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Trauma Talk In Feminist Clinical Practice

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Chapter Seven

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> Both client and therapist use their skills as novelists as well as historians or detectives as they labor to get a story to work right and to feel right. . . . The therapist as historian, humbled by the new understanding that any account of a client's life . . . is but one of a hundred possible versions, . . . collaborates with the eyewitness.
>
> (Baur 1995)

> I'm haunted by the questions I didn't ask in the late '70s where I now know that those were women who were sexually abused as kids.
>
> (Therapist #159)

Male violence against women—rape, battering, and childhood sexual abuse—has been a major focus of the second wave of feminism. From the early 1970s onward, feminists initiated shelters and crisis services for victims, advocated for changes in legal and criminal justice institutions, and spearheaded scholarly research and theory. As women voiced what had gone unsaid, a new lexicon for speaking about the sexual and physical violation of women, along with a narrative framework for explaining women's problems, developed. This lexicon circulates freely not only among feminists but also in the mental health professions and the mass media. I call this lexicon *trauma talk*. To say that trauma talk is a set of linguistic practices for narrating a woman's problems is not to question whether abuse occurred. Nor is it to deny victims' suffering. Instead, trauma talk refers to the system of terms, metaphors, and

modes of representation for talking about the physical and sexual abuse of women.

In this chapter, I listen to the words of some forty feminist therapists. How, I ask, does trauma talk enter the everyday work of these therapists? Which meanings of experience does trauma talk bring to light? Which ones does it submerge? Descriptions are never just descriptions; they are also explanations. How does trauma talk shape therapists' understandings of their clients' lives and of therapy itself? What narratives about women, therapy, and feminism are possible when trauma talk is the medium for telling them?

The form of my questions intimates my approach, that of a social constructionist. For social constructionists, language is not a transparent medium through which reality can be seen; rather, language creates the reality of which we speak. Language practices shape what we can see and think. Moreover, language is not a vehicle for expressing private thoughts formulated inside a speaker's head; it is a social practice. Trauma, with all its attributes and associations, exists by virtue of cultural agreements to package it in this particular way. As Jonathan Potter (1996, p. 126) has said, "The terms and forms by which we achieve an understanding of the world and ourselves are . . . products of historically and culturally situated interchanges among people." These terms and forms—variously called "discourses," "interpretative repertoires," or "consensual discursive practices"—are systems of meanings so habitual and so familiar that they are taken for granted, if not invisible. In the interviews I analyze below, trauma was a central theme, even though not a single interview question asked about it. Moreover, although we did not recruit therapists who worked with trauma, over 70 percent of the respondents identified sexual or physical abuse of women as one of their clinical specialties.

Interviews

In spring and summer of 1996, Diane Kravetz and I, with the help of student interviewers, gathered a set of interviews with feminist therapists. The therapists were recruited from a variety of work sites, including state and private agencies, solo and group private practices, and college counseling centers. All were from the state of Wisconsin; most were located near the university town of Madison. We located our respondents by a variety of means, including peer nomination, utilizing the work and friendship net-

works of the student interviewers, and inquiring at agencies specializing in therapy for women.

Potential participants were contacted initially by telephone. This contact served both as an invitation to participate in the study and as a screening interview. In the screening interview, therapists were asked if they considered themselves to be feminists and if they brought a feminist perspective to therapy. In accord with long-standing custom in such research, we let potential participants define *feminism* for themselves. As Shulamit Reinharz (1992) has pointed out, feminism takes so many forms that it is impossible to impose a single definition on it.

Advanced social work graduate students carried out the interviews as part of a class on qualitative research methods.[1] Interviews lasted between ninety minutes and two hours; they consisted of nineteen open-ended questions about feminism in therapy, with probes for specific incidents and case examples. None of the questions concerned abuse, trauma, post-traumatic stress disorder (PTSD), and the like. All interviews were conducted in private; they were recorded on audiotape with the therapist's permission. Therapists' names were not given on the tapes, and all other names were removed from the transcripts, except for references to theorists, authors of books and articles, professional lecturers, and the like. Respondents indicated if they were willing to have verbatim quotations published and how much descriptive information could be attached to a quoted remark. Only one therapist did not give permission to publish verbatim material; her tape was erased.

We have transcribed the interviews of forty-four therapists to date, proceeding as funds allow. All were currently working; clinical work was their primary or sole paid occupation. Only those respondents who had some advanced training (i.e., beyond the bachelor's degree) in a mental health profession were kept in the sample. As a group, the respondents represent different schools of therapy, different professional backgrounds, different personal backgrounds, and different levels of training. All but two are women. Their ages range from thirty-one to fifty-seven. Eight identified themselves as lesbians, two as bisexual. All but three are white. All are experienced, with an average of nearly fifteen years in practice (range = five to twenty-eight years). Three are psychiatrists, twenty-eight are psychologists (seventeen with doctorates and eleven with master's degrees), and thirteen are social workers.

The interviews were transcribed verbatim. The transcripts were punctuated and paragraphed first by the transcribers and then by me, using

our best judgment as to the intended meaning. The raw transcripts contain many sentence fragments, false starts, and digressions. The extracts presented below are not the verbatim transcriptions; in the interests of brevity and ease of reading, the dysfluencies and digressions have been edited out.

Analysis

Discourse analysis is a family of approaches to working with language. Discourse analytic approaches all focus on language and the way in which meanings are made. This form of analysis is different from customary academic reading practices, in which one reads quickly to get the gist of a passage. A discourse analyst attends to the details of the talk, to the process—the twists and turns of language—by which meanings get made. Clinicians who work in interpretive modes of therapy may see a resemblance to therapeutic listening processes. It is true that the mode of listening (or reading) is similar, but there is a key difference. In discourse analysis, the goal is not to infer mental states, defensive operations, or inner thoughts and beliefs but to identify the repertory of concepts and categories, the systems of statements, and the narrative frameworks that speakers rely on to make themselves intelligible.

I used two main strategies to help me see the practices that trauma talk entails. The first involved examining and contrasting the dominant and marginal discourses in the interviews. Dominant discourses are the ones that are granted the status of truth, the agreed-upon frameworks of language and meaning. Marginal discourses, in contrast, are counterhegemonic; they refuse or challenge received wisdom. Only a few therapists ventured such thoughts; they often spoke hesitantly or with trepidation. In our interviews, for example, respondents prefaced such statements with phrases such as "Most feminists might not agree" or "You'll probably be surprised by this" or "I guess I'm not what you call a politically correct feminist." In one instance, a respondent broke off abruptly in mid-sentence and asked nervously, "You said you're not going to use any names, right?" In my interpretive analysis, I focus on the points of contradiction, tension, and paradox inside the dominant discourses and between the dominant and marginal discourses.

My second interpretive strategy focuses on dichotomies, especially those related to gender. This strategy draws loosely on feminist deconstructive lit-

erary analysis and the ideas of Jacques Derrida. In Derrida's linguistic philosophy, words do not have single, immutable meanings; instead, they take their meanings from the systems of oppositions in which they are embedded (Hare-Mustin and Marecek 1990). In trauma talk, the dichotomy male–female is aligned with a set of other dichotomies, such as predator–victim and innocent–evil. I trace how this system of gendered oppositions produces the gendered identities of the respondents, their clients, and men who abuse women, as well as the meanings it lends to feminism and feminist therapy.

Trauma Talk in the Office

I use the term *trauma talk* to refer to a widely shared lexicon for speaking about the problems women bring to therapy. Trauma talk includes a particular vocabulary of distress, consisting of terms such as *trauma*, *wound*, *injury*, *emotional pain*, *brokenness*, and *damage*, to describe clients' problems. It supplies a diagnostic category for these experiences: post-traumatic stress disorder, or PTSD. It invokes highly charged language for men who have engaged in abusive behavior—*abusers*, *predators*, *perpetrators* (or *perps*), *batterers*—that unambiguously brands them as morally reprehensible. It figures therapy as a process of healing or recovery. Not all our respondents used every idiom of trauma talk, but few eschewed trauma talk entirely. Trauma talk produces new meanings of assessment, diagnosis, therapy, and feminism in therapy. In what follows, I examine these meanings.

For many respondents, trauma talk served as a rhetorical resource for voicing their objections, as feminists, to conventional diagnoses and the medical model.[2] Many saw diagnostic categories (except for PTSD) as stigmatizing and pathologizing "normal" women. Others saw labeling a woman as scapegoating, blaming the victim for the maltreatment she has suffered. For others, imposing any label (again, except PTSD) was an abuse of the therapist's power.

> There's lots of women who get labeled as borderline who have those characteristics but it comes out of twenty years of being beaten by their husbands or a severe incest. If you treat that as borderline personality disorder versus PTSD, [laughs] you get really different outcomes. . . . There's a continuum of sexual violence, and most women have experienced some amount by the time they're eighteen, and so I recognize that, and I recognize how it con-

> stricts their lives that way, in terms of how they have to keep themselves safe, that may be what, that is the case in most inner cities or Detroit or South Chicago. . . . If we hadn't taken that step, we would have just said, "Oh, borderline personality." (Therapist #67)

> The whole category of borderline personality sort of bothers me—it's very much blaming the victim or blaming the individual for what would be a real normal response to a lot of the situations they've been in. (Therapist #123)

> Almost all my clients have PTSD and I tell them what it means. I say, "This means you are having a normal reaction to trauma. You're not having a sick reaction to trauma. You're having a normal reaction to trauma." The reason I like PTSD as a diagnosis and I'm glad it's there is that it says right in the definition that this is a normal response to trauma that most people would have. (Therapist #121)

In sum, trauma talk in the interviews positioned women clients as the victims of catastrophic events that are undeserved and beyond their control. It insisted that, whatever problems bring such women to therapy, the women are normal. Trauma talk thus affirms a number of core tenets of feminist therapy (Ballou and Hill 1998; Wyche and Rice 1997). It takes an unequivocal stand that women are not responsible for male violence; it insists that oppressive social and cultural circumstances are causes of women's distress; and it seeks to empower women, bolstering their confidence and self-esteem.

In some ways, however, trauma talk runs the risk of constructing women exclusively as objects of oppression. It did not stop with exculpating women from responsibility for male abuse but went further to exonerate them from responsibility for the effects of abuse on their lives. A counterdiscourse emerged in a few interviews, suggesting that trauma talk, by positioning women as victims, can rob them of responsibility and agency. As one therapist put it:

> I do think in spite of being victimized by husbands and society and all of that, women bring their own problems and their own difficulties to the situation and need help with that. Sometimes just saying, "OK, you've been victimized by this abusive guy. That's all that's wrong; you don't have to look at anything else; it just isn't helpful." (Therapist #20)

For another therapist, a clinical psychologist with ten years of experience as feminist therapist, giving a PTSD (or any) diagnosis deflected attention from the work of therapy:

> I would much rather talk about . . . how in context with me or with other people is this person. How fulfilling is their life? What are their goals? What are they hoping for? Where do they get blocked? What are the old patterns of thought that keep them locked in a behavior, locked in a certain position? Where are they stuck? That is much more interesting to me than what their diagnosis is. Much more interesting! And I think much more productive. And it may come out in the diagnosis in part; but somewhere in those descriptions and diagnoses . . . they seem like they're patterns in and of themselves. They don't lead to logical things that you could do. . . . "Oh! So this person has Post-Traumatic Stress Disorder." It's much more interesting to say, well, every time they try to do their creative writing, they run up against this wall of "No, you can't get enough" and all those patterned ways of thinking. That to me is much more interesting. . . . What's the key to unlock that? What's the key to changing it? Rather than "Oh, yeah, you've got Post-Traumatic Stress Disorder." (Therapist #205)

Trauma Talk and the Medical Model: Against or Within?

Many respondents voiced further objections to what they termed the *medical model*. They rejected the authority of experts to judge and label women. They opposed psychological or psychobiological explanations for problems created by oppressive life circumstances. They regarded medicalized mental health care as de-humanizing and anti-feminist.

> Like the medical model is very nonfeminist, where the doctor is the expert. . . . So, there are some essential things about the medical model that put power in the hands of the expert. The other thing it does is pathologizes the individual. Often in an abusive or a negative situation, it used to penalize the woman. There was something wrong with the woman that she couldn't live in that abusive situation, as opposed to saying the context is crazy. So, there's that stigmatizing or scapegoating the individual for having the problem. (Therapist #158)

> The HMOs and the medical model go against the very essence of, certainly, feminist therapy, as I define it, but therapy in general. The humanness, the nurturing, the support, those things. (Therapist #69)

In sum, respondents extolled the trauma model as not only opposite to the medical model but far superior. When we probe trauma talk in close detail, however, what had looked like clear differences between the two evaporate; many of the grounds for superiority disappear before our eyes. I

begin by noting that the trauma lexicon describes clients' problems using medical and bodily metaphors: trauma, injury, insult, wound, brokenness, and pain. It also frames the action of therapy in medical metaphors: relieving pain, facilitating recovery, setting "healing processes" in motion. Some respondents, such as Therapist #106, figured the effects of trauma as bodily experiences. Blurring the distinction between emotional pain and physical pain, she recommended the same pain control techniques for both:

> A lot of people who've been through trauma, it's emotional pain instead of physical pain. . . . [A lengthy description of pain control techniques developed by Jon Kabat-Zinn ensues.] He's teaching mindfulness meditation and a form of yoga. . . . A lot of these people have back problems, neck problems, multiple injuries, surgeries, chronic pain. . . . I think this technique has implications for trauma people.

Ironically, trauma talk, far from countering the medicalized idiom of conventional psychiatry, has merely replaced one form of this idiom with another.

What is accomplished by this linguistic blurring of emotional and physical pain and the representation of women's suffering as (metaphorically and even literally) bodily pain? Feminists may couch the suffering of women in physical rather than emotional terms because physical suffering seems more real and therefore harder to dismiss. It is also true that biomedical practitioners and theories hold the highest status in the mental health field. Feminist therapists—who are, after all, part of that field—may consciously or unconsciously model their discourse on the privileged one.

It is not only at the level of vocabulary that respondents' trauma talk mirrored the conventional, medicalized model of psychopathology. Trauma talk operates within much the same logic as that model. It subsumes the particularities of a woman's experience into abstractions (e.g., "trauma," "abuse") and reduces experience into discrete, encapsulated symptoms (flashbacks; revictimization). It offers cause-and-effect explanations that are linear, mechanistic, and mono-causal. It sets aside a client's understanding of her own experience in favor of a uniform narrative: a single cause reliably (even invariably) produces a fixed set of symptoms. Furthermore, the goal of therapy is to produce healing. In trauma talk, both the verb *to heal* and the noun *healing* are in passive voice. Thus, clients "heal from" abusive relationships; women "do their healing" in therapy. This language practice implies a process that unfolds without an active agent. It risks transforming clients to patients, that is, those who wait passively while processes of repair and restoration take their course.

The respondents who were enthusiasts of EMDR (eye movement desensitization and reprocessing; Shapiro 1995) produced the most extreme examples of reinscribing trauma within a medicalized framework.[3] Locating PTSD in the brain, they narrowed their sights to trauma memories, which they construed in pseudo-neurological terms. Their descriptions of the EMDR procedure, which involves rapid eye movements and visualization of traumatic events, constituted highly mechanistic models of trauma and its treatment. The effects of the procedure were described as instantaneous, dissipating troubling emotions and magically restoring the victim to her or his (or its: one therapist claimed to use the procedure successfully on her cat) "healthy" self.

> She was abused sexually and physically by her father, and then her husband, her ex-husband, actually her two ex-husbands. And [I] help[ed] her in many different ways, using EMDR, using visualization to remember what she used to be like, and kind of allowing herself, or helping her become that person again. (Therapist #133)

> I'm going to throw my pitch in here because I think it's absolutely wonderful. . . . In the last two years I have learned about EMDR, which is Eye Movement Desensitization Reprocessing. It's trauma recovery. . . . It's a procedure that . . . actually helps your brain kind of reshuffle the deck. So you walk away from an EMDR session where the trauma feels like it happened in the past. And why I think that's so important as a feminist therapist is that the goal of feminist therapy is to work yourself out of a job. You're trying to get people to not be in your office for ten years. You want people to be able to do their healing and it's just phenomenal how it's stepped up the pace of healing. (Therapist #95)

> What happens during the EMDR therapy is that we process the abuse, all the different abuse they've experienced, and essentially it's just a sense of being able to deal with the situation, to access their adult coping mechanisms and skills. They may still remember the abuse, but it doesn't affect them as much emotionally any longer. So it's basically healing from old experiences. (Therapist #41)

It is deeply ironic that EMDR, which seems a caricature of the medical model, could be construed as its antithesis. The EMDR procedures are couched in mystifying mumbo jumbo. The therapist administers the procedure to a client who passively awaits the obscure processes of brain rearrangement to take place. EMDR promises instantaneous cure through a focalized, formulaic treatment. Indeed, in all these respects, EMDR serves up precisely the standardized quick fix that managed care demands; more-

over, clients in EMDR are constructed as exactly the docile selves that managed care requires (Guilford 1996).

Several respondents favored the diagnostic category PTSD because it embeds the idea that the woman to whom it is applied is normal. This is a paradox that warrants further examination. We need to consider some features of the medical model of psychopathology on which diagnostic categorization is based. One feature of the medical model is that it is a discrete model, rather than a continuous one, with "normal" and "abnormal" regarded as qualitatively different states (Siegler and Osmond 1974). Moreover, the term *normal* has multiple meanings when applied to psychological conditions. It can mean "average," that is, lying within a statistical range of the mean—for example, normal height or normal blood sugar. It can also mean normal according to an absolute criterion. It can also mean "not deviant." This often boils down to whether or not the speaker approves of the behavior in question, for example, "People who pierce their eyelids aren't normal."

In trauma talk, the diagnostic category PTSD slides between different meanings of "normal." It asserts that a woman is normal even though she face difficulties severe enough to warrant psychiatric diagnosis and problematic enough that she seeks treatment. Here it seems as if the third meaning of *normal* is the relevant one. Therapists use the label "normal" to reassure clients of their approval, to relieve their shame.

Clinically speaking, one can question whether such preemptive reassurances are helpful. They seem to contradict a client's felt experience or, at the least, fail to understand it. It seems contradictory that feminist therapists, for whom (as we shall see later) empathy is a key therapeutic process, would assert their view of a client's state of being over the client's own. Moreover, such reassurances foreclose opportunities for clients to explore and resolve issues of shame.

For our respondents, the linguistic practice of declaring women with PTSD "normal" achieved an additional clinical aim. As feminists, they strove for therapy relationships that were collaborative, egalitarian, and nonauthoritarian (Wyche and Rice 1997). They objected to diagnostic labels as disempowering, stigmatizing, and victim-blaming. Moreover, they believed that the labeling process set up an expert doctor–sick patient hierarchy. For them, insisting on clients' normalcy seemed to suspend the therapist's power to judge and thus to dismantle that hierarchy. However, as Laura Anderson and Karen Gold (1994) have argued, the diagnostic process replicates the traditional mental health paradigm, whatever diagnosis is

given. "Normal" is a diagnostic category; declaring a client "normal" reaffirms therapist's power to judge, as well as the hierarchy built into the therapy relationship.

The trauma model and the medical model are close cousins. Why, then, did trauma talk *seem* so radically different and so politically congenial to so many respondents? One difference seems key: trauma talk identifies clients as injured rather than sick. Trauma (or the trauma memories), like a fish bone lodged in the throat, merely needs to be excised. There is no question of whether the psyche is diseased or malfunctioning. In other significant respects, trauma talk is not opposed to the medical model but merely a variant of it. Why are the similarities so hard to see? Why is it so hard to move outside the medical model, even for those who vehemently reject it? Perhaps we should not be surprised by our difficulty. After all, the medical model is part and parcel of the professional culture of psychotherapy. Therapists, feminist or not, are part of that culture. Thus, paradoxically, trauma talk seeks to oppose a system of which it is part.

Abuse: Unbound and Unbounded

In trauma talk, categories such as "abuse," "trauma," "violence," and "battering" have ballooned to encompass virtually any negative encounter with another person or an institution. In our respondents' view, this often included therapy encounters.

> I think therapists abuse clients, obviously in the more overt ways, by becoming sexually involved or personally involved. I think therapists abuse clients by not listening to clients, not believing them. That doesn't mean that you shouldn't be skeptical, but to out-of-hand discount what people are saying because it doesn't meet with your reality is an abuse of power. I think to not support clients in their own search for help is abusive. As a general rule, for the therapist to impose the treatment on the client without working with the client to design that treatment and taking into account her unique stuff is abusive. (Therapist #159)

For Therapist #24, "imposing my goals" on women in therapy was "abuse." She goes on:

> I think a potential exists for even well-meaning and well-intentioned and really skillful therapy to inadvertently abuse a client just through the relationship's power dynamics.

Therapist #51 sees therapists who impose their values on clients as akin to husbands who batter their wives:

> I think staying in a battering relationship by and large is not [healthy]. Maybe on very rare occasions there theoretically may be a reason why that was healthy, but I think you can also beat somebody up in the position of therapist by trying to invalidate them and disempower them.

For Therapist #120, the medical model itself perpetuates violence:

> I guess we could go maybe to the top of the list, the medical model, of pathologizing women's experience and labeling [that] as mental illness. Having grown up in a world of violence and anything that perpetuates that. And that a lot of people practice in ways that perpetuate that.

For Therapist #98, working with male clients who had abused women would constitute victimization for a woman therapist:

> It just seems like almost another element of perpetration if the woman [therapist] is working with abusers day in and day out when she is a member of the group that they have targeted. She's grown up with her own experiences of abuse or assault or attempted abuse or assault, as most of us have.

When *abuse*, *battering*, and *violence* become portmanteau words, that is, words into which we pack many disparate meanings, then they lose all meaning. We speakers lose the ability to make distinctions. When "not listening" becomes equivalent to physical violence or to forcing sex on a child, we run the risk of trivializing those severe transgressions. Mona Eliasson (1998) raises a parallel objection:

> Is the violence and are the humiliations experienced by battered women at the hands of men they live(d) with and love(d) similar enough to the injustices of economic discrimination, or being forced to give one's baby up for adoption, to justify the same label without removing meaning from the word "violence"? (p. 229)

When the category of "abuse" is enlarged to encompass *any* negative, coercive, or uncomfortable encounter with the world, then trauma talk threatens to impose a totalizing psychology of personal development:

> It's my own belief that there are other equally terrible things that happen to children in addition to childhood sexual assault—the wearing away of the child by inconsistently effective or neglectful parenting or critical parenting. And those terrible events certainly have awful consequences for children . . .

> that leave people damaged, leave people developing with wounds they carry into adulthood. (Therapist #3)

Moreover, as we shall see later, terms such as *abuse* and *trauma* are laced with gender meanings. Thus, trauma talk is also a way of producing male-female relations, imposing a highly charged set of meanings on them.

Trauma Talk as Feminism

> After several months of hearing all of these stories of women being physically abused and sexually abused and emotionally abused, all of a sudden I can remember it just hitting me at one point. I thought, "Oh my God, this is the way the world is for women." I had never known that depth of pain or that kind of pain. . . . That epitomized my transformation into a feminist therapist. (Therapist #121)

Over the past thirty years, feminist therapists of every theoretical persuasion have assembled a rich and vital array of clinical theories, practice innovations, empirical studies, and ethical reflections (cf. Brown 1994; Enns 1997; Lerman and Porter 1990; Marecek and Hare-Mustin 1991). Yet, for some respondents in our study, trauma talk eclipsed feminist therapy's rich intellectual history. They saw the trauma model as the *sine qua non* of feminism in therapy. Assessment, clinical formulation, and treatment all were reconceived within the trauma framework.

> [Is there a feminist approach to assessment?] It's helping to construct a little history in terms of some of these [abuse] experiences and helping her understand what she's been through. Most women who come here often have a collection of various abuse experiences, from mild to sometimes horrendous. (Therapist #121)

> [Can you tell me how your feminist perspective is reflected in your therapy?] OK, I screen very early for [abuse]. A lot of times people come in with a whole cluster of symptoms, but the assessment is always for trauma and abuse in the background. To be able to recognize that as a part of the wounds they carry and to address those and give them their due in terms of how we try to work with the healing process. (Therapist #12)

> Post-Traumatic Stress Disorder comes probably closer than any diagnosis to recognizing the reality of women's lives. When women come in a nervous wreck, they may fit the criteria for a dysthymic disorder or some of the other mood disorders or such. But often you're also working with a Post-Traumatic Stress Disorder. (Therapist #69)

Thus, for some respondents, retelling a woman's life as a trauma narrative was both the feminist way and the one true way to tell a life. Yet, even though a woman has experienced abuse, narrating her life in terms of that experience produces only one of many possible stories. There is no single life story, nor one correct feminist version. Many versions are true; many are feminist. The constructionist's question is "Which ones are useful?" One therapist, carefully verifying her feminist credentials as she spoke, ventured the point of view that trauma narratives were not helpful to women:

> I think that one of the ways that things have shifted for me is that I still very much hold the cultural, societal perspective that we live in a very patriarchal society, but I don't think it's helpful that women just view themselves as victims of this society. I think it is just not a psychologically healthy position. I think we need to view ourselves as responsible adult human beings who are learning hopefully to make choices and figure things out for ourselves a little better. Now I know that there are women who are in very much victimized places. I'm not saying that's not a reality. But I get a little leery of some women just never having ever to be responsible for their own behavior, because they've been victimized. (Therapist #205)

Taking these therapists' voices together, we can see how different angles of vision yield different views. On the one hand, trauma stories respect and acknowledge women's experiences of violation, "recognizing the reality of women's lives." On the other hand, they run the risk of reducing women clients to nothing more than those experiences. Life histories do not merely tell about the past; they create possibilities for the present and future. Plotting a woman as a victim may leave her "never having ever to be responsible for her own behavior." Reflecting on these ideas, we can appreciate how many layers of complexity lie within our feminist commitment to empower women.

For therapists like #121 and #12, feminism dictates that the therapeutic task is reconstructing the client's history into a trauma narrative. But the practice of constructing a trauma history raises issues about the influence of the therapist and the power dynamics involved in constructing a clinical narrative (Haaken 1998). Respondents in this study were deeply committed to monitoring the power dynamics of therapy and determined to foster egalitarian relationships. But they seemed unaware of the power involved in seizing interpretive authority over a client's life.

When women clients are construed as "wounded," "damaged," or "broken" victims, therapy becomes refocused around the goal of healing their pain. Therapists become caregivers whose most important (or only?) actions are providing compassion, support, empathic acceptance, and nur-

ture. For some respondents, these qualities had become the essence of feminist therapy.

> [What does it mean to you to say that your therapy is feminist?] It's softer . . . less critical, . . . less dualistic . . . less judgmental. It's a more open way of looking at an individual. (Therapist #64)

> I guess I would say the personal empathy. (Therapist #133)

> I think it means a consciousness of the relational model that is so important to women. . . . It means collaboration, and valuing connectedness and empathy. (Therapist #53)

> That all people who come through the door would be treated with dignity and respect, and compassion and equality. That's the essence of it. Safety. I would add safety to that. (Therapist #72)

> The humanness, the nurturing, the support, those things. (Therapist #69)

> Say a woman has been in a particularly abusive relationship and she comes in and she tells this to the therapist. She can either get understanding and compassion about what she has been through, or she might get the therapist questioning her and assuming that she possibly did something to provoke the physical abuse. Which is very different from a feminist orientation or even a nonfeminist orientation that there is never ever any justification for someone abusing you. (Therapist #121)

Do gentle compassion, support, and empathy constitute therapy? Or feminism? Framing therapy as "healing" submerges other goals, such as change, self-knowledge, and personal growth.

A subterranean stream of dissenting views ran through the interviews. In the excavation of these counterdiscourses, a variety of reservations come to light:

> [How have your ideas about feminist therapy changed over time?] I've probably become more aware of some need for boundaries as I come in more contact with more and more difficult clients. . . . From a feminist perspective, [we have] a continual awareness—especially with women—of how much they come into our offices and kind of hand over power. We have to continually empower and empower and give that message very strongly. [But] I think that particularly with borderline folks, . . . you have to work counterintuitively. Certainly I still think it's important to empower folks but that population has been real challenging, so caution for the therapist. [She speaks about her feminist training that emphasized creating relationships that feel respectful.] With that population, I have been more challenged. I

> don't know that it's particularly helpful. I think it's a more boundaried stance, some need to be more cautious, not as free. (Therapist #226)

> I'm actually in [a network for treating sexual offenders]. I've always treated sex offenders. Here's my bias, which a lot of feminists probably won't like to hear. I don't think you should work with victims unless you work with offenders. I think that if you're so emotional that you are upset with being in vicinity of a sexual offender, then you should not be treating the victims. That it's going to get in the way of your work. The job of the therapist is not to be the best friend; it's to be an objective professional. If you can't do that, then you shouldn't be doing that specific kind of work. (Therapist #12)

> [Women don't] know how to do anything else. I'm currently spending a lot of time talking with clients and thinking about how women join together in suffering. There's an enormous amount of pressure, peer pressure to do that. And there's not a whole lot of pressure to necessarily be proactive. So, you hear it in teachers' lounges and you hear it in meetings. And it's a joining strategy for women, much like playing sports is a joining strategy for men, but how we stay locked in it! There's some good stuff about "let's talk about feelings, let's talk about feelings," but at some point you gotta take action. (Therapist #64)

Additionally, some therapists worried that trauma talk, far from epitomizing feminism, was a dilution or even a betrayal of it:

> I have a twenty-year perspective. I started as part of, not a therapy movement, but a political movement. What we were doing was early intervention, education about sexual assault, connecting people with natural support systems, setting up groups, and that kind of stuff. . . . Now, I wouldn't say that nobody needs therapy having been sexually assaulted, and it's probably true that more incest survivors and typically people who have been severely abused could benefit from therapy. But what I'm a little concerned about is it seems like that experience has gone from being a political experience. That one out of every three females and one out of every five males are sexually abused before age eighteen is a political issue. And instead [it's] pathologized so that every rape victim gets her turn for individual therapy and then they all go off and deal with it as if it's their individual pathology. (Therapist #5)

Masculine Subjectivity and Feminist Identity in Trauma Talk

Trauma talk tells gendered stories, ones that encode male and female as opposites. These stories restrict the possibilities for each sex: woman, the in-

jured party, is produced as innocent of responsibility, blameless, and powerless; man, the perpetrator, is her dark complement—coercive, domineering, unrepentant, even evil. Therapist #44, a man who treats male batterers, enunciated such a view:

> So my model of mental health is to teach men . . . to give up the need to have power and control over other people for their own happiness and well being. For women, it is to not accept that kind of control. . . . I just finished a group a few minutes ago with women, an orientation group for women whose battering and abusive partners are coming into the program. The message to them is that they don't have to change in order for their partner to change.

Another therapist related how she "cooked" her clinical assessment techniques to reproduce her beliefs about male batterers and female victims:

> [I was wondering, what are some of the issues with assessment tools that you're finding?] What I did was I just took the assessment instruments that had been used for a lot of years with batterers. So I just took the same ones, except I pulled out the ones on anger and hostility because . . . I didn't want to measure that because I didn't want to send that message, that [women] needed to have that measured. (Therapist #101)

Themes of male malevolence saturated respondents' trauma talk. We asked if there were "any individuals or types of problems that you do not work with for reasons connected to your feminism." With only a few exceptions, women told us they would not see abusive or violent clients (a category assumed to be composed entirely of men). Men involved in abuse were branded as predators, scary, evil. Indeed, the ubiquitous term *abuser* shrinks a man's identity to a single dimension, just as the term *victim* shrinks a woman's identity (cf. hooks 1989). Even though many respondents had no actual experience treating abusers, they believed that such clients could not be helped and did not want to change.

> I think it's harder because the rapists and the abusers and batterers and all tend to come from a very different frame of mind and often don't want to change. (Therapist #203)

> In order to be a good therapist I think you have to be able to understand the person's world view. And, I'm not sure because of my perspective on the world, that I could get my mind around into a space that I could say, "Yes, this person has an honorable intention" or find a rationalization for the behavior or whatever. And I'm not sure that I want to take the time to stretch myself in that direction. I couldn't do justice to them. And I'm not sure that I want to. (Therapist #158)

> It [an experience of working with perpetrators] actually gave me a different perspective: that the men going through those treatment programs are individuals and are not complete evil people. You know, [that they] could be in some cases worked with and helped. But not in all cases. (Therapist #205)

Rachel Hare-Mustin and I have warned that

> when the emotionally fraught issues of intimate violence and sexual abuse are under discussion, the slide into unreflective male-female dichotomies becomes all too easy. . . . If women are victims, men must be oppressors. Although this formula serves to simplify a complex reality, it does so at the cost of ignoring the diversity of experiences of both men and women.
> (Hare-Mustin and Marecek 1994, p. 16)

Cruel, manipulative, brutal men; vulnerable and suffering women—these dichotomies spilled over into the therapists' own identities, as women and as therapists. Many, seeing themselves in terms of feminine powerlessness, held that they were not confrontational enough, not strong enough to withstand the anger and resistance of abusive men. Some argued that doing therapy with abusive men constituted a form of victimization for a woman therapist. Many assumed automatically that working with abusive men was a man's job.

> I think that for the woman it's going to be really hard to come home [and] take it in, in some ways that really tie in to what it's like growing up female in this culture. If this were a culture in which women were not in danger every day, it would feel different to work with the occasional abuser or rapist, but as long as my choices and my mobility are limited and constricted in a lot of ways because of my concern for my personal safety from men, it's not good for me, as a woman, to work with men who perpetrate violence.
> (Therapist #98)

> I do not work with violent offenders because I'm afraid. (Therapist #159)

> It seems like another element of perpetration if a woman is working with abusers day in and day out; she is a member of the group they have targeted.
> (Therapist #95)

> I learned a lot about confrontation and I did some successful work, but I don't enjoy it. Taking power in a way that I don't enjoy, and the confrontation . . . it really doesn't suit my personality. (Therapist #22)

> I will not work in isolation with an abuser. . . . I don't think I've got enough power usually to really take that on. I'm talking physical abuse. Emotional or verbal abuse, I have no problem. But if there's ongoing physical or sexual

> abuse, usually with those particular individuals, it takes such harsh confrontation and I think it needs a different style than what I have. I'm not afraid to confront, but it's just constant confrontation; and I think it's better done in a group setting or situation. I think it takes a male to carry the credit and the power to have an effect. (Therapist #123)

> I much prefer a model in which men [work with] men who are batterers and abusers. (Therapist #98)

The gender oppositions of trauma talk positioned women—therapists and clients—as vulnerable and powerless vis-à-vis male abusers. But raw emotions leaked into the interviews, contradicting this image. When it came to abusive men, some therapists felt a tide of righteous rage so powerful that a therapeutic encounter was impossible.

> I don't work with rapists and my husband works more with perpetrators of sexual assault or family assault. I find I usually feel too angry with their behavior to really be able to be empathic enough. . . . I'm too sure of my own negative feelings about whatever they've done. (Therapist #3)

> I would not work with men who sexually abuse their children. . . . That's my own anger and I realize that I have this problem. It's like I want to cut off his balls. [Interviewer and therapist both laugh.] (Therapist #225)

When we look critically at the gender antinomies of trauma talk, a number of questions emerge: Is compassion uniquely and universally womanly? Is confrontation uniquely and universally male? Is the former always and only good for victims? Is the latter always and only good for perpetrators? Are victims always women? Are victims always powerless? If we reject the idea that power is a static quality that individuals either do or do not possess, what alternative metaphors can we conjure? (Cf. Marecek and Kravetz 1998.) What new lines of vision open up? Suppose we borrow from Foucauldian theory and re-vision power as always negotiated, always provisional, and always in motion, circulating through personal relations, institutions, and knowledge structures (cf. Marecek, Fine, and Kidder 1997); how then would the terms *women/powerless/victim* and *man/powerful/victimizer* be realigned? Therapist #159 hesitantly confesses that she has moved toward new ways of working with power:

> [Long silence] . . . I started off looking at it as a difference between men and women. You know where men had the power and women didn't. And I don't see it quite that way anymore. It's who's got the power? Where? And how are they using it? You could use it in benign ways. You could also use it in malig-

nant and malevolent ways. I see that women do that. And I look at power of being a victim and how that victimization carries with it a lot of power—the power to control and manipulate.

Conclusion

My goal has been to trace how therapists' language practices construct clinical realities. I do not claim to have produced an exhaustive typology of therapists' language practices. Nor do I claim that all feminist therapists share the linguistic practices of my respondents. Rather, my aim has been to show how specific language practices create certain clinical realities, certain identities, and certain therapeutic practices.

In significant ways, the methods of an inquiry determine its results. Two features of the method deserve comment. One is the sample. The respondents are clinicians whose primary identities are as therapists and whose work is direct service. The voices of practitioners like these are not often heard in the professional clinical literature, nor does the research literature typically document their practices. Most of those who write about feminist therapy are positioned with one foot (sometimes two) in the scholarly world; studies surveying feminist therapists typically gather their respondents from the rosters of professional organizations. Only one of our respondents reported that she belonged to the Feminist Therapy Institute; no one, to the Association for Women in Psychology. Our respondents relied on occasional professional workshops, popular psychology books, and word of mouth for new ideas, not on scholarly or professional literature. Thus, this study complements others in the literature because it looks at a slice of the feminist therapy community that is usually hidden from view.

Another feature of the method is that students served as interviewers. For the most part, the student interviewers stuck closely to the interview protocol; they did not always seek the clarifications that we would have wanted. Nor did we have the opportunity to revise the protocol in response to unexpected trends. For instance, we did not anticipate how much the interviews would center on trauma and its treatment; had we known, we might have amended the interview protocol to ask about these issues directly. Moreover, the therapists were in dialogue with students and no doubt tailored their remarks to their audience. I stand outside their dialogues when I interpret them, working only from tapes and transcripts. This position involves an inescapable but uncomfortable power hierarchy.

A research process in which therapists could comment on and adjust my readings of their words would have been more satisfying.

Whatever the shortcomings of method, the study raises an important question: Why did trauma talk hold such appeal for the feminist therapists who took part in the research? What does it accomplish for feminists, and especially for feminist therapists?

One set of answers may come from situating the groundswell of trauma talk in its historical context. Trauma talk serves to overturn long-standing cultural practices of denying or minimizing the sexual and physical violations of women, practices of not believing (Haaken 1996). For many, trauma talk honors women's reality. As two respondents said:

> I can already hear myself going off onto this sort of lengthy discussion because to me, feminism [in therapy] is certainly primarily about women's issues and women's reality. (Therapist #120)

> [Do you use feminist therapy in your support groups?] Most of the time, I don't have to say it because the women are saying it themselves and discovering that they are not crazy and they're not alone and maybe it's not necessary to take on so much responsibility for an abusive relationship or for a sexual assault or for what happened in childhood. (Therapist #106)

The commitment to women's reality closely resembles a venerable epistemological stance in feminist theory: feminist standpoint theory (Harding 1986; Hartsock 1983; 1997). For standpoint theorists, women's knowledge of reality is different from men's. Following Marx, standpoint theorists argue that there are ethical and political reasons for privileging the knowledge of women and other oppressed social groups.

The current state of feminism forms another key part of the context in which our therapists practiced. Mari Jo Buhle (1998) captures what second-wave feminism has become in the 1990s: a "mix-and-match of diverse systems . . . devoid of strong moorings. Indeed feminism itself became in the process less and less a centering concept, turning instead into a secondary premise shifting with the ever changing political moods of the participants" (p. 276). Against this backdrop, the victimization of women offers solid ground, a space of certainty and solidarity, a flagpole around which all feminists (and perhaps all women) can rally. As Janice Haaken (1996) notes, the rubric of trauma holds out the promise of forging unity among feminists.

Feminists in the United States must also contend with an unrelenting media backlash, abetted by a profound cultural swing toward social and

economic conservatism. Feminists in clinical practice confront backlash head-on in their everyday work. Many of our respondents, for instance, worried that their overt self-identification as feminists would alienate clients and colleagues, jeopardize referrals, discredit their words, and possibly even put their physical safety at risk. In response, they had come to relegate most feminist values to the far edges of therapy; the only feminist value that was safe to articulate was their intolerance of victimization and physical violence.

> Always I have to accept what [a couple's] mutually agreed upon goals are. Whether or not they would be my goals as a feminist, if those are their goals, then I know I can't impose on those views. What isn't OK with me is abuse and addiction. (Therapist #98)

> My job as a therapist is to reach their goals as long as they don't involve abuse being let go or ignored. (Therapist #116)

Exaggerated dichotomies of male and female and the celebration of women's virtue also can be situated in the context of the backlash against feminism. Janis Bohan (1993) has described how gender dichotomies that extol such traditional virtues as women's innocence, caring, and relational orientation can be seen as a response to the anti-feminist backlash of the 1990s.

As Judith Herman (1992) noted, public discussion of wife-beating, rape, and the sexual abuse of children cannot be sustained without a political movement. Acknowledgment of "the common atrocities of sexual and domestic life" (Herman 1992, p. 4) challenges myths of family harmony and patriarchal beneficence, as well as the norm that women should suffer in silence. Furthermore, challenging male violence condenses anxieties about the shifting relations of power between men and women. With its powerful and compelling vocabulary, trauma talk proclaims patriarchal abuse of power; its stark, simplifying rhetoric furnishes a political rallying point.

As a clinical discourse, trauma talk has its limitations. It does not suffice for capturing complexities of motives, meanings, and emotions or the shifting, layered, and ambiguous dimensions of personal relations. Furthermore, when trauma talk enters the clinician's office, it is imprinted with the professional culture of psychotherapy. From a systemic position, we see that oppositional knowledge, whether feminism, postmodernism, or trauma talk, inevitably takes its meanings from that which it opposes. Just as second-wave feminism takes its shape within late-twentieth-century capitalism, trauma talk in the office is framed within the medical model.

Oppositional politics always move under the sign of irony: they stage their fight on a terrain already mapped out by their antagonists.

The project of a feminist constructionist psychology is the critical examination of the practices of the discipline. Psychology's habits of authoritative expertise and its claim of privileged access a single Truth, even when practiced in the name of feminism, should be received with skepticism. This chapter is such a critical examination. I have tried to set up an abrasive interaction between taken-for-granted discourses and some counterdiscourses. I have called attention to therapists' language practices in hopes of showing not only that language constructs reality but also that different language practices shift that reality. As feminists, we need to embrace reflexivity, to incorporate a cultural analysis of our practices into those practices. Whether we are therapists, clients, or researchers, we labor to "get the story right," but we need to remember that there is no story that is right forever and for all.

NOTES

1. Diane Kravetz taught the class, trained and supervised the interviewers, and managed the recruitment of respondents and the collection of the interviews. For more information regarding the methods, see Marecek and Kravetz 1997.

2. The term *medical model* has many meanings in the mental health literature. Therapists in these interviews used the term as a kind of shorthand, without elaborating on what they meant.

3. Whether EMDR actually accomplishes lasting and significant change is highly disputed in the research literature. Moreover, controlled clinical research has found that the rapid eye movements are irrelevant to the treatment outcome. EMDR is thus more parsimoniously explained either as a placebo effect or in terms of well-established principles of exposure therapies (cf. Feske and Goldstein 1997). The brain mechanisms postulated by EMDR's originator (and echoed by our therapists) are almost certainly a red herring.

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