effort. A therapy that does not include the social context in which women have been systematically taught to accept disempowerment as "natural" perpetuates disempowerment by presenting empowerment as an isolated individual act. (Smith & Douglas, 1990, p. 44, italics in original)

This is a clear articulation of how victim blame is perpetuated and women's oppression is maintained and set up to be self-fuelling. Many feminist agencies believe in the rights of women to live and exercise personal choice from an "empowered" standpoint. In these agencies awareness of women's rights and promoting this awareness in the community is a standard of practice. However, awareness of women's location in an oppressed subjectivity must be taken into account when talking about choice and empowerment

(Brown, 1991; Burstow, 2003; Profitt, 2000b). At an earlier time in history, feminist response (service) was about support, advocacy, and telling women's stories to the community. Feminist services rejected the hierarchy, patriarchy, and capitalism of professional systems (Yancey Martin, DiNitto, Byington, & Maxwell, 1998). Because feminist practice looks at society as problematic and not the individual as problematic, advocacy and social action are inbuilt. Feminist therapy includes a feminist analysis of the social context of rape (Lebowitz, 1993). Therefore, therapy on its own is not an option (Lerman & Porter, 1990). Laura Brown (2004) states that the overarching goal of feminist therapy is that clients develop a feminist consciousness that much of their suffering is due to being systematically invalidated, excluded, and silenced as a result of being women. Feminist practice works to construct egalitarian relationship, focusing on client strengths and resiliencies, as well as distress (Brown, 2004); control is shared and respect is mutual (Lebowitz, 1993). As well, Mardorossian (2002) argues against Wendy Brown's critique and dismissal of speak-outs (1995), saying that speak-outs are important in women's empowerment, healing, and prioritize a discourse of freedom.

The philosophy of the sexual assault program I work for and from which I recruited my participants, holds that sexual assault is an act of violence and domination where "sexual" contact is forced or coerced, regardless of the relationship between the victim and the assailant (Information for friends, partners, or family of survivors of sexual assault, 2007). This program recognizes that women have traditionally been treated as men's property, and sexual assault has been viewed as a crime committed by one man against another man's property. As well, fear of and experience of sexual assault forces women to restrict their activities and this fear acts to control women's behaviour.

This is due to, and is maintained by, the widely accepted belief held by both men and women, that a woman can act and live in a way that prevents sexual assault; women are responsible for avoiding violent acts against them (Information for friends, partners, or family of survivors of sexual assault, 2007). Furthermore, the program's statement of philosophy proposes that sex-role stereotyping by society supports and maintains attitudes that contribute to the occurrence of sexual assault. Sexual assault ranges from verbal abuse to physical violence and penetration. Penetration includes the violation of any bodily orifice by any object in a sexual context. As well, there is an acknowledgement that the majority of sexual assault victims are women and children, although it is an extensive problem that all people can and may experience regardless of race, sex, sexual orientation, ethnic or socioeconomic background, age, or relationship status. The existence of sexual assault is related to the presence of pornography, child abuse, domestic violence, sexual harassment, all types of discrimination including but not limited to racism, sexism, homophobia, ageism, ableism, and the limiting of women's reproductive health choices. Finally, the program philosophy states that the effects of sexual assault are both immediate and broad-ranging. There are emotional, physical, and psychological impacts for the victim as well as the secondary victims (friends, family, supports) (Information for friends, partners, or family of survivors of sexual assault, 2007).

Feminist social services originally promised to work according to a new ethic, which is different from that of the male-dominated psychotherapy profession, which fails to be sensitive to the unique needs of women, minorities, the poor, and other classes of people (Kanuha, 1990). With this promise, "feminist therapy has created an expectation

that sometimes has been difficult to fulfill" (Kanuha, 1990, p. 29). Often, due to a conflict in values, there is a divide between feminist services and mainstream services. Then, in order to work together, or due to the demands of government funders, one or the other may have to compromise their stance.

History

Many services for women were started as grassroots services by feminists in the early seventies (Burstow, 1992; Foley, 1996; Gillespie, 1996; Mardorossian, 2002; Profitt, 2000b). They were run mainly by non-professional women, some of whom had gone through similar experiences, some of whom had a heart or a passion for helping women dealing with these issues, and others who felt responsible to fight for the rights of women and teach women to fight for themselves (Burstow, 1992). Rape awareness and appropriate social response to victims was at the top of the to-do list of the women's movement. Activism and advocacy were also critical elements of healing. Sasha Roseneil (1995) speaks of feminist goals as creating liberatory spaces in order to provide opportunities for women to actively rethink and reconstruct ways of understanding their world and sense of themselves. Social change was seen as essential; it would empower women, educate men and women, and change the present and future for both women and their children. Social empowerment was more important than, and a necessary prerequisite for, personal empowerment. Cowger (1994) speaks of the importance of social empowerment. In this, the individual's definitions and characteristics cannot be separated from their context and personal empowerment, which are related to opportunity. Social empowerment acknowledges that individual behaviour is socially derived and identity is "bound up with that of others through social involvement" (Falck,

1988, p. 30). Social justice, social empowerment, and personal empowerment are intimately related, with personal empowerment contingent on the social context. Within this understanding, counsellors cannot empower others.

Most rape crisis centres were started outside of the medical and mental health systems, and provided support for the victims of sexual assault (Herman, 1997). For example, the sexual assault program I work for was started by a group of women who wanted to address violence against women, and who wanted to see a change at a social level through work at the personal level. Over time, however, and as the community centre became more inclusive and began providing more services to larger populations, funding became a more critical issue and the centre came under regular (and "dependable") government funding. The sexual assault program was one of the services among many within this agency. A trend of rape crisis centres being overstretched and under-resourced with growing demand and need for services for women added pressure to find some financial stability (Gillespie, 1993; Gillespie, 1996). The question arises, therefore, whether or not feminist agencies can uphold their founding philosophy, mission, and mandate under the hand of government funding. Further, can these agencies exist without this contingent funding, and if so, how? Can they exist in the current mental health system? A part of my research is to understand what discourses are in operation and what impacts and values are currently promoted in a sexual assault program with feminist origins and proposed (current) philosophy.

Present: Depoliticizing, Institutionalizing, Pathologizing

The social services started up by women for women are not exempt from the draw of financial security (Burstow, 1992; Burstow, 2003; Mardorossian, 2002; Yancey Martin,

DiNitto, Byington, & Maxwell, 1998). The shift from independent grassroots feminist services with social change as their primary goal to the collaboration with, and incorporation of, medicalized mental health invited the formation of professional and institutional policies, which impacts every aspect of violence against women services (Burstow, 1992; Hammons, 2004). For example, shifting our language, within the sexual assault services, from "rape" to "sexual assault," and to "trauma services" (with nameless cause and genderless perpetrators) has helped guarantee government-funding opportunities. All these actions have centred "trauma" and PTSD as pathological conditions requiring support and professional help. In this picture, perpetrators and violence are out of focus.

As a result of insurance matters and a lack of government funding of certain services for women, changes have been made to the services and to the way those services are carried out. Consequently, the services must follow the conditions set out by the funding (governing and monitoring) bodies (Burstow, 1992; Hammons, 2004). Grassroots organizations that were started and run by women have either struggled to survive due to lack of support and resources or have come under regular government funding or governing funders (and therefore need to comply with the requirements and conditions of the government). This has the effect of silencing the political voice of agencies that believe, and/or previously believed, that political activism and advocacy is a critical step in the healing process for women who have experienced violence (Foley, 1996; Fook, 2000; Gillespie, 1996; Hammons, 2004; Mardorossian, 2002). Many social services that have previously been stand-alone are now being amalgamated with other services to provide service that is more fluid and accessible for clients. With this joining

comes universalized standards, governing boards that are further removed from the frontlines, and a general trend towards depoliticization as resources and outputs are counted and managed from the top down (Foley, 1996). For instance, in Winnipeg, the rape crisis van started out as a grassroots, feminist action (service) for women who had been raped. The feminists who started this response team had the goal of abolishing sexual violence towards women. However, over time the rape crisis van has become a trauma service for women and men who have experienced any form of sexual assault. The sexual assault crisis program is housed within a conglomerate agency, funded by the Winnipeg Regional Health Authority (WRHA) due to its medical clinic component. Over this time as well, the feminist philosophy has been removed or picked apart as the agency as a whole is divided on foundational values, and conditions for government funding come with stipulations to where and how resources can be spent. Unfortunately, most of the conditions required for sustained funding from the government are based on the dominant model of healthcare and require that the social services get in-line with the rest of the mental health and medical health fields. (Note: Much of the information on the rape crisis van to present has been gathered in conversation with individuals currently working in the agency in various programs, as well as past employees and volunteers. This is due that this history has been almost completely erased from any 'official' source, such as training manuals and websites).

A primary goal within the professionalization of the governmental healthcare system is to attain standardized diagnosis, treatment, and cures for illness (Gordon, 1988; Foley, 1996). The language of the funding applications and proposals from sexual assault services must fit with what is required and deemed as valuable and valid by the medical-

model-run healthcare system. Posttraumatic Stress Disorder, Vicarious Trauma, and Secondary Traumatic Stress are diagnosable with their predetermined and easily recognized symptoms. Treatment may follow, and may include the administration of psychotropic medications or trauma counselling, and any cessation of the symptoms is a return to normal health and societal productivity (Burstow, 1992). Along with many feminist authors, I believe that the outcomes of this system for women—both the victims/survivors and the workers—are devastating, especially in their refusal to address violence that often precedes the current conditions/experiences of these women (Mardorossian, 2002). However, the pressure to comply with larger systems to secure funding acts to control access to knowledge (Foley, 1996). Funding *security* actively silences voices that deviate or are different from the dominant and accepted voice of the current patriarchal politic, as it dictates how and with what resources activism can be carried out. The adoption of trauma discourse, prioritizing it in our sexual assault programs silences women in their experience of violence against them (Rosewater, 1990). In this way, programs such as the sexual assault program I work for have become depoliticized because they must work within the confines of a larger agency run by policies and conditions that are not necessarily concerned or committed to a feminist value system, political change/activism, and are certainly not aiming to challenge the current medical/political/economic model of healthcare. With this government- and larger system-pressure, if there is a problem it is most often focused on the most changeable/controllable unit—the frontline worker and the service user. This pressure and focus leaves the societal issue of violence against women untouched, unchanged, and unchallenged (Mardorossian, 2002).

Thus operates the trend towards the depoliticizing of formerly highly political organizations (Hammons, 2004; Profitt, 2000b). As long as the independent service agencies are desperate to stay afloat financially, they will allow society to remain complicit in violence against women. The organizations, which at their conception were focused on supporting the victims of rape, naming the perpetrators, advocating on the victim's behalf and on behalf of all women, and actively working against violence against women in our society, are now dependent on various funding bodies, and must work in harmony with other service providers, as well as uphold the conditions/policies placed on them and the standards expected of them by the medical and mental health organizations that they are members of (Foley, 1996; Rosewater, 1990). These policies and standards are built on the medical model of practice where science, statistics, standardized care, treatment, money and politics (the ruling politic) are the focus and determine the legitimacy of the service. Very often the individual—along with her unique needs, unique experiences, and unique stories—is lost or actively overlooked as she is serviced within the constructed institutions.

Under these circumstances women become a number, a list of symptoms to be diagnosed and treated by the health services, preferably within the least amount of time, or the predetermined amount of time, and expending as little professional and fiscal energy as possible. Many of the people who enter the service system due to a traumatic experience, such as sexual assault, are soon labelled with a disorder (such as RTS, PTSD, traumatized), and have their symptoms treated. This labelling directly relates to the lack of understanding and sensitivity to the effects of their experiences and is evidence of the little time that is spent learning about the experience of the woman seeking support. The

list of symptoms the woman is exhibiting becomes the grounds for her diagnoses, determines the level of "care" needed, and allows her to be treated in a standardized medical manner within the institutions that have been erected to treat these symptoms and return the ill back to what is considered normal functioning and productive human beings (Burstow, 2003; Profitt 2000b). Once they are cured, they can be re-integrated and accepted back into mainstream society, which values *normalcy*, compliance, and productivity. At no time within this framework for care does society take responsibility for the cause of the trauma (including vicarious), or acknowledge the violence enacted by men to produce this trauma, and at most the woman's story may be spoken in confidence to the individual whose job it is to treat and counsel the victim (Mardorossian, 2002).

Over the past few years, there has been movement within the sexual assault program that I am a member of to work more collaboratively with different organizations as well. I believe that the understanding and the information that I have gathered in discussion with past and present workers in my agency and reading about its history to present is transferable to other locations and services that started out as grassroots supports for women—with political awareness and action as centre. Currently, due to economic and political issues and incentives, the sexual assault program works closely with the governmental justice system and medical system (Foley, 1996). For example, sexual assault workers, police officers, and nurses work together on various boards with the intention of better servicing sexual assault victims.

However, working closely with other systems can have an oppressing impact on the feminist sexual assault service (Foley, 1996). The "feminist" agencies that work closely with the judicial and medical systems are somewhat silenced in order to uphold

the dominantly accepted standard of practice. Standardizing practice and collaboration take precedence over challenging the systems that exist (and the dominant patriarchal value set). At what cost to women do these working relationships operate? When feminist agencies remain silent, cordial, and/or friendly with services that oppose or do not value the deconstruction of dominant patriarchal ideology, there is further and supported depoliticization of societal responsibility for sexual assault. Currie (1990) and Fraser (1989) have documented and analyzed the processes through which feminist demands for fundamental social change have been absorbed and recast into professionalized, bureaucratized, and depoliticized discourses. Women are viewed as a set of symptoms that signify a disease or mental disorder (trauma, PTSD, RTS). Women are institutionalized within private, professional hospital and counselling rooms in order to be treated and counselled through their adverse feelings and symptoms, and taught to be successful again—according to our society's definitions of success and productivity (Burstow, 1992).

In my study of the secondary trauma literature and research text, I explore the language of pathology, diagnosis, and treatment, which are effective tools of women's oppression. These tools are active and being used in all levels and areas of social services, even within the services that consider themselves feminist. In Chapter 3, the fourth section, I will discuss the pathologizing, institutionalizing and isolating, and depoliticizing effects that the secondary traumatology studies in sexual assault workers have, including how these constructed discourses impact the supportive services provided to women. In the interviews, I analyze what discourses are in operation on the frontlines.

I introduce the text and a gendered lens and interpretation of the literature to begin a critical exploration and understanding of the context within which sexual assault counsellors are trained, work, and speak. Clearly, the women I spoke with had adopted much of this discipline, but also challenged it. This look at the discourses in operation within the historical and current language, knowledge/power, and discursive context is critical to a feminist poststructural methodology (Epstein, 1999).

The Sexual Assault Counsellors

Effects on Counsellors

The economic and political pressures on services for women affect those who have been sexually assaulted, but also impact the women who work in these programs as counsellors. The frontline workers (those in direct contact with victims) often have supervising and governing boards above them. The management and policy-making levels often have little to no contact with victims, or even the frontline workers. This disconnect can lead to the oversight of the best interests of victims, loss of mission and vision, and attention to the political and financial maintenance and gains. With management and policy-makers so far removed from the frontlines, the needs of victims and frontline workers are at stake. The women working directly with victims are greatly impacted by this disconnect and potential loss of grounding philosophy. Due to sexual assault workers' time and energy spent in the sexual assault service, they are contributing to and working for a current system that holds the patriarchal values of women, promoting and ensuring male dominance, and in this, allowing male violence to continue. Through available and valued discourse in operation within our institutions, we

(re)constitute a certain truth about violence against women, as well as the value of the victim, her supports, the perpetrator, and the subjectivity of woman as ill (whether she be a victim or the one who helps the victim).

Just as particular discourses circulating around violence against women have become normalized, there are particular discourses that have become normalized within the sphere of sexual assault counselling. For example, the fact that women counsel/treat women reinforces the idea that it is the responsibility of women to hold and heal their own. In the agency I work for there are only female sexual assault counsellors, probably originally due to its feminist start and value system, however, now it seems due to an assumed greater sensitivity of both victims and counsellors. And further, the resulting trauma/effect/empathy/fear in the female counsellor is then described as disorder, because they cannot deal with their responsibility/job/task addressing what is *normal* (occurring everyday) in society. These constructed disorders are currently popular research and theoretical topics.

The discourses of trauma constitute and impact the relationship between women—victim and therapist. This relationship is very segregated, boundaried, and othered; there are clear client versus professional/counsellor subjectivities. The current language, knowledge, and power relations oppose original feminist intention of community, support, strength, and unity. I look closer at the relationship between women in reading the social texts of female sexual assault counsellors.

Secondary Traumatic Stress Disorder and Vicarious Trauma

As a volunteer and employed sexual assault counsellor at a local community health centre, I provide both crisis and trauma counselling to survivors of sexual assault.

Throughout my involvement in this program, I have noticed a high level of turnover among workers and volunteers and have noticed that workers frequently complain of symptoms such as increased fear, nightmares, and depression, which are all common symptoms of vicarious/secondary trauma (Figley, 1995a). Unfortunately, because dialogue about vicarious trauma is minimal, and strategies to alleviate this trauma are still relatively unknown and *unproven* (Arvay, 2001), workers (including volunteers) often leave the social services field distressed and feeling incompetent.

Recently, vicarious trauma, otherwise known as secondary trauma, has been acknowledged as a significant problem among therapists who work with survivors of trauma (Arvay, 2001; Pearlman & MacIan, 1995). Pearlman and MacIan (1995) define vicarious traumatization as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences" (p. 558). Most research has provided evidence supporting the existence of vicarious trauma and attempts to reveal predictors that are suspected to increase susceptibility to vicarious trauma (e.g., Baird & Jenkins, 2003; Betts Adams, Matto, & Harrington, 2001; Ghahramanlou & Brodbeck, 2000). Studies have also shown that 93% of a sample of therapists reported having treated at least one sexual assault survivor (Dye & Roth, 1990).

Within the research and literature on secondary traumatization, terms such as vicarious trauma (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990), traumatic countertransference (Herman, 1997), empathic strain (Wilson & Lindy, 1994), burnout (Maslach & Jackson, 1986), secondary traumatic stress disorder (Figley, 1983), and compassion fatigue (Figley, 1995b) belong. These terms belong to a discourse, one that

presents and makes accessible and portable certain knowledge and it therefore impacts individuals, service systems, and social power relations. I argue that within this secondary traumatology literature and research are gendered discourses, and their effects are to normalize, medicalize, pathologize, isolate, institutionalize, and depoliticize effects of violence against women both in the immediate (victim) and further-reaching (helpers, counsellors). As I've already shown, this ultimately results in society's abdication of responsibility for violence against women. Furthermore, the language available to sexual assault workers (re)construct these discourses that promote and maintain these impacts (see Hammons, 2004).

Secondary traumatic stress disorder, vicarious trauma, PTSD, compassion fatigue, empathic strain, countertransference, and burnout are all conditions and disorders that potentially befall the sexual assault counsellor. I acknowledge that secondary traumatic stress disorder (or compassion/empathy fatigue) and vicarious trauma are considered separate and different experiences by the authors who have differently/separately named them. Although, for my purposes, secondary traumatic stress disorder and vicarious trauma refer to the same observed phenomena, which are the changes in a therapist or any other person as a result of their exposure to someone who has experienced a traumatizing event (Baird & Jenkins, 2003). Therefore, in my study I will not distinguish between the two labels. However, in the literature, they differ in that secondary traumatic stress disorder (later renamed compassion fatigue) places more of an emphasis on the DSM-IV PTSD-based symptomology with relatively sudden onset, with Figley originating the concept (Figley, 1983; 1995b), whereas vicarious trauma is a theory-driven construct, emphasizing more gradual, covert, and permanent changes in cognitive schema rather

than attaching the experience of the full spectrum of PTSD symptoms, and is a concept developed by McCann and Pearlman (1990a). I follow in the footsteps of other researchers who have used these labels interchangeably because I believe that they have similar foundations and consequences (for example, Etherington, 2000; Neumann & Gamble, 1995; Trippany, Kress, & Wilcoxon, 2004). Like in the work of Motta, Newman, Lombardo, and Silverman, "given that terms such as STSD, vicarious trauma, compassion fatigue, and the like are not included in the psychiatric nomenclature, the general term, 'secondary trauma' will be used from this point on" (2004, p. 68).

Unlike much of the literature, which states that the originating cause of these disorders is based on exposure to a traumatized individual, I argue that the causes are systemic and societal. I primarily use the term *secondary trauma*, though my interest lies in the more general construction of a discipline, theory, language, and promoted practice of power/knowledge of *disorder* as a result of exposure to individuals who have experienced violence. Thus, I take the stance that secondary traumatic stress disorder, compassion fatigue, and vicarious trauma, in theory and purpose, are the same; the terms act to pathologize, isolate, and maintain oppressive power relations in our society.

To this point, I have presented my perspective on the systemic normalization of violence against women, providing a social context for the construction of the victim subjectivity as well as trauma language and labels. I then presented the originating feminist response, which included service goals of social action and consciousness-raising. I demonstrated what has happened between that time of the original feminist response to male violence until the present time when the systemic depoliticizing of violence against women, and the pathologizing and institutionalizing of women survivors

has become ubiquitous. Thus, I have presented the contextual framework within which the sexual assault counsellor works. I critically introduced the dominant language of secondary trauma and pointed out that it continues to mask the underlying causes of violence against women.

Chapter 2: Methodology

Introduction

The purpose of Chapter 2 is to orient the reader to the theoretical perspective that underlies everything that I write, how I read the literature and interviews, and how I perceive the work that I do. This section gives context to the lens through which I have moved throughout this research, and how I am focused on power, knowledge, and language. This section also describes how I collected and analyzed my data.

I have chosen to use a feminist poststructural discourse analysis as my methodology because it best fits within my personal beliefs and the way that I have chosen to work with my participants. I am constantly and consistently concerned with issues of gender, subjectivity, power, language, and knowledge (Gavey, 1989). With these foundational concerns, as I have read the literature of secondary trauma I have noted that there are four dominant mechanisms or impacts of discourse, including: normalization, medicalization/professionalization, pathologization, and depoliticization that arise over and over again. These impacts are constructed within dominant phallocentric discourses in the secondary trauma literature, and I tie them specifically to the context of the rape and sexual assault helping field through listening to the stories of women doing this work. Importantly, a feminist discourse analysis of the narratives of sexual assault workers prioritizes the voices of women (Gavey, 1989).

In section one, I outline my feminist poststructural approach and define discourse analysis, as I attempt to do it. In this section I locate myself and discuss constructs such as power, subjectivity, and knowledge as I struggle to understand them. In describing the guiding principles that ground my work, as well, I explain how I read the literature and

transcripts, my need and impetus to do critical research, and the benefits of using this methodology in the area that I am studying. In section two (*Research Methods*) I explain the methods that I used in this research, how I recruited participants, who the participants are, and how I analyzed the transcripts. Section three (*Evaluation and Assessment*) is an evaluation and assessment of the methodology. In this section, I discuss how I work to remain reflexive and transparent throughout my work. I assess my research and appeal to the need to consider critical research by different standards than are held for positivistic scientific research methods that claim to be valid, reliable, and bias-free.

Feminist Poststructural Discourse Analysis

Location: Need for Feminism

A fundamental concern that impassions and drives my work is my abhorrence of both the prevalence and the societal acceptance of violence against women. I use a feminist perspective in my discourse analysis because I feel the need to place a gender lens onto the topic of secondary traumatology, trauma, and the client-therapist relationship as it directly relates to violence against women. Like in other feminist research (Renzetti, 1997; Ristock, 2002), I strive to create a strong argument for and with women. I appreciate the work of bell hooks, who states that "women can and do participate in politics of domination as perpetrators as well as victims—that we dominate, that we are dominated" (hooks, 1990, p. 186). Reading transcripts of sexual assault workers explores how discourse constitutes experience, and further, how experience constitutes discourse.

As Susan Strega clearly outlines, feminist poststructural methodology "offers a useful approach for those seeking a social justice orientation in their research," one which

"requires that researchers examine power and how it operates through discourse and subjectivity" (2005, p. 200). It was my intention to centre gender in secondary trauma discourse and rename violence against women as the cause of all women's experience of what we call trauma and secondary trauma. My primary challenge is to the discursively constructed division between "professional" and "victimized" women.

The argument that I make in this study is useful to practitioners working with survivors of trauma as it looks closer at gender in a discourse that presents itself as neutral. Like other feminist researchers (Becker, 2000; Becker, 2004; Haaken & Schlaps, 1991), I am concerned with the impacts of this discourse on women . It is also imperative to look at history and social context, which Foucault exemplifies and promotes (Epstein, 1999; Hook, 2001). I included a social contextual overview of the issue over time, focused on violence against women, social response, servicing the victims, the labels and language (PTSD), and the impacts on the therapist. The discourses of secondary traumatology pathologize, isolate and institutionalize the woman who has experienced violence; as well, these discourses normalize woman's responsibility for the violence perpetrated against them (Dineen, 1996; Penfold & Walker, 1983). The devastating impacts of these medicalizing/professionalizing, pathologizing, normalizing, and gendered discourses include depoliticization, which silences women, as well as the maintenance and promotion of violence against women as society redirects attention to the woman as ill and the therapist as infected and dangerous (Burstow, 2002; Mardorossian, 2002). These discourses constitute women's relationships within boundaries of fear, illness, and professionalism.

As well, looking to the community is important when doing feminist poststructural research. As outlined by Seibold (2000), feminist research must prioritize women's experience, and for this reason I include interviews with women, and attempt to centre the stories of women who support other women who have experienced sexual assault. Thirdly, my goal and intent is to make this research, with my exploration of the social context, literature, and stories of women, a critical and active piece to better the lives of women (Seibold, 2000; Strega, 2005).

Another critical reason for feminist research and voice is that knowledge "creation" has been predominantly within the male domain (Fook, 2000). Who has the power to create knowledge? Historically it has been White men; we depend on men to write it down before we call it theory, we wait for men to place their name on it before it *exists*, to plant their flag. For example, the 'G' spot was *discovered* in 1944 by Dr. Ernst Grafenberg and a prominent gynecologist Dr. R. L. Dickinson, M.D. They called it "The Grafenberg Spot" (Salla, 2004). This "discovering" is a clear example of how the construction of knowledge and power relations (both (re)creating legitimacy) are related. In our Euro-Western society, ownership is power. The assumption is that everything can and should be owned: land, knowledge (we can patent it and place our name on it), people (women, immigrants, refugees, First Nations people, and children), and animals. However, it is only a privileged few who have the right to be owners. I am quite certain that the place in the female body now well known as the "G-spot" existed before it was named by the powerful and legitimate male duo. However, naming it creates it, language creates truth—what our Euro-Western society calls *discovery* is perhaps better represented as *invasion* (e.g., Columbus *discovered* a new world, a new people). The

"discovery" of what was already in the experience of women (however, I have no "proof") is offensive to women. Women's bodies, experiences, stories, are and have historically been defined and named by men, after which they are recognized, legitimized, and accepted into a body of knowledge that can be distributed throughout society (Fook, 2000; Hammons, 2004; Moreton-Robinson, 2000). This is regardless of whether or not women can find themselves or feel connected within that definition. Historically, women's bodies and experiences have been subject to men's deconstruction, discovery, and claiming (Burstow, 1992). The phallocentric language used to define women's experience rape all women over and over again. Challenging this societal phallocentrism impassions my drive to do feminist work, centring women's experiences and stories.

Foucault (1979) stated that we cannot divide the world into accepted and excluded discourses; rather we need to find their potential uses, both as instruments and effects of power, and as points of resistance. In my research I attempted to do just that; using feminist poststructuralist discourse analysis to deconstruct trauma work discourses, the purpose and effects of these discourses, their role in constituting the subjectivities of both therapist and client and where they might be resisted. This thesis attempts to provide evidence and argument of how dominant discourses maintain the oppression of women, as well as how 'discursive elements' can be used "proactively to resist negative constructions" (Dell & Papagiannidou, 1999, p. 401) of violence against women and its resulting traumas. Furthermore, I was interested in the counselling relationship between women, especially considering that the initial response of second wave feminists to rape and sexual assault was active rejection of therapy (Yancey Martin, DiNitto, Byington, &

Maxwell, 1998). As well, as discussed in Chapter 1, feminist services at their birth rejected the professional boundaries that segregated women into clients and helpers (professionals) (Bustow, 1992; Profitt, 2000a). The goal of feminist services and rape response teams, which was how my program started, was abolishment of violence against women through consciousness-raising and social action (CASAC, 2008).

Feminist poststructural discourse analysis allows for and encourages awareness through critically exploring discourse (Profitt, 2000b). Language as a component of discourse "both serves and masks ideology" (Strega, 2005, p. 217). Language does not passively describe reality, "language constructs and constitutes 'reality' insofar as we can apprehend, understand, and describe events and experiences only through the words, language, and discourses that are available to us" (Strega, 2005, p. 217). Feminist poststructural discourse analysis challenges dominant discourses which maintain the power and privilege of only a few, through awareness and beginning to uncover the masked (Strega, 2005). Only through exploring how dominant discourses are in operation can we uncover the masks and challenge the current hegemony (Foucault, 1981). As well, to explore and criticize language and discourse helps us understand power relations (Wang, 1999).

A feminist perspective is foundational in this thesis. I locate myself as a White, institutionally educated person, in this I have many privileges and power within our Euro-Western, capitalist, and patriarchal society. I also struggle as a woman, who has both experienced violence and held the role of helper within a social service agency for women who have experienced sexual assault and rape. As well, I am angry, I am emotional, I am sad, and overwhelmed at times, I wish not to offend in my writing and

research, but to challenge and encourage questions and considerations. I have chosen to adopt bell hooks' broad definition of feminism as "a movement to end sexism and sexist oppression" (1990, p. 189) as the foundation of my work. Moving towards this end is a foundational criterion for doing feminist work, using women's voices and stories to do so (Renzetti, 1997; Ristock, 2002; Seibold, 2000). However, I claim that this thesis is my interpretation as I am the researcher and author and acknowledge that it is one of many interpretations (Stoler, 2002). At another time in my life and within society, I am certain that this thesis would look very different.

Intimately related to both feminism and poststructuralism is the assumption that all behaviours occur within a context (Lerman & Porter, 1990; Wang, 1999). For the purpose of location I have presented, in Chapter 1, the context of violence against women and societal response, as well as (in Chapter 3) an introduction and presentation of the gendered, normalizing, and pathologizing dominant discourses within mainstream secondary trauma literature (Fairclough, 1993; Potter & Wetherell, 1987). The context I have presented is the one from which I now move to explore narratives of women working as helpers in the sexual assault service system.

In doing this research I strove to remain reflexive and transparent throughout my work. My subject position remains implicated in the formation and presentation of my perspective. As a White, middle class, institutionally-educated individual I am extremely privileged and have a great deal of power in many social relations. My education gives me a language that is revered and equated with intelligence, legitimacy, and superiority. It has also given me a list of credentials that create opportunity; irrespective of my own representation, the letters behind my name communicate a kind of authority. The process

of this master's thesis work has also taught me about patience, humility, self-honesty, and forgiveness as I have struggled to get to this, and every, point.

As another example of my privilege, the colour of my skin grants me access to almost every opportunity society deems valuable, and it ensures that society views me as more valuable than certain others (for example, see McIntosh, 1998; Moreton-Robinson, 2000). The media depicts *beauty* as a completely White virtue; the underlying belief is the whiter, the better (see McIntosh, 1998; Mullaly, 2002). To gain a greater sensitivity to oppression I read authors like McIntosh (1998), Mullaly (2002), Bishop (1994), and McGoldrick (1998), and specifically to gain insights and sensitivity of the impacts of my skin colour, I have read articles and books by women who are not White, such as Aileen Moreton-Robinson (2000), bell hooks (1990, 1984). In my own work with sexual assault survivors I have *continually* noticed that a woman with brown skin who is raped elicits a completely different and much more derogatory and unfair response from our medical and justice systems than does a woman with white skin. For example, in my experience it is not unique for police officers to treat an Aboriginal victim differently than a White victim of rape when they interview them immediately following the assault. I witness from police officers (not all officers) more negative affects, disbelieving tones of voice, judgmental and negative attitudes reflected in eye rolls, derogatory and disbelieving comments to others in the room in front of and behind the back of the Aboriginal victim. In my experience, when questioning an Aboriginal woman following a rape, the police officers will more often ask her whether she has been drinking alcohol or doing drugs, they will often also not believe her if she says "no," and will repeatedly ask her the same questions. As well, I have witnessed police officers increase the amount of alcohol when

repeating back to the victim what she stated she consumed. More often than with White women, police officers will ask Aboriginal women if they had been "working" at the time of the assault—assuming that the woman is street-involved—further implying, both, that these women cannot experience *rape* due to their *choice* of "work" and that they *have asked for it*, all common stereotypes and rape myths supporting differential treatment (Burt & Estep, 1981; Burt, 1998). The prejudices and stereotypes held by police officers are commonly displayed in my experience, clearly confirming the idea of "real" rape (Burt, 1998). Exemplifying this, at the hospital I have been told in private by the police that a woman is not a "real victim" when she finally fought back and injured the man who held her captive for two days, repeatedly raping her. This woman was also Aboriginal; she was arrested. I am not saying that these actions and violations by the police are unique to Aboriginal women, they are *not*, however it is my experience that they occur far more often with non-White women, as observed by myself and my colleagues in the sexual assault program.

Discourse analysis works to expand create consciousness of shortcomings and unacknowledged agendas and motivations in the discourse of treating sexual assault trauma (Palmquist, 1999). Underlying my research is the critical assumption that, "language constructs how we think about and experience ourselves and our relationships with others. Discourses are regarded as, patterns of ways of representing such phenomena in language" (Lupton, 1998, p. 8). Discourse analysis is, "primarily concerned with analysis of the use of language and how dominant belief systems are reproduced in discourse" (Crowe, 2000, p. 71). As well, discourse analysis is concerned with the effects of language, and how language acts to discipline women (e.g., victim blame) and

normalize assumptions (Hekman, 1990; Penfold & Walker, 1983). Discipline is a technique that "makes" individuals; it governs and regulates behaviour, diagnosing deviance and norm (Chambon & Wang, 1999; Foucault, 1999). As well, discipline reveals how power operates, it is a technique of repression as it punishes those who act in ways that counter centred discourse (Chambon & Wang, 1999). As I have demonstrated, sexual assault counsellors have available limited language and knowledges in order to understand our experience and construct subjectivities. Only certain discourse is legitimate and acceptable for us to use as we describe and (re)construct our experiences, as well we also select what discourse to talk in (Hammons, 2004). I explored 'official' secondary trauma discourse through a feminist poststructural lens to provide a context for my analysis of the narratives of sexual assault workers. Foucault asserted that history and social context are important in analysis of current discourse (Foucault, 1980; Foucault, 1984; Gavey, 1989).

My research topic was driven by my need to provide a space in which women's experience was centred. Such spaces have been called "liberatory spaces" (see Profitt, 2000b). Thus, it was necessary that I used a feminist lens, as too often academic and professional research proposes to be neutral, bias-free, objective, and non-gendered (Caplan & Caplan, 1999). I believe, however, that all language, discourse, and knowledge is gendered, constantly (re)constructing gender rules, norms, subjectivities, and values. A feminist poststructural lens (Saulnier, 2000; Weedon, 1997) seeks to deconstruct assumptions about gender embedded in discourse, to question the ways that power and knowledge act to naturalize the discourses that construct and maintain gendered roles, even within sexual assault services whose beginnings were feminist. A discourse is a "set

of sanctioned statements which have some institutionalized force, which means that they have a profound influence on the way that individuals act and think" (Usher, 1997, p. 62). Dominant discourses are gendered, hierarchical, based on modernist thought (with clear dichotomies), have clear boundaries and carry stereotypes and rules, as well, they are governed by certain value systems. Throughout this work I critiqued and explored the value systems, assumptions, rules, et cetera, that are imbedded and all too often remain masked.

I specifically looked at the gendered power relations within the sexual assault therapy room, and how certain truths shape both victim and helper subjectivities. I use the term *certain* to indicate my belief that these are only some of the truths available to us. The dominant, gendered discourses within secondary trauma literature and research constitute and maintain our knowledge, and as these discourses currently exist and go unchallenged, they limit our ability to learn new truths. As well, these truths implicate us as active participants in (re)constructing, maintaining, and perpetuating the status quo—the power hierarchies, patriarchal value systems, and stereotypes so entrenched in the sexual assault response system. We are complicit in maintaining our own oppression if we uncritically and passively accept these discourses. My analysis demonstrates the relationship between what women know, what is available for them to know, and the discourses they employ to constitute their experience and the experiences of those with whom they work. Listening to the voices of women in the field of sexual assault is necessary to understand how they speak of this experience, if they are aware of the discourse of secondary trauma, how they accept and challenge it themselves.

Subjectivity

Foucault (1983) proclaimed that subjectivity is a work of art. It is something that we construct from the possibilities available to us courtesy of our social/discursive situation within a particular time and place, within a specific and contingent historical context. However, Susan Hekman (1999) asks: what if our available possibilities for constructing identity are so limited by the discourses, knowledge, and our social location that we cannot create a satisfying subjectivity? As I have demonstrated, secondary trauma literature limits women's access to empowered, strong, healthy subjectivities, and divide victims and helpers, with clear professional (legitimate and ethical) boundaries drawn between the two. By examining women's narratives I can understand where they conform to and/or challenge those divisions. I have borrowed from Janice Ristock (2002) to sum up my intent for this thesis:

> The feminist analysis that I develop in this volume attempts to rise to the challenges raised by third wave feminisms that seek to open up spaces for subjugated voices, while seeing the situational, local, and particular condition that shape women's experiences, and that expose the limitations of mainstream dualities for defining subjectivities. (Ristock, 2002, p. 22)

I am interested in the subjectivities available to women, and the boundaries of those subjectivities. Dominant discourse segregates shared subjectivities of women from each other. These segregations are called dividing practices (Chambon, 1999; Chambon & Wang, 1999; Foucault, 1999), and I explore these in my analysis.

Asking women to tell their stories explores impacts and gives their voices priority in exploring how dividing practices, subjectivity and experience are constituted through discourse. Due to the participants' differing backgrounds and social locations, the discourses they drew on to constitute their experience were both differing and similar.

Power and Knowledge

My perspective on power is strongly influenced by the works of Michel Foucault, who states that power is existent in all relations; it is always present (Foucault, 1980). Power in itself is neither negative nor positive; it "holds good" and needs to be considered as a "productive network, which runs through the whole social body" (Foucault, 1980, p. 119). Foucault states, "power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms" (Foucault, 1981, cited in Weedon, 1997, p. 117). Power, for Foucault, produces knowledges, histories, and subjectivity, regulated by regimes of truth. Regimes of truth are embodied through discourse and include special status for certain types of discourse, criteria for determining/establishing truth and falsehood, rewards, approvals, and restrictions, favoured ways of gaining truths, and establishing authorities and legitimacies for regulating and instituting truth (Foucault, 1980). In exploring the literature, reflecting on my experiences, and listening to women who work as sexual assault counsellors, I have attempted to unmask some of the mechanisms that maintain power relations especially those that support and promote violence against women. I was especially interested in the relationships between workers and victims. I was also interested in women's awareness of power relations inasmuch as they are revealed in how they talk about sexual assault work, trauma, and vicarious trauma. I was particularly curious about their awareness of mechanisms of power and awareness of their participation in these mechanisms—discourse, knowledge, language—that promote violence against women and keep the societal issue of gendered power relations masked, promoted, and unchallenged.

What is Discourse Analysis? Why Discourse Analysis?

I chose discourse analysis to achieve an analysis that is sensitive to power as enacted through discourses of violence against women, including their material effects. As well, I chose discourse analysis in order to challenge dominant discourses and implore others to think critically about how we are responding to rape and violence against women. As Palmquist (1999, ¶ 9) suggests, discourse analysis as a methodology "can lead to fundamental changes in the practices of an institution, the profession, and society as a whole."

Discourse analysis from a feminist perspective is useful for my research because the world as perceived by women may be confined and organized by structures of oppression not apparent to participants themselves (DeVault, 1990). Therefore, a feminist poststructural analysis of the interviews within the context of women's oppression, language, discourse, power/knowledge was important to me. The use of feminist poststructural discourse analysis to examine the sexual assault services field is a good fit. Looking closely at the language used by the female participants allowed me to come to an understanding of how their experiences fit, how they made them fit, and how language represents thoughts about something (Ristock, 2002).

From the discourses I introduce from the literature, I selected two gendered discourses to explore further as I analyzed the transcripts of sexual assault counsellors. I chose the *therapist as dangerous* and the *client as infectious*, discussed in Chapter 3, as these discourses appeared frequently within secondary trauma literature and had not been explored in the past. I am interested in how these discourses influence the relationships that the therapist has, or can have, with her clients and self. It is my contention that these

two discourses segregate the client and the therapist from *normal* society, each other, and themselves. I was also interested in what impacts these discourses have on women, how they navigate their experiences and devalued subjectivities, and how they resist. My intention was to explore these discourses in operation.

Looking closely at the community/micro/societal practices as reflected in the interviews is necessary to understand discourse and impact language and experience (Hook, 2001, Parker, 1999, Seibold, 2000). Feminist poststructuralism values the study of social texts; interviews with participants as "social texts not only mirror but also actively construct a version of things" (Seibold, 2000, p. 152).

My analysis explores how the discourses counsellors use reflects and constitutes our experience of ourselves, the women we support, and the relationship between client and counsellor. Thus, I explored how female sexual assault counsellors talk about sexual assault, its impacts on the women/victim and themselves, and society's response. I looked for how trauma discourse is being challenged and how it is being perpetuated and maintained, following guidelines by Gavey (1989), and the example of Kitzinger and Thomas's (1995) discourse analysis of sexual harassment.

Previous studies have not looked in-depth into the effects secondary trauma discourses have on the experience of the therapist and how these discourses fit into (interact with, reflect, and (re)constitute) the greater societal issue of violence against women. Many past researchers have stayed at the surface of the issue, attempting to find causality remaining focused on the individual (woman), symptoms and diagnosis (victim pathology), secondary trauma treatment, and servicing the "disorder."

Research Methods

My analysis begins with a critical reading of the literature and research on secondary trauma and vicarious trauma (Chapter 3). This is the research that is seen as "legitimate" in academia and is most often used in the social work practice settings, due that it uses scientific methods and reports to be unbiased and objective. This research does not label itself alternative, unlike feminist authors who claim their location. This literature and research is where I look initially to understand current 'official' discourse in operation in our social services. Secondly, I analyze the discourse in operation in a sexual assault program (Chapter 4).

The program that I drew participants from, and within which I volunteer and work, started as a grassroots feminist support system for women who had experienced rape and violence.

I chose semi-structured interviews with sexual assault counsellors to produce texts for analysis. This allowed for greater interaction with the participants, and more in-depth conversation and analysis of meaning (Reinharz, 1992). The questions that I asked participants to reflect on and then discuss with me fell under topic areas of their work, people, trauma and vicarious/secondary trauma.

I work in the agency from which my participants were recruited as a sexual assault crisis program volunteer and casual intake worker and sexual assault trauma counsellor. The sexual assault crisis program is one of the many programs within this Winnipeg community health agency. Ethics approval through the University of Manitoba was obtained (see Appendix A), as well, approval to do my research within the community health agency was obtained from its board of directors.

Participants were recruited for this research through a letter requesting their participation (see Appendix B). Each volunteer and staff sexual assault worker received a letter in their mailbox at the agency, outlining my interest in hearing their stories. In the call for participants I let potential participants know that I was interested in exploring the effects of working with women who have been sexually assaulted. The participants were informed that I was requesting their participation in a conversational-style interview with me, with the possibility of a follow-up interview. I informed potential participants that I was interested in their experiences and stories of working with women who had been sexually assaulted, including the effects of doing this work. In order to participate in the interviews, I requested that the women had been working with the agency for six months or more, and had been in the role of ongoing counsellor for women who had experienced sexual assault in the sexual assault counselling program. The latter criterion intended to encompass the fact that the participant's job had included both crisis counselling, on the telephone, in-person, at the hospital, as well as longer-term trauma therapy with women who are seeking counselling and support following sexual assault.

The participants were given a list of questions at least five days before their interview in order to situate them in the topics that I was interested. I was not interested in surprising the participants, instead I wanted a dialogue and conversation that was meaningful and had depth (see Hammons, 2004). The interview guide was extensive, containing over thirty open-ended questions under the themes of their work, people, and vicarious/secondary trauma (see Appendix C). The interview guide was intended to situate and prompt the participant before the interview, and was far more extensive and structured than the actual interview, which included asking the participants more

generally about their experience doing sexual assault work, how they felt about their relationship with the women they worked with, their feelings and impacts of the work, and their experience and knowledge of secondary/vicarious trauma. In the interview I started with these general questions about their experience of the work and ideas about trauma and vicarious trauma, and allowed the natural flow of conversation to guide the course of the interview. It was my hope that receiving the interview guide before the interview would lead women to discuss the questions and topics that were most meaningful to them in the conversational in-person interview. However, it turned out that only one out of the four women interviewed reviewed the questions prior to the interview, this was Bailey.

Interviews ranged in length from one hour to one and a half hours, were conducted in an office at the program's agency, and were audio taped and transcribed by me. Four interviews were conducted with female sexual assault counsellors, who emailed me or let me know in-person that they were interested and willing to do interviews with me. Each participant was given a list of support numbers and contacts (see Appendix E) if they felt that they needed support following the interview, especially if the interview or research process brought up any feelings or thoughts that they would like to work through with someone other than me. After the interviews were transcribed, the transcripts were emailed to the participants for their review before they were analyzed and included in the thesis (as suggested by Lee & Renzetti, 1993).

Due to the small number of potential participants for my research (the sexual assault program was made up of less than fifty women at the time of the interviews), I made all attempts to conceal identities. To ensure anonymity, I did not attach descriptive

or demographic information and I have changed the participant's names, using aliases for identification. In the interview, however, I did ask for a personal description of age, number of years in the program, education level/background, employment status and sector, class, and race. This information was for my use to aid in reflection, provide context, and deeper understanding of who the participants were and what their social location was (Kirby, Greaves, & Reid, 2006). For the most part, I only speak generally about the participants. Due to the context of the research and history of the program they worked for, I also asked each woman whether they considered themselves to be a feminist and all four participants stated that they did consider themselves feminists.

Interviews were conducted over four weeks. Analysis of the data was done simultaneously with the interviewing process, as encouraged for qualitative research by Glaser and Strauss (1967). I journalled and made notes following each interview in a reflection log. I focused on emotions that I felt during and after the interview, as well as emotions that I saw and experienced in the participant. I attempted to capture my observations of what had happened verbally and non-verbally in the interviews. I journalled about my experiences, feelings, thoughts, and any discourse that I felt was prominent in the interviews. This reflection process began the analysis of the data (Kirby, Greaves, & Reid, 2006). This reflection log was important because with all four women there was follow-up immediately after the recorded interview. These reflective notes about what was discussed when the tape recorder was off and the formal interview was over allowed me to capture important information. This included information about how I felt the interview was experienced by the participant including our conversations when the recorder was off, feelings that I noted, and contextual and personal information that

she did not feel comfortable having in the transcript. Though this information was not used directly and could not be presented in my analysis of the interviews, it added to my reflections and analysis by providing depth and context to my research process and analysis (Kirby, Greaves, & Reid, 2006).

My analysis of the interview transcripts looked at what was said in response to the questions and probes, and at what was *not* said, or where I heard contradictions in how the participants talked about the work that they did and their experiences of it (Ristock, 2002). I listened to the story they were telling me, I listened for discourses they employed, and listened to the language they were using. Some of the questions that informed my analysis include: How they were speaking? And what did this mean for how we do sexual assault work? And how does it impact the greater societal issue of violence against women? Looking through a poststructural lens increased my sensitivity to the intimate and inseparable relationship between knowledge and language. This language-knowledge relationship was especially apparent and marked due to the differing background experiences, access to information, and formal academic education that the women counsellors represented.

Three guidelines directed my analysis of the transcripts. The first concern I had was what the women were saying overall (Potter & Wetherell, 1987; Ristock, 2002). Specifically, I was concerned with what and how they responded to the questions that I asked them directly, what language they used, how often they used that language, and any contradictions. I was interested in their terminology, i.e., whether they used the term "violence" or substituted the term "trauma," how they talked about their work and its impacts, and their relationship with victims/clients. Secondly, I was interested in how

their experiences and the words they used to describe these experiences appeared to be shaped by the discourses that were available to them (Ristock, 2002). I was interested in how and what discourses constructed their experience and their subjectivities. Within this analysis I reflected on their social location and the language that the women used to tell their stories. What discourses did they draw on and what could I infer about the discourses available to them? Thirdly, I compared discourses across the interviews, looking for patterns, congruencies, and differences or counter-patterns (Ristock, 2002). Here, I looked for how discourses interact with each other, support and conflict, counter and oppose, and appear side-by-side (Gavey, 1989). Much of my analysis relied heavily on reflection and personal review, making up my audit trail, which was a journal of my research process from beginning to end. Specifically, reviewing my questions, ideas, and thoughts, which were key elements in detecting alternate discourse, which require a sensitivity and critical lens. This sensitivity was at times very difficult to maintain as it is counter to current dominant practices in which my work, aside from my thesis, is embedded.

In transcribing the interviews, I made decisions about how to write them out, what to include in terms of breaks, "um"s, et cetera, and, how much grammatical correction to make. I decided to make very few grammatical changes to the transcripts. I felt that this was important to capture how the participants spoke, such as whether they struggled (frequencies of "um," "like,") whether they paused, laughed, used silence, et cetera. The transcripts were reviewed by the participants for accuracy, clarity, and I invited them to add or remove what they wanted to have in the transcript. One of the four participants sent back a few changes.

I analyzed the transcripts by identifying discourse, highlighting where and which discourse was employed, when there were counter-discourses presented and how that occurred. I identified common language, pronoun use, consistencies in language, ideas or language that were different, inconsistent, or contradictory. I analyzed how discourses interact and contradict. I highlighted and made notes in the transcripts what discourse I read. I also looked for subjectivities and the regulations of these subjectivities within the data. I was looking for who they talked about, including themselves, me, clients, victims, and/or others. As well, when did they talk about these themselves and others, what was happening, what discourse was employed, and what were the impacts. For example, I noticed that pronoun use changed and was inconsistent, which led me to pay attention to what pronouns were used, when, and how.

When I was well into my analysis, I found myself, in moments, constrained by my preconceived ideas, which were then *proven* by the data, especially those that I had already found in the literature review. At this point, when I felt that I could not see past these ideas, I began to ask myself another question in the analysis process. Because, even though I had interests in specific discourses I read in the literature of secondary trauma, prior to the interviews, I did not know *how* of *if* they would be in operation, and what other discourses may be centred and prominent, what discourses would support and interact, and what impacts these discourses would have. Thus, in order to ensure that I made it clear that the information was coming from my analysis of the transcripts I had to ask myself more clearly, and repeatedly, and while disengaging somewhat from my exploration of the literature and research texts: What is happening in this text? What discourses are employed? And how?

I read the transcripts over and over again and listened to the recorded interviews, asking myself these questions. During the analysis stages, which were ongoing and more intensive at times, I highlighted sections, words, chunks of text that represented or employed discourse that became common. I went through the printed transcripts, making notes on what discourses or discursive impacts I felt and read in the language. In an electronic version I made files for the different discourses that I found and began compiling examples of text for the discourses found in the talk. I analyzed the text for ideas and messages that fit within dominant discourses, as well as those that did not fit or were challenging to the dominant discourses, sometimes called resisting, counter-, and oppositional discourses (Gavey, 1989). Throughout the analysis stage I went back to the literature on discourse analysis, secondary trauma, trauma, and feminist practices. This review helped me contextualize the information, and reinforce my critical lens; I found that it was really easy to get lost in the data and forget context. During my analysis stage I was developing significant sensitivity to my own work as a sexual assault counsellor, and to discourse that constructed my experiences and have included some of these reflections throughout the thesis.

My biggest struggle was to demonstrate how discourse operates, and not to come across in my critical analysis of discourse as judgmental or critical of the participants. This was especially concerning for me because I believe the intent of sexual assault workers, especially the four women I interviewed, is to make positive social change in our communities and the lives of women, and to increase the victim's quality of life. All four of the women I interviewed have devoted so much of their time and energy to caring for and supporting victims of violence, and I have the deepest respect and regard for

them. Therefore, I have struggled throughout my thesis to speak and act in such a way that critically analyzes discourse and discursive impact and presents *other* truths for reflection and consideration without being critical of the participants themselves. Furthermore, I believe that these four women are not unique; they reflect the current social and professional context of professionalized sexual assault trauma services. Thus, I believe that my analysis of the words and stories of these four women may be transferable to other sexual assault services, especially those that work with women who have experienced violence. While these four women appropriate dominant discourses, they do not *create* them.

I listened closely for the appearance of discourses and counter-discourses of trauma and secondary trauma as these related specifically to the relationship between the counsellor and the victim of sexual assault. I was interested in how this relationship was constituted through language used to understand the victim's experiences and the counsellor's experiences. I wanted to know how dominant discourses of trauma, professionalism, and secondary trauma constituted sexual assault trauma work. I was interested as well in how and when feminist activist discourse emerged, especially due to its prominence in the program philosophy, which I will refer to as an "official" discourse. This official discourse is the program philosophy that I presented in Chapter 1, *Feminist Agency Philosophy*.

My analysis section in Chapter 4 is organized into two parts. The first section relates to victim subjectivities including discourses that constitute the *client as infectious*. The second section relates to the construction of therapist subjectivities, including discourses that constitute the *therapist as dangerous*. I was interested in how the

participants used these two discourses, whether and how other discourses were used, and whether and how counter-discourses were used. I analyzed how participants presented victim subjectivities, which discourses participants seemed to find acceptable and unacceptable, and how discourses interacted, were struggled against/within or promoted. I listened for when participants seemed uncomfortable, when there were inconsistencies in their talk, when and if they contradicted themselves, and when they spoke cautiously or with certainty.

In the first section I concentrate on the *client as infectious* discourse as it is supported and resisted in the narratives of the sexual assault counsellors. I was interested in whether they talked in this discourse and to what extent. I wanted to know where and how the discourse appeared in the talk, and what other discourses constructed and were in a *client as infectious* discourse. First I reflect on the discursive dividing practices that are used to construct an "us"-"them," separating the infectious client from the therapist. Here, I am interested in how discourse pathologizes and objectifies the client/victim and I explore how discourse divides the therapist from the client, as well as from herself if she has also experienced violence or trauma. I am interested in the construction of client and therapist subjectivities, including as contagious and as objects. I also seek to identify resistant and counter-discourses to the *client as infectious* discourse. Counter-discourses include moments of shared subjectivity of therapist and client. Within the interviews, regulation of therapist behaviours and feelings and the struggle between compliance and resistance to the discourse are evident. I looked for what disciplinary practices were presented by the participants, and I analyzed what discourses these disciplinary practices

were in. Within this exploration of disciplinary practices, I look specifically at empathy and fear, speaking about male violence, activism, and self-care.

Within the section of *therapist as dangerous*, I was interested in how acceptable therapist subjectivities are positioned and regulated. I note where the participants had internalized acceptable therapist subjectivity and where they resisted this disciplining. Specifically, I looked for instances where therapists were disciplined to be silent on certain matters related to their work, such as sexual assault and rape and male violence. Throughout, I paid attention to how the constitution of acceptable subjectivities regulates the relationship between therapists and clients—who are, in this case, both women. To understand the constitution of subjectivities, I reflected on language usage. For example, did therapists use the terms "client" or "victim" or "woman" and did they characterize client experiences as "trauma" or "rape" or something else?

Evaluation and Assessment

Undertaking feminist poststructural research often challenges dominant criteria for valid research. For example, Foucault (1980) states, that each society has its *politics of truth* in which specific "techniques and procedures [are] accorded value in the acquisition of truth" (p. 131). Because the acquisition and creation of knowledge is a privilege of only a powerful few, the value of my research needs to be decided through alternative measures.

I took measures to ensure quality and transparency—increasing reliability or dependability and consistency—in the data. Techniques such as using peer examination, investigator's position, and an audit trail can help accomplish validity (Merriam, 2002). An audit trail, as stated by Merriam, "describes in detail how data were collected, how

categories were derived, and how decisions were made throughout the inquiry" (2002, p. 27). I kept a research journal throughout my research process. This research journal includes reflections, questions, dialogue with key people/professors, issues, and ideas. I have threaded pieces of my journal throughout this thesis as I struggled and dialogued with questions and concepts. The audit trail is "visible" in my thesis in my personal reflections and process of writing, centring and claiming my voice and perspective, throughout the thesis. My research journal holds discussions of many pieces of this thesis, from feminism and poststructural theory, to the stories from the sexual assault program that I work for, including clients, volunteers, staff, and past volunteers and staff. As well, though I have included some of my processes, questions, and reflections, my journal helped to process arguments and thoughts out, in much more raw form, allowing me to write more clearly and non-tangentially in this thesis.

Through feedback from my thesis committee members, my peers and colleagues, and the women I met who have experienced violence, I was continuously reminded of other perspectives, and guided to be self-reflexive and transparent in my critical analysis and reading of the literature and formulation of my argument. Contact with others facilitates transparency and keeps me aware of my location and my own position from which I approach this work, in the sense that I open myself up for questions, concerns, and am reminded of the need for clarity. It was and is an ongoing work to become aware of my biases, my values, and my attitudes. As well, it often deepens my understanding of my work and perspective as I must make my work accessible to others. Sharing my work with others along the way opened my perspective, introduced valuable questions that I had not earlier considered, and encouraged me to put my work into practice. In this, the

research process has been extremely beneficial and influential in regard to how I move in the world, and in relationships with women I support/counsel, colleagues, and others.

The ultimate goal of this research was to contribute to *praxis* in the area of therapeutic work with survivors of violence. Used in this sense, *praxis* means that "explanations are valued when they help people to really understand the world and to take action that changes it" (Neuman & Krueger, 2003, p. 87). Social work values the relationship and integration between research and practice (Fook, 2000). I am attempting to bring awareness to discourses that are embedded in the trauma and secondary trauma literature and research that make up the traumatology discipline. These discourses impact therapists' relationships with sexual assault survivors and with themselves.

To achieve my goals for this thesis, I looked to Susan Strega's outline for assessing feminist poststructural research (Strega, 2005). She questions "what use the notion of validity is to research that discards the notion of objective truth" (Strega, 2005, p. 228). As well, how do we meet the goal of the researcher: to have their work be "valuable to those who are neither accepted nor accorded status as authorities" (Strega, 2005, p. 229)? I was concerned about women as victims of violence and helpers, both labelled ill, weak, and infectious, and needing treatment—effectively silenced. Strategically, through the mechanisms of power (discourse, language, knowledge), both are continually isolated and segregated from the other and self—ensuring shared focus on violence does not occur.

Strega (2005) suggests a few ways to assess feminist poststructural research, which were important factors for my own research. First, she suggests that "we must assess the political implications and usefulness of what we produce for progressive, anti-

oppressive politics in marginalized communities" (Strega, 2005, p. 229). Thus, I questioned what the needs and standards are for the community that I am concerned about. The community that I was concerned with included both the female sexual assault counsellors and the women who are supported—all women who experience violence at every level. A goal of my research was that it be "reconstructive as well as deconstructive" (Strega, 2005, p. 229). This research unmasks some of the oppressive mechanisms that hold women in oppressed positions. Following my discourse analysis of the sexual assault workers' narratives, I offer direction for how we can integrate what I have learned, begin challenging dominant discourses and making change.

Secondly, it is imperative that I make the research process and findings available to the community that I researched. The results need to be in a format and language that makes them accessible to the people from whom it comes (Strega, 2005). This includes making my language accessible not only to the academic population that is most often the target group in graduate writing, but to my colleagues and coworkers that represent many different locations, coming from varied academic levels. Sharing my research, process, and perspectives with friends, family, co-workers, and colleagues requires that I use accessible language. Through the process of doing this research, I have also learned how important it is to talk and bring my work into every day. Therefore, to live my work, put it into language, begin and engage in discussions that change and challenge trauma and secondary trauma discourses that pathologize women where mechanisms of oppression have not been considered. I discuss my responsibility, pursuit of awareness, and need to take action in the final part of this thesis (Chapter 5).

Lastly, transparency and personal accountability was an important goal throughout my research process. This included transparency and reflexivity throughout the process, "including the extent to which we have considered our own complicity in systems of domination and subordination" (Strega, 2005, p. 229). This reflexivity kept me accountable throughout the research process, located the researcher in the research, and questioned the idea of an objective truth or neutrality in research (Absolon & Willett, 2005; Strega, 2005). As well, throughout the process of learning and exploring this area, it was important that I shared my experience when I could as I asked for others to share their experiences. In personal, ongoing self-reflection, I looked carefully at myself and the language that I use within which I promote certain power relations that maintain the patriarchal professional hierarchies. I was concerned with when I employed discourses of rape myths, professional and pathologizing discourses, and with whom I employed what discourses, depending on where they were acceptable and valuable. In an attempt to attain transparency, I invited the counsellors to review and edit their transcripts prior to their analysis (in following with feminist and participatory research, Lee & Renzetti, 1993; Merriam, 2002).

Fairn herising (2005) states that "attending to politics of location empowers research to explore the various interpretations and accounts of the meanings that undergird our findings" (p. 136). Clarity about my position/location as the researcher—interpreter, writer—was important (see Absolon & Willett, 2005). It was my goal to be transparent throughout my work and in my writing so that it was clear that it was my voice and perspective. This was so there would be no question that this is one perspective (my own), which has context within a specific time, place, and social location.

In the next section of this thesis I look closer at dominant discourses of vicarious trauma and secondary trauma, located as 'official' discourse due to there positioning in academia, the mental health, and social work systems, and I start to construct an argument for the disciplining and regulating impacts of these discourses.

Chapter 3: The Cost of Caring: Vicarious Trauma and Secondary Traumatic Stress Disorder

Introduction

According to the information circulating in academic and social service systems about vicarious and/or secondary trauma, working with traumatized individuals is risky. In the first section I argue that secondary trauma, like PTSD and other primary diagnoses of trauma, is a construct, label, illness, and theory, which is then an active tool for oppressing women and removing responsibility for violence endured by women from society and men. I propose that secondary trauma is steeped in hegemonic, phallocentric discourse, which maintain patriarchal power. Therefore, rather than naming the perpetrator, holding men and society accountable for violence done to women, our society labels the woman (women) disordered, ill, pathological ("traumatized"). Further, these discourses permeate and constitute the experience of the sexual assault worker, whose experience of working with women and ultimately having relationship with other women is determined. This further labelling and disordering of women, is a domino effect of systemic violence and oppression of women.

I felt the term "phallocentric" was especially fitting to describe the dominant discourses of secondary trauma. Phallocentrism was coined by Jacques Derrida to refer to the centring and privileging of male (the phallus, women's lack thereof) and masculinity in the construction of meaning and power relations (Derrida, 1978). He discusses how women are covered and located as subjects within a *generic* (phallocentric, male) "human" construct. Phallocentrism is a story of violence and oppression and the very word connotes rape. Social systems pathologize, institutionalize, and disorder women in

institutions of language and power/knowledge and the concrete walls of treatment centres. These factors filter down to impact and construct the experience of, possibilities for, and subjectivities of the counsellor and the sexual assault victim.

I outline the symptoms and diagnostic criteria of posttraumatic stress disorder (PTSD) because secondary trauma mimics this illness. This information is based on the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR) and I include it in order for the reader to gain an understanding of the constructed and disseminated mental illness, medical language, and context.

The remainder of this section is an analysis of text, which I have selected from journal articles and textbooks on secondary trauma, vicarious trauma, and countertransference when it is found within this body of work. The authors included in my review of this literature are those who are often cited in the traumatology discipline. The themes that I identify—normalization, gender, and pathologization—are themes that arise again and again in the comprehensive reading that I completed on the subject of secondary trauma through a feminist poststructural lens with attention to women's oppression, power, knowledge, language, and subjectivity. Within these overarching themes, I isolate and identify several specific discourses in order to unmask various mechanisms of power.

Finally, in last section (Exceptions and Contradictions to the Dominant Discourses in the Secondary Trauma Text) I present the contradictions and exceptions to and within the argued phallocentric discourses. Among my reasons for including these examples of text is to present that our knowledge and language are not fixed. As well, it reflects the conflict between the feminist and medical/professional model of sexual

assault response and relationship between women. We have alternative knowledge and truths available to us, yet we often actively choose not to attend and promote these alternate truths.

By exploring and dissecting the secondary trauma texts, I set a context within which sexual assault counsellors are located. Due especially to the studied sexual assault program's genesis, I work from a feminist perspective, as that is how this program started and, in pockets (e.g., affiliation with CASAC), continues to claim.

What is Vicarious Trauma?

Vicarious trauma is a by-product of violence against women, which is a systemic issue in our society that has largely gone unchallenged. In fact, we might say that just as rape is used to oppress, control, and shame in the context of war, it is similarly used to maintain the systems that keep the "deserving" powerful in the context of everyday North American society. Violence against women is accepted and it functions to maintain the dominant patriarchal status quo, as it ensures that women are continuously weakened, through threat or harm. Furthermore, women are expected to spend their energies supporting the healing of other women who have been threatened or harmed. Women are placed in services, mostly volunteer, and expected to "deal" with the issue of sexual assault trauma as efficiently as possible. Sexual assault workers are essentially dealing with the trauma of survivors of violence without being encouraged to make political connections and take political action. This inevitably leads to hopelessness and completely disables individuals to consider or even realize the root cause of the issue, which, in turn, leads to further acceptance and promotion of violence against women.

Women volunteer to care for their own. Burstow (1992) writes about how women have been positioned to care for women, as does Profitt (2000b). These women are often isolated, masked, and silenced within the government agencies or non-government agencies that operate under the governing and dominant ideological conditions in order for them to receive their allotted funding (Mardorossian, 2002). They take their ration and keep their voices down (Foley, 1996). They listen to countless stories of women's pain and terror. They take it in, are encouraged to make time for self-care and carry on (Spencer Faunce, 1990). Within this reality there is no room for dreams of change. The actions of these women who work with other women are isolated to the individual case; there is little or no hope for change at a systemic level (Burstow, 2003; Mardorossian, 2002). At the end of the workday, there is no hope that perhaps there will be less violence against women because of the accomplishments or energies expended in that day. Labour force studies have shown that job satisfaction increases when workers feel that they are part of a bigger picture (Foley, 2006). It is important that they can see how their energies are affecting overall change and the end result. In social services involving violence against women, what is the end result?

As I started researching this area and the context of women sexual assault counsellors, I had many discussions with many different people. In my discussions with women in the sexual assault program, it was suggested and questioned that if equality and egalitarianism were truly goals of society, the positions filled by the many volunteers working to support women who have experienced violence would be paid (or well paid and valued) positions. Society's values, ideologies, and hierarchies are established and maintained using a monetary reward system. Poverty is a functional and necessary

element of this capitalist system; to keep the rich and powerful in their privileged position. The people in power in North America are not interested in change. Someone has to be marginalized, and because the underlying conductor is our society's patriarchal, capitalist, and globalization values, it chooses that those some be women, children, immigrants, and disabled persons. Our society's promoted and valued discourses actively maintain the current, dominant value system and power relations. Our Euro-Western society is not interested in empowering women; therefore violence against women is functional and serves a valuable purpose, as does "trauma" and "secondary trauma."

Time spent in healing takes away from creating—it also takes away from actively speaking out against the cause for our need to heal, namely male violence. What could women accomplish if they were not spending their time and energy healing or supporting other women's healing? How would this society look if women felt safe, were paid equally, and were valued? Keeping women "traumatized" (as a result of violence and/or threat of violence) is a direct way of oppressing women and keeping them silenced. Our society does not need to listen to or consider the stories (as truth) of women who have experienced violence due to the labels attached to them: *ill, hysterical, disordered, traumatized.* When these women begin to speak or act out, they are quickly and *professionally* labelled, in order to contain and locate the ill, hysterical, traumatized woman—ultimately silencing her and isolating her from ears of those who may hear her story or see her pain. Furthermore, the small select group of women who do listen to the ill, traumatized, and hysterical women, as a result of hearing the stories of hurting women, may experience *secondary* trauma if they act out behaviours that are not deemed *normal* by our society (Brown, 1991; Burstow, 2003). This secondary trauma is linked to

the individuals' pathology (the counsellors') and they are now seen as infected or ill as a result of the work that they do with traumatized women, as well as there being some predictable weakness in her. This secondary victim labelling is another way to maintain the oppression of women. Furthermore, illness discourse sets women up to fear each other and contain their professional relationship.

Human services work is delegated to women. Though, at the conception of the rape crisis centre, women-helping-women was based on principles of "collectivity, consciousness-raising, the primacy of women's experience, and respect for women's strengths, resilience, and power" in which staff and volunteers "acted as educators and organizers, providing abused women with practical assistance, information, peer support, and a political understanding of men's violence" (Profitt, 2000b, p. 22). The intent and purpose for all the women involved (staff, volunteers, service users) was to be empowering, community-building, and socially active. More reflective of the present state of social services for women, Bonnie Burstow (1992) discusses how women are positioned as social workers and nurses, "the physical and emotional caretakers," who "mete out" the patriarchal discipline of psychiatry (p. 34). She states, "psychiatrists as absent but powerful father resocializes woman as sick infant, with Woman as Laboring Body functioning as servant and scapegoat—all this for the greater good of patriarchy" (Burstow, 1992, p. 34). This, I contend, is the context within which the *laboring woman* is now herself being labelled "ill" through 'psy' discourse and the construction of vicarious trauma.

Alas, the woman helper position for other women is undervalued—poorly funded and unacknowledged. Instead, the women who fail to do their work and fulfill what has

been deemed by our society their natural responsibilities, taking care of other women, children, men, and also caring for themselves (avoiding becoming burned out, stressed, et cetera), are called ill. Our society is constructing a discourse to place these *ill, failing, disordered* women into legitimated knowledge that we can learn and disseminate, and therefore avoid, predict, detect, and treat. Women who do not, or cannot, manage to care for others, are pathologized—considered disordered, diseased, and ill. Our society has constructed terms like vicariously traumatized, burned out, secondary traumatic stress disorder, which shift all of the attention away from societal issues (such as rape, sexual assault, stalking and the first- and second-hand experiencing of these) that affect all women—and, instead medicalize, once more, the female body/mind/heart and isolate her within institutions of discourse (constituting power/knowledge) and erected treatment centres and trauma programs. The discourses of secondary trauma set up and maintain gendered power relations and oppression within the woman's social context. This is the social context within which the sexual assault counsellors I speak to must navigate.

Interestingly, I have noticed in my review of the research and literature that the vast majority of research on vicarious trauma, burn out, compassion fatigue, and secondary stress disorder has been done with female participants (Kassam-Adams, 1994; Mardorossian, 2002). Caplan and Cosgrove (2004) in their edited book provide many examples of bias in psychiatric diagnoses. This is perhaps because women are often in roles where secondary trauma is a problem, women are more willing and expected to participate in the research, women are seen as the ones afflicted, or perhaps the assumption already exists that women are the ones with the problem—they are the ones both with traumatization (due to violence) and secondary traumatization. This fits with

what Mardorossian (2002) talks about as research's and theory's gaze on and critique of women, which overlooks men, making issues like rape, its prevention, and impacts, women's problem; both one that they should solve and that they have caused.

The information presented within the research and literature is conflicted on the causes and/or predispositions for therapists' development of vicarious trauma and secondary traumatic stress (Arvay, 2001; Pearlman & Mac Ian, 1995). Much of the research has focused primarily on discovering the cause of secondary trauma, specifically by looking at the gender, experience and age of the worker (Lerias & Byrne, 2003), the workload involving traumatized victims (Brady, Guy, Poelstra, & Brokaw, 1999; Schauben & Frazier, 1995), paid versus volunteer workers (Baird & Jenkins, 2003), history of personal trauma in the therapist (Salston & Figley, 2003), attachment styles (Marmaras, Lee, Siegel, & Reich, 2003) personal coping history (positive or negative), therapists' view of the world (positive or negative) (McCann & Colletti, 1994), sense of coherence (Ortlepp & Friedman, 2001), and job satisfaction (Ghahramanlou & Brodbeck, 2000). Research that investigates the causes and susceptibility to vicarious trauma and secondary traumatic stress find no consensus—one study finds correlations where another does not link those same variables. Therefore, in this critical review, I have chosen not to go into great detail about what studies attempt to find what cause.

Another focus of the academic and professional research is the development of standardized measurement tools, instruments, and questionnaires for assessment of vicarious trauma, empathic stress, countertransference, secondary traumatic stress disorder, and burnout (for example, Betts Adams, Matto, & Harrington, 2001 and the Traumatic Stress Institute Belief Scale; Figley, 1995a developed the Compassion Fatigue

Self-Test). Therefore, isolating risk factors and symptoms are necessary in order to detect, diagnose, and properly treat secondary trauma in an individual (Kadambi & Truscott, 2004). However, the goal of the professional literature is not wholly based on intention to care for the individual who experiences secondary trauma as it seeks to develop "more effective strategies to cope" with the effects of working with survivors (Schauben & Frazier, 1995, p. 50). Intention is also economically driven, as "the development of such strategies could benefit clinics by reducing the high turnover rate among sexual violence counsellors. This would both increase staff continuity and decrease agency training costs" (Schauben & Frazier, 1995, p. 50).

Symptoms of secondary stress or compassion fatigue are outlined by Figley (1995a; 1995b) and include re-experiencing the victim's traumatizing event, avoidance, numbing in response to reminders of this event, and persistent arousal. On the other hand, McCann and Pearlman (1990a) distinguish vicarious trauma from secondary stress disorder and burnout, when they state the therapist's cognitive world is shifted through verbal exposure to victims' traumatic stories. Cognitive shifts and intrusive imagery are the primary impacts on the therapist according to McCann and Pearlman (1990a), and this includes losses or disruption in safety, esteem, trust, intimacy, and control regarding self and others. They go on to state that these cognitive schema changes may have negative effects on the therapists' feelings, relationships, and non-work life as well as their work with clients. These researchers have developed traumatic stress scales to measure therapists' levels of vicarious trauma (McCann & Pearlman, 1990b; Pearlman, 1996).

I will refer to the DSM-IV symptomology of PTSD briefly in order to provide an understanding of the language from which the disorder of secondary trauma originates. I will outline the diagnostic criteria and symptomology of posttraumatic stress disorder (PTSD) because it relates directly to secondary trauma, as the symptoms are reflective of PTSD. The difference between PTSD and secondary trauma is that the latter mimics PTSD and is a secondary response, resulting from PTSD (Brady, Guy, Poelstra, & Brokaw, 1999). Therefore secondary trauma is experienced not by the person who has experienced the traumatic event, but by the people who come in contact with that traumatized person. The symptoms of secondary trauma mimic those of the traumatized person. Figley (1999) allocates that secondary traumatic stress is a syndrome of symptoms nearly identical to PTSD. Steed and Downing state that therapists experience a "variety of severe negative effects, which may have a pervasive impact on their functioning in both personal and professional domains" (1998, p.1).

Diagnostic criteria for PTSD includes a confirmation that the person was exposed to a traumatic event in which the "person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and "the person's response involved intense fear, helplessness, or horror" (APA, DSM-IV-TR, 2000, p. 468). In secondary trauma the therapists/helpers are affected due to exposure to people who have experienced a traumatic event. Through hearing the stories and experiences of a client, and by empathizing with a client, *negative* consequences may be experienced by the therapists/helper (Figley, 1995a; Figley, 1995b; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; Neumann & Gamble, 1995).

For the individual with posttraumatic stress disorder the traumatic event is persistently reexperienced in one (or more) of the following ways: 1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions, 2) recurrent distressing dreams of the event, 3) acting or feeling as if the traumatic event were recurring (sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated), 4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event, and 5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (APA, 2000, p. 469). In secondary trauma, therapists report similar experiences to that of their clients, including somatic symptoms such as headaches, nausea, sexual dysfunctions, difficulty trusting others, emotional numbing and flooding, intrusive imagery, and increased feelings of personal vulnerabilities (Pearlman & Saakvitne, 1995).

The person with PTSD persistently avoids stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), including at least three of the following behaviours: efforts to avoid thoughts, feelings, conversations associated with the trauma; efforts to avoid activities, places, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; markedly diminished interest or participation in significant activities; feeling of detachment or estrangement from others; restricted range of affect (e.g., unable to have loving feelings); sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span) (APA, 2000). In secondary trauma the therapist

experiences a negative transformation of their inner experience, and a significant shift in their view of the world. Their world view changes, such that they experience everything through a *trauma lens*. The above mentioned effects, feelings, and behaviours are often experienced by the therapist with secondary trauma. As well, Neumann and Gamble (1995) state that the helper identities of *all* therapists who work with traumatized individuals are challenged. This occurs as "reenactments and projections of roles of perpetrator, victim, and helpless witness occur with regularity in trauma work, casting the therapist into affective experiences, which sharply conflict with his or her identity as healer" (Neumann & Gamble, 1995, p. 344). Trauma therapists may find themselves becoming more fearful and suspicious of others, more concerned about personal safety, despairing about violence and cruelty in our society, and pessimistic about the potential for therapy to make a difference and about the human condition (Etherington, 2000; Neumann & Gamble, 1995).

The individual who has PTSD experiences persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hyperviligance; exaggerated startle response (APA, 2000). In PTSD as well as in secondary trauma these symptoms are common. In the therapist, if these symptoms are left untreated, they can lead to what is known in the literature as burnout (see Maslach & Jackson, 1986).

The duration of all of the above symptoms must be present for more than a month in order for the individual to be diagnosed with PTSD (APA, 2000). As well, the disturbance must cause clinically significant distress or impairment in social,

occupational, or other important areas of functioning. There is no determined timeframe for diagnosis of secondary trauma. However, the literature emphasizes the seriousness of the symptoms and effect on the therapist, and outlines the harmful effects. However, Neumann and Gamble (1995) also state, seemingly as a reassurance to all therapists, that secondary traumatization is a normal response to "doing the hard work of trauma therapy and does not reflect the therapist's competence," even though most therapists feel helpless and question their competence when experiencing secondary traumatization (p. 344). As well, Trippany, Kress, and Wilcoxon (2004) state that secondary trauma is a normal response in therapists as a result of their work with traumatized clients and that the "*irrational* perceptions develop as self-protection against these emotionally traumatic experiences" (p. 32, italics added).

Finally, treatment and prevention of secondary trauma are focal points in the current research. Education around prevention, positive coping techniques, caseload management, peer supervision, normalization, self-care/help, which includes healthy boundary setting (for example, with clients, and between personal and work life), maintaining professional relationships, and depersonalizing are some of the techniques for prevention and treatment of secondary trauma (Hesse, 2002; Neumann & Gamble, 1995; Phipps & Byrne, 2003; Salston & Figley, 2003; Steed & Downing, 1998; Trippany, Kress, & Wilcoxon, 2004). These techniques are taught in classrooms and supervision meetings for current and aspiring counsellors. I have heard quite often in my discussions with peers and colleagues that we need to "leave work at work," "leave our baggage at the door," and "not take it personally." Neumann and Gamble refer to it as "putting themselves [therapists] on hold while they focus on their clients" (1995, p. 345).

Vicarious Trauma as Discourse

It is critical that research move beyond the immediate experience of the workers to activate and make links to a larger societal context, which is maintained by dominant discourses. To maintain focus on the effects of these traumas does not change the cause. This thesis seeks to link secondary trauma to violence against women through discourses we have available to us and therefore begin opening up the systems and deconstructing the isolation, which is maintained by the language that we use (see Strega, 2005). In her study, Woliver (1993), showed how important rape reform efforts are within the large diffuse women's movement and how controversial sexual violence is for people their entire lives. My research tracks the effects of discourses we use that constitute the knowledge we have about violence against women, and uncover how it affects large populations, beyond the immediate target (individual) being violated. To identify discourse, it is imperative to look critically at the knowledge and language available to us in the professional literature and empirical research into working with "traumatized" individuals, and to explore the intentions and effects of these discourses. Practicing a feminist perspective allows me sensitivity to, and awareness of, the experience of women and their oppressed position in society.

In naming discourse, I challenge the current language and power/knowledge, and in challenging the language that we use, I also challenge "the truth," within which most people find comfort, ways of coping, identity, and the very context of our existence. Within this, I challenge the construct of "woman," including my own female subjectivity. Often when what we know and believe is challenged, we resist. This occurs even when accepting the challenge and shifting our awareness and knowledge, centring oppositional

discourse, could provide opportunities for women to construct healthier, more valued, and strong subjectivities.

Ideological constructions shape people's thinking, as displayed in the choice of discourses we use (Ristock, 2002). Discourses as social practices construct particular truths/realities/subjectivities and therefore reproduce certain dominant power relations and normative frameworks. These normalized lessons that we learn about ourselves and the world around us are taught to us through ideological and social processes that are often masked; we are not conscious of them (Elliot, 1995). Thus, to have understanding is to begin to unmask the ideological and social processes. Discourses regulate and discipline, including what a subject can and cannot participate in, and how they can behave. As a result, there is backlash when discourses are challenged (Wang, 1999). Questions that are foundational to me as I explore various discourses in the secondary trauma literature are: how is the servicing of sexual assault victims promoted and maintained in the discourses that we use? How is this servicing of a greater social/political (gender) issue reflective of our society's dominant ideology? What are the options and subjectivities afforded to women for self and relationship with other women in sexual assault work discourse?

I explore the research and literature of secondary trauma through a feminist poststructural lens to gain an understanding of the discipline and social context within which the sexual assault field is currently positioned. I argue that there are three overarching discursive themes within the secondary trauma research: normalization, gender, and pathologization/medicalization.

Normalizing Discourses

The terms *normal* and *natural* often introduce the phenomenon of secondary trauma in the research and professional literature on working with people who have experienced traumatic stressors. For example: "Secondary traumatic stress is defined as "the *natural, consequent* behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999, p. 10, italics added).

This information communicates that we can expect and anticipate the negative consequences of being a helper, or wanting to help. However, there is no implication of an offence; the offence is removed. It is now simply the trauma (without origins), which is also transmittable to vulnerable other. The symptomatic behaviours and emotions are "natural" as a result of wanting to help someone else and working with traumatized others. Yet, this *natural* and *normal* consequence is in turn being considered disorder. "It's important to stress that vicarious traumatization is a *normal* response to doing the hard work of trauma therapy and does not reflect the therapist's competence" (Neumann & Gamble, 1995, p. 344). The authors state here that a trauma response in the therapist is not reflective of her competence, but elsewhere in this article, the authors outline the violations, difficulties, nonempathic distancing, and victim-blaming responses from the therapist if they do not deal effectively with their secondary traumatization (see my discussion on the *therapist as dangerous* discourse).

World view – A Correct Way to View the World

The body of literature and research on trauma work also assumes that there is a *normal* way of viewing the world and there are disrupted, disordered, and negative ways of

viewing the world. One such negative way is identified within the allocation of secondary traumatization and trauma work, and is considered viewing the world through a *trauma lens*. This is a term that describes the presumed shift in world view and perspective brought on through the transmission of traumatic content. There seems, then, to be a constructed *correct* (normalized and valorized) way to view the world, and a devalued view of the world within trauma ("trauma lens"). This normalized world view I have named to be in dominant discourse of correct world view, which is set in juxtaposition to a *trauma lens*, which the affected trauma therapist holds. For example, Neumann and Gamble (1995, p. 344), in their meta-analysis, use language that places negative value on the world view of the trauma therapist: they describe the "*pervasive and devastating*," "*intrusive* imagery," "*negative* transformation in the therapist's inner experience."

> [Vicarious trauma] results in *disruptions* in the therapists' sense of identity, worldview, spirituality, ability to tolerate strong affect, and central cognitive schemas (e.g., core beliefs about safety, trust, esteem, control, and intimacy). In addition, VT [vicarious trauma] also may affect the therapist's imagery system of memory. (Neumann & Gamble, 1995, p. 344, italics added)

In language/text such as this, the person with secondary trauma is not viewing the world in a correct way, or a way that can be trusted, considered legitimate or valid. The acceptability of the therapist who experiences secondary trauma to be a legitimate knower is brought into question. Through questioning her view of the world as legitimate or an acceptable truth, her voice and experience of the world, similar to the traumatized client, is questioned and labelled incorrect (traumatized, trauma lens). Even her memory is not to be trusted or legitimated. The authors go on to give an example of an "intruded," "negative," "disrupted" world view:

> Over time, the therapist begins to view the world through a *trauma lens*. He or she is painfully attuned to human suffering, not just at the office, but also during off-work hours. The sound of a child's cry at the grocery store evokes images of a client's brutal narrative describing childhood abuse. The therapist feels filled with grief, anger, and a sense of helplessness. (Neumann & Gamble, 1995, p. 344, italics added)

Certainly there are *disruptions* to identity, world view, imagery, and memory systems of the therapist. I wonder, however, if this necessarily constitutes a disorder. Could it more *neutrally* be labelled *learning* just as we learn from all other experiences in our lives? The language used makes this new world view (this trauma lens) less legitimate and ill revealing intent of dominant discourse. What these researchers have labelled a "trauma lens" world view is absolutely legitimate in the sense that it is made real by the images and stories (and consequent shift in beliefs, identity, values of the listener) spoken by the woman who experienced that particular violence. Gillian Walker (1986) writes about the process of legitimacy as "conceptual imperialism" in which, "new issues and concerns are embraced by professional, researcher, and social scientists in general, and brought within the realm of the discourse; that is, the field of an academic discipline empowered to define, theorize and prescribe a particular area of knowledge" (p. 36). Legitimacy has been historically determined by White males, patriarchy, and capitalism (Burstow, 1992; Mardorossian, 2002). Dorothy Smith (1990) articulates how certain discourses are made legitimate and powerful. Stacy Hammons (2004) in her study shows how female shelter workers select legitimate discourse in order to be seen as competent and professional. Here again the language used to speak of the impacts of trauma work is technical and medical, delegated again to an ambiguous (perpetratorless) "trauma" impact—both for the victim and therapist. As well, both traumatized victim and therapist within the text assume devalued subjectivities that are irrational, disrupted, othered, and inferior. Their

stories, voices, and experiences are labelled such that they are easily dismissed, ignored, falsified, and denied due to their traumatized view of the world.

This trauma lens becomes the socially *othered* reality of many women who have experienced violence. I believe that the *devastating* and *pervasive* response of the therapist is a result of empathizing, feeling, listening, and then being confined inside the institution (agency) walls, and the *professional* subjectivity. This professional subjectivity negates parts of the relationship between women who hear the stories of other women. Both these women are in danger of being labelled (PTSD, vicarious trauma, secondary traumatic stress disorder) and having their experience of the world qualified as disordered or ill. The female therapist experiences story after story of pain and violence against women and is subsequently silenced by the blanket of the *trauma lens*, with definable symptoms, gender, and behaviour (to support her silencing and need for fixing). By positioning her, in trauma discourse, as ill and needing to be fixed, her voice is silenced and experience made illegitimate. Ultimately, the stories of violence of countless women stay at the individual victim/survivor level, and do not have a chance to affect the prevalence of violence against women in society or make an impact for social attention and change. The language used to describe a trauma lens and the shift in world view (which is *other* or marginal) clearly shows that there is an assumed natural, *correct* way to view the world. This correct and natural way of viewing the world is different from that of the victim or trauma therapist. This is a dividing practice in the traumatology discourse that judges and segregates a normal from an abnormal.

The literature also suggests that a shift in world view, which is normal, is potentially harmful to the client:

> The therapist whose worldview has been changed as a result of vicarious traumatization may blame the victim or join together with the client to avoid working through the trauma. The therapist may fail to hear or allow clients to speak about things that challenge the therapist's beliefs about the world or people. On the other hand, the therapist may unwittingly prompt the client to discuss that which will restore his or her "shattered" worldview, but may not allow the client to express and process his or her own feelings or views of the world. (Hesse, 2002, p. 301)

The author of this text starts from an assumption that the therapist once held a benign world view. Bonnie Burstow (2003) talks about the assumption within this normal world view which are problematic to women: First that "the world is essentially benign and safe, and so general trust is appropriate, and (2) people who have been traumatized have a less realistic picture of the world than others" (p. 1298). The message within the 'official' secondary trauma discourse is that there was a better world view that existed prior to the therapist's vicarious traumatization. But with a shift in world view, the therapist may do a number of things that she would not have done previously. These behaviours that the therapist may engage in, such as blaming the victim, joining together with the client to avoid work, failing to hear the client, or allowing her to speak, are all depicted as negative effects of vicarious traumatization and shift in world view. There is no mention of how the therapist's previous-to-"shattered" world view made an impact in the therapy sessions prior to the shift. We are to assume that whatever world view that the therapist held before hearing women's stories of violence, pain, hurt, fear, survival, resilience, was benign, correct, and did not cause the therapist to fail to hear the client, blame the victim, or avoid work with the client. Now this new world view—which as I have established has been called a *trauma lens* and includes overgeneralization of violence, not trusting others and feeling unsafe—is identified as potentially damaging to the client, due to actions by the traumatized therapist.

The secondary trauma literature also assumes that reactions in the trauma therapist are due to working with traumatized clients versus a legitimate response to increased awareness of the high prevalence of violence in our society that occurs in many situations and settings, perpetrated by both known and unknown people (usually men). For example:

> The therapists' self-protective beliefs about safety, control, predictability, and attachment are challenged through working with trauma survivors. Consequently the therapist may become anxious, and avoidant of situations they now perceive as potentially dangerous, such as being home alone, driving at night, and walking through car parks. These and other effects, which can be disruptive and painful for the therapist, may occur as a short-term reaction to working with traumatised clients, or may persist for months or years after the completion of such work. (Steed & Downing, 1998, p. 3)

Here, one who has secondary trauma is considered to have an unrealistic perspective of women's/self's danger. Despite statistics that state a woman has over a 50% chance of experiencing violence in her lifetime; she is just as likely to experience violence as not (Statistics Canada, 1993). However, to be concerned about self-protection is now seen as the result of work with victims. The prevalence and occurrence of male violence still remains unstated and unacknowledged. Instead, the victim is named as the reason the counsellor experiences secondary trauma, an increase in fear, and concern for personal safety. The woman victim is constructed as the cause of the therapist's secondary trauma.

Laura Brown (1991) offers a counter argument, from her location as a feminist therapist, working extensively with "trauma," states that when we "start to count the numbers of those for whom insidious trauma is a way of life, we must, if we have any

morality, question a society that subjects so many of it inhabitants to traumatic stressors" (p. 129). Brown (1991, p. 128) argues that all women, due to living in a culture where "there is a high base rate of sexual assault, and where such behaviour is considered normal and erotic by men as it is in North American culture," experience continuous insidious trauma. She goes on to cite that:

> Many women who have never been raped have symptoms of rape trauma; we are hypervigilant to certain cues, avoid situations that we sense are high risk, numb in response to overtures from men that might be friendly, but might also be the first steps toward our violation. (Brown, 1991, p. 128)

The 'official' secondary trauma text also suggests that high workload (many clients) is the cause of secondary trauma in the sexual assault worker. Overlooked and unmentioned is the subsequent increase in the number of scenarios and stories of violence where people (men) have chosen to violate another person (women/children) in so many varied and common situations. For example, from the woman who is dragged into the back alley of a bar at three in the morning, to the elderly woman carrying her groceries home at twelve noon through a suburban park, the mother and wife whose husband will not take "no" or "I'm exhausted" for an answer, and the 12-year-old who is swarmed on a playground. The stories go on and on, until there is not a place that does not carry a story of a woman who was terrorized by a man, or a number of men. I have been working in this field for only seven years, and there are few places or situations remaining that do not mark a woman's experience of sexual violence. For the sexual assault therapist, every time of day and every minute on the clock can tell a story of a woman who went numb as she was being raped or assaulted and the fear and loss became so great. The literature of

trauma and secondary trauma conveniently labels the women who are aversely impacted by the untold/unheard (socially) stories of violence *disorder*ed.

The female therapist's shifts in self-protective beliefs about safety, control, predictability, and attachment (relationships) are responses to a society that holds and allows all of the lived experiences of violence against women to exist and be (re)created over and over again. The therapist's anxiety and avoidance of situations they now perceive as potentially dangerous, such as being home alone, driving at night, and walking through parking lots is a result of learning and it is responsivity to social unresponsiveness—she *must* change due to the fact that society is not changing. These and other effects, I believe, *are* disruptive and painful for all women. Their persistence and maintenance is removed and hidden within the medicalized jargon used in the secondary trauma literature. Though, using positivist research jargon, one might hypothesize that when the trigger or independent variable (the traumatized clients) is removed, the therapist should return to her original state (correct world view, safe, untraumatized), though she often does not. Could we then assume that the stimulus is still present? In fact, I argue that the stimuli are our systems and society that do not respond to end violence against women and she has just become more attuned to it in her world. The literature on secondary trauma exudes a sense of urgency; the therapist must deal or work with or otherwise fix the secondary trauma shift that occurs within her. Though the secondary trauma literature states that the shift in world view is *natural* and *normal*, the undoing and reframing of this transformation is imperative.

Further, it is the sole responsibility of the therapist to detect this normal, predictable, inevitable change:

> VT [vicarious trauma] is a result of empathic engagement with survivors' trauma material. It is recognized as normal, predictable, and inevitable, yet, if the caregiver does not work with the transformation that is taking place, it can have serious effect on the caregiver as an individual, as a professional, as well as with interpersonal relationships. (Salston & Figley, 2003, p. 169)

The message is that there is an inevitable transformation within the therapist, but if it is not addressed (or treated) properly, it will have serious effects. The language is that of threat and harm, losing self, and being transformed. It is the responsibility of the therapist to detect this normal, predictable, inevitable change of form. Salston and Figley (2003) speak of relationship, segregating victims from professionals, establishing identities, rules, boundaries, and fear of the other. The therapist must be afraid of contact and infection of trauma from the client, and then of serious effects on her whole self (professional, individual, interpersonal relationships).

The transformation is ultimately a shift in how one views the world. This language displays how the traumatology literature is focused on segregating and othering the world view that is considered "trauma." Someone who views the world as unsafe, dangerous, threatening is viewing the world through a *trauma lens* and their resulting behaviour is considered *trauma adaptation*. Effectively, this medicalizes the state of seeing the world and our society as a place that allows, promotes, and maintains violence against women perpetrated primarily by men at devastatingly high rates. This medicalized state *others* the population of women (labelling them victims, primary and secondary, ill, and disordered) who become keenly and painfully aware of the violence, threats towards, and dangers for women. By labelling the holder of this transformed, disruptive, intrusive, world view "traumatized," their competence, professional and ethical practices, and subjectivity are all called into question. The above quote by Salston

and Figley (2003) sounds like a threat to me, rather than a caring caution, or a benign passing on of information. Because awareness can lead to social action, *othering* this population eliminates the ability of these women to speak out and threaten the status quo.

The word *cynicism* is both called for at the same time it is criticized in the trauma therapist. Therapists are asked to depersonalize and avoid becoming cynical about humanity. At the same time to depersonalize from the victim may include becoming cynical of her and the prevalence of violence. Cynicism directed towards the victim and her stories is socially preferred over cynicism toward the rest of humanity (including men). We are urgently taught how to avoid developing a trauma lens, and effectively, the therapist is disciplined in how and what to feel. "The cynicism and overgeneralized negative beliefs about humanity that signal vicarious traumatization must be actively challenged and wondered about" (Neumann & Gamble, 1995, p. 346). This language portrays the therapist as possibly negative and cynical. She is called bitter, traumatized, and ill rather than given a space for expressing her legitimate and justified anger, sadness, and frustration. Instead of validation and support due to women's responses (anger, fear, sadness, hurt) to continuous rape and oppression of women and our children, women are called hysterical, over-reacting, and traumatized (disordered). We are constructed as the problem (Brown, 1995; Lamb, 1999b; Lewis, 1999).

According to the Canadian Oxford Dictionary (2004), a cynic is "a person with little faith in human goodness who sarcastically doubts or despises sincerity and merit." I would say that due to my work with sexual assault survivors, and through hearing countless stories in and outside of work of violence against women and children, I am a cynic. The female therapist is said to hold "overgeneralized negative beliefs about

humanity." Yet statistics show that within "humanity" over fifty percent of women experience violence in their lifetime. That does not sound like an overgeneralization to me. But it does sound like there is a powerful message of a correct or preferred way of looking at the world. I note the choice of language in this statement, where "negative" beliefs could more accurately be named *awareness*, *consciousness*, *unmasked*, and perhaps even a more *realistic* world view. Laura Brown (1991) argues that this world view is more accurate than the less traumatized due that they have lost the cloak of invulnerability. Lewis (1999) states that the normalizing of the untraumatized world view is elitist, due that for women, Blacks, native people, and Arabs, the world is not a safe or benign place, and so mistrust is appropriate. The latter, unused, terms are ones of hope and beginning that potentiate action and movement, where there is a space and a reason for naming the perpetrator, placing responsibility onto him and the systems that continue to ensure his unaccountability. We must remember that if he did not choose to be violent there would be no trauma or secondary trauma—*there* is our cause. However, nowhere have I found that cause named in the research texts.

Kim Etherington (2000) writes about her personal experience of being vicariously traumatized due to her research with men who had experienced abuse as children. She experienced intrusive thoughts and images, vivid dreams, and other symptoms that mimicked those of her male participants. She explains how the subject matter of her research made it a difficult topic for her to talk about to others, and for others to listen to. When she answered questions about the topic of her research, the conversation would end and "they moved away—as if I had some infectious disease—they didn't want to know" (Etherington, 2000, p. 380). Etherington (2000) states that this response is inherent in all

people, Pearlman and Saakvitne (1995) support this, stating that individuals "in response to powerful cultural and personal taboos and instinctive withdrawal from pain" (Pearlman & Saakvitne, 1995, p. 88). As therapists we also want and work to protect ourselves from the images and stories of the traumatized individuals we work with. Etherington (2000) considers this an internal battle that goes on inside—protecting oneself from further cost to the self of the therapist in hearing/experiencing the images and stories of the client at the same time as knowing that the client needs to tell their stories. Though because Etherington refers first to her response from others in her life and then to her own distancing, I question if she would have felt the need to self protect to the same degree if the response from others had been different, if she wasn't perceived as having some "infectious disease" (Etherington, 2000). Certainly, if she had a correct view of the world, she may not have experienced the same social withdrawal. However, the valued and prioritized discourse of a *correct world view* is conditioned as normal and healthy within us all. This *correct world view* does not include violence against women, fear, and terror inflicted by men.

Interestingly, Neumann and Gamble suggest that trauma therapists:

> Combat secondary trauma by noticing and sharing with others the acts of kindness they witness in everyday life: the stranger who could be trusted, the unexpected resolution to a seemingly unsolvable problem, the nurturing appropriate interactions seen between parents and their children. (Neumann & Gamble, 1995, p. 346)

The authors go on to give an example of:

> A colleague telling us about a stranger who stopped to help her change a tire referred to the experience as an "anti-VT" event. As commonplace as such events may be, it is important to recognize and celebrate their occurrence and reflect on how these experiences may be at odds with a strictly trauma-centred worldview. (Neumann & Gamble, 1995, p. 346)

Neumann and Gamble (1995) have an othering term for a world view that include "cynical" and "overgeneralized negative beliefs" about humanity, trauma-centred. However, again, they imply that there is a *common*, normal, and healthy world view from which the trauma-centred world view differs. Within this normalized world view there occurs everyday, commonplace, appropriate events, which do not focus around trauma, pain, and ultimately violence and threat against women.

The authors here have chosen to juxtapose these "everyday," "commonplace," "appropriate" events, and label them "Anti-VT." They imply that this is the antiseptic or the antibody to combat and work against the "cynical," "overgeneralized negative" belief system that is transforming the trauma therapist. Apparently these authors are ill-informed, or have not worked with enough trauma clients to know that violence against women is an everyday, common event as well. These opposing *commons* or *normals* construct a very confusing world for women, where violence is normal but/and overgeneralized, and to be under or overly aware is to potentially be labelled irresponsible or cynical.

Finally, what is the "anti-VT" event? There is a stranger, let us assume that it is a male, however he is not named. Here is an *exception*, "anti," so perhaps an exceptional male, at least an exceptional *action* by a male. It may be necessary and strategic that we are not informed on the stranger's gender, because if he was named, we would question what his behaviour was "anti" to. If we would question the behaviour that might require an "anti," we may come up with a violent male, a man who takes advantage of the stranded woman, et cetera. Within this text the implied "anti" event sends a message that

fits. Here, within hegemonic discourse our understanding of the situation and the subjects that are constructed is assumed.

Gendered Discourses

Woman as Weaker

The literature and research on secondary trauma also contains gendered discourses. Embedded within these discourses are tools that enact further isolation and pathologization of women. Women are weaker: ill, lesser than, more susceptible to disorder, and victim. For example, research states that being female is one of the best predictors of secondary traumatization (Brady, Guy, Poelstra, & Brokaw, 1999; Brewin, Andrews, & Valentine, 2000; Lerias & Byrne, 2003; Resick, 2000). In the literature on secondary trauma, the female experience within the context of a patriarchal society is overlooked. Instead, the discourse of the mental illness of secondary trauma again subjugates women and judges women's experiences as *wrong*. "One of the most consistent findings in the different studies related to risk factors is that men are at higher risk for traumatic exposure than women" (Hildago & Davidson, 2000, p. 7). As well, "there is general agreement across the studies that women are at higher risk than men for PTSD, despite being less frequently exposed to traumatic situations" (Hildago & Davidson, 2000, p. 9).

The "most consistent findings" state that men are at higher risk and experience more traumatic situations than women. These statements about men's experience construct knowledge that they have higher rates of exposure to traumatic situations, yet they manage to overcome and adapt in healthy ways. However, according to these

"consistent" findings, women experience fewer traumatizing situations but become disordered more easily, and/or become symptomatic more frequently than men. The results of these studies with their "most consistent" classification constructs an idea that something within women makes her weaker and less able to handle her (less traumatic) life. The term "consistent" carries weight with its scientific ring of legitimacy and truth; it is unwavering. Traumatic exposure in this text has been quantified, with the study pitting men against women and assuming they are a comparable sample. However, Laura Brown (2004) argues that adult sexual assault is the "single-blow" most likely to "lead to lasting symptoms of PTSD, not because it is uniquely a source of physical danger, but rather because it occurs at the locus of female sexuality and is a strategy, deliberate or not, for enforcing male domination" (Brown, 2004, p. 468). Janice Haaken (1999) exerts that males experience fewer invasive experiences, and states that "male intrusions into female spaces—psychological and physical—continue to be deeply normative (p. 25). This normative position of female spaces may contribute to a social blindness to it.

The discourse employed by these authors constructs an idea that certain traumas are more serious than others, specifically trauma that befalls men, such as theft, robbery, participating in war (Hildago & Davidson, 2000). The authors have chosen certain traumas, and with these selected traumas it is clear that women, according to the implied statistics have a much easier life, with fewer difficult, life-threatening, terrifying events. The traumatic experience of women are less valued or potentially overlooked altogether, such as rape, abuse, pornography, sexual exploitation, sexual harassment, stalking, war crimes, slavery, purchase and trade of women and children, participating in war, et cetera. Generally, the experience and traumatic content of women's lives seem to be considered

less important or concerning than men's. This has historically been the case for women's experience (Brownmiller, 1975). As an addendum, I want to mention, that both sets of traumas, the ones considered by Hildago and Davidson (2000) and the ones that I have presented to include women's trauma experiences, are all perpetrated and controlled, in the vast majority, by men.

The language of secondary trauma is constituted and maintained through a *woman as weaker* discourse, which is already prevalent in our society. No women are exempt from this weaker allocation, both those who experience firsthand violence as well as the women who support them, listen to them, live with them, and relate to them.

It is argued here that woman as a subject in comparison to men are more susceptible to disorder and becoming symptomatic:

> Gender effects have been found in many studies looking at victims of vicarious trauma. Females tend to suffer from anxiety disorders to a greater degree than males. Being female was found to be one of the best predictors of vicarious traumatization. (Lerias & Byrne, 2003, p. 134)

Here women as victims who are weaker and more susceptible to disorder is confirmed through discourse that isolates the category of *woman* as prediction for disorders. Simply "being female" is used in the text as though it is a concrete, homogenous category. However, it is used without context and sensitivity to the social construction of gender. Fish (2004) states that women's coping and resistance strategies are more often reframed as disorder, thus they are diagnosed as PTSD—ill and needing fixing. The empirical literature of secondary trauma, vicarious trauma, and PTSD are consistently without social context (Burstow, 2003). This is despite that women experience threats and acts of male violence at such a high rate that it is considered normal. However, to state that *being female* is a predictor also implies that being female is a stable state, transferable to all

other females, and a consistent category that defines all females. This language, *a priori*, sets up women for allocation into a socially constructed and contained subjectivity for all women in the community. Within the research and literature that compares men and women there is absolutely no account of women's position in society. Women are simply labelled disordered, weaker. This language implies that there is a general weakness in women, in that women experience less trauma but become traumatized (disordered) more often.

Women are expected to deal with their own personal trauma histories as well as the trauma experienced by the women with whom they work. As well, I assert, that they must also contend with what theorists have called transgenerational trauma or community trauma, in that they experience trauma do to the conditions of social context, occupying the same social location as a marginalized group (see Danieli, 1998; Duran & Duran, 1998). Thus, the treatment of both client and therapist is done within the sexual assault programs (within therapy), confined to the institution—keeping the stories silent, hidden, and isolated, keeping the "disordered" woman contained. There is a constant threat of being labelled *disordered* if the treatment is not effective within a certain amount of time, and if the symptoms become pervasive and intrusive—both the PTSD symptoms of the client and the symptoms of secondary traumatization in the counsellor.

Interestingly, Ghahramanlou and Brodbeck list the "combined effects of gender, personal trauma history, and cumulative exposure to sexual trauma survivors" (2000, p. 230) as significant predictors of secondary trauma (PTSD) in the counsellor. In other words, predictors are being female, having experienced personal violence, and hearing stories of other women's experiences of violence, torture, rape, beatings, pain,

oppression. Furthermore, these women are living in and working for a society that isolates these factors and adds them up, and does nothing about them but to isolate, blame, and hand out labels. This can lead to persistent feelings of anger, sadness, cynicism, body pain, terror, helplessness, et cetera (PTSD, secondary trauma).

Woman as Responsible

I've shown that women have a dual responsibility: they are expected to care for themselves and care for other women. Further, they are expected to avoid traumatic situations and they are also expected to support, nurture, and heal women who do become traumatized. We are socialized and disciplined as women to be caregivers, from birth. Little girls are given dolls and kitchen sets and little boys are given guns, action figures, and trucks—these categorizations are made clear in the way they are marketed (advertised); the genders of the intended audience are clearly visible on the product packaging. On the Target Web site, toys have even been categorized into "Boys' Toys" and "Girls' Toys," as well as "Gifts for Girls" and "Gifts for Boys" (http://www.target.com). The toys designated and marketed to girls socialize nurturing, caring, relationship expectations, and domestic responsibility. Thus, when women begin to respond, or react (become symptomatic), acting outside of the regulated behaviours, as a result of the functions of caring for self and others they are blamed and labelled ill; they are not performing with their "natural" caring and nurturing subjectivity. This labelling and blaming is called backlash when she behaves outside of the valued and regulated behaviours for a good, nurturing woman (Burstow, 1992; Profitt, 2000b).

Within this socialized and normalized discourse of responsibility, women counsellors must navigate caring for others and themselves, while becoming more and

more aware of the staggering rate of male violence. Though, the fear of violence has been described in the research as a positive emotion in women. In a study of emotional responses of sexual assault victim advocates by Wasco and Campbell (2002), for example, they state, "the fear of rape may also have an adaptive role for women" (p. 121). Astin (1997), who calls fear generated by working with rape survivors a "gift," provides another example: "I don't live in a fantasy world and I take active steps to reduce risk and vulnerability" (p. 107). Although this concept of the woman who is aware of danger and can take precautions to protect herself seems ostensibly to be an empowering one, this narrative is communicating another underlying message: women have control over whether or not they are violated and that there are always steps that can be taken to protect oneself. This statement is indicative of a deeply-rooted belief system that maintains "victim blame." As well, this *awareness*, considered a "gift" (Astin, 1997) and "adaptive" (Wasco & Campbell, 2002) by the women who talk about their experiences working with women who have experienced violence is also called a "preoccupation" with potential danger by the developing dominant body of research/knowledge on secondary trauma (Gidron, Gal, & Glesser, 1999; Lerias & Byrne, 2003; Lugris, 2000; Van der Kolk, McFarlane, & Weisaeth, 1996). Consequently, this "preoccupation" is a predictor of secondary trauma–disorder and illness. The expectations on women are contradictory, to be both aware and reduce their risk of assault, yet not to be preoccupied, overgeneralize, cynical, or paranoid. Hence, women again are placed in an impossible binary, each/both resulting in woman blame, woman as responsible, and maintained focus away from the perpetrating male. I have personally experienced this double bind as I have been called a "bitch," and told to "relax," amongst

other things when I have expressed concern for women's safety and my own. On the other hand, I have been questioned about why I did or did not do things to prevent my own experience of sexual violence, as though my behaviour determined or could have changed the outcome, and was the cause of threatening and/or violent acts against me. Women are disciplined to behave in ways that implicate their responsibility in their experience of violence by the often unmentioned male. This risk, harassment, and violence are construed as normal and standard female experience—seemingly inevitable.

So, using this logic, it follows that the enlightened, vigilant counsellor can preserve herself with awareness, but she is also there to help someone who did not do a good enough job at taking precautions. What value does the woman have who did not succeed in living in a way to keep herself safe? The phallocentric value system of the woman's responsibility discourse is present even within the intimate care of the sexual assault counsellor. The irony is that even counsellors have been socialized to believe that *women are responsible* for their own safety, an assumption that Wasco and Campbell (2002) support in their work.

> Heightened awareness and fear of rape may serve to limit women's mobility, freedom, and opportunity. However, because their gender increases risk of being sexually assaulted across their entire lifespan, fear of rape may also have an adaptive role for women. (Wasco & Campbell, 2002, p. 121)

This focus on women's responsibility is consistent within the sexual assault and trauma discourse. Women have internalized the discipline of this responsibility and we often hold these beliefs as judgement against ourselves and other women. However, responsibility and the ability to choose based on our behaviours is a myth constructed and promoted as truth to oppress and blame women. Women internalize these rules and

judgements, which makes them difficult to unmask (Brown, 2004; Profitt, 2000a). There have been a number of times when I have been at the hospital with a woman who has left a nightclub with a man who became violent and raped her. I have at times caught myself thinking: "Why did you get in the car?" I have heard many mothers, female friends, and sisters of the recent victim of rape say that had she (the victim) not done a particular thing, the assault would not have happened. In many ways, we do hate the perpetrator, but we have not been taught that *he* has choice and responsibility. For example, we rarely spend time interrogating his every move and action (ultimately his choice to be violent) as we do with women. Most people, women and men, can give a sequential account of what it was that she did that led to sexual violence. Did she walk alone at night? Did she smile at a guy and accept a drink? Did she let him buy her dinner? Or did she move her body "provocatively"? Our society has spent its time scrutinizing, categorizing, and documenting the woman's behaviours instead of the male's (perpetrator's) behaviours. Teenage girls are taught health courses and given information and pamphlets that outline how to keep safe from violence. Schools and women's centres offer self-defence and assault prevention classes. The messages of responsibility are so well-taught that we simply live them out and rarely question the value system that they are perpetuating.

Coping style is considered another predictor of secondary trauma (Gidron, Gal, & Zahavi, 1999; Green, Grace, & Glesser, 1985; Lerias & Byrne, 2003; Resick, 2000; Van der Kolk, McFarlane & Weisaeth, 1996). *Coping* is defined as how a person uses their intellectual and behavioural resources to respond to a stressful situation (Dollard, Dollard, Byrne, & Byrne, 2003). The literature and mental health field have delineated what constitute negative (e.g., alcohol and self-mutilation) and positive (e.g., green tea

and yoga) coping mechanisms. Negative coping styles increase the risk of secondary traumatization and increase the level of subsequent distress. Certain behaviours as coping styles are assumed to be negative and *problem-focused*:

> This includes checking behaviour, constantly reminding oneself that they are in a potentially dangerous situation and preoccupation with one's safety. The more the person is focused on their safety, engaged in checking behaviour and feelings of distrust, the greater their anxiety. This coping style makes the person focus more on the stressor and associated beliefs emphasize the uncontrollability of the potential for danger. (Lerias & Byrne, 2003, p. 135)

Unfortunately, positivist research conducted and published on the topic of secondary trauma does not take social context into account, which set apart the experiences of and possibilities for men and women. Power relations between men and women seem to be ignored and a male standard is promoted. Catherine MacKinnon (2006) notes how men are always the standard against which equality claims are measured, in contrast to trauma treatment literature that speaks about negative coping responses as though every person (regardless of gender) has equal opportunity and privilege to choose to be unraped and untraumatized.

The Invisible Perpetrator

The potential for danger is a daily reality for women within a patriarchal society that does not acknowledge male/systemic responsibility for violence against women. Women are more likely to be diagnosed with PTSD and rape survivors are the largest group of persons diagnosed with PTSD (Foa & Rothbaum, 1998). As I have shown, secondary trauma has become accepted as an individual woman's problem, and is never attributed to society's continuing ineffectual response to the issue of violence against women.

> The negative effects of secondary exposure to a traumatic event are nearly identical to those of primary exposure, with the difference being

> that exposure to a traumatizing event experienced by one person becomes a traumatizing event for a second person. (Bride, Robinson, Yegidis, & Figley, 2004, p. 27)

Writing about secondary trauma is consistent in regard to this one phenomenon: the perpetrator is completely erased. There is no reference to the initial violence that was experienced by the woman, and at the therapist level there is only the exposure to traumatized individuals. This erasure and subsequent negation of the woman's story and experience is similar to the common practice of our justice system in Canada, which considers an assault a crime against the Crown; the woman who is assaulted is called a *witness*. As well, the language of secondary trauma is decidedly medical and prescriptive in its focus on symptoms, which apparently originate with the primarily "exposed" individual and are transferred from that individual to others.

Although the language of secondary trauma attempts to be neutral, it is not neutral at all. The language used in the study of traumatic stress is actively erasing the stories of women who have experienced violence, perpetrated by men (Burstow, 1992; Burstow, 2003; Lamb, 1999b; Mardorossian, 2002). The cognitive, emotional, spiritual, and physical responses in the therapist, I argue, are natural and normal, valid, and justifiable responses to hearing stories of rape, fear, terror, sadness, and brutalization of other women. Though, the secondary trauma literature names and categorizes these persistent reactions and responses "symptoms" and attributes them to "exposure to traumatized clients." So, in an attempt to explore what could be, I take the opportunity to place the perpetrator back into the language/text. Using the last text, I am taking liberties with the language:

> The effects of hearing the stories of male violence (rape, terror, et cetera) against women are nearly identical to those of the woman's

> impacts/effects who experienced male violence, with the difference being that the male violence experienced by one woman becomes an emotional, mental, physical, and spiritual event for a second person. (Adapted from, Bride, Robinson, Yegidis, & Figley, 2004, p. 27)

The messages and responsibility shift when the perpetrator is placed back in the practice context. As well, shifting the language to emotional, mental, physical, and spiritual reactions to harm done to self and others remove the disorder, isolation, institutionalization, and need for treatment of women. This shift in language allows the woman's response to have a space and be a legitimate truth. Women's responses and survival techniques are reframed within trauma talk (trauma and secondary trauma discourse) as symptoms to be treated (Lamb, 1999b; Marecek, 1999; Ristock, 2002). Finally, by naming the perpetrator and the violence, there is more space for all women's stories and their unique experiences, they no longer need treatment or fixing, rather empowerment and support (Brown, 2004). When we prioritize the female story we create liberating spaces in text for emotional, mental, physical, and spiritual healing, allowing the woman, and women around her, to find meaning outside of the phallocentric discourses and subjectivities created in secondary trauma texts. When we change the language, we learn that people are impacted greatly by the experiences of others; we also challenge the objectification of women in the trauma discourse. Violence does not begin and end with the victim; it is carried on and is felt by others who hear, care, and relate.

As a result of collaboration with the medical and legal systems, the language within sexual assault programs has changed over recent years (see Hammons, 2004); this change is strategic and it acts to take the focus off the act of violence against women, and more importantly, the perpetrators. For example, changing "rape" in the service name to "sexual assault trauma program" indicates intent and goal of the program, as

programming for "sexual assault trauma" is responsive and reactive, focused on the traumatized, and does nothing to prevent or change the occurrence of rape and sexual assault. In the 1970s, the feminist movement proclaimed rape as a crime of violence versus a sexual act (Herman, 1997). However, the shift within the legal system also intended to include and capture more acts of violence, as the term "rape" was limited to penetration, most commonly penis in vagina. Interestingly, now we use the term "sexual assault," which reintroduces "sex." The change from "rape" to "sexual assault" moves away from focusing on "victims" and social activism. As well, the move from a definition of rape connoting penis and vagina made "sexual assault" gender neutral, both the victim and the perpetrator (Gillespie, 1996). Further, the switch from "victim" services to "trauma" services takes the focus off of the act of violence and transfers it to the consequences of an unnamed event, removing the offence (implied in the construction of a victim). This move to trauma language is criticized by Burstow (2003) as a tool to objectify and oppress women. Charles Figley, a leading theorist on secondary traumatic stress disorder and compassion fatigue, reveals the neutralizing of women's experience of violence as he articulates foundational values, knowledge, and intention for the secondary trauma field. Figley (1988) speaks to this language switch as beneficial move for the victim themselves, because he states, they do not want to be known or thought of as victims, due to the stigma around this term in our society. Figley suggests that rather than focusing on the term victim, or "one who is an *object of abuse*," we focus on the traumatic stress in order to direct attention to the "*unwanted consequences* of highly stressful events" that are not limited to victimization (1988, p. 638, italics added).

However, I argue that this is an active removal that fails to recognize crime or implicate the one who commits the violence. Instead, it simply becomes an isolated set of symptoms (consequences of an unidentified cause). This is an active admission by Figley of depersonalizing the issue of violence against women, and instead medicalizing the after-effects, or the resulting set of symptoms. Figley (1988) goes on to state that the focus of victim studies, victimology, and victimization is limited, whereas trauma studies encapsulates victimization, but more importantly, covers all forms of highly stressful events. The study of traumatic stress deals with recovery and treatment following exposure to the precipitating event, "irrespective of the status of the person" (Figley, 1988, p. 638). I read this to imply that with a focus on "trauma," the story of the individual and social location are unnecessary for treatment and trauma prevention—treatment being the primary goal. Burstow (2003) opposed the label of trauma (and I extend it to secondary trauma) when she states that "trauma is not a disorder but a reaction to a kind of wound" (p. 1302). Finally, Figley states, "this field [trauma studies] is concerned about the prevention and crisis intervention, irrespective of the nature or consequence of the highly stressful event" (1988, p. 638). This is concerning to me (as a woman and a sexual assault counsellor) since it isolates victims and lists their symptoms as consequences of unnamed wrongs and stressors. They are removed from the events that caused their current state of being. The fact that Figley mentions that this depersonalizing move saves the individual from the stigma of being called a victim is frightening. The fact that society sees a "victim" as something weak and an "*object of abuse*" (Figley, 1988, p. 638) is concerning to me. It reflects victim subjectivity, woman

as responsible and weak, and the missing perpetrator. Where are the perpetrators? It seems they are somewhere within a "stressful event" (Figley, 1988).

Client as Infectious

If the professional literature on secondary trauma has one overarching theme, it is that there are negative consequences of working with traumatized individuals. These consequences have been variously described: serious and devastating (Trippany, Kress, & Wilcoxon, 2004), negative (Neumann & Gamble, 1995), problematic and damaging (Walker, 2004), hazardous and disruptive (Bride, Robinson, Yegidis, & Figley, 2004), for example. I suggest that the concept of transmitting trauma, or trauma effects from client to therapist, constructs and is constituted in *client as infectious* discourse.

> The term secondary traumatic stress has been used to refer to the observation that those who come into continued close contact with trauma survivors, including social workers, may experience considerable emotional disruption and may become indirect victims of the trauma themselves. Consequently, secondary traumatic stress is becoming viewed as an occupational hazard of providing direct services to traumatized populations. (Bride, Robinson, Yegidis, & Figley, 2004, p. 27)

Trauma is produced here as an infection, though no distinct origin. The man (or the perpetrator), along with the tears, terror, sadness, suicide attempts, and feelings of helplessness have been removed. In its place there is a one-size-fits-all definition of "trauma." The trauma is labelled *hazardous* and *disruptive*. Now that we have removed the perpetrator and violence, the trauma can be attended to. However, this removal of the perpetrator and violence has left a contaminating culprit—the traumatized woman, who becomes the cause of others' potential infection. Once more the discourse is woman as infected, ill, disordered, and contagious. She needs to be removed and treated, those who

come into "close contact" with her need to be warned of the hazard of this contact and the potential for also becoming a victim of the *trauma*.

Lacking in this hegemonic discourse is naming the perpetrator, hearing women's stories, placing cause in the violence against women, and systemic oppression of women, and instead represents our society's victim-blaming response. The individual stories of violence and impacts of violence are lost, as well as the far-reaching effects of violence beyond the victim. What remains is a list of traumatic symptoms, as the violence goes unnamed, untold, and unchallenged. Furthermore, at the secondary level (therapist) the violence is even further removed, just the client, therapist, and *trauma* remains.

> It is important to note that the impairment seen in those who are exposed to traumatized individuals could be due to factors other than secondary trauma. For example, therapists who have regular contact with others, who are traumatized, may develop difficulties due, in large part, to their own trauma history. Therefore, the linking of emotional impairment specifically to exposure to traumatized persons should be done with caution. It should be noted that intervening influences such as one's personal history may be a potent mediating factor. (Motta, Newman, Lombardo, & Silverman, 2004, p. 68)

Terms such as *exposure*, *contact*, *impairment*, *potent*, et cetera are common in the secondary trauma literature. These terms locate hegemonic secondary trauma discourses in the realm of the medical model that prescribe individual pathology, which tends to give it more legitimacy in our Euro-western society. The construct "trauma" completely nullifies the responsibility of society and men for violence perpetrated by males. The cause of *impairment* is solely due to *exposure* to trauma, whether from the therapist's personal trauma history or contact with traumatized others. Trauma is construed as a completely pathological and contagious impairment or illness. Studies are going so far as to link PTSD to permanent brain dysfunction and damage (Buckley, Blanchard, &

Trammell Neill, 2000), which only leads to further concern for women's location and legitimacy in society.

The client is infectious, or else infection may lie in a latent and *potent* aspect of the therapist themselves, in other words, unwritten, the therapist's past experience of abuse or violence. The language is medical and attempts to find cause in isolated aspects of the person, or *exposure* to potent others—perpetuating victim blame.

The same group of authors give strength to this medicalizing intention and impact of trauma discourse that focus us away from the violence and onto the victims when they state that the impetus of the field is that "future studies must place greater attention to isolation of causative agents [of secondary trauma]" (Motta, Newman, Lombardo, & Silverman, 2004, p. 73).

> Many competent caregivers are most vulnerable to this mirroring or contagion effect. Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress…resulting from helping or wanting to help a traumatized or suffering person. (Salston & Figley, 2003, p. 169)

The language illustrates the *client as infectious* discourse, in which the client has "contagious" emotions that can be "passed from person to person," such that the therapist can "catch" the emotions of their clients (Sabin-Farrell & Turpin, 2003, p. 456). "Competent" caregivers are targeted as the most vulnerable to becoming infected. Competent caregivers are constituted as those who have an enormous capacity for feeling and expressing empathy and those who help or really want to help those who are suffering and have experienced violence. Through discursive mechanisms of *client as infectious*, both the client and the therapist are pathologized and isolated. Contact with the client is defined as hazardous and risky. Empathizing and building relationship are

then risky behaviours for the therapist. To feel along with other women who are sharing their stories of violence, pain, fear, terror, sadness, et cetera is constituted as weakness in the therapist and increases susceptibility to "catching" the trauma.

The act and experience of empathizing within the relationship between therapist and client comes at a "cost." To feel in response to hearing another woman's story of violence is set up as a loss of self:

> There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our own sense of self to the clients we serve. (Figley, 1995a, p. 1)

Negative and problem-focused language, such as *costs*, *service*, *risk*, *contagious*, *losing ourself* to others, stigmatizes feelings and empathic responses, and implies that we as therapists and social workers should do this work with clients "objectively." Pat Usher (1997) writes that men (considered "neutral thinkers") constitute "male," which is positioned as legitimate and objective. Whereas, women and that which is "female" are constituted as and constitutes "subjective" and "irrational." The text holds within it rules for relationship between women—these rules constitute the disciplining in the discourse. Trauma discourse opposes feminist values and intent for women's relationships (feminist discourse and its discipline of women). This contradiction in professional versus feminist discourse leads to conflict and confusion for social services, such as the program that I work for, as they struggle to hold on to their feminist roots and alliances as well as stay *current*. The *current* expectation is a move towards professionalization, standardized care, which leads to adoption of trauma language and mainstream, medical language and knowledge.

The discourse also operates to divide the "client" as different from the therapist, a family member, or a friend, and that the therapist's responses of empathy and caring to the client's story should be separated from other kinds of relationships, which are non-therapeutic and not connected to work:

> Several therapists reported self-protective responses in which they actively sought not to imagine the client's experience. "I protect myself in some ways. I sometimes find myself automatically able not to let it get to me." Others reported being able to focus on therapeutic responses, "to concentrate on what my role is and what my job is" without the apparent need for self-protection. (Steed & Downing, 1998, p. 5)

The language used in Steed and Downing's research article implies that the female sexual assault counsellors they interviewed should compartmentalize their lives into therapist self and personal self. I read this as revealing the discipline of therapist subjectivity who has a standard set of behaviours to carry out, and treatment to administer (in this case clinical therapy), but she is not meant to "overly empathize," "involve herself," she should "concentrate on what my [...] job is," with consequence of being affected by the client she is warned to "not let it get to me" (Steed & Downing, 1998). My concern is that these sorts of instructions lead to isolation and institutionalization of women's whole experiences, meaning, in this context, women's relationships and common experiences are held within a treatment centre, governed by phallocentric, hierarchical, and professional therapy and trauma discourse. The professionalized therapist-client relationship is constructed in prioritized discourse that regulate what is ethical and responsible. These discourses operate to isolate and pathologize both victim and therapist, with threat that to deviate from the valued subjectivities of client and therapist can lead to loss of self and disorder.

In short, cutting one's self off—within self and from the client—has become an appropriate therapeutic response, because the client is dangerous, infectious, and the therapist must take self-protective measures. The professionalization of sexual assault services supports and is supported in dominant discourses of disordering and pathologizing "trauma," the *client as infectious*, and the *therapist as dangerous*, which promotes boundary-setting, objectivity, and distancing in the client-therapist relationship.

On the whole, the secondary trauma literature ('official' discourse of secondary trauma) tells us that therapists are in risky, high cost relationships with their clients.

> Another common trauma-linked countertransference response is what Kauffman (1992) has termed "the countertransference hostage syndrome". In this scenario, the therapist feels silenced and controlled by the client; her therapeutic options seem closed off, and the therapist has the sense of losing her own perspective in the face of the client's sense of reality. (Neumann & Gamble, 1995, p. 342)

Language of "losing self" and "controlled by the client" set up a battle and conflict environment between the female therapist and client. Women in positions of helping women are situated in defensive positions before she even meets the woman who has experienced violence and who she is proposing to help and support. The imagery constructed by terms like being taken "hostage" by the client, or victimized by the client (remember that this is the person who is seeking support and help following experiencing violence) divides women and places limits on the relationship between women (placing these women in juxtaposed subjectivities of helper-client). The stage is set for fear, and therapists are warned to be on the defensive and manage risk within the therapist-client relationship.

The Therapist as Dangerous

'Official' secondary trauma discourse also deploys and (re)constitutes a *therapist as dangerous* discourse. In short, the therapist is responsible for dealing with her trauma effects or she is described as potentially dangerous. Secondary trauma discourse is laden with implied risk for and potential harm by the therapist to her clients, society and the community outside of her organization, and her organization. To reduce her risk, the traumatized therapist is expected to receive treatment:

> If unaddressed, the results of VT [vicarious trauma] can be pervasive, ranging from occasional nonempathic distancing from clients, to victim blaming, to a progressive loss of energy and idealism on the part of the clinician (depression). Boundary violations and other difficulties managing the therapeutic frame occur more frequently when a therapist is suffering the effects of vicarious traumatization. (Neumann & Gamble, 1995, p. 344)

The therapist has now been set up for blame, even though secondary trauma is also considered natural and normal by the same body of work. More importantly, there is again a denial that the root cause is someone's decision to violate another. Instead, the therapist who is irresponsible and neglects to deal with her secondary traumatization becomes a risk to her clients. A *therapist as dangerous* discourse pervades in the research and literature of secondary trauma. For example, "vicarious trauma that goes untreated can be dangerous for the mental health of both the therapist and the client" (Hesse, 2002, p. 304). As well, "VT [vicarious trauma] and burnout are responsible for a decrease in concern and esteem for clients, which often leads to a decline in the quality of client care" (Trippany, Kress, & Wilcoxon, 2004). Finally, "even well-trained and skilled therapists may not be able to remain empathic towards clients if they are suffering from secondary trauma" (Hesse, 2002, p. 301).

The impetus is placed on the individual therapist as well as the larger social services organization to adequately "deal with" and "treat" their traumatized therapists. The organization's work can be compromised by a "suffering," "untreated," infected therapist. The agency is told to focus and "treat" its disordered therapists, an instruction that contributes to depoliticizing this particular trauma.

> When therapists are suffering . . . the quality and effectiveness of the organization's work can be compromised. Therapists who do not adequately deal with vicarious traumatisation are likely to experience more disruption of their empathic abilities, resulting in therapeutic impasses and more frequent incomplete therapies. Therapists are also likely to have greater trouble maintaining a therapeutic stance, and to engage in more boundary violations. (Sexton, 1999, p. 397)

Therapist as dangerous discourse warns that the traumatized individual is a threat and hazard to the therapist's self, clients, and organization.

Especially in the relationship between client and therapist, *therapist as dangerous* discourse disciplines women.

> Burnout and STS [secondary traumatic stress] are common outcomes of providing counselling and psychotherapy and may lead to counsellor impairment. A diminished ability to function professionally may constitute a serious violation of the ethical principles and consequently place clients at risk. (Everall & Paulson, 2004, p.25)

This text is extremely threatening to the therapist.

Medicalizing and Pathologizing Discourses

Within Euro-Western society, mental illness comes with great stigmatization and isolation. The primary goals of social services are to diagnose, fix, cure, and develop the correct treatment plan in order to return the patient to normal, productive, or preferred functioning. Often in the case of PTSD and secondary trauma (according to the dominant

positivist research on these disorders), the characteristic that seems to need treatment is the very condition of *femaleness*. Female subjectivities as constructed by our society are laden with symptomatic behaviours and tendencies that quickly position women in devalued, deviant, and unaccepted subjectivities.

The discourses of trauma and secondary trauma are medicalized. The definitions, labels, and symptoms are based on an illness model and deficit model.

Symptoms and Diagnoses

The secondary trauma literature is saturated with pathologizing discourses and costs of doing trauma work. Vicarious trauma is "profound changes in the core aspects of the therapist" (Pearlman & Saakvitne, 1995b, p. 152). As well, "findings suggest that VT [vicarious trauma] effects can have a profound impact on both personal and professional domains of functioning" (Steed & Downing, 1998, p. 2). Here are examples of the division of the therapist self into personal and professional. "This anxiety disorder [secondary trauma] provokes significant occupational, psychiatric, medical, and psychosocial disability. Likewise, its consequences are enormously costly not only to the survivors and their families, but also to the health care system and society as a whole" (Hildago & Davidson, 2000, p. 5).

The tendency in the professional literature of secondary trauma is to normalize and medicalize the effects of doing trauma work, segregating this affected population from a healthy *normal*. Secondary trauma is a construction, something within the individual's body that can be measured and assessed, with identifiable somatic and psychological symptoms (see Foote & Frank, 1999 discussion on the normalization and medicalization of grief). The language outlines the devastating effects of this "disorder,"

including "occupational, psychiatric, medical, and psychosocial disability" (Hildago & Davidson, 2000, p. 5). The cost of this disorder is considered a drain on the health care system and society as a whole.

There is medicalizing and pathologizing tendency in 'official' secondary trauma discourse. As well this discourse acts to remove the perpetrator (the man) and any kind of societal responsibility for violence against women. A potent *client as infectious* discourse, constituted as the cause of secondary trauma, in which infectious trauma is situated in the body of traumatized individuals. This medicalizing discourse constructs a contagion (trauma), which becomes isolated within the infected individual's body. Further, the therapist who has secondary trauma is effectively pathologized through discourse. Socially, it is easier and more convenient to deal with the traumatized therapist and victim than to address violence against women.

By now we have an understanding of the origin of the disruptive, aversive, and disordered feelings and behaviours experienced by the helper. These are the symptoms of the affliction of secondary/vicarious traumatization, due to contact with or exposure to a traumatized individual—*the client as infectious* (Bride, Robinson, Yegidis, & Figley, 2004). As well, we know that these impacts of working with traumatized people are considered *normal* and *natural* (Bride, Robinson, Yegidis, & Figley, 2004; Figley, 1999). However, even though the secondary trauma response may be considered *normal*, there is still a move to categorize and isolate this afflicted population—both the primary and secondary traumatized. Isolation of the secondary victims allows for proper symptom detection, diagnosis, and treatment. Thus, the search for causes and cures is focused on the individual: "In studies on professional trauma therapists, most authors have proposed

a dose-dependent relationship with higher current and career caseloads associated with elevated risk for developing secondary trauma" (Ghahramanlou & Brodbeck, 2000, p. 230). As well, "confrontation with visual and auditory cues that are reminiscent of one's own trauma history can be distressing" (Ghahramanlou & Brodbeck, 2000, p. 230). Finally, "recent and cumulative exposure to trauma clients are also essential risk factors in the development of secondary trauma in sexual assault trauma counsellors" (Ghahramanlou & Brodbeck, 2000, p. 230).

The number of trauma clients and the severity of the case are labelled "dose," assuming that the amount of "trauma" (women who have (re)experienced violence) that the therapist works with is measurable and quantifiable, and that rations and limits can be imposed. Women who have experienced trauma in the past are set apart as more susceptible to secondary trauma. The language used in this body of work almost entirely removes the person and their experience of violence; only trauma remains. When the person is mentioned, she is only mentioned in part, leaving only a pathogen, with quantifiable and qualifiable confrontations that have "visual and auditory cues." For example, "secondary trauma can emerge rapidly with little warning and can cause helplessness and confusion" (Hesse, 2002, p. 297). The discourse not only removes women's stories and replaces it with a cover-all "trauma" label, but at times it victimizes the therapist. The medicalizing discourse places therapists in a victim role, where "secondary trauma" can suddenly come out of nowhere. The medical and pathological discourse is fear-inducing and contains a catastrophic tone in its operation. For example, the therapist's plight is *helplessness* and *confusion* due a "trauma" that emerges rapidly and with no warning.

I believe and propose rather that this *helplessness* comes as a result of the social context within which women's stories are unheard and often untold, except to the few woman counsellors who choose to work with and support these women. This is supported by feminist authors that argued against the decontextualizing of trauma such as Becker, (2004), Brown (1994), Burstow (1992, 2003), Haaken (1996, 1999), Lamb (1999b), Marecek (1999), Mardorossian (2002). These women counsellors' experiences differ from the rest of society as they acquire a new awareness that comes from listening to story after story (in many therapists' case) of violence against women. As well, these helpers experience firsthand and secondhand (through other women) the lack of response and support by the social systems (justice, medical), which can increase feelings of isolation and helplessness in the trauma therapist.

In the same sense, "confusion" (used by Hesse, 2002) is a term that attempts to illustrate the trauma therapist not understanding something clearly or correctly. She is disoriented perhaps, and not fully capable of comprehending. Alas, *confusion* is a term that further isolates and *others* the trauma therapist, for now her new view of the world (that includes that it has a great deal of violence towards women in it) can be easily dismissed because she is "confused."

Hegemonic discourses seem to avail victim-contagious and therapist-dangerous subjectivities. Both subjectivities have the greater societal issue of past, present, and ongoing threat and experience of violence removed and actively dismissed in text, language, and power/knowledge. The secondary trauma research prioritizes the isolation of societal variables that anticipate cause—trauma becomes the variable that is controllable in the form of the client and her symptoms. Therefore, with a trauma focus,

the only prevention lies in characteristics and attributes of the individual that predispose them to experiencing secondary trauma. She is the subject of study for deviance and disorder:

> Multiple aspects of the therapist and their life are affected [by secondary trauma], including their affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and experience of their body and physical presence in the world. (Pearlman & Saakvitne, 1995, p. 280)

> The therapist may experience general changes, such as having no time or energy for self or others, and increased feelings of cynicism, sadness, and seriousness. They may experience other strong emotions such as anger, grief, or despair. The therapist may also develop an increased sensitivity to violence, for example, when watching the news on television or in the cinema. (Steed & Downing, 1998, p. 3)

> Two major factors that contribute to VT [vicarious trauma]: aspects of the work, and aspects intrinsic to the individual therapist. Aspects of the work include the nature of the clientele, specific facts of the traumatic event, organizational contextual factors and social/cultural issues. Therapist characteristics include personality, personal history, current personal circumstances and level of professional development. (Steed & Downing, 1998, p. 3)

Steed and Downing (1998) also speak to the therapist's responses, "therapists were also aware that their responses were influenced by their workload and by whether it triggers something personally in me, some kind of memory of myself, or some kind of connection that I make" (p. 5).

Treatment

Violence against women both at the acute level and at the vicarious/secondary level, as it is interpreted in the literature, means that all women, whether they directly or indirectly experience violence, are susceptible to being labelled disordered, distressed, and victim. Within secondary trauma and PTSD discourse, the need for treatment is paramount. Society's (institutions/social services) focus is on treatment and fixing the individual who

has become mentally ill (PTSD, vicariously traumatized), disabled, in order for them to be made *normal* again so they can re-enter society *fixed*, no longer a threat to others—contagious or dangerous. Concurrently, the causal violation (rape, assault) is overlooked, no longer relevant or needed in order to attain the essential diagnosis and treatment plan.

Seeking out effective treatment focuses on the traumatized individual(s) in isolation (e.g., therapy and self-care) instead of encouraging activism, movement and shift in society's response to violence against women, speaking out, breaking silences, and placing the cause on the perpetrator of the violence (Burstow, 2003; Mardorossian, 2002). Institutions are erected to treat "trauma" in the client as well as in their afflicted therapists.

Treating the individual.

Similar to the literature for trauma therapy, healing processes and stage theories aimed at fixing individuals with secondary trauma are now receiving much attention to uncover what works to heal those inflicted:

> The ways in which VT [vicarious trauma] can be addressed is through acceptance and recognition of the changes that occur, through giving oneself permission to limit exposure, and to continue in education in the field of traumatology, but also in the general field to maintain contact with theory and to develop new interests. For therapists it is also important to name the reenactments that occur during therapy for the benefit of the client as well as the benefit of the therapist, and to set limits with clients. (Salston & Figley, 2003, p. 169-170)

As well, "most experts agree that one of the easiest ways of preventing secondary trauma in the workplace is by limiting exposure to traumatized clients" (Hesse, 2002, p. 304). The individual therapist is given permission to *accept* and *recognize* the changes in the self that occur, as a result, they can actively limit their exposure to trauma. Salston and Figley (2003) refer to education in the field of traumatology and maintaining contact

with theory as preventative and helpful in treating secondary trauma. Language of *limiting exposure* connotes an objective of isolating *trauma* exposure to the workplace, containing it (leaving it) within institutional walls. The language of trauma and practice that ensues is far from the feminist value of relationship, community, shared experience, unity, and strength.

In terms of self-care, therapists are called to be "committed to their own health and well-being," where "self-care is an ethical responsibility; if therapists do not care for themselves, they are at much greater risk of hurting their clients" (Neumann & Gamble, 1995, p. 345). The onus is on the therapist to deal with her own health. First she is called to be responsible for caring for other women, then she is dangerous and a burden on society when she becomes disordered by her work (Penfold & Walker, 1983). *Responsibility discourse* comes full circle when it demands that the therapist must care for her clients, act ethically, and care for herself, or risk hurting her clients.

To treat secondary trauma the therapist must segregate out and successfully institutionalize the trauma, both her client's and her own:

> [Secondary trauma] is an invasion of work into all areas of a therapist's life. To counter this, we recommend setting firm boundaries around one's work and home lives. Decompression rituals such as listening to relaxing music on the way home, spending some time alone reading, repeating affirmations, changing clothes, and exercising. (Neumann & Gamble, 1995, p. 346)

The authors continue to say, "this [need for social support] means developing and maintaining solid, non-work-related interpersonal relationships in which the therapist's needs for esteem, intimacy, safety, and trust can be nourished" (Neumann & Gamble, 1995, p. 346). As well, "they must consciously notice how their work as a trauma

therapist may be affecting their significant others and take the risk of initiating dialogue about that" (Neumann & Gamble, 1995, p. 346).

The "invasion" of her work (by other women's stories of violence) into other areas of her life is construed as dangerous. Because it is risky to take trauma home, cautions must be in place, and actions for decompression must become ritual. For example, in order to decompress—which can be defined as "reducing pressure in an organ or part of the body" (Encarta Dictionary, 2003)—the therapist is told to change clothes, not infect others (there is risk in talking about work to others outside of the trauma field), divide work self from home self (representing the dichotomy of personal and professional), and leave work at work. The trauma therapist is encouraged to have "interpersonal" relationships, which are different from work or client relationships, to have her needs met, however, she must take care not to infect these significant others with *trauma* dialogue.

The therapist is encouraged to further leave trauma within the walls of the institution by limiting her exposure to *traumatic material* outside of work. "[Trauma therapists should] limit their exposure to traumatic material on the news, in television programs, and at the movies" (Neumann & Gamble, 1995, p. 346). As well, "new therapists are often acutely aware of how much they are putting themselves 'on hold' while they focus on their clients" (Neumann & Gamble, 1995, p. 345).

With professionalization of previously feminist services, the self on hold becomes more significant. The program I work for, as an example, rates "inappropriate" self-disclosure and displaying too many personal issues as "red flags" during the training

process, which can lead to that person being pulled aside and asked if they can really do this work at this time.

The medicalized discourse of trauma places responsibility on the individual therapist to isolate trauma as a disorder, rather than a social condition of perpetuated and supported violence against women. If we replace the context, traumatic material breaks down to people's stories of hurt, violation, feeling unsafe and terrorized by another person, persons, or system. It is a current, continuous, and prominent reality for most women. For the woman who has experienced violence, it is not her privilege to place self "on hold," change her clothes, transition out of a *trauma lens*, leave self somewhere (at work, home, et cetera). For her, the impacts of violence are constant and real, they are not turned off or limited. But the messages are clear in the discourses of trauma and secondary trauma that she is infected, contagious, disordered, and should be removed, hidden, and kept silent (quarantined).

Wasco and Campbell (2002) found that female sexual assault victim advocates experienced higher levels of anger and fear (symptoms of secondary stress) when the advocate felt that the client was like her. Their results found that advocates avoided the thought that the victim is "like me," which helped to alleviate their fear. They found that likeness to self increased the feelings of fear experienced by these women. Leaving work at the office, leaving themselves outside the therapy door, putting themselves on hold, and depersonalizing are prominent lessons for therapist in classrooms, in the literature, and called self-care. However, I believe this "leaving" is an active denial of oneself as a woman, and is an example of the isolation and segregation/detachment required in attempting to remain emotionally neutral and "objective" (see Bell, 2003; Wasco &

Campbell, 2002). Further, it does not take systemic oppression of women into account, in that women's experiences are different from men's due to their social locations. The "healthy therapist" discourse is constructed based on an assumption of women's privilege to choose from the same options that are in reality only afforded to men (MacKinnon, 2006). Unlike women, men are systemically guaranteed (at least to a much greater degree than women, especially White men) personal, physical, and sexual safety.

Within the medicalized treatment discourse of secondary trauma, there is an assumption that we all know what a "healthy character," "ability to control anxiety," and "active conceptual skills" look like—these terms act to *normalize*. As well, we are given obscure instruction to empathize but disengage from identifying with the women who are our clients:

> A therapist with healthy character structure, will be able to control anxiety, actively employ conceptual skills, be able to maintain empathy while disengaged from the process of identification, and work on bringing unconscious material into conscious awareness in order to effectively manage [secondary trauma]. (Salston & Figley, 2003, p. 170)

This instruction is contradictory in its form, because to empathize is the identification and understanding of another person's feelings and experiences (Encarta Dictionary, 2003; Canadian Oxford Dictionary, 2004). With current trauma and secondary trauma discourse, women have limited options to find relationship and support in their experience of male violence, especially due that the women who are in roles to hear about the violence (woman counsellors) have already been warned of the risks of contact with the client. The woman counsellor is disciplined and governed in her behaviour, experience, and subjectivity.

Work with women who have experienced violence is constituted as hazardous, with potential impacts of psychological distress, intrusive ideation, and cognitive avoidance. These fear-inducing messages directly impact the client-therapist relationship, by constructing and limiting the knowledge and language available to female therapists, that which they use to relate to the women who they listen to and support. It also effects the client's ability to have her story heard, understood, and affect change at both the personal and political levels. The impacts of dominant discourse of secondary trauma keep women segregated by *professional boundaries* (bound in acceptable and valued subjectivities of therapist-client) and fear of becoming infected (*client as infectious*) or unethical and harmful (*therapist as dangerous*).

In summary, within secondary trauma literature and research, trauma remains the focus rather than the violence that *causes* it. I have identified several discourses that fall within overarching categories of normalizing discourses, gendered discourses, and medicalizing/pathologizing discourses through which the oppression of women is maintained because violence against women remains unimplicated. Through dominant discourse, we no longer seem to need the stories that cause the symptoms that countless women experience. It seems we do not even need the women themselves, other than to quantify, name, diagnose, and treat their symptoms. Trauma has become, through discourse, its own catch-all, cover-all condition. Social response to trauma is depoliticized and blind to its cause: violence.

Exceptions and Contradictions to the Dominant Discourses in the Secondary Trauma Text

Within the literature and research of secondary trauma I came across a few exceptions and contradictions to gendered, normalizing, and pathologizing discourses. Many times these exceptions were contradictory within its own text or body of work.

One study by Schauben and Frazier (1995) provided a unique and uncommon statement that implicated the governmental systems within which therapists and support workers are forced to work:

> Many counselors say that it is not working with the clients themselves that is most difficult; rather, it is dealing with the ineffectiveness and injustices of other systems, such as the legal and mental health systems. Thus, counselors, like clients, can be traumatized by the victimization itself as well as by the systems purported to assist survivors. (p. 62)

This study had 148 respondents, many of whom noted that a major problem lies in society's responses to the violence that is occurring to the victims of sexual violence. Despite this, Schauben and Frazier's (1995) suggestions for secondary trauma treatment are still focused on the individual, and include solutions such as the counsellor's personal acknowledgement and working through of the effects of trauma counselling, as well as professional training on prevalence, effects, and treatment strategies for sexual violence clients. Although systemic societal impacts were mentioned by the participants in their study, the authors fail to suggest ways to address the "ineffectiveness and injustices" within the social systems.

In another example of a contradictory text, the therapist-client relationship seems to be promoted and the act of distancing through diagnosis is implicated for its harmful impacts. Neumann & Gamble (1995, p. 342) state:

> Beleaguered therapists may be tempted to intellectualize or make generalizations about their clients' experience (e.g., by labelling clients "hysterical," "manipulative," "borderline," or "multiple"). Such diagnoses, however technically accurate, serve to distance therapists from understanding the personal experiences of their survivor clients. This distancing buffers the therapist from the pain engendered in authentic human relating with traumatized clients, but is usually experienced by survivors as disengaged and countertherapeutic.

The authors fail to mention that intellectualizing and generalizing statements are embedded discipline and practices within the social services system, not only the individual therapist. It is my contention that the professionalization of sexual assault "trauma" services sets the client up to be labelled. In my experience, most women who have used more than one social service resource already have a file with a diagnostic label in it (e.g., PTSD, anxiety disorder, depression, and any or all of the labels mentioned by Neumann & Gamble, 1995). Regardless, here the blame for distancing too much seems still to be focused on the individual therapist (not on the system that simultaneously teaches and encourages therapists to distance). In trauma and secondary trauma discourse therapists are disciplined to quantify, measure, and assess symptoms, which directly contradicts a "human relating," "personal experiences," and overall survivor-sensitive practice. Thus, this text is uniquely incongruous within the overall discourse of "trauma" and "secondary trauma" research and literature, as well as within the authors' own article. However, this text represents options for resistance to the dominant discourses that focus on pathology.

As I have argued, in most of the secondary trauma literature, coping styles are deemed negative or positive, with a tendency for styles that represent a "male" experience of the world considered correct and positive. However, in her text, Kim

Etherington (2000) proposes that we *honour* the diverse strategies that people use to survive:

> People cope with trauma in a variety of ways that are not always well understood and judgements can be made about the coping strategies used which, in themselves, might cause problems in living. However, these same strategies may also have enabled the person to survive and should be honoured as such. (Etherington, 2000, p. 378)

The tendency in the secondary trauma body of literature is to label and construct disorder symptomology based on response to violence and coping behaviours in the women who experience violence firsthand and secondhand. Although Etherington still does not name the violence, she invites understanding and honouring survival in individuals. This invitation challenges pathologizing discourse as it allows for non-judgemental consideration for persons coping with trauma.

Social implications are generally missing in the literature of secondary trauma. However, I did find a few examples in the literature where social action and breaking the silence by telling the stories of violence are encouraged. But even in the promotion of social action, a discourse of a correct world view remains prominent, as these samples indicate:

> Keeping perspective often requires that we challenge some of our overgeneralized negative assumptions. There is good as well as evil in the world. There are random acts of kindness as well as senseless violence. We need to pay attention when our perspective becomes jaded, tinted with negativity; we must work to bring the full complexity of contradictions and nuance into view. Finding community transforms the existential isolation that comes with despair and grief. Communities offer connection with shared visions, beliefs, hopes, dreams, and goals. They speak to the potential creativity and constructive outcomes that result when humans work together to bring about positive change. (Saakvitne, 2002, p. 448)

> Working for social justice can provide a way of restoring a positive worldview, as well as lending balance to the therapist's neutrality and

> bystandership. Comaz-Diaz and Padilla (1990) have written about the restoration of a sense of purpose which can come about through social action by therapists. Such activity can help us overcome our sense of helplessness and deal with the rage we may feel toward our society. (Pearlman & Saakvitne, 1995, p. 397-398)

These authors propose that the goal of working for social justice can be a way to restore a positive world view. This language supports classification between a positive and negative world view and position "negative" world view as still something that needs to be fixed. This world view is characterized as jaded, negative, despairing, grieving, and includes overgeneralized negative assumptions with attention to the occurrence of evil and violence.

Unfortunately, the encouragement for social action is still focused on fixing the therapist's sense of helplessness and rage. However, community and relationship is introduced, potentiating deinstitutionalization of trauma, as the stories of women are spoken outside the walls of the agencies. Yet, is still not the client and therapist relationship that is promoted. The construct of community presented does not seem to include these two women together, which is concerning, as well, for the woman who is both these women—victim/client and counsellor. Challenging dualistic therapist-client subjectivities and embedded power relations constituted through professional discourse of trauma and secondary trauma service is not presented as an option.

> We need to encourage counsellors to come out from behind the closed doors of the counselling room and use others who can befriend and support them in the work, both formally and informally. Just as clients cannot do this work alone, neither can counsellors or supervisors. (Etherington, 2000, p. 378)

Hesse (2002) was the only author, out of countless authors who refer to the work of the leading authors on vicarious trauma, Pearlman and Saakvitne (1995), who made

reference to social action. All the other authors whose work I reviewed stayed focused at the individual level or supervision/organization level and on fixing the therapist. For example, "organizations can become involved in social action that works to end or decrease our clients' victimization, increasing the rights of victims, developing community education programs, and working to raise awareness of trauma issues" (Hesse, 2002, p. 307).

Hesse resists the singular focus on the traumatized woman. Thus, as well as speaking about the consequences within the individual (trauma issues), she presents the cause (the violence) as needing awareness raising and community education to stop the violence from occurring and shift our response from *removing the perpetrator* to holding him and society responsible.

Below is an excerpt of the first text that I came across, written by one of the leading authors on vicarious trauma (Karen Saakvitne, 2002), which mentions the emotional and spiritual aspects of people. This mention of the person as more than a cognitive and physical being is impactful, unique, and contradictory to the body of literature in which it is embedded:

> What works against us is our tendency to emphasize the intellectual over the emotional and spiritual in our process. Further, our unrealistic expectations for ourselves and each other about professional detachment and 'neutrality' can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work. We need to deconstruct the shame that has silenced so many of us in our analytic communities and be willing to speak the language of feelings, rather than constructs, and to express fears and doubts, rather than solely analytic formulations. (Saakvitne, 2002, p. 446)

Even though this text is still focused on the individual, and she isolates *shame* as the conductor of therapists' "vicarious trauma" (Saakvitne, 2002), she implicates the analytic

community. Saakvitne (2002) introduces options for a more integrated and whole identity of the therapist. She locates "professional detachment" and "neutrality" as unrealistic and points out that they produce barriers that prevent honest disclosure of feelings. Saakvitne (2002) also speaks to silencing and pathologizing ("analytic formulations") effects that secondary trauma constructs have, making room for feelings, emotions, and the spirit of the person. This text provides a small space for commencing deconstruction of the professionalizing, institutionalizing, and pathologizing discourses of trauma and secondary trauma. As well, this text presents a language for constructing a helper subjectivity that is not unprofessional, dangerous, and disordered if she *feels* and attends to the relationships with the women whose stories she carries and, in part or whole, whose stories become her own as she goes through life.

In conclusion, there are few contradictions and challenges to the dominant discourses of trauma and secondary trauma that I have outlined. However, these contradictions are points of resistance to hegemonic truths that pathologize and blame women in their experience of violence and oppression. I contend that we need to pull apart these scraps and pieces/contradictions and enhance them to place dominant secondary trauma discourse under a critical gaze.

In Chapter 4 I present my analysis of the interviews I conducted with female sexual assault counsellors. I present discourse that I found in operation within the talk.

Chapter 4: Discourse Analysis

Introduction

I interviewed four female sexual assault counsellors who all volunteer with and work in a community-based sexual assault program within a multi-service agency. All four women were Caucasian. All four interviews took place in an office at the agency we all work for, and had all been working in the program for more than eighteen months. I have assigned pseudonyms to the participants to protect their identity. I asked the participants about their role, experiences, and perspectives of sexual assault, in particular, their experiences of the work and its impacts (see Interview Guide, Appendix C). My main interest was to learn what discourses are in operation within the sexual assault program and the impacts of these discourses. My discourse analysis has two main sections focusing first on the construction of the victim subjectivities and then the therapist subjectivities. I focus on appearances and use of the discourses that construct the *client as infectious* and the *therapist as dangerous*. However, I was also alert to the presence of other discourses and impacts. I analyzed how they talked about their work, the victims, and themselves, what language they used, and how they talked about their experience. Within my exploration into the relationship and the potential impacts of doing sexual assault work, I was interested if counsellors employed discourses of trauma and secondary trauma and what impact those had. I was listening for messages, discipline, and consequences within the talk, and I analyzed what discourses these were in. I was interested in how discourses interacted, and whether discourses like secondary trauma, therapy, and professionalism opposed or supported one another.

In my study of the *client as infectious* discourses, I reflected on what was said in response to being presented with this idea. Then, I looked for what was not said, where they said the impacts they experienced, including secondary trauma, came from, and the use of counter-discourses.

Within my analysis of the *therapist as dangerous*, I focused on participants' response to the presentation of this idea. I wanted to know if they talked in this way, with caution, if they rejected the idea of the therapist being dangerous and if their talk matched or did not match their rejection. I listened to the interviews and read the transcripts for discourse that constructed who the therapist is, and how she is disciplined. Words that triggered my interest were shifting pronouns ("we," "you," "us"), cautions and warnings ("careful," "should"), and statements of consequence. I was interested in discourses that construct the therapist as dangerous, as well as discourses that were present that support and challenge this main discourse. How the sexual assault counsellors talked about the therapist, client, women, her position, her behaviours, and her power were all explored.

Throughout, I explore the available subjectivities constituted by secondary trauma work discourse used by the counsellors in their interviews. This discourse constructs and regulates options for behaving, feeling, and relationship between women through the subjectivities it constitutes as acceptable—or not. In this exploration of subject positions, I took a closer look at how the counsellors talked about themselves as counsellors, women outside the agency, in the community, victims, etc. Professional subjectivities include the woman at work, the professional woman, and the woman therapist, whereas personal subjectivities include the woman in the community, the woman at home, and the social woman (the divide between the woman's social and professional life). Within the

dichotomous discourse of personal and professional, participants seemingly wrestled to construct acceptable and valuable subjectivities. To explore subject positions constructed through discourse, I analyzed the language and terminology used by the sexual assault workers, for example, pronoun use, ways they behaved at work or outside of work, how they talked about their relationships inside and outside of work. I highlighted these examples of text in the transcripts, and then I took these examples and compared them to each other.

Discourses and the subjectivities constituted by these discourses have material effects on relationships between women. I have presented the discourse in operation to illustrate my argument that as women we are agents in our own oppression by (re)constituting phallocentric discourse. Whether this is because we are complicit or because we opt into dominant discourses to ensure our own survival, the impacts include the silencing and institutionalizing of women's stories of oppression and male violence, pathologizing the woman subject as ill in her survival of violence and locating her in a devalued subjectivity (victim/client). However, I have also presented how our complicity is often wrought within discursive struggle and binaries.

Constructing Victim Subjectivities

My analysis of how the discourses used by the participants construct victim subjectivities produced three significant findings. One is that although the "official" discourses of the agency deplore and counter rape myths, these myths were repeatedly referenced by the participants as explanations for why rape occurred (see Meyer, 2000 for a discussion of rape myths). Another is that these rape myth references often appeared side by side with

the "official" discourse, especially in discussions about prevention. These contradictions may represent the struggle to resist pervasive, normalized, and hegemonic discourses of victim and woman blame. Finally, I noted that conversations about prevention seemed to almost inevitably focus on women – a phenomenon that I believe reflects the difficulty that most women have in ascribing responsibility for male violence to men.

The discourses operate to construct and promote certain subjectivities for women, which constitute women as scapegoats for male violence and women's own oppression. Within her construction as scapegoat, she is responsible and blamed, as well as a *real* or valued victim subjectivity.

The Responsible and Treatable Woman: Constructing the Scapegoat

Victim blamed.

Rape myths construct and perpetuate subjectivities that blame the woman, setting her up as the scapegoat for systemic violence against them. Within rape myths she is blamed and her behaviours are monitored and judged.

Cat's knowledge of rape myths is evident in her description of many women's initial response to being raped:

> Cat: 'Why is this happening to me?' I have heard so many women ask, 'Why...why would they do this to me?' 'It's not like I went out and asked for it.'...I think that a lot of this is shock.

Cat went on to state that women experience shock following a rape as the victim questions herself trying to figure out what she did wrong, how she behaved to fit into the "rape victim" subjectivity constituted through dominant discourses about rape. I discussed these dominant discourses, including the notion that only certain women 'get raped'. Women's awareness and internalization of dominant discourses about rape

(including what feminists call rape myths) is evident in references such as the one quoted by Cat: "It's not like I went out and asked for it."

Women's actions are governed and judged through dominant discourse. The prevalence and hegemony of rape myth discourse was evident in the talk of the counselors who could speak about what women should and should not do.

> Dana: Because if you are drunk or high or whatever it is, you shouldn't be doing things like that.

Rape myths construct a knowable subject, the raped woman, who can be avoided. For example, Bailey reveals how discourse appears side by side even when they seem to contradict:

> Bailey: So, if anything, my sense of safety is always on my mind [...] I do things to lessen my risk of being assaulted, in my mind for my own kind of emotional, being able to sooth myself in that way, if I can reduce my risk of violence. And also knowing that everything I do to reduce the risk, isn't going to necessarily keep me from being assaulted. But it is something that I can do to help me feel a little more in control of what could potentially happen to me. [...] I have a sense that this is a high-risk time for me, and that is due to all the things that you hear about stranger danger and all those things. [...] I have an alarm on the keypad for my car that I keep in my hand or I keep my keys out, and sometimes I'll have my cellphone out to make it look like I am actually communicating with somebody.

Rape myths that perpetuate the belief that women control, by their actions and behaviours, whether they experience sexual assault or violence were side by side to discourse of oppression and violence against women in which women are not in control of the violence that they experience and it is not due to their behaviours (that only certain women get raped). However, the intent and hope to "reduce the risk" of violence through employing rape myth discourse increased a sense of control for Bailey.

I found that rape myths, especially the idea that women are responsible if they are raped, were most prevalent in discussions on prevention. This is illustrated in Cat's response to my question about prevention.

> R: How about prevention?
> Cat: I am amazed at the situations that some of these women put themselves in. Because really everything is about choice. These women aren't choosing to be raped. That's a fact. But when they choose to hitch hike...when they are only 14 years old, they are putting themselves in an unsafe position.

Here is an example of how official discourse and myth appear side by side. Both the agency's philosophy and rape myth exist together. Women's choice and positioning are implicated at the same time that the official discourse that women do not have choice is deployed.

Further to this Cat continues:

> Cat: They are not going out and asking to be raped, and I get that, but they are asking to have harm done to them when they are hitchhiking in the middle of the night, alone, and getting into a vehicle with a person that they don't know.

In this text Cat again applies conflicting discourses in the same moment. She restates that "they are not going out and asking to be raped," which falls within the agency's philosophy (official discourse) but "they are asking to have harm done to them" (rape myth that women ask to be raped by their actions). This conflict represents a struggle between an internalized and learned official discourse and rape myth, which still inform us and are promoted in the community. As well, in this text, agent deletion occurs when she states that the women get into a vehicle with "a person," where she means a man but cannot or will not say that. She names the women, but does not name the rapist:

> Cat: So, you're going to have a consequence there. I'm amazed at how many situations we see out there. Or meeting up with people, and not

> even knowing these people, and going to their houses and they're getting drugged and raped. I think that women really need to look after themselves more.

Here, the shared subjectivity of counsellors is used when she says, "we," implying the counsellors within the agency see women as responsible. This talk with conflicting discourses of rape myths and woman responsibility to the official discourse of the agency implies that the counsellors have learned the official discourse, but they believe something different with all the "situations we see out there." Cat states that women need to look after themselves more.

In the talk of responsibility and prevention, dominant rape discourses were deployed, through degendering the problem and blaming women. The use of "people" in the above text is an example of degendering.

> R: So what would prevention look like? If you were to write a book on prevention what would it look like? [...] How about for men? If it was written for men?
> (SILENCE – Cat stopped talking or moving at this point. The easy-going and conversational-style to the interview stopped abruptly at this point. I felt uncomfortable with the abruptness of the stop in conversation. The silence felt extremely long, due what felt like tension or confusion, just seemed to be a complete loss.) .....
> Cat: ...prevention for men...?! (The use of both an exclamation and a question mark is intended to indicate Cat's seeming surprise and unknowing. She slowly exclaimed the statement repeatedly while kind of asking it back to herself and me?)
> (SILENCE – Here Cat slowly repeated my words, I have placed both a question mark and an exclamation because of the way she stated this. It was as though she was asking it, but yet stating it. She said these words very slowly and quietly, followed by another long silence.) ...
> R: I know. It's a novel concept isn't it? (laugh – Here, I am attempting to make her feel more comfortable. I tried to infuse a bit of energy back into the interview, especially due that until this piece, there had been constant talk.)
> Cat: ...That's a really hard question. (SILENCE) ...

As this excerpt indicates, Cat was speechless and seemed to have no discourse available when I asked her about prevention for men. The very idea of prevention with men seemed shocking to her. The silence indicated in the text was long, she seemed perplexed, this was the first and only time in the interview where she did not readily have an answer and the conversational style was significantly shifted. As soon as I asked about prevention for men, our conversation-style interview came to an abrupt stop. It was a long moment in the interview, and I felt the silence and length of pause was long. I felt uncomfortable with the shift in interview style at this point, and felt the need to care for and move things along, with a lighter tone and a laugh. In my response, due to the abrupt and long silences, I felt that I needed to interrupt the silence and encourage her, I gave a laugh as I wanted to validate the unknowing of a response.

> R: That is interesting, because we have all the books written to women. And it is a hard question; however, they [men] are the ones making the choices to actually rape. Right?
> (SILENCE)
> Cat: That's a really huge question you know?!
> (SILENCE)
> If there was such a thing as castration. (both laugh)

In this text I attempt to validate the difficulty of the question, I present that we have the books written to women, but that men are the ones making the choice to rape, as this is an official discourse of our agency and we know this. However, when I ask her if this is "right" she does not answer or agree with me, but continues in the silence and what felt like confusion and uncertainty. During this time, it felt like she was not engaging with me, even in my attempts to engage, break the silences, ask her a question. Throughout this piece on male prevention, Cat spoke very tentatively, quietly, and seemingly at a loss and perplexed.

The difficulty of focusing on men as a prevention target is evident through Cat's repetition of the question, and her description of this question as "a really hard question," and "a huge question." The comment about "castration" that follows is interesting for many reasons. It displaces responsibility for rape *from* men and *onto* their penises, something that is only coherent to Cat and I because we both know and understand the discourse about rape as related to men's "natural" sex drive—a discourse that often appears as jokes about men being controlled by their penises. At the same time Cat challenges another rape myth—that only certain men, monstrous men, commit rape by implying that all men might commit rape—therefore the only true prevention is castration for all men.

If the participants did not mention prevention with men, I asked what that might look like and if it was a possibility. For example, Dana responds to how prevention with men would occur.

> Dana: And then educating guys, for sure, in terms of...I don't know where to start...just in terms of everything. Just dispelling, first, all those bullshit things about girls, all those myths and everything. And I mean this would take years and generations, because this is patriarchal stuff going back to... Dispelling those things like you have a right, are you kidding me you have a right to shit [nothing] with my body, you have nothing, no right on my body. And that, but there is so, and you'd have to...And there are so many things you'd have to change if you did that, because you'd have to take out pornography, just don't get me started.
> So, educating guys on just, I don't know, being good guys (laughs), being respectful of women's bodies, they are not ornaments. But, yah, just being respectful and it is always a choice, it is never yours, it is always a choice.
> Just more counselling programs, more awareness, we don't have enough awareness.

When Dana speaks about prevention with men, she cannot seem to form a complete sentence or statement. This difficulty could be due to the same reasons I

proposed for Cat's difficulty responding to the question of prevention with men. Dana's talk implies that the idea of prevention efforts with men is just too daunting and too immense. This may reflect the pervasive societal difficulty and unwillingness in naming men as agents in violent acts and holding men responsible that I commented on earlier in my literature review. The challenge of holding men responsible may play into Dana literally 'giving up' on each sentence that she speaks about men's responsibility, and then states "don't get me started," "I don't know," and finally ends by going back to focus on women, "just more counselling programs, more awareness, we don't have enough awareness."

While prevention focused on men was a challenge for participants, the notion of prevention focused on women seemed to be familiar and comfortable and a discourse easily accessed by the participants. Governance of women's actions, behaviours, and ultimately responsibility, were prevalent in the prevention talk. Dana's response to my question about prevention was "more counselling" and education for girls.

> Dana: More counselling. And it's really good to have immediate counselling and later on. Anytime. More things like [agency name], the program is amazing.
> Um, more education, for sure... Girls should just be taught to have voices. I don't think we are, and I discovered my voice late in life, not late late, but later in life...thank god. And now I am strong enough to be in a relationship, and be healthy. But if I was in a bad one, to recognize and say, 'this isn't healthy. And what you're doing isn't good, and I need to get out of this.' But I am not sure how that comes. I think that it definitely needs to be nurtured and I think taught too, with some skill lessons too, I think it is both.

As well, this text made me wonder what discourse would inform developing, teaching, and nurturing a strong healthy girl subjectivity? In response to what this training might look like, Dana states, "I'm not sure how that comes."

Real victim

In my analysis, I found that the counsellors spoke about victims in certain ways or talked about certain victims. I am naming this way of speaking about the victim the *real victim* subjectivity. She is the normal victim, here, described as "run-of-the-mill case":

> Ally: In terms of, let's say just a woman I see in the hospital who gets assaulted and it's, yah, whether it's your run-of-the-mill case.

It is the victim that was constructed through accessible discourse. For example Cat stated about the victim who is traumatized that:

> Cat: They have lost their dignity, some have lost their virginity. And not the way a young girl would want, and I say young girl, which I don't mean as in young girl...but just let's just say a girl, would want to lose her virginity.

The real victim subjectivity constructed here as "they" has "lost their virginity," is "young," "girl." This victim subjectivity is constructed through dominant discourse of the socially acceptable and socially legitimate (normalized) real victim. The real victim is a young girl, who is a virgin, and who has been shamed. This young, beautiful, virginal victim is also the one that we often see in movies, on television, and in other entertainment and media (see Mardorossian, 2002, for discussion on media construction of "real" and "fake" victims of sexual violence; Meyers, 1995 and Rambo Ronai, 1999 also analyze media construction of victims).

The victim subjectivity is (re)constituted in Cat's language of her victim. The virginal, dignified, young, girl victim is recast as the knowable subject—the real victim. Acceptable real victim subjectivity is learned and internalized in dominant rape discourse. Cat's text also exemplifies the disciplinary functions of discourse. When she states "I say young girl, which I don't mean as in young girl," as well as other times

throughout the interviews including pauses and where there are long silences, she is working out whether she is going to resist the discipline of the discourse or concede to it and therefore participate in it.

The use of "lost their virginity" insinuates an act of sex. Sexual assault/rape as a sexual act fits with rape myth discourse as opposed to a discourse of sexual assault/rape as violence, part of the 'official discourse' of the program mentioned in Chapter 1. The dominant discourse of rape as a sexual act removes the "victim" and the "perpetrator;" it masks and silences the violence in the experience of women by reshaping the encounter as one of mutual participation. Dana's analysis of this discursive duel reflects the prominence and hegemony of rape discourse that presents sexual assault as an act of sex and places women in subjectivities of mutual responsibility.

> Dana: Sex is usually something you do with someone you love or like, and trust and feel safe. So having that totally kind of switched upside-down is super hard...it is a violent act and it is not connected with love, and actual intercourse of love. And how to separate kind of the incident from when you're with your partner who you love and trust. And that is probably one of the things that has changed [working in this program], just working on that for myself and with people...Yah, it's hard, it's hard to separate those two things for a lot of women that I've talked to...and for me personally...like, that's hard.

Here, the victim is also assumed to be heterosexual, with her experience of sex with her (male) partner jeopardized and negatively impacted due to sexual violence.

> Dana: 'Well, why can't I have a normal sexual relationship? What's going on?' And it was just a lot of fear. Why am I so afraid, and yah, what's going on with this? And the only thing I could connect it to was that experience. And when I connected it to that experience, I was then needing to talk about this, and when I talked about it, I was, phew, 'no wonder I am having so much trouble, in terms of now it kind of makes sense that I was scared.'

Constructed through dominant discourse, "normal" sexual relationship is heterosexual, which in this text increases negative rape impacts due that the victim may have trouble separating the violence and "actual intercourse of love" and be scared in this act, which leads to serious concern ("what's going on with this?") and seemingly needs to be fixed ("makes sense"). Here, acceptable and valued woman subjectivity is constructed as needing to "normal sexual relationship" that involves "intercourse of love," she must then be fixed in order to continue to have intercourse with her male partner. This is similar to what Marian Foley (1996) stated in her discussion of how the medical model problematizes women's responses to rape, and in turn, needs to fix them (intervention). In this, where feminist would view dislike and distrust of men as a realistic response to sexual violence, the medical model (that which constitutes trauma) "defines a return to sexually active heterosexuality as goal of successful treatment" (Foley, 1996, p. 172). As well, normal treatment and recovery does not include women's choice to abstain from heterosexual sex (Heller, 1990) or women positively choosing to become lesbians (Kelly, 1988) as positive coping strategies.

I found that the 'real victim' subjectivity is not only the one recognized, but she is the one who impacts and is remembered most often in the counsellors' talk. The image of the young, virginal, beautiful victim has lasting and significant impact on Cat. She speaks about her encounter with this image being the one time when she was really impacted by a victim.

> Cat: Absolutely. There has only been one time and that was when I first started, where a victim really impacted me. I saw her face for probably two weeks after seeing her at the hospital. She was only 16 years old, she was fetal alcohol syndrome, but not to a severe degree that I have seen these children, and um, she was gang raped. And she was a beautiful, beautiful girl. And she just held me and cried and cried and cried. And we

> just held each other and I helped her through the process of the forensic exam. And her foster parents just could not stop thanking me for all the help that I gave her. Without me there, they did not know what they would have done. But I could not stop seeing her beautiful face. And thinking what a wonderful life this little girl will have, and after this, how she will be traumatized...I can still see her face.

The beauty of this girl victim seems to increase her assumed trauma—"she just held me and cried and cried and cried." The language makes it seem that the trauma is worse, the impact of the gang rape, and the need for support, are all greater due to her being a "beautiful beautiful girl." The power within beauty as a social construction and cultural ideal disciplines the counsellor as she responds to this girl. Beauty is constructed and valued in our society as it categorizes women as feminine and good. The language used to speak about this victim and the impacts on the counsellor construct the legitimate 'real victim'. She is sad, beautiful, afraid (vulnerable) and young.

> R: Hmm, so what made the difference in that situation? Why did that one stay with you?
> Cat: Because out of all the women that I've seen, she was the most traumatized by fear. She really let her emotions out in sadness and crying. Whereas a good majority of the other women were angry. They cried. But you could see that their anger was there first. They wanted revenge. This little girl said nothing about revenge. She was just beautiful. Just so serene and just innocent, just a beautiful 16 year old child. She was 16 but she was more childlike.

The sad, crying victim had more of an impact on Cat than the angry women victims. Instead of wanting revenge and being angry, Cat states that this "childlike" girl was "just beautiful," serene, and innocent. The hegemonic discourse of femininity that construct accepted and valued subjectivities for women are exemplified in Cat's text. As well, this is reflective of the dominant discourse Mardorossian (2002) discusses about the angry woman (feminist) whose anger is seen as "self-contained" and "pathological," which has impact of negating her victimization due to a resentful (revengeful) motivation (p. 767).

Juxtaposed good and bad woman subjectivities are presented in Cat's text. The good woman (victim) is afraid and sad, she is described as not talking about revenge, not being angry, being beautiful, serene, innocent, and childlike. The powerful discourse of beauty locates this woman as good, feminine, innocent, and this is where I found sadness and fear. Opposed to her is the angry woman, she may cry, however, due to her anger, it seems her tears have differing value, she is performing a bad woman victim subjectivity. Within this bad woman victim subjectivity, wanting revenge, she jeopardizes her positioning as beautiful, and therefore is compromised in being located as good and innocent.

In Cat's following text, messages about the male and female as *real victim* are presented, including why the woman is treated and how the male is discursively removed from treatment.

> R: Can you tell me about that? Can you tell me about the difference between working with offenders and working with victims?
> Cat: ... You're not going to like this. Because I don't believe that sex offenders can really be rehabilitated...I really don't.

Cat premises her response with a statement that I will not like it. However, the subject of the sex offender who cannot be rehabilitated fits within dominant discourse.

> Cat: Um, the boys that I worked with were all youths. And they all had their same kind of story, 'Well, daddy abused me,' 'my uncle abused me so that's why I abuse.'

Here, Cat employs the dominant discourse that locates all sex offenders as having experienced childhood abuse. However, within dominant discourse of offender-victim the subject who is both is placed within conflicting discourses as we see when Cat further differentiates between victims and offenders. Here, different victim subjectivities are being activated.

> Cat: Well, it's true that young sex offenders, you have to redirect their sexual aggression, but you can't blame everything on your past. That's a crutch. With sexually assaulted women, there's no crutch there. They are truly victims. When you see a woman in triage [in the emergency room of the hospital] who just had a lamp smashed against her head, and she has lacerations all over, and she's a cutter because this isn't the first time this guy has abused her, and she is there crying and crying...that really happened to you, and there's evidence there, of your trauma. So helping them, just comforting them, showing them that someone cares is huge.

The conflict of opposing victim subjectivity is represented in this text. Here, in the power struggle between conflicting discourses, the discourse of a real (true) victim subjectivity is promoted, which opposes and devalues discourse of victim as offender. Cat argues for this promoted and valued discourse of the real (true) victim because she knows what that real victim looks like and employs this powerful discourse to locate the offender as not a real victim. The construction of the *real victim* is implied with the idea of a true victim who can be rehabilitated and is "not the victimizers," as well, she (the real victim) feels sad ("crying and crying"), and needs caring ("showing them that someone cares is huge"). Juxtaposed to the real/true victim subjectivity was "sex offenders on the other hand." Through discourse, the victim who becomes an offender is not a real/true victim.

The reference to "evidence" of violence over and despite the word of the victim is also present here. This language reflects access to the powerful discourse for a *real* victim subjectivity, where proof of the crime must be legitimized external to the alleged victim, "that really happened to you," and "there's evidence there."

> Cat: Sex offenders on the other hand, I'm not sure that they feel that. It is totally different...sex offenders. Because sex offenders see themselves as being the victims, not the victimizers.
> Sexually assaulted women are the victims. They're not the victimizers. But sex offender males always see themselves as the victims, 'I am, because of what happened to me.'

The duality of victim and offender subjectivities makes for a perplexing situation when working with and treating the offender. Here, offenders recast themselves as victims. In this, the offender recognizes himself as something different than what others recognize him as. This self location as "victim," is dangerous because it further removes responsibility from the offender, degenders the issue of sexual violence, and deletes the agent. Offender responsibility is not possible when offenders discursively position themselves as victims.

Within the constructed offender subjectivity lie assumed and normalized sexual aggression—"redirect their sexual aggression." This aggression is implicated as inherent in males, and specifically sex offenders. This sexual aggression, potentially due to past sexual abuse, and inability to reform/rehabilitate, constructs male subjectivity. Cat states, "I don't believe that sex offenders can be rehabilitated." Without an accessible offender responsibility discourse, and without the offender's recognition of their location as an offender, in order to have change, control, and treatment, we are forced to and legitimated in treating the woman, changing and regulating her behaviours. The male subject is discursively exempt from responsibility for women's experience and impact of violence in promoted dominant discourse and due to the assumption of an inherent, normalized, and untreatable male aggression.

The Client as Infectious to the Therapist – Dividing Practices

Dividing practices are a feature of discourse and have the effect of segregating and differentiating the normal from the abnormal, or healthy from pathological. Dividing practices segregate people and subjects from each other and themselves, through

categories and differentiations (Chambon & Wang, 1999). The discourses and concepts I noted in the literature review section (professional discourse, trauma discourse, and client as infectious) all feature dividing practices. In analyzing the interviews, I noted that dividing practices that segregated the client from the therapist and the therapist from herself were both reconstituted and resisted by attending to how participants spoke about the impacts of this work on their lives, where they said the impacts came from, whether they located the impacts as positive or negative, what they did to minimize negative impacts and what they felt increased the risk and intensity of impact.

"Us-Them".

In my location as a feminist counsellor, someone who is sensitive to my own impacts of male oppression of women, and experiences of sexual violence, I am extremely sensitive to how women are both victims and helpers, whether these two subjectivities can co-exist, and how they do so. I am also aware of feminist history's prioritizing of women victim's voices, and their active role in supporting healing in other women victims as well as activism to now with professionalization of social services for women (Foley, 1996; Hammons, 2004; Lamb, 1999b; Marecek, 1999; Walker, 1990; Whalen, 1996). As well, I am interested in the relationship between women, what discourse constitutes them, what they are constituted as, whether they are allowed to be, and how they are allowed to be (how they are governed).

During my own time working in the sexual assault program, I spoke with a woman who had received counselling due to past rapes and who decided that she presently wanted to volunteer and help others who experienced sexual assault. When she approached the program to volunteer, she was told in her understanding that she could

not work in the program due to her recent involvement as a client, even though the rapes that she had come to the program for support around had happened a number of years earlier. I noted a similar division between counselor and client and pathologizing of clients in the interviews as well as other discursive dividing practices.

In reading the transcripts and listening to the interviews, I noticed how the counsellor would talk about "us" and "we" and differently "they" and "them." Throughout my analysis, I would note this separation between the counselor and the client, and I found it to hold intention and impact. At times, throughout the interviews, this "us" language allowed the counsellor and me to not have to speak all the words, or allowed us to simply give a look or some non-verbal cue or make a noise that conveyed understanding and commonality. In my analysis, I gathered all the instances of this talk, in order to understand its function, and in this section I present some of these samples.

The common dividing practice, explicit in the use of "us-them" language, has many functions and impacts. For example, "us-them" language segregates the therapist from the client, establishing the hierarchy of professional and client. As well, this language locates the client as needing to be changed or treated:

> Dana: And at the end, it's not a positive, I'd never say it's a positive, but they leave, it's very different from when they walked in [...] It's painful, and you feel so sad to hear someone talk about really painful things and really scary things, but at the same time it's so, it's an honour to be in there and get to listen to somebody talk about that and to get to kind of walk through that really hard time with them... When I am sitting with them, it kind of clicks and just goes through, 'Yah, you'll get there, one thing at a time.'... You want to be careful, they come to you for an hour...so that one hour I am there just to listen to their story and do cool things like art therapy and fun things and get them to talk and open up and process feelings.
>
> Ally: But out of that, obviously, it transformed into a genuine interest in this topic and a genuine interest in helping women and working with

> them... I've had people say to me, like, 'I wish I didn't have to be alone in this.' They've said that specifically after a sexual assault when I am seeing them in the hospital or when I am seeing them in person...as an individual client.
>
> Bailey: So, I guess I have to go with what the client is open to, what they are looking at working on, you know. I think that I am flexible and I don't really have an agenda when I go into doing in-person counselling especially. Not an agenda in the first few sessions. Like, I am not trying to change someone's identity, I am just trying to give them some more perspectives so that they can find their identity again... I think that once you get to the core of the person and see how they're processing and how their process of functioning in the world, and their process of healing... Those symptoms that you see, the nightmares, whatever, the night terrors, not being able to sleep, the depression, once you get to the core of somebody, then they start to do their own healing processing and you kind of help them and support them while they are going through that, those effects can lessen, and you'll see that.
>
> Cat: But can you understand how these women feel when they have something taken away from them that they cherish? They have lost their dignity, some have lost their virginity...This is not what they envision themselves as happening... Even though these women want to heal themselves and move on, there is always something in society that's going to remind them of it. So how can they ever put it to bed?

The client is different from the professionals; here the "us" includes the other service systems involved with the victim of sexual assault, including the police and the medical staff.

> Bailey: I think that if they can see us working together, definitely if we are at the hospital, they will see us working with the medical staff, they'll see us working with the police sometimes... I have never even asked them about that process, and what that is like for them, to have all these systems in their life for this brief period and then they go home, or whatever, and then they are by themselves again.

Another impact that "us-them" language has is that it devalues the client due to her experience, as less than, less educated, less healthy, less able, et cetera. This dividing practice constructs the victim subject as something to be acted upon and treated.

Being less educated and needing to be educated or helped by the counsellor, is a mechanism of "us-them" language:

> Dana: You educate them, to know about themselves and have a voice so they will be confident to know 'this isn't right, that's right? [...] Because a lot of them I've talked to, they are not happy with after how they are feeling.
>
> Ally: And I am just starting to deal with it now and, uh, I guess just help them discover what they want to do right now in terms of where their life is right now.

Here, "us-them" language divides women as fortunate and unfortunate. Women who have experienced violence are less fortunate, and damaged. Within this dividing practice, women who have not experienced violence (or request support) seemingly are more fortunate, as they can be helpers to others.

> Cat: I am very fortunate, that I have had such a good life, but these women who are being abused, and some of them are so young, they are not going to have the best life if somebody doesn't give their time to helping them to get through this trauma [...] I want to help people, you know, get past stuff that will help them later in years to be a better person. And if they don't fix that area of their life, then they will not be able to go and fulfill other areas in a happier part of their life, cause they'll always be going back to that.

This "us-them" language segregates women as damaged, needing to be fixed, and less than.

Another function of "us-them" language as a dividing practice is that it segregates the healthy from the unhealthy.

> Dana: For them or for me? Yah, the PTSD, they come in with that and I am seeing a lot of symptoms, of just like can't eat now, can't sleep now and it happened a long time ago. Nightmares, things like that. I have had clients who came in ten years later from the actual assault and they are still dealing, and that I would say is a lot of PTSD, and they haven't worked through it.

> Bailey: Here we are containing it, this individual has been traumatized, now they have this label, they have been traumatized.
>
> Cat: I don't know if I'd use that term [trauma]. But they definitely are affected by trauma. (pause) Um, one woman was extremely traumatized, and she had been in sessions with me for...probably 6 weeks, and our next session she said to me, 'I was so scared.' And I said, 'Well, what's the matter, let's talk about it.' She said, 'I got on the bus, and there was a guy that got on the bus, who looked just like my assailant, and all the feelings came up again.' (pause) So, she was traumatized by that. You never know what is going to traumatize them.

The use of "these women," "they," "them" suggests that *they* are different kind of women. Where this "us-them" talk is active, it de-politicizes the issue, confirms them as different from the counsellors, it confirms them as victims, and as less than. This dividing practice also confirms them as weaker, deficient, dependent, and unable to deal with their own lives, symptoms, and selves on their own. "Them," "they," "these women" are spoken about as different and separate from "I," "us," "we," and "you" (speaking to me or at least someone other than "they").

The difference seems to be due to trauma. Cat's excerpt exemplifies this further:

> Cat: Their trauma from 1 to 10, their trauma starts at 10 and then it goes to maybe a 1, but maybe for some it doesn't go to a 1. Maybe some of these women don't get over it. Because they can't move on. That happens to women. That's why we get calls at [agency name] from people who have been sexually abused 5, 7 years back and they have these flashbacks. Or something happens to them in their life to bring that trauma back to the surface.

A more subtle example of dividing practices occurs in Ally's talk about "their" experiences and her responses to "them."

> R: So when you say they can speak out, what do you mean by that? And where do you envision that happening?
> Ally: Well...a couple of times...more than a couple of times...I've had people say to me, like, 'I wish I didn't have to be alone in this.' They've said that specifically after a sexual assault when I am seeing them in the hospital or when I am seeing them in person...as an individual client. 'I

> want to share this story, I don't think that I should be quiet about this.' And then I say to them, 'Well, what made you think that you need to be quiet?' And the stereotypical answer is that, 'well I didn't know I could talk about it, and I didn't know that there was anyone who would listen to me, and I didn't feel like I should, I didn't think anybody would want to hear that.' And so kind of just talking about it, 'Of course you can seek out other people.' And being very honest that I don't know of any sexual assault groups that operate, if I did I'd tell you (laughs). But uh, but yah, that you don't have to be quiet, you can share this, this is your story, this is your life. So go ahead and share with anyone you want.

This text was one that really has caused me great challenge in how to place it. I have read it and reread it. I have felt a full range of emotions and experience, both concerning and really hopeful, as I have broken it apart and always placed it back together. I have finally chosen to interpret it as a dividing practice, though it could be placed in many of the sections of this analysis. However, I believe that it really does represent the division between the victim and therapist. The division is created with use of the terms "I" and "you," "them," "they," "people." As well, the direction to "seek out other people," which I read as meaning other people like "you" (the client, within a "sexual assault group") is divisive. Where Ally states to the client that she can "tell anyone you want," what I read as implied is that the client needs to tell others *like herself* within "sexual assault groups." I read this division in the segregating pronoun, "you," set out as other to the counsellor in "*you* can seek out other people." There is no mention of the counsellor (Ally) as being the other people. Further, Ally's declaration that she does not know of sexual assault groups implies that these groups are where telling stories, sharing, and others like her could be found. The client is thus set apart from the counsellor, in "*you* don't have to be quiet," "*you* can share this," and "*your* story."

Ally's narrative also contains evidence of resistance to the silencing of women who have experienced sexual assault. However, where this feminist counter-discourse

fell short was in the operation. The invitation to *resistant* behaviour (breaking silence and isolation) is contradicted when Ally acknowledges that, while she is encouraging the client to seek out other women who have experienced violence and tell her story, there is no location for her to do so, "I don't know of any sexual assault groups that operate."

Pathologizing.

Dividing practices are inherent and often difficult to attend to. Dividing practices work to pathologize the othered subjectivity from a normal, valued, acceptable subjectivity. In trauma discourse, dividing practices set up the raped woman as damaged goods and contagious. As I have noted, the impact of the counsellor's work, both named vicarious trauma and not, is repeatedly positioned as coming from the client and her trauma. This positioning of words and phrases, and active arrangement, promotes certain discourse, it reflects the dominant and prioritized discourse.

> Dana: There is trauma and that trauma brings the vicarious trauma. Um, it's a temporary infection. I don't know. It is something temporary.

Dana's language reflects a pathologizing discourse of trauma, which constructs the client as the one with trauma and as infectious. In talk about the work and contact with the client and her trauma, the concern with getting "it" is present and positioned. This concern requires Dana to "be careful."

> Dana: I would say the most vicarious is at the beginning, for me, but you deal with so many clients over and over. And you have to be careful because you can always get it...But you are vulnerable at the beginning and you're vulnerable throughout it all, but you are vulnerable when it's very emotion-driven and high and just happened, and scary, and yesterday and all that. And as it goes on, it changes it. I don't know. And at the end, it's not a positive, I'd never say it's a positive, but they leave, it's very different from when they walked in.

The participant employs vicarious trauma discourse in stating the impacts are a result of contact with clients. Dana's language constitutes and promotes risk and warning that is common to dominant vicarious trauma discourse ("you have to be careful") and the therapist's "vulnerability" (used three times in the narrative above) due to contact with the client ("you deal with so many clients over and over," and "but they leave"). The therapist and client are divided through language practices that constitute the *client as infectious*—the client is pathologized ("the most vicarious," "with so many clients," "get it").

The subject (client) was often removed from the language used to talk about where the secondary trauma came from. This discursive tool objectifies her and leaves just the contagious or infecting trauma (she has been made the pathogen), "you can always get it."

The word "it" is a synecdoche referring to all the parts of sexual assault, the impacts, trauma, and the impacts on the counsellor, vicarious trauma. More fittingly, "it" is a euphemism for violence, enacting a technique of repression in part that it hides and silences the violence. Instead of naming these things in their place, the word "it" is used. This discursive tool constitutes a form of dislocation (repression), which diverts attention away from that which is *not* mentioned. In this text, and due to its representation of the whole, almost everything from the experience of violence ("*it's* very emotion-driven and high and just happened, and scary, and yesterday") to the impacts on the victim and the counsellor, and therapy. The application of this euphemism in this form and to represent so much (all) masks the message and leaves ambiguity. As I have read and reread this piece, and surrounding context, I still do not know what all of the "its" stand in for.

However, what is unsaid, unimplicated, and displaced is women's experience of sexual violence and oppression and women's responses and impacts. The consequences of using this discursive technique (euphemism) ultimately include degendering and depoliticizing the issue, agent deletion (the victim, the offence, and the offender—again the male is not named or blamed), and deletes the impacts of violence against and the responses to this violence.

> R: Do you think that the trauma, vicarious trauma, that you experience, come from their symptoms or their trauma?
> Dana: Oh yah. For sure...but uh, definitely what I am feeling in terms of my vicarious would just be, it is usually just around them.

The client is again by the use of the term "them," divided from the therapist. As well, the impacts of sexual assault work comes from them.

Further, I found that talk of the victim being "damaged goods," needing to be "fixed," to be an example of pathologizing. It is my contention that trauma and secondary trauma discourses implicate the client/victim as damaged, incomplete, and the source of other's trauma. The discourses that constitute trauma talk, therapy, and response to violence against women inherently locate women as *damaged*. This is in-line and supports the discussion Nathanson (1991) presents about women being considered "ruined" due to sexual violence. I experienced this as a discursive impact throughout the interviews. In analyzing these discourses I find that rape and sexual violence against women as Lamb (1999b, p. 110) states, "have become a mental health issue instead of a social one," wherein "treatment of victims of sexual abuse...focuses on the woman's reactions and the mental illness or trauma the experience is assumed to have caused." Through my study of the trauma and secondary trauma literature, as well as sexual assault work discourse in operation in the interviews, I found that this statement applies

to rape and sexual violence against women. The impact of trauma work discourse constructs the victim as damaged and contagious. As in Ally's statement that "almost a hundred percent" of the people she talks to about what she does inquire into her safety and state.

> Ally: And an example I can use to illustrate that, is very often, almost a hundred percent when people ask me what I do and I say I am a sexual assault trauma counsellor, 'Oh, that must be really difficult, are you ok?' And right away assume that I am damaged goods as well.
> [...] Or 'oh, be careful around that one, she could be flighty...' and definitely the messages I get back from people are, 'oh, watch out.' I mean there are several ways that they let me know that either, 'oh, that must be really hard,' or 'let's talk about something else,' 'don't go there.'

The assumption by others "that I am damaged goods as well," (re)constructs victim blame and the objectification and dehumanization of women in their experience of violence. "Damaged goods" is a well-known female subjectivity that must be avoided (Lamb, 1999b). The discourse of "damaged goods" objectifies the client subject and constructs her as a pathogen. Historically, woman as damaged goods has been intimately related to her sexuality, in this, she has become flawed, spoiled, impaired, inferior, and defiled. Labelling a woman "damaged goods" refers to women who are no longer virgins, especially prior to marriage, women and girls who have experienced sexual abuse, rape, divorce, and more currently, women who have a chronic sexually transmitted infection (STI).

Similarly, while Cat does not state outright that these women are damaged goods, she implies it in how she talks about the impacts of the abuse and trauma.

> Cat: These women who are being abused, and some of them are so young, they are not going to have the best life if somebody doesn't give their time to helping them to get through this trauma...So, I want to help people, you know, get past stuff that will help them later in years to be a better person. And if they don't fix that area of their life, then they will

> not be able to go and fulfill other areas in a happier part of their life, cause they'll always be going back to that.

The language of trauma discourse constitutes the victim as damaged when Cat states "if they don't fix" that part of their life. The discourse turns our focus onto the victim, she is the subject in trauma discourse, the perpetrator (and violence) is removed because he is not a subject of trauma discourse. Thus, she is not seen as a victim, but someone with trauma.

As well, in Cat's text I read a transition from abuse discourse ("these women who are being abused") to trauma discourse, wherein the traumatized woman is constituted as weaker. This impact is due to the message that "if somebody doesn't give their time to helping them" they will not have the best life. The messages within trauma discourse indicate that the traumatized woman cannot do this on her own and she needs help, from somebody different/better (not one of "these women"), to become "fixed" and a "better person." Again, the dividing practice within trauma discourse sets the woman counsellor ("if somebody doesn't give their time to helping them," "I want to help people") apart from the "these women" (victims/clients/traumatized). To be "a better person" categorizes the subject of the traumatized woman as less valuable and lesser than, less "better." Further, within this trauma discourse that constructs victim subjectivity, she is unable to access certain options in life or be happy ("not going to have the best life") in that she will not be able to "fulfill other areas."

The consequences of the sexual assault trauma work discourse employed to speak about the victim include directing all focus onto the woman victim who is pathologized and becomes the traumatized woman. She is talked about as "different from" and "lesser than," "damaged," and needing to be helped and fixed. This sole gaze on the victim

places all responsibility on her for her situation, her life, and her healing. The violence is deleted, and she is assumed to need fixing. Her survival and resiliency is overlooked, and she is located as damaged, deficient, unable on her own, and powerless. Within this hegemonic illness discourse in which the only subject is the traumatized woman, the perpetrator and the violence is removed.

The dominant trauma and secondary trauma discourse place trauma deep within the victim's self, in her transformation to something or someone "debilitated," "damaged," needing to work through and heal, be fixed, and becoming a different person, and a different identity. These discursive messages are exemplified further in Bailey's text, where she talks about trauma in the victim.

> Bailey: Like definitely someone dealing with trauma, it is debilitating for some people, and maybe for all people and then we have different ways of working through those things. And some people get stuck, you know, and can't find the tools to work through it. Not that that trauma is going to always be a part of their life, it does become part of your identity, it does become part of who you are. You know, you are a different person after a traumatic event that's for sure.

In this text, the discursive technique within trauma discourse to mask violence against women is presented. Within this discourse, "trauma" is a synecdoche and is a cover-all term for the violence and the impacts and responses in the victim. The consequences of this discursive tool, again, include deletion of the violence, agent (the perpetrator), honouring survival responses in women, and depoliticizing and degendering the issue of sexual violence against women. Further, as Lamb (1999b) states, "PTSD makes sexual abuse 'treatable'" (p. 111). I believe this statement is transferrable to all forms of sexual violence against women.

Professional – Client: The need to be healed.

Another impact of accessed and dominant discourse that I found repeatedly in the interviews was the idea that women need to be fixed, healed, and treated. Dominant professional discourse constructs the client as needing professional treatment due to trauma, this need for treatment is dependent on a pathology of trauma. This discursive tool (pathologizing), segregates the professional from the client.

> Cat: But they definitely are affected by trauma. Um, one woman was extremely traumatized, and she had been in sessions with me for...probably 6 weeks, and our next session she said to me, 'I was so scared.' And I said, 'Well, what's the matter, let's talk about it.' She said, 'I got on the bus, and there was a guy that got on the bus, who looked just like my assailant, and all the feelings came up again.' So, she was traumatized by that.

Trauma discourse maintains focus on trauma and trauma material. Here the symptoms are talked about, without an analysis of the violence and the presence of the perpetrator, though the victim mentions him. A violence or rape discourse is masked by a dominant trauma discourse, as Cat continues:

> Cat: You never know what is going to traumatize them. And bringing up those feelings...um...I like to look at it like when they are sexually traumatized and they are victimized, that's A and now we are going to try to get them to Z with their healing. But when they are traumatized they are going right back to A again. [...] You know? And then you have to work harder to get back to Z.

Within this text trauma ("traumatized") and rape discourse ("victimized") appear side by side, however, the focus still is on the victim's healing from trauma with the counsellor. Cat's text is an interesting one in that it reflects the power of dominant discourses, because it is still about the *trauma* even when the perpetrator (or someone "who looked just like my assailant") is present. Within trauma discourse, the violence is masked and we are diverted from women's oppression to a trauma focus. This is exemplified in the

text where the victim tells the counsellor that she was "scared" due to seeing her perpetrator (or a man who looks like him); the victim does not talk about trauma. Even though the victim makes the causal link between her feelings and experience, the counsellor reframes the victim's story and experience within trauma discourse. Through trauma discourse the violence and perpetrator are removed even when the result is ambiguity and unknowing something that is previously known—we "never know what is going to traumatize them." The subject is the traumatized woman within trauma discourse, our focus is diverted onto her trauma and her "healing." This text reveals intent and impact of dominant trauma discourse. It shows how trauma discourse removes the experience and story of violence in that Cat states, after the victim sees her "assailant" that "you never know what is going to traumatize them." In reframing into a dominant trauma discourse, we see how other discourse and potential subjectivities are masked, and truths are hidden, even truth that was seemingly available and knowable. Even though it seems that the concern of the victim was the contact with the "assailant" on the bus, the focus in therapy with the client is turned back to the process of trauma healing.

> Cat:...Yah. And everybody heals in their own way and in their own time. Even though we offer counselling for 12 weeks. It may take some women 24 weeks, it may take them 24 months. And I don't think that we can put a deadline on when they're going to heal. The most important thing is that they heal, not how long.

In my analysis, I found trauma discourse a dividing practice between client and professional through the repeated positioning of assaulted women as women in need of counselling. Here, Bailey talks about the client's need to find their identity again.

> Bailey: I don't really have an agenda when I go into doing in-person counselling [...] Like, I am not trying to change someone's identity, I am just trying to give them some more perspectives so that they can find their identity again.

Further, this text uses professional discourse, and reveals its divisive impact between client and professional.

> Bailey: I think that what I learned about trauma in university, um, and through working here, is that it is pretty severe, and it is quite an intimate experience for people, and it is something that everybody will experience quite differently. And it is one of those things that if you are going to work with trauma, if that is what you are choosing to do, I think that you are going to need to have some of those flexible qualities within you. I don't think that there is one guideline for working with trauma. Although we can assume...and there is some consistency in effects you'll see in people for sure, but, I think that that is something I am still learning as well.

Dominant trauma and professional discourse has impact of dividing the professional subject from the client. The language of trauma discourse has a pathologizing impact, shown here, in talk of severe effects, working with trauma, guidelines, and consistency.

Bailey's text contains support for professional discourse and trauma work. Professional and dominant trauma discourses divide the therapist and the client due to trauma pathology. Through use of the professional, trauma, and therapy discourses, sexual assault work in this program focus on the symptomatic individual client.

For Ally there seemed to be a struggle between a professionalized agency mandate and her own strength- and relationship-focused, and community-minded feelings and actions. This struggle constructs resisting and counter-discourses to professional discourse.

> Ally: Um. Well apart from the stuff that we're required to do with our job (laughing slightly), like with...(laughing)
> With the handing out of pamphlets, and just being there.

I read Ally's text to imply that there is an acceptable professional therapist subjectivity within the agency ("we're required to do with our job"). Ally behaves within this subjectivity, however, she also parts from it, constructing an other subjectivity within her "own personal flair":

> Ally: My own personal flair, I definitely would say it's relational, is to say, like, be honest with them with where I'm coming from, and be honest with them if I'm hurting as well or if I'm feeling confused. So, having that honesty with them I think is part of our relationship.

Ally sets up this other subjectivity as being different or extra to the acceptable and expected therapist subjectivity within the agency when she states "apart from." She then goes on to further differentiate how she behaves within this other therapist subjectivity by naming it her "own personal flair" and describing that it is "relational" within which she is "honest" about her feelings and where she is coming from, and she positions honesty in her shared relationship with the women she works with. She further states the impacts of this other "relational" and "honest" subjectivity.

> Ally: And I think that that just draws us in with people I see, either with clients or on the phone, at the hospital, wherever I'm seeing people. Even just friendships and relationships when we talk about these kinds of things. Uh...yah...I see it as this circular pattern, just kind of going down the trail. (laugh)

In her expression it seemed that Ally's own style challenged the professional regulation of the therapist. She stated that she operated in more of a "relational" way with women, which she defined as behaving with "honesty," sharing her feelings, including hurt and confusion, and reciprocity within their relationship. Ally speaks about the relationship between client and therapist in a different way, "apart from" the expectation of the therapist within the program.

Counter-discourses and Resistance to Trauma Discourse

In these counsellor's narratives, there were examples of contradiction and resistance to dominant discourse. These counter-discourses included the implication of the system as traumatizing rather than the client, within which the response by police and the medical system were implicated for counsellor's experiences. As well, resistance to professional subjectivity when the counsellors shared woman in the community and woman as prey (gendered violence) subjectivities with the victims,, and a presentation of a gendered experience of violence and oppression discourse. Within this counter-discourse, a gendered gaze on society was presented, through which all women are at risk or experience some form of oppression due to their gender, within this discourse there is a global condition of gendered violence against women, where women are prey (marginalized and victimized).

It's not the client, it's the system.

Cat stated that what are considered in official discourse (secondary trauma literature) to be impacts of the work, such as nightmares, persistent memories, anger, fear, and increased concern for safety, were more prevalent after contact with the system. When I use the term "system" I am referring to the legal, medical, and judicial services that respond to sexual assault. These are the services that the sexual assault counsellors come into contact with. The "system" also referred to processes of these services, including the laws, procedures (interviews, investigation), and the results (convictions, charges, investigation). "It's not the client, it's the system" discourse counters official vicarious trauma discourse, in that it looks beyond the client for cause of frustration, feelings, and impacts on the sexual assault worker.

> Cat: My frustration with sexual assault is not the victim but mostly, when I do have frustration, it is never from the victim it is from the police and the situations around the legalities.

Cat locates her frustration in her work due to the response of the court system.

> Cat: You know? You are not helping that victim get from A to B when the spokes are going in opposite directions. And I feel that that is part of the healing and getting past some of the trauma. It is bad enough that the victim has been victimized by her assailant. But now she is being victimized again by the court system.
> R: Yah, which is interesting. Hmm, it seems that working together, as the medical system, the police, and us, is kind of a big focus. What do you think?
> Cat: Yes. Cause they say, 'Oh we're all on the same side.' Okay, well if we're all on the same side, then how come what I am projecting out there is totally empathy and caring for the victim, and you call your questioning empathy and caring, but it's turning everything around.

Cat, prior to the interview, had not heard of vicarious trauma, and though she did talk about some impacts that fit within official secondary trauma discourse, she did not attach them to her work with women who have experienced sexual assault. She stated that most of her feelings and impacts were due to the lack of help from police and the poor to no consequence for the perpetrator of rape and assault.

Shared subjectivity - challenging the dividing practices.

My analysis found that the counsellors at times used discourse that positioned them in the same subjectivity as the woman clients.

> Cat: It is all about the victim and what's happening to her, it doesn't matter if she's been drinking. I go out to the bar and I have a few beer. I am not out there asking to get raped because I am socially interacting with people, well so are these women.

This text references counter-discourses to victim-blaming, *woman as responsible* discourse, rape myths, and removal of the perpetrator. As well, Cat shares a woman-in-the-community subject position with the victim, both who go out, drink, and socially

interact. Cat resists rape myths in her statement by saying that she and women-in-the-community/victims are "not out there asking to get raped."

As well, Dana speaks about women's common and prevalent experience of some form of non-consensual inappropriate sexual violation (represented in Dana's text as "..." which is what is not said).

> Dana: But uh, I think nowadays, you're hard-pressed to find anyone that hasn't had...maybe not a sexual assault, but hasn't had an inappropriate...any woman that hasn't had an inappropriate pass or gesture or...you know what I mean?

In discourse that contains women's common experience of oppression, the division between us is broken down. This challenges dividing practices in therapy discourse.

Ally resists professional discourse and dividing practices in how she talks about her experience that "this" is happening to her as well.

> Ally: I can't remember what I said before about how I feel traumatized by this...or whatever language you want to use, I think maybe I was quick to say that I don't feel it. There is definitely, the more I think about it the more I am recalling instances and timeframes in my life that I do actually feel like, uh, this is happening to me as well. Again, it's a little bit more broad than the actual experience [sexual assault, rape], but definitely, um, and this is kind of an odd experience, or maybe not that odd.

Her difficulty locating it and valuing it as either odd or not implies its location as a devalued discourse. She seems to not be confident in whether this feeling that she has had, this experience, is normal or perhaps abnormal. In "instances and timeframes" Ally finds a common or shared subjectivity of woman victim in a gendered experience of rape and oppression discourse. Ally's earlier lack of access to this counter-discourse of gendered experience of rape to my initial question of work impact, her mention that this experience is "odd," and that it occurs inconsistently in "instances and timeframes," signify devalued discourse.

I found that a discourse of a gendered experience of rape or oppression discourse was deployed in talk in moments. Though there was still a division between the victim and the helper, the gendered female experience of violence was shared. In her narrative, Bailey employs discourses of *women as prey* and *women as systemically oppressed* ("gendered experience of violence").

> Bailey: The positive effects is a sense of community, even the sexual assault program that we work in, I am a part of that community, and we outreach to victims of sexual assault and that is a whole other community. So it gives me a sense of being a woman, and that we share this kind of gendered experience of violence, whether we are victims or the helpers, and those kinds of things.

The practices in language that are used to divide the client group from counsellors are resisted here—"community," "gendered experience," "sense of being a woman." Herein, both women can and do experience violence.

An other discourse for vicarious trauma.

Ally deploys an oppression discourse, which counters trauma and secondary trauma discourse when talking about where vicarious trauma comes from.

> Ally: Umm...I think that systemically it's a patriarchal society. It's easier for a patriarchal society to put it back on the victim, to put it back on women, or poor people, or whomever the marginalized group is that is being oppressed. You see it in colonization all the time, I think that that's why it's easier. That is my honest belief about it, that, um, it's the gender issue within colonization in a patriarchal society that holds women responsible, they're the ones that are supposed to have ownership over sexual assault. Or the act of it...I mean, that's where most of our myths come from...(laugh)...So, yah, that's where I think it comes from.

Within this other discourse for where vicarious trauma comes from, a discourse of male responsibility is deployed. However, when she gets close to these gendered discourses she "checks" herself.

> Ally: Uh, yah, I should definitely probably check myself here...by no means is it only women who get assaulted...(pause)...and when I say ownership, I mean ownership as in prevention and how we take care of people in our society. I mean, maybe it's not likely that men are going to become sexual assault trauma counsellors, but definitely to be as supportive, if not really proactive about healing these wounds of sexual assault. Uh, and that's complicated in itself. I don't necessarily, I don't mean that men need to come and save the day...(laughs)...but take onus over a problem that is developed out of a patriarchal society and colonization...so....I don't know if that kind of clarifies it, how I define ownership, but uh, for men to take young boys and give ownership and say 'this is what has happened to women, we are going to be, we are going to try and be different, we are...' like taking ownership in that way.

Ally reflects the struggle and policing within dominant discourse, in presenting a gendered counter-discourse. She does not implicate men completely and "checks" herself, and feels the need to say that men also are victims of assault—these "checks" show how she is disciplined in dominant discourse. However, she also deploys an anti-oppressive discourse, presenting within it a male subjectivity of 'becoming an ally' and involving men in ownership of structural oppression and their location and privilege therein.

In her talk about where vicarious trauma and trauma come from, Ally states it is found within colonization and marginalization:

> Ally: I go back to colonization and oppression of marginalized people, it's easier to keep them down when they think that they can't be cured. It's in, whoever is at the top, it's in their best interest for us at the bottom to be fighting with each other to be dealing with trivial problems. It keeps up the hierarchy. It keeps it working, and good for them for being so successful at it. Damn, I wish I was at the top. (laughs)

Ally seems to locate herself, generally, in a neutral location when she talks in mental health, hierarchy, and oppression and colonization discourse. She implicates a technique of repression in mental health by talking about oppression and colonization that keeps

"them down," speaking about the oppressed people who "think that they can't be cured." However, she othered herself ("they") from this uncured group by. Then, Ally employs discourse that places power up there ("at the top") in addressing the "top" she locates unknown and ambiguous "they" and "whoever." She states that "their" interests of maintaining the hierarchy are maintained. Here, Ally moves into a shared subjectivity of "us at the bottom" (the oppressed), who are fighting with each other and dealing with trivial things. Ally further implies that "the top" is a better place to be ("I wish I was at the top"). I am not certain what all of these "trivial things" include, however Ally presents an analysis on one "debate":

> Ally: I mean, whether or not it's an illness [trauma and secondary trauma], whether or not it's a mental illness, I mean, people will debate that for forever. To me, understanding how I deal with it and understanding how other people deal with it, it doesn't even become a factor because it's not...just for me...it's just not an issue, it is not issue that I need to touch, because that's just not how I operate.

In this struggle between mental illness discourse and colonization and oppression, she locates herself as "us at the bottom" and then seems to step away from it to a more neutral subjectivity where "it's not an issue." In these moments, when Ally talks about oppression and colonization, I wonder who she sees as clients and victims in her work? What impact does race have in her involvement or non-involvement in this "debate" that will go on forever? If colonization is an impact of woman-blame and rape myths, then perhaps racialized othering and distancing is also a factor in the division between counsellors and victims?

Further discussion on where vicarious trauma comes from implicates women's experience of oppression and fear in her devalued subjectivity of being a woman in

society. This is in-line with how Bonnie Burstow (2003) talked about trauma, as due to systemic oppression and resulting conditions therein. Here, the woman in the community is not safe.

> Ally: Just her perceptions of being a woman in society...it's frightening. It's frightening to know that you're not safe. And so you think about that with vicarious trauma, um, you just need to stack a bit more oppression on and...boom. There you go, that's my guess.

Ally employs an oppression discourse to locate women's subjectivity in being vicariously traumatized. She continues to explain this further:

> Ally: I wouldn't even really think to go in the direction that it's a characteristic of women. I don't think that that's an answer that I...that was my first anti- thought. (laughs)...better not be because of being a woman. (laughs)...I don't think it's our nature as women. I think it's because we are closer to the marginalization and we're closer to the isolation and we have had so much trauma piled on top, that yah, of course we would experience a lot of it.

In this text, Ally resists the discourse of vicarious trauma being inherently due to being female. Ally presents an oppression counter-discourse to the pathologizing discourse of trauma and vicarious trauma, and implicates women's oppressed and traumatized subjectivity due to marginalization.

Bailey also deployed a counter-discourse to dominant vicarious trauma and pathologizing discourse. She locates women's subjectivity of being unsafe in the community. Both Ally and Bailey in these texts reflect a gendered discourse of violence against women.

> Bailey: Oh, that's a good question. Where does vicarious trauma come from? I don't even know where I learned where to start...I think it is just the messages that I got growing up, to be aware of my safety...'don't walk alone at night.' Maybe that was something that I learned in school and so I think that just as being a female growing up in society, you get those messages that we're unsafe. And now that I am doing this kind of work, where I am dealing with violence all the time, it just increases that sense

> that I really need to be aware of what is going on for me, and my environment. So, I think that vicarious trauma is a consequence, consequence isn't the right word, but it is an effect of working in this field.

These gendered counter-discourses allow the counsellors to reflect on their subjectivity as being both women trauma counsellors and women in the community. A gendered discourse of oppression and marginalization counter degendered discourses of trauma and vicarious trauma.

The discourse in operation in the sexual assault program constitutes victim and therapist subjectivity. Within the social context of violence against women and ensuing trauma, woman subjectivity is constructed as responsible (scapegoat) and in need of treatment and fixing. As well, the subjectivity of a real victim is presented and elicits response that differs to victims who look and act differently. The talk in the sexual assault program engage dividing practices that segregate the professional from the client, the helper from the one who needs help, and the healthy from the unhealthy, this division is due to trauma. However, counter-discourses and resistance to dominant discourse are present in sexual assault counsellor's talk, which challenge the dividing practices, and the focus on the client as cause for secondary trauma impacts in the counsellor.

Constructing Therapist Subjectivities

In my analysis I found that therapist subjectivities were constructed through discourse. Within the applied discourses, the counsellors spoke in ways that outlined valued-devalued and acceptable-dangerous subjectivities, as well as regulation and discipline of these subjectivities. As well, my analysis revealed policing of these subjectivities, how they are maintained and promoted.

Trauma Discourse in Trauma Talk – Impacts

Throughout my analysis I found that performing acceptable therapist subjectivity involved not talking about male violence, but talking about "trauma" instead. "Trauma" was often used in places where "sexual assault," "rape," and "violence against women" would have been equally deployed. Bailey describes her work using trauma discourse:

> Bailey: I think that we are human and we are going to respond in different ways. Like definitely someone dealing with trauma, it is debilitating for some people, and maybe for all people and then we have different ways of working through those things. And some people get stuck, you know, and can't find the tools to work through it. Not that that trauma is going to always be a part of their life, it does become part of your identity, it does become part of who you are. You know, you are a different person after a traumatic event that's for sure.

Within trauma discourse the "traumatic event" replaced the need to name or talk about the violence. Without naming what is the traumatic event, much of the talk is reframed to fit within trauma discourse versus violence against women discourse. For example, Bailey employs trauma discourse to further explain its impact and the required skill to work with trauma.

> Bailey: I think that what I learned about trauma in university, um, and through working here, is that it is pretty severe, and it is quite an intimate experience for people, and it is something that everybody will experience quite differently. And it is one of those things that if you are going to work with trauma, if that is what you are choosing to do, I think that you are going to need to have some of those flexible qualities within you. I don't think that there is one guideline for working with trauma. Although we can assume and there is some different, uh, probably some consistency in effects you'll see in people for sure, but, I think that that is something I am still learning as well.

Trauma discourse is explained as valuable and necessary for women, it has a purpose. Trauma discourse here is internalized as valuable and acceptable. Dana explains its place for victims.

> Dana: PTSD serves a big purpose, for me it did. It gets the ball moving in terms of realizing that something is off or wrong, or you're hurt or angry for some other incident, and it's coming up this way and you need to deal with it or talk about it or cry or whatever, but it's symptoms of something that has happened, you know? I don't know, that is how I see it...Yah, it helps you get there, because usually at the PTSD part, if you are really PTSD, if it is getting really bad and it's starting to interfere with something, and so yah, that is when you go in and see someone and talk about it.

In this text, I read that trauma discourse is a valued and accepted discourse that leads people to get help. The therapist and the client understand this as the acceptable time, when she is trauma symptomatic, when it is really bad, to get professional help ("go in and see someone and talk about it"). With this consequence of trauma discourse, where the woman is receiving help, its value and need is promoted.

Ally talks in multiple discourses and she seemingly struggles between them in her role as therapist, performing an acceptable therapist subjectivity and concern for the greater societal issue of violence against women. Ally implicates trauma discourse as masking the societal issue of violence against women.

> Ally: I guess that shift happens out of a choice that I try to make daily that people...things happen to people...um, so in respect to violence...um, I think it [trauma] just masks, I think trauma just sometimes masks the cause of an experience...I think that sometimes trauma and those labels and however we label it, whether it's an illness or not, kind of masks the initial causes of some of that trauma. So we have to spend less time dealing with violence and more time dealing with trauma, which in that grand circle puts it back on the victim. 'Ok you're the one who needs to be fixed, not the person who raped you.'

Ally implicates trauma discourse as masking violence by placing the focus on the victim as needing to be fixed. As well she implies that how "we" as counsellors are dealing with it employs and prioritizes trauma discourse "trauma and those labels." Ally's text reveals a conflict of oppositional discourses of trauma and violence against women.

> Ally: Um, and again, like I was saying before, I don't know if that necessarily means that trauma is causing more violence, but the way that we are dealing with it isn't stopping the violence. So, and like I said before, I don't know if because you're not stopping something means that you're promoting it, but just to say it like that, just not stopping it.

Here, these two discourses (trauma and violence against women) appear side by side, the counsellor's behaviours within trauma discourse are analyzed; clearly we are not stopping violence.

Where can we talk about sexual assault?

Trauma discourse was deployed in talk about the therapist's behaviours. However, speaking about rape and sexual assault had its place. For example, Dana states that she does not talk about "it," but outlines that talking about "it" should be done for education purposes and personal/group therapy.

> Dana: I don't talk about it. I totally talk about it in term of educating. Like the best thing I did here was the training. And I would talk about it for sure in any group [therapy] setting. But I would not disclose personal feelings about my hospital calls to people, and I would not disclose personal feelings of my experience to people. Family members, no, but that is my choice, in terms of who I would tell that to. And my feelings are personal about those things...That's personal. So, it's to who I feel comfortable with. But yah, I mean, talking in general to young people about sexuality, sex, what sexual assault is, in a fun interactive way so that they are not bored out of their mind. Like that should be a chapter with all those other chapters that they bring to schools, and just more awareness.

Dana employs educational and professional discourse to maintain the choice to disclose her personal feelings and experience to others. Speaking generally is preferred behaviour

in these discourses, promoting a personal-professional boundary. As well as in educational settings, Dana states the sexual assault should be talked about for professional debriefing. She explains this:

> Dana: (Laughs) Umm, It's just like, I don't know, I just don't feel like some of them get it. It's not the getting, like you have to get something, but it's the...I just feel like it's way easier to talk about my feelings around a hospital call with someone who's done it, than with someone who's not. Not to say they can't listen and empathize, because they for sure can, but I just feel like also, they don't see that every day and it's not my job to bring that to them, you know what I mean. I don't want to be the one that's describing to them, like someone who's been beaten so bad and had objects...you know...and terrible things that you don't wish upon anyone. And I know that they are not naïve and little kids. They're adults, but I don't want to be that one, telling them those kinds of things, not that they couldn't handle it, they probably all could, but it's not...yah just not. And I think the best people [to debrief with] are the people who've done it. Like the supervisors, or any of the people that I go on my hospital call with, um, anyone basically in this building. It's way easier to, be like, 'yah, I need to debrief that, that was a bit of a rough one.'

Within discourse, acceptable therapist behaviour includes debriefing. This fits within a trauma and professional discourse that governs that all talk of work should stay within the agency. The behaviour that is acceptable is "debriefing," with other counsellors for therapeutic and professional purposes. Dana presents an analysis of speaking to people who do not do this work, versus people who do this work. Value is placed on talking to people who are supervisors and who do this work, because it is easier on the counsellor, and better. I felt that the difference between talking to someone inside the agency was also about feeling that she is protecting people on the outside in the community ("it's not my job," "I don't want to be the one that's describing to them"). An impact of debriefing as the acceptable therapist behaviour for talking about sexual assault work is that it has therapeutic versus political purposes.

Speaking about trauma versus sexual assault also seemed to be acceptable and valued behaviour within the therapy experience. Dana talks about how little time in therapy is spent talking about the "secret."

> Dana: We spend so much more time not talking about [sexual assault]...And it is never until they are ready. And that session is the session that they will disclose usually and my experience is that they will want to tell you everything cause they haven't told anyone everything, and you're just an objective ear, you know...It lets the secret out. So, it is usually an emotional session for them. And I go home and I'm usually exhausted but that session feels good. Because afterwards, their shoulders just slump, you know what I mean, they got it off their chest, and it's not a secret anymore. So, that's probably the hardest session, I'd say.

Dana mentions the idea of secrets, both the therapist and the client know that rape, the experience and impacts, are secrets.

In discussing the gendered experience of violence and its pervasiveness in women's experience, Dana talks further about, and here exemplifies, the secrecy of a rape discourse. She seems to struggle between performing an acceptable therapist subjectivity who talks about trauma, and does not talk about violence, as well as breaking the silence and normalizing the gendered experience of violence and not talking about it at all.

> Dana: I know, cause you want to group them all [women] in the same room and be like, 'Look!' and then group everyone who has had a terrible experience, like all of us, and be like, 'Look!' (haha) You know? And chances are, if a friend would ask a friend, and say, 'I had a really bad experience,' the friend would probably say, 'Well, me too.' But we don't talk.

Though Dana states that she is amazed that people are surprised at hearing that other women have been through this, she states that she does not talk about it. Even here she does not name the violence. Here, I analyzed this text as Dana struggling between and within subjectivities, first she is a victim, common with the rest of women ("all of us").

Then she talks about the constraints by "secrets" ("we don't talk"), and is disciplined by this regulation. She is diverted to how women are segregated (we are *not* "group"ed "in the same room").

From the shared subjectivity of women victims in a gendered experience of violence I read that Dana shifts into the safer, accepted therapist subjectivity. This shift is made here, with the knowing that women are disciplined to hold the secrets of their "terrible" and "bad" experiences, as she seems defeated and states, "I don't know."

> Dana: Those are secrets, you know. I don't know. That is super hard with clients, cause I will say generalities to them, like, 'so many women feel this way.' And it still amazes me how many people say, 'Really?' (laughs) Or they will tell me a symptom and I will say that is normal to feel, to do that, have nightmares, or it is normal to wake up sweating and it's the way we deal with it.

She has made the shift into an accepted and valued therapist subjectivity, away from a dangerous woman subjectivity (victim, all women experience violence). This shift is done through use of trauma and therapy discourse, where she is now speaking in generalities (not making it personal), and speaking to "clients" about "symptoms." This text exemplifies the contradictory discourses of violence against women and trauma, and the struggle that women have in finding an acceptable and safe subjectivity as therapists.

Further, the secrecy of rape discourse is hard to break, and to do so means performing outside acceptable therapist subjectivity unless it is "debriefing." Dana exemplifies this struggle ("hard") to talk about "it":

> Dana: And she'll be like, 'Really?' You know, and I don't know, it's hard. And the hard part too is the dealing with it and then, I can't really talk about it. I can, but I can't, do you know what I mean, when I can and can't talk about it. Yah, so, it's hard, I don't know, there is not really an easy answer, you just gotta...deal (laughs). You gotta deal, and the best you can do is debrief about certain things, but yah, it is hard in general and it is hard from client to client, because that will always be there. I

> don't know how that will ever change...the confidentiality...and the knowing and not knowing.

The secrecy and not talking about rape seems to lead to difficulty dealing with it. However, in Dana's language there is a shift between breaking the secrecy and not talking about it. It is acceptable therapist behaviour to talk about "things" in debriefing. Here, Dana presents a professional discourse, which constitutes an acceptable and valued therapist who debriefs and understands that the secrecy is due to confidentiality. The silencing of women's experience of rape and violence has been reframed as "confidentiality." Within this discourse, there is a helplessness to act differently, "I don't know how that will ever change."

The division and segregation practices through discourse of the professional therapist and woman in the community promote and police not talking about work in the community. Bailey explains the regulations she upholds for herself within these subjectivities. She segregates herself as a friend (woman in the community) and a counsellor (professional woman)

> Bailey: I only talk about work with my friends that do the same work. If I am with my other group of friends who don't do this work, then I don't talk about it. It is something that they're curious about, but that's my limit, that's my boundary. I just don't talk about it with them, because, like I said I need to unplug and I need an away time. I need to not be a counsellor for a few hours of the day.

Within professional discourse, not speaking about work (violence against women, what she sees/hears) is valued and accepted behaviour. This behaviour is valued within discourse of self-care including setting limits, boundaries, and segregating professional self from personal self ("away time," "not be a counsellor").

It seems to be the role of the sexual assault therapist to be the living container of the "father's secrets" (Haaken, 1999). This keeper/holder subjectivity for women's stories of male violence is constituted in trauma and secondary trauma discourse, and these discourses were practiced through the sexual assault counsellors' narratives. Counsellors' behaviours are also regulated through discourse with imbedded rules for acceptable behaviour. The professional, counsellor is regulated and governed by dominant discourses that have consequences for the therapist who misbehaves, including *therapist as dangerous*.

In my analysis, I found that agent deletion was a mechanism in trauma and professional discourse. Often the violent male was missing in the language. In Cat's text, for example, it is the therapist who speaks in the community, outside of work, who causes harm to the woman in the community. Cat speaks about her choice between using language of rape and sexual assault.

> Cat: I don't want to use that word [rape].
> (SILENCE)
> R: Hmm. Why?
> Cat: I don't know. I just feel that it's demeaning to a woman, as opposed to sexually assaulted. I just try to give it a better name, to maybe not make it sound so severe.

The text states that the word "rape" is demeaning to women. This meaning and impact of the word rape, constructed through discourse, is a powerful practice that keeps women silenced and not speaking of rape. The disciplining of women into silence is, thus, further internalized and learned through mechanisms of language and operationalizing preferred discourses of trauma, sexual assault, and being professional. Here, Cat is policed in professional trauma discourse with consequences of being

demeaning to women. The discourse constructs subjectivity that if the therapist talks about rape in the community she is performing a dangerous subjectivity.

I asked Cat about the severity and consequence for victims, women in the community, and society. In this excerpt I found an example of how dominant sexual assault discourse degenders the event, through agent deletion.

> R: But isn't it severe?
> Cat: It's severe. But I think that using the word rape is more severe than sexual assault.
> R: Do you think that maybe it would get more people's attention, and not just the women who have been assaulted, but society, if we actually did call it rape?
> Cat: Maybe so, but you know, the majority, no, all of the men that I have spoken to about what I do have nothing but admiration for me. And then they will say, 'I don't know how a guy can do that?' But maybe that is just the type of men that I know.

Here, in my analysis, I find a shift from protecting women by talking about rape in the community, to protecting men, as a majority good man subjectivity is constructed. Seemingly in this statement of the "type of men" she knows reaffirms her use of sexual assault discourse versus rape discourse, it has moved from being about protecting the woman. Cat seems to resist rape discourse, and especially when I connect it with activism as I ask her about getting society's attention. I read this as resistance as she shifts from impact on women to impact on men, and she seems to position herself to protect men, which is performing an acceptable subjectivity of women in the community, professional, and therapist. She seems to find legitimacy for this shift in a common ("majority") *good* non-raping man. She only has (she shifts from "majority" to "all of the men") non-raping men in her life ("nothing but admiration for me," "don't know how a guy can do that").

Finally, I watch as she moves even further away from protecting women and especially the victim into both a safe and othered woman in the community subjectivity,

as she states that her community does not include guys that "do that" and that "maybe that is just the type of men that I know."

Activist-Therapist Subjectivities

In my analysis of acceptable and dangerous subjectivities, I found that all of the women counsellors had some sense of the political issue of violence against women. In moments, the counsellors positioned themselves in more political subjectivities, spoke about the gendered issue of violence against women and deployed activist/feminist political discourse. A significant finding in my analysis was the discursive struggle around political and activist discourse. When political or activist discourse was employed, often professional, trauma, and other degendering, mediating dominant discourses were present in the talk. For example,

> Bailey: Yah, I guess just from doing this work and hearing the global situation that women are in. Like not just locally but globally. With the war in Iraq and Afghanistan, those kinds of things where women are treated completely unfairly, has certainly brought me a global awareness that women are vulnerable all over the earth, and perhaps we might be the most lucky ones living in Canada or the US, in North America, which is scary, because I still feel unsafe here. So just having more of an awareness of this is something that affects, it is mostly a gendered kind of act of violence, it is mostly geared towards women. Not to demean that men are sexually assaulted as well, but just seems that if you are going to hurt a woman this would be the way to do it. So, that didn't really click for me, like I learned that over the years, and it doesn't seem to end. I don't see that ending any time soon, which is the most disturbing part I think. That is the part that could really slow me down or get me down most, is knowing that we're fighting this huge battle, there's only a few of us, and we are fighting this huge battle and it feels like we are kind of screaming and no one's listening.

Bailey gives an overview of the global gendered experience of women, though she does ensure to include men experiencing sexual assault as well. To disclude men in the

analysis of victimization may be seen as intolerant, overgeneralizing, or that she is a man-hater (Lamb, 1999a talks about the backlash towards victim advocates who are labelled "man-haters" when they have spoken about male power over women). In this text Bailey positions herself in a political, activist way, she locates herself in a shared subjectivity ("we") of women who experience violence and are targeted, as well as fighting and battling against it. Bailey talks about the impact of this battle on her ("slow me down," "get me down") as well as on society ("no one's listening"). Here, Bailey's success and competence is challenged in the impacts of sharing subjectivity with women as being oppressed. Hammons (2004) discusses the concept of success through prioritizing dominant discourse versus alternate discourses.

In the next excerpt, Bailey makes a shift from activist to therapist. This is a more acceptable subjectivity, where she is teaching women who have been sexually assaulted, versus trying to change the global issue of violence towards women where "no one's listening," it is a "huge battle" with "only a few of us" and she doesn't see it "ending any time soon."

> R: Tell me a bit about that. What do you do with that awareness and what does that fight look like?
> Bailey: Um, well, I really like to turn those things into educational moments. Anytime I get to interact with a woman that's been sexually assaulted, I like to turn it into an educational moment. You know, this is something that happens to women, it is not personal. Try to make it not such a personal thing, like this didn't happen to you because you were bad, this is happening all over the world...(laughs) and could you repeat the question, I got lost.

Here, Bailey shifts from an activist subjectivity to a therapist subjectivity, in this she also distances herself from the victim, she moves into a subjectivity of educating a victim, versus being in the same subjectivity as victim (being so close to the vulnerable woman

in the community subjectivity within the context of global gendered violence against women). Just as she is educating the victim to not make it personal, it seems she is moving to not having it so personal for herself in the shift to a safer and more valued therapist subjectivity, as well in this subjectivity of therapist she can more easily be successful and competent. She does this as well, with shifting her language from "we" to "you." In the last line, Bailey states that she got lost, which I feel reflects the struggle to (re)position herself within a valued and safe subjectivity, even with her feelings of being unsafe and afraid. To position herself with all women, in her known context of global gendered violence, she is placed in a dangerous subjectivity, where she as a woman is in danger. The need to move out of woman as prey/in danger subjectivity follows her talk that it is a "huge battle" and "no one is listening."

I asked Bailey for more of an understanding of what she does with her awareness of a gendered issue of violence against women.

> R: What do you do with that awareness, that this is so huge, this is such a global thing, it's quite gendered, that women are being hurt, and we are a small group fighting this. Tell me about that fight with that awareness.
> Bailey: Well, it keeps me going. It is definitely a motivational thing. That is what keeps me doing this work. Cause if I don't do it, who will do it? Not that I am doing this alone. But if I think that I am capable, I can take care of myself while I'm doing this, it is something that I am passionate about, then it definitely keeps me motivated. So I want to continue working with women and hoping that I am a piece of the photograph of their life. If I can reach out and share what I know about this thing to even one person even once in a while, even with my friends, and my male friends especially. That for me is a good thing.

I was interested in how she integrated her understanding of the political issue of violence against women into her work in the sexual assault program. Because this is a struggle for me as well, I ignored her shift to a therapist subjectivity and focused back on the activist/feminist subjectivity. I feel that this subjectivity is rarely talked about in our

work, so I was excited to talk about it and explore how others felt about it. However, with my attempt to shift Bailey back to the "fight" against global gendered violence, she remains in a professional therapist subjectivity. In the therapist subjectivity she remains outside of a woman in the community/as prey/in danger subjectivity as she reinforces her own independence, success, and strength as she states, "I can take care of myself," "working with women," "reach out and share." She does not mention the fight, battle, or gendered violence.

Again, I ask Bailey about the fight.

> R: So that sharing and changing the awareness for others, is that the kind of fight you're talking about? Is that what you mean?
> Bailey: Yah, it's um, yah, it's definitely that grassroots kind of mentality, where it is not a big political issue so we can't really rely on our political system, our legal system, to help us through this right now, because they seem not to be as concerned as we are with it, so it's that needing to get our voices heard, needing to educate each other, needing to support each other as women and building that community around this violence that I think needs to happen, we need to keep moving forward. Forward-thinking women, and I think of all the women that came before us, like our generation of feminism and equal rights and all that stuff, and we are continuing that fight, and we are going to be doing this for the girls that come behind us, you know those little girls out there that will be affected by sexual assault.

Again Bailey locates herself with women in the community, as activist/feminist. However, this activist subjectivity has community, generations of support, success, and purpose. This shift back to an activist/feminist subjectivity has impacts for Bailey:

> Bailey: There are also times when I feel defeated. Like, I go through times that I feel defeated cause we are kind of dealing with the aftermath of sexual assault, so what I would like to see more, and I do not know how to do this yet, but do more preventative stuff. So, more preventive work, geared towards the perpetrator, not so much the victim. Or equally, the perpetrator and the victim, kind of educational stuff, let's get in the schools and things like that. That is my hope, and that is what keeps me doing this work. Cause I think that one day that can happen.

This impact was meaningful to me, as I feel very similar. Here, it seems that the two subjectivities of acceptable therapist subjectivity within a professional, depoliticized context and the dangerous, devalued activist/feminist woman subjectivity meet. Bailey, in this position, feels defeated at times, talks about dealing with the aftermath of sexual assault, versus prevention, recognizes the missing perpetrator, and has hope.

Here Bailey reflects on how she is doing in making a difference, what impact she is making. This explanation follows prevention discourse with reference to a political approach to gendered violence including education. She states that this is not currently happening and at times she feels defeated in the current therapist subjectivity who deals with the aftermath of the sexual assault. In this excerpt she employs both political activism and professional discourses:

> Bailey: Hmmm, I think for the most part you don't even see the difference that you're making. I mean you get to see the rapport that you have with the client, you get the 'thank-yous' and all those things. And you know, that's good enough, but for the most part I don't think that, I am not really invested in how I've made a difference or how I can see I've made a difference. I think that if anything, just with a woman around sexual assault, and that understanding of being non-judgmental, and just creating a comfort zone around it, is making a difference I think.
> It's the really small things. I don't see myself as being a big mover and a shaker in this field. I'm not shaking up the legal system, I'm not shaking up the medical system, you know, but I am doing my part, I guess in a more subtle way, from a different angle, I guess.
> R: Tell me about that way...
> Bailey: Like, just the in-person client stuff and the things we do for the program. Like, it's not focused on, we are not gathering and challenging the legislature, or that sort of thing. Maybe there is another group that is doing that, maybe there are people that are doing that in the city and I am unaware of it. So, I am kind of approaching it through clientele, through our clients, the people that we meet through the program. So that is kind of my way of working in this big huge topic, is to work with the victim of sexual assault.

Here again Bailey reflects the discursive struggle between the activist and therapist subjectivities. Bailey, in searching for her position, removes herself from the more radical and dangerous activist subjectivity in stating that she is not "shaking up the...system." Bailey moves from "screaming" and "battle" to working with clientele in the program. She moves from the global gendered issue of violence against women, through a discursive struggle and challenge between and within professional and political subjectivities to distancing herself from the political subjectivity completely and establishing her position ("my way") as working with victims.

In my analysis of the professional-political discourses, I found that the women often struggled between the two, especially with value and awareness of the gendered societal issue of violence against women. In this, they found ways to remove themselves from dangerous and unsafe (devalued) subjectivities, where they might be implicated as unprofessional or may be in danger along with the women whom they work with. In this struggle and division, value of the therapist is presented using professional discourse. For example, here as Bailey seemingly calms herself and settles within a valued, professional therapist subjectivity she talks about its value as she discusses the positive changes that have occurred in social services response to sexual assault:

> Bailey: I think that we're...I think that it is better than it has been. I think that all that stuff has come a long way. Like even our work here at the sexual assault program, being able to work kind of hand-in-hand with the police and with the medical system, I think that is really important. I think that we have a ways to go, like definitely we have a ways to go, but what we have been able to accomplish so far, we can be pretty proud of that. You know, coming from not dealing with the issue at all to where we are actually having a sexual assault program, putting a name to sexual assault, trying to get that information out there, I think is a good thing. Um, definitely there needs to be more attention drawn to the topic. I don't know how to do that, you know, I think that it needs to be a more political issue, nobody talks about it. Nobody who's running for any political

> position is talking about sexual assault. I don't know what's happening in the schools now. So, I think that there will always be need for improvement and space for that.

Bailey promotes the successes and value of the work that has been done in response to sexual assault. She employs professional discourse in valuing the cooperation between the service systems. Then she comes close to activist/feminist discourse as she states that we have a ways to go and that sexual assault needs to be made a political issue, "nobody talks about it," and "definitely there needs to be more attention drawn to the topic." However, immediately she removes herself from the responsible activist subjectivity when she states that she does not know how to do that, she does not know what is happening in schools, and places it onto an othered political subjectivity ("nobody who's running for any political position").

The struggle to construct valued and acceptable subjectivities was a consistent and significant finding in my analysis. The discourses available for female sexual assault therapists often contradicted one another. For example, Ally employs and has internalized valued and accepted professional and trauma discourse as she knows how she should behave, however, she resists it at the same time.

> Ally: I don't know, you are just opening up a whole can of worms for me that...I don't know...outside of this place, I maybe could be a little more vocal about cause this is my paycheck...(laugh)...and I need it. But um, definitely I struggle with the term 'trauma' even, whether it's about sexual assault, and I've kind of been hinting at...individual counselling is difficult for me, and even outside this interview I remember saying, 'I don't really think I want to be a counsellor.' It does bring up issues for me, and like the original question, it is difficult being in this environment, with this construct of how we heal, and definitely I use the word 'construct' because we are setting ourselves up for something specific. And I mean, I definitely question everyday, 'Am I just making somebody complacent enough to deal with this big issue, so that they can individually get along in their day and function the way they think they

> want to function?' Am I just part of that system? Which most days I say, 'Yes.' (laughs)

Ally monitors her language and is aware of backlash, she needs her paycheck, which implies that she has concern for losing her job if she is more vocal about certain things in this location. This excerpt at least partially refers to the location, in the program, in the building, where the interviews took place. I feel that this example of self-monitoring in this setting (because the interviews were done at the agency) indicates that this could have been a regulating factor for all the women.

Ally, in the above text, struggles between subjectivities of being a trauma therapist, in this environment with its constructs, and being more of an activist. This talk of environment reflects not only the program, but extends to the larger, societal environment and "just part of that system." She questions what impact she is having on women in individual counselling, whether her acceptable and valued (employed) "trauma" therapist subjectivity is making women more complacent with this big issue, referring to women's oppression and colonization. She implicates herself in the acceptable and valuable therapist subjectivity as part of the system.

Ally goes on to explain the impacts of this struggle of working within a program that clearly employs trauma and professional discourse, which conflicts with her own intrinsically valued discourse of women's oppression, community, and activism. As well, she describes how she personally responds to these contradictions within her therapist subjectivity.

> Ally: But um, yah, like I was saying before, it's hard to have these ideas, 'Yah, you should be speaking out if you want to, let's explore why you feel that you can't talk about it.' And so I don't want to totally disregard the work that I have done here or the work that hundreds of other women have done here.

Including complacency, and not addressing the societal issue of sexual assault, Ally talks about another impact of challenging professional discourse, which is that she does not want to disregard the work that she or other women have done.

Ally, within professional discourse, speaks about the impacts and perceptions of the women victims, and how she works within professional discourse and an accepted trauma therapist subjectivity and also challenges it.

> Ally: And I mean, there's still so many women that just still want that complacency, 'I just want to get back to my normal life,' but then there are a few who come that I see who say, 'I want to share this with at least one friend, so that they know where I am coming from cause they don't know.' And so how do we get to that point? And how do I be honest with them saying, 'I'm in this, I want to help, but I do feel this way about trauma, I do feel this way about sexual assault, I do feel...and...it's sharing with them, because I do feel it's that balance, either within yourself or with the community around you, it's always about balancing. Yah and ideas of what counselling should be. I definitely try and struggle against it, in the ways that I feel like I can. Um, and definitely I want to try and challenge the system, those social constructs that we have that keep our society going, as well as always challenge myself with, 'Why do I even believe this? Is it important?'
> Um, yah, it is different, it is definitely a daily struggle. Who knows, hopefully pretty soon I'll just be complacent and fall into line...just kidding.

The struggle between an activist subjectivity and professional therapist subjectivity is reflected here in Ally's text. She alludes to activist/feminist discourse being more theoretical and then moves ("strip that away") into practice, which seems to fit more within professional discourse. This, I read, as due to the positioning of activist/feminist discourse as devalued and unpracticed, versus professional and trauma discourse, which constitute our therapist subjectivities, behaviours, and programming.

> Ally: It's just a struggle on a daily basis how to make sense of that, but um, I'm not sure if it's a choice that I just don't want to give up just yet. It's difficult, I mean, I will definitely take responsibility for most of this

> conversation being in much of a theoretical realm, and when you strip that away and put it into practical terms, I don't want to wash away the work that people are and have been doing here, I think that's really important that I remind myself of that, because I'm a part of this machine (laughs), but uh, it is that really delicate dance between these constructs that are causing more oppression. What can I do to change that without discounting all of that work that people have done? So the dance that I do is through individual counselling, and like a said before, I use the analogy of our mini-group, it's the two of us, we are the group now, I don't want to necessarily participate the same way you might think counselling to be of expert and client. Um, and by sharing those things with people, by no means is it the perfect answer, but it's where I am starting and yah, it's definitely where I am at now and where I am starting.

Ally moves away from an activist/feminist subjectivity into an acceptable and valued therapist subjectivity ("through individual counselling"), though she still names the struggle ("delicate dance"). The struggle is ongoing for her, as some of her concerns are "discounting all of the work that people have done," and "causing more oppression." She talks about deciding to work within the therapist subjectivity, and shifts language to fit individual counselling into group work, attempting to shift power relations between "expert and client." Throughout the struggle, Ally shares that it is not "the perfect answer," and within professional discourse and the therapist subjectivity, does not find a fit for her values on women's oppression and a woman in the community subjectivity.

Behave: Disciplining the Therapist

In my analysis of the transcripts, I found that certain behaviours were more acceptable for the therapist subjectivity than others. The participants had internalized these regulations in discourse. I found that certain discourses were employed in regulating the therapist's behaviours. The participants used discourse which constructed acceptable therapist subjectivities, as well as dangerous therapist subjectivities. Professional, trauma, and

secondary trauma discourses were the hegemonic discourses present in the counsellors' talk about their behaviours.

In my analysis, I found that the participants were disciplined through dominant discourse. For example in Ally's text she implicates trauma and professional discourse as she talks about the messages that she has received about being traumatized in the therapist subjectivity due to working with trauma.

> R: We were talking about vicarious trauma and the individualizing and focusing of trauma onto the individual. Whether it's the victim who has sexual assault trauma or PTSD, and then the helper, the worker, or the counsellor that is then vicariously traumatized. So what do you think of, taking all that into account, the idea of the client as infectious? The client as being contagious? Do you see it fitting with some of the messages that we are given?
> Ally: Yah, again, I think that's the notion that is out there, but it conflicts with what I believe. But as you were saying, that definitely, I mean if you look back at the way we're taught to deal with trauma, as counsellors, take care of yourself...more self-care, what's the dose that we can do, keep your life separate from here. Definitely, I think, if people do not get it directly, they are definitely internalizing it unconsciously. That yah, this work is going to traumatize me.

Trauma discourse disciplines the therapist, Ally states that this is 'the notion...out there,' 'the way we're taught,' and that these messages are internalized unconsciously if not received directly. The dominant discourses in trauma work have mechanisms to regulate and discipline the therapist. Dominant trauma discourse constructs the concern with becoming traumatized; this concern regulates the therapist's behaviours. Through discourse she is taught to deal with trauma, with self-care, monitoring the amount of trauma she is exposed to ('dose that we can do'), and have boundaries between personal and professional subjectivities ('keep your life separate from here').

Personal-professional – do not speak about personal experience.

Within discourse the therapist is governed to not speak of her personal experiences. For example Dana states:

> Dana: It never comes up in therapy...god no...it would never come up in a counselling session...my experiences, but I mean, just to know in the back of my head too that, 'yah, you can totally get through this,' is something that makes sense to me.

Even when Dana's intention would seem to provide hope and support for the victim ("you can totally get through this") in counselling she does not speak about personal experiences.

> Dana: Yah, I guess it's an interesting spot to be in, because I can say in my head...god, never to someone else...but I would say in my head (laughs), I would say in my head that, like, I've been there. So I mean...In a way, I can't equate it, like it's not equal to their experience AT ALL. It's very different and it's nothing, nor should it be the same...you know. But uh, I can say in my head, I can say that you start here, and yah something bad happens, no matter what bad thing it is, and you can get to a spot where things will be okay and you can go on and like, have a life and a partner and be happy, and have it be just something that happened to you, not have it be the thing that defines you.

I was interested in where Dana learned these rules to not share her personal experiences, and what it means to her.

> R: Why do you choose not to share your experience with your clients?
> Dana: I think one day I will...but, when I have a degree. (laugh). I have to be honest, okay, because I don't know how to properly do that at this point, being a counsellor, being like a counsellor with this program's training, and the other place I work with counselling...doing a lot, but I don't think I know how to do that in an effective way, do you know what I mean? [...] I'm definitely in a spot in my life where it's shelved and clean and neat in terms of my feelings around it and I don't go into distress about it, and I'm pretty okay about it. But I think that as a counsellor, sharing personal detail is important, can be really important and really well used. Like, I've seen my supervisors use it all the time to people, in group settings and I think it's awesome.

Dana has internalized the rule not to share her personal experiences, especially if there is emotion ("distress") with it, she states it is "shelved and clean." Though, she has learned that it can be used as a tool within therapy, she feels she needs a degree or training. Dana further describes personal sharing, which reveals the regulation of this behaviour in an acceptable therapist subjectivity.

> Dana: But you need to know how to use it appropriately...I think it is just a tool that is...any disclosure of your own is a tool that you have to know how to use in therapy, not...um...just...'yah that happened to me too!' Do you know what I mean?! So, and I don't think that, I'm not sure yet if this program is the setting that I can do that, cause I am just there to listen and I am just there to use the tools that they have taught us to use, and the ones that I think I intrinsically know...empathy (laughs) and things like that, but I don't think that it is a place to practice, kind of, your therapy skills if you're not in [the profession]...yet...do you know what I mean? You want to be careful, they come to you for an hour, you're still a volunteer when you're doing it.

The tool of personal disclosure is governed through professional therapy discourse. Dana further outlines the consequences of not having the implied legitimate skill or tool. Consequences are what police the therapist, due to the threat of backlash or becoming dangerous.

> Dana: So that one hour I am there just to listen to their story and like do cool things like art therapy and fun things and get them to talk and open up and process feelings, but uh, definitely not to go into...uh...you know...you just gotta...I think you have to be careful with that kind of stuff. So, not until I hopefully have a real skill set (laughing)...not a real skill set...but a skill set that maybe is, that I can definitely know when it works well and when to do it and how...because you don't want to make the client feel minimized with their experience when you're talking about yours. That's the last thing I want to do...so yah, I just think that I need to be more prepared before I do that (laughs)...

Dana talks about having a skill set and learning the tools and being more prepared before sharing personal experience. The consequence of behaving outside the professional

therapist subjectivity (within your skill set) is the client feeling minimized, the therapist behaves within a dangerous subjectivity.

Dana emphasized the need to be well-trained in order to perform an acceptable therapist subjectivity within hegemonic professional-educated discourse. Dana explains further the need for training, which seems to imply legitimacy in the therapist subjectivity. Here, she mentions levels of counselling.

> Dana: So, maybe not a degree, but maybe some sort of training for that. That's just, yah, that's a different kind of level of counselling than just what we do here. So, yah, and it's, you know, personal too. So I don't know if I'd actually share that, I've never thought of that and I've never actually thought, 'Oh, well tell them about your experience.' So, I don't know, I'd have to think about that too, yah.

Finally, Dana states that she has not thought about sharing her experience, however, she has internalized what her behaviour should be and what consequences are. Dana reveals internalized regulating discourse for how the acceptable therapist should behave, and why.

Boundaries/Limits.

Another significant finding in my analysis was the disciplining of therapists to have professional boundaries, limits, and division between being a woman at work with the acceptable therapist subjectivity and a woman in the community.

> Dana: I think that I've gotten good at...um...not compartmentalizing it, but, just being able to turn it on when I come here and think of it and process it after when I want to do something with the client, but not in a way where I am going home pained.

I found that within trauma and secondary trauma discourse, is disciplining for leaving work at work, not taking it home, performing separate subjectivities at home, in the

community (personal life) and at work (professional). Dana employs trauma and professional discourse when she talks about "turn it on when I come here."

These professional discourses instruct acceptable and healthy therapist subjectivities regarding professional boundaries. I found that the counsellors also knew the consequences, through vicarious trauma discourse of acting outside of these governed behaviours.

> Bailey: What I have done to lessen vicarious trauma is to cut out the things I see on TV. I have definitely seen more disturbing things on TV than I have dealt with in my work. So, um, that way I can kind of lessen it a little bit. I also try to take care of me. I definitely have learned that I need to unplug, from this work and everything. And I am able to do that now, I am able to actually unplug from this work, go to a different environment. Even if that is for a weekend vacation that is completely helpful, I can come back with a completely different perspective. And that is something I learned really recently, so I know that I have to incorporate it a little bit more, cause I know that I can get really submersed in work and then it's kind of, the vicarious trauma continues to happen and then you forget that you get the worst of it.

Bailey has internalized the directive for the acceptable and healthy trauma therapist to limit the amount of trauma in her personal life and to unplug.

Further, Bailey discusses the consequences that effectively police the acceptable behaviours for the trauma therapist, as well as what she does if she is thinking about work at home.

> Bailey: Um, I definitely don't take my work home with me. Like when I think about working and debriefing, like I can leave it here, it's good and I have friends that are outside this kind of work, and that is my away time. And so it feels good, I mean I am definitely vulnerable to vicarious trauma, but I have some limits and I have boundaries around it. Like, if I find myself, I can tell, if there is something going on on shift and I am thinking about it at home, then I need to do something about it. So, what I do is, what I turn to mostly is doing something creative. So, listening to music or art therapy stuff.

Dana speaks about the division between the professional and personal (community) subjectivities.

> Dana: And it's also the joining of those two worlds, I like to keep those worlds separate, just for me, they are separate. The most I'll say, like I've said to my partner, 'I've had a really hard night, that was a really tough one.' And sometimes I'll say, 'Super tired, sad, that was hard. But think I'm going to go to bed.' But that's the most. And the best is if he is just, 'Cool, do what you need to do.' You know what I mean? He never would ask, 'well tell me exactly what happened, and tell me how you're feeling.' (laughs) You know. No. Just a hug, a comfort and it's a safety and then I'm good to go usually, and eat some food, and then feel better, and then, yah. Yah, I don't like to mix those. I don't like to mix those two worlds.

Through professional and trauma and secondary trauma discourse, the world of trauma work and personal life are kept separate. Here, in the discourse used Dana does not speak about what happened at work, she keeps her worlds separate. As well, her partner also seems to have internalized this regulation of not speaking or asking about the work.

In the following text, Ally exemplifies a challenge or resistance to known/dominant discourse that regulates therapists' behaviour.

> R: So how does that fit, I am sure you have been in this field long enough that you have heard about boundaries, and you know, leaving work at work, being professional, bringing it home, into your personal life, and sharing it with your family and friends. Do you get those messages?
> Ally: Yah, I totally get those messages! There's professional boundaries, don't cry in front of your clients, don't tell them that you're scared... I mean, yah, and while I do think that there is a huge majority of things I need to leave at work, um, there are just things that I can't or won't. Like some of the big societal things like, even without experiencing sexual assault or rape, but here at work, or even if it was personal, I don't think that's something I ever would want to just leave at work, but um, in terms of boundaries, again, I think that you're opening up a whole can of worms for me.

Ally directly challenges the dominant messages and directives for the counsellor's behaviour as she "totally gets those messages." This is a challenge to the known truth and dominant discourse that regulate therapists' behaviour. Ally resists the

disciplining practices as she is aware of what therapy is dominantly constituted as, what behaviours are expected in the acceptable/valuable therapist subjectivity. She has internalized dominant discourse that regulate the "professional" therapist, she can put them into language as she talks about "professional boundaries," not to "cry in front of your clients," "don't tell them that you're scared," "leave work at work." However, she states that there are things that she "can't or won't" leave. This challenge to the dominant discourse constitutes a counter-discourse that allows the therapist different options for action and experience. In these other options, she can take the societal issue of rape and sexual assault home with her, and into the community. In this act, there is an opening for the walls of the institution to be weakened, the silencing of women is challenged, and the societal responsibility for systemic violence against women is put into language and has the potential to be known by others.

Feeling empathy – how should I feel?

Within secondary trauma discourse, direction for how the therapist should behave is given, including what she should feel, how she should feel, and when she is feeling too much. In my analysis, I found that feelings were regulated as well, especially fear and empathy.

> Dana: You can feel empathy, but not in a way where, you know, not going home and being scared to leave my house. That's a problem. That would be a big problem. [...] So, I don't know, just seeing how painful it was for somebody else, and you're just, kind of, you're there but you feel helpless, kind of, you know what I mean?

Dana (re)constitutes professional discourse that governs therapist subjectivity and reflects a professional distance and segregation between client and counsellor. Dana has internalized the regulation and warns in her talk: "that's a problem."

Ally presents a counter-discourse to empathy and connection with the victim and women more generally.

> Ally: Umm...It connects me to them because I think I have this belief that we are all connected, regardless of sexual assault, so when people in my community are hurting I need to...not experience that, but when they're hurting, I'm hurting if they are, because this circular connected thing...It connects me because it gets that passion in me that I was talking about, I mean, maybe they're not experiencing passion but kind of if we are connected like that and in that circle and they're experiencing this trauma for the first time, I'm the representation of the other side of it, like what can come out of it, uh...if that makes sense. So, a little bit of balance. Of course I can't balance it enough to fix it, but if there's sorrow or there's trauma, then I'm the passion or the catalyst, or whatever comes out of it that's trying to balance the other side, so in that way I see us connected.

Within the talk about empathy I found counter-discourses to professional and medical discourses that regulate therapist subjectivity.

> Dana: And, it's just hard because you see someone crying and they fall into your arms and you don't even know the person but you feel, oh my god, you feel so connected and so sad for them and hurting for them.

The regulation of therapist subjectivity is challenged by Dana as she describes the connection and sadness she feels when the victim falls into her arms. The isolation and division through dominant professional discourse between client and therapist is disrupted in this contact, as she feels "connected." The physical contact between the victim/client and the counsellor is counter to how the professional therapist should behave performing an acceptable subjectivity. This counter-discourse of connection resists both the hegemonic dividing practices between counsellor and client, and the disciplining of the professional therapist. In this contact, the segregation of these two women is challenged.

The impact that Cat stated she experienced as a result of doing this work was "empathy." The experience of empathy as a result of working as a sexual assault counsellor is a counter-discourse to trauma and secondary discourse.

> Cat: I feel completely empathetic. And I think that even working [in other positions], that I have always had a gift for feeling empathy for individuals and you know, it is a gift, because not everybody can feel empathy. But to actually feel the pain that some of these people are feeling, I can feel it, I can feel how they feel.

Empathy being her first and only response to the question of the impact of the work with sexual assault victims would likely be construed in trauma and secondary trauma discourse as high susceptibility for vicarious trauma and empathic strain. The focus on empathy challenges the dividing practices inherent in trauma discourse. To discuss her personal feelings and to speak about really feeling the pain of the women she works with resists professional discourse that disciplines and regulates the therapist's feelings with professional boundaries and objectivity. Seemingly, without secondary trauma knowledge, the regulating discourses that prescribe behaviour are not initially mentioned. Cat does not respond to the question of work impacts with the same caution, or secondary trauma response that the other counsellors did. Cat uses terms like "completely," "actually feel," and repeated "I can feel." Her response was different from the other counsellors, in that she stated empathy as her impact of the work versus secondary trauma responses, such as awareness/concern for safety, flashbacks, shift in world view, cynicism, and memories outside of work.

I found that empathy was regulated in dominant professional discourse presented in the interviews. Cat talked about her own life experiences in connection with the women she supports.

> Cat: So I feel their loss. And they feel abandoned. I felt abandonment when I lost people that I loved. You know what I am saying? But I am not doing this to make me feel better, for my losses, I am just saying that I can be empathetic and understand. And if I can help somebody through a loss because of the experience that I have had, then that is a good thing. It's kind of a teaching, a learning...mechanism, you know. I learned how to cope and deal with my loss, now maybe I can help them cope with their loss and their feelings.

Shared experience (of loss) constructs a counter-discourse to the dominant trauma discourse of the client experiencing the feelings due to their traumatic event and the therapist witnessing or hearing about it. The counter-discourse allows other options for therapist behaviours. These behaviours include empathy, shared experience of loss, teaching and learning, as well as introduced a shared subjectivity of women in the community due to shared emotional experience.

Self-care: Avoid vicarious trauma.

I also found that remaining within a valuable and healthy subjectivity included internalized discipline of trauma self-care. Bailey spoke about how she stops or prevents the impacts of working too much.

> Bailey: Well, the first thing that I have to do is realize that that's what's happening, and I can hear it in the way that I speak to people. So that is my first cue, and then I just have to change my focus. Self-talk my way to, 'well, what happened? Let's look back a little bit and see what happened. Oh yah, I haven't been socializing that much. I have been working more hours than I usually do.'

When I asked Dana about how the therapist becomes potentially dangerous she responded that:

> Dana: But definitely I think that is true, because the therapist isn't dangerous but has the potential to be dangerous if they are not careful with everything in their life in terms of balancing and being healthy and content, and everything with the client, just coming in and being in a good spot with the client. And just being honest, if you can't deal...with everything...then you either have to stop immediately or take some time

> off, or question whether this is something you can do. You know. Because you might be time-limited, you might be able to only do it for a few years, or maybe you can do it for 10 or 20 years, but then you better just make sure you're prepared you know, and make sure you can be helpful. You don't want to be unhelpful, not helpful, not good.

In this, the therapist is disciplined in her behaviour and response to her clients, others, and herself. Dana repeatedly states that the therapist must be "careful," revealing an acceptable therapist subjectivity and her potential danger and risk to others and herself. The therapist knows her responsibility, to avoid becoming dangerous.

Dana's text reveals internalized discipline, to be not dangerous, to be healthy, balanced, in a good spot, content, and deal with everything. The language presents the assumption that we as therapists inherently know what these things are and must do them, however these are the subtle impacts of prioritized professional and trauma discourse. Dana employs secondary trauma discourses, which holds regulating consequences, the *therapist as dangerous*. For example, "have to," "stop immediately," "you better just make sure," and "make sure," all discipline and regulate the therapist. These are all disciplinary practices of dominant discourse of vicarious trauma, being "healthy and content," balanced, "everything with the client," "being in a good spot." The implication for challenging or not following through with these regulations, are constructed in a dangerous, devalued therapist subjectivity that is "not helpful," and "not good." The therapist is policed by consequences in governing discourse; she "can't deal with everything," is "time-limited." These consequences act as punishment and backlash for the therapist subjectivity through professional and trauma/vicarious discourses.

Debriefing.

In my analysis, every participant talked about debriefing as behaviour they engaged in. This behaviour is regulated by professional and secondary trauma discourse.

> Cat: Debriefing, they have supervision groups here every third week, and they expect us to come and just talking about it with all the girls, with the supervisors is huge. Cause just all the shit that you collect, you get to dump there, and the support that we have in the sexual assault program with our workers is huge. I find that to be the biggest...cleansing for me.
> R: So that debriefing...
> Cat: That debriefing and talking about it with the girls. Like when we come back from a hospital visit and we've had encounters with some shitty cops, we'll talk about it and we'll get it out. I don't repress anything.

I found that talking about trauma and work is acceptable for the therapist for therapeutic purposes, to discuss client work, in therapy with clients and to debrief at work with other counsellors or supervisors.

> Dana: So, no, it hasn't gotten anything like that, and the most thing I feel is that sometimes it's nice to debrief with the supervisors just because if you want to talk something out, um, like a client set and you're not sure and it's a little worrisome and you're feeling a little nervous…those kinds of things.

Cat goes on to talk about the value and purpose of debriefing. She has internalized the discursive policing within and through the value, importance, and consequences of this behaviour for the acceptable and healthy therapist.

> Cat: I think that we are very lucky in this program, because the most important thing about working with people with trauma is debriefing, because if you never get opportunity to talk about what is bothering you when you are working with people who are bothered, then it's just going to be a ripple effect and you are going to be going around in circles...So if you are honest with these people [co-workers] and you tell them how you feel, then you are not going to be traumatized as a counsellor, because then you are getting rid and you are dumping the bad out of you. If you repress that, then you are going to be traumatized.

Cat employs trauma discourse in her explanation of debriefing and the consequence of behaving outside of the discursive regulation—"you are going to be traumatized."

Cat further articulates the consequences, which police the therapist's behaviour:

> Cat: Getting rid of the crap that I'm feeling. And I do. I never, hardly ever, miss a supervision meeting, and if stuff is bothering me I always talk it out. I never had the opportunity to do that when I worked with sex offenders. I would read their charts, and think about it. I read charts here, actually I am writing up these charts, yet I never have had a bad dream working with sexually assaulted women. And I am sure that is because we debrief so much and we talk about how this is affecting us. Psychologically, I feel that if we repress, it's gotta come out somehow, so it's going to come out in a dream. I am convinced of that.

The therapist is disciplined to debrief, with the purpose and intent of remaining healthy, dumping it, getting rid of it, not becoming vicariously traumatized, and not going home pained. The acceptable and healthy therapist subjectivity, with these governed behaviours, has learned to speak about their work within the agency, not outside in the community. Debriefing, or talking about sexual assault trauma work, is regulated; it is enacted only for therapeutic purpose rather than an activist or political purpose.

Keeping the Therapist Disciplined

In my analysis I found that not only had the counsellors internalized the discipline of an acceptable and valuable therapist subjectivity, people in the community know these regulations as well. The examples Ally gives of interaction with others reflect their knowing of hegemonic discourse. In dominant professional and trauma discourse, speaking about work in the community is dangerous. Ally talks about the response from people in the community, which acts to police and regulate behaviours of the therapist.

> Ally: I hear 'oh, be careful around that one, she could be flighty...' and definitely the messages I get back from people are, 'oh, watch out!' I

> mean there are several ways that they let me know that either, 'oh, that must be really hard,' or 'let's talk about something else,' 'don't go there.'

These messages from others, outside the agency, discipline the acceptable therapist subjectivity to be silent, as well as police with consequence the therapist who performs outside the valued discourse. The text reflects the disciplining through dominant discourse of the therapist as dangerous to society, outside the agency.

The therapist is divided ("that one") from the rest of society ("they," "people"). Here, the therapist is a threat to the community and to others around her outside of the agency. Ally receives the message from the community upon hearing that she is a sexual assault trauma counsellor—"watch out," "be careful around that one." Ally also experiences policing from the client.

> R: So, how do you think your clients perceive your relationship [with them]?
> Ally: I don't know (laughing). It depends. I definitely have had a mixed experience with it. That's the choice that I've made and how I want to deal with it, cause I try to be really up-front with people when they meet me, either through the phone, the hospital or if I'm seeing them in-person, um, like I have a client right now who hates that about me. And I very plainly told her, that this is a strong belief I have about sexual assault.

When Ally behaves outside of dominant professional discourse it seems to disrupt her client's held beliefs about women, trauma, violence, and both the acceptable and valued therapist and client subjectivities. Ally's challenge to acceptable therapist subjectivity receives backlash and policing from the client—she has clients who hate that about her and called her "confrontational" in her "up-front" approach, which suggests that they are employing a misbehaving woman discourse. Ally's strong beliefs about sexual assault are met with "hate" and backlash from her clients.

Ally deploys an activist/feminist discourse as she speaks about actions of advocacy, speaking out, and feelings of anger and passion. However, as she deviates from the accepted and valued therapist subjectivity the client seems to struggle. Though Ally's intentions seem to be positive and empowering for the women who have experienced sexual assault, she "hates" that about her.

> R: She hates...what?
> Ally: She doesn't like that...um...that uh...ability to confront sexual assault if you can call it that, so like I was explaining before, of course you're going to have all these emotions, let's say anger for example, I believe we can use anger as a catalyst for passion, a catalyst for advocacy and...ummm...she really dislikes that. Um, and I've told her, that's who I am, I won't compromise. I mean, (laughing), it's hard to explain that, uh, yah, just for the purposes of this that I won't compromise some of those beliefs I have. Um, I don't think she has to follow me in it, but she needs to know that's where I'm coming from. So, I've had clients like her who dislike that, and I think she used the word 'confrontational' so that's why I'm using it now (laughs). And other people are very excited, not excited, yah excited about 'okay, so I can change from this, like I know I'm at my lowest right now, but I can do this? I didn't know I was able to speak out about this', those kind of things...so, some people really like that.

Ally states that she does not compromise, she expresses her beliefs and where she is "coming from" honestly to the women she supports—"that's the choice that I've made and how I want to deal with it." Ally resists dominant discourse with an awareness of other, less valued, discourses because "this is a strong belief I have." These counter-discourses that she presents to the women she supports challenge dominant discourse and the client "hates"/"dislikes" it even though these counter-discourses seem to be empowering for the victim and women. Ally's text reveals the struggle between resistance and compliance with the dominant disciplining of the woman client and therapist.

The statement of "confrontational" implies the internalized regulation and discipline of women to be silent, accommodating, and non-"confrontational." This is especially in their experience of violence; women are disciplined to be silent. This punitive response by the female client/victim towards Ally who is calling for social action implicates an internalized dominant discourse and discipline to be silent. The female counsellor, then, in this activism counter-discourse, though seemingly empowering to women, challenges and threatens the good woman client/victim subjectivity. As well, this conflict with and backlash from the client/victim constitutes a relationship of potential struggle between these women.

Another finding in my analysis of trauma work talk was that dominant discourse masks violence against women through regulating and policing the acceptable and valued therapist subjectivity. Cat reflected the regulations that she follows for talking about her work in the community. She explains what consequences police her actions.

> Cat: No, no, never. If anything, I am very cautious talking about sexual assault in the public, because you never know who might hear you. For instance, people might say, 'Well, what do you do?' And I'll say that [I'm a sexual assault counsellor], and how do I know that a person, 3 feet away or 3 yards away doesn't hear me, and that person could have been sexually assaulted, and it will bring up feelings. I am very, very, very cautious of who and when I talk to people and how I say that I work with sexually abused people. I'll never say that I work with rape victims.

Cat spoke about her concern of retraumatizing sexually assaulted women in the community if she speaks about what she does outside of the agency. This language disciplines the therapist and outlines the risk of her breaking the silence outside of the agency/institution walls—"I am very cautious," "it will bring up feelings," "very, very, very cautious." Trauma and professional discourse construct speaking about violence and trauma in the community as performing a dangerous subjectivity.

Overall, dominant discourses of trauma, vicarious trauma, and professional constitute, discipline, and police therapist subjectivity. In my analysis I found that the counsellors had internalized discourse that constitutes valuable and accepted therapist subjectivities. Through counter-discourses, all the counsellors, in moments, resisted dominant discourse with consequence of performing dangerous or devalued subjectivities.

Chapter 5: Discussion

The final section of this thesis summarizes the impact of the dominant discourses within secondary trauma work in regards to how these discourses affect women, contributing to their pathologization and the maintenance of their oppression. In this discussion, I explore the impacts of the dominant discourses within sexual assault work, professionalization, responsibility, and the construction of the victim/client and the therapist subjectivities and their relationship.

In this final part, I assess my own research based on the guidelines suggested by Strega (2005), which I outlined in Chapter 2. These include assessing the political implications and usefulness of the research I have done, and how it contributes to progressive, anti-oppressive politics in marginalized communities. I also further discuss how to make the findings available to the service systems and academic settings that are informing, impacting, servicing, and influencing the social issue of violence against women. My intention was to infuse hope by proposing a direction for action and research in the areas of violence against women, the helping services, and the research/literature of secondary trauma.

The societal issue of violence against women and women's oppression has been constructed into a services issue. More specifically, due to the professionalization of the once feminist-minded services, the responsibility for dealing with violence against women has fallen on the shoulders of frontline workers (sexual assault counsellors and advocates) and the woman victim. This responsibility is evidenced and maintained in dominant discourse operating in the literature of the traumas and the voices/narratives of the sexual assault workers. However, we are not, and our work is not about dealing or

impacting the societal issue of violence against women, rather our focus is on the aftermath—the trauma that becomes the client and our need to avoid becoming traumatized.

Secondary trauma is a concept/label that contributes to the depoliticizing of the impacts of violence against women as it pathologizes the victim and the helper, blaming and isolating them both. The language used to talk about secondary trauma and subsequently to talk about the effects of violence against women is highly medicalized. In fact, rarely is violence against women mentioned in the literature and research at all; neither was it heard in operation in the narratives of the female sexual assault counsellors. Instead the catch-all terms *trauma* and *secondary trauma* were positioned cause and concern rather than men's sexual violence towards women. As I have argued, much of the current research on secondary trauma seeks to find cause within personal characteristics of the *traumatized* woman in order to properly "identify people who would be vulnerable [to PTSD and secondary trauma disorder]…and allow treatment to address the characteristics" (Lerias & Byrne, 2003, p. 137).

In analyzing the transcripts of the sexual assault counsellors, I focused on the dominant discourses that discipline, regulate, and I found, subjugate women, both as victims/clients and helpers/professionals. Discourses that pathologize women include professional, trauma, therapy, and secondary trauma discourses inherent in trauma work, with mechanism, interaction, and impact of constructing the *client as infectious* and the *therapist as dangerous*, dividing women from each other, silencing them, and blaming them in and for their own oppression.

In the next section I will review and discuss three underlying and threaded issues that run throughout my thesis. These include the contradictions in normalizing violence against women; the dangers in speaking about this violence; and how trauma discourse constructs the relationship between women.

The governance of women's actions, behaviours, and consequently women's responsibility for the violence they experiences is foundational to woman-blaming rape myths and the construction of the woman scapegoat. Implicating men seemed to be perplexing for participants as it seems to be in our society as well. Disciplining women to be responsible for changing *their* behaviours, for example by avoidance of dangerous situations seemed to be in operation for the counsellors as well as for their clients. This was particularly evident in the dividing practice of good and bad victims, marked by race, class and gender dimensions. As I noted, victims who were angry and potentially even wanted revenge seemed to elicit resistance from the counsellors. Angry women are penalized and punished, and often they evoke anger in others (Brescoll & Uhlmann, 2008).

The sexual assault program from which the interview participants were drawn circulates a counter-discourse in the program's philosophy (presented in Chapter 1). Though this discourse appeared in moments in participants' talk, this 'official' discourse often appeared next to rape myths and dominant rape discourse. This suggests that there continues to be discursive struggle about violence against women despite the proliferation of dominant 'psy' complex discourses.

A central question that I pose is as a result of my research is: If violence against women is seen as normal, why is it so dangerous to talk about it, and damaging to hear

about it? Danger is evident in the reframing of women survivors of male perpetrated violence, into clients and mentally ill (PTSD), and the therapist as infected (VT), and the strict disciplining of the therapist's behaviours, especially regarding speaking out about male violence against women. Speaking about trauma is acceptable behaviour and speaking about male violence is unacceptable behaviour. A therapist who speaks about men's violence performs a dangerous subjectivity, where she can harm others around her in the community, including women who have experienced violence. Trauma talk was persistently valued over speaking about violence and participants were keenly aware of negative consequences for misbehaving, which included personal, therapeutic, and community impacts. Further research and critical thought need to be focused on the contradiction between violence against women as normal and how we all (especially women) are disciplined in how damaging it is to talk about it and hear about it.

My analysis of trauma and secondary trauma discourses makes clear that victimized women, and by extension all women (since any woman may become a victim) are continuously discursively positioned in a double-bind: we are, or have been, in danger and, once victimized, we are dangerous. The double-bind silences women and is a concerning issue, as Laura Brown notes:

> But when we admit to the imminence of trauma in our lives, when we see it as something that is more likely to happen than not, we lose our cloak of invulnerability. A feminist analysis, illuminating the realities of women's lives, turns a spotlight on the subtle manifestations of trauma, allows us to see the hidden sharp edges and secret leg-hold traps whose scars we have borne, or might find ourselves bearing. We are forced to acknowledge that we might be next. We can not disidentify with those who have already been the victims of a traumatic stressor when we hold in consciousness our knowledge that only an accident may have spared us thus far. "It could have been me, but instead, it was you, and it could be me, dear sisters and brothers, before we are through," sings Holly Near; a poetic expression of what it means to know deeply that we are vulnerable.

> And when we make this identification, admit that we can all be on the receiving end, we rest much less easily with those institutions of the society which might eventually make us their target. (Brown, 1991, p. 129-130)

Relationships between Women Constructed in Discourse

Relationships between clients and those who seek to help them are of special interest in feminist and anti-oppressive theory. As I demonstrated, trauma and secondary trauma discourses fracture the relationship between women and provide little opportunity for community, friendship, equality, and empowerment. The counsellor is trained to know the client *through her trauma.* Where once both helpers and helped worked together to reduce men's violence, dividing practices now position relationships with "clients" as not fulfilling, appropriate, or healthy. In agency policies, relationships between counsellors and clients are seen as "red-flags," evidence of poor boundaries, and unprofessional conduct.

Pathologizing the victim establishes the need for the counsellor to be careful with and around her, to avoid or ameliorate the risks she poses. Along with the risk of becoming vicariously traumatized, the counsellors avoided being labelled or seen as "damaged goods" alongside their clients. In a recent training of new sexual assault volunteers in the program from which I drew my participants, volunteers were told that they "could not be friends with clients," even if they seemed to have a lot in common or in another time and place they could have really gotten along. Though many women come to this agency for support, my analysis suggests that they are isolated and segregated from each other. Talking to other women has a therapeutic rather than a political function and relationships between women in this context are saturated with

threat and risk. Participants talked about the reduction of trauma symptoms as the goal of their work; the social justice goal of abolishing violence was not spoken of – something that is now common to sexual assault services (Burstow, 2003; CASAC, 2008; Mardorossian, 2002).

Feminist Services: What Needs to Happen Next?

This thesis presents an argument and exploration into how sexual assault programs and workers are active and complicit agents in the movement from feminist to professional, from activism to pathologization. The counsellors felt that the program had come a long way due to its increased cooperation with police and medical systems, as well as its accessibility to victims of rape and sexual assault. Sadly, the feminist history and goals of social action and abolition, versus servicing the impacts, of male violence were not known by the counsellors I interviewed. This history has virtually disappeared from the official discourse of the agency, effectively erased by the proliferation of dominant discourses of pathology and risk. But I would suggest within this feminist discourse and historical context, we could not state, "we have come a long way."

Can feminist goals be attained if we continue to appropriate and use trauma and secondary trauma discourses in sexual assault programs, or other places where men's violence against women is serviced? Even if feminist in intention, therapy is bound within a system that perpetuates the isolation, depoliticization, pathologization, and normalization of violence against women. Within the institutions of our dominant healthcare system, such as the program that I work for, I must ask myself how I am ultimately contributing to silencing women in their experiences and revictimizing them

with the language that I use. In short, feminist agencies or agencies interested in helping women that profess to work for and with women, may not be doing all that they need and are responsible to do. A goal of feminist agencies must be to return to (or continue) activities designed to abolish violence against women. Deconstructing and challenging dominant discourses are important pieces of this work.

Each one of us is responsible to pursue awareness beyond what we have learned though dominant phallocentric discourses that are most accessible in our Euro-Western society. With awareness comes the need to choose. We must remember that choice is inevitable and inbuilt. Even when we do not act, under the guise or pretence of *not choosing* or *not deciding*—remaining "neutral" or "objective"—we have indeed *chosen* and we are inevitably *acting*. Our silence and inaction is voice and action, in this case, for the continued societal/systemic oppression of women.

Becoming aware and the pursuit of awareness require personally giving validity, value, and legitimacy to other truths and stories. Awareness comes through education, asking questions and being willing and wanting to learn, allowing for response. This includes seeking evaluation outside of ourselves and our comfort. Questioning everything needs to become our goal as individuals. For example, we must ask what informs the stories that we hear? What are the values that underlie the language, information, and action occurring around us? Who is (and is not) benefiting from the language, information, and action? How does this language, information, and action affect people in different social locations, such as (trans)gender, sexual orientation, ethnicity, religion, age, ability, income? We must take into account that oppression exists, and in response we must actively give value and legitimacy to the languages, the truths, the locations that

are often silenced, delegitimized, and othered (Ristock, 2002). Questioning everything aids us in pursuit of unmasking oppression and its tools/mechanisms.

Not only are we responsible to become aware, pursue, and value other power/knowledge, truths, and language, we must *choose* with our awareness of other truths to *act*.

With awareness, or consciousness, comes choice (Gavey, 1989, talks further about choice). What will we do with our knowledge, with women's stories of violence, with a society that blames the victim and values and prioritizes discourse that masks and maintains woman oppressing power relations? We *will* be made uncomfortable through challenge to dominant discourse. We will be resisted, resented, labelled, disliked, and even hated. Phyllis Chesler (1972) discusses the double jeopardy that women are in, overly conforming to the socially prescribed role for women and veering from it. To challenge the language, knowledge/power, is threatening to everyone—both men and women—as it challenges our very identities. However, as we deploy these dominant phallocentric discourses, we are uncomfortable as well. The subjectivities available to women within dominant discourse leave us segregated from others and ourselves, unsafe, isolated, pathologized, and unvalued.

As women we need to be active and build community. We must challenge and resist the dividing practices of the phallocentric, professional, trauma discourses. Haaken states that "for women to speak up about their own oppression, to refuse to continue to serve as guardians of fathers' and husbands' secrets, requires courage and solidarity" (1999, p. 17). Our focus as sexual assault counsellors should be on supporting and

irrevocably constructing a safe place and a home (solidarity) from which women can stand up (and out) to name their abusers.

As counsellors and social workers, we need to keep societal context and condition in our view. It is easy, especially within the current hegemonic medical and 'psy' discursive context, to focus only on the client and the popular notion of and direction for *self-care*. At a conference on compassion that I attended a few years ago, I remember this comment about the limitations of self-care and, rather, the need for compassion, love, and community. This comment was made by one of the presenters, forgive me that I do not recall who said it, but it went something like this (if you have insight into who it may have been, please let me know, however, due to its strong message I will place it here as I jotted it down years ago):

> The raped woman cares for herself the way that she has *learned*—the way she knows. Her self is a construction by society; in which she is 'worthless,' 'object,' 'fuckable,' 'care*giver*.' Then, how can she care for her self on her own. As women, we cannot be left to care for ourselves due to our constructed subjectivities in this patriarchal society, because left alone we can only care for our selves as we are allowed, depending on our subjectivities, power relations, truths, discourses. We "love" ourselves and care for ourselves only as far as we know how.

By speaking, listening to other women, naming the perpetrators, honouring strength and survival instead of pathologizing the impacts of violence on the woman (cognitive, emotional, physical, and spiritual), perhaps we can begin to change what is dominant discourse, that discipline, punish, and pathologize her/us.

How can we *change* the language that we use and operate within *other* discourse? We must always name the offence—rape, violent man, rapist, violence. We must use his name and name the violence, rather than the trauma. We must constantly be mindful of linking the consequences that the woman is experiencing back to the violence done and

violators who choose to harm, within a patriarchal, male-centred, society. We must speak our stories and support other women to tell their stories, standing with them, both at the office and outside the office. We must actively remove and fight against the gag of shame and blame placed on women by a liberal individualistic patriarchal society, honouring versus pathologizing her survival.

Our therapy and social work practice must look different as well, in order to improve the lives of women, children, and men, as we challenge oppression. As Brown (1991, p. 131) questions and challenges:

> How, rather than desensitizing survivors to symptom triggers, a currently fashionable approach to the treatment of post-traumatic symptom, can we help them to reconstruct their world-views with the knowledge that evil can and does happen? Rather than teaching trauma [rape and sexual assault] survivors ways to attain their pre-trauma [pre-raped] levels of denial numbness, how can we facilitate their integration of their painful new knowledge into a new ethic of compassion, feeling with, struggling with the web of life with which they relate? How can those of us who do the work of therapy with survivors become, not traumatized by our exposure to these stories of pain, but heightened in our sensitivity, exquisitely aware of how life needs to be fine-tuned, moved to be the changer and the changed?

Burstow (2003) states that we must reject psychiatry, with its diagnoses and fixations on symptoms and pathology that act to objectify and locate women as ill. Instead of focusing on symptoms and trauma, we must validate and honour the survival responses of women who have experienced rape and violence. Instead of labelling world views as traumatic, cynical, and inappropriate, acknowledge that it may be more accurate and realistic, especially if our societal practices of male-domination (e.g., rape, pornography, mainstream media) go unchanged.

The foundational practices of feminist therapy must be re-centred, including development of *feminist consciousness* and viewing therapy not simply as a professional

healing relationship between individuals, but an experience that potentiates social transformation (Brown, 2004). The relationship between individuals within feminist (and other anti-oppressive social work practices) must strive to be egalitarian, reflexive, and empowering.

With this alternative approach to doing therapy and working with women who have been raped or sexually assaulted, we also shift our women subjectivities, opportunity of relationship, community building, and will ultimately impact what constitutes vicarious trauma. This is due that we can make impacts beyond the therapy room, we no longer are simply treating symptoms, that mask violence; we no longer are the holding tanks for the wreckage of sexual violence against women.

I have felt at times that the work that I do with women, one-on-one, who have experienced violence, is not getting at the real issue. I wonder whether I am spending too much of my time at the individual level and should spend more, if not all, of my time focused on challenging the systems levels. However, I believe that the impacts of violence are real, they are occurring everyday, and I need to do both jobs. Challenging the discourse starts with and is important at all levels, with each man and woman that I come into contact with, and those who I help to support and counsel. This—one person, one challenge, one story/testimony, question, critique, at a time—is where I find my community. This is how we build community, because for this battle against oppression, we require "courage and solidarity" (Haaken, 1999, p. 17).

Sasha Roseneil (1995) discusses the need for "liberatory spaces," which "provide opportunities for women to actively rethink and (re)construct ways of understanding their world and sense of themselves" (p. 91). It is important to ask ourselves as feminists,

social workers, therapists, counsellors, and advocates: Do we have these liberatory spaces in our institutions?

Profitt (2000a) succinctly and powerfully gives direction to those working with survivors of violence and abuse. She outlines what to be sensitive to in the process of change, from awareness to action.

> Feminist social work theory and practice with survivors must therefore take into account a number of elements in the change process. First, they must recognize the multifaceted and difficult nature of women's journey in recognizing and naming abuse, making sense of their experiences, and acting on this knowledge to work for change. Second, they need to attend to the social, material, and psychic costs that women face in undertaking personal and social change. Third, they must acknowledge the discursive and material conditions that facilitate women's movement to activism. (Profitt, 2000a, p. 81)

One of feminism's goals is women's empowerment. Cowger (1994) talks about the need to promote social empowerment and argues that client definitions and characteristics cannot be separated from their context and that personal empowerment is related to opportunity (Falck, 1988). Therefore, we as women, and non-complacent men, need to act towards achieving social empowerment.

Assessment and Evaluation of this Research

Implications and Results of this Project

Strega (2005) has outlined an assessment framework (see Chapter 2) for doing for doing critical research, which I use in my conclusion to assess the political implications and usefulness of this project..

To begin, my feminist poststructural analysis of the discourses imbedded in the secondary trauma literature commences the deconstruction of the masks that hide

women's oppression. This epistemological dissection of secondary trauma contributes to the accessibility of *other* truths, language, power/knowledge. Therefore, when a gender and anti-oppression lens is applied to the academic and service systems, these alternative truths, language, power/knowledge can begin to challenge the dominant phallocentric discourses. This research poses questions and promotes awareness by unmasking the dominant discourses and their intent that make up this social service discipline. In this study, I have argued that through the informing and legitimized text and language society has made women's pathology a social problem (manifested as PTSD, vicarious trauma, secondary trauma, compassion fatigue) instead of violence against women.

To make the findings available, I intend to participate in conferences, take opportunities to speak with, write to, and challenge the service systems working with women who have experienced violence. Because the perspective from which I speak of vicarious trauma and secondary trauma is in conflict with the dominant literature and study, I anticipate resistance and challenge. It is my responsibility to take opportunities to speak my perspective and challenge the oppressing dominant discourses. Through discussion and sharing what I have learned, and am learning, with my clients, co-workers, colleagues, family and friends, I live my work and my passion for abolishing violence against women. Simultaneously, however, in living and speaking my work I find community.

Directions for Future Research

This project initiates a very necessary critique on dominant discourse embedded within secondary trauma and examines how it constructs women's oppression. In future studies, the experiences of more frontline workers, as well as service users, and management

personnel need to be considered and examined using some or all of the themes and discourses outlined in my analysis of the research and literature of secondary trauma. We need further and more extensive analysis of what, and how, discourses are in operation in our social services, and we need to study what impact these discourses have.

My feminist poststructural discourse analysis of the secondary trauma text introduces a unique awareness of language, one which challenges current power/knowledge. My intention throughout this research process has been to place responsibility back on society for the endemic oppression of women. The text of secondary trauma too often negates the offence and violence, and critical research must begin to name the perpetrator, politicize, and gender the issue of women's oppression. As individuals with the goal of abolishing violence against women and women's oppression, we need to change our language, and thus, challenge the existing power/knowledge and dominant discourses.

We now have a sample of the dominant phallocentric themes and discourses imbedded in the literature and research of secondary trauma, and points of resistance. My hope is that further research can focus on talking to more members of the community. For example, there is a need to undertake critical discourse analysis with people working in other social services, those impacted by the service system, the victims, and the ones making policy and management decisions. This research needs to be expanded, branching into all areas of social servicing including domestic violence and child abuse. The research must stay focused on the purpose of placing responsibility for women's oppression and experience of violence on the perpetrators and society. I believe that we

do this by changing the language and available truths by which we learn about and construct our experiences.

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APPENDIX A: Ethics Approval

APPROVAL CERTIFICATE

18 January 2007

TO: **Raegan Plett** (Advisor K. Clare)
Principal Investigator

FROM: **Bruce Tefft, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2006:100**
"Feminist Poststructural Discourse Analysis: A Closer Look at Vicarious Trauma"

Please be advised that your above-referenced protocol, as revised, has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval has been issued based on your agreement with the change(s) to your original protocol required by the PSREB. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

APPENDIX B: **Call for Participants**

Hi, my name is Raegan Plett; I work at Klinic in the Sexual Assault Crisis Program as a sexual assault counselor, both as a volunteer and a casual worker. I am currently working on my Master's of Social Work at the University of Manitoba. I am working on my thesis, which explores the effects of working with women who have been sexually assaulted. I am interested in hearing the stories of women, such as yourself, who do this work. I am looking for volunteers to participate in my study, which includes participating in a conversational-style interview with me, and possibly a follow-up interview (each interview will be approximately 1 ½ hours).

I am interested in your experiences and stories of working with women who have been sexually assaulted, including the effects of doing this work.

If you:

-Have been working with women who have experienced sexual assault for six months or more,

and

-Have been the counselor for women who have experienced sexual assault in the sexual assault counselling program (seen clients).

If you are interested, please contact me , or email me ... . All correspondence is confidential, no personal or identifying information will be released in the process of the interview, thesis writing, or presentation. Collaboration with you, as the participant, is my primary goal, so if you have any questions or concerns, please feel free to contact me at any time (at the above number or address). Participation is completely voluntary and declining to participate will have no negative consequences, including that you can choose to drop out of the study at anytime without penalty.

Thank you for your consideration and time.

Raegan E. Plett

Advising Professor:
Kim Clare
Director
Inner City Social Work Program

APPENDIX C: Interview Guide

Thank you for your willingness to participate in this interview. I am going to ask you questions about your experience working with women who have experienced sexual assault. There are no right or wrong answers; I am interested in your story, and your experience. If you have any questions or concerns, please stop me at any time throughout the interview.

Your work:
-What is your role in working with women who have experienced sexual assault?
-Tell me about your experience doing this work?
-Why did you choose to work with women who have been sexually assaulted?
-What does this work mean to you?
-What are some of the effects in your life through working with women who have been sexually assaulted?
-Why do you think you have experienced these effects?
-Where and how have you learned about these effects?
-How do you experience them impacting your life?
-And what, if anything, do you do to avoid or improve them?
-What are your beliefs/assumptions about the impact of sexual assault in women's lives?
-Do you feel differently now then you did when you started doing this work? How?
-How has your view of sexual assault changed since you started working in this area?
-What do you need to, or do you think would be helpful, to help you manage the effects of working with women who have been sexually assaulted?
-What do you feel should be done to help people who work in trauma, deal with the effects of doing this work?

People:
-What does it mean for you to do this work? With clients? With other volunteers/staff? How do you view you relationship with your clients?
-What is your client's experience of the work, your relationship?
-How are you instructed to relate to clients?
-What is (in)appropriate for your work? Are you supported in your work?
-How could this work be done differently?

Trauma and vicarious/secondary trauma:
-What is trauma? What is vicarious trauma? What do you think causes vicarious trauma? Why do some people become vicariously traumatized sooner than others?
-Have you heard of the term vicarious trauma? How would you define it? How did you learn about vicarious trauma? What does it mean to you?
-Have you experienced vicarious trauma?
    -Why do you think you have experienced it?
    -What is the cause of your experience?
    -Why do you think you experienced these effects?
-Do you think that vicarious trauma may be linked to violence against women? How?

-Do you feel that sexual assault is being dealt with well in our society? Through the programs/services (like this agency)? The medical system (hospital)? The judicial system (police, courts)?

-What do you think is society's view on violence against women? How does that differ from your own perspective of violence against women?
-What advice would you give women who are trying to decide whether, or are just beginning, to work with women who have been sexually assaulted?

1) **How would you describe yourself?**
2) **How would you describe your age? Race? Social class?**
3) **Who are you? How did you come to do this work? Are you a feminist? How do you define this?**
   -Do you identify yourself as a feminist? What does that mean to you?
4) **How long have you been working with women who have experienced sexual assault?**
5) **Are you currently working anywhere outside of the agency? What kind of work do you do? Can you tell me about your education?**

Thank you for your participation in this interview. Do you have any questions for me, or any concerns that you would like to discuss? Please feel free to contact me anytime, if anything else comes up for you. My phone number and e-mail address are on your copy of the consent form. Thank you, again.

APPENDIX D: **Consent Form**

Project Title: The effects of working with women who have experienced sexual assault

Researcher: Raegan E. Plett (B.A. Hons.)
Masters of Social Work Student

Research Supervisor: Kim Clare
Director of Inner City Social Work Program (UofM)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I, _____, agree to participate in this research project on the effects of working with women who have experienced sexual assault. This research is being conducted by Raegan Plett as part of the requirement for the Masters of Social Work degree at the University of Manitoba. Participating in this project will give me the opportunity to share my experiences and stories of working with women who have been sexually assaulted. The information gained through this research will contribute to the understanding of the experience of sexual assault workers, and specifically the issue of vicarious trauma. My participation in this study is completely voluntary and I can, at anytime, decline to participate without any negative consequences.

I agree to be interviewed regarding my experiences and understand that the interview will be audio taped. I understand that Raegan Plett will solely conduct the interview, and that a follow-up interview may be requested, each interview no longer than 2 hours. I understand that all notes and records of the interviews will not contain information that would identify me and that this material will be stored in Raegan's home office in a locked filing cabinet until the defense of her thesis. Raegan is the only person who will have access to the interview and contact information. The tapes, all the data, and all identifying information will be destroyed at the time of thesis acceptance, expected September, 2007. However, due to my position within the agency (either as a volunteer or a staff member), I understand that my participation in this interview may be known of to others. I understand that all measures will be taken to preserve my identity throughout the interview process, the analysis, and the writing of the research.

I understand that my participation is voluntary and that I am free to withdraw or ask for a break at any time. I understand that I do not have to answer any question that I do not want to. I have been told that the interviews may result in some emotional distress as I will be asked to talk about my work with women who have experienced sexual assault. I have been informed that a feedback and follow-up session will take place directly

following the interview. I understand that this will be an opportunity for debriefing that is not part of the interview and will not be recorded. My participation is completely voluntary and I can choose not to participate without any negative consequences at anytime.

I understand that when completed, the research will be compiled in a thesis report and may be presented to professional audiences and may be written about in professional journals. I was informed that the information gathered in the interviews will contribute to these reports, and that all names and identifying information will be omitted from the presentation of the analysis. I have been told that all efforts will be made to conceal the identities of all the participants. I understand that I will be sent a summary of the research results, that I will have access to the full thesis, and that I will receive an invitation to the oral presentation of the research. This information will be provided for me through the contact information that I provide following the interview.

My signature on this form indicates that I have understood to my satisfaction the information regarding participation in the study and agree to participate. In no way does this waive my legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. I am free to withdraw from the study at any time, and/or refrain from answering any questions I prefer to omit, without prejudice or consequence. My continued participation should be as informed as my initial consent, so I can feel free to ask for clarification or new information throughout my participation. Any questions or concerns may be directed to Raegan Plett or her advisor Kim Clare during or following the interview(s).

This research has been approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba. If I have any concerns or complaints about this project I may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to me to keep for my records and reference.

_____

Participant's Signature Date

_____

Researcher's Signature Date

Contact information to receive updates on the research, summary of findings, and notifications of date and time of oral presentation of research (e.g., e-mail and/or phone):

_____

APPENDIX E: **Support Numbers**

Project Title: The effects of working with women who have experienced sexual assault
Researcher: Raegan E. Plett (B.A. Hons.)
Masters of Social Work Student

Research Supervisor: Kim Clare
Director of Inner Citv Social Work Program (UofM)

Talking about your experiences working with women who have experienced sexual assault may trigger unexpected feelings. In case you experience any feelings of discomfort, stress, or aversive emotions following your participation in this study, emotional support can be found from:

24-Hour Crisis/Suicide Line.....786-8686
Toll Free.....1-888-322-3019
The Laurel Centre Inc.....783-5460
Elizabeth Hill Counselling Centre.....956-6560
Fort Garry Women's Resource Centre.....475-9127
Pamela Jackson (private therapist).....

As well, if you have any questions or feedback regarding your interview or the study, please feel free to contact Raegan or the research supervisor, Kim Clare.