Trauma Theory Without Feminism? Evaluating Contemporary Understandings of Traumatized Women

Emma Jane Tseris

Abstract
In this article, I critically examine contemporary notions of trauma and how they have informed mental health interventions for women. The feminist underpinnings of trauma therapy invite practitioners to understand women’s mental health “symptoms” within the context of such experiences as child abuse and sexual violence that disproportionately affect women. However, this article poses the question: Has trauma theory caused paradigmatic shifts in mental health interventions that have increased practitioners’ capacity to engage with sociopolitical issues, or are preexisting assumptions about the biological basis of women’s mental illness guiding treatment approaches simply by another name? Implications for social workers are discussed.

Keywords
feminist theories, mental health, postmodernism theory, resilience, social work practice

This article examines the extent to which trauma theory has influenced a shift toward socially aware, anti-oppressive mental health interventions for women. Trauma theory, guided by feminist values, challenges the conventions of traditional mental health interventions with women by questioning the assertion that the assessment and diagnosis of clients are the cornerstones of effective work. As such, the focus of counseling is extended beyond the micro level of the “client in treatment,” instead emphasizing the sociopolitical context of women’s lives, especially high levels of trauma experienced by women, such as child abuse and sexual violence, and the impact of these experiences on women’s mental health. As a result of the conceptual shift offered by trauma theory, it is sometimes accepted that mental health practitioners have developed an understanding of women that is much more holistic and progressive than in the past. However, in this article, I argue that a critical dialogue regarding the extent to which trauma theory has resulted in significantly improved mental health practices for women is required.

1 Faculty of Education and Social Work, University of Sydney, New South Wales, Australia

Corresponding Author:
Emma Jane Tseris, Faculty of Education and Social Work, University of Sydney, Education Building A35, Sydney, New South Wales 2006, Australia.
Email: emma.tseris@sydney.edu.au
I begin by describing the emergence of feminist trauma theory and use the example of the diagnosis of borderline personality disorder to demonstrate the transformative potential of trauma theory. However, I argue that a large proportion of interventions for trauma, despite the use of the term trauma, continue to be informed by assumptions about the biological basis of women’s emotional distress—assumptions that privilege diagnostic assessments as the foundation of effective work—that increasingly rely on neurobiological understandings to frame interventions and devalue interventions that involve social change and activism. Furthermore, medically oriented understandings of trauma often contain deterministic assumptions about the lives of women following situations of abuse or violence that may not recognize women’s resilience. Thus, in this article, I claim that trauma theory may not represent the radical paradigm shift that is sometimes claimed. I conclude by exploring alternative trauma narratives that may assist social workers to engage more effectively with women within their life contexts.

This article primarily explores possibilities for best practice in social work with women and trauma and investigates contemporary therapeutic discourses. It is not an attempt to provide incontrovertible knowledge but, rather, to offer a critical analysis of some of the assumptions and values underpinning contemporary trauma paradigms. The use of I in the text is an acknowledgment of my partial, subjective perspective, constructed by my own experiences as a postgraduate student, a woman, a young professional with all the privileges attached to this status, and a social worker who is committed to feminist praxis. The use of the term we is not an attempt to hide differences among social work practitioners but, rather, to reflect social work’s shared values regarding social justice and the pursuit of human rights, notwithstanding an acknowledgment that social work practice is characterized by complexity, uncertainty, and diversity.

**Trauma Theory and the Feminist Critique of Psychiatry**

Trauma theory has a history dating back to the late 19th century in early psychoanalytic theory. At that time, hysterical symptoms in women were seen as resulting from psychic trauma, and hypnosis was used to access and transform traumatic memories, but Sigmund Freud later abandoned his investigation of trauma (Haaken, 1998). However, the effects of two world wars resulted in a resurgence of interest in trauma theory as a means of describing emerging evidence of the long-term psychological distress experienced by returning soldiers (Courtois, 2004). Posttraumatic stress disorder (PTSD) was first included in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1980 (Courtois, 2004). Trauma theory aimed to create a language and method for understanding the effects of exposure to war, including nightmares and flashbacks, which previously had not been named or properly understood.

Once the PTSD diagnosis was available, it was appropriated by feminist therapists to describe issues relevant to women’s mental health, including exposure to such traumas as child abuse and sexual assault (Brown, 2004). Thus, trauma theory has been able to illuminate and name problems that have previously been underrecognized. In addition, it has located the problems experienced by individuals within their larger sociopolitical contexts and, as such, has demonstrated the social causation of psychological distress (Haaken, 1998).

Trauma theory added to an already existing body of feminist critique of psychiatry and focused on advocating for the social context of gender inequality to be taken into account in psychiatric assessments, allowing for a more holistic understanding of women’s distress (Berg, 2002). Numerous publications have stipulated that women experience approximately twice the rates of depression and anxiety than do men because they are biologically more vulnerable to mental illness; other studies have argued that women have less “adaptive” coping mechanisms than do men (Fullager, 2002). Trauma theory added an alternative voice to the debate. Instead of understanding women’s emotional difficulties in terms of brain-based disorders or behavioral differences inherent in
being female, trauma theory allowed for a social analysis of women’s psychiatric presentations (Brown, 2004). The elucidation of the social contexts of women’s lives meant that women’s over-representation within the psychiatric system was able to be radically reconceptualized. Rather than assessing women’s inherent vulnerabilities, trauma theory demanded that practitioners take into account the emotional problems that ensue from women’s exposure to trauma. The effects of trauma in women’s lives are now well understood and documented (J. Briere & Jordan, 2009; Harvey, 1996; Root, 1992; Webster & Dunn, 2005).

In *Trauma and Recovery*, Herman (1992) argued that women’s exposure to traumatic events results in significant psychological harm that gives rise to a number of mental health symptoms, including difficulties in regulating affect, problems in relating to others, and alterations in self-perception. The psychosocial difficulties stemming from traumatic events have come to be known as trauma symptoms. However, although Herman outlined the symptoms that are frequently present in individuals following trauma, she stated that trauma therapy must occur within the context of a broad social movement that would focus on the patriarchal assumptions that allow for women’s ongoing exposure to trauma. In this way, Herman moved beyond symptoms to explore the ways in which individual women may be empowered and groups and societies may be equipped to challenge gender inequality.

Over time, the usage of the term *trauma* has become increasingly widespread, to the extent that Miller and Tougaw (2002, p. 1) wrote, “If every age has its symptoms, ours appears to be the age of trauma.” “We are living in an age of PTSD” (Theidon, quoted in Scheper-Hughes, 2008, p. 37). Indeed, the language of trauma has become mainstream and normative, and a proliferation of trauma therapies has emerged. This article engages with the contemporary enthusiasm among therapists for trauma work and asks the crucial question: Has the new language of trauma caused paradigmatic shifts in psychiatry that have significantly increased its capacity to engage with the social, or are preexisting assumptions about the biological basis of women’s mental illness guiding treatment approaches simply by another name?

**Feminist Trauma Theory and Borderline Personality Disorder**

As a result of trauma theory, movements in psychiatry toward an increased engagement in the social context of women’s lives have occurred. One example of a shift in perspective is that there is more skepticism today surrounding such terms as *borderline personality disorder* among some mental health professionals. A disorder that is diagnosed much more frequently in women than in men (K. Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004), the diagnosis of borderline personality disorder represents a stereotypical woman at her most extreme—emotionally labile, relationally dependent, and self-destructive. There are significant uncertainties regarding the effectiveness of psychoactive drugs in the treatment of borderline personality disorder (K. V. B. Lieb, Vollm, Rücker, Timmer, & Stoffers, 2010). A consequence of the failure of the disorder to respond to medication is the labeling of the disorder by professionals as “attention seeking,” as opposed to a genuine psychiatric illness. As a result, women with this diagnosis have often been described as manipulative and undeserving clients (Simpson, 2006) by mental health professionals who want to treat “real” biological problems and who believe that their time is being wasted on these clients. Consequently, women with borderline personality disorder have usually failed to receive effective help psychiatric help and have often faced significant prejudices within the mental health system (Simpson, 2006).

However, the diagnosis of borderline personality disorder has been critiqued by feminist trauma therapists as a label that is used to describe female clients whose emotional difficulties are linked to problems that are neither attention seeking nor biochemical (at least, not biochemical in their origin), but deeply embedded in a sociopolitical context of gender inequality. Borderline personality
disorder is linked strongly to experiences of chronic child abuse (Herman, 1992; Wagner & Linehan, 1994). The persuasive feminist critique of the borderline personality disorder construct has meant that although *borderline personality disorder* remains a frequently used term, some mental health professionals have become more skeptical about its validity and its meanings. Recent efforts have focused on recategorizing borderline personality disorder, changing its name to “complex posttraumatic stress disorder,” to recognize that the problem lies not in the character of the client but in a social milieu of patriarchal abuse (Brown, 2004).

It is arguable, then, that mental health services have progressed considerably, with trauma being recognized and women less likely to be blamed for the emotional difficulties arising out of trauma. However, in the next section, I outline the ongoing struggles of women to be heard and to receive effective help within mental health services, with a particular focus on the ways in which trauma theory has reverted in many ways to the constraints of biomedical reductionism and has lost its activist voice. Thus, while it is evident that gains have been made in how women are understood by some mental health practitioners, it is also the case that the language of trauma theory, in and of itself, does not equate with a progressive, socially informed counseling stance.

**Trauma Theory Without Feminism?**

When Herman (1992) wrote *Trauma and Recovery*, she said that the book “owes its existence to the women’s liberation movement . . . a collective feminist project of reinventing the basic concepts of abnormal psychology” (p. ix). Two decades later, it appears that mainstream trauma theory is no longer centered on feminist values and intentions, having become preoccupied with medically oriented issues concerning diagnosis and standardized treatment (Berg, 2002; Burstow, 2003; Gilfus, 1999; McKenzie-Mohr, 2004; Worell, 2001). Of additional concern is the notion of evidence-based practice and the “search for certainty” in mental health services, which has led to a reduction in the particular types of evidence that are considered acceptable, with quantitative studies, especially randomized controlled trials, and increasingly, neuroscientific studies being privileged (McDonald, 2003). The relational components of feminist counseling are difficult to measure quantitatively and therefore are often outside the realm of what is considered evidence-based practice.

An important issue lies in the definition of trauma. It is not uncommon for chapters and articles on trauma to begin with a description of the broad scope of events that the authors are including in their understanding of trauma, for example, “exposure to warfare, disasters, serious accidents, sudden deaths of loved ones, and physical and sexual abuse” (Kubany et al., 2000, p. 210). It would appear that an emphasis is being placed on assessing and treating the effects of trauma, rather than on examining issues of context and experience, a shift that may contribute to a greater concentration on women’s symptoms. Notwithstanding the devastating nature of accidents, disasters, and sudden loss and the fact that some effects of trauma may resemble one another despite their causes, the trauma of long-term abuse is a qualitatively different experience. In particular, it is distinguished by its chronic, interpersonal nature, as opposed to a single overwhelming event (Bath, 2008; J. N. Briere & Lanktree, 2012).

The distinct components of the trauma of abuse led to Herman’s (1992) proposal of a new diagnosis, “complex PTSD,” and other authors have used the terms *developmental trauma, attachment trauma, or relationship trauma*. In addition to the classic PTSD symptoms of reexperiencing, experiential avoidance, and hyperarousal, individuals with complex trauma may have difficulties with chronic affect dysregulation, self-harming behaviors, dissociative problems, somatization, and distortions in concepts of self and others (van der Kolk, McFarlane, & Weisaeth, 1996). Nevertheless, despite the important naming of complex trauma having been made, the distinction between simple or acute trauma and complex trauma is not always clear. For example, some authors have argued that...
trauma is a universal or essential aspect of being human and have incorporated a vast array of difficulties into their definition of trauma, including grief, accidents, relationship breakdowns, and the individualistic nature of industrialized city life (Cyrulnik, 2007; Levine, 2010). This far-reaching definition of trauma reflects the cultural importance of the notion of trauma to contemporary Western societies and its use as an organizing concept or master narrative for understanding human experience (Scheper-Hughes, 2008). In this way, trauma is conceptualized as covering a range of frightening or unpleasant events, many of which are qualitatively different from the trauma of gender-based violence. In a context in which trauma therapies are said to be relevant to any kind of unwelcome event, it is necessary to ask whether the space for women’s voices and the acknowledgment of women’s experiences is diminishing. Does the universality of the concept of trauma signal an increasingly limited capacity to engage with the sociopolitical issue of gender inequality?

Of additional concern, indicative of the medicalization of trauma, is the emphasis on the need for social workers to understand and remain up to date with advances in neuroscience. In particular, evidence has emerged regarding the physical changes that appear to occur in the brains of traumatized populations compared to “normal” populations. Images of the brains of traumatized women appear to be different from those of “normal” brains in a number of ways. In particular, it appears that traumatic experiences correlate with abnormalities in the amygdala, the hippocampus, and the medial frontal cortex (Nutt & Malizia, 2004). Changes such as these are sometimes referred to as the biological markers of trauma. Some feminist and pro-feminist therapists have been relieved about this emerging evidence, hoping that this new information will enable psychiatry to understand the socio-political contexts of women’s pathology. For example, the psychobiology of trauma has been used when making the claim that severe childhood abuse is a major driver of mental health difficulties (Perry, 2009; Ross & Pam, 1995). A positive dialogue between neuroscience and feminism is both possible and commendable (Wilson, 2004). Many clinicians are optimistic that neurobiological evidence supports “what feminists have known for a long time” about the effects of trauma, thus rendering the minimalization of trauma in psychiatry as untenable. However, a critical dialogue about this reliance on biological knowledge to promote a social justice framework in mental health services is needed, since it potentially reinforces the privileged status of biology and medical knowledge over social science and women’s own narratives. The proliferation of books, journal articles, and conferences on the counseling–neuroscience relationship, mostly in the past decade, has elevated the perceived importance of neuroscience to trauma work. Slaby (2010) noted that the allure of neuroscience has ontological implications for how we understand ourselves—the assumption that “we are our brains” means that notions of personhood are being replaced by “brainhood,” a clearly reductionist concept. The sociologist Rose (2003, p. 57) commented on the contemporary excitement regarding neuroscience and its apparent relevance to counseling: “A way of thinking has taken shape ... all explanations of mental pathology must ‘pass through’ the brain and its neurochemistry ... sexual abuse has effects through its impact on this brain ... A few decades ago, such claims would have seemed extraordinarily bold—for many medico-psychiatric researchers and practitioners, they now seem ‘only common sense.’” Unlike the nuanced accounts of trauma that women themselves articulate in counseling, neuroscience often implies a deterministic relationship between experiences of abuse and deficits, as seen in the following examples:

Children who had a history of sexual abuse, physical abuse, or exposure to domestic violence were found to have smaller intracranial volume (brain size), lower IQs, poorer grades, smaller corpus collosi (the part of the brain that connects the right and left hemispheres), than children who did not have such trauma histories. (DeBellis et al., research findings summarized in J. A. Cohen, Mannarino, & Deblinger, 2006, p. 14)

[The] total brain volumes of our trauma-exposed patients with PTSD were decreased, and the amount of global atrophy (brain:skull ratio) increased. (Weniger, Lange, Sachsse, & Irle, 2009, p. 383)
[Our] findings implicate dysfunction of [the] medial prefrontal cortex (subcallosal gyrus and anterior cingulate), hippocampus, and visual association cortex in pathological memories of childhood abuse in women with PTSD. Increased activation in posterior cingulate and motor cortex was seen in women with PTSD. (Bremner et al., 1999, p. 1787)

There are benefits to understanding that the impacts of trauma are so significant that they may extend even to the structure and capacity of the brain. This knowledge sets right any remaining skepticism about the significant and far-reaching effects of trauma. However, there must be caution in how this knowledge is interpreted. Emerging discourses on brain atrophy and dysfunction seem incongruent with feminist goals of empowering women and resisting pathologizing understandings of their experiences. A neurobiological framework for trauma risks the development of a biomedical focus, reducing the perceived role of women’s and children’s resilience and autonomy in contributing to outcomes following trauma. It is alarming that neuroscience can also be used to stigmatize women who experience the effects of trauma, citing their biological vulnerability to symptoms of trauma and minimizing the social context in which the trauma originated, as in the following quote:

Recent human studies show smaller hippocampal volume in individuals with the stress-related psychiatric condition posttraumatic stress disorder (PTSD). Does this represent the neurotoxic effect of trauma, or is smaller hippocampal volume a pre-existing condition that renders the brain more vulnerable to the development of pathological stress responses? (Gilbertson et al., 2002, p. 1242)

Furthermore, there are issues of the validity of the “real-world” implications of brain imaging being claimed by neuroscientists. Despite the claims of relevance to everyday situations often made by neuroscientists, many of the experimental results are only at a provisional stage (Slaby, 2010). The neuroscientist Fine (2010, p. 155) stated that it is necessary to use “extreme caution when making the perilous leap from brain structure to psychological function.” In her book, Fine (2010) showed that because of the rising popularity of neuroscientific explanations of everyday life, inferring a psychological state from brain activity is a popular, yet fraught, endeavor: "There just isn’t a simple one-to-one correspondence between brain regions and mental processes” (p. 152). In other words, even in our technologically advanced age, a person’s level of trauma symptomatology is still best measured with a behavioral observation or an interview, not a brain image. Yet, brain imagery makes psychological phenomena seem more objective than evidence collected in a more ordinary fashion, for example, by clients reporting on their levels of distress, symptoms, or functioning before and after therapy (Fine, 2010). If the counseling–neuroscience relationship continues to blossom, without a critique (and by a critique, I mean a critical gaze, not an outright refusal to engage with neuroscientific knowledge as it emerges), it is possible that neurobiological understandings of trauma may result in a devaluation of the centrality of women’s knowledge within the context of counseling. The expertise of social workers, for that matter, who are not trained in neuroscience, is also potentially at risk. The preoccupation with brain images is reflective of the way in which physical violence against women is often seen as more significant than emotional violence because of its visible nature (Davies, Lyon, & Monti-Catania, 1998). Although neuroscience may offer some benefits to trauma work, I do not believe that it is remotely comparable to the importance of the development of fundamental counseling skills, proficiency in planning for women’s safety, and feminist and social justice theoretical frameworks.

In summary, it appears that trauma theory often continues to be articulated within a medical framework. Its capacity to engage with the social issue of gender inequality is at stake as it becomes preoccupied with decontextualized symptoms. It appears that the issues that feminists originally made visible in trauma theory have been translated into medical problems that “bear little relation to our original demands or intents” (Brock, 1991, p. 12). As such, it could be said that the trauma
experienced by women is undergoing “depoliticization” and “reprivatization” (Naples, 2003, p. 1152).

**Diagnosing Traumatized Women**

Although the medical-diagnostic model has been a highly successful model in the treatment of physical illnesses, I agree with other authors who have questioned its legitimacy as the dominant treatment paradigm when dealing with issues of the mind and mental illness, particularly when working with women whose mental distress is firmly situated in a sociopolitical context of trauma (Bentall, 2010; Bracken & Thomas, 2005; Burstow, 1992; Newman, 2000).

Gilfus (1999) stated that a difficulty with the medical model of emotional trauma is that it often carries an implicit assumption that all experiences of trauma will lead, in a predictable fashion, to psychological problems. Brock (1991, p. 14) warned that “women who reveal themselves to have been sexually abused when young risk having this become constructed as the crux of their identity—considered the formative experience of who they are.” Similarly, Haaken and Schlaps (quoted in Naples, 2003, p. 1164) wrote that “incest becomes the unifying event around which the patient’s symptomatology and difficulties are organized . . . who decides the importance of sexual abuse in a woman’s experience?”

Indeed, it is both incorrect and damaging to understand trauma as a fixed phenomenon and to engage in a deterministic trauma paradigm, in which consultation with the woman herself becomes optional and peripheral. There is marked variation in the effects of trauma from person to person. About 1–2% of the adult female population are said to fit the criteria for borderline personality disorder—a much lower proportion of women than the proportion of women who experienced abuse in childhood (Australian Centre for the Study of Sexual Assault, 2012). Most people who have been abused never come to the attention of psychiatrists; they must, in at least some respects, be leading well-functioning lives (Harvey, 1996; Herman, 1992). Gilfus (1999) argued that we tend to assume that people who have experienced trauma must be helpless and in need of expert assistance. In this way, a deficit-based, deterministic trauma theory is being articulated. Is this understanding any less stigmatizing than a pejorative term, such as **borderline personality disorder**?

It is evident that even when the term *trauma* is used to describe a woman’s experience, hidden assumptions can constrain the possibilities for how a woman’s identity can be constructed and understood. Some of the assumptions that have clustered around the trauma paradigm for women, such as a presumption of lifelong difficulties, have diluted its social justice stance significantly and have in many ways divorced the concept of trauma from its original meaning and the feminist values underpinning this meaning.

Many practitioners, particularly liberal feminists, have often used a diagnosis of PTSD or complex PTSD as a compromise between the deficit-based assessment templates of psychiatry and a sociological understanding of the links between gender inequality and women’s mental health difficulties. PTSD and complex PTSD have been thought of as benign diagnoses without the stigma and blame contained in other psychiatric labels and as terms that elucidate the sociopolitical factors that have led to a woman’s mental health difficulties (Berg, 2002). However, Burstow (2005) questioned what it is that we are doing to a client who has suffered extreme harm when we label her response to trauma with a diagnosis of any kind. Even if it is a process of naming that provides a context to her suffering and does not blame her for it, Burstow contended that it is wrong to place pathologizing parameters around a woman’s reactions, for it is the perpetration of trauma—and a society that condones it—rather than the response to it, that is pathological.

Another consideration that social workers must make is the extent to which a diagnostic paradigm allows for an acknowledgment of complexity and uncertainty. A postmodern frame places several demands on practitioners: Rather than claiming to possess all the necessary knowledge, we look at
the gaps in our theories; we examine what we can learn from our clients and the expertise they have; we wrestle with our examples of therapeutic clumsiness and the times when our interventions do not work; we take risks and use our imagination; and although we may aim to make sense of our work, we do not expect tidy, fully satisfying “truths” but, rather, local narratives within shifting contexts. Yet, postmodern theory does not fit easily with mainstream psychiatric practices, and the task for social workers of integrating competing paradigms into a coherent practice framework is difficult. It raises questions and tensions. The ideological power that is assigned in mental health organizations to psychiatric and neuroscientific conceptualizations of what it means to be human radically limits the possibilities for different ways of knowing when working with women and trauma. Within a diagnostic context, how does one validate components of a postmodern imagination, such as narrative ambiguity or the use of uncertainty, as necessary for effective counseling? And what to make of the experience of some clients, who—despite the philosophical objections to the diagnostic paradigm that a clinician may have—find that a diagnosis provides them with relief and a sense that they are being validated and supported? In the next section, I comment on the challenges for social work of articulating a feminist trauma theory and of constructively engaging with issues of diagnosis in ways that exemplify feminist values, defying the movement toward the medicalization of trauma and its effects.

**Trauma Theory With Feminism**

Trauma is not a unitary concept; it is a contested term (Burstow, 2003). Although in discussions with our colleagues we may make the assumption that we are all talking about the same construct, we may not be. I believe that trauma theory, which is constructed within the constraints of biomedical reductionism, has moved significantly away from the intentions initially attached to trauma theory by feminist practitioners. However, although some components of trauma theory have been subsumed into the reductionism of the medical model of mental distress, trauma theory that is imbued with feminist values remains a lively possibility. As social workers who are charged with the task of advocating for the needs of clients in disadvantaged circumstances, it is imperative that we engage critically with trauma and its multiple interpretations.

The lives of trauma survivors are often complex and complicated (Harvey, 1996). Standard cognitive behavioral therapy strategies, such as interventions for “maladaptive” thoughts and relaxation/mindfulness/self-soothing strategies, can be useful for the treatment of single-episode, noninterpersonal traumas (Smith et al., 2007). The same strategies, if offered on their own, may offer only superficial and inadequate support to women who have experienced complex trauma and could even be harmful (Courtois, 2004). Addressing themes of power, betrayal, self-blame, and stigma are additional critical components of complex trauma work (J. N. Cohen, 2008). However, these components are easily overlooked in mental health contexts that emphasize short-term interventions and that require interventions to fit neatly within the dominant “evidence-based practice” paradigm.

Furthermore, strengths-based social work is premised on the notion that clients maintain strengths despite significant adversity, thus disrupting a symptom orientation (Kelly & Gates, 2010; Saleebey, 2008). Strengths-based practice prevents the therapist from making too many assumptions about the impact that a client’s experiences “must” be having on the client. By avoiding a deterministic trauma framework, strengths-based practice facilitates an engagement with clients by freeing practitioners to be more fully present with clients and their unfolding narratives. According to Tedeschi (1999), positive effects following trauma occur through the struggle to find a new way of living after the event, which happens in the midst of highly confronting negative emotions that may resemble or even constitute PTSD. It is this meaning-making process that can create an impetus for developing deeper relationships, increased personal strength, and changed priorities (Hartman & Zimberoff, 2007). For example, a qualitative study of women thriving as adults after experiencing child abuse
found that their stories of success often followed extended periods of depression, eating disorders, or substance abuse (Hall, Thomas, Tennison, & Bolton, 2009).

This complex picture of strengths and problems disrupts simplistic understandings of resilience as being merely the absence of symptomatology. As practitioners, we have often pathologized the very behaviors that have helped people to survive (Burstow, 2005). There is an increasing interest in therapeutic approaches that recognize that negative thoughts and emotions are an intrinsic part of being human, thus challenging the traditional cognitive behavioral therapy approach of reducing the prevalence of negative cognitions (Harris, 2007). For survivors of trauma, emotional pain is ever more present. Feminist approaches may be the most effective when they focus not on the abatement of all symptoms, but on the survivor’s ability to predict and manage the outcomes of trauma; this focus recognizes that experiences of shame, self-blame, and isolation may persist, even in the face of the superficial relief of symptoms, such as the cessation of self-harm (Harvey, 1996).

There are several understandings of mental distress that move beyond a psychiatric counter-narrative; these understandings are not defined in opposition to the psychiatric narrative but instead are part of an entirely different discourse (Adame & Knudson, 2007). Newman (2000) argued that the characterizations in the *Diagnostic and Statistical Manual of Mental Disorders* can be of substantial value—but that it is a fallacy to believe that the human psyche can be understood by way of empiricist science. Rather, he contended that the manual is “a poetic glossary, a compendium of the usual characterisations of human emotionality” (p. 258). In a similar vein, the postpsychiatry perspective does not claim that psychiatric assessments are false, but limited (Bracken & Thomas, 2005). Within this paradigm, diagnosis is seen as an exploratory process, conducted in full collaboration with the client. This framework aims to grapple with issues of context and meaning, challenging the primacy of biological explanations and yet not denying that mental distress is an embodied experience. As Bracken and Thomas (2005, p. 107) stated, “Are there other ways of encountering and understanding states of madness and distress? ... Traditional psychiatry ... [has] theorized on the basis that there is some basic core of human psychology that is universal, not context bound. We disagree. We believe that the ‘mind’ is social through and through, cannot be understood apart from ‘its’ body, and never static.”

As social workers, we are involved in meaning making with our clients. The search for meaning is often of even higher importance to survivors of trauma because their experiences have denied their human rights to safety and dignity. Diagnostic categorization may enable some women to make sense of their experiences of victimization and to feel less blamed within their current contexts. However, it does not allow women to find their own voices. Feminist social work aims to empower women to reclaim the voices that were silenced within a context of trauma, so they may tell their own stories. Privileging the voices of women and avoiding a reliance on a diagnostic manual enable a social worker’s beliefs and assumptions to be challenged and, at times, radically reconceptualized, in order to understand situations of injustice more fully. Understanding the narratives of women means that women are not confined to a one-size-fits-all assessment of their experiences. The willingness to wrestle with uncertainty and difference allows social workers to engage more genuinely in the processes of social change that are intrinsic to feminist practices.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author was supported by an Australian Postgraduate Award.
References

Adame, A. L., & Knudson, R. M. (2007). Beyond the counter-narrative: Exploring alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry, 17*, 157–178.

Australian Centre for the Study of Sexual Assault. (2012). Review: International Violence Against Women Survey: Findings from the Australian component. Retrieved from http://www.aifs.gov.au

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*, 17–21.

Bentall, R. P. (2010). *Doctoring the mind: Why psychiatric treatments fail*. London, England: Penguin Books.

Berg, S. (2002). The PTSD diagnosis: Is it good for women? *Affilia, 17*, 55–68.

Bracken, P., & Thomas, P. (2005). *Postpsychiatry*. Oxford, England: Oxford University Press.

Bremner, J. D., Narayan, M., Staib, L. H., Southwick, S. M., McGlashan, T., & Charney, D. S. (1999). Neural correlates of memories of childhood sexual abuse in women with and without posttraumatic stress disorder. *American Journal of Psychiatry, 156*, 1787–1795.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence and Abuse, 10*, 375–388.

Briere, J. N., & Lanktree, C. B. (2012). *Treating complex trauma in adolescents and young adults*. Thousand Oaks, CA: Sage.

Brock, D. (1991). ’Talkin’ ‘bout a revelation: Feminist popular discourse on sexual abuse. *Canadian Women’s Studies, 12*, 12–15.

Brown, L. S. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*, 464–471.

Burstow, B. (1992). *Radical feminist therapy: Working in the context of violence*. Newbury Park, CA: Sage.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women, 9*, 1293–1317.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the DSM. *Journal of Humanistic Psychology, 45*, 429–445.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford.

Cohen, J. N. (2008). Using feminist, emotion-focused, and developmental approaches to enhance cognitive-behavioural therapies for posttraumatic stress disorder related to childhood sexual abuse. *Psychotherapy Theory, Research, Practice, Training, 45*, 227–246.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*, 412–425.

Cyrulnik, B. (2007). *Talking of love on the edge of a precipice* (D. Macey, Trans.). London, England: Allen Lane.

Davies, J. M., Lyon, E., & Monti-Catania, D. (1998). *Safety planning with battered women: Complex lives/difficult choices*. Thousand Oaks, CA: Sage.

Fine, C. (2010). *Delusions of gender*. Duxford, England: Icon Books.

Fullager, S. G. S. (2002). Rethinking, gender, risk and depression in Australian mental health policy. *Australian e-journal for the Advancement of Mental Health, 1*, 2–13.

Gilbertson, M. W., Shenton, M. E., Ciszewski, A., Kasai, K., Lasko, N. B., Orr, S. P., & Pitman, R. K. (2002). Smaller hippocampal volume predicts pathologic vulnerability to psychological trauma. *Nature Neuroscience, 5*, 1242–1247.

Gilfus, M. E. (1999). The price of the ticket: A survivor-centered appraisal of trauma theory. *Violence against Women, 5*, 1238–1257.

Haaken, J. (1998). *Pillar of salt: Gender, memory, and the perils of looking back*. New Brunswick, NJ: Rutgers University Press.

Hall, J. M., Thomas, S. P., Tennison, C. R., & Bolton, K. M. (2009). Thriving as becoming resolute in narratives of women surviving childhood maltreatment. *American Journal of Orthopsychiatry, 79*, 375–386.

Harris, R. (2007). *The happiness trap*. Auckland, New Zealand: Exisle.
Hartman, D., & Zimberoff, D. (2007). Posttraumatic growth and thriving with heart centered therapies. *Journal of Heart-Centered Therapies, 10*, 65–85.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*, 3–23.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York, NY: Basic Books.

Kelly, B., & Gates, T. (2010). Using the strengths perspective in the social work interview with young adults who have experienced childhood sexual abuse. *Social Work in Mental Health, 8*, 421–437.

Kubany, E. S., Leisen, M. B., Kaplan, A. S., Watson, S. B., Haynes, S. N., Owens, J. A., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment, 12*, 210–224.

Levine, P. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. Berkeley, CA: North Atlantic Books.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet, 364*, 453–461.

Lieb, K., Völlm, B., Rücker, G., Timmer, A., & Stoffers, J. M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *British Journal of Psychiatry, 196*, 4–12.

McDonald, C. (2003). Forward via the past? Evidence-based practice as strategy in social work. *The Drawing Board: An Australian Review of Public Affairs, 3*, 123–142.

McKenzie-Mohr, S. (2004). Creating space for radical trauma theory in generalist social work education. *Journal of Progressive Human Services, 15*, 45–55.

Miller, N., & Tougaw, J. (2002). Introduction: Extremities. In N. Miller, & J. Tougaw (Eds.), *Extremities: Trauma, testimony, and community* (pp. 1–24). Chicago: University of Illinois Press.

Naples, N. A. (2003). Deconstructing and locating survivor discourse: Dynamics of narrative, empowerment, and resistance for survivors of childhood sexual abuse. *Signs, 28*, 1151–1185.

Newman, F. (2000). Does a story need a theory? Understanding the methodology of narrative therapy. In D. Fee (Ed.), *Pathology and the Postmodern: Mental Illness as Discourse and Experience* (pp. 248–262). London, England: Sage.

Nutt, D. J. M., & Malizia, A. L. (2004). Structural and functional brain changes in posttraumatic stress disorder. *Journal of Clinical Psychiatry, 65*, 11–17.

Perry, B. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma, 14*, 240–255.

Root, M. P. P. (1992). Reconstructing the impact of trauma on personality. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 229–265). New York, NY: Guilford.

Ross, C., & Pam, A. (1995). *Pseudoscience in biological psychiatry*. New York, NY: John Wiley.

Scheper-Hughes, N. (2008). A talent for life: Reflections on human vulnerability and resilience. *Ethnos, 73*, 25–56.
Wagner, A. W., & Linehan, M. M. (1994). Relationship between childhood sexual abuse and topography of parasuicide among women with borderline personality disorder. *Journal of Personality Disorders, 8*, 1–9.

Webster, D. C., & Dunn, E. C. (2005). Feminist perspectives on trauma. *Women and Therapy, 28*, 111–142.

Weniger, G., Lange, C., Sachsse, U., & Irle, E. (2009). Reduced amygdala and hippocampus size in trauma-exposed women with borderline personality disorder and without posttraumatic stress disorder. *Journal of Psychiatry and Neuroscience, 34*, 383–388.

Wilson, E. A. (2004). *Psychosomatic: Feminism and the neurological body*. Durham, NC: Duke University Press.

Worell, J. (2001). Feminist interventions: Accountability beyond symptom reduction. *Psychology of Women Quarterly, 25*, 335–343.

**Author Biography**

**Emma Jane Tseris**, BA, BSW (Hons), is a postgraduate research student in social work at the University of Sydney, Education Building A35, Sydney, New South Wales 2006, Australia; e-mail: emma.tseris@sydney.edu.au.