A feminist post structural analysis of Trauma Informed Care policies in BC

by

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

My study examines trauma informed practice (TIP) policies in BC, Canada. My chosen methodology, what is the problem represented to be (WPR) (Bacchi 2009), makes politics visible in policies. I am interested in the effects of trauma policies on women who experience male violence. How does discourse produce certain effects and constitute specific subjects within these texts?

I extend a politicized analysis of TIP policies, specifically, an in-depth feminist post structural analysis. I advance an understanding of the effects of policy, particularly for women who have experienced male violence and who receive services under the TIP guidelines. I note the absence of an intersectional analysis and the lack of attention paid to power relations, specifically associated with the provision of care within the health care system, the construction of the traumatized female subject and the absence of a social justice lens in TIP policies.

My study addresses the meanings, and resulting practices arising from the TIP policy and its impacts on women's lived experiences. My feminist post structural analysis provides a critique of TIP policies glaringly absent from the literature. I examine available literature, which evaluates TIP. My analysis deepens the understanding of the policy's inherent assumptions by revealing the problem of trauma, as represented in TIP policies.

I explore the emergence of the dominant concept of trauma in the completion of a genealogy of trauma. I uncover the commonly accepted trauma ethos, a set of principles and beliefs about violence against women that has set the path for a trauma discourse in BC's guidelines, policies, and programs. I explore my interest in

the ontology of trauma, the nature of trauma itself and the way of being when trauma has occurred. While exploring this interest through a genealogy of trauma, I identify five historical figures; the traumatized female figure, the assaulted woman figure, the wounded veteran figure, the colonized Indigenous woman figure and the emancipated woman figure.

My study explores how women are obscured and invisible in policies intended to address violence against women. I demonstrate that this invisibility results in gender-neutral policies-if there is no gender-based violence- we, therefore, do not have to think of gender-based treatment. The patriarchal erasure of women from trauma policies continually repositions what the problem is represented to be.

These policies constitute women as the less valued subjects, fundamentally damaged and flawed. Trauma policies shape women as people who can damage staff; assuming they are a source of trauma infection; they can infect staff with their trauma resulting in vicarious traumatization of staff. Trauma policies characterize the traumatized female subject as fundamentally different from the staff or the professional expert. Only certain kinds of women can be traumatized, the mentally ill and substance-using women. My study exposes the presupposition embedded in policies that only certain women are violated, and other women are unlike them. This trauma discourse is grounded in racism, colonialism and sexism, built on stereotypical patriarchal representations of women, resulting in the stigmatization of women who experience male violence.

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Dedication

First of all to the remarkable women who have shared their stories with me –you are my true teachers.

In gratitude to all health care practitioners who work tirelessly on behalf of women who experience violence, mental health and substance use concerns. A special thanks to those leaders and direct care staff that participated in my study.

Thank you to my supervisory committee Dr. Strega (Susan), Dr. Worthington (Cathy) and Dr. Prince (Michael) - your support of this grey scholar was unwavering and I could not have done it without you.

To Doug and Ada with love, the parents who encouraged your feminist daughter's education and life long learning – even when it was not popular to do so- you were truly before your time!

Parker, beneath my feet, my true companion on this journey, your steady breath guided my way, it is complete-may you rest in peace.

Lou, my deepest and sincerest appreciation for your love, support, encouragement and life long commitment to our dream- another one off the bucket list!

Ad astra per aspera

John James Ingalls

Through adversity to the stars

Chapter One: A Feminist Post Structural Analysis of Trauma Informed Policies in BC

I have worked in various community and health care settings with women who have experienced male violence. During my work in women's centers and rape crisis centers, I developed a strong sense of myself as a feminist. I incorporated these values into my social work practice. I learned about trauma informed practice (TIP) in 2010 and immediately felt an affinity for this value-based practice. As my journey progressed, I appreciated colleagues in the health care sector who responded overwhelmingly to this approach with well-intentioned enthusiasm. I continue to admire the work completed within these guidelines, including by the leaders and direct care staff participants who graciously volunteered to participate in my study.

The unfolding of my Dissertation

My dissertation follows a congruent format with my methodological approach; what is the problem represented to be (WPR)? The writer's location provides a foundation for this approach to policy analysis. What are the writers' perspectives and analyses of questions addressed by policy proposals? I begin with my self-location in the analysis of trauma informed policies. What do I bring to the table in beliefs, understandings, knowledge and attitudes when investigating this policy proposal?

I explain the common understanding of trauma informed practice and provide definitions of foundational concepts to set the knowledge for understanding more complex concepts such as feminist post structuralism (FPS). I move into a genealogy of the concept of trauma to provide a historical context for TIP development. This genealogy includes a history of psychoanalysis, feminism, the women's and other social

movements and the development of the concept of trauma. The WPR approach utilizes genealogy to prepare for the analysis of problem representations in policy proposals. I chose to present this genealogy first in my work in order to share a historical critique of the concept of trauma and to set the context of my study. I present my theoretical foundation for my analysis, feminist post structuralism because the context of feminism and post structural theory are essential factors in developing my analysis of TIP policies.

My methodology and data chapters follow. During my dissertation writing, it became abundantly clear that little evaluative or analytical literature on TIP policies existed even though this value-based practice occurs extensively across North America. To confirm my suspicions, I completed a literature review to support my understanding. This literature review is located in Chapter 8, serves to introduce my summary and findings and confirms that my analysis contributes to the literature related to policy analysis in health care.

My location in the analysis

The WPR approach requires that I describe my own genealogy as it relates to the genealogy of trauma (Chapter Four). Bacchi and Goodwin (2016) insist on a self-problematization of the author's perspective of the topic under examination (p. 20). I am a clinical social worker who has worked for several decades under the guidance of the trauma ethos in the health care field. My life's work has been primarily dedicated to women who have experienced male violence; my work and personal journey have been interwoven and influenced by the women's narratives of their experiences of violence, as well as by my own personal experience of violence. I was introduced to feminism during my undergraduate degree, during which time I read feminist authors like Susan Brownmiller, Susan Griffin, and Mary Daly. In 1980, I began working as a volunteer

(and later, as a paid staff member) with a community-based rape crisis center and a women's center located in a primarily blue-collar town. I was an active participant in the women's anti-violence movement, and became involved in a consciousness-raising group, which influenced the way in which I thought about gender-based violence. I began to understand the sociocultural context of violence against women and, as a White woman within the feminist movement, struggled when confronted with my own racism. I consequently worked as an ally to support important changes within women's organizations for the inclusion of women of colour. I provided support to women who had survived male violence and was involved in activism around these issues, such as organizing Take Back the Night marches.

My work with survivors inexorably interweaves with my political activism. My experience of feminism situates within a hierarchy of power; I was taught that women are the oppressed, and men are the oppressors. The gender binary shaped my worldview, and in turn, my worldview presented a challenge to my post structural analysis. I developed the lens of women having power asserted over them as the oppressed, while men wielded power over women as the oppressors. This understanding is contrary to the post structural view of gender relations as fluid and non-fixed, and power as recursive.

I have worked in various women's organizations where these binary views were supported, and have worked with women in various service settings such as battered women's shelters, residential treatment centres, and prisons. In each setting, I worked through the lens of the impact of male violence in women's day-to-day lives. When I started working with women in prison, my worldview began to shift. I witnessed women who resisted male oppression in various ways, sometimes by choosing intimate

relationships with other women, becoming self-supporting by working within non-traditional occupations, or by defending themselves by killing their violent male partners. I began to understand that women could assume power in the context of their lives albeit sometimes in a destructive way. However, this acquired knowledge did not alter my analysis of power relations; my analysis remained simplistic, non-recursive, and fixed in the view of power as binary, of one over the other.

My exposure to a diversity of women, my struggles with the non-responsiveness of systems such as the criminal justice and health care systems, and witnessing women's stories of male violence have shaped my understanding of the world and my work with survivors of violence. Through my work and research in feminist post structuralism (see Chapter Three), I now see power relations as fluid, recursive, and productive.

My growth through the decades—just like the changes in the services and practices addressing violence against women—has been exciting, fractured, circular and at times regressive. My personal and professional history reminds me of the importance of the context and the conditions of women's lives. I have come to appreciate how the intersections of class, culture, race, gender, sexual orientation, and gender identity interfacing with practices within the system of care highlight the power relations faced by women when utilizing these systems. My location and privilege as a White professional working woman is not lost on my knowledge that my identity has been created by a different and more privileged location than the raced, poor, and homeless assaulted women that I encounter as clients. My Whiteness, access to a home of my choosing, and educational opportunities has led to a distinct and privileged material reality. This knowledge has challenged me to expand my analysis of patriarchal power structures to

include an intersectional analysis of violence against women; "the various ways in which race and gender interact to shape multiple dimensions" of racialized women's experience of violence (Crenshaw, 1991, p. 1244) and to integrate this analysis into my work.

I believe an intersectional framework can be consistently applied in a feminist post structural analysis. I am interested in the genealogy that reflects the complexity of the development of policies and practices in the health care field. An intersectional framework is congruent with my acquired knowledge, meaning, and location in the field of trauma and violence. The complex and recursive intersections of power relations are relevant to my specific study of women in British Columbia (BC) accessing services under specific policies and guidelines (see Chapter Six). These guidelines are influenced by the concept of trauma under a modern trauma ethos (Chapter Four). The field of practice (healthcare) influences and impacts the problematization of trauma (violence) in policies in British Columbia, and historical figures are created through particular practices under the guise of a trauma ethos.

My Analysis

In my analysis of TIP policies, I do not intend to judge those who enact these guidelines or the organizations that incorporate them into practice. Nevertheless, I provide a critical appraisal of TIP policy and its role on the lived effects for women who experience male violence. Policies are problematizing activities. "They assume the existence of a problem that needs to be fixed" (Bacchi, 2009, p. xi). Also Bacchi (2009) reinforces, what we propose to do about something, indicates what we think needs to be changed (p. xi). "This characterization of the problem is the place to start in order to understand how an issue is being understood" (Bacchi, p. xi). While policies represent the problem to be solved and provide solutions for these problems, other unintentional

consequences arise, including creating new presuppositions about those individuals the policy identifies as requiring assistance. It is important to emphasize that the focus of this analysis is not to determine if there is an intentional shaping of issues but "rather, the task is to *identify deep conceptual premises* (italics in original) operating within problem representations" (Bacchi, p. xix). These conceptual premises go undetected by those working within the policy. My analysis identifies taken for granted premises in the trauma informed care policies and the presuppositions about the women's experiences of trauma and violence and their response to these experiences.

Trauma Informed Care

Trauma Informed care (TIC) refers to a way of being with a person who is receiving services or working to deliver services in the public service sector. TIC also applies to the organization of services and how they provide those services. TIC was developed from a foundational understanding that most individuals receiving human services had experienced some physical, psychological or sexual trauma (BC Provincial Mental Health and Substance Use Planning Council, 2013; Fellitti et al., 1998). The research regarding adverse childhood experiences led to the development of practices that would guide the way professionals treated individuals in the public service sector.

Many organizations chose TIC as the guiding philosophy for compassionate and non-judgmental care in many organizations (Bryson et al., 2017). The TIC principles provide guidelines for practitioners' practice. The literature uses the terms TIC and trauma informed practice interchangeably. However, it is important to note that; trauma informed care refers to a philosophy of practice within a system of care (McKenzie-Mohr, 2012, p. 136). Trauma informed practice refers to working within a system

providing direct care to staff and clients/patients (BC Provincial Mental Health and Substance Use Planning Council, 2013).

In the human services in British Columbia, such as health care, child and family services, and education, an increasing number of service providers have adopted TIC as a practice philosophy. I focus my study on the healthcare sector. To understand the breadth of the application of TIC principles and practice, I complete a genealogy of the concept of trauma in Chapter Four and review TIC guidelines adopted by various organizations and government-generated reports in Chapter Six.

Authors have described TIC as a movement that has swept across North America even though "the lack of high-quality research on the process and effectiveness of TIC is a roadblock to broader adoption" (Baker et al., 2018, p. 672). The Substance Abuse and Mental Health Services Administration (SAMHSA) established the National Centre for TIC in 2005. SAMHSA (2015-2020) conducted a significant research study to investigate services for women with co-occurring mental health and substance abuse disorders who have also been victims of violence. The first phase of the study developed integrated system service strategies, and the second phase evaluated those services. Several publications grew from this study. The genesis of violence against women discourse to trauma discourse is apparent in these publications. In Chapter Four, I trace the genealogy of trauma in order to highlight the ramifications of this transformation for women-serving organizations.

Trauma experiences became recognized early on in psychotherapies and were formalized in the Diagnostic Statistical Manual for psychiatry (American Psychiatric

Association, 2013). Human services began to take note of TIC and apply these principles in mainstream human service work.

Socio-structural conditions such as the women's liberation movement inspired increasing revelations from women about their abuse from intimate partners and strangers. As early as 1992, authors such as Judith Herman, in her book *Trauma and Recovery*, began to recognize the need for a new approach to working with women who had experienced violence. In *Creating Sanctuary* (1997), Sandra Bloom published a model of care; strategies to build organizations based on TIC principles.

In Winnipeg, Canada, Klinic, a community-based healthcare clinic, began publishing its TIC model in 2008 and in 2011, and established a trauma information and education centre. The BC Provincial Mental Health and Substance Use Planning Council published the *Trauma Informed Practice (TIP) Guide* in 2013, building on Klinic's work. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) is a practitioner's handbook for working with individuals who have experienced trauma. This guideline is the centrepiece in my analysis of TIP policies in Chapter Six. Throughout the dissertation I refer to this guideline as the TIP Guide (2013). BC Mental Health and Substance Use Services, the organization within which I collected my data, also utilizes the SAMSHA guideline, *Concept of Trauma and Guideline for a Trauma Informed Approach,* published in July 2014 and is explored in Chapter Six. Both of these guidelines list a set of TIP principles.

TIP principles

The TIP principles remain essentially the same regardless of the source, whether in grey or peer-reviewed literature, practice guidelines and handbooks. The principles

directed towards practitioners included in the *TIP Guide* (2013) include awareness of trauma, emphasis on safety and trustworthiness; the opportunity for choice, collaboration and connection; and strength-based and skill-building approaches to practice (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp.13-14). The *TIP Guide* applies these four principles to work with both individuals and systems.

The first principle, the awareness of trauma, is foundational to practice. TIP expects practitioners to be aware of the population they work with and their clients' lived experiences, such as childhood traumatic experiences and violence experienced as adults. The *TIP Guide* assumes that awareness of these traumatic experiences "increase the capacity among MHSU [mental health and substance use] practitioners and organizations to better serve people impacted by violence and trauma thereby improve[ing] health outcomes for clients" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4). The practitioner needs to understand the population health literature. For example, up to 90% of individuals accessing mental health and substance use services in Canada have experienced violence as children and adults (BC Provincial Mental Health and Substance Use Planning Council, 2013 p. 9). In specialized populations, the rate may be higher. For example, as I discuss in Chapter Four, statistically, Indigenous women experience more violence than non-racialized women.

The awareness of trauma experiences and the prevalence of violence for Indigenous people is considered vital to practice, so much so that even if the person receiving service does not disclose a traumatic experience, they are to be treated as though they are a traumatized client (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 12). This approach is a universal approach; everyone is

treated as though they have experienced trauma. The awareness of trauma informs health care practitioners' practice. The awareness of trauma focuses organizations on developing policies, practices, protocols, and guidelines to ensure that trauma and its aftermath inform healthcare planners' work in every organizational detail (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 5).

The second TIP principle, emphasis on safety and trustworthiness, relies heavily on trauma treatment stages in Judith Herman's (1992) work *Trauma and Recovery*. Herman explored three phases of trauma treatment for the practitioner. The first phase she defined as safety and trustworthiness within the therapeutic alliance between the individual practitioner and the client/patient. Herman assumes that the client has experienced several breaches of trust in formative relationships as children and intimate relationships as adults. She postulates that these breaches impact the therapeutic care relationship. Herman maintains that the first phase of trauma treatment must be the re-establishment of trust and safety. She articulates that this first phase must occur before any other treatment, is foundational to the healing relationship and might be the only treatment required. In other words, re-establishing trust and safety is a priority and does not necessitate discussing the trauma details. Discussing details of the trauma too soon in the relationship may be viewed as unsafe and a breach of trust. The *TIP Guide* (2013) applies Herman's first stage of trauma treatment to the second principle of safety and trustworthiness.

Safety and trustworthiness are essential in the therapeutic relationship and the physical environment (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp. 25-29). The practitioner exhibits trustworthy behaviour when they do

what they say they will do when they say they will do it. The practitioner may work in a complex healthcare environment that changes quickly, preventing the intended intervention from being completed. If the practitioner cannot follow through on commitments, they need to collaborate with the client on the next steps—safety in the relationship increases as trust increases. Psychological safety relies on trustworthiness. Physical safety is also a component of trustworthiness. Organizations are responsible for the safety of the clients/patients in their care. The *TIP Guide* (2013) outlines requirements for an organization to provide safe care. Categories include overall policy and program mandate, leadership, hiring practices, training for staff, support and supervision of staff, screening and assessment of clients, policies and procedures, and monitoring and evaluating services (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp. 47-57). The *TIP Guide* has a far-reaching approach to applying TIP to the individual care of clients/patients and as a guiding edict for entire organizational operations.

The third TIP principle, the opportunity for choice, collaboration and connection, reminds the practitioner of the concept of client-centred care (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp.29-31). Carl Roger's philosophy of client-centred care was introduced in the 1950s-1960s before TIP appeared in the literature. The client-centred care philosophy encompasses the ideals of choice, collaboration, and connection and the idea that the practitioner is required to view the situation and choices for intervention from the client perspective. According to client-centred care, the power within the helping relationship within the context of the client--practitioner relationship is acknowledged and actively addressed through empathic

responses and client-centred conversations. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) attends to choice and collaboration by indicating the opportunity for empowering the client to make choices regarding their care. Client-centred care, choice and collaboration have a subtle distinction in that one may collaborate with a client in providing services while at the same time maintaining a power position within that relationship. An example is when a practitioner only presents to the client choices for treatment that only the practitioner sees are appropriate. This distinction is explored further in the Chapter Six analysis of the *TIP Guide*.

The fourth TIP principle, strength-based and skill-building approaches to practice, relies on the previous history of the 1980s of strength-based approaches in social work practice (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 14). This philosophy and way of practicing remind the practitioner that individuals receiving care are resilient and have a set of qualities and coping strategies that allowed them to survive the past violence they have endured. The practitioner must recognize these strengths and help the client utilize the strengths to build a new set of positive coping skills. For example, the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) encourages qualified practitioners to link past traumas and current thoughts, feelings and physical sensations (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). In doing so, the practitioners are encouraged to teach clients a new way of coping and emotional self-regulation. The *TIP Guide* states that emotionally self-regulated clients increase the likelihood that they will be successful in accessing mental health services (BC Provincial Mental Health and Substance Use Planning Council, 2013 p. 40).

Substance Abuse Mental Health Administration (SAMHSA) principles

TIC has been developed and applied across Canada and the US with health care practitioners and organizations. Studies consistently utilize TIC as a foundational philosophy or value statement on which to build practices and programs. The SAMHSA multisite study at nine women's treatment locations in the US reinforced the dissemination of trauma informed care (Markoff et al., 2005, p. 526). Organizations in BC supported TIC as a care model for individuals struggling with the effects of trauma (Bryson et a. 2017; Torchalla et al., 2015, p. 7). A more thorough literature review is found in Chapter Eight, highlighting some of the inconsistencies, misperceptions and truth claims in the TIP literature intended to solve a myriad of ills.

SAMHSA published the manual: *Concept of Trauma and Guideline for a Trauma Informed Approach* in July 2014. SAMHSA's TIC principles are consistent with the *TIP Guide's* (2013) principles. SAMHSA (2014) identifies TIC key components; recognizing the signs and symptoms of trauma; realizing the widespread impact; understanding the paths of recovery and client's resiliency; responding with fully integrated knowledge about trauma in policies, procedures and practices; and the practitioner ought to actively resist re-traumatization of clients (p. 9). SAMHSA presents six principles of TIC that encompass the *TIP Guide* principles. The six principles are; safety, trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; cultural, historical, and gender issues. The SAMHSA principles detail the impact of TIC principles on the relationship between the health care practitioner, the person receiving services and the person's family. They also reflect the client resilience by including peer support, mutuality of decision-making, empowerment, and voice as critical principles in the TIC approach (SAMHSA, p.10). Strength-based and skill-building are encapsulated

in peer support and empowerment principles. The inclusion of cultural, historical and gender-based trauma includes intersectional identities in terms of specific populations such as women, LGBT2S and Indigenous peoples.

Summary

The application of TIC and TIP principles has exploded across service sectors in BC over nine years. I have included examples of these applications in Chapter Six: a feminist post structural analysis of the TIP policies. I have worked in several program areas in healthcare that adopted the TIP principles. As I began to apply these principles to my social work practice, I became curious about the principles and their adoption among various service sectors. I was curious about the inclusion of the social determinants of health when working under the guidance of TIP principles. In order to explore my curiosities, I chose to complete a feminist post structural analysis (see Chapter Three) of TIP policies and guidelines in BC, utilizing the what is the problem represented to be approach to policy analysis described in Chapter Five (Bacchi, 2009). I analyzed in detail the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) to understand how TIP creates meaning, subjects, and governing practices. I chose to complete a post structural interview analysis designed by Bacchi and Bonham and outlined in *Poststructural policy analysis* (Bacchi & Goodwin, 2016) to interview participants, including leaders within the organization who are instrumental in operationalizing the TIP principles and direct Care staff who work with clients. The analysis of the interviews appears in Chapter Seven. My curiosities and interests, my history with Feminism and activism led me to pursue the study of TIP from a feminist

post structural analysis detailed in Chapter Three. I focus on taking apart the endless layers that constitute social reality, and taken for granted truths in the TIP policies.

In Chapter Two, I introduce foundational concepts that I believe are useful in understanding my analysis and its foundation in feminism, Michel Foucault's influence and an introduction to feminist post structuralism, which inform my study of TIP policies in BC.

Chapter Two: Foundational Concepts

Feminist post structuralism (FPS) relies on foundational concepts drawn from both post structuralism and feminism. In this chapter, I set a theoretical context for FPS. I begin with a description of three major and distinct streams of feminist thought and their relationship to FPS. I next discuss why Foucault is important to the theoretical underpinnings of FPS. Then, I explore the concepts of governing and women's materiality, central to my critique of the TIP policies. I define the concept of self-problematization to elucidate the underpinnings of my location in the study. Finally, I incorporate the critique of positivist epistemology by feminist post structuralists to highlight FPS and its unique perspective in critiquing policies related to women, gendered violence and trauma. This chapter defines core concepts as they are applied to FPS, and in Chapter Three, I describe the theoretical foundation of FPS in more depth.

Feminism

Feminism has become a common term in modern history. When the Prime Minister of Canada declares, "I am a feminist," certain assumptions are made, and meaning is attributed to feminism that makes the term common parlance. Trudeau's statement;

> I'm going to keep saying, loud and clearly, that I am a feminist. Until it is met with a shrug," he told the UN women's conference Wednesday, in an auditorium filled with a near-total female audience. "It shouldn't be something that creates a reaction. It's simply saying that I believe in the equality of men and women and that we still have an awful lot of work to do to get there. That's like saying the sky is blue and the grass is green.(Maloney, 2016)

Contemporary feminism consists of not one but many theories of feminism, including most prominently liberal, socialist, and radical feminism (Hekman, 1990, p. 2). Generally, feminism is rooted in the gender equality movement, with gender equality premised on socially constructed categories of men and women. In the emergence of the first wave of the feminist movement, the suffragettes set a foundation for liberal feminism, the second wave (see Chapter Four). In the present moment, Prime Minister Trudeau's reference to feminism and gender equality illustrates liberal feminist views rooted in the binary categorization of men/women.

Liberal Feminism

Liberal feminism is characterized as the first contemporary feminism. Liberal feminism separates biological sex from the social construction of gender (Cahill, 2001, p. 23). A pattern of critique subsequently emerged from this distinction. Liberal feminism is grounded in the sex-gender distinction that gave rise to a feminist perspective in the policy reform of the 1970s (Cahill, 2001, p. 16). According to Cahill (2001), " liberal feminism of the 1970s assumed that it was the distinction between men and women that oppressed the latter in favour of the former" (p. 31). The male/female binary implicitly supports the dualism that privileges the man over the woman; as Hekman (1990), recognized as an early feminist post structuralist, states, "the rationality of male thought is still the standard by which the virtues of 'female nature' are judged" (p. 6). This dualism implies that a woman must aspire to be like a man to gain equality.

Hekman (1990) warns, "the attempt to privilege the other side of this dualism [the female] will only meet with failure because it will result in perpetuating these dualisms" (p. 5). I am wary of liberal feminist theorists who continue with the simplistic gender binary of male as the oppressor and female as the oppressed. I believe these binary

gender categories are simple and singularly framed. The category of ‘woman’ utilized in liberal feminist theory contains presuppositions and static representations—this woman is the generic woman (Cahill, 2001, p. 6). Cahill (2001) argues that by removing this distinction, "justice would more easily be achieved" (p. 31) because a gender analysis frees us from a paradigm in which women's distinct role competes with a more 'valued' male gender. I find the liberal feminists’ dichotomous gender approach to be reductionist and a limiting factor that has outlived its usefulness when analyzing power relations contained in health care policies. I believe that an in-depth analysis is required when examining women, violence, and related health care policies. A FPS analysis lends itself to an inclusive and deeper analysis of women's experiences of male violence.

Socialist Feminism

Socialist feminism expands liberal feminist theory to include a broader analysis by examining factors such as class oppression. Socialist feminism relies on Marxist theory to incorporate an analysis of the oppressive forces of capitalism with patriarchy. Socialist feminists reject the notion that gender oppression is a subset of class oppression and instead focus on class oppression and the interplay of gender (Hekman, 2010, p. 3). Socialist feminists are concerned with women's material lives as impacted by all economic, social, and culturally oppressive sources (Hekman, 2010, p. 3). Socialist feminism builds on the foundations of liberal feminism and applies these to the Marxist theory of oppression. My criticism of liberal feminism stands true for social feminism. The value of socialist feminism focuses on the patriarchy's lived effects in women's lives, albeit economically focused, socialist feminism begins to expand our thinking beyond

theory to material effects. A FPS analysis of violence must attend to the lived effects in women's lives (Hekman, 2010, p. 3).

Radical Feminism

Radical feminism is concerned with the patriarchal oppression of women while, at the same time, incorporating a broader perspective of a more extensive system of domination (Cahill, 2001, p. 183). While both liberal and radical feminists espouse the possibility of women's autonomy within a given just political structure (Cahill, 2001, p. 45), radical feminism concentrates "its efforts primarily on the transformation of political institutions" (Cahill, 2001, p. 64). In contrast, liberal feminism focuses on "the increasing degree of representation of women in them" (Cahill, 2001, p. 64). Radical feminism challenges what remains invisible in the liberal feminist project, the unquestioned "degree to which those institutions were distinctly marked as masculinist" (Cahill, 2001, p. 64). Radical feminism repudiates political structures and societal institutions, refusing to join them and seeking to disrupt their operation and existence. For example, in the case of rape, radical feminist theory emphasizes the role of rape "in sexual hierarchy that renders women socially and politically inferior," rather than the act of rape as an individual phenomenon (Cahill, 2001, p. 183). While radical feminism's attention to power in systems is consistent with certain aspects of FPS, it is the third wave of feminism that informs and most closely aligns with FPS thought (see Chapter Three).

Feminism's relationship to FPS

Even though feminism informs FPS, feminist poststructuralists often do not distinguish between which feminist theorists they draw on. Feminist poststructuralists agree feminists are interested in social constructionism as an "invaluable tool for

explaining the workings of the social structures that create and maintain the subordination of women" (Hekman, 2010, p. 5). Feminists are concerned with women's oppression and their material day-to-day lives and agree, "that their social, economic, and political status is inferior to that of men (Hekman, 2010, p. 3). Hekman comments on the association of patriarchy and oppressive structures producing material effects for women; for example, “they suffer sexual abuse at the hands of men" (Hekman, 2010, p. 3). The dynamic tension amongst feminists and poststructuralists lies in postmodernism’s frame of gender neutrality. It is crucial to feminists that the effects of gender distinction are at the forefront of the analysis.

Feminists claim that a feminist epistemology is required to replace the masculinist one based on gender neutrality (Hekman, 1990, p. 5). Masculinist epistemologies utilize gender-neutral discourses, which frame women as non-sexed subjects with no consideration of the socio-cultural context of gender oppression. Masculinist assumptions about personhood and an assumed autonomy of the gender-neutral subject are reflected within gender-neutral policies and, for this reason, such assumptions “sit in some tension with feminist discourses” (Moulding, 2016, p. 186). Hekman (2010) argues for a newly developed "feminist settlement, “which incorporates a feminist analysis. Hekman insists that this new settlement is best positioned for solving the crisis in knowledge; the knowledge formation of the sexed subject who experiences lived effects related to gender oppression (p. 67). This new feminist settlement addresses “epistemological, ontological, political, scientific, and technical issues” (Hekman, p. 67) and indicates that this settlement remains unnamed; however, it has a relationship with postmodernism (Hekman, p. 67)

Hekman (2010) emphasizes that feminist theory supports the linguistic turn of postmodernism (p. 67); she contends that feminist theorists have developed an approach that offers the most explicit definition of a new critical path of analysis (Hekman, 2010, p. 67). Warner (2009) adds that the "desire to challenge gender inequalities by providing an emancipatory framework for social transformation" (p. 4) is significant to the feminist social action agenda. In her more recent work, Hekman emphasizes that "feminist theorists have a particular stake in retaining reference to reality" (p. 3) and notes that feminists understand this reality and act to alleviate the pain caused by it (p. 5).

The marriage of feminism and post structuralism has featured both harmony and discord. Warner (2009) responds to uniqueness among women and their experiences and asserts that feminist poststructuralists need to "claim a feminist voice, whilst not denying our differences, it is crucial to theorize, rather than simply accept gender distinctions" (p. 5). FPS expands Michel Foucault's critique on fluid subject positions, power/knowledge, power relations, disciplinary practices, and governmentality to make visible the lived effects on women's material lives. Feminist post structuralists lead this intellectual project, resisting dominant and pathologizing discourses in positivist epistemology and challenging this paradigm's underpinnings while studying women's lives (Moulding, 2016, p. 36). I next introduce post structuralism before describing Michel Foucault's work in more detail.

Post structuralism

Post structuralism names a theory or a group of theories concerning the relationships between human beings, the world, and the practice of making and reproducing meanings (Belsey, 2002, p. 5). Post structuralism critiques or 'troubles' these

relationships primarily through discourse analysis, which examines language, symbols, and images (Belsey, 2002 p. 3). For example, theorists such as Bacchi (2018) trouble problematizations in policies by "elaborating concerns with the ways in which the concepts of problems and problems operate" in a field of practice (p. 3). I use the concept of troubling, exploring and analyzing how patriarchy works to erase women and constructs their material reality in my analysis of policies and discourses involving women who experience male violence. As a modern theory, post structuralism is a product of the last few decades of theoretical development (Belsey, 2002, p. 8).

Foucault is recognized as the leading theorist of French post structuralism (Walters, 2012, p. 87). As Belsey (2002) notes, "[h]is studies of madness, medicine, punishment and sexuality had in common a preoccupation with the power relations involved in the control of what constitutes reason, knowledge, and truth" (p. 56). Foucault was deeply suspicious of the taken for granted truth claims he uncovered during his exploration of history. To illustrate, Belsey reports, "he deplored psychoanalysis because it co-opts us in the name of truth of our innermost being, understood to be sexual" (p. 56). Foucault's critique of madness and medicine is particularly relevant to the critique of mental health care delivered in the context of health care settings. I have come to understand how a post structuralist analysis informs my study. For example, the development of the policies and guidelines in health care occurs within power/knowledge formations. In turn, policies and guidelines produce and shape subjects, including the subjects in my study: women who receive services, leaders, and direct care staff. My understanding of Foucault's critique of madness and institutions, therefore, advances my analysis of the concept of trauma.

Foucault

There are five features of a Foucauldian view. The first, who we are, is a collective matter, meaning that we live in relation to one another (Foucault et al., 2007, p. 121). The second is, who we are as a historical embedded legacy—in other words, who we become is the result of a contingent history and not merely a matter of individual choice (Foucault & Sheridan, 1977/1995). Thirdly, the determination of who we are is complex and ever changing. Foucault's fourth view makes visible historical practices (Foucault & Sheridan, 1977/1995). These practices shape how we act, how we go about knowing things, how we attempt to know things or think we know them, and how we go about knowing ourselves. Foucault's fifth view is about practices of knowing, which we create; they are fluid and can change. These five features lay a foundation for Foucault's thinking in his studies of systems and power relations. I rely on these foundational concepts to deepen my understanding of women and trauma policies.

Foucault's first concept—who we are, is a collective matter—is essential in that it counteracts the medico-scientific paradigm built on gendered biases and individualism. In *Power and knowledge,* Foucault (1972/1980) points out that we exist among others, power resides within these relationships, and these relationships are shaped within a historical context. My study relies on the concept of the collective matter: who we are, is shaped in relationship to others, to the environment, and history.

Foucault's second concept enriches the first. In *The History of Sexuality:Volume 1: An introduction,* Foucault (1978/1990) points out that who we are is not merely a matter of choice—it is the result of a contingent history and a historically embedded legacy, I explore the making of the female traumatized subject and complete a contingent history of trauma (Chapter Four) to reveal how women are shaped as traumatized

subjects in this embedded legacy. Within this historical context, the matter of choice is vital to FPS, as individual choice and empowerment are important feminist concepts. Foucault's third view—the determination of who we are—is complex. Foucault traces the historical fractures of who we are shaped to be in history and problematizes the identities of "the insane, criminal, [and] the deviant" (Walters, 2012, p. 9). In his work, *Discipline and Punish: the Birth of a Prison* (1977/1995), Foucault hoped to find vital clues for what our society deems as normal in treating these marginal existences (Walters, 2012, p. 9). In Chapter Four, I trace the interplay of historical themes and normalization practices that arise from the normalizing judgment based on what is deemed normal (Foucault et al., 2007, p. 56). The evolution of historical figures weaves together, reforms, and transforms throughout the contingent history of trauma. In Chapter Four, I explore the evolution of historical figures in the contingent history of the concept of trauma.

Foucault's fourth view makes visible historical practices. These practices shape how we act, how we go about knowing things, attempt to know things or think we know them, and how we go about knowing ourselves. Foucault focused on these norms in his study of the insane *Madness and Civilization: a History of Insanity in the Age of Reason*, identifying mental institutions as a practice that has shaped the insane identity (Foucault, 1965/1988). Through practices, the psychiatrist conducts the conduct of the insane, shaping who they are, how they know, and how they act (Foucault et al., 2007, p. 120). Mental institutions take up these practices, usually formed as knowledge in practice (research) and held as true, and enforce them through policies, protocols, and procedures (evidence based practices). These institutional frameworks conduct the psychiatrist's

practice, and. The identities of both the insane and the psychiatrist are shaped and adapted within the contingent history of institutions.

These revelations inform my analysis of trauma-informed care policies, as many practices connected to trauma treatment are within hospitals and mental health institutions. These institutional practices conduct health care practitioners' conduct, as they act by these institutional frameworks with little or no awareness of the consequences of their actions (Foucault et al., 2007, p. 121). In *An interview with Michel Foucault*, Foucault states, "people know what they do, why they do it, but often do not know what they do does" (Dreyfuss, & Rabinow, 1982, p. 187). In other words, people are not aware of the unintentional consequences of their practices on their patients' material lives in the field of medicine/psychiatry. When unintentional consequences are revealed, the effects of the practices on women's material lives can be identified. The practices of health care practitioners are shaped, and the conduct of women served by the programs is conducted. The effects of practices that remain elusive in trauma informed care policies to both leaders and direct care staff are revealed through FPS analysis (Chapter Seven).

Foucault's fifth view speaks to knowledge formation and enacting knowledge in practice. My genealogy of the concept of trauma in Chapter Four reveals historically contingent complex practices, each of which shifts and changes to inform TIP's modern context in BC. In Chapter Four, I also explore the contingent history of psychoanalysis, war, and social movements to reveal practices that have shaped figures in history in the context of a trauma ethos.

These broad Foucauldian concepts are useful in thinking about TIP as a ubiquitous historically contingent practice nested in psychiatry and health care practices.

May (2006) surmises from Foucault, “if knowledge occurs within our practices, and power arises within these same practices, then there must be an intimate connection between power and knowledge” (p. 20). FPS takes up this intimate relationship of power/knowledge formations and practices.

According to Gutting (2005), Foucault defines power relations as a more- or- less organized, hierarchical, coordinated cluster of relations (p. 52). Health care policies are created within the context of these power relations. In Gutting's (2005) interpretation, Foucault demonstrated that modern power was exercised by creating new discourses inextricably interconnected in a recursive relationship of power/knowledge to discourse and discourse to power/knowledge (p. 92). Research creates knowledge, knowledge forms policies, and knowledge is reformulated, resulting in the revision of policies. Foucault (1972/1980) spoke of knowledge in exploring sites of knowledge, including psychiatry and medicine (pp.109-112). These “entanglements of knowledge and power configurations and multiple connections and disconnections” (Moss & Prince, 2014, p. 183) constitute truth claims. In Chapter Four, I explore the history of the hospital as a site of truth claims in health care.

Foucault examined practices in hospitals, clinics, and mental institutions in *The Birth of a Clinic* (1963/1994) and *Discipline and Punish* (1977/1995). My reading of Foucault helped me understand these sites of knowledge and the interfacing effects among power relations, knowledge formations, and truth claims. I apply this understanding in my analysis of trauma as a cultural artifact. In Chapter Four, I explore the historical context of trauma within the fields of practice of medicine and psychiatry, which makes visible the material effects of these practices on women's lives. The

traumatized patient subject—the woman receiving services—is governed through the practice of medicine/psychiatry, where knowledge converges within power relations. Feminist post structuralists are interested in the sites of power relations through the lens of gender and take up Foucauldian concepts.

Governing

In Foucault's project of knowing, knowledge is inseparable from our practice (Foucault, 1972/1980, p.187). The nexus of the mutually constitutive triad of knowledge/ power/subjectivity was central to his work; Foucault was interested in the intersections of power and knowledge and how subjects are governed. Biopolitics refers to the attribution of governmentality's political rationalities; these rationalities are not directed to any one person but rather exist within broader philosophical and political traditions (Foucault et al., 2007, p. 120). According to Walters (2012), Foucault's study of governmentality is a framework for analysis that "examines the exercise of power in terms of the conduct of conducts" (p. 11). The practice of governing is "not confined to the sphere of the state, but something that goes on whenever individuals and groups seek to shape their own conduct or the conduct of others (e.g. within families, workplaces, schools, etc.)" (Walters, p. 11). In the matter of women and trauma, the disciplines of medicine and psychiatry seek to shape the traumatized patient's conduct through biopower practices and technologies.

Foucault (1972/1980) illuminates the concept of biopower within his governmentality studies. The governing technologies of biopower, including governmental regulations, are held in a political sense and are contained within policies, protocols, and disciplinary practices. "Foucault used the term biopower to describe life

power-desire, agency, and resistance and power over life-increased management, organization, and control by institutions over bodies" (Moss & Prince, 2014, p. 60). He also described psychoanalysis as a disciplinary practice and as a technology of biopower; that is, how people are conducted through the surveillance and monitoring of the body. Biopower comes into play when the knowledge of a discipline (in this case, psychiatry) intersects with power to control a person through practices such as diagnosing and monitoring mental illness. For example, this monitoring of the patient occurs when an individual is hospitalized and deemed to be 'insane'. The techniques of biopower require analysis because, through these techniques, states of domination are established and maintain themselves. Through this process, things come into existence (Bacchi & Goodwin, 2016, p. 29). Power relations develop in the field of practice as the biopower techniques show up, and Foucault names these techniques—they are the normalizing practices found within the field of psychiatry explored in Chapter Four. FPS builds on Foucauldian ideas of knowledge/power and normalizing practices, though it dissents with Foucault in a critical area: women's materiality.

Materiality

Materiality is critical to Foucault as he takes up the realities of social and political worlds. He is concerned with how discourses shape these realities—how the interplay of power/knowledge and the effects of practices offer an understanding of the relationship between discourse and the material. Feminist theorists have criticized Foucault for his elusive treatment of women's material lives; Hekman (2010) argues that Foucault's works, such as *Discipline and Punish, The Birth of a Clinic,* and *Madness and Civilization,* are gender-neutral (p. 60). Gender neutrality in the context of any literature,

policies, or practices produces meanings of women's material lives. It excludes knowledge of the social construction of gender and the social reality of women. Feminists maintain that our socially constructed knowledge has real and material consequences (Hekman, p. 75). Policies based on gender neutrality do not embrace the problem of power imbalances for women in their intimate relationships, or in their economic and occupational lives. As FPS emerged as a theory, the concern with women's material lives was brought into post structural analysis by feminist post structuralists.

Weedon (1997) notes that the lack of female theorists is "a consequence of gender relations that have structured women's absence from the active production of most theory within a wide range of discourses over the last 330 years" (p. 13). The influence of feminism—and women's increased role in knowledge production—led to Weedon's introduction of FPS theory (p. 13). The concepts introduced by Foucault's philosophical critique provide a foundation for modern post structuralism. At the same time, FPS informs a critique of power relations, knowledge formation, and meaning making in a gender-based context explored in the following chapter.

Feminism and Foucault

Feminists find many aspects of Foucault's critique of power relations and the cultural construction of power useful (Soper, 1993, p. 35). Of interest in my study is that Foucault "has provided some considerable ammunition to feminists seeking to reclaim the body from 'medicalization' and subjugation to an 'intrusive' male science" (Soper, 1993, p. 35) (Chapter Four). Foucault's "focus on the body as a site of objectivizing disciplinary power" (Soper, 1993, p. 35) is a useful concept for feminists and FPS in

deconstructing the female subject and, in my study, the traumatized female subject that I explore thoroughly in Chapter Three.

Many feminist authors have drawn upon Foucault's theory of subjectivity because "the major enterprise of feminist theory is the deconstruction of female subjectivity" (Grimshaw, 1993, p. 53). The deconstruction of female subjectivity includes how women experience themselves as traumatized subjects "constructed within discourses, practices and power relationships" (Grimshaw, 1993, p. 53). The construction of the female subject within the power exercised through various medical, educational, military and penal institutions and their associated knowledge formations have "alerted us to the co-opted and collusive role of the subject as a dutiful and desiring individual, in the operation of this bio politic and its routinising and confessional techniques" (Soper, 1993, p. 35). Foucault named psychotherapy as one of these techniques. The discussion of psychotherapy as a disciplinary practice conducting the conduct and shaping of the female traumatized subject is relevant to my study and discussed more extensively in Chapter Three. In *Discipline and Punish: the Birth of the Prison* (1977/1995*),* Foucault theorized that "docile bodies are produced through and through by the power processes of normalization which in turn increase materialization effects in women's lives" (Grimshaw, 1993, p. 53). Foucault (1977/1995) maintains "there is no power relation without the correlative constitution of a field of knowledge" (p, 27). Foucault's work on subjectification, power/knowledge and disciplinary practices provide the basis for FPS, as discussed in Chapter Three.

Feminists note some shortfalls of Foucault's critique. Firstly his critique of power "fails to see the clear picture of the interrelationship between the bio-political and socio-

economic dimensions of female subordination" (Soper, 1993, p. 35). I argue in chapter Three that not only does a centralized notion of power support a binary view of women, but also Foucault's gender blind critique of power leads to an omission in his critique of the complexity of power relation's in women's lives. By neglecting the plurality of identities, including racialized women in this critique, Foucault excludes these marginalized voices from his analysis. FPS deepens our analytical understanding of women's material lives and power.

In my study, the shaping of the subject is revealed by analyzing gendered violence in the context of power /knowledge formations. Feminists argue that Foucault's lack of analysis of power over is missing, one onto the other, understood through the lens of patriarchy (Grimshaw, 1993, p. 55). Foucault's gender blind approach "overlooks the differential impact on the lives of men and women of the general 'disciplining' procedures to which he does attend" (Soper, 1993, p. 39).

FPS provides useful concepts that attend to the plurality of women's subjectivity and disciplinary practices that impact women differentially. For example, Million (2013) introduces the concept of dense transfer points of power where the intersections of gender, race, culture, and gender identity coalesce to impact the power relations residing in medicine's disciplinary practices. These dense transfer points of power are deconstructed in Chapter Three. Overlaying these dense transfer points are a mangle of knowledge practices, women's material reality, and power relations in the field of practice. According to Hekman (2010), the concept of the mangle explains, "scientists' concepts are constitutive, but they are only part of the mix—the mangle—that produces our understanding of reality in both science and everyday life" (p. 24). Moss & Prince

(2014) explain that because Pickering "conceptualizes science as a mangle of practice, he is better able to understand the doing of science as complex, unpredictable, and fluctuating performances" (p. 64). Hekman extends the use of the concept of the mangle beyond science to analyze the realities of our everyday lives; we are "in a mangle of social, political, technological, biological, [and] global elements which impact on our day to day lives" (p. 25). In the next chapter, I explore the dense transfer points and utilize the concept of the mangle to explore the practices in the medical field of practice as it relates to women, violence and trauma.

The medical field takes on the treatment of patients as non- gendered entities, especially in the treatment of mental health. I take up this topic in Chapter four. Similarly, feminists note that Foucault's study in ethics is a study in male ethics. The degendering of the subject's construction lies outside of feminist theory. Most notably, in Foucault's exploration of the changes in marriage, his focus remains on the male ethics of marriage and not on the change in the relationships between men and women (Grimshaw, 1993, p. 41). Of import is the story of the rape of a female child in the *History of Sexuality: Volume 1, an introduction* (Foucault, 1978/1990,,pp. 31-32). This story highlights Foucault's exclusion of women's experiences in the context of male sexual violence. Foucault's minimization of the act of rape, his focus on the male perspective and his calling out of the attention given to "this everyday occurrence of village sexuality" (Foucault, 1978/1990, p. 31) leaves feminists feeling an essential part of the story is missing (Grimshaw, 1993, p. 41). This part, the gendered experience of violence, is the critical part for feminists, FPS, and in my study of the concept of trauma.

FPS honours the concepts of empowerment, autonomy, and agency, another departure from Foucault (Davies, 1991). Foucault maintains that discourses create the subject, and he "took issue with all notions of man as autonomous and a self determining agent" (Grimshaw, 1993, p. 53). Feminist post structuralists disagree and assert that women need to find autonomy within a socio-cultural context. Autonomy- "resisting the aspects of the social construction of female subjectivity has sometimes led to feminist views of the inauthentic feminist self" (Grimshaw, 1993, p. 57). The view of the authentic feminist self has at times "been contemptuous of any woman who does not conform to feminist behavior or lifestyle" (Grimshaw, 1993, p. 57) (Chapter Six). Two aspects of the feminist autonomy conversation impinge upon FPS. The first, autonomy, is often discussed in relation to one central site of power: male oppression, "the sole effect of male power and ideology" (Grimshaw, 1993, p. 57). This view sets the course for a linear and directional focus of power one over the other. This simplistic view of power is static and one-directional and is inconsistent with an FPS analysis that views power as relational and recursive (Chapter Three). Secondly, feminism is a theory of change. Without the ability for the female subject to find a locus of action, she is naturally disempowered. If autonomy is impossible, change is also.

The distinction between the disempowered and the empowered is vital to my study. After all, women's autonomy is an essential concept in the history of the concept of trauma and treatment programs that target women's self-empowerment. This self-empowerment is assumed to lead to autonomy and is considered a positive health outcome for those who have experienced violence. Autonomy and agency are discussed in Chapter Three, and the concepts of power and agency nest within my feminist post

structural analysis of gendered violence and trauma. The notions of women's agency and autonomy are also intimately connected to power relations, knowledge, meaning, and truth claims. The specifics of these power/knowledge complex relations are taken up later on in Chapter Three.

Self-problematization

It is important throughout my study to incorporate self-problematizing as part of the analysis. My chosen methodology demands it, and it has become a practice of feminism and is consistent with FPS. Self–problematization is a concept that requires critical scrutiny of one's own thinking, "given one's location within historically and culturally entrenched forms of knowledge" (Bacchi & Goodwin, 2016, p. 24). I have chosen the methodology what's the problem represented to be? which requires a thorough self-problematizing. I detail the WPR approach in Chapter Five. The process of self-problematization ensures that the author does not shy away from discussions of power and contestation of commonly held thoughts and ideas (Bacchi & Goodwin, 2016, p. 25). The questions utilized in the WPR approach during policy analysis are repeatedly applied to self held beliefs and assumptions during the policy analysis (Bacchi & Goodwin, 2016, p. 24). Self-problematizing can raise doubts about propositions, policy proposals and our own shaping of 'the problem' (Bacchi & Goodwin, 2016, p. 38). The exercise of self-problematization focuses on our own contingent beliefs and judgments, ensuring the critique of the problem captures these biases and assumptions about the problem (Bacchi & Goodwin, 2016, p. 39). In the following section, I provide a comment on positivist medico-scientific epistemological paradigms and their influence on the beliefs and judgments that shape problems in research and the FPS critique of these approaches.

Positivist medico-scientific epistemological paradigm

As evidenced in quantitative studies, the positivist enlightenment approach to scientific research represents gender as a fixed and static object. Similarly, psychopathology is an object to be studied in mental health research. “Psycho-medical research into gendered violence, abuse and mental health seeks to identify causes and delineate the nature of psychopathology from within a positivist, medico-scientific epistemological paradigm” (Moulding, 2016, p. 36). Theories about women's experiences are built on a faulty foundation of masculine constructs, such as presumptions about gendered reality and masculinist theories about women; these are generally accepted as truth. Feminists reject the positivist enlightenment approach, citing rationalism as both masculinist and gendered biased (Hekman, 2010, p. 5). This feminist critique of positivist enlightenment theories is particularly relevant to my study of women and trauma; for example, in Chapter Four, I thoroughly explore the origins of trauma theory based on the research of male experiences of war. Trauma theory built on masculinist assumptions excludes the socio-cultural realities of women's material lives.

FPS challenges hegemonic discourses of dualisms and positivism while bringing women's material lives into the analysis (Hekman, 1990; Moulding, 2016; Usher, 1997; Warner, 2009; Weedon, 1997). The rational male/irrational female binary reflects dominant patriarchal discourse. As reflected in the representation of women in medical/psychiatric and trauma knowledge/discourses, this dualism underscores practices in health care. Hekman (1990) asserts that “the dualism of masculine thought needs to be displaced by a pluralism and fluidity that transforms categories which have continually positioned and named women as inferior” (p. 46). FPS deconstructs masculinist thought and examines its lived effects in women's material lives.

For example, women who have experienced gendered violence and trauma become the objects of study— entities within the positivist medico-scientific paradigm that can be known and treated in an objective sense (Moulding, 2016, p. 36). Aspects of mental health identified as problems, such as trauma, are considered objects that can be solved and quantified within a positivist medico-scientific paradigm. The knowledge formation from these studies is translated into evidence-based practices (EBP) (see Chapter Three for more discussion). EBPs are accepted as true and utilized as interventions across multiple programs and policies in mental health treatment. EBPs are applied, without questioning, to services for women and "these associated interventions in which they [the women] participate become imbricated in their actual experiences of distress" (Moulding, 2016, p. 36). In the *TIP Guide*, the imbrication of these experiences of the system of care is named re-traumatization of service users, or "events that reflect earlier experiences of powerlessness and loss of control" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 12). In a feminist post structural analysis, interventions are critiqued as normalizing practices, as defined by Foucault and discussed in the next chapter. The influence of positivist approaches occurs when knowledge formation transforms into disciplinary practices that construct the conditions they seek to "quantify, explain and treat" (Moulding, 2016, p. 36). Systems of care create conditions whereby women are re-traumatized. Women who have experienced violence are treated with EBPs—their conduct is conducted, that is, through processes or acts by some that intend to direct others regarding specific obligations (Foucault, 2007, pp. 193-194) and they are shaped as the unknowable traumatized patients (see Chapter Three for further discussion). On the other hand, FPS rooted in feminism and post structuralism theorizes

the shaping of the female subject and informs an understanding of the effects of these practices on women's day-to-day lives.

In the next chapter, I present my theoretical foundation of FPS. I draw upon several feminist post structural theorists to apply the concepts of governance, biopower subjectivity, meaning making/power/knowledge dividing practices, resistance and materiality to the concept of trauma.

Chapter Three: Feminist Post Structuralism

I have chosen feminist post structuralism (FPS) as the theoretical foundation for my critical analysis of trauma informed policies and practices. FPS advances an understanding of the underlying complexities of trauma informed practice (TIP) and policies applied to women in healthcare settings. A FPS critical analysis of policies and practices makes visible the intended and unintended effects of those policies on the material realities of women's lives. In this chapter, I rely on scholarly work that utilizes FPS as a critique of gendered violence, alcohol and drug policies, and in the field of Indigenous studies. Bacchi & Goodwin (2016); Cahill (2001); Hekman (1990, 2010); Million (2013); Moulding (2016) and Weedon (1997) guide my theoretical exploration of FPS. These authors have influenced my thinking about policies and programs for women who have experienced male violence in their lives.

This chapter explores the feminist post structural concepts of power relations, power/knowledge, governmentality, disciplinary practices, subjectivity, agency, and resistance. The examination of power relations through the lens of feminist post structural concepts makes visible the interplay of power/knowledge in the healthcare system for women who have experienced male violence and trauma. I discuss how medical/psychiatric discourses constitute subjects within these power relations and how disciplinary practices impinge upon women's subjectivity and agency. FPS builds on the theoretical underpinnings of feminism and the common understandings of feminism in modern history.

Feminist Post structuralism

FPS is "a mode to knowledge production which uses poststructuralist theories of language, subjectivity, social processes, and institutions to understand existing power relations and to identify areas and strategies for change" (Weedon, 1997, p. 40). Feminist post structuralism is critical to my study of the effects of medical and psychiatric discourse and disciplinary practices affecting women's subjectivity and material lives in the context of TIP. FPS explains the working of power in social institutions and analyzes opportunities for resistance and possibilities for change (Weedon, 1997, p. 40). Theoretical interest in power relations links feminism with post structuralism. Warner (2009) notes that, like feminism, "post structuralism is concerned with how the landscape of reality is constituted through the relationships between power and knowledge" (p. 5). Power relations are situated within disciplinary practices in fields of knowledge, and within medical and psychiatric knowledge, these power relations influence practices concerned with violence against women. In my experience of power relations in this field of practice, medical knowledge prevails as the truth in the hierarchy of knowledges (see Chapter Four).

Feminist poststructuralists challenge the privileging of the scientific model as a singular truth claim based in a hierarchical episteme (Hekman, 1990, p. 4). My experience working with women who define their lived experience in myriad ways mirrors this challenge—women's truth claims reflect their experience. FPS challenges the idea of one singular truth, supporting the notion that women's truth claims are varied and distinct. FPS also details the concepts of knowledge/power paradigms, truth claims, and whose voice is heard from these paradigms. Weedon (1997) determines that "[feminist] post structuralism offers a useful, productive framework for understanding the

mechanisms of power in our society and the possibilities of change" (p. 10). The critique of these mechanisms of power allows for the destabilization of the problem representation in policies and their effects, opening up the possibility of examining these policies and resulting changes (Bacchi & Goodwin, 2016, p. 23).

Within problem representations, "three specific kinds of effects need to be considered—discursive effects, subjectification effects, and lived effects— though these need to be understood as interconnected" (Bacchi & Goodwin, 2016, p. 23). Bacchi & Goodwin (2016) rely on feminists with post structural sensibilities to discuss practices and their effects (p. 42).

Discursive effects within problem representations show how the "terms of reference established by a particular problem representation set limits on what can be thought and said" (Bacchi & Goodwin, 2016, p. 23). The terms trauma and trauma informed care are referenced in policies in specific ways and attribute particular definitions to the concept of trauma and trauma treatment. These terms set limits on how trauma is thought about and what is said about trauma treatment. "Subjectification effects draw attention to how 'subjects' are implicated in problem representations, [and] how they are produced as specific kinds of subjects" (Bacchi & Goodwin, 2016, p. 23). Trauma informed care policies and guidelines produce specific subjects, such as health care practitioners providing services under the direction of policies and guidelines and women who experience violence and receive services. The production of subjects is directly stated or implied by discourse in the policy or guideline, and the subjectification effects produce provisional subjects (behaviours, characteristics) contingent upon "the effects of politics, always in process, and a product of power/knowledge relations" (Bacchi &

Goodwin, 2016, p. 49). The critique of the material or "lived effects ensure that the ways in which discursive effects and subjectification effects translate into people's lives form a part of the analysis" (Bacchi & Goodwin, 2016, p. 23). This analysis of lived effects ensures that the emphasis remains on the material effects of women's day-to-day lives and answers FPS's concern with their lived reality.

Discursive, subjectification, and lived effects coalesce into dividing practices (Bacchi & Goodwin, 2016, p. 23). Dividing practices "function to separate groups of people from one another. . .which can also produce 'governable subjects' divided within themselves" (Bacchi & Goodwin, 2016, p. 23). The effects produced by the trauma informed care policies and guidelines produce particular subjects, further examined in Chapters Four, Six and Seven. As illustrated later in this chapter, an FPS analysis of governed subjects makes visible dividing practices, which show up in the contingent history of the concept of trauma. PTSD definitions and terms of reference—developed postwar in veterans' treatment—show up in trauma policies for women's treatment (see Chapter Four). The woman is problematized as a gender-neutral trauma survivor (Chapter Six), and discursive, subjectification, and lived effects coalesce to build a bridge from the symbolic concept of trauma to women's material lives. Like FPS, this analysis insists on the inclusion of lived effects so that the thinking "does not reside in some representational universe cut off from daily life" (Bacchi & Goodwin, 2016, p. 23). To this end, FPS relies on important constructs, including governance, biopower, subjectivity, knowledge formations (meaning making), materiality, power as recursive, and generative and disciplinary practices.

FPS Constructs

Governance, Biopower, and FPS

In its broadest sense, governance concerns itself with many forms of public and private power relations, and—being inextricably interwoven with these power relations—is an essential analytical focus of FPS. Bacchi & Goodwin (2016) apply Foucault's concept of governing practices in broad terms (p. 15); Bacchi (2009) explains, “to study governmentality, attention is directed to rationalities and technologies” (p. 43). Public governing of the subject takes the form of technologies and practices enacted through policies and protocols. The conduct of the individual is shaped (subjectification effects) through these rationalities and technologies of governance. In turn, individuals shape themselves through their compliance, resistance, and counter conduct to these power relations. Through the veil of governance, women’s embodiment of the violence they experience compels FPS to take up Foucault’s concept of biopolitics to analyze political rationalities and biopower, in order to make visible the lived effects in women's day-to-day lives.

Bacchi (2009) defines biopower and biopolitics as "a triangle of sovereignty, discipline and governmental practice" (p. 43). Biopolitics is concerned with the study of surveillance, monitoring, and risk; in response to risk, how does one conduct oneself and others through monitoring and surveillance? Biopolitics relies on biopower technologies to maintain governmental regulation of the population's biological processes (Bacchi, p. 43). In the case of violence against women, the home and other "private" locations are sites of dangerous power relations enacted through physical and emotional violence. If

the police or courts become involved, individuals' conduct is governed through the biopower technologies of security and protection.

An example of political rationality in medicine is evidence-based practice (Bacchi & Goodwin, 2016, p. 43). Most current healthcare policies rely on and promote evidence-based practices (EBP), which are established in research in fields of practice such as medicine and are considered to provide the best way to diagnose, treat, and respond to individuals (Lancaster et al., 2017, p. 61). EBP driven by medical discourses in policies and research encourages the therapisation of societal issues arising from wider oppressive structures based on class, culture, economics, and politics (Ecclestone & Brunila, 2015, p. 457). Nevertheless, as Bacchi (2018) points out, “we are governed, not through policies, but through the problematizations, that is, through the ways in which policies characterize and conceptualize issues" (p. 6). EBP that are cited in policies and based on these problematizations are accepted as truth or are used as a claim for best practice in delivering services to particular populations. Given that they are instantiated in positivistic medico-science, it is unsurprising that EBP treats the female subject as a gender-neutral uniform subject.

Medical knowledge formations inform violence and trauma policies as well as institutional practices in the current health care field. Biopower, disciplinary practices, and technologies are essential concepts in examining violence against women and trauma. As a feminist and health care practitioner, I am curious about how power relations and biopower technologies in medicine/psychiatry impact and construct the concept of trauma. How are biotechnologies, such as surveillance and monitoring,

applied in this field of practice? How are policy proposals influenced by these problematizations? How and where are truth claims integrated into these practices?

Bacchi and Goodwin (2016) take up this dialogue and ask: in fields of practice, what is culturally created that is accepted as truth? They also point out that "knowledge in this context is not truth; rather, it refers to what is 'in the true'—what is accepted as truth—and is understood to be a cultural product" (Bacchi & Goodwin, p. 35). Feminist post structuralists such as Bacchi and Goodwin, Cahill (2001), Hekman (1990, 2010), and Weedon (1997), as well as Indigenous theorist Million (2013), speak to the effects of power/knowledge as material and true in women's lives. The construction of the female subject relies upon the materialization in women's lives.

Subjectivity

Many feminist post structuralists have been concerned with the female subject, the construction and constitution of materialization, and the embodiment of and categorization of woman as subject (see, for example,; Cahill, 2001; Davies, 1991; Hekman, 1990, 2010; Weedon, 1997). They agree upon some aspects of the female subject but also engage in disparate discourses related to subjectivity. It is beyond this chapter's scope to fully explore these similarities and differences; rather, I draw upon these theorists to trouble the female subject and relate this discussion to women who have experienced violence (known as trauma in modern terms) in their lives.

Foucault declared that one of the great illusions of enlightenment is the assumption that an autonomous, self–determining subject exists; he "proposed instead that subjects are created in and through discourse and discursive practices" (McNeil, 1993, p. 154-155). Similarly as Weedon (1997) points out, humanistic discourses

“presuppose an essence at the heart of an individual which is unique, fixed and coherent and which makes her what she *is*" (italics in the original) (p. 32). Contrary to the humanistic claim, “post structuralism proposes a subjectivity that is precarious, contradictory, and in process, constantly being reconstituted in discourse each time we think or speak" (Weedon, p. 32). According to Weedon, subjectivity is the “conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (p. 32). Women are constituted as traumatized subjects through disciplinary practices in the fields of medicine and psychiatry, and “[t]he historical emergence of a specific form of subjectivity” (Walters, 2012, p. 34) occurs in the context of the concept of trauma (as described in Chapter Four).

The female subject as a sexed subject raises questions related to agency, resistance, and the gender dichotomy of the male/female binary. If women are a fixed, stable, and unified category who share one common experience in the construction of their material lives, it becomes that only “in the play of alterity (otherness), to the one uniform male subject, that the female subject and their reality exists at all” (Cahill, 2001, p. 106). “That is, this is not to say that individual subjects can be wholly determined by their sex, nor that subjects who share the same sex can be assumed to share a defined set of characteristics or behavior” (Cahill, 2001, p. 104). The dichotomy risks the theoretical assumption of biological determinism. That is, sociobiological discourses determine in advance "what constitutes normal femininity and masculinity, to fix subjectivity by insisting that certain meanings are true ones because they are determined by natural forces beyond our control" (Weedon, 1997, p. 126). This fixed meaning of biological sex

fits women and men into specific types of gendered social roles in the family, occupations, particular ways of life, and forms of sexuality (Weedon, 1997, p. 126). A dense transfer point of power relations restricts women in challenging this discourse, as they do not have access to power within the discourse to challenge it. "Resistance within the terms of this discourse is impossible because it denies women any alternative place from which to speak," except from the location of the female-gendered, less valued position (Weedon, 1997, p. 126). FPS makes an impact on "the discourse hierarchy of existing writing and research" (Weedon, 1997, p. 126), ensuring the recognition of the difference and the fluidity of the subject as a sexed subject rather than Foucault's gender-neutral subject. FPS places difference "at the basis of an understanding of human agency," while at the same time avoiding the trap of the discontinuous gender dichotomy (Cahill, 2001, p. 104).

The impression of a category of "sameness" of one socially constructed woman is troubled by FPS. According to Cahill (2001), the concept of sameness—alternatively understood as the universal subject—is dangerous to female subjects. She relies on Braidotti's (1994) work on the embodiment of the nomadic subject to explain that sexual differentiation is vital to underscore the universalism that "necessarily renders one aspect of the human being as lesser, weaker, more incomplete, and ultimately less valuable than the other" (Cahill, p. 188). This argument challenges the ethics of masculinist thought. The gender-neutral norm sets up the woman as the lesser, the passive female traumatized subject and fails to incorporate the complexity of the female subject position. In FPS, subject positions are plural, and identity intersections such as class, race, ethnicity, sexuality, gender identity, ability, and culture must be considered.

FPS challenges static representations because a static, singular definition of identity does not allow for an understanding of complexity and fluidity in categories of persons, gender, sexuality, systems, and the resulting intersectional realities of power relations. In FPS theory, the female subject is “an embodied, fluid, intersubjective being whose materiality is the basic condition of possibility for existence” (Cahill, 2001, p. 108). FPS deconstructs the mechanisms of power/knowledge through the lens of gender fluidity and embraces the ever-changing constancy of identities throughout time. Cahill (2001) notes, "the individual embodied subject is thus properly understood not as a distinct and stable entity, but rather as a constantly shifting conglomeration of physical, psychical, emotional, and intellectual characteristics" (p. 107). The tensions apparent within class differences, race, culture, sexuality, and gender identity are recognized within the female subject's discontinuity and fluidity as ever changing and interplaying in historical moments (Cahill, p. 108; Fine, 2012, p. 4).

FPS is concerned with subjectivity (including the constitution thereof), agency, resistance, and the self-constitutive nature of subjectivity (Hekman, 1990, 2010; Million, 2013; Weedon, 1997). The gendered body and the interplay of power and biology are a concern for FPS: "Feminists have been and continue to be concerned about the reality of women's bodies. We want to be able to talk about women's pain, their biology," (Hekman, 2010, p. 3) but not limit that discussion to one framed within the discourse of biological determinism.

An FPS analysis troubles the socio-cultural context interface and the lived effects on women's day-to-day material reality as an embodied subject. For example, the problematization of the violated female subject position constitutes women into one of

two choices: that of the passive victim or a resistor to the vulnerability inherent in this subject position. The constitution of the vulnerable subject position shapes a future characterization of vulnerability; the traumatized subject is shaped into vulnerability when accessing services under trauma policies. She is problematized as a powerless subject in the face of abuse, thus taking up the constituted passive subject position and accepting the practices of the knowing expert—the constituted health care practitioner. The vulnerable subject may return to the abusive intimate partner and, in doing so, shapes herself as a vulnerable subject exposed to ongoing violence. Questions arise related to these subjectification effects—the lived effects of women's material reality—"including resistance to dominant, pathologizing discourses of blame and victimhood" (Moulding, 2016, p. 36). Discursive, subjectification, and lived effects produce dividing practices that result in governable subjects divided within themselves (Bacchi & Goodwin, 2016, p. 23).

I have witnessed dividing practices in problematizations of the subject come alive in discussions in the field of practice—including the vulnerable and the resistant subject positions—which may co-exist in time and space. The problematization of the vulnerable subject position discourse asks: If she is so vulnerable, why does she stay in the violent relationship? Why does she not call the authorities for help when she is abused? The problematization of the resistant subject position characterizes the abused female subject as strong and independent. Other questions arise from this subject position: If she is so strong, why does she stay? If she is so resilient, why does she not call the authorities when she is abused?

External socio-political structures shape subject positions and produce lived effects in women's material lives. Technologies of power based on gender discrimination—including barriers to employment and housing and variable responsiveness from the criminal justice system—reinforce how the subject is shaped and give rise to lived effects in women's day-to-day lives. Hekman (1990) evokes Foucault's perspective on knowledge and power, observing, "power is not localized in one social sphere, whether economic or political, but, rather, is diffused throughout the multitude of institutions that constitute society" (p. 186). The violated woman subject is impacted by institutional knowledge and meaning that constitute effects and dividing practices in criminal justice, medicine, and psychotherapy.

Meaning making/power/knowledge

FPS insists that the deconstruction of meaning making occurs within a historical and structural context. Million (2013) evokes Foucault to conceptualize "acts of sexual coercion beyond individual pathology as an especially dense transfer point for relations of power between men and women, young people and old people" (p. 43). These dense transfer points for power relations produce knowledge, making meaning that characterizes violence, trauma, and the female subject.

FPS scrutinizes knowledge (truth claims) production, the dictation of who is allowed to produce knowledge, and the formulation of knowledge in a field of practice. In my experience, women's knowledge is subjugated by medical knowledge, and I am fully aware of the hierarchical power relations in this system of truth and knowledge. FPS has helped me understand that women's truth claims reflect their material reality and that women's truth claims are varied and distinct. Meaning making relies upon an

understanding of women's material realities; because FPS attends to these, it opens up possibilities for shaping knowledge formation in the field of medicine/psychiatry. The practice of attending to the lived effects and material realities of women's lives make women's truth claims more visible (Weedon, 1997, p. 13), and feminist scholars such as Bacchi and Goodwin (2016), Cahill (2001), Hekman (1990, 2010), Weedon (1997), and Indigenous scholar Million (2013) have pursued FPS as a way of making meaning of the mangle of women's day-to-day realities in the world.

Meaning making and knowledge production in disciplinary practices such as medicine is complex and fraught with sociopolitical influences. The dense transfer point of patriarchal social constructs is present not only in relationships but also in the institutions intended to address violence; this violence is a socio-cultural artifact that resides in the meaning making of the woman's location in society, which is influenced by such factors as race, culture, gender and socioeconomic status. The dynamics in her family of origin, messages received in school and other social institutions, and the media influence her location in society. The meaning derived from these locations and the problematization of her subject position shapes the woman's meaning making of her role in the violence and her experience of violence. She may be the recipient of services within an institution where practices either blatantly or subtly support oppressive women-blaming messages/meanings. Practices may include questions taken out of the context of her day-to-day reality, such as those related to leaving or staying in the relationship or the care of the children in the home. The meaning of her day-to-day reality is crucial because it coalesces into dividing practices attached to this meaning, either in the support she receives based on the discursive construction of her identity as a woman experiencing

male violence or in the victim-blaming discourse that may result in the removal of her children from her care.

The dense transfer point of power relations associated with a patriarchal societal structure creates patriarchy as a practice. In turn, patriarchy as a practice constructs the narrative of the abused woman subject as vulnerable and in an inferior position to other women and men. The plurality and fluidity of meaning over time and space is an essential aspect of the feminist post structural critique of discourse and, in particular, the importance of multiple and intersectional meanings that take into account class, gender, race, sexuality, identity, and culture.

Weedon (1997) draws on Foucault's work in describing the meaning-making attached to women's bodies subjected to the discourse of *hysterization* utilized in early psychoanalysis (p. 105). The meaning/knowledge ascribed to women's bodies by psychoanalytic theories is vital in my study. Namely, Freud shaped the meaning of violence against women as a product enacted upon the female body. Women were shaped through psychoanalytic discourse into over-sexualized and erotic beings (subjects), who invited sexual acts, and these meanings remain visible in modern practices of victim-blaming (see Chapter Four). The meanings attributed to the female body were generalized beyond psychoanalytic discourse; the "discursive production of the nature of women's bodies was central to the reconstitution of social norms of femininity, the patriarchal subjection of women and their exclusion from most aspects of public life" (Weedon, p. 105). Discourses related to the female body became institutionally located and enacted in institutional practices (EBP) within the law, medicine, social welfare, education, family, and work (Weedon, p. 105). As Weedon asserts, "all meanings have

implications for existing social relations, contesting them, reaffirming them or leaving them intact" (p. 134).

I have come to appreciate that FPS critique reveals whose knowledge/power is privileged, promoted, and created and the lived effects on women's material lives through dividing practices connected to that knowledge. I now understand that the construction of knowledge (meaning making) has a recursive and intimate relationship with power. Women who have been violated experience this power when faced with an abusive partner in her home, a medical practitioner who questions her truth claim, or a legal officer of the court who expresses uncertainty when taking a victim statement of the women's fact (knowledge) for a court appearance. Power relations within these social institutions—originally established to address violence against women—construct these dominant patriarchal knowledges and inform practice in institutional policies such as TIP. Hekman (2010) notes, "feminists have pointed us in the right direction as we attempt to define a new theoretical approach" (p. 3).

Knowledge and dividing practices

Feminist knowledge production has received criticism from some feminist post structuralists (Cahill, 2001; Hekman, 1990). In particular, Hekman (1990) contends that feminist theorists support the dualism of male/female when they extol feminine virtues that have for so long been diminished in the face of the honoured male virtue of rationality (p. 5). The feminist stance of advancing the 'natural' virtues of women, including emotional sensitivity, is built on an assumption of an existing female irrationality. Women's virtuosity as emotional and sensitive beings belies the power analysis emphasized in feminist theory. For women who do not conform to this female

paradigm, such dualism presents a dangerous predicament contributing to dividing practices (Fine, 2012, p. 6).

Knowledge intersects with power in what I call the “good girl’ position, which constitutes some violated women as "good trauma survivors" through dividing practices. If women emote in what is deemed an appropriate, natural way, including by keeping their anger of being abused in check and emoting in the right space, to the right person, at the right time, they are shaped as trauma survivors in recovery. To be good survivors, they must also keep their rage about the violence they have endured subdued. The dominant discourse/practice of powerlessness and compliance confirms the meaning making and 'truth' of their traumatized subject position as a compliant, passive female subject. Usher (1997) points out that “by not challenging the dichotomy, the privileged concept maintains its power of definition”; in this case, the privileged concept is of the female as emotional and the male as rational (p. 42). The privileging of male as rational over female as irrational underlies the mainstream Western thought that informs positivist ontologies, shrinking the critical gaze instead of “feminist psychology designed to cultivate wide angle evidence for outrage, protest, and justice” (Fine, 2012, p. 4). These concepts have helped me understand women's conundrum, of the choice of being a passive, compliant subject or an outraged traumatized subject.

The dividing practice in the discourse of a 'true natural victim' is located within each assaulted woman’s lived reality. Is it one who emotes and is passive and compliant, or is it one who fights back and gets angry? If a woman can get the timing right, both meanings can be validated. She must fight back at the time of the assault and not be passive. She must give a clear message of non-consent. After the assault, she must not

express fury at the injustice of her experience; she must become compliant, shaped as an emotional subject. As a traumatized subject, she must produce a congruent portrayal of the dominant socially constructed view of what an assaulted subject must feel and do at particular times during the attack, as well as in the aftermath of violence. This discursively constructed and socially accepted view of the victim produces truth claims and practices— resulting in knowledge formation in the field of trauma treatment.

The unintended consequences of these dividing practices have dangerous lived effects on the material lives of women receiving services. Women may return to violent partners based on their belief that they are somehow responsible for the violence and live with the belief that they can shape themselves to prevent it from happening again. The knowledge shapes practices in programming and policies, therefore producing dense transfer points of power among women and institutions created to assist them (Fine, 2012, p. 4). When a woman who has experienced violence turns to the medical/psychiatric system for support, she becomes part of the interplay of power/knowledge where these dense transfer points of power create effects that coalesce into dividing practices.

Power/knowledge

FPS is concerned with power relations among individuals and within systems, troubling the notion of unidirectional power as a static object in one historical moment. Warner (2009) notes that, like feminism, "post structuralism is concerned with how the landscape of reality is constituted through the relationships between power and knowledge" (p. 5). I work with women who have experienced violence in a field of practice affected by medical/psychiatric knowledges and practices, and power relations

are situated within these disciplinary practices. The FPS definition of power as practice moves analysis away from the well-known feminist definition of power as hierarchal or power of one person over another. Power is not a stable object held by one person or one institution; rather, power is enacted as a practice within a set of complex and multi-dimensional power relations.

FPS theorizes that power is constitutive and productive through the practices of power relations; that is, power as a practice occurring within relationships has recursive qualities. This means that while power is not a limiting force, the practice of power in relationships and discourse can spark resistance and change. Therefore, the practice of power is also a productive force. This concept of power relations is fundamental to FPS. Ramazanoglu (1993) reiterates, “power has no intrinsic value and as such can be both a generative force as well as a restrictive opportunity” (p. 109). Warner (2009) agrees that “power is understood to be a practice rather than a possession” (p. 5) and that when power is enacted, "it forms a mutually constitutive triad with knowledge and subjectivity” (Warner, p. 5). Hekman (2010) calls on Foucault’s central thesis, stating that "power is everywhere; it does not stop with the political but extends into the interstices of our lives" (p. 62). As I understand the concept, power relations allow for a broader view of the constitution or shaping of subjects regardless of their social, cultural, and systemic positioning within organizations.

I now understand that power relations also shape physicians who have hierarchal power and that women who are patients of these physicians enact and resist power in different ways in the context of power relations within the health care system. As I theorize with this broader view of power relations, possibilities open up to identify

resistance and courageous acts of social change. FPS enables a detailed description of power as a recursive practice and the resulting lived effects on women's material lives. The concept of power as a practice, both generative and restrictive, has helped me understand the shaping of trauma informed care practice in the context of medical/psychiatric knowledge.

Medicine as dominant knowledge

Most people receiving medical services are impacted by the fact they have little or no access to medical knowledge, knowledge coalescing with power and linguistic turns in medicine. Medical discourses are a specialized language accessible to few who have been allowed entry to academia and the practice of medicine. Medicine has a complex relationship with language and practice and medical professions and maintains the proprietary right over the practice of medicine (Conrad, 2007, p. 8).

As Conrad (2007) notes, medical discourses have impacted women's lives in many ways (p. 8); he points out that the discipline of medicine has medicalized the individual, that "medicalization studies by sociologists and feminist scholars have shown how women's problems have been disproportionately medicalized" (Conrad, p. 10). Medical discourses have grown within various disciplines (medicine, psychiatry, social work, etc.), as well as through social movements that advocate for the recognition of the knowledge of "trauma" (Conrad, p. 9). Conrad (2007) names these social groups as collaborators in the medicalization of "problems", such as the gay movement in the case of AIDS, and the Vietnam war veterans' movement in the case of PTSD (p. 9). This has never been more evident than with the advent of the naming of the rape trauma syndrome in the 1970s (Burgess, 1983, p. 100) and the establishment of the diagnosis of Post

Traumatic Stress Disorder (PTSD) in 1980 (Young, 1995, p. 94). The intended effect of naming these syndromes was to ensure that PTSD symptoms were acknowledged as a psychiatric disorder (see Chapter Four). The acceptance of this diagnosis of PTSD entered psychiatric practice, emphasizing post traumatic stress as a disorder that validates peoples' experiences as true and legitimate according to medical/psychiatric knowledge and practices.

Known as the problematization of the problem, knowledge formations in the field of medicine define what the "problem" is that needs to be solved. Researchers impose theoretical stances and terminologies onto the defined "problem," and "the 'problems' being addressed are readily identifiable and uncontroversial" (Bacchi, 2018, p. 4). These problem definitions contribute to a problem-solving paradigm that shapes evidence-based practices in the field of health care (Bacchi, 2018, p. 4). As I described earlier, evidence-based policy movements are a powerful influence in research. From an FPS framework, the evidence-based policy approach to "research establishes relations of governing that privilege those who get to set 'problems' to be 'solved' illustrating the centralizing power effects of evidence-based policy discourse" (Bacchi, 2018, p. 4). Physicians and psychiatrists are at the center of these evidence-based knowledge formations.

Knowledge formation/power/resistance/ material realities

FPS acts as a form of knowledge translation or meaning making that takes up feminist political assumptions and identifies types of discourse from which particular feminist questions arise and where knowledge is formed. Weedon (1997) takes up a Foucauldian view as a foundation "to address the questions of how social power is exercised and how social relations of gender, class and race might be transformed" (p.

20). These questions are then located socially and institutionally, broadening the analysis of knowledge formations to address systemic locations of power rather than focusing on individual pathologies (Weedon, p. 20). In this knowledge translation, power relations become visible in power/knowledge formations, including whose voice is heard, what knowledge is valued, and how that knowledge is utilized within power relations. Power is linked to knowledge formation and is actualized in truth claims such as evidence-based practices. Truth claims are made (in)visible in disciplinary practices linked to evidence-based practices in healthcare systems; FPS makes power relations visible by exposing truth claims and disciplinary practices that support these claims.

FPS offers a useful theoretical foundation for exploring practices and power relations. In contrast to positivist epistemology's definition of power—centred with one person (s) or object (s) over another—FPS is concerned with power relations that congeal into states of domination and create knowledges in a field of practice such as medicine/psychiatry. Therefore, FPS moves to deconstruct power/knowledge; define resistance to practices associated with forms of power/knowledge, and describe associated discourse and technologies. Taking up my analysis through FPS allows me to identify the oppressive practices that govern (conduct the conduct) the field of medicine/psychiatry as these pertain to gendered violence and make dividing practices visible for further examination (Hekman, 2010, p. 51).

FPS constructs applied: An example

In my work with women who have experienced violence, I have witnessed mechanisms of power/knowledge in many forms located in many systems and structures. Feminism and FPS have helped me understand how these effects are raced, cultured, and

gendered (Fine, 2012, p. 4), and I have observed the resulting lived effects on women's material day-to-day lives. Feminists must be concerned about and connected with the reality of women's day-to-day lives to enact change and transformation (Hekman, 2010, p. 2). Therefore, FPS must "define an alternate approach that brings the material back in" (Hekman, p. 2) and make visible the intersectionality of women's material lives. Making visible layers of oppression, including gender, race, and cultural discrimination, lays bare the power relations that contribute to the cumulative lived effects of power/knowledge in women's material day-to-day lives.

As noted previously, medicine and psychiatry as practices and sites of knowledge create dense transfer points of power relations. Bacchi and Goodwin (2016) connect "techniques of knowledge and strategies of power," and explain they "are joined together in discourse forming local centers of power knowledge" (p. 31). The practice of power as a technology in medicine/psychiatry is discussed in my genealogy of trauma (Chapter Four). In medicine/psychiatry and TIP, knowledge formation techniques take the form of policies and guidelines, and these knowledge formations appear as truth claims in evidence-based practices in medicine/psychiatry. These discourses are socially produced forms of knowledge "that set limits upon what is possible to think, write or speak about a given social object or practice" within the context of power relations (Bacchi & Goodwin, p. 35). The limits of who can say what and what can be said make visible power relations in the field of practice; what is said by a physician/psychiatrist is what is heard and enacted upon.

Medical/psychiatric discourse forms a local center of knowledge, and the formation of this knowledge has lived effects on women's material lives. To illustrate,

consider this scenario: a woman who has feelings of depression may access her physician for support. The physician refers her to a psychiatrist who, in turn, provides a prescription for antidepressants. The nexus of power in the patient/physician/psychiatrist relationship lies in the dense transfer point of physician and psychiatrist's expert knowledge and the unknowing depressed woman subject. This expert diagnosis is a disciplinary practice that names the woman's experience as "depression". The physician treats her as a diagnosed patient, constitutes her as a depressed subject, and using medical knowledge (evidence-based practice), applies the technology of the prescription of medication. The depressed diagnosed patient is monitored through various forms of medical technologies, such as electronic records and office visits, to ensure she is compliant with her diagnosis and her medications as a constituted depressed subject. Through the forces exerted upon her to accept current socio-cultural understandings of depression as a mental illness, the depressed subject (woman) is constituted into a particular subject position within medical and psychiatric power relations.

Power relations and medical knowledge formations in the system of care evoke both the physician's expert position, who treats the illness and the subject position of the depressed (woman) patient who takes the antidepressants. The root of the latter's sadness and suffering may lie in the material reality of her day-to-day life, including poverty and/or abuse from her intimate partner, and the diagnosis (technology and practice) is unlikely to relieve her sadness and suffering. The subjectification effects produce a dividing practice for this subject position. If the depressed patient resists (gives up on) the medication, her physician questions her about her choice and she is almost certainly labelled a "medication non-compliant" patient. Alternatively, she may find her voice

through this medication resistance, disclose her truth of poverty and/or abuse, and identify these as the source of her depression. While her resistance and truth claim allow the lived effect of the abuse to be made visible, it is unlikely to shift the physician's discourse about the "true" source of her suffering, based on the physician's knowledge of the biochemical root cause of depression.

The physician's practice supports the problematization of depression as an illness diagnosed as a chemical imbalance centred within the woman's psyche. This problematization has the subjectification effect of shaping the diagnosed patient as a subject who has a damaged brain. Power relations in a complex system such as healthcare are multi-dimensional, and knowledge that is produced—resting with a "professional expert" and often accepted as a singular truth—becomes identified as an EBP. These truth claims are translated into meanings about women's day-to-day realities and reinforced as rationalities in day-to-day medical practices and research (knowledge formation) within healthcare.

Power relations and the "Mangle."

Scholars who speak to intersections of power relations such as Crenshaw (1991), Million (2013), and Tuhiwai Smith (2012), and have confirmed for me that power relations are not only associated with gender differences but also with social dimensions of health, the latter of which reflect power imbalances in the dialectic of power relations. Culture, ethnicity, race, education, poverty, wellness, ability, age, able-bodiedness, sexuality, gender, and gender identity coalesce in intersections of identities. This concept of intersectionality has helped me to understand how lived effects are differentially experienced, how those with differing experiences share effects, and how those effects

shape individuals. Women's lives encompass several identities, exposing them to stigma and systemic oppression (Cahill, 2010, p. 16); however, contrary to identity being disempowering, Crenshaw speaks to identity politics as a "source of strength, community and intellectual development" (p. 1242). She is concerned that identity categories in mainstream liberal discourse are viewed only as points of bias (stigma) and domination (oppression) rather than as sources of strength and resilience. Crenshaw reframes the feminist and racial liberation movements mantra into "the view that the social power delineating difference need not be the power of domination; it can instead be the source of social empowerment and reconstruction" (p. 1242). According to Hankivsky (2012), the interplay of power relations is most relevant when considering intersecting identities of gender, race, class, sexual orientation and identity, ability, and culture (p. 8). Like Crenshaw, Hankivsky discusses identity politics or intersections of identity as sources of social power (p. 8). An example of social power is the women's movement (see Chapter Four) and, most recently, the Me Too movement ("metoo, History and Vision para.7, n.d."). The FPS framework has helped me to expand on the complex landscape of power to include the mangle of multiple truth claims, knowledge, meaning making, and visible recursive power relations within and beyond the gender analysis. This expansion of the framework beyond a gender analysis to include identity intersectionalities allows for examining the lived effects on women's day-to-day material realities within those intersecting identities.

Hekman (2010) evokes Pickering's concept of "the mangle" in order to assert her focus on the material reality of women's lives (pp. 22-26). This concept has informed my critique of policies and helped me to understand the complexity of the contingent history

of gendered violence and trauma, the shaping of women's material realities as they work in and around programs that serve women, and the subjectification and lived effects on the material realities of women's lives who access these programs.

I find that the concepts of intersectionality and the mangle (see Chapter two) intertwine here—the social dimensions of health, culture, and identity shaped by practices constitute the mangle. Hekman (2010) notes that in a discipline such as medicine, the mangle is "a complex of factors constituted by medical knowledge, technology, politics and social forces" (p. 25). I have witnessed this mangle of practices and lived effects of women's socio-cultural realities and have experienced the mangle as a health care practitioner. The women I work with are caught in the mangle of practices and intersecting identities every day. Consider an Indigenous woman who may access and be shaped by trauma treatment, appears in court as a witness to her own abuse, has a chronic disease and mobility issues, and identifies as a lesbian. In this example, the woman may experience the mangle of these complex social, racial, and cultural locations of disempowerment and empowerment on any given day. An Indigenous woman may experience discrimination in accessing services such as health care and at the same time be honoured as an Elder who leads healing ceremonies in her community. She may have access to resources and supports directly funded by her Band, but she may also remain untreated for physical and emotional pain in her local community health care clinic. She may be disrespected for her cultural practices in mainstream society while finding respect and acknowledgement for her cultural practices in her community.

I have learned that I cannot separate the mangle of practices from women and their bodies, nor from women's violence experiences. Hekman (2010) states that "the

linguistic, social, political, and biological are inseparable in the constitution of women in modernity" (p. 25), and women are caught in the mangle while receiving services to address their trauma. The mangle concept highlights the complexity of the lived effects on women's lives as they move through time and space, systems and institutions. Lived and subjectification effects coalesce into a problem representation of the honoured Indigenous woman and the disgraced Indigenous woman. She experiences the fluctuation of honouring, witnessing, stigmatizing, healing, and harming forces that constitute her through these subjectification effects as the traumatized patient (see Chapter Four), towards which medicine's dominant knowledge formations show up in technologies and practices.

Power relations and trauma practice

The medicalization of trauma (PTSD) raises concerns about power relations in the field of practice of medicine. Conrad (2007) cites medicine's knowledge/power dynamic specifically as an example of a triad that coalesces knowledge/power, discourse/practice, and subjectivity. He criticizes the medical system as a transformer of "aspects of everyday lives into pathologies, narrowing the range of what is considered accessible" and emphasizes that "medicalization also focuses the source of the problem in the individual rather than in the social environment; it calls for individual medical interventions rather than collective or social solutions" (Conrad, p. 7). Thus, the problematization of the trauma becomes an individual problem whereby the woman needs fixing, and the medicalization of the "problem of trauma" increases the amount of medical social control over women's behaviour and bodies (Conrad, pp.7-8).

Trauma discourse as medical discourse

Discourse constitutes representations of women and is influential in making meaning of women's experiences. Knowledges deemed to be true produce lived effects that impact women's material lives, the most apparent of which is the influence of dominant medical discourses (Ransom, 1993, p. 125). I have come to understand that women take up these meanings as part of their self-identity, and in practices such as psychotherapy. Women are categorized based on the therapist's interpretation of the woman's experiences of violence. Discourse shapes practice when these experiences are framed as an individualized intra-psychic phenomenon. An emphasis is placed "on assessing and treating the effects of trauma, rather than on examining issues of context and experience" (Tseris, 2014, p. 156). This "shift may contribute to a greater concentration on women's symptoms", and the practice becomes 'evidence' of and reinforces the view of women as emotive and irrational" (Tseris, 2014, p. 156). Psychotherapeutic trauma discourse constitutes women as traumatized emotional/irrational subjects, and women take up this identity as they enter treatment programs to solve the problem of their trauma.

Based on the science of psychiatry, medical discourse (knowledge/language) has been adopted and adapted into current trauma work with women who have experienced violence. Trauma theory that aimed "to create a language and method for understanding the effects of exposure to war" (Tseris, 2014, p. 154) has been adapted to treat trauma in civilian populations. Trauma discourse—a medicalization and problematization of the "problem of violence against women and resulting trauma"—prescribes specific therapeutic strategies to "treat the problem of" trauma. From an FPS perspective, "far from liberating women, therapeutic strategies can reinforce and proliferate the

mechanisms of self regulation and self control which are precisely at the heart of the problem" for which women seek treatment (McNeil, 1993, p. 157).

Ransom (1993) reflects on the positivist aspects of psychiatric epistemology, which maintains the holder of knowledge as a rational, stable human being who speaks one truth connected to a body of scientific proof (p. 136). As noted earlier in this chapter, FPS challenges positivist epistemology. Usher (1997) critiques the rationality of science to expose knowledge as an assumed truth, which through the "rules of formation and the conditions of possibility created by a specific discourse . . .allowed certain statements to be made as if they spoke the truth" (p. 44). I argue that this knowledge and trauma theory—assumed as truth—relies heavily on positivist research in the field of medicine/psychiatry and very little on the lived experiences of women; therefore, women's knowledges or truths of their own experience are subjugated or disappear entirely. The knowledge formations reflected in discourse (meanings) become even more complex in the mangle of intersectionalities of identity and culture.

Indigenous scholars Clark (2016) and Million (2013) observe the mangle of trauma discourses through the lens of colonization while neither scholar identifies herself as a feminist post structuralist, both interweave a Foucauldian analysis into their critique. To briefly summarize, Clark explains that trauma discourse defines violence within normative neocolonial constructions (p. 4) and that structural violence enacted through policy, racism, and land dispossession is disappeared by this neocolonial framework (p. 4). Million highlights the constitution of the colonized subject (see Chapter Four) and emphasizes the material effects of colonization on Indigenous people (pp. 6-7). These Indigenous scholars have helped me understand the broader structural context of trauma

for Indigenous women and have helped me gain insights into the structural forces that affect all women caught in the mangle of trauma discourse.

Trauma and psychoanalytic discourses make meaning of women's lives within a historical, cultural context (see Chapter Four). Clark (2016) and Million (2013) present a cultural and historical context to the conversations about trauma and violence, which hover in the background of each interaction with the traumatized patient (subject) in the medical system.

FPS is concerned with the patriarchal and systemic structural oppression inherent in the medical field. Psychoanalytic discourse in the context of medical knowledge formations forms meanings—which are then applied to psychiatric practice—and reinforces the power relations found in the medical/psychiatric field of practice. The use of language produces discursive effects, which "show how the terms of reference established by a particular problem representation sets limits on what can be thought and said" (Bacchi & Goodwin, 2016, p. 23). Hekman (1990) reasons that language's primary assumptions are masculine, therefore rooting women's oppression in language. She posits that "phallocentric language offers women only two options: either they can speak as women, and hence, speak irrationally, or they can enter the masculine sphere of rationality and speak not as women but as men" (Hekman, p. 42). Women being treated for trauma who express emotions rationally—with level tone and affect—are recognized as stable and emotionally regulated. In contrast, emotional distress articulated as an affect congruent with that distress is seen as emotionally dysregulated or mentally unstable. Supported by discourse/texts such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, physicians hold the rational discourse in medical practice. In the

medical system, the traumatized patient takes up the disempowered subject's position juxtaposed with this expert/physician subject. These relational power positions support the dominant positivist view of the irrational patient/rational physician subjects. Power relations and colonizing effects entrench the dense transfer points of power between the medical/psychiatric knowledge (truth claim) and the patient as the unknowing subject.

FPS emphasizes attention to women's subjugated knowledges, defined as "voices and views that have been suppressed, unarticulated or denied by traditional discourse" (Usher, 1997, p. 46). Simultaneously, it must be noted that women are not immune to being dominated and influenced by hierarchal and patriarchal knowledges. Women's meanings concerning their day-to-day realities are discursively constituted in the nexus of dominant knowledge/power constructions. Medical/psychiatric discourses in trauma theory exert particular knowledge/power into the physician/patient relationship, honouring dominant knowledge while suppressing subjugated knowledge. These discourses construct meaning for physicians, health care providers, and the women and shape the meanings of what it is to be a woman who has experienced violence. The historical practices of knowledge formations shape how these subjects act, go about knowing things, go about attempting to know things or thinking they know things, and how they go about knowing themselves (May, 2006, p. 16).

Disciplinary practices

Discourse, practices, and technologies in the treatment of trauma braid together to constitute subjects, both the woman receiving the service and the healthcare practitioner providing it. Heckman (2010) describes the "unique way discourse is dependent upon, yet feeds back and influences discursive practice" (p. 52). The most commonly called upon

discourse in the treatment of trauma (both historically and in the modern present) is located in the field of psychiatry. A strong example of the influence of discursive practice is in the creation of the psychiatric diagnostic category PTSD, which is the primary means through which to understand and conceptualize people's responses to violence (See Chapter Four for the history of the development of this discourse). The PTSD diagnostic category was heralded and supported by some feminists to recognize the violence experienced by women and the impacts of abuse. Conrad (2007) argues that in the case of PTSD, it was the collaboration of social movements to define trauma as a medical problem that politicized, mobilized, and moved the categorization forward to gain recognition and credibility of women's experiences of violence and trauma. Once defined by the medical professions as a practice (diagnosis), resources followed to treat this disorder in the medical system (Conrad, p. 9). Naming trauma as PTSD—a psychiatric category—awards it a disease status with a life of its own, and "the horror of war is reduced to a technical issue tailored to western approaches to mental health" (Summerfield, 2011, p. 96). One outcome of this professional dominance in its extreme is the medical colonization of the "problem" of violence and trauma (Conrad,, p. 9). The collaboration of social movements in establishing PTSD discourse contributed to this medical colonization. Trauma remains firmly attached to individual pathologies, namely, maladaptive responses and symptoms arising from the violence and treatment through therapy practices.

Critical social justice debates are increasingly refracted through a therapeutic understanding/knowledge and discourse of trauma under the guise of a helpful theory intended to treat and support the "vulnerable subject" (Ecclestone & Brunila, p. 488). The

practice of therapy (therapisation) enacts discursive biopower as a disciplinary practice, and Stevenson and Cutcliffe (2006) explain that protocols, procedures, and policies enact power as a set of actions upon actions becoming a complex nexus of interrelated practices (p. 719). The discourse of madness generated by psychiatry is used in the practice of the governance of deviance and is held together by power/knowledge/discursive practices and technologies (Stevenson & Cutcliffe, p. 718). I understand that trauma treatment is informed by medical discourse, therapisation, and the contingent history of disciplinary practices explored in Chapter Four. It is important to trouble this practice, among other disciplinary practices, to make visible its effects on the persons involved in the practice. In post structural terms, these questions arise: How is a person conducted through these practices, and how do they conduct themselves in response to these practices? Moreover, since the subject is constituted through conducting, how does this impact their resistance to the conducting?

Agency

The discussion of women's agency in the therapisation process is necessary because it is often the stated goal of treatment programs to increase women's agency, autonomy, and self-efficacy through, for example, teaching assertiveness and emotional coping skills. Women find their voice within these therapy programs, begin to speak out and challenge oppressive social structures such as the institution/medical/ psychiatric discourse within which they receive therapy. The embodied, fluid, and intersubjective subject is an important concept in FPS and trauma discussion. Ecclestone and Brunila (2015) understand the multifaceted and multi-dimensional subject who is constituted within the wider structures of class, culture, economics, and politics (p. 457); their

description of the therapisation of social justice issues and the governing of vulnerable subjects in mainstream therapeutic programs are relevant and important to trauma treatment. Constituting the subject in this form of therapisation exists within the context of power relations, both of which are regulatory and productive (Ecclestone & Brunila, p. 488).

Through this analysis, I have come to understand the conundrum for women who have experienced violence. A dividing practice constructs how they are problematized as subjects. On the one hand, to receive support in a trauma treatment program, she must constitute herself as the vulnerable traumatized subject (non–autonomous). This non-agentic subject position is characterized as the traumatized patient in medical discourse and the evidence-based research literature. On the other hand, the agentic traumatized patient may resist being conducted into the vulnerable traumatized patient position. As she takes up resistance, choice, and voice—a practice of counter-conduct to dominant medical discourse—she may attract increased governing (conduct of conduct). This governing may include increased surveillance and monitoring through medical/psychiatric technologies such as increased medication and seclusion. Her resistance (counter-conduct) is an attempt to move toward the agentic empowered subject with voice, knowledge, and truth claims as described by Cahill (2001), Davies (1991) and Fine (2012).

FPS scholars have critiqued the concept of agency as an Enlightenment concept that is used interchangeably with "autonomy, rationality and moral authority" (Davies, 1991, p. 42). The argument rests in the contradiction that if a woman has agency, why can she not resist the violence? In past feminist arguments, the woman's victimhood was

emphasized to ensure she was not blamed for violence occurring in the context of a patriarchal society. Commonly, we understand this feminist strategy to bring attention to and resist the patriarchal structure perceived to be supporting male violence against women. However, I have come to believe that the complexity of the passive victim subject position situates women in a location of helplessness, wherein they are dispossessed of agency and autonomy and unable to act on their own behalf. A contradiction—a dividing practice—exists. In patriarchal power, women are constituted as helpless victim subjects shaped by practices in medicine/psychiatry, police, and the courts. Constituted victims need rescuing. On the other hand, if women are constituted as autonomous agentic subjects able to act on their own behalf, how is meaning formed of their experiences? Hypothetically and provocatively, if a woman is a passive victim subject, neither responsible nor able to act on her own behalf, how may she be an active agent in resisting violence, getting better or recovering from the violence?

Feminists are interested in the emancipation of women through the development of agency and autonomy. The simplicity of the subject as a passive object and recipient of oppressive acts shapes the female subject as one who cannot resist or take up her own counter-conduct. Taking up the female subject in this passive static fixed position circumvents the feminist agenda. The constitution and problematization of the female subject in phallocentric discourse constructs an available passive, compliant subject and has been made visible and taken up by women themselves by adopting this discourse. I understand that taking up the dominant discourse by the subject (the passive victim subject, as above) is problematic to the feminist vision of women's emancipation from patriarchal power relations.

FPS envisions an active female subject who takes up her subjectivity—in counter-conduct and resistance—within the context of the mangle of socio-cultural influences and knowingly interacts with these forces to her benefit. Davies (1991) explains that in the dominant humanist discourse, “a person has an obligation to take themselves as knowable, a recognizable identity who speaks for themselves and accepts responsibility for their actions” (p. 42). In other words, the dominant discourses available to the female subject include choices/non-choices and freedoms/non-freedoms that are inconsistent/consistent with those dominant discourses. The body is marked and shaped by the political discourses surrounding it, and the embodiment of the female subject accounts for bodily experiences and dynamics specific to women (Cahill, 2001, p. 67).

The embodiment of the Female Subject and Materiality

Subjects are embodied, and because of their experience with this embodiment, they are distinct from one another. The concept of the embodiment of the subject is taken up by FPS as a way of making visible "the body as lived and experienced by the situated subject" (Cahill, 2001, p. 74). Violence against women has become an interlocutor with sex and gender and is tied to the female body in the modern world (Hekman, 2010, p. 25). In FPS, the body that is “lived by the human being should not be confused with the body as approached by the scientific discipline, that is, the mechanic knowable object subjected to the medical gaze” (Cahill, 2001, p. 66). The female body has been claimed as a possession in modern times through laws and medical/psychiatric practices; feminists attempted to "take back" ownership of the body to empower women to resist the mechanization of the body and ownership by the sciences with the hue and cry that “biology is not destiny” (Cahill, 2001, p. 105). At the time, this strategy appeared

successful in rallying women to have a voice about women's health and health decisions. Theorists, however, "most notably Foucault, noted that the body, far from being a natural and therefore politically innocent entity, is marked indelibly by the political discourses that surround it" (Cahill, 2001, p. 66-67). The intersubjectivity of the female body's biology, including sex, mental processes, neurobiology, and intersections of class, culture, race, and sexuality/identity, are relevant to women's experiences of trauma. As Hekman (2010) explains, through the concept of the mangle, it is the interaction of all these practices that embody the female subject (p. 25).

Violence against women—an assault against women's bodies (minds)—is impossible to discuss without "accounting for bodily experiences or dynamics specific to women" (Cahill, 2001, p. 67). Psychoanalysis "constituted the body as a reflection and expression of interior dynamics and struggles" (Cahill, 2001, p. 67). As Cahill (2001) notes, "[t]he body is in no sense natural or innately psychical, sexual, or sexed. It is indeterminate and indeterminable outside its social constitution as a body of a particular type" (p. 67). The embodied subject includes internal and external forces impacting the day-to-day realities of women's material lives. Moss and Prince (2014) note, "as a concept, embodiment needs to capture the tension between the specific materiality of a (soldier's) body in a particular place and the discourses and practices that constitute that same body historically and in the present" (p. 27). Hekman (2010) evokes the concept of the mangle to illuminate discursive practices and the economic and political structures acting to produce the human body: "identities are created; gender, race, class and ethnicity are defined; bodies are disciplined" (pp. 123-124). FPS theorizes that female bodies are discursively produced in distinct and different ways within patriarchal societal

structures, therefore constituting and embodying women and affecting their lives' material reality. Identities are constituted and self-constituted by "the interweaving of all the complex elements that create social reality—ontology—without denying the agentic force of any of these factors" (Hekman, p. 123). The concepts of embodiment, the discursive constitution of women as subjects, and intersectional identities are foundational to FPS (see, for example, Bacchi & Goodwin, 2016; Cahill, 2001; Davies, 1991; Hekman, 2010).

The Nomadic Embodied Subject

The most useful concept in consideration of the mangle and tangle of the female subject's constitution is that of the nomadic embodied subject. This subject is "capable of significant and meaningful action, always in process and never wholly reducible to its membership in one class (be it sexual, racial, or other) of beings" (Cahill, 2001, p. 77). My understanding of this embodied material subject opens up the possibilities for change, resistance, and action consistent with feminist theory and goals. The concept of the nomadic embodied subject recognizes the mangle of discursive practices, economic and political structures, and the interior working of the body. All the while, this concept interfaces and interacts with the external forces that act upon it, constituting one another and mutually constructing, making separation from the other impossible (Cahill, 2001, p. 81). In the case of women who have experienced violence, this interplay of biology and social determinants of health are linked and experienced simultaneously, shaping the subject. For that matter, the experience of trauma—and trauma treatment—becomes integrated into the person's subjectivity and acts on the construction of the subject simultaneously. The embodied female traumatized subject's constitution occurs, as

women are in the mangle of the violence they have experienced and the medical/psychiatric treatment they receive.

FPS troubles embodiment, the mangle of practices, and the constitution of the agentic subject. Davies (1991) envisions a speaking/writing subject who is aware of dominant constitutions, can move in and between discourses, and speaks to her own experienced subjectivity using the "terms of one discourse to counteract, modify, refuse, or go beyond the other" (p. 46). The nomadic material subject described by Braidotti is similar in that "what sustains the entire process of becoming-subject is the will to know, the desire to say, the desire to speak, to think, and to represent" (Braidotti, 1994, as cited in Cahill, 2001, p. 73). As Hekman (1990) elucidates, the ability to write/speak allows the subject to "create discourses that avoid dualities, essences and the temptation to privilege the feminine over the masculine," (p. 46) thus acknowledging that a subject can resist the power structures inherent in discourses. The nomadic subject is reminiscent of the writing and knowing subject (self-efficacious and autonomous) described by Davies. In her discussion on agency and autonomy, Davies advances the thinking of agency beyond a passive, receiving subject to one who has the ability to resist and act.

Resistance is possible, however difficult, given the inherent power relations interplaying in the mangle for any particular subject at any particular time and place.

Resistance

The nexus of disciplinary practices, power/knowledge, and resistance provides a picture of how the subject is conducted or resists (counter-conducts) the conduct. Counter-conduct—defined as correlative counter-movements, resistance to being conducted—impacts power relations (Foucault et al., 2007, p. 193). Understanding

counter-conduct allows for a comprehensive concept of power as relational and repressive while at the same time productive. As Foucault (1978/1990) theorized, "[b]ecause power is not a thing, resistance cannot be its opposite; rather, points of resistance are present everywhere in the power network" (p. 95). An analysis of practices nested in medical/psychiatric discourse must recognize that resistance exists within power relations.

Foucault's concept of governmentality is primary in exploring the subject's constitution, the conduct of others, and the self in the context of power relations. To speak of resistance, I must first speak to the conduct of self and others within these power relations. Foucault et al. (2007) describe, on conducting the conduct: the activity of conducting, the way in which one conducts oneself, let's oneself be conducted and finally in which one behaves under the influence of a conduct as the action of conducting or of conduction . Consistent with this perspective is the resistance to the conduct, otherwise known as counter-conduct (Foucault et al.,, p. 197). "Resistance and counter-conduct modify force relations, counter locally stabilized organizations of power thereby affecting new possibilities of actions of others" (Davidson in Foucault et al, 2007, p. xxii). According to Million (2013), Foucault is interested in the "diagrams of governance" (p. 29); he explains that "counter-conduct in the sense of struggle against the processes implemented for conducting others; which is why I prefer it to misconduct which only refers to the passive sense of the word, of behavior, not conducting oneself properly" (Foucault et al., p. 201).

I have realized that in discussing the agency/autonomy of the female subject, it is vital to name resistance as counter-conduct rather than naming it misconduct or

misbehaviour. When women struggle against processes in their trauma treatment, they are typically labelled as “misbehaving” or “non-compliant” patients. The infantilizing discourse of “misbehaving” constitutes the subject and constructs the female subject as an unthinking and irrational subject rather than an agentic, knowable subject who actively resists oppressive forces. Cadman (2010) explains that governmentality has become a thought-imbued practice and a problem (p. 544). The agentic subject benefits from the knowledge of governing rationalities and techniques; these practices entitle the knowing subject “to think: how to be governed, by whom, to what extent, to what ends and by what methods” (Cadman, p. 544).

I became interested in agency and resistance when I witnessed different women's responses within a trauma treatment environment. What explains the manifestation of women’s conduct? If the choice is available, what shapes some women into resistance and others not? As Gavey (1989) asks, “[h]ow to make sense of woman’s apparent acceptance of what appeared to be clear instances of subjugation and exploitation?” (p. 185). The context of violence against women in an oppressive patriarchal social structure is necessary to understand what is taken as normative and natural (Gavey, p. 185); this context explains how women experience violence, how violence impacts their material lives, and the power relations within therapeutic structures. Gavey (1989) explains the importance of a post structural analysis to understand women’s apparent lack of resistance to violence perpetrated towards them. She evokes “Foucauldian ideas around the role of discourse in providing subject positions or ways of being in understanding ourselves and others in the operations of disciplinary power promoting self-governance” (Gavey, p. 185).

Cahill (2001) explains that when agency is situated within a defining context, I may not be free "to choose anything at any time (precisely because my context is specific, and therefore limited), nevertheless my context is never or rarely so limited as to preclude any options whatsoever" (p. 46). Within the context of a societal rape culture coupled with the threat of rape, it is helpful to explain women's lack of resistance, "what could be seen as compliance in the absence of direct physical force or the threat of violence" (Gavey, 1989, p. 185). The rape culture context is linked inextricably to agency and autonomy, shaping the female subject position. Women's material lives are impacted by the complexity of the intersubjective subject position and power relations that are recursive and generative.

The problem of women and violence (trauma, in modern terms) is a wicked problem, a "'messy,' 'fuzzy,' and 'complex' multi-causal" problem that requires "intersectoral interventions" (Bacchi & Goodwin, 2016, p. 61). Within these intersectoral interventions exists a subject who is conducted and who, in turn, has the "freedom" and agency to resist conduct. Generally, feminists struggle with the concept of a free subject. How can a woman who is raped be free to resist? How can any woman be free to act/resist when she is vulnerable to an attack? These questions assume that freedom means freedom from all oppressive and violent structures in a patriarchal society, which differs from freedom as understood by FPS (Gavey, 1989). The freedom to act within power-imbued structures, however limited, resists governance (conduct), and in these spaces of resistance, transformation or change may occur.

The notion of the free subject with the freedom to act acknowledges counter-conduct (resistance to being conducted). "Counter-conducts, a term used to describe

struggle against forms of governmentality, simultaneously challenge and reinforce dominant power relations" (Bacchi & Goodwin, 2016, p. 31). The subject maintains a critical attitude with the right to question truth and its effects of power and the right to question power on its discourses of truth (Cadman, 2010, p. 546). This is not to assume that the questioning of power/knowledge relations as a right is easy, for as the subject questions, she is also "desubjugated through the act of questioning" (Cadman, 2010, p. 547). Subjects operate within a society suffused by discourses that define their very being (Bacchi, 2005, p. 205). As she questions, she is changed in the questioning—this is the power inherent in the counter-conduct. This insider and outsider position allows the subject to identify discourses—within which she is positioned—and to use them selectively (Bacchi, 2005, p. 205). Bacchi (2005) confirms, "this understanding creates the possibility of theorizing a subject who is simultaneously made a speaking subject through discourse and who is subjected to those discourses" (p. 205). Cahill (2001) and Davies (1991) reflect on the subject as one, which is fluid, non-fixed, and discontinuous—the writing, speaking, knowing subject. This view on subjectivity is useful to feminist post structural analysis when considering "how governmental problematizations produce particular kinds of provisional subjects" (Bacchi & Goodwin, 2016, p. 40). It is through this critical attitude, the questioning of power relations, self-conduct, and counter-conduct that the possibilities of change exist.

Summary

I have discussed FPS as a theory to understand and explore violence against women and trauma treatment. I have compared FPS to post structuralism to make visible the gendered reality of women as subjects, arguing that a gendered analysis of violence

must take up fluid and complex identities and a historical sociopolitical genealogy to make visible women's knowledge and truth claims. I have outlined the importance of the nexus of power/knowledge, subjectivity, and disciplinary practices that constitute women as subjects in the transactional field of medicine and psychiatry. This inquiry is critical given that most trauma treatments occur under the gaze of these fields. Importantly, I have discussed the embodiment of the female subject and the notion of agency and subjectivity related to FPS, particularly to women who have experienced violence in their lives and sought treatment for it.

The governed and the governors are constituted through the same modes of subjectification of their conduct (Cadman, 2010, p. 549). The "transactional realities subsist at the interface of the governors and governed. They [the governors] support the governmental technologies that direct the conduct of the governed, who in turn conduct themselves accordingly" (Cadman, 2010, p. 549). Acts of resistance in this transactional reality space open up the possibilities of re-problematizing male violence against women and the concept of trauma. "During governmental contestations or counter-conducts, neither governors nor governed act directly on each other; instead, they act on the transactional field or domain though which they are engaged" (Cadman, 2010, p. 549). Million (2013) describes these as dense transfer points of power, and this transactional space lies in part in the protocols and guidelines that define practice in the field of trauma treatment. It is critical to recognize that the transactional field's truth regimes are built on particular problematizations. "The critical task, therefore, becomes tracing and assessing the specific forms of reality that power creates" (Bacchi & Goodwin, 2016, p. 29). In order to critically reflect on the transactional field of violence against women (trauma) in

the transactional field of health care, the problematization of violence against women (trauma)—or, "what is the problem represented to be?"—is important and the focus of my study.

Knowledges are adopted, adapted, and transfixed through individual experiences, and meaning making immersed in the mangle of these practices. Through the lens of FPS, I am interested in problematizing the practice guide identified by participants in my study as the primary protocol for their practice and one that shapes and assumes dominant knowledges in the field while subjugating other knowledges. I am interested and curious about how the problem of trauma shows up and is problematized in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and the SAMHSA (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach*. In the following chapters I begin my analysis of these guidelines.

I have chosen the methodology of the WPR approach, which is fully explored in Chapter Five. This methodology troubles problem representations, how particular problems are constituted in policies and guidelines and provides the opportunity to probe underlying assumptions that render these representations acceptable. I utilize this methodology to trouble TIP guidelines as an example of disciplinary practice. I adopt FPS to theorize the effects of practices on women's subjectivity; material lives, power relations, knowledge formations, subjugated knowledge and freedom to resist the dominant discourses enveloped in trauma treatment. I extend my analysis by utilizing post structural interviews —a methodology introduced by Bacchi and Bonham in Bacchi and Goodwin (2016), and in the next chapter, a genealogy of the concept of trauma. This

chapter answers question three in the WPR approach: How has this representation of the "problem" come about? (Bacchi & Goodwin, p. 20).

Chapter Four: Genealogy of the Concept of Trauma

In this chapter, I explore the emergence of the dominant concept of trauma. This concept of trauma has been widely accepted in the health and social service fields. Professions such as medicine, psychiatry, nursing and social work have accepted this understanding of trauma and implemented it in practices with women who have experienced violence. My historical examination of practices, which makes visible a trauma ethos, includes the problematization of soldiers' psychological trauma, the influence of feminism and the women's movement, and the colonization of Indigenous peoples in Canada. I utilize genealogical critique to trace the disruptions, fractures, and moments in the time leading to the introduction of Trauma Informed Care (TIC) policies in British Columbia. First, I trace the history of the development of the medical model and the practice of psychoanalysis. Next, I braid together the historical practices and influences of medicine/psychiatry, colonization, trauma conceptualizations, and the first, second, and third waves of feminism. These historical practices are interlocutors in the political history of violence against women and trauma. I intend to make visible the dominant concept of trauma to reveal the histories of present knowledge domains, practices, and beliefs.

My genealogy's historical developments are chosen from my literature review on the concept of trauma, TIC, and my personal experience of the women's movement of the 1970s and 1980s. These historical developments contribute to my genealogy of the concept of trauma. The historical junctures in this genealogy include acts of war; colonization of Indigenous peoples by church and state; the emergence of the medical model and psychoanalysis; individual aggression such as rape and battering; and systemic

violence occurring in institutions and systems of care. These events are not exhaustive; however, they illustrate the power/relations and knowledge formations in the field of health care related to the concept of trauma. My interest is driven by my feminism and my work as a social worker with women in health care since 1979. Over this time, I have witnessed dramatic changes in policy and treatment services for women who have experienced violence in their lives. I intend to trace these changes in a genealogy of practices, making visible the development of a trauma ethos in modern healthcare practices.

Setting the context

Trauma is an outcome of an act or acts of violence and is born from physical, emotional, mental, spiritual, and/or sexual violence. Violence or witnessing violence and emotional neglect are the root causes of what has been shaped and defined as trauma. The current conceptualization of psychological trauma relies on the theories developed in modern postwar history. The medical field paid attention to soldiers' psychological health, which opened the space for further development of psychoanalytic theories. This history has influenced the current interventions in women's psychological health treatment; other influencers have been social movements—including the women's movement—feminism, and other socio-cultural, historical contexts like the colonization technique of residential schools.

Over time, colonialism, feminism, social movement activism, and the fields of practice of medicine/psychiatry have intertwined to create cultural and historical junctures in time that produce the ontology of trauma. For my purpose, the ontology of trauma is the nature of trauma itself and the way of being when trauma has occurred,

including the response to trauma within a system of care. Practices in the health care field have been widely accepted and premised on this trauma discourse. The documents I critique for my study— including the *Trauma Informed Practice Guide (TIP) (2013)* and the *SAMHSA Concept of Trauma Informed Care (2014)* —are premised on this dialectic. The documentation of the prevalence of violence (trauma) in the general population (Fellitti et al., 1999), residential school survivors (Truth and Reconciliation Commission of Canada, 2015), and war veterans (Moss & Prince, 2014) have led to significant attention to survivors of trauma in government policies and practices. Foucault (1972/1980) defined these policies and practices as apparatuses that are a "thoroughly heterogeneous set of discourses, institutions, forms, regulations, laws, statements, moral propositions; the said as much as the unsaid" (pp. 194-196). Feminist post structuralists are interested in these apparatuses, the resulting normalization practices, and the effect on women's day-to-day lives (Cahill, 2001), including the lives of those health care providers working with women who have experienced male violence.

I aim to explore present health care practices (policies, protocols) that affect women's day-to-day lives. I examine omissions, fractures, and disruptions in history, allowing me to trouble current practices and policies in the field of health care as they relate to women, violence, and trauma. My genealogy of trauma makes visible the current problematizations of the concept of trauma, and I discuss the historical figures that emerge within these problematizations.

Genealogy Defined

Genealogy, a philosophical critique method, integrates a modern understanding of history by tracing evolutions of practices that interweave with power-knowledge formations (May, 2006, p. 63). These formations of knowledge create a confluence of intersections of power where new practices emerge. A genealogy critiques historical events, the connection to ethics, and practices tied to external conditions and makes visible and troubles the nature and development of modern power; the critique opens up the field of practice to different knowledges (Tamboukou, 1999, p. 202). Michel Foucault, the recognized scholar of genealogies, was interested in modern power's nature and development.

Foucault utilized genealogy to critique processes, procedures, apparatuses, and technologies supported by knowledges within fields of practice and critiqued the influences of sociocultural-political conditions at specific historical junctures in time. May (2006) says of Foucault, he sees us as products of a contingent history, one, which may progress, regress or circle and repeat “because of particular local conditions that have arisen, not because it lies in the character of history itself to do so” (p. 15). Foucault did not adhere to any specific methodology in his work but often mentioned genealogy as "his form of reflection on the nature and development of modern power" (Tamboukou, p. 202). As a method, genealogy stimulates the questioning of both practices and the relations of power aligned with those practices. It is a way of thinking about an identified problem while critically examining historical developments. Koopman (2013) defines genealogy as a “philosophical and historical critique of the present” (p. 5) that is used to “clarify and intensify the dangers of history” (p. 88). These dangers may take the form of unintended consequences arising from practices and policies that have not before been

identified or critically examined, such as TIP policies. To explore the concept of trauma in modern times, I have chosen the methodology first introduced by Carol Bacchi in 2009, the What is the Problem Represented to Be? (WPR) approach.

Methodology: WPR and Genealogy

The WPR approach asks, "how has the problem representation come about?" (refer to Chapter Five) (Bacchi & Goodwin, 2016). To answer this question, Bacchi and Goodwin utilize a Foucauldian genealogy, which they define as "a detailed mapping of practices that produce identified problem representations" (Bacchi & Goodwin, 2016, p. 22). As a critique, genealogy traces the historical and cultural practices in the context of power relations, identifying intersections or dangerous junctures in time that produce effects in individuals' material lives. Practices evolve out of this history and, in turn, influence knowledge in the fields of practice. Genealogy makes visible various conditions—including power relations in a field of inquiry—and exposes commonly held knowledges and practices in that field. "[Genealogy] makes sayable and visible, that which is conceptually available, the problematization of our present" (Koopman, 2013, p. 24). In my genealogy, historical points of importance in the development of practices are examined, laying a foundation for my analysis of the problematic representation of women's trauma in trauma informed care policies and guidelines.

Genealogical critique uncovers submerged problems and practices and the underlying problematizations of any issue; as such, it "functions as critical histories of our present" (Koopman, 2013, p. 24). Foucault (1972/1980) coined the term 'problematization' to explain the importance of identifying underlying knowledges

(presuppositions), which lead to practices (actions) within the field (p. 1). Carol Bacchi (2012) utilizes Foucauldian problematization in her WPR approach, a post structuralist approach that examines how problems are constituted within the policy proposals and how representations of the problem lead to specific practices related to these representations. Bacchi asserts that a policy analysis requires a historical context to determine how the problem is represented to be in specific proposals (p. 2). A genealogy does just that, making visible how the problem is represented to be by exposing the intersections of policies, practice, and power/knowledge relations. A genealogy also uncovers subjugated knowledges, such as knowledges held by women who have experienced male violence. Further discussion of women's subjugated knowledges can be found in Chapter Three.

In turn, this examination of policies and subjugated knowledges opens possibilities for change in practice. Bacchi and Goodwin (2016) explain that policies drive practice. If the constituted problem is in dispute—as it may well be as uncovered in my WPR analysis of women and trauma (violence)—it follows that the practice such as trauma informed practice (TIP) flowing from that policy needs critical examination (p. 39).

I wish to trouble policies meant to address women's trauma because of my knowledge/herstory with feminism and the rape and battered women's movements. In my health care experience, persons who develop and implement policies are well intended and expect policies to produce positive outcomes for those receiving the services. The WPR approach uncovers complex problems (wicked problems), such as trauma, which appears difficult to solve and identifies practices requiring attention. The WPR approach

lays bare practices within policies that may be dangerous and could produce unintended consequences; my genealogy makes visible some of these practices. The WPR analysis disrupts evidence-based practices that have been unconditionally supported in the field of healthcare, such as TIP policies. The disruption of practices destabilizes the system and opens new possibilities and ways of thinking about these practices, potentially uncovering creative new ways of thinking about problem representations and resulting practices (Bacchi & Goodwin, 2016, p. 39).

Genealogy destabilizes continuity—or linear history of knowledges and practices—while challenging historical presumptions and making visible subjugated knowledges (Bacchi & Goodwin, 2016, p. 47). Bacchi and Goodwin (2016) state that "genealogy highlights the battles that take place over knowledge," highlighting the power relations inherent in these battles (p. 46). Genealogy emphasizes the heterogeneity of practices that coalesce into present practices. I have grounded my time frames for my genealogical analysis beginning in the 1700s to capture the history of medicine and psychiatry. I focus on the time frame post WWI because many authors have explored the psychological harm caused by this wars, including the development of the diagnosis of post traumatic stress disorder and the treatment of postwar trauma (Fassin & Reichtman, 2009; Herman, 1992; Leys, 2000; Micale & Lerner, 2001; Moss & Prince, 2014). These historical junctures have contributed to the modern trauma ethos present in current times.

Trauma Ethos and the traumatized female patient figure

Trauma ethos is a set of ethics, principles, and beliefs about violence against women and the accepted treatment modalities for this violence's problematized effects. I trace the historical development of this ethos that has arisen post-millennium. The trauma ethos sets the central tenets for the modern interpretation of violence against women.

Trauma discourse, one facet of the ethos, has allowed us to attach meaning to the violence in the world, whether it be collectively—as in Indian Residential School experiences—or individually, as with a woman who has experienced intimate partner violence, rape, and/or childhood sexual abuse. Meaning making within violence-against-women-discourse has been subsumed into a more generalized trauma discourse. This ubiquitous discourse fails to drive a necessary course of political action and loses the site of political contestation that demands a change to oppressive patriarchal and racist systems. Trauma discourse avails itself of "representations (which) not only describe reality but transform it...practices not only follow from a priori of reasoning but justify it in retrospect" (Fassin & Rechtman, 2009, p. 277-278). Since the transcription of trauma as a physical wound to a psychological one, the field has opened to the idea of trauma as a common experience, allowing us to speak of violence throughout the world (Fassin & Rechtman, 2009, p. 277). Although,

> we may wonder if it is reasonable to group in the same category the adult who was sexually abused as a child and the earthquake survivor…contra to popular assumption that trauma is self-evident and that those who speak of it are simply revealing a reality (what we need) to understand (is) what is at play when we interpret the world and its disorders through this concept, which has moved from clinical psychiatry into everyday parlance. (Fassin & Rechtman, 2009, p. 277)

The omnipresent trauma discourse has reached epidemic proportions on an international scale (Fassin & Rechtman, 2009; Million, 2013).

Public witnessing of violence narratives in the context of government-initiated commissions, as in the case of truth and reconciliation, provides a rarely taken

opportunity "to evaluate what is power in our times" (Million, 2013, p. 3). Giving voice to what has been named trauma makes violence visible while at the same time shaping our understanding of violence. In the dense web of medical practices, psychiatric practices, policymaking, and political activism, the day-to-day realities of women's lives are made (in) visible; their knowledges subjugated. They are impacted through the shaping of their roles in the family and their work, and the services they receive; their conduct is governed through these meanings, practices, and health care technologies.

Foucault and normalization practices

Formed by the interplay of historical themes and practices, the determinations of 'who we are and how we are' are complex, Foucault views subject positions (who we are) as products of a contingent history (Foucault et al., 2007, p. 354), and who we are is deeply embedded in this history. May (2006) interprets Foucault's discipline as "the project for the body's optimization for turning the body into a well-regulated machine" (p. 73). Historical practices are tied to how we act, how we know things, how we go about knowing things, and especially how we go about knowing ourselves (May, p. 16). Foucault coupled power relations to practices of normalization (May, p. 63).

According to Foucault (1978/1990) in the *History of Sexuality Volume 1: An Introduction*, there are three forms of normalizing disciplinary practices: observation, normalizing judgment, and examination. In the field of health care, these three forms of practice include hierarchical observation—always looking from a distance to monitor the patient. The second disciplinary training is the binary operation of normalizing judgement. Normalizing judgement "works by means of both conformity (the standard that each of us must strive to meet) and individuation (the requirement of a set of

interventions on particular individuals in order to get them to achieve the norm)" (May, 2006, p. 74). The third disciplinary training is examination, and when "these interventions are trained on minute elements of a person's behaviour, they come to bear out in specific points in the behavioural unfolding of an activity, seeking to maximize it through rewards, punishments or other types of motivations" (May, 2006, p. 74).

In hierarchal observation, the observer is unseen—the observed does not see the observer. While the subject is under the observer's gaze, the observer monitors how well the observed are doing, what they are doing, and how they are doing it (Foucault, 1963/1994, pp. 89-91). This hierarchical observation process gives rise to self-monitoring; that is, we "normalize" our behaviour and act as if we are being monitored (May, 2006, p. 76). In other words, we are created and create ourselves in the process of normalizing practice. As the project of normalization continues in a society filled with psycho services (psychologists, social workers, physicians), there is no need for everyone to be watched. "As these services proliferate, most of us will begin to watch ourselves" (May, 2006, p. 77).

Normalizing judgement gives rise to the third disciplinary practice of examination. Attention is given to minute elements of individuals' behaviour, and interventions are targeted based on a preconceived notion of normality (Foucault et al., 2007, p. 63). "Conformity is the norm itself, the standard that each must strive to meet" (May, 2006, p. 74). Interventions are intended to maximize activity and motivate individuals to achieve this norm (May, 2006, p. 74). As I trace the genealogy of trauma, I reveal these disciplinary practices and the impact of the emerging historical figures within the genealogy of trauma.

Foucault and historical figures in the genealogy of trauma

Figures are created within normalization practices in the context of historical phenomena. Power lives in practices, and through our participation in these practices, "certain types of beings are created" (May, 2006, p. 89). For example, Foucault identified the constructed figure of the hysterical woman in psychotherapeutic practices. Over the course of the 19th century, psychoanalysts linked sex to women and their nervous conditions. In the genealogy of trauma, several figures emerge in the historical phenomenon of the trauma ethos.

The figures produced are the traumatized patient (which includes the hysterical woman figure), the assaulted woman, the emancipated woman, the wounded veteran, and the colonized Indigenous woman. I bring to light each of these figures as I explore normalization practices within the genealogy of trauma in the 20th century (See Table 4.1).

By tracing the development of the trauma ethos, I trouble the web of disciplinary practices reflected in current policies and practice protocols in the field of health care and the treatment of trauma.

Table 4.1 Timelines of Historical Figures

Time frame	1600s First Indian residential school 1700s Scientific revolution – medical gaze	1800s Civil war Charcot and Freud Suffragettes-First wave of Feminism Mind wounds	1900s 1914-1918 WWI 1939-1945 WWII Shell shock 1918 women vote in Canada	1955-1975 Viet Nam war	1960s Anti-war movement Betty Friedan Second wave of feminism Birth Control pill
Historical figures	• Indigenous Colonized woman figure • Physicians as experts • Unknowing subject	• Wounded veteran • Hysterical female • Traumatized female patient figure	• Wounded veteran figure (traumatized patient) • Emancipated	• Wounded veteran • PTSD	• Liberated woman
	Trauma Ethos develops across time				
Time frame	1970s Boston Woman's Health collective Royal commission Status of women 1975 International Women's Year Rape Crisis Centers	1980s Medicalization of trauma Traumatized patient's brain Rape trauma Syndrome Influx of psychiatry to Indian communities	1990s Sexual assault law reform in Canada Third wave of feminism Race and sexism enter conversation 1999 UN day for the Elimination of Violence against	2008-2015 • Truth and reconciliation Commission Missing and murdered women Inquiry	2020 In plain sight report
Historical figures	• Emancipated Woman Figure • The assaulted woman figure • Indigenism as a movement	• Traumatized ill patient • PTSD applied o women incest survivors	• Last Indian residential school closes in BC in 1996	• Colonized Indigenous woman figure	• Health care reform planned to address anti-Indigenous racism

Genealogy of Trauma

Historical Juncture: The Medical Model and Psychoanalysis and the traumatized patient figure

Psychoanalysis has shaped the emergence of the traumatized patient figure, and the advancement of the medical (disease) model has impacted the development of psychoanalysis. The medical model—based on positivist scientific inquiry and the germ theory, a chief model of disease and its treatment—dominates health care practice in modern times (Bates, 2000, p. 14). I trace the contingent history of the medical model, psychoanalysis, and the shaping of the traumatized patient figure in a genealogy of trauma beginning post WW1. Historical figures emerge throughout history in forms that weave together in my study of trauma. I locate these figures throughout the history of trauma treatment located in hospital settings and the disciplinary practices of observation, normalizing judgment, and examination located in institutions such as hospitals. These practices shape the traumatized patient under the medical gaze of medicine and psychiatry, and these sites of medical knowledge sustain the physician as an expert under the medical model.

The discipline of medicine has owned the social privilege of knowledge of disease; that is, knowledge held by a few educated individuals (Foucault, 1963/1994, p. 55). Foucault (1963/1994) coined the term 'medical gaze' to advance the understanding of the medical field as "a permanent corpus of knowledge about the health of a population" (p. 38). Developed during the scientific revolution, the medical model held Western medical technologies' focus and excluded Indigenous knowledge of healing (Bates, 2000, p. 22). The patient became the passive recipient of treatment, the observed, and the

examined under the westernized medical gaze. The physician (the medical expert) became the holder of the knowledge and truth of the human body's mechanisms. Medical practice and knowledge, through normalizing judgment, coalesced with power in systems and relationships in the practice of medicine. As a discipline, medicine further characterized the traumatic patient as the observable subject in need of normalizing.

Within the scientific revolution of the late 1700s, the physician acquired the status of the expert who held knowledge over the functioning of the human body into a well-regulated machine. This discipline of turning the body into a well-regulated machine is applied to the bodies and the interaction between them (May, 2006, p. 74). Bates (2000) reviews the development of medicine as a profession, noting that the "scientific revolution of the 17th century had a big impact on the understanding of how a healthy body works, but it had very little impact on how medicine was practiced" (p. 13). Medicine is a science that decrees that there is a magic bullet to attack an internal ill (germ theory) (Bates, 2000, p. 15), and the science of medicine puts the knowledge squarely in the hands of a few experts—those who have access to education and the laboratory (Bates, 2000, p. 20).

A dynamic tension developed in medicine in the late 1700s; at this time, the study of medical practice in the academy of medicine fought for recognition of the practical teaching of medicine at the bedside in hospital settings. The institution, therefore, became the location of the experts, and the hospital played an essential role for the physician. Foucault (1963/1994) emphasized, "for the doctor's gaze it was the locus of systematic truths" (p. 48)

The development of hospitals as the site of medical knowledge established physicians as expert knowledge holders (Foucault, 1963/1994, p. 70). "If knowledge occurs within our practices, and power arises within those same practices, then there must be an intimate connection between power and knowledge" (May, 2006, p. 20). The physician's power/knowledge conducts the conduct of the ill traumatized patient as an unknowable passive subject who receives care from the knowledgeable expert.

As physicians became experts in medicine, psychiatrists became experts in the study of the human mind, as exemplified by Freud and Charcot in the late 1800s. Psychoanalysis established itself as a field of medicine and, by association, acquired all the privilege and power/knowledge afforded to the medical field. The treatment of psychological trauma began with the advancement of psychoanalysis, which, as a normalizing practice within the field of medicine, coalesced the knowledge/power of the psychiatrist to conduct the conduct of the ill traumatized patient. Psychological knowledge is part of a larger body of knowledge, a discipline "that does not simply understand but at the same time created who we are" (May, 2006, p. 76). The problem with psychological knowledge lies in its effects, not its truth claims because it creates what it studies, which is its truth (May, 2006, p. 95). For example, establishing hospital structures to house the afflicted led to a cemented belief that the disease is intrinsic and lives within the person. In my experience, as women enter a treatment program within a health care setting, this truth remains in current practice. Women are seen to be holding their trauma, in their bodies and their minds, and must be healed; one woman told me she learned in one of her groups that "my brain is broken" (client in treatment centre, personal communication, 2017). The disease lying within the person is a presupposition

that allows for conducting the conduct and subjectification of the ill traumatized patient (see Chapter Three).

The unknowable, vulnerable and broken subject requires the monitoring (observation) and healing (normalizing and examination) provided by the knowing other—the health care practitioner. The traumatized patient is monitored for any 'unusual' reactions or behaviours, such as being frustrated when not attended to by the health care practitioner. Normalizing judgment is utilized to identify conforming behaviours. The traumatized patient is observed while in hospital, for example, being asked to let the practitioner know where they are at all times. Night checks are done with a flashlight as the nurse moves from room to room, recording each traumatized patient's presence, completing a checklist, or reporting an absence to the physician.

Another example is the normalizing judgment that occurs in treatment groups and individual sessions. Physicians and other health care practitioners examine minute language and responses while rewarding women for the correct responses consistent with the therapy manuals. Normalizing is achieved through examination of specific behavioural points unfolding in an activity "seeking to maximize it through rewards, punishments or other types of motivation" (May, 2006, p. 74). These manuals provide instructions on normal behaviour in a well-intentioned effort to heal the traumatized patient's mind.

In a disciplinary practice such as psychoanalysis, the traumatized patient is studied and created as an all-encompassing identity. The psychoanalyst, the physician and social worker create themselves and other beings and are part of the trauma ethos's historical phenomenon (May, 2006, p. 89). This contingent history makes visible

practices at the center of the creation of certain types of beings or figures (Foucault, 1963/1994, p. 70). These beings weave together throughout time as historical junctures converge, giving rise to the creation of figures in the context of a trauma ethos. The creation of figures is shaped by ethics, principles and beliefs about violence against women as defined by this trauma ethos. This ethos delivers central tenets informing the modern interpretation of violence against women and the treatment provided for the women who experience this violence. I examine the created figures and trace the events in this contingent history, revealing the trauma ethos's formulation in modern times.

Historical Juncture: the emergence of the hysterical female and traumatized female patient figures

The initial emergence of Foucault's figures appeared in his work The *History of Sexuality Volume 1: An Introduction (1978/1990*). Foucault exposed the emergence of the hysterical female figure as a created type of being within a contingent history.

The term hysteria was appropriated by psychoanalysis over the course of the 19th century to link women and their nervous conditions to sexuality (May, 2006, p. 89). According to the Science Museum (https://www.sciencemuseum.org.uk/objects-and-stories/medicine/nerves-neuroses), the study of hysteria—a nervous condition identified only in women—laid the foundation for exploring reactions to trauma patients. Charcot, the father of neurological medicine who practiced in a medical asylum (hospital), garnered notoriety for his theories of hysteria, a disorder thought to be the physical embodiment of psychological pain (Herman, 1992, p. 10). The relatively new neurology and psychiatry disciplines merged at this significant historical juncture, from which the current traumatized brain theory arose. This theory has been supported by brain studies

and medical technologies such as computed tomography (CAT) scans. Health care practitioners and patients are taught about the neurobiological fight or flight response to explain avoidant or aggressive behaviours towards others. Hence, the traumatized patient's statement "my brain is broken" begins to become normalized. The traumatic brain's intrinsic ill is established as the foremost importance in treating the disorder of trauma.

In the late 19th century, the study of hysteria was predominant and focused on institutionalized women who had been "beggars, prostitutes, and insane" (Herman, 1992 p. 10). The hysterical female figure emerged during this time in the practice of psychiatry, while today, the hysterical female figure would be characterized as vulnerable and marginalized. This important juncture in history begins to synthesize women, the concept of trauma, and trauma treatment within medical institutions (hospitals). The hospital as a site carries the medical practices of observation, examination and normalizing judgment (Foucault, 1963/1994, pp. 64-85). Charcot's practice shifted the normalizing judgment to observation, that is, listening to women's narratives. Charcot's practice gave credence to women's symptomology and experiences, and he is credited with opening the field of psychoanalytic practice to women's truth claims.

The practice of listening to women's truth throughout history has both advanced and regressed across time. When we discuss the assaulted woman figure, we witness a regression from Charcot’s understanding of women to Freud’s assumptions to reject women's narratives of the truth. Charcot advanced psychiatric knowledge by listening to women's narratives; however, he translated these narratives into the medical knowledge

of the times. This knowledge took the form of the categorization of symptoms into a medical classification system.

Medical classification shows up in modern history as the psychiatric diagnostic statistical manual (see Chapter Three). The medical model supported the practice of categorization or diagnosis, and the creation of the female hysterical figure laid the foundation for the diagnosis of women in modern times. Through observation and examination of the hysterical woman, normalizing judgments are made by the physician expert and set into the psychoanalytic practices for the foreseeable future.

Foucault describes this as the project of normalization; the body becomes the site of normalization and the site of pain (Foucault, 1963/1994 p. 84). The hysterical female figure is created to be amoral in psychoanalytic practice, such as over sexed, beggars and prostitutes (Herman, 1992, p. 10). The medical practice did not contextualize the diagnostic practice of normalizing judgment to women's day-to-day experiences as poor, undereducated women in Victorian society. This lack of contextualization of social determinants of health sets the parameters of psychiatric practices over the next century. Charcot's work marks the beginning of the (subjectification) creation of the traumatized female patient figure, which shapes women's experience of violence into the psychologically ill traumatized patient's current subject position. Notwithstanding the lack of structural context, through Charcot's experiments, he directly correlates women's psychological symptoms and their external traumatic experience.

The coalescing of the hysterical female and the traumatized female patient figure

The pioneering psychiatrists Freud and Janet were inspired by the link between hysteria and early traumatic experiences. They moved beyond the classification of

symptoms to advance the treatment of the traumatic condition by listening to women's narratives of their abuse. By the 1890s, Breuer, Freud and Janet had theorized that hysteria was a result of psychological trauma (Herman, 1992, p. 12), a theory dominating modern psychotherapy. The modern practice of psychotherapy evolved from listening to women's narratives and informs the treatment of trauma in modern history—the contingent history of the original psychotherapists shaped modern practice. Freud continued in this vein until he found the abuse disclosures irreconcilable with his perception of men in his society.

Freud discovered that child abuse was prevalent for the bourgeoisie women in his care and was unable to reconcile the contradiction of this form of abuse in his society with his beliefs that males are the protectors of women and children. He succumbed to the pressure of his peers to revise his hypothesis. Freud's reassessment had a lasting impact on the practice of psychotherapy. He determined that women could not be telling the truth about their abuse. He fashioned a turn of truth that women's claims of abuse must be untrue because the abuse was so prevalent and so outside of society's beliefs of the time they could not be true. Freud reframed his patients' stories of abuse into their desire for erotic excitement. This was a dangerous juncture in history for assaulted women. The newly established normalized judgment that women lie about the violence they have endured followed the traumatized patient—in both her personal life and the courts—right into the 21st century.

The assaulted woman figure endured questioning in the courts about her personal sexual history. Through the minute examination of the violated woman, authorities questioned how a man could have chosen to assault a woman at random; there must have

been a reason. This critical juncture influenced feminist activists to neutralize the laws calling rape 'sexual assault' to exclude women's sexual history from the examination. The effects of this legal reform are detailed later in this chapter. One hope of this social justice initiative was to change the assaulted woman's characterization as someone to distrust, or the traumatized female patient as a woman who falsifies and who is promiscuous, to a reliable witness to her own assault.

The dangerous conflation of the abuse of children, eroticism, and female sexuality set the stage in the field of psychoanalysis for blaming traumatized female patients for the violent acts perpetrated against them. The power of psychoanalytic interpretation was bolstered by the medical field of practice as a discipline of expertise, prestige, and a mode of social control, conducting the conduct of the traumatized female patient. The idea of distrusting the traumatized female patient's veracity was only fractured when social movements such as the Suffragettes and the first wave of feminism took up women's truth as reliable.

Medicalization of the field of trauma treatment and the emergence of historical figures

Medical social control over health and wellness has expanded with the increased use of surveillance and technologies of biopower (Foucault et al., 2007, p. 1). Medical social control "concerns itself with how to promote and intervene in the human life" (May, 2006, p. 90). Technologies of biopower intervene in human life by conducting the conduct of the patient and practitioner alike, shaping practices in the field of medicine/psychiatry (Foucault et al., 2007, p. 118). Normalizing judgment shaped in observation, examination and normalizing is found in these disciplinary practices. Disciplinary practices as a set of power relations "come together to induce individuals to

become normalized and inseparably to think of themselves as normal" (May, 2006, p. 85). The normalizing practices create new expectations for bodies, behaviours and health (Conrad, 2007, p. 151).

The field of psychiatry involves itself with such normalizing judgment techniques as the monitoring, observation and examination of the patient. Psychiatric biopower technologies include imaging technologies of the brain, psychotropic medications, and a standardized categorization system—*The Diagnostics and Statistical Manual (DSM),* which models psychiatric diagnosis after medical diagnosis categorizations (Young, 1995, p. 271). The patient with PTSD is the traumatized patient. This disorder has a specific cluster of symptoms identified through psychiatric observation and examination of minute details in the patient's life and behaviour. The psychiatrist prescribes treatment based on the cluster of symptoms and acceptable behaviour identified by their professional standards. Medical control "is manifested in diagnostic systems and the medical profession's expectations that define well-being, health and medical norms intended to guide behaviour" (Conrad, 2007, p. 151). These medical practices based on medical knowledge shape practices in the field of psychiatry.

The psychiatrist is the medical expert in the field of psychiatry. The psychiatrist holds the psychiatric gaze much like the physician holds the medical gaze. The psychiatrist utilizes bio-medical technologies (biopower) such as brain CAT scans, the management of psychotropic medications and psychotherapy. In more recent history, the technology of psychotherapy in the field of trauma treatment has shifted to other health care experts. The shift in practice has led to increasing responsibilities for clinical

psychologists and social workers to manage the psyche and conduct the traumatized patient's conduct through the technology of psychotherapy (Young, 1995, p. 271).

Psychiatric practices based on medical knowledges first targeted trauma treatment during and post-WWI. The wounded veteran figure was created as a traumatized patient. Since then, the psychiatric knowledge developed during this history was applied to other traumatized patients like those in my study: women who have experienced violence, including the assaulted woman figure and the colonized Indigenous woman figure. These figures are shaped in this knowledge by biopower technologies, which are integrated into healthcare services, particularly in mental health facilities where the traumatized patients receive treatment (Foucault, 1963/1994, p. 70). Common technologies in use are cameras for patient surveillance and secure rooms for patient seclusion and observation (Conrad, 2007, p. 151). Upon admission into the health care facility, a health care practitioner completes an examination to look for trauma symptoms and self-harm behaviour and assess the risk of self-harm and suicidal ideation. These assessments are standardized. If there is a high and imminent risk of harm to self or others based on this assessment, the patient is secluded in a separate observation room. This room is sometimes locked and monitored by cameras. The patient is controlled through close observations from 15 minutes to one hour apart. The physician, the most responsible health care provider, is notified and orders medication to control the patient's behaviour in the hope of keeping them safe (normalized). The patient may be certified (held against their will) under the Mental Health Act, and therefore lose all autonomy in decision-making. The patient is now under the physician's order to stay in the hospital with few privileges, separated from social supports, and kept in seclusion with minimal human contact. Their paranoia may

increase due to isolation. Their self-harm behaviour may increase due to despair; therefore, the technologies intended to keep the traumatized patient safe may unintentionally create traumatic experiences. The traumatized ill patient is continually created into a suicidal, paranoid, unknowable traumatized patient. The psychiatrist is shaped as the expert knowledge holder who knows what is best for the patient and what is normal behaviour. The psychiatrist is shaped into a medical professional who utilizes specific disciplinary practices intended to normalize the ill- traumatized patient's behaviour.

Technologies within the medical model inform disciplinary practices that conduct the conduct of the ill traumatized patient. These practices are unevenly applied in the medical field. Not all ill traumatized patients are treated equally (Baker, 2007, p. 207; Conrad, 2007, p. 10). As I move through the contingent history of violence against women, I make this disparity visible. The medicalization of psychiatric care and the categorization of trauma symptoms have conducted the conduct of psychiatrists and traumatized patients alike.

Traumatized patients have been conducted or governed into compliance (normalized) under the psychiatric gaze since the inception of the discipline of psychiatry. For example, when a psychiatrist diagnoses a traumatized patient, she may comply by taking up the identity of the diagnostic label. She describes herself as traumatized, requesting treatment for her trauma. The trauma becomes her dominant identity; she becomes the broken brain with scarce attention to her other qualities and strengths. Patients may also resist these normalizing practices. The traumatized patient resists normalizing by refusing psychotropic medications, leaving the treatment program

when the psychiatrist has revoked privileges, or refusing to comply with program guidelines—for example, not attending group sessions. The patient exerts her autonomy by resisting, and in doing so, it is deemed non-compliant or non-normalized. She may be cited for poor behaviour, judged as not appropriate for the program, and asked to leave. This practice is in contradiction to the program's goal to increase women's autonomy. It disrupts the relationship between the patient and health care practitioners, therefore adversely impacting the ill traumatized patient's healing.

It is a tricky business or a wicked problem speaking to autonomy in FPS. The women's movement views autonomy as a metaphor for women's equality. If women are autonomous, they are courageous, they are strong, independent, and act on their own behalf. When women enter a treatment program, they are encouraged to find their voice, express their concerns and gain insight into their illness. All these actions are connected to autonomy. Autonomy related to safety is particularly rewarded when, for example, the assaulted woman decides to leave an abusive spouse. The tricky problem arises when women are asked to comply with normalizing practices such as following psychiatric orders for medications. If they comply, they are perceived as autonomous in their own care; they care about themselves and their health and act on their own behalf. They are depicted as a good healthy patient. If they do not comply, they are often labelled as a person lacking insight into their illness and unaware of the consequences of their own actions. They are shaped as an ill patient with a less than desirable prognosis. The expert psychiatrist's actions are not challenged or judged in this scenario. Compliance is viewed as synonymous with autonomy in medical discourse and practice. The tricky business of autonomy is an important feature in my analysis of TIP policies discussed in Chapters Six

and Seven. A dense transfer point for power relations (Million, 2013, p. 49) occurs between the patient and the health care practitioner when the traumatized patient is normalized, complies with orders and integrates the normalizing discourse that rewards her compliance.

As the relationship is disrupted, the traumatized patient is created as an ill person and takes up the notion of health as a lack of illness. "This notion of health is encouraged by a purely disease or medical conception of health or wellness" (McLachlan, 2006, p. 20). Two significant new concepts within health care emerged post-WWII. In 1948, the World Health Organization (WHO) conceptualized a new definition of health as a multi-dimensional state of physical, mental and social well-being. At this historical juncture, WWII also increased attention to the concept of trauma (McLachlan, 2006, p. 20).

The war made visible psychological trauma. The wounded veteran figure became firmly established in general awareness, and the concept of trauma took up the definition of wellness as an embodied experience. Health defined as social well-being opened the possibility of external factors influencing psychological health, meaning the traumatized patient emerged as someone shaped by external structural factors outside of their control. The assaulted woman figure emerged as a woman who had experienced violence outside of her control, and who required rescuing from these external factors. With the intent of protecting women from their abusers, organizations built entire services around this normalizing judgment. They generated policies to reflect the problematization of the assaulted woman as a victim. Policies also reflected the increase in medicine's professionalization in the early 20th century (Bates, 2000, p. 20). The problematization in policies evoked the traumatized patient as a passive recipient of care provided by an elite

health care professional, as well as someone seen to need patronizing guidance and control (Baker, 2007, p. 297). The neoliberal framework of "social control and efficiency became common themes" in health care technologies and practices (Kunitz, 1974, p. 180).

In the 1970s, the WHO emphasized deinstitutionalization and community participation in all health matters, and community-supported health care was considered to reduce stress, increase disease resistance and influence adherence to treatment (normalization) (McLachlan, 2006, p. 21). The World Health Organization (WHO) recommended that resources be moved from expensive hospitals into the community (McLachlan, 2006, p. 210). However, the physician still retained the expert knowledge in these less expensive community-based services. Contrary to the WHO's recognition of the interplay of culture and social complexities, biomedicine remained insular to extraneous social-cultural influences. Simultaneously, the strong self-help tenets of the 1970s grew from this community orientation to health care, and the women's movement took up the call to action to improve women's health, as discussed later in this chapter. Contrary to this movement, the 1980s ushered in further medicalization of women's experiences of violence and trauma.

In 1985, Bessel van der Kolk released his first of many works on the physio-biology of trauma (Leys, 2000, p. 250). Like van der Kolk, many current practitioners rely on neurological explanations for the behavioural responses that commonly occur in reaction to perceived emotional or physical threats. The traumatized patient's brain became a keystone feature of trauma research and treatment. Leys (2000) discredits traumatized brain theory as weak and unsupported by scientific study (p. 258); other

authors disagree. Research into soldiers' experiences in combat, emerging as the wounded veteran figure, supports the link between common neural pathways shared with physical brain injury. The impact of chronic stress is included in the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD) (McAllister & Stein, 2010). Psychiatric practices have taken many turns over the centuries; however, in the case of traumatic neuroses of war, biological accounts remained continuously important. From WWI forward, psychological trauma is firmly planted in the category of a disease of the mind (Young, 1995, p. 271). The wounded veteran emerges as a historical figure within the historical phenomenon of the trauma ethos.

The trauma ethos is supported by the medicalization of trauma, including the widening of medical categories and expansion of healthcare practitioners' roles. The traumatized patients in the diagnostic category of PTSD include survivors of sexual abuse, rape, violence, natural disasters, and people who have witnessed violence or disaster. Other diagnostic categories include alcoholism and drug addiction. The women in my study are often diagnosed with both PTSD and addiction. Treatments are provided for these complex conditions based on the medical model, corresponding to these diagnoses (Conrad, 2007, p. 152).

These categorizations become known as the illness, and the patient is constituted as the traumatized ill patient. The diagnosis is a subjective assessment made by the psychiatrist that pathologizes normal life events, shaping the patient's response to these events. To illustrate, the subjectification of the ill traumatized patient occurs in a recursive pattern of them being diagnosed, complying or resisting the diagnosis, the psychiatrists reformulating the diagnosis, and so on. The medical diagnosis prevails even

though the patients' response is connected to life events, such as social determinants of health, poverty, and homelessness. The physician, blinded by diagnostic categories, fails to see the social root causes of the patient's distress. This phenomenon is known as the medicalization of a social problem (Conrad, 2007).

> Medicalization reinforces the individualized approaches to social problems that are common in our society. The focus on the individual has reinforced the proclivity of treating complex societal problems with technological fixes (e.g. medical, surgical, or pharmaceutical interventions) rather than changing the social structure. (Conrad, 2007, pp. 152-153)

Structural determinants of health such as poverty, poor access to education, and homelessness are precursors to trauma that affect women's material lives. These social determinants remain invisible in the medical model's individualized approach to treatment. Similarly, Indigenous knowledges and culture were disrupted by Western medical practices. Million (2013), an Indigenous scholar, articulates an example of medicalization following an influx of psychiatrists into Indian country in the 1980s (p. 156). Another example of the disruption of culture and an attempt to annihilate Indigenous culture in Canada is colonization techniques like the residential school system, active in BC until the 1990s. Colonization gave rise to the Indigenous colonized woman figure. The assaulted woman and the Indigenous woman figures share the dubious position of being shaped in the trauma ethos as those requiring rescue. These two figures also emerge side by side in treatment facilities that utilize psychiatric diagnoses as their basic tenet.

Historical juncture: individual aggression such as rape and battering and the emergence of the assaulted woman figure

The women whose identities reflect the assaulted woman figure experience a high rate of sexual violence, including incest and rape (Torchalla et al., 2015), and women are the largest group who suffer from PTSD (Torchalla et al., 2015; WHO, 2006). Medicalization of women's trauma through diagnosis and categorization firmly cements medical power/knowledge in the field of trauma treatment. In this paradigm, women's knowledges of their own experience are subjugated. The assaulted woman figure becomes the unknowing ill, traumatized patient.

Women who have experienced rape understand that the world is a dangerous place for women. Cahill (2001) describes rape as the most degrading truth a hostile world has to offer to women (p. 2). The socio-cultural realities of rape remain invisible in the intra-psychic and disease-focused medical model. "Gender based violence against women is based on an understanding that (such) violence is influenced by gender roles and discrepancies in power and status and supports the legitimization and perpetuation of gender inequalities" (Torchalla et al., 2015, p. 7). However, services, organizations, and entire disciplines have been organized around diagnostic categories and biotechnologies under the medical gaze. The services intended to treat trauma are not exempt. The assaulted woman figure receives services directed toward her intra-psychic space, medication to treat her traumatized brain, and psychotherapy to change how she thinks about the experience, with little or no intervention in the social determinants (root causes) of her distress. The assaulted woman figure is created to be a fractured and damaged figure who requires mending. She must readjust to the patriarchal reality of violence perpetrated against women even though this reality remains invisible in the treatment she

receives. She must participate (conform) in treatment programs to heal herself intra-psychically (normalize) to be considered a whole person by herself and others.

Social movements of the 1960s and 1970s made visible a broader interpretation of women's responses to violence and trauma. In 1970, the Boston Women's Health Collective opened the field of practice to new concepts of women's psychological and physical health. From this new knowledge formation, the assaulted woman figure emerged as a woman who required education about her body. This new knowledge empowered women to act on their own behalf, and classes to teach women about their sexual health grew during this period. They were armed with information and encouraged to question physicians when receiving treatment. The women's movement of the 1970s discussed later in this chapter, continued to move in the direction of self-help in matters concerning women's health. The emancipated woman figure began to emerge with this acquired knowledge, and women were taught self-defence as an empowerment technique against male violence. Development of TIP principles followed, including client-centred services and collaboration in treatment planning; these principles are discussed in Chapter Six.

Despite the movement to empower the assaulted woman figure, the development of the psychiatric expert in the field of trauma treatment continued to advance. The medicalization of trauma as a concept paved the way for the professionalization and institutionalization of trauma treatments (Figley, 2006, p. 1). Traumatology became a specialization, and the psycho-traumatologist was described as a professional expert in psychiatric trauma treatment. This professionalization of trauma treatment shaped those

providing the services, with trauma therapy constituted as a medical technology in trauma treatment.

The normalizing judgment inherent in the psychiatric field of practice reinforces the power relations between the patient and the health care practitioner. These power relations extend beyond the psychiatrist's role to nurses, social workers and other practitioners working in these treatment programs. Health care practitioners are governed, and the traumatized ill patients' conduct is conducted in the field of trauma treatment by trauma treatment as a normalizing practice. The health care practitioner conducts the conduct of the patient as a traumatized ill patient. The subjectification of the traumatized patient entrenches the psychiatric understanding of trauma as a mental illness. This illness is individualized and disease-focused. The traumatized patient holds the disease within them and relies on the expert to cure it, much like cancer. Many scholars have challenged the singular biological interpretation of illness (Conrad, 2007; Lauster & Tester, 2010; McLachlan, 2006). They have raised awareness about the root causes of trauma that lie in the social determinants of health.

More recent health and well-being studies have highlighted the intersections of oppressions such as culture, gender identity, race, poverty, and social location (Baker, 2007; Crenshaw, 1991; Lauster &Tester, 2010; McLachlan, 2006). These studies are relevant to my work because the women who access trauma treatment experience many of these oppressions, often several at the same time. The intersections of oppression are braided into the individuals' experiences of violence, and the resulting trauma, meaning the problem of women's trauma is complex, or as Bacchi (2012) states, a 'wicked problem'. The complexity is created in the contingent history of subjugated knowledges

and the lack of attention paid to the socio-cultural context of violence (trauma) and women in modern history.

Historical Juncture: War, psychological trauma, and the wounded veteran figure

The wounded veteran figure emerges in North America during the Civil War from 1861 to 1865. The treatment of nerve injuries and 'mind wounds' leads to the emergence of neurology and private practice psychiatry (Micale & Lerner, 2001, p. 135). Trauma previously defined as a physical wound became defined as a psychological wound, and Charcot developed concepts for the treatment of psychological trauma during this critical historical juncture.

Charcot's work with middle-class men in a large municipal hospital stood in contrast to Freud's work in private clinics with traumatized female patients from society's middle and upper echelons. "[Charcot's] construction of male hystero-traumatic typecasts…challenged class and gender identity of the neurosis" commonly held from Freud's work with female patients (Micale & Lerner, 2001, p. 118). Charcot's work with men and trauma remained mostly in the private sphere, and it was not until after WWI and WWII that psychological trauma was attributed to men in the public sphere. The male experience authenticated this kind of trauma; it was no longer seen as an exclusively female problem, carrying with it sexist notions of the time, such as women's erotic responses to violence. The wounded veteran figure emerged as a broken man in need of healing.

War exposed soldiers' trauma to public scrutiny, advancing the acceptance of the concept of trauma as new psychology in the sciences of the mind. This concept was applied to male war veterans in WWI, at which time psychological trauma was named

shell shock and hysteria nervosa (Micale & Lerner, 2001; Moss & Prince, 2014). From this historical contingency emerged the modern wounded veteran figure. When applied to men, the diagnosis of trauma did not prevent them from being labelled and stigmatized as malingerers, most commonly when they sought compensation for harm done (Moss & Prince, 2014, p. 63). "The malingerer forfeits the positioning of the traumatized individual, grounded in psychiatric knowledge, for another, a disgraced faker, grounded in military norms and general morality" (Moss & Prince, 2014, p. 110). The wounded veteran figure created, as a falsifier of truth claims, was one that is reminiscent of Freud's early works defining women's abuse stories as misplaced eroticization. This knowledge formation cast a shadow over the traumatized patient that remained well into the following century. Likewise, as a falsifier of truth, the constitution of the victim follows women in current history in the construction of the traumatized female patient and the assaulted woman figures. Women who have experienced male violence continue to be accused of falsifying claims of rape and domestic violence. Postwar characterizations of the traumatized patient and the beliefs held in psychoanalysis have influenced the stigmatization of current violence survivors as falsifiers of truth. This stigma follows women into modern psychoanalytic theories.

Psychoanalytic theory is interwoven in the postwar conceptualizations of trauma. When braided with disciplines/practices such as psychiatry, the experience of war defined the concept of trauma. The practice of trauma treatment constituted many soldiers as the traumatized patient and the wounded veteran. Similarly, women in the historical present who have experienced male violence are constituted as the traumatized patient and the assaulted woman. The traumatized patient figure carries the stigma of helplessness; they

are viewed as a less agentic subject (Chapter Three) damaged by their experiences. The disciplinary practices of psychiatry, such as memory reclamation and neuropsychiatry, coalesced into an interpretation of individuals' trauma experiences as an intra-psychic experience and a biomedical phenomenon. Psychiatry relied on the practice of memory reclamation with the wounded veteran enduring war trauma recovery. This practice supports medical discourse and interlaces with the culture of women's herstory and stories of violence and trauma. It is evident these contingent practices based on the cultural experiences of war were set in the disciplinary normalizing practice of psychiatry and continued in the normalizing judgment in the treatment of the assaulted woman.

WWII brought a heightened awareness of the wounded veteran figure. While the wounded veteran figure was more vulnerable to psychological illness, war accentuated women's strengths. Women stepped into the void to support both the war effort and the troops upon their return from battle. These and other socio-cultural changes affected women's material lives and societal beliefs about women's roles in society and the family. The emancipated woman figure emerged from these reformulated beliefs.

> World War II changed both the type of work women did and the volume at which they did it. Five million women entered the workforce between 1940-1945. The gap in the labor force created by departing soldiers meant opportunities for women. In particular, World War II led many women to take jobs in defense p lants and factories around the country. These jobs provided unprecedented opportunities to move into occupations previously thought of as exclusive to men, especially the aircraft industry, where a majority of workers were women by

1943. (https://www.khanacademy.org/humanities/us-history/rise-to-world-power/us-wwii/a/american-women-and-world-war-ii)

Moving pictures and local theatre portrayals of real-life war images brought the war closer to home. Women became invested in the war effort by enlisting to work overseas or working in ammunition factories. The breakthrough of women into non-traditional occupations contributed to women's suffrage, discussed in more detail later in this chapter. Women temporarily enjoyed increased autonomy in their lives and their occupations; however, their work in war times and the impact on them postwar remain invisible in wartime literature (Mattocks et al., 2012, p. 537). This remains true in modern war history.

The Vietnam War gave rise to the current diagnosis of PTSD, and with this diagnosis, the wounded veteran figure was further entrenched as an ill traumatized patient. During this historical period, the increased awareness of postwar trauma advanced psychiatric practices to focus on preventing traumatic stress reactions after the war. Moss & Prince (2014) report a decease in breakdown rates as a result of psychiatric testing when coupled with more extensive psychological training for combat troops (p.174). The theory of preparing soldiers for trauma exposure to pre-empt trauma reactions is tenuous. A variety of factors intercede in stress and trauma reactions—for example, soldiers' use of opiates during the Vietnam War as a mechanism for coping with PTSD. The relationship to soldiers' experience of psychological trauma and their drug use is non-existent in most literature (Robins et al., 1975, p. 955).

It is estimated that by 1971, soldiers' drug use had reached epidemic proportions at the height of the Vietnam War. Twenty percent of soldiers returning to the US reported

an opiate addiction (Robins et al., 1975, p. 955). The US government became concerned that addiction counselling programs would be overwhelmed when soldiers returned from the war. Still, surprisingly, the use of opiates returned to pre-war levels upon soldiers' return to the United States. I am interested in this seminal study in many ways. Firstly, the study of Vietnam veterans, who experienced less combat stress than expected, built the introduction of a diagnostic criterion in psychiatry in 1980 (Moss & Prince, 2014, p. 174). Secondly, the use of opiates was interfaced with soldiers' experience but remained unaccounted for, therefore making the use of opiates as a relief for PTSD symptoms invisible. Combat stress was not considered a cause or trigger for substance use or substance dependency; however, psychiatry constructed the diagnosis of PTSD within the context of soldiers' drug use. Furthermore, though it remains invisible, soldiers' drug use is impactful in developing the concept of trauma and the emergence of the traumatized patient, the assaulted woman and the wounded veteran historical figures. The diagnostic criteria for PTSD are current practice for psychiatrists when diagnosing women who have experienced violence.

In 1981, Courtois and Sprei decided the most accurate diagnosis for symptoms related to the experience of incest was PTSD. They faced criticism because this diagnosis had only been used previously with Vietnam War veterans (Million, 2013, p. 89). The PTSD diagnosis, constructed within the context of the wounded veteran experience and opioid dependency, is translated into normalizing judgment practices for women who have experienced violence and are treated for the resulting trauma. These include the traumatized female patient and the assaulted woman. The knowledge formation about the female traumatized patient is constructed in the psychiatric power/knowledge within the

mangle of American Vietnam veterans' experiences of war, the majority of whom were male who, for the most part, utilized opiates for symptom alleviation. The PTSD diagnostic category is developed outside of women's socio-cultural context, violence, and patriarchal power relations. The trauma ethos has been forced into the public domain due to the after-effects of war.

Additionally, in current history, the increased awareness of the impact of colonizing practices on Indigenous peoples worldwide highlights issues of sexual abuse and their resulting trauma effects. The colonized Indigenous woman figure emerges with the missing and murdered women movement and the rise of Indigenous feminism (Million, 2013, p. 28).

Historical juncture: the colonization of Indigenous peoples by church and state and the emergence of the colonized Indigenous woman figure

Indigenous peoples in Canada have been devastated by the practice of genocide, commonly referred to as colonization, a form of governing through power relations. The recognition of colonization as a normalizing practice has made visible the far-reaching effects of institutionalized violence. Indigenous authors, government publications and, most recently, the Truth and Reconciliation Commission of Canada (2015), formed in response to a successful class action suit by Indian Residential School survivors, have documented these colonizing practices (genocide) (Million, 2013, p. 1). Million (2013) writes a thorough genealogy of Indigenous rights, rebellions and Indigenous women's experiences across time, exposing the colonized Indigenous subject as the trauma victim. She echoes the work of other Indigenous authors (see for example, Clark, 2016; de Leeuw, 2013) as she weaves a picture of colonization into what she has called a trauma

ethos in Indigenous communities in Canada and the United States (Million, p. 12). Million asserts the historical phenomenon of a trauma ethos predominant in western research and governmental policies affecting the modern present-day practices in the field of health care (pp. 2-4). The trauma ethos rises through a history of systemic abuse, institutional practices such as segregation of cultures in residential schools, the sixties scoop, and the institutionalization of the mentally ill. Institutionalized abuses are revealed in mainstream services during this time including in foster homes, the courts and police services. The assaulted woman figure is also shaped by patriarchal institutionalized practices in ways similar to the Indigenous colonized woman figure. In response to colonizing practices, Indigenous peoples have actively pursued land and language reclamation and a resurgence of cultural and spiritual healing practices. Unfortunately, structural power relations as a productive influence of colonizing effects are evident in the current statistics.

In 2011, Indigenous peoples in Canada represented 4.3% of the total population and were the fastest-growing segment of the Canadian population. Their population increased by 20.1% between 2006 and 2011, compared with 5.2% for the non-Indigenous population (Statistics Canada, 2013). One of the highest populations of Indigenous peoples is in British Columbia. Sadly, these colonizing effects impact social health determinants in Indigenous peoples' material lives, and child poverty rates on reserve worsened between 2005 and 2010. A total of 51% of status Indigenous children live in poverty; when they reside on reserve, this number increases to 60% (Statistics Canada, 2013).

> The incarceration rate for Aboriginal adults in Canada is estimated to be 10 times higher than the incarceration rate of non-Aboriginal adults. Since 2000-01, the federal Aboriginal inmate population has increased by 56.2%. Their overall representation rate in the inmate population has increased from 17.0% in 2000-01 to 23.2% today. Since 2005-06, there has been a 43.5% increase in the federal Aboriginal inmate population, compared to a 9.6% increase in non-Aboriginal inmates. Aboriginal women are even more overrepresented than Aboriginal men in the federal correctional system, representing 33.6% of all federally sentenced women in Canada. (Office of the Correctional Investigator, 2013)

Million (2013) attributes these chronic and epidemic social conditions to colonization. She describes gender violence against Indigenous women as “a mobile and durable feature of colonial power” (p. 7). The colonized Indigenous woman figure emerges from the colonizing effects in the context of patriarchal power relations.

To understand trauma in the modern age, it is important to make visible the intersections of colonial power and social movements —including the women's movement and neoliberalism in policy and action. Both the Indigenous movement and the women's movement make visible the power relations of the postwar era. As women were entering the labour market after WWII as the emancipated woman figure, "Indians were seen as a problem…In the 1950s and 1960s Aboriginal people lived segregated and tightly controlled under an Indian Act bureaucracy" (Million, 2013, p. 82). In the 1960s, as the Coast Salish people began to revitalize spiritual and cultural practices for healing (Million, 2013, p. 84), provincial governments took Indigenous children from their

homes in what would become known as the sixties scoop (de Leeuw, 2013, p. 64). The 1960s gave rise to social movements on an international scale. Anti-racism movements abroad—strongly represented in the US —brought attention to Indian segregation in Canada and the US (Million, 2013, p. 82). The Indigenous colonized woman emerged as distinct from the White settler assaulted woman.

The second wave of feminism —with the publication of Betty Friedan's *The Feminine Mystique* in 1963 and the Canadian Royal Commission on the Status of Women in 1967—made gender inequalities more visible. They did not, however, do much to expose racial discrimination towards the colonized Indigenous woman and women of colour. As discussed later in this chapter, this historical fracture in the women's movement follows the political women's movement into the 20th century. Likewise, strategic power relations inherent in colonization continued in the *Indian Act*, neoliberal governmentality deployed to dispossess land and culture from Indigenous peoples.

The 1970s and 1980s ushered in a new political era in the United Nations, driven by Indigenous peoples worldwide, who had "created Indigenism as a movement and the development of language for increased political activity and social revitalization" (Million, 2013, p. 84). In the mid-1970s, the Vietnam War was ending and fuelled by media images of men, women, and children dying and soldiers returning home as the wounded veteran. The anti-war movement was strong. In 1974, the Native Women's Association (NWA) of Canada formed, and was rejected by men and labelled "women libbers" being compared to early White settler feminists (Million, 2013, p. 127), even though they did not describe themselves as feminists and therefore rejected this

comparison, instead insisting they were practicing politics of inclusion. The colonized Indigenous woman became politically distant from other women and other social movements (Million, 2013, p. 127).

In the 1980s, "aboriginal peoples began to name their family atrocities using language connected to social justice movements. This was heavily informed by the new field of criminology studies and victimology" (Million, 2013, p. 89). The *Badgley Report on Sexual Offenses Against Children (From Sexual Abuse of Children in the 1980s)* (1986) heightened awareness of widespread child abuse in Canada. The government revised the Canadian criminal code in 1988. The revision reflected this new awareness of sexual abuse concerns (Million, 2013, p. 88). The increased awareness of violence and its ensuing trauma resulted in Western healing practices' intruding into Indigenous communities. Indigenous communities experienced an influx of White settler self-help programs such as Alcoholics Anonymous, representing a significant shift towards self-help.

> There was a difference between psychology and the self-help in peer support groups…one difference was the absence of a psychiatrist's formal demand to attend to a diagnosis or a psychiatrically trained method of eliciting certain dialogues in service of a diagnosis. (Million, 2013, p. 89)

Self–help tenets based in Christianity emerged with self-help groups shifting the power relations in alcohol and drug dependency treatment. However, psychiatric practices prevailed for trauma treatment.

In the 1980s, psychiatric normalizing judgment practices introduced to the traumatized patient appeared in Indigenous communities. At this historical juncture,

medicine integrated the traumatized patient figure with the colonized Indigenous woman figure. During this period the normalizing of trauma recovery practices named trauma as a phenomena. The concept of trauma takes on new meaning as a precursor for self-empowerment. "Healing from trauma begins to be narrated as a prerequisite to self-determination. If the Indigenous don't heal they may not be able to self govern; in any case, they need to heal to be self-sufficient" (Million, 2013, p. 105). The healing from trauma movement became intimately connected to the movement for self-governance.

The historic juncture of the trauma movement and self–governance links trauma to self-determination. It is a significant paradigm shift to attach healing from psychological trauma to self–determination, particularly for traumatized ill patients like the assaulted woman and colonized Indigenous woman figures. In this paradigm, the psychological wound of trauma becomes paramount in the effects on the material reality of women's lives, wellness, autonomy, and self-determination. Trauma recovery becomes the precursor to autonomy and self-determination. Through the expert physician's normalizing judgment, a traumatized patient who is not recovered is not deemed to be autonomous or capable of self-determination because she remains ill. The heightened awareness of Indigenous traumatic experiences opens the field of psychiatric practice to other populations, such as assaulted women. The constituted colonized Indigenous woman figure in modern history continues to impact the perception of trauma in modern time and contributes to the universal trauma ethos.

Indian residential schools in Canada were established as early as the 1600s in Quebec (Canadian Geographic, 2020). They were reinforced as an intervention under the *Indian Act* passed in 1876. The last residential school closed in BC in 1996. The exposure

of residential school abuses and political action inspired community action, politicizing trauma as a cultural artifact. The first conference on residential schools was held in Vancouver, BC, in June of 1991. The political action taken up by Indigenous peoples — including the Oka uprising in 1990 and the 1995 ISTA protest in BC—gave rise to Indigenism in modern times. The protest for social justice moved into a larger demand for a "greater degree of autonomy, self-determination, and sovereignty" tied to the Indigenous peoples' land and well-being (Million, 2013, p. 81). The struggle continues in BC as concluded by a review commissioned by the BC Ministry of Health in June 2020 to investigate reports of Indigenous specific racism and discrimination in the health care system (Turpel-Lafond, 2020). The purpose of the review was “to examine Indigenous specific racism and in particular systemic racism-in the BC health care system” (Turpel-Lafond, 2020, p. 5). The review found that “widespread Indigenous specific stereotypes, racism and discrimination exist in BC health care system” including for the Indigenous health care workers and patients (Turpel-Lafond, 2020, p. 36). A significant finding is the health gap between Indigenous women and non-Indigenous women is greater than that of Indigenous and non-Indigenous men (Turpel-Lafond, 2020, p.75).

There is a marked contrast between the politicizing of trauma as a cultural artifact and the Indian subject shaped by the *Indian Act*. The Indian rights movement transforms the Indian subject from a passive subject to a subject who takes back power and knowledge and restores culture as an important truth claim. For example, Indigenous peoples challenge the use of their unceded territories and push for national inquiries such as that into missing and murdered Indigenous women (Truth and Reconciliation Commission, 2015). The colonized Indigenous woman figure emerges during this

historical juncture, and the phenomenon of missing and murdered Indigenous women becomes the centrepiece of political action (Truth and Reconciliation Commission, 2015, p. 3). The colonized Indigenous woman figure moves towards emancipation through this political movement. Indigenous groups' political action intended to achieve self-determination and self-efficacy is in stark contrast to what is to become the next decade's focus: intra-psychic healing of trauma. The women's movement significantly influences the shift in power/knowledge relations from intra-psychic healing to political action in the field of violence against women.

Historical Juncture: the women's movement, Feminism and the emancipated woman figure

Elizabeth Cady Stanton and Susan B. Anthony initiated the suffrage movement, the first wave of feminism, in the United States in 1848. They advocated for the vote for women, and in 1918 most women were given the right to vote in the US; others, however, such as recent immigrants, were still denied this right. In Canada, Indigenous men and women were excluded from voting until 1960 (Canada and the First World War, 2017). Ultimately, the disparities in these applications of rights to some but not others foreshadowed the fractures seen in the women's movement of the 1970s and 1980s. These fractures were significant in services for women who had experienced violence. Indigenous women, women of colour, lesbians, gay and bisexual women began to be delineated by their specific differences compared to White women. Services were structured around these differences, and caucuses were formed to address specific groups' specific needs, further fracturing the group of women's potential political power (personal observation).

Fractures of race and culture in the movement occurred historically in the suffragette movement, and the emancipated woman figure emerged as the White emancipated woman. The disempowerment of Indigenous women and women of colour was not a priority for the Canadian suffragettes. For example, Mary Ann Shadd Cary was the first Black female newspaper publisher in Canada. She supported the suffrage movement in her newspaper, was an abolitionist, and established the first racially integrated school in Canada (Canadian Encyclopedia, 2017). The suffragettes did not protect or support her. As a result of being ostracized, she returned to Washington DC in the 1860s.

Suffragettes in the western provinces were strong. A critical analysis of this strength highlights the suffragette movement as a strategy to displace Indigenous people from the land (Canadian Encyclopedia, 2017). The White settler woman was rewarded with the vote in 1873. The white settlers cleared the land to advance future western development; meanwhile, the colonized Indigenous woman remained invisible during the colonizing settlement and land dispossession of western Canada. Other marginalized women, such as LGBT2S women, were also invisible in the suffragette movement.

Closeted lesbians and bisexual women were active in the suffragette movement. These women were marriage-less, lived a spinster life, and were not considered men's property. As such, they had more freedom than other women to speak to women's (dis) enfranchisement. In retrospect, lesbian and bisexual women have been identified as influential in the 'first wave' of the suffragette movement. For example, Susan B. Anthony was a lifelong spinster who developed passionate friendships with other women, such as Elizabeth Cady Stanton (Gianlouis, 2015).

In 1869, the women's suffrage movement in the United States split into two organizations: the National Women's Suffrage Association and the American Equal Rights Association. The concern for the Black vote separated the Black cause from the women's cause, hauntingly foreshadowing the fractures of race and culture in the second wave of feminism, the women's movement of the 1970s. Less solidarity among disenfranchised groups resulted in less power to influence change. The campaign for suffrage as a "continuing source of activism and political sophistication" shaped the women's movement for generations to come (Dubois, 2007, para.12).

Strategic power relations based on "white is right," hetero-normativity and patriarchy laid a foundation for the women's movement for decades to come. The binary thinking of 'women in opposition to men' led to further fractures in the movement, while intersectional identities such as Indigenous women, trans women, lesbians and women of colour remained invisible. Policies and women's services were established to address the needs of the visible generic White women.

Specific power relations developed in the treatment of trauma and violence against women in the context of social movements. Social movements began to demystify psychiatric practices and the expert physician. The second wave of feminism emerged in the 1960s amidst a flurry of social change inspired by the anti-war and anti-racism movement. Feeling empowered, women began to question the practices that impinged on their autonomy. Their advocacy influenced the development of policies and practices in trauma treatment, becoming more client-centred and paying attention to women's voices and decisions in their own treatment. These principles show up in the TIP policies critiqued in Chapter Six.

In 1963, Betty Friedan published her landmark book *The Feminine Mystique*, a study based on a survey of her peers—educated middle-class white women. Friedan is heralded for beginning the second wave of feminism and identifies early American feminists who confronted the societal belief that women are happiest as wives and mothers. Friedan led with constructive criticism of Freud's theories of women as childlike and destined to be housewives; her analysis initiated a new knowledge formation and proved to be significant in the future development of feminist strategies directed to working with women who have experienced violence. The normalizing judgment of Friedan's work was swift and immediate. Women criticized Friedan for undervaluing their intelligence and importance in the family. Others criticized her for trying to destroy the institution of the American family and all the economic production it afforded. Critique of the women's movement was strong as the Americas attempted to recover economically from the devastation of another world conflict—the Vietnam War.

At the same time, advancement in biomedical technology made women's reproductive choices possible. Margaret Sanger opened the first birth control clinic in 1916. She completed research before advancing the birth control pill's approval and release in 1960 and was criminally prosecuted for her efforts. Women's increased autonomy over their reproduction freed them from the stereotypical role of mother and home keeper. Still, it was not until 1972 in the US that the pill would be legally sanctioned for all women, including those unmarried. The normalizing judgment of women's role in the family began to shift, and the advancement in power over reproductive rights was further emancipation of women. Power was linked to women's autonomy over their bodies. Ironically, the concern of violence against women was left

untouched, treated as a private matter between husband and wife not worthy of police intervention; it, therefore, remained invisible to the public eye.

The private home concept in policies strategically separated women's emotional and physical well-being from the public economic life. Any concern for the violated or assaulted woman within the home was governed by property and criminal laws, therefore subordinating it to the desire for intact nuclear families. The liberal perspective of the family unit—a key economic unit for American success—was that as a viable economic entity, it remains intact. The nuclear family functioned to drive the economy, and through normalizing judgment, the assaulted woman figure remained a part of this economic unit.

The freedom movement of the 1960s gave way to a more radical women's movement that demanded equality for women in the public sphere. The Royal Commission on the Status of Women in Canada (1970), chaired by Florence Bird, addressed equal rights in employment, political equality, birth control, pension and daycare. In 1970, the Boston Women's Health Collective published *Our Bodies Ourselves*. This work was noted as the beginning of the women's health movement. The medical model of power/knowledge began to shift from the medical professional elite to collective women's experiences of their own bodies. This shift in knowledge set the stage for constructing an empowerment model focused on women's individual autonomy and agency.

The intent of the Boston's Women's Health Collective was to address the embodied female subject within a model that recognized that sexual difference exists but is not hierarchal. It "is accepted but not exploited for the purposes of an oppressive political structure" (Cahill, 2001, p.207). When *Ms.* magazine, edited by Gloria Steinem,

was published for the first time in 1972, it engaged middle-class women to advance advocacy for women's equality. Numerous feminist authors wrote books around this time on topics of women's health, psychology, and sexual violence, such as Chesler's *Women and Madness* (1972); Brownmiller's *Against our will; Men, Power, Women and Rape* (1975); and Baker-Miller's *Toward a New Psychology of Women* (1976), a relational cultural model of therapy. The assaulted woman figure was encouraged by the intra-psychic healing movement to participate in treatment (normalizing practice). She was expected to recover from sexual abuse, rape, and domestic violence through intra-psychic healing. In this decade, feminist theory and the women's movement actively collaborated with the medical/psychiatric fields to promote the intra-psychic healing of violence through individual interventions. Government initiatives followed.

The Canadian Research Institute for the Advancement of Women (CRIAW) was established in 1976, one year after International Women's Year (1975), to highlight the lack of research for and by women. Notably absent within this equality agenda were issues of violence against women. The Canadian government funded CRIAW in 1979, sparking criticism from feminists who declared that the Institute, once a non-profit organization, was now an arm of government; to them, this implied a lack of connection and focus on grassroots issues of importance to women. Feminists explained their concern of this transfer as a form of movement co-optation into state governance, which suppressed any advancement in the women's rights movement. This historical political split distinguished the emancipated professional woman figure who wants government funding from the assaulted woman figure who wants to connect to other women peers as a support during their healing journey.

I worked and lived through this transition and can recall the powerlessness I felt as a feminist activist speaking out about co-optation of the services into bureaucratized public (state) funded services. Assaulted women's knowledges of their experienced violence were lost. Women serving organizations no longer contextualized the violence in structural gendered oppression knowledge. The second wave of feminism attempted to address this dialectic by supporting government initiatives for women's equality and making visible the continued struggle in the 'relief of rape' in oppressive systemic structures such as the courts and hospitals.

Braiding of the historical Junctures: the violence against women movement, trauma and the assaulted woman figure

Community-based grassroots services organized by women for women began in the early 1970s in Canada. Rape crisis centres were established in Vancouver (1972), followed by Toronto and Ottawa (1974). The anti-rape movement made visible the rate of violence against women in these three communities. The agenda of these services was a political one: to expose rape as a common socio-cultural phenomenon that impacted women. During this time, the term 'rape culture' appeared in the literature, a normative historical term referring to society as a place of violence for women. The mantra was that "if it happened to me, it could happen to you," and the assaulted woman figure became everywoman. Women's experience of violence was recognized as ubiquitous, and the understanding that this violence and the resulting trauma was a common experience contributed to the trauma ethos of modern times.

As the awareness of violence against women increased, domestic violence was taken up as a common cultural, historical phenomenon. The "reframe (of) the cultural

understanding of domestic violence from the apolitical, individual problem to a profoundly social problem rooted in structural systems of patriarchy and ideologies of gender equality" revealed domestic violence as a cultural artifact (Lehrner & Allen, 2008, p. 220). The rape crisis and battered women's movements exposed the common occurrence of the assaulted women's experiences of violence in the home and the community (Gladstone, 2013, p. 9).

Gladstone's (2013) feminist analysis of violence against women challenged the concept of the private sphere of the home. She challenged the commonly held notion that male violence is to be condoned and managed as a private family concern (Gladstone, p. 9). Women serving organizations created shelters for battered women and children, and the later bureaucratization of these services increased paid professional staff within them (Gladstone, p. 9). The increased observation, surveillance, monitoring and examination of women and children in the name of security reflected normalizing violence against women as a societal construct. This policy period problematized the assaulted woman and her children as vulnerable, at-risk, and in need of patriarchal protection. All the while, violent men were allowed to pursue freedom of movement and enjoy their employment continuation in communities.

During this time of surveillance and protectionism, medical and psychological practices prevailed. The conceptualization of violence lost its systemic interpretation, and the focus remained on violence committed by an individual towards an individual. This is significant to my study because when practices such as TIP are introduced, they are layered or nested into the current knowledge based on medical discourse. The knowledge of power relations of patriarchal oppression once held by women's services is absent and

silenced. As services transferred into hospital settings, medicine devised new technology in 1970: the physician gathered biological evidence for criminal courts using a rape kit. The raped woman's body became a legal vessel for evidence, and she became a witness to her own rape. Acting as peer support, rape crisis centre's volunteers sat alongside hospital social workers as physicians and nurses gathered evidence. Since the hospital was a legacy of institutionalized patriarchal power, women's organizations recognized the need for an advocate during this depersonalizing process. If the raped woman wanted to pursue justice, using a rape kit, more widely utilized by the late 1970s, (a biopower technology) was her only option. New hospital and police practices supported criminal justice initiatives to increase the arrest and conviction of men, and community services began to adapt to the professionalization of legalized rape interventions.

Driven by the use of medical technologies, community organizations began to hire more professionally trained women. The gap between the emancipated professional woman providing services and the assaulted woman receiving services became larger. Women serving organizations no longer invited the assaulted woman to be part of the organization providing the services, as she was considered the other—the victim receiving services. The emancipated professional woman was viewed as different, in solidarity with—but not sharing the identity of—the assaulted raped woman. The emancipated woman figure became an educated intervener in the context of sexual assault services, and the distinction among the emancipated women and the assaulted women became even more apparent for women of colour, women of differing socio-economic status, and lesbians (Gladstone, 2013, p. 9; Smith, 2014, p. 118). Women who had been raped and violated were not seen as contributing to the organization and the

social movement of stopping violence against women; rather, they were now constituted as the other, the assaulted woman needing assistance. Professionalization of women's services set the stage for future services responding to violence to be incorporated into mainstream health care services with professional staff. These systems began to incorporate the philosophy of trauma informed care into their service delivery.

As services became integrated into hospitals, a linguistic turn took place from rape culture political language towards medical discourse nomenclature. Burgess, a registered psychiatric nurse and researcher and Holstrom, a sociologist, are co –founders of the first hospital-based rape crisis centre at Boston University Hospital. They coined the term rape trauma syndrome (RTS) during a study completed within a victim counselling program at the Boston School of Nursing and Boston City Hospital. They studied the immediate and long-term effects of rape as reported by assaulted women. Most of these women were single, between 17 and 29, and represented diverse racial backgrounds and work statuses, including employed, unemployed and those receiving income assistance. This study landmarked the use of medical discourse in the field of rape interventions. RTS defined women's lived experience within a medical model of health care. In 1974, the original study contributed to the biomedical focus in the field of practice, which supported the foundation for the psychiatric categorization of trauma as PTSD in 1980. The medicalization of rape does not attend "to the structures and dynamics of power, how it creates the possibilities of various discourses by constituting the subjects who undertake them" (Cahill, 2001, p. 148).

Before this, in women-centred services, rape was considered an act of patriarchal violence. Organizations intentionally targeted the response to this act towards systemic,

cultural, and structural change in women's status in society. Theoretically, if women achieve equality, they are empowered, societal beliefs shift, and women become less vulnerable to rape. Burgess and Holstrom (1974) linguistically inserted RTS as medical discourse into the field and practices of rape interventions.

RTS located the act of rape as an intrinsic experience within the individual woman, and this label shaped the assaulted woman figure at this historical juncture. The newly emerging field of sexual assault treatment adopted medical/psychiatric discourse, including normalizing judgment and examination practices. The assaulted woman's experience was now shaped as "a syndrome of behavioural, somatic, and psychological reactions...an acute stress reaction to a life threatening situation" (Burgess & Holstrom, 1974, p. 982). RTS validated the intrusion of medical/psychiatric discourse into the field of practice of rape violence/victimization. The professional women discussed earlier readily adopted this practice and inserted this meaning into their work in hospitals and institutions providing rape crisis interventions such as psychotherapy. This shift in historical time foreshadows and sets the practice formations for TIP in modern times.

Rape had now become a syndrome, an acute stress reaction experienced by an individual compared to rape as a tactic of patriarchal power and control or an act of violence. This meaning fused with the PTSD diagnosis. "To redefine rape not as something a man does, but something a woman experiences shifts the conversation in important ways" (Cahill, 2001, p.145). Rape had become an individual phenomenon rather than an act of productive power relations shaping and governing the female body in the context of social hierarchy. In the context of the trauma ethos, this discourse is cemented into future work in the field.

The University of British Columbia utilized RTS terminology in a 1992 follow-up study of women who had been sexually assaulted. This study is an example of the assaulted woman figure and the female subject's embodiment being shaped by research discourse. Research created the assaulted woman figure in the following descriptive terms: "denial and avoidance behavior, history of psychiatric condition, disability (deafness), characterization as a street person, high degree of violence or injury in the assault and threat by assailant" (Herbert et al., 1992, p. 1177). Research activates discourse in a field of practice, and this discourse is then generalized to assaulted women (Cahill, 2001, p. 151). For example, in the RTS study, the assaulted woman was constructed within a dominant medical discourse as a fragmented and broken individual with a traumatized brain. During the 1980s, feminists in the United States garnered psychiatry support to authenticate traumatic memory (Fassin & Rechtman, 2007, p. 114). Feminists and advocates for wounded veterans have been collaborators in establishing medical diagnoses (normalizing judgment) to obtain credibility for conditions since the 1980s. In turn, going forward, all assaulted women were characterized through medical/ psychiatric discourse in the same way.

Consistent with the strategic power relations constructing the traumatized female patient, the study recommended a strategic medical disciplinary practice as an intervention. The recommended emergency room crisis interventions—delivered in the hospital context—constituted both the assaulted woman as a victim and the knowable physician as the expert on the embodied female subject (Hebert et al., 1992, p. 1177). The diagnostic category of RTS and this study did not attend to the intersectionality of women's reality in the rape, including being involved in a patriarchal, hierarchical system

of care or the racist and disablist notions that constructed women either as deserving or undeserving victims.

A critical juncture in Canada in the re-problematization of rape as a crime of sexual assault was the rape law reform in 1982. Struggles for the legitimization of rape as a form of violence against women—and ultimately, as power relations that shaped women as subjects—led feminists to lobby lawmakers to remove penile penetration as a requirement for the charge of rape. De-gendering the violence—that is, no longer requiring penetration of the vagina by a penis—was an attempt to recognize rape not as a sexual encounter but as a violent act. Feminists expected that this change to the criminal code would eliminate the court's constitution of the assaulted woman figure as complicit in the act of rape and a falsifier of the truth. The intention was to eliminate the questioning in the court of the assaulted woman's past sexual history and implied promiscuity as causation for the violence and to reshape the assaulted woman as a 'pure rape victim,' and one who did not need to be and would not be questioned about her truth claim. The common question asked was this: would we require a robbery victim to explain their behaviour and how they were dressed during the robbery? This generic assaulted woman could be any woman, assaulted anywhere, anytime.

The change in federal legislation included recognizing that husbands can rape wives, and wives were no longer seen as property or chattels of the marriage obligated to provide sex. Giving the right to wives to complain and crown attorneys that ability to lay charges. The ability to charge husbands with rape reframed the underlying principle of the subject (woman) as property. Women were now viewed as persons (subjects) who men had violated.

The distancing of hetero-normative sex from violence opened the field to the concerns of men who had been sexually violated, thus presumably legitimizing the survivor's experience of the act of violence. McKinnon (1992) explains, "detaching rape from women by calling it sexual assault seemed to communicate that it could happen to anybody, a full citizen, a real human being, a man" (p. 188). The unintentional consequence of rape becoming de-gendered violence was to eliminate from the discourse the assaulted woman's socio-cultural patriarchal context as an oppressed female subject. The feminist analysis of power and control underpinning male violence was made invisible and removed the political narrative of patriarchal effects on all women.

Categorizing sexual assault akin to any assault towards a person, and perpetuated by any person resulted in unintentional effects embodying the violated subject as any subject., Although, the 1982 law, supported by feminists, recognized women as autonomous individuals—the emancipated woman figure outside of marriage—it lost sight of the patriarchal oppression analysis of rape, as it was known in community-based feminist activist circles. In the case of the Canadian sexual assault law reforms, McKinnon (1992) cautions, "we need to look at what rape is to women, what rape is to men, to unpack the non-gender neutrality of its reality" (p. 188). These changes in knowledge formation had a distinct impact on how services were organized.

Corresponding to the law change, rape crisis centres changed their names to sexual assault centers and achieved higher government funding levels. The neoliberal rationality imbued in this funding arrangement increased accountability and monitoring through state apparatuses for activities within the centres. This observation (normalizing judgment) conducted the organizations' conduct to follow government normalizing

policies and practices. In short, this curtailed any political action the centres previously initiated, such as public demonstrations against the government, courts, and police (Fraser, 2014, p. 47).

In the 1990s, the third wave of feminism increased political action and critical intersectional analysis of violence against women. The term 'third wave of feminism' has been attributed to Rebecca Walker, author Alice Walker's daughter. She challenged the injustice of Anita Hill losing her case of sexual harassment in 1991 against Clarence Thomas, a Black Supreme Court Justice. In a statement attributed to her, Rebecca Walker said, "I am not a post-feminist feminist, I am the third wave". Walker identifies herself as a Black/White, Jewish, bisexual feminist who broadened the goals of feminism to include ideas of queer theory and to honour individuality and intersections of identity. While Susan Faludi released her book *Backlash: The undeclared war on American women* (1991), discussing a regression in the advancements of women's liberation, Kimberle Crenshaw (1991) introduced the concept of intersectionality, a wakeup call for inclusion politics. Crenshaw (1991) explains,

> the problem with identity politics is not that it fails to transcend difference, as some critics charge, but rather the opposite—that it frequently conflates or ignores intragroup differences. In the context of violence against women, this elision of difference in identity politics is problematic, fundamentally because the violence that women experience is often shaped by other dimensions of their identities, such as class and race (p. 1242).

In 1991, the intersecting patterns of racism and sexism were often not represented in rape and violence discourses (Crenshaw, 1991, p. 1244). Writers created systemic injustices in the policies, structures, and institutional practices that ignored intersections of identities; this made individuals within these contexts vulnerable. Identities were presented as positions of marginalization and subordination, paradoxically disempowering women of colour and marginalizing the issue of violence against women of colour (Crenshaw, 1991, p. 1245). The discourse of a traumatized rape victim was implicitly the White traumatized rape victim who received services, while women of colour were othered or made invisible, as rape victims who were less deserving than White rape victims. Throughout the 1990s, the struggle continued for the assaulted woman figure to be recreated as a complex identity, and the struggle for structural, systemic change to stop violence against women continued.

In 1999, global awareness of violence against women increased as the United Nations declared the International Day for Elimination of Violence Against Women. They emphasized that the violence had not stopped. Over 70% of women experience some sort of violence in their lives, and 20% are victims of rape or attempted rape. Moving into the new millennia, the UN continues the decree, under the equality agenda, that violence against women needs to end. "Policies to prevent this violence should be implemented as part of the agendas for equality, development, public health, and human rights" (Garcia-Moreno et al.,, 2005, p. 1282). During the latter part of the second decade of the century, the Truth and Reconciliation Commission (2015) came to its conclusion; Robert Pickton, a serial murderer of women in BC, came to trial; and missing and murdered Indigenous women were counted after decades of disappearances, while

Indigenous protesters contested their exclusion in the roundtable inquiries. These noteworthy events brought to the public eye the prevalence of violence against women. In an era of neoliberalism, these historical junctures shape a trauma discourse that is "the ubiquitous explanation and site for action, capable of making sense of the multiple social, psychological and material outcomes of colonialism" (Million, 2013, p.100). Violence against women discourse becomes integrated into an international trauma discourse permeating policies and services locally and giving rise internationally to a trauma ethos.

Summary

The trauma ethos has had an impact on women who have experienced violence. Modern herstory has shaped practices governing the traumatized female patient. This included second wave feminists who shaped the traumatized female patient as a victim of male violence, a passive subject who required support and was at times secluded (imprisoned) with their children in fortified women's shelters. On the other hand, the men were left in their homes to continue with connections in their communities.

The traumatized female patient is conducted under the medical gaze of psychiatry, relying on the power/knowledge gained throughout the ages by male-centric war experiences. Governance of conduct shows up in the modern history of trauma treatments: the traumatized female patient is governed in trauma treatment practices, including pharmaceutical interventions and women's development programs meant to teach coping skills for women in managing the aftermath of male violence. Constellations of symptoms become a disorder, identified in the psychiatric category of PTSD governing the subject into specific conduct as a recipient of medical technologies. Power relations are made invisible in the categorization of women's experiences of male

violence. The concept of the embodied subject recognizes the human body as "the possibility not only of the repressive mode of power but also of agency and action…the body, rather than being that which is most private, emerges as the public surface of the subject" (Cahill, 2001, p. 79).

Elucidation of the body as a public, political, and dangerous site for women in modern society allows for a critical examination of governance (conducting the conduct) within the nexus of power/knowledge. By problematizing the traumatized female patient position as the victim of violence, the genealogy of trauma in modern history illuminates the historical junctures; these dangerous crisis points in modern history in the field of violence against women (trauma) have set the stage for modern protocols and policies within BC, and a modern day trauma ethos is revealed. Examining the medical model—psychoanalysis, postwar responses to men's experiences of trauma, colonization of Indigenous peoples, and the women's movement—makes visible a trend towards gender-neutral policies and practices. The constructed historical figures of the traumatized female patient, the colonized Indigenous woman, the assaulted woman as victim, and all these figures are nested in the traumatized patient figure. These figures are characterized as subjects requiring support and compensation, which supplants the agentic subject of women survivors of violence once envisioned by feminists. This vision was to take back the night; to invoke the power/knowledge of women's lived experiences of violence. Within this trauma ethos, the structural violence that exists for women in Canadian society is left unchallenged. In the age of medical models and interventions, gender-neutral technologies prevail as the treatment for women who have experienced violence and seek help. The absence of a critical analysis of societal structures allows space for the

questioning of women's responsibility (blame) for the violence perpetrated against them, as well as the accusatory questioning of the (mal) adaptations they have developed to survive this violence.

Chapter Five: Methodology

I have introduced foundational concepts for a feminist post structuralist (FPS) approach to policy analysis and presented Foucauldian concepts as an underpinning for my theoretical approach for examining TIP policies in British Columbia in Chapters Two, Three, and Four. In this chapter, I turn to my chosen methodology-- Carol Bacchi's approach to policy analysis; what is the problem represented to be? (WPR). I selected this approach because the traditional approach to policy analysis implies specific taken for granted definitions of the problem while not questioning the problem definition. WPR is a post structural method that deconstructs problematizations created within public health care policies. In this chapter, I introduce the WPR approach and provide an initial analysis of one self-problematization. I then explain Bacchi's use of Foucauldian problematization as a foundation for the WPR approach. Finally, I present my use of the WPR approach to analyze TIP policies in BC.

My Journey: a self-problematization

One requirement of WPR methodology is that the researcher is to problematize her location in the analysis. I first referred to the concept of self-problematizing in Chapter Two and have included many self-problematizations throughout Chapters Three and Four. My self-problematizations reveal assumptions I have made from my experience and how these assumptions have influenced my work and my thinking about the concept of trauma. Feminist post structuralism and the FPS approach to discourse analysis have shaped my thinking about women and the concept of trauma. My first exposure to discourse analysis was the book *Gyn/Ecology* by Mary Daly, published in 1979.

Mary Daly was a theologian and philosopher, a radical feminist, a creator of a new language, and a critical analyst of patriarchal language, which she deconstructed in

texts such as *Gyn/Ecology* (1979), my first foray into the deconstruction of the power of language. Daly would call me a Journeyer (Daly, 1979/1990, preface, para. 10). I am a feminist dedicated to working with women impacted by patriarchy in violent and demeaning ways; through acts of rape, physical violence, racism, sexism, homophobia, economic and systemic oppression. Daly (1979/1990) opened my mind to a new look, a new cerebral Spin (Daly, preface, para. 14). I was invited in by Mary Daly to continue the Journey, to "confront the old molds/models of question asking by being itself an Other way of thinking and speaking" (Daly, preface, para.12).

Daly (1979/1990) questioned the Journeyer, who is one who described herself as part of the women's community of the 1970s. She noted, "the women's movement was transformed into the women's community, a symptom of settling for too little, of settling down, of being too comfortable" (preface, para. 15). I refer to this transformation of the women's movement in the genealogy mapped in Chapter Four. Daly asks, what about the movement? How does the cerebral Spinning continue? My Journey, my cerebral Spinning, continues through my feminist post structural analysis of trauma. I discovered an Other way of thinking and speaking about trauma policies through Bacchi's (2009) WPR methodology.

What's the problem represented to be? (WPR) Methodology

Bacchi's WPR approach supports policy analysts to delve deeply into the underlying presumptions made in a policy, including, most notably, the problematization of the problem (Question one: what's the problem represented to be?). Bacchi (2009) contends that policies give shape to problems; hence, governments are active in creating, producing, and reproducing policy problems. This revelation that governments create

problems is not a statement on the manipulations in which governments engage. Instead, it refers to a necessary part of the policy-making process.

All policies make proposals for change. Policies make implicit representations within these proposals and thereby create specific types of problems. The creation of problems in policies leads to specific recommendations for change and particular proposals for resolutions. The specific type of problem created is kept alive in public policies for generations, in a circuitous process of creating and recreating the problem's representation. New policies build on the previous policy proposals, and act as truth claims. My study traces this phenomenon in the creation of the concept of trauma in policies in BC.

Bacchi (2018) states, "in evidence-based policy, there is a grounding assumption that the 'problems' being 'addressed' are readily identifiable and uncontroversial" (p. 4). Her work on problematizations of drugs in public policies addressed the questions: who gets to define the problem; how are problems constituted in the interventions designed to solve them, and how do practices constitute subjects and object (Bacchi, 2018)? I read this article with enthusiasm and began to imagine a similar approach to the problematization of the concept of trauma within BC's trauma policies.

The study of problematizations makes politics visible (Bacchi, 2012); "[t]o inquire into the terms of reference within which an issue is cast-into its problematization" (p.1) is at the heart of the WPR approach. Bacchi draws on Foucault's specific approach to problematization as a critique (*Discipline and Punish, History of Madness*) to begin at the place of practices and work backward to discover what problematizations emerge of the problem the policy intends to solve (Bacchi, p. 3). The meaning-making developed in

policies, the problematization of subjects, and the historical processes of their production interested me (Bacchi, p. 4). I began to reflect on Mary Daly's remarks on "patriarchal perspectives, working out of hidden agendas, concealed in the texture of language," a logic based on male ethics (Daly, 1979/1990, preface, para.14).

Ethics in the study of problematizations refers to complex strategic relations that shape lives. These political strategies require investigation. An investigation is warranted if a policy is developed from a patriarchal perspective partially based on the exclusion of women's experiences and knowledges (Bacchi, 1999, pp. 32-49; Lancaster et al.,, 2017, p. 61). This investigation uncovers the shaping of women's lives based on masculinist discourse and frameworks in TIP policies. As discussed in Chapter Three, FPS theorizes the language within the problematizations in TIP policies that propose solutions for women who have experienced trauma.

Bacchi has written extensively on women, policy, and politics over several years (1996, 1999, 2004, 2006). Bacchi's work on gender mainstreaming (1999) and feminist discourse methodology (2006) rely on a feminist analysis. I find her work during these periods and her reliance on post structural thought congruent with FPS. Bacchi first took up post structural theory and the practice of policy analysis in 2009 and thoroughly applied this methodology in her book, *Analysing Policy: What's the problem represented to be?* She explored it in more detail in her latest book with Susan Goodwin (2016), *Poststructural Policy Analysis: A Guide to Practice.* I rely primarily on these two works to guide my problematization of British Columbia's TIP policies (BC).

Introduction to a Post structural analytic strategy: What's the Problem Represented to be? (WPR)

The WPR approach provides "guidelines for thinking about policy development at a level uncommonly probed - the deep-seated presuppositions and assumptions that underpin policies" (Question Two: what propositions or assumptions underlie this representation of the problem?) (Bacchi & Goodwin, 2016, p. 107). In my work, these deep-seated presuppositions are made visible and unearthed in the review of TIP policies in BC. During this analysis "the ways in which policies actively produce, or constitute, 'problems', 'subjects', 'objects' and 'places' in specific contexts" are analyzed" (Bacchi & Goodwin, 2016, pp. 107-108). I focused my policy inquiry on two TIP policies in BC, utilized in the health care organization within which I completed my study. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and the *Concept of Trauma* (SAMHSA, 2014) are the current policies utilized at the site where the study participants work and therefore became the focus of my analysis.

The WPR approach relies on six specific questions to analyze a policy (Bacchi, 2009) (Table 5.1). Bacchi & Goodwin (2016) released a more recent guide to policy analysis, including post structural interviews (p.113). Interview transcripts are analyzed to determine what sort of subject it is possible to become during the interview process (Bacchi & Goodwin, p. 115). In my study of TIP policies in BC, I analyze both transcripts of interviews and written guidelines. The discursive practice related to TIP is analyzed based on the interviews with direct care staff and leaders. Bacchi & Goodwin (2016) state, "[i]t is necessary to consider how specific discursive practices relevant to the interview topic generate things that can be said within the true" (p.117). I identify normative implications of discursive practices related to subject positions and problem representations within the policy (Bacchi & Goodwin, p. 117).

Table 5.1 The WPR approach's six questions

Question One: What is the problem represented to be in a specific policy?
Question Two: What presuppositions or assumptions underlie this representation of the 'problem'?
Question Three: How has this 'problem representation' come about?
Question Four: What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?
Question Five: What effects are produced by this representation of the problem?
Question Six: How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

(Bacchi, 2009, p. xii)

* See data analysis section for the application of these questions.

Foucauldian Problematization

Bacchi relies on Foucauldian problematization as a core concept, in both the interview and the policy analysis, to expose problem representations in policies. According to Bacchi (2012), "Foucault employs the term problematization in two ways; first, to describe his method of analysis and, second to refer to a historical process of producing objects for thought" (p. 1). Bacchi (2012) defines problematization as a "description of thinking as practice" that challenges taken for granted dominant truth claims (p. 1). Problematizing truth claims makes visible the assumptions within policies that render specific representations of problems possible (Bacchi, p. 1). The analysis of policies, through problematization, exposes the complex power relations that produce

taken for granted truth or presumptions within those policies (Bacchi, p. 2). Policies based in institutionally legitimated truth claims (Bacchi, p. 3) become evidence-based practices when guidelines and rules govern how we act, how others act and how we conduct others to act (see Chapter Two and Three). If the problematization of policies does not occur, these legitimated truth claims remain unchallenged by those who are conducted and governed, leaving the effects of practices invisible. The effects of TIP, as a practice, flows from policies in medicine/psychiatry. The lived effects of TIP policies on the material lives of women remain invisible without problematization. The invisibility of lived effects is a political and ethical concern for Bacchi and my study of TIP policies in BC.

A WPR approach "elaborates a post structural understanding of politics as strategic relations and practices, and of theorizing as a political practice" (Bacchi & Goodwin, 2016, p. 13). Theorizing strategic relations and practices as a political practice is congruent with feminist post structural policy analysis. The WPR approach is "a means to engage in such theorizing and to assist in the analytic task of making politics visible" (Bacchi & Goodwin, p. 13). Making the politics or ethics of governing (conducting the conduct of subjects) visible exposes the effects of the policies on vulnerable subjects. Policies as practice produce "gendering, racializing, hetero-norming, classing, disabling and third-worldizing effects" (Bacchi, 2017, p. 20). Bacchi (2017) contends, "when we analyze a policy, we need to ask how it may encourage the production of behaviours and characteristics conventionally associated with those women and those men" (p. 20). I am concerned with the production of specific types of subjects and how TIP policies characterize women as subjects.

Bacchi's (2017) work on gender mainstreaming in policies takes up a feminist analysis while at the same time contesting the category of feminism itself as a fixed taken for granted category. The WPR approach understands gender as a fluid subject position. Gender as a non-static position is consistent with FPS. Bacchi's approach makes space for theoretical tensions by utilizing a post structural analysis of fluidity and movement in and among concepts. These ideas advance my study because they attend to how women as subjects are not fixed and how they are conducted through practices and complex power relations. In the case of TIP policies, subjects are produced as vulnerable traumatized subjects (see Chapter Three). Policies as practice in governing, in conducting the conduct of women, create a vulnerable subject through the subjugation of their knowledge. The gender fluidity and other subject positions' intersections inform my work by opening up the subject position, delimiting the constructs set by feminist categories. For example, an Indigenous colonized woman's subject position is produced as a subject through the practice of colonization and as a woman governed by patriarchy as practice (see Chapter Three). The problematization of these subject positions reveals strategic political relations nested within the TIP policies.

Problematization demands that we think about examining complex strategic situations that both restrain and produce our thinking (Bacchi, 2012, p. 4). The WPR approach is useful in the problematization of policies designed to address violence against women and practices in the field associated with those policies. The analysis of these policies makes visible governing practices (how conduct is conducted) and the lived effects, including subjectification (how subjects are produced or constituted). The analysis locates dominant uncontested knowledges and how they are disseminated in the

fields of psychiatry, medicine, and health care. Policies are a discursive practice that have a productive role in knowledge formation and strategic relations "that shape and reinforce the categories of 'men' 'women' and other relations" (Bacchi, 2010, p. 70).

Post structuralists are interested in how individuals make sense of their lives in an ever-changing movement of existence. Feminist post structuralists are specifically interested in the discursive, material and subjectification effects of these meanings in the context of gender and patriarchal oppression. Bacchi & Goodwin (2016) note that there is a return to the founding subject of humanism within the context of qualitative research and specifically in the analysis of participant interviews (p. 15). The concept of the founding subject poses difficulties for post structuralists who wish to use interviews as part of their analysis (Bacchi & Goodwin, p. 114). Post structuralists do not believe in a disentangled humanist self (Bacchi & Goodwin, p.115).

Bacchi & Bonham have introduced a post structural approach to interview analysis intended "to provide support to practitioners in developing alternative approaches to a program or project they wish to challenge" (Bacchi & Goodwin, 2016, p. 114). Within this context, subjects are "provisional and opportunities for modification are many" (Bacchi & Goodwin, p. 115).

Politics and the interplay of power and knowledge

Politics refers not only to political institutions but also "includes the heterogeneous strategic relations that shape who we are and how we live" (Bacchi & Goodwin, 2016, p. 14). The interplay of power/knowledge is critically interwoven in strategic relations. Mechanisms and technologies of power are strategic in that they

produce effects and establish practices, which in turn conduct those involved. Subjects, knowledge, and events are continually in the process of becoming.

Materials such as policies, guidelines, or protocols are chosen for WPR analysis because they are prescriptive in that they stand as a proposal for action and a guide to conduct (Bacchi & Goodwin, 2016, p. 18). As a WPR interrogation advances policy analysis, problematizations are explored, and new problematizations are revealed, creating a recursive pattern of exploration. The WPR approach identifies and explores presuppositions and assumptions and problematizes institutionally legitimated truth claims. My beliefs, based on the body of knowledge and politic that shape my analysis, are unveiled.

For this reason, critical self-reflection during the analytic process is essential. The WPR approach troubles how my and others' underlying assumptions problematize particular problems in policy proposals. These problem representations are analyzed by asking questions about the subjects' meaning-making and problematizations of specific concepts such as trauma and TIP.

Methods

Bacchi (2009) explains, “the WPR approach is broader than most other approaches to policy study and analysis" (p. 25). The analysts’ interest is how subjects are governed and constituted and is paramount in the WPR approach. I am interested in the governing and constitution of subjects "looking beyond the state in order to identify other forms of influence on governing conduct," in particular for those who are "positioned outside of citizenship" (Bacchi, p. 25). Bacchi (2009) notes, "government in this usage is fashioned from a diverse set of elements and includes the role of experts,

that link the conduct of individuals and organizations to the objects of politics" (p. 26). My choice for inclusion of specific actors relies on this WPR proposition and inclusion of direct care staff and leaders (Bacchi, 2009, p. 25). I included the Poststructural interview (Bacchi & Bonham, 2016, p.113) to make visible the direct care staffs' and Leaders' truth of the concept of trauma in an environment that specifies the use of TIP policies, protocols and guidelines, and to critically challenge the TIP policy as a discourse at an individual and organizational level (Bacchi & Bonham in Bacchi &Goodwin, 2016, p. 114).

Setting

My study takes place in a large health care organization responsible for providing mental health and substance use services in BC. This health care organization defines TIP as a core principle of service delivery.

Human Research Ethics Board

I obtained a certificate for ethics approval (BC 18-144).

Institutional Ethics

I received institutional ethics approval from the Provincial Health Services Authority BC Mental Health & Substance Use Services (BCMHSUS) Research Committee, Dr. Jehannine Austin, Chair, BC Mental Health & Substance Use Services Research Committee, Executive Director, BC Mental Health and Addictions Research Institute.

Recruitment, interviews and eligibility

My project was commonly known within the organization, and several volunteers came forward. Two leaders (L) involved in the trauma informed practice (TIP) initiatives

requested that I interview them. These interviewees recommended the third leader as someone who had been instrumental in the TIP initiatives. I contacted her through the organization's global e-mail directory, and she agreed to the interview. Direct Care staff (DC) recruitment was similar in that two volunteers contacted me and volunteered for the interview and referred a third to me who had discussed an interest with them. I reached out to her by a telephone number one of the other direct care staff interviewees provided.

The direct care staff provide health care to clients, and the three leaders offer supervision and guidance to direct care staff in same health care authority. The direct care staff work directly with clients in a setting that provides psychiatric, medical, and substance use treatment services to clients from across BC. The leaders provide operational and clinical leadership for this program and were at the time of the study directly involved in trauma informed practice and policy implementation in the program areas where the direct care staff worked. Including these participants allows me to examine problematizations in the policies selected for analysis. The choice of participants' categories brings value to my study by making visible subjugated and widely accepted institutional knowledge formations in the field and the policies' subjectification and the lived effects. The health care organization commonly applies trauma informed practice, which sparked an interest in my study.

Interview process

I presented the options for the location of the interviews and then set the interview times. One leader and one direct Care staff opted to come to my private office within the organization, and the other interviews took place at the interviewees' offices. Each interviewee received an e-mail before the interview confirming the interview time, and I

provided them information about the study and the consent to participate (see Appendix A). At the beginning of the interview, I reviewed the consent to participate and the participants signed it. I provided a copy to each participant.

To re-confirm eligibility criteria for my project, I obtained verbal confirmation of the interviewees' positions within the organization, that the length of their employment was over two years, and that they had worked with TIP during this time.

The interviewees confirmed permission for recording the session at the outset of the interview. I utilized two recording devices to ensure I captured the interviews accurately. I transferred the recordings to a password-protected USB for use by the paid transcriptionist. The transcriptionist signed a confidentiality agreement (see Appendix B), I saved the transcripts on the password-protected USB, and returned it. The transcriptionist did not retain a copy. I stored the written transcripts and recordings in a locked filing cabinet in my home office. They are retained for one-year post completion of my Ph.D.

Interview questions were developed based on Bacchi & Bonham's seven processes (Bacchi & Goodwin, 2016, pp. 113-121) (Table 5.2) (Appendix C). These questions guided each semi-structured interview. I probed the responses to questions for clarification and understanding. I allowed interviewees to add any additional information they wished to provide at the end of each interview. I provided each interviewee with a $20 gift card in recognition of their participation. They were also provided with a list of resources for post-interview support based on the understanding that the subject matter of trauma may be triggering for some participants. I provided my and my academic

supervisor's contact information on the consent to participate form for any questions or concerns that may arise later.

Data Collection in the WPR approach

a) *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, May 2013) and *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014) were accessed through the Internet.

b) I accessed individuals within the organization through internal e-mail with permission from the organization. A semi-structured interview schedule was utilized during the interviews (see Appendix C) and each participant signed consent for participation (see Appendix A). I chose the health care professionals interviewed because their practice is guided and governed by the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, May 2013) and *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014) to explore to what extent political subjects shape discourse(s) or are delimited by their location within discourse(s) (Bacchi, 2005, p. 202).

a) First data set: A genealogy of the concept of trauma

A genealogy of the concept of trauma is required to answer *Question 3: How has the representation of the problem come about?* The WPR approach requires a genealogy of the policy for analysis. I completed the genealogy of trauma in Chapter Four.

A Foucauldian genealogy maps the practices and problem representations of trauma, how the problem took on a particular shape within a contingent history. The genealogy makes visible, how the concept of trauma has emerged, how it produced particular kinds of subjects, how the subjects were governed, what knowledge formations are produced and held as true, and exposes what the lived effects are for women who

have experienced violence. This contingent history reveals the formation of problem representations within practices nested within a ubiquitous trauma ethos. This analysis pays particular attention to knowledge formations and subjugated knowledges in problem representations.

The concept of trauma arrives in the field of practice of medicine/psychiatry and continues to grow, change shape, and permeates the consciousness of practitioners across sectors (see Chapter Four). The concept of trauma is nested within TIP policies. I determined that a contingent history of the practices leading to the development of the *TIP Guide* (2013) was required to understand this contingent history's effect on the modern concept of trauma and policy development in BC. The wicked and complex problem of trauma that the TIP policies try to solve is inexorably assumed within the policies. One cannot have a TIP policy without having trauma incorporated as a concept in that policy. Trauma as a concept shows up as a legitimate truth claim in policies with unconditional acceptance. The history of the concept of trauma informs my analysis of problem representations made within the policy proposals in BC explored in Chapter Six.

b) Second data set: Policies and Guidelines

The WPR methodology requires researchers to choose a specific policy proposal and work backward through the critical analysis utilizing the structured questions outlined in the WPR approach (Questions One and Two). As the main focus of my study, I have chosen the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, May 2013) and *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014*)* as a supporting document to the TIP Guide. As an internal actor in the organization, I was aware of standing policies and protocols for TIP.

Research participants (leaders and direct care staff) confirmed the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, May 2013) as a guide to their practice in the organization. The organization added SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014) as an organizing guide in 2019. Both documents are reviewed and analyzed in Chapter Six. These guides inform the health care practices at the health authority in BC, the site of my study. I analyze trauma discourse within these policies and make visible the lived effects of this discourse.

I adhere to the WPR methodology to probe "the premises that underpin particular problems representations within policy statements" (Bacchi, 2009, p. xiv). I have chosen to include policies in BC across service sectors that propose solutions to trauma as a problem. These policies and guidelines provide a context for practice and policy development in BC that targets the problem of trauma. The policies I review would be considered cross-sector policies, as they represent the ubiquitous concept of trauma at play in policies and practices in BC. It is useful “to think of these ideas as travelling ideas or more precisely as travelling problem representations” (Bacchi, p. xx). Travelling ideas are adapted and refined as they travel across these sectors with little or no analysis of the problem they are intended to solve.

Trauma discourse carries with it meanings and language representing the problem. These meanings are adopted and adapted within policies without further critique or problematizing of that discourse. The discourse within the guidelines carries representations of the problem of trauma and those who experience the problem of trauma. The guidelines propose solutions to resolve the problem of trauma. In turn, policies shape the problem. Subjects who work with the problem of trauma (health care

practitioners), and those receiving services for their problem of trauma are shaped by the policies. In traditional policy analysis, the problem stands outside the policy, extraneous to it, a 'wicked problem to be solved'. While in the WPR approach, problems are understood to be produced as particular types of problems within the policies and policy proposals (Bacchi, 2009, p. 1).

Bacchi (2012) in Bacchi & Goodwin (2016) explains that problem representations produce problems as special types of problems, and subjects as particular kinds of subjects (p. 17). According to Bacchi & Goodwin (2016), "[the] simple idea is to work backwards from a proposal to how a problem is represented" (p. 17), in other words, to critically analyze the problem representation from the proposal (policy) and the proposed solution contained within that policy. The subjectification effects stemming from the problem representation through the practices of conducting the conduct (governing) of the subject (see Chapter Three) are revealed during the analysis. A post structural approach to policy analysis such as WPR questions how governing takes place (Bacchi & Goodwin, p. 3).

Governing is an activity enacted in the policy. Governing activities occur in state institutions and in the agencies and professions involved in maintaining the social order (Bacchi & Goodwin, 2016, p. 18). My analysis identifies the kinds of subjects produced through governing activities in the policies. The WPR approach encourages theorizing and reflection on policy workers' role "in governing and to engage in the productive and political practices of interrogating, theorizing, and resisting" (Bacchi & Goodwin, p. 3). I analyze the policies by identifying common meanings, language, and presuppositions that

emerge from the text. During the analysis, I self-problematize by identifying my presumptions about the policy and the problem representations I hold to be true.

c) Third data set: Interviews

Bacchi & Bonham in Bacchi & Goodwin (2016) demonstrate the use of interviews in a critical post structural policy analysis. Bacchi & Bonham argue, "interview subjects are considered to have privileged (first person) access to a kind of truth about their experience" (Bacchi & Goodwin, p. 114). As noted in Chapter Three, FPS requires an analysis of truth claims; who makes them, how they show up in policies and how they come alive in practice. The information gained in interviews is utilized to "challenge the discourses in relation to self and at the broader societal level" (Bacchi & Goodwin, p. 114). The individual shows up as the subject "since practices are multiple and ongoing, subjects are always in process, fluid and relational rather than fixed essences of any sort" (Bacchi & Goodwin, p. 115). Bacchi & Bonham propose an approach focused on the politicization of personhood.

This politicization of personhood requires that post structural interviews are treated as knowledge practices and, like policies; interviews are inherently political in shaping relations and understandings (Bacchi & Goodwin, 2016, p. 114). Politics are "understood as the heterogeneous strategic relations that shape lives and the world" (Bacchi & Goodwin, 2016, p. 6). The interview itself is practice, an enactment of relations between things (Bacchi & Goodwin, 2016, p. 115). "Particular social arrangements involve politics, meaning the active shaping or making of the taken for granted" (Bacchi & Goodwin, 2016, p. 4). Ethical questioning and the politics of the

construction of policies are required as there is a “disquiet regarding connections between the thinking in policies and inequality” (Bacchi & Goodwin, 2016, p. 4).

The interview analysis is an opportunity to explore the ethics and politics of inequality. Bacchi & Bonham (2016) emphasize, “the purpose of the approach is to highlight the contingency and politics involved in shaping the kind of person it is possible to become” (Bacchi & Goodwin, p. 120). The analysis of the interview transcript “is to consider the particular kind of subjects produced within the interview settings, while also reflecting on how subjects' status can be questioned and disrupted” (Bacchi & Goodwin, p.115). The interview is a moment in time where the fluidity of the subject is appreciated and the impact on the lived effects of the subject interweaves with the contingent history of governing practices in the field of medicine/psychiatry. The WPR approach increases “the purview of analysis beyond the state to include other ‘governing parties’, such as professionals and social scientists” (Bacchi, 2009, p. xx).

The WPR approach encourages the researcher to analyze policies attending to cross-cutting themes, such as "making citizens responsible for ever-enlarged aspects of their lives, and an emphasis on risk in governing discourses" (Bacchi, 2009, p. xx). Presuppositions and travelling ideas are teased out in the transcripts of the one-to-one semi-structured interviews with the three direct care staff and three leaders. I analyze the interview transcripts according to Bacchi & Bonham’s Post structural Interview Analysis (Table 5.2). This approach is congruent with FPS and with Bacchi's (2009) WPR methodology.

Bacchi & Bonham outline seven processes utilized in this post structural interview analysis and highlight the analysis's interconnected nature (Bacchi & Goodwin,

2016, p. 115) (Table 5.2). In my endeavour to challenge the trauma informed discourse and practice, I interviewed three leaders and three direct care staff. I translated the seven processes to questions that I believed would open up dialogue and space for participants to discuss the knowledge formation of the organization's TIP policy, their beliefs, values and assumptions about the policy, what problem was represented in the policy, what problem they expect to be solved by the TIP policy, the lived effects for women in the policy and any questions or contestations they may have about the policy. These questions are noted in Table 5.2 and were based in my reading of Bacchi's work and my experience in the field of practice. I have designed study interview questions based on the seven processes in order to highlight key discursive practices, interrogate the production of subjects, explore transformational potential and to question the politics of distribution of the TIP guidelines.

Table 5.2 Post Structural Interview Analysis

Processes for Post Structural interview analysis	Dimensions of each process	Examples of questions utilized in interview analysis	Study Interview questions
1. Noting "what is said"	Interviewee speaks of the self in terms of an available subject position	What "things said" have been noted? On what grounds (common knowledge, taken for granted truths) have they been noted?	Has the implementation of this policy made a difference in your role, in your work, and/or in your life? Please describe.
2. Producing Genealogies of "what is said"	Reflection on specific 'things said", what could be said, and how what is said is considered "truthful"	What meanings need to be in place for particular "things said" to be intelligible? Where and how has a specific "thing said" come to be accepted as "truth"?	Does your organization have a TIP policy, protocol, or guideline? Please describe?
3. Highlighting key discursive practices	How discourses (practices) operate to establish their own knowledge credentials, things can be said "within the true", what are the normative implications	What discursive practices are relevant to the "things said" that are the focus of the analysis? Which subject positions are made available within these discursive practices?	What values, philosophies are inherent in the TIP policy, protocol, and guideline?
4. Analyzing what is said	Things said have important functions in installing certain subject positions and give authority to certain discursive practices	What norms do the "things said" evoke? What "subjects" are produced? Which "objects' do they create? Which "places" are produced as legitimate?	How is the policy applied in your workplace? What problem or problems is this policy meant to address?
5. Interrogating the production of the subjects	Interviews are important resources for	"What" does the individual relate to self?	Has it made a difference to the women (and in their

	considering how we are continually produced as particular kinds of provisional subjects	What ways of moving, thinking, characterizing, and feeling has the interviewee excised and related to the self? In which discursive practices have these attributes been, and continue to be, formed?	lives) who have received services within your organization? Please describe?
6. Exploring transformative potential	Use the interview material to explore mutations in subject positions	Does particular interviewee's comment appear unusual, inappropriate, or out of context? Does a particular comment offer an alternative to a taken for granted "reality"?	What meaning does it have for you generally and specifically in your day-to-day work? Can you think of a way this problem (trauma) could be thought of differently? Are there other instances when you believe that the policy ought not to apply?
7. Questioning the politics of distribution, Political uses of material	Role of the researcher in analyzing, distributing "what is said"	Do particular interviewer comments ("things said") challenge or reinforce pervasive ways of thinking? Do the questions asked function to reinforce or challenge persuasive ways of thinking? Are the sites for distributing research results constrained in ways that reinforce persuasive ways of thinking?	How did you come to know about this policy (protocol, guideline)? Are there instances when it is difficult to apply this policy or where others disagree about the policy? What are your thoughts about this? Are there instances when you believe that the policy ought to apply but is not applied?

(Bacchi & Goodwin, 2016, pp. 115-121)

Data Analysis

Policies and protocols

The WPR approach investigates problem representation by asking and addressing six questions. I applied each of the six questions to the documents, seeking out problem representations of the concept of trauma, violence against women, and the constitution of subjects -- women struggling with substance use and mental health concerns, health care practitioners, and leaders. The six questions need to be asked several times in the process of analysis of the initial problematization because problem representations tend to nest one within the other (Bacchi & Goodwin, 2016, p. 24). The emerging problematizations in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, May 2013), *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)*, and interviews highlight the nesting of the representations and the underlying rationalities contained within the problematizations.

I repeated the analysis to seek out nesting problem representations in my problem representations, searching for travelling ideas related to the concepts of trauma, women's trauma, and women struggling with mental health and substance use concerns.

Six questions for policy data analysis

Question 1: What's the problem represented to be in a specific policy or policies?

The opening question intends to probe the policies, seeking to analyze those ideas and presumptions that "appear natural and obvious" to the writer and reader, as accepted institutional truth claims and governing techniques (Bacchi & Goodwin, 2016, p. 20). The stated problem solutions allow for an inquiry into the implicit and unstated

problematization(s) of trauma. It can make visible complex constructions of the problem (Bacchi & Goodwin, 2016, p. 21).

Question 2: What deep-seated presuppositions or assumptions underlie this representation of the problem?

This question "identifies the meanings (the presuppositions, assumptions, unexamined ways of thinking, knowledges/discourses) that need to be in place to make sense or to be intelligible" (Bacchi & Goodwin, 2016, p. 21). As a discursive practice, policies produce knowledges that gain truth status (for example, evidence-based practice) within a network of relations in the field of practice (Bacchi & Goodwin, 2016, p. 22). For instance, in the case of the concept of trauma, meanings are sought directly in the proposal, policy, program, or technologies, not in what is presumed to be in the minds of individuals who were instrumental in enacting the guidelines. How is the problem constructed based on specific concepts and binaries such as public/private, man/woman? Are there patterns of problematizations that signal the operation of a particular political governmental rationality? (Bacchi & Goodwin, 2016, p. 21).

Question 3: How has this representation of the 'problem' come about?

Question three requires the completion of a genealogy, a historical, cultural examination of the interactive forces that have affected the characterization of the problem. The genealogy of the concept of trauma requires a "detailed mapping of practices that produce identified problem representations" (Bacchi & Goodwin, 2016, p. 22). It includes "differential power relations and discursive practices that create forms of authority for certain knowledges" (Bacchi & Goodwin, 2016, p. 22). The genealogy makes visible the disappearance and re-appearance of subjugated knowledges, including

those of the mentally ill, the nurse, and women who have received treatment for their trauma (Bacchi & Goodwin, 2016, p. 48). “Subjugated knowledges (which) consist of historical knowledges that have been buried or masked by functional arrangements or systemic organizations” are revealed (Bacchi & Goodwin, 2016, p. 48). Subjugated knowledges are surfaced and played off dominant discourses contributing to my analysis of power relations in the field. I reveal through questions and probes (see Table 5.2: Post Structural Interview Analysis: politicizing "personhood") underlying thoughts, suggestions, and concerns about the influence and impact of forming ideas and the subjugated conceptualizations in the field of practice.

Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be conceptualized differently?

This enquiry makes visible that which has been silenced or made invisible in problem representations ensconced in policies. “Comparing problematizations of selected issues, across time and cross culturally, provides a particularly powerful intervention to promote an ability to think otherwise” (Bacchi & Goodwin, 2016, p. 22). Identification and comparison of certain problematizations in particular practices and relations give the problems a certain shape in a certain context (Bacchi & Goodwin, 2016, pp. 22-23). Bacchi (2009) insists, “close attention to the role of discourses in constraining ways of thinking is crucial here" (p. 40). I am most interested in subjugated knowledges for women and violence and trauma and what remains invisible in medicine/psychiatry's transactional field of practice. I am curious how the problem of trauma may be conceptualized differently. I interview women who provide the services and women who

are leaders to make visible how women in varying subject positions conceptualize the problem of trauma and how this may differ from dominant medical/psychiatric discourse.

Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?

The lived effects on the material realities of women's day-to-day lives are revealed in an analysis of the constitution of subjects (subjectification effects), conducting the conduct (governing), and the discursive effects of policies as practice (Bacchi & Goodwin, 2016, p. 23) flowing from the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014). The problem representation in the policy "shows how the terms of reference established by particular problem representations set limits on what can be thought and said" (Bacchi & Goodwin, 2016, p. 23). The lived effects on the day-to-day realities of women's lives are highlighted in this portion of the study to ensure "that the ways in which discursive effects and subjectification effects translate into people's lives forms part of the analysis" (Bacchi & Goodwin, 2016, p. 23). The lived effects are essential to the FPS theorizing of the trauma policies (see Chapter Three).

The effects of the representation of the problem within the policy show up in the making and unmaking of problems, subjects, and objects. "These interconnected effects can coalesce in what Foucault calls dividing practices, which function to separate groups of people from one another and which can also produce governable subjects divided within themselves" (Bacchi & Goodwin, 2016, p. 23). I discussed dividing practices in Chapter Three and interrogate these constructions in the policies, exposing problem

representations and reveal how these representations can take on a life of their own (Bacchi, 2009, p. xviii). Question five thus introduces into the analysis a bridging from theory to concerns of material reality, making visible the contested space between policy and the effect of the material reality of women's day-to-day lives. The interviews expose these effects for analysis.

Question 6: How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

This question, as Bacchi and Goodwin (2016) explain, "opens up space to reflect on forms of resistance and counter-conduct that challenge pervasive and authoritative knowledges and dominant problem representations to destabilize taken-for-granted truths" (pp. 23-24). Contestation may take many forms, including counter conduct and resistance, as discussed in Chapter Three. I am interested in searching out dominant knowledges and their dissemination in the field of practice, the effects on women who have experienced violence (trauma), and points of counter conduct or resistance, including courageous acts for social justice. Has the practice been disrupted or displaced if the research reveals a lived effect? Can it be disrupted or displaced? What proposals arise from this discovery?

Data Analysis: Post structural interview

I listened to the recorded interviews on two occasions, once before reviewing the written transcript, and once after reading the written transcripts, to note emphasis in tone and inflection. The written transcripts were reviewed three times. The first time, I used track changes in each document to note any references to subject positions,

problematization of the concept of trauma, or governing and production of particular subjects. Governing takes place through the ways in which problems are represented and constituted in policies, the unexamined forms of thinking the problem representation relies upon, and the practices that generate these problem representations. The written transcripts were reviewed again for themes or characterizations of discourse effects. The "term, effects; captures the ways in which particular problem representations limit what can be thought (discursive effects)" (Bacchi & Goodwin, 2016, p, 108). The third review of the transcripts allowed for a comparison of these discursive effects among the participants. The third reading identified transformational potential for the mutation of subject positions. I identified interconnected ideas in the third reading of the transcripts. I then extracted quotes denoting common themes in discursive practices. Bacchi & Bonham highlight that "things said have an important function in installing certain norms and subject positions" (Bacchi & Goodwin, 2016, p. 118). I collated the comments for the group of direct care staff and leaders under each key discursive characterization, paying attention to discourse themes observed in the *TIP Guide* (2013). I also noted unique discourse in each of these groupings, which may indicate mutable subject positions. I compared the key discursive effects between Leaders and Direct Care staff. I then reviewed my journal entries that I had made after each interview to ensure that I incorporated any impressions related to discursive effects regarding subjectivity and transformational aspects of the interview.

During the review of the transcripts I noted the characterization of certain objects and subjects. "This particular approach to subjects as in process makes it possible to treat interviews - or more precisely interview transcripts - as texts" (Bacchi & Goodwin, 2016,

p. 115). The post structural interview reveals transformational aspects of subjects as a process or movement within the interview itself. Paying attention to the transformational process allows me to speak to what type of subjects it is possible to become, what subjects are produced, and how subject status can be disrupted and questioned. The procedure to deal with the text of the interview, allows for the ethics of the discourse practices to be examined, including the normative ways for people to be; interconnected practices that make TIP apparent and intelligible and give knowledge formations authority; and how specific discursive practices generate things that can be said to be in the true (Bacchi & Goodwin, 2016, pp. 115-120).

Data Analysis: Self-reflection - final step of WPR approach

The final step in the WPR approach is to apply the six questions to my problematizations of the concept of trauma. (Bacchi & Goodwin, 2016, p. 24). I repeat the analysis to examine my problematizations and proposals for solutions to the problem to maintain a self-problematizing ethic by asking myself the six questions. Bacchi and Goodwin (2016) offer a "rationale for this commitment to self-problematization is that, given one's location within historically and entrenched forms of knowledge, we need a way to subject our own thinking to critical scrutiny" (p. 24). I need to reflect on my location and my conceptualization of the 'problem'. I must critically question my positionality as a White settler, privileged, educated woman and the effects of my positionality on my conceptualization of a problem. I incorporate self-problematization throughout the chapters on Feminist Post Structuralism and Genealogy (See Chapters Three and Four).

Self-problematizing takes this reflection into a political space of contestation, conceptualizing myself as a subject conducted into the practices and mechanisms of dominant institutional knowledges. I am "subjected" into and, in turn, conduct others (subjectification) through these institutional, discursive, and at times dividing practices.

Limitations of study

The study includes interviews with direct care staff and leaders in one health care setting and so their perspectives are limited to this setting. I did not interview the women who receive services; therefore, I base my analysis on the interviews with staff members and the policy itself within a FPS theoretical framework. Interviewing women receiving the services would enrich a future study and enhance the analysis of the TIP policy's material effects. In the next chapter, I analyze the TIP policies accepted in the health care setting chosen for my study. In the Chapter Seven, I present a post structural analysis of the interviews with direct care staff and leaders.

Chapter Six: TIP Policies in BC

In this chapter I analyze BC policies that name trauma informed care as a mechanism for delivering services. The problem of trauma, nested within trauma policies, is a travelling idea (Bacchi, 2009, p. 44), a mode of governance that has moved across and within sectors of the human services field. Trauma policies within the mental health and substance use field in BC in the health care sector rely on information and policies supported by the Ministry of Health to shape client care. The constitution of female subjects within these policies and the impact of male violence, supported by patriarchal societal structures, in women's material lives is a focus of my feminist post structural analysis. A review of trauma policies reveals an application of the concept of trauma in family, child welfare and health care services. I aim to explore the problematization of the concept of trauma; the subjectification effects and resulting lived effects on women's material lives. I focus on how the concept of trauma shows up concerning violence against women in the health care sector.

In this chapter, I begin by tracing trauma informed care discourse in cross-sectoral policies in BC. These policies are a historical backdrop for the policies I explore in-depth, *TIP Guide* (2013) and the *SAMHSA Concept of Trauma and Guidance for a Trauma Informed Approach* (2014) documents. I problematize the representation of trauma, the traumatized subject, and the discursive, subjectification, and lived effects in these guidelines. Furthermore, I problematize the guidelines to make visible the governing techniques, disciplinary practices, subjugated knowledges, and the shaping of certain types of provisional subjects within these policies exposing the political problems that arise through these representations.

What's the Problem Represented to be?

Despite the best efforts to develop policies and practices to eradicate male violence against women in Canada, violence continues to be prevalent with significant impacts on women's material lives. According to the most recent Canadian reports,

> more than 11 million Canadians have been physically or sexually assaulted since the age of 15. This represents 39% of women and 35% of men 15 years of age and older in Canada, with the gender difference driven by a much higher prevalence of sexual assault among women than men (30% versus 8%). (Cotter & Savage, 2019)

Women tend to under-report physical and sexual assaults to police by an estimated thirty percent; therefore, these statistics do not reflect the actual numbers of assaults that have occurred (Statistics Canada, 2013, p. 10). How violence against women is conceptualized and represented as a problem of trauma shapes the discourse for policy development in BC. The generalized concept of trauma, previously discussed in Chapter Four as a trauma ethos, is based in psychiatric/medical discourse in the field of health care and conflates rape, sexual assault, and physical violence against women. The problematization of the concept of trauma influences a path of development in policies and protocols that has impacted practices in the human services sector, specifically in the field of provincial health care. Bacchi (2009) asks how and where has this representation of the "problem" been produced, disseminated, and defended? How has it been, and how can it be disrupted and displaced? (pp. 71-73)

In the following section, I discuss contemporary policies that have produced, disseminated, and defended the representation of the concept of trauma. A trauma ethos is a set of principles and beliefs about violence against women. The accepted treatment

modalities for the problematized effects of this violence are a coherent travelling idea in policies. A trauma ethos supports knowledge formations based on medical discourse. These knowledge formations contribute to making responsibilized subjects and effects such as self-regulation (Bacchi, 2009, p. 134; Bacchi & Goodwin, 2016, p. 73). In the next section, I explore contemporary trauma policies, the concept of trauma and the effects of individual responsibilization.

The conceptualization of trauma in contemporary policies in BC

From 2002 to 2016, a coherent trauma ethos was developed and applied in trauma policies in BC. I now turn to post-millennial policies in BC to illustrate this trauma ethos. I also note the gender-neutral approach, individual responsibilization, and the lack of socio-cultural and social justice approaches in these policies.

In 2002, a beginning and important acknowledgement of violence and women's trauma and its treatment appeared in a major study commissioned by the Ministry of Health in BC. *Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provision in British Columbia* (Morrow, 2002) advocates for a paradigm shift in the field of health care for women who have experienced violence. The report's intended audience was health care providers who had an understanding and relationship with trauma, characterized in a similar way to physical wounds and mental disorders under the medical gaze of medicine and psychiatry.

Morrow's (2002) report is a promising start in recognizing the effects of male violence in women's lives in BC. She highlights the impact of violence in women's lives, recognizes trauma as an outcome of the violence, describes the lasting effect of abuse on women's mental health, and includes abuse within systems of care as a precipitator of

trauma (Morrow, p. 9). Morrow calls to action mental health policymakers and planners to provide leadership in developing practice guidelines for working with women who are violence and trauma survivors (Morrow, p. 4). Morrow draws on both bio-medical and social justice understandings of violence and trauma as the best framework for designing programs for women (Morrow, p. 4).

Morrow (2002) reflects critically on the *British Columbia Mental Health Plan* (1998) to support her social justice approach. The plan asserts a commitment to a bio-psychosocial framework to address mental health problems. Morrow's research indicates that a bio-medical paradigm guides the medical practice at the current time of her report (Morrow, p. 3). Morrow contests the practice, claiming this paradigm does not consider "women's past experiences of violence and their increased vulnerability to abuse once they become ill…although some practitioners recognize the impact of violence and trauma on the lives of their clients" (Morrow, p. 3). To gain recognition of women's experiences of male violence, Morrow begins to nest violence against women within the concept of trauma.

Contrary to Morrow's desired social justice goal, the discursive effect of nesting male violence in the generalized terminology of trauma enacts policies as gender-neutral and softens the edge of violence. As explored in my study, the TIP Guide (2013) is one example of a gender-blind policy. The trauma becomes a treatable illness. Male violence against women is invisible, and descriptions of physical and sexual assaults are absent. Through this process, Morrow integrates the conceptualization of violence against women with mental health trauma effects. Trauma, known in medical discourse as a physical injury to the body, is now translated to an injury of the mind, just as Charcot

fashioned trauma definitions in the late 19th century (Herman, 1992, p. 10). Practices flowing from the policies focus on the reparation of an individual's trauma response. These practices promote an individually responsibilized approach meaning that the consequences of violence, trauma, and the applied resolutions to trauma become the responsibility of the violated woman.

Bacchi (2009) emphasizes that conceptualization of health is, and in this case, mental health, "has important implications for the particulars of the policy" (p. 128). The individual approach to trauma reparation is consistent with medical discourse within the *Diagnostic Statistical Manual V*. The application of medical discourse to the conceptualization of trauma displaces the culture of violence discourse in favour of an "individual ill" discourse. The structural discourse travels from a systemic discourse towards a psychiatric and therapeutic discourse enabling a powerful medical discourse that overtakes the social justice discourse.

The theory of ill health within policy plays a significant role in the establishment of health policy. Bacchi (2009) contends, “these theories form some of the 'knowledges' through which we are governed" (p. 128). In the matter of the traumatized female subject, the theory of the sick traumatized subject evokes "the themes of individual responsibilization and self regulation… as a dominant way of thinking in current governmental regimes” (Bacchi, p. 134). When applied in this manner, the medical discourse effectively discounts a patriarchal socio-political culture of violence discourse.

Morrow contextualizes women’s experiences of violence as these experiences relate to trauma treatment. “A recognition of gendered social factors reveals that men and women sometimes have different kinds of experiences and when they do have the

same experiences they may be impacted differentially" (Morrow, 2002, p. 18). She firmly places violence and trauma for women as a severe health concern shaping the traumatized subject as a responsibilized self-regulating subject responsible for her health and welfare (Bacchi & Goodwin, 2016, p. 73).

The Ministry of Health, the government department responsible for the treatment of health issues in BC, supported the Morrow (2002) report in a number of ways including through funding, having a senior Ministry employee on the advisory committee, and requesting and receiving feedback and edits to the report from the Ministry representative (pp.1-2). The shift of discourse from 'violence' inflicted on women towards a discourse of 'trauma, an individual ill' as a result of violence becomes a trend in policy documents. I explore this phenomenon later in this chapter.

The trend towards medical trauma discourse in policies discounts the socio-cultural root causes of violence against women. Unlike Morrow's policy approach to violence and social justice responses, subsequent policies in BC endorse a medical trauma discourse, decontextualized from the gendered reality of women's material lives. Trauma becomes a condition to be treated, an injury impacting the mind rather than an act of male violence requiring social and political solutions. The WPR approach explores the shift from socio-cultural roots of violence to a medical paradigm in the questions; what is the problem represented to be in the TIP Guide (2013), and what presuppositions or assumptions underlie this representation of the 'problem'?

Policy solutions flow from medical trauma discourse and focus on individual women's mental health. Production of the responsibilized subject in these policies "diverts attention from broad based social factors that shape lives" (Bacchi &Goodwin,

2016, p. 73). Beginning with Morrow, policies defend the concept of trauma, contributing to a trauma ethos, legitimized by the Ministry of Health, and disseminated in future policies related to women, youth and children.

Morrow's report is a historical political juncture in BC. It is the earliest call for developing a practice within the health care field to address concerns about violence against women and its impact on women's mental health. Morrow (2002) calls for a social justice perspective, utilizing a socio-political framework; however, Morrow's paradigm shift to a social justice perspective is made invisible in future policy documents. This invisibility occurs with a gender-neutral problematization of the concept of trauma. Within subsequent trauma informed care policies, this gives space for the exclusion of ideas about the social construction of gender and women's social reality. The trauma ethos becomes the set point for future policies addressing women's experiences of individual and patriarchal systemic male violence. This decontextualized approach supports the problem representation of trauma shaped within a trauma ethos in the health care system as an individualized, mental health problem. This approach does not embrace the problem of power imbued for women in their intimate relationships, economic and occupational lives (Bacchi, 2009, p. 134). The discussion that follows reveals a dominant medical discourse in contemporary policies in BC despite Morrow's recommendations and feminist call to action.

Trauma, mental health, substance use and social determinants of health

Eight years later, after the Morrow report, the Ministry of Health took up the idea of mental health and substance use from a social determinant of health perspective. The report, *Healthy Minds, Healthy People; A ten-year plan to Address Mental Health and*

Substance Use in British Columbia (2010), is a joint effort between the Ministry of Health Services (MOHS) and the Ministry of Children and Family Development (MCFD). The report declares that the impacts of mental health and substance use are the problems to address in BC. "Over any 12 months, about one in five individuals in the province will experience significant mental health and/or substance use problems leading to personal suffering and interference with life goals" (MOHS, 2010, p. 1). This problem representation is significant to my study in health care related to women who struggle with mental health, substance use and trauma. The report acknowledges previous milestones in the advancement in research, the establishment of specialized residential treatment services for persons with serious and complex mental illnesses, and specialized community mental health teams implemented in the previous three years before the report. This representation of the problem evokes individual responsibilization without addressing health inequities "the ways in which social and environmental influences harm some groups more than others" (Bacchi, 2009, p. 141). To address women's inequities and male violence would require profound structural changes in the patriarchal societal structure itself.

Male violence inflicted on women reflects the inequities in a patriarchal societal system. These inequities in policies take a gender-neutral stance in their problem representations and proposed solutions. For example, The *Healthy Minds* plan is gender-neutral; it does not call out specific recommendations for women. Therefore, proposals for action do not address solutions specific to women. Contrary to Morrow's (2002) call to action for women-specific solutions, she emphasizes, "generally the care of this group of women [mentally ill] is not specialized and very few specific programs, and protocols

have been developed to work with them" (p. 17). Her recommendation that gender analysis be the foundation for the treatment of violence against women is unanswered. Regardless, the *Healthy Minds* plan observes, "exposure to violence and trauma or lack of social support, can be mitigated through strategic intervention" (MOHS, 2010, p. 20). The *Healthy Minds* plan recognizes "a major contributor to poor emotional health of women is violence by an intimate partner" (MOHS, 2010, p. 23). To emphasize the argument, the term intimate partner violence, as an example, continues to mask the 'problem' of male violence against women.

The MOHS notes that the health care system tends to operate in isolation from other systems that impact women's lives, such as justice, access to housing, and poverty created through the experience of violence and dislocation when escaping violence. "Women who are not able to escape violent relationships or who face inadequate supports when they leave suffer a wide range of potential health, social and economic consequences, including mental health and substance use problems" (MOHS, 2010, p. 23). The Report's conceptualization of "women who are not able to escape" evokes a different idea, that women who can escape violence escape this range of consequences. The consequences of violence against women are thus directly connected to women's actions to escape violence, rather than the oppressive patriarchal structures that produce these effects.

The subjectification effect inherent in a characterization of the subject who can act autonomously, who can escape, shapes her as a responsibilized subject, responsible for stopping the violence and its effects. What does this representation imply for women who do not escape? This representation defines these kinds of subjects as suffering from

mental health and substance use. They are shaped as non-autonomous subjects, unable or incompetent to act on their behalf. The material effects of violence (social and economic consequences) tied to the individualized 'pathological' response of not escaping the violence constitutes the female traumatized subject as complicit in continuing the violence. The problem of mental health and substance use, an individual problem-pathology becomes nested with the problem of male violence inflicted on women. The nesting of these problem representations evokes the mentally ill and substance-using women as a particular subject within the discourse of the autonomous and non-autonomous traumatized subject. The discourse of the mentally ill, substance-using traumatized female subject is subsumed within the trauma discourse and is legitimized and disseminated in future policies as a dividing practice, discussed later in this chapter.

The constitution of violated women as substance-using and addicted can generate further harms, creating those who use substances as pathological (Seear & Fraser, 2014). The representation of the problem of substance use stigmatizes the female subject who has experienced violence, a stigma that is prevalent in the treatment of substance use. This stigma highlights a lack of control over substance use and enhanced accountability for individual actions (Bacchi, 2015, p. 132). The focus now becomes one of a problem that needs fixing (women's substance use and behaviours) rather than a conceptualization of a socially constructed problem; that is, women's status in patriarchal social structures that permit male violence against them. What kind of problem is violence against women represented to be in *Healthy Minds*? The problem of violence against women is a static, fixed problem that, with strategic interventions, individualized to each woman, can be solved one woman at a time (MOHS, 2010, p. 20).

Bacchi (2009) contends that policy representations nest together or "are embedded one within the other" (p. 21). Problem representations compete with one another when they are nested together in the policy. Two problem representations nested within the violence policy are violence against women and children who witness violence. To illustrate, the report *A Vision for Violence Free BC: Addressing Violence Against Women* (Province of British Columbia, 2015) emphasizes children's exposure to violence against women, their mothers. The emphasis on children displaces recognition and acknowledgment of the effects of violence on women's health and well-being. The protection of children, our most vulnerable citizens, is noted to be of paramount importance. The problem representation constitutes the violence perpetrated against a woman as a problem of protecting children and the impact on the economy. Women, as traumatized female subjects, are valued in the policy as mothers first. Emphasis on the impact on their families and, ultimately, society is paramount (Province of British Columbia, 2015, p. 1). The dominant governmental rationality of this policy, neoliberalism, is a generalized way of thinking about the problem representation.

Neoliberalism and violence against women policies

Neoliberalism is a governmental rationality that has dominated the 1990s to the present. Neoliberalism as an ideology in action "refers to a tendency to privilege market relations as a motif for thinking about all forms of human relationships" (Bacchi, 2009, p. 276). Neoliberalism abounds in the introduction to the *Healthy Minds* report.

> The human, social, and economic costs of violence against women in our society are substantial…Experiences of violence can also result in increased employee absenteeism, leading to lost wages and decreased productivity.

> Demands on the justice, health and social service systems cost taxpayers in Canada hundreds of millions of dollars a year. According to the Department of Justice Canada, the total economic impact of spousal violence in Canada in 2009 was estimated at $7.4 billion. Based on this data, the socio-economic impact of spousal violence in British Columbia was close to $1 billion in 2009 alone. (Provincial office of Domestic (PODV), 2012, pp. 4-5)

Thus, the problem representation of violence against women becomes a problem creating economic costs to taxpayers, employees, and employers. SAMHSA (2014) recognizes domestic violence by evoking an economic concern, "women who are victimized by domestic violence may have trouble performing at work" (SAMHSA, p. 3). Violence against women is problematized as an economic problem whereby violence results in a loss of work productivity for the individual and the employer. There are increased costs of providing services to the substance-user. Both the *Healthy Minds* report and the *SAMHSA* (2014) report boasts a neoliberal framework by focusing on economic costs as indicated above, with little attention paid to the human costs of violence inflicted on women. Economic costs are a prominent driver of policies and programs designed for the prevention of violence against women.

A travelling idea in domestic violence policies is the need to address acts of violence impacting children. One travelling idea includes the propensity for most policy documents addressing domestic violence to focus on the impacts on the family. Other forms of violence against women, such as rape and sexual assault, remain largely invisible in the policy documents (MCFD, 2016a). Most government documents attend to domestic violence and the impacts of that violence on children and youth; however,

sexual assault statistics are briefly referenced. The documents describe domestic violence alone, excluding other forms of violence against women, such as sexual violence. In these policies, domestic violence occurs within the family unit context and renders solutions directed towards families and specifically children.

> The human, social, and economic costs of violence against women in our society are substantial. Domestic violence in the home can negatively impact a child's ability to be successful in school, and can increase their likelihood of being in an abusive relationship as an aggressor or victim as an adult. Incidents of sexual violence can damage a community's sense of safety and Individual well-being. Experiences of violence can also result in increased employee absenteeism, leading to lost wages and decreased productivity. (PODV, 2012, p.4)

A plethora of reports and actions occurred from 2012 forward related to domestic violence policies. The provincial government announced the establishment of a new Provincial Office of Domestic Violence (PODV) on March 1, 2012. In the report, *Taking Action on Domestic Violence in British Columbia* (2012), the province responded to the report by the Representative for Children and Youth into the deaths of three children, Kaitlynne (10), Max (8), and Cordon (5) Schoenborn. Their father, Allan Dwayne Schoenborn, "suffered from long-standing, untreated mental illness and severe substance related disorders" (PODV p. 2). The heinous act of the murder of three children by their father is pivotal in reinforcing children's protection. This report's release shifts the problem representation in policies from violence to trauma, reinforcing the need to focus on children as a priority and contributing to a coherent trauma ethos in policies in BC.

Trauma ethos reinforced in BC trauma policies

My exploration of the rapid production of government reports from 2012 to 2016 related to trauma reveals a momentum to the fulfillment of a trauma ethos in advancing policies related to trauma informed care and treatment.

In 2012 the BC Centre for Excellence in Women's Health coordinated the first publications in a series on trauma informed care, *Becoming Trauma Informed* (Poole & Greaves, 2012). The publication of this work is the same year as the *Taking Action On Domestic Violence* report (PODV, 2012). The field of practice provides "compelling evidence that mental health and substance use problems are connected to people's experiences of violence, abuse and trauma" (PODV, 2012, p. xiii). MCFD calls for trauma informed care as an intervention to address mental health and substance use concerns. It had been many years since Morrow's initial work in BC on violence, women, and mental health.

A flurry of activity in health care from 2012 to 2014 reflects the intensity and gravity of the need to respond. The report by Mary Ellen Turpel-Lafond, a Cree judge and the Representative for Children and Youth (RCY), *Trauma, Turmoil and Tragedy: Understanding the needs of children and youth at risk of suicide and self-harm (November 2012),* is a catalyst in BC to change practices and policies for the protection of youth and children in government care. Five of the twelve recommendations mention the word trauma, and the summary of the recommendation reasons are,

> based on the information in the files of these youth, trauma was not a primary focus of service delivery. The components listed above are not evident in the Ministry's approach to children and youth, and better outcomes require a trauma-informed approach. (Turpel-Lafond, 2012, p. 37)

This report foreshadows violence and trauma policy and practice development in BC over the next four years. The focus on the protection of youth and children dictates a critical approach to mobilize trauma informed care across fields of practice, including the health care sector.

The BC Provincial Mental Health and Substance Use Planning Council supported by the MOH, publishes a *Trauma Informed Practice Guide (2013)*. A trauma ethos developed in this document outlines principles of practice in working with clients and governs how systems of care organize following the same principles. The *Guide* and *TIP Organizational Checklist* (BC Provincial Mental Health and Substance Use Planning Council, pp. 46-57) intends to support the translation of trauma-informed principles into practice, conducting the conduct of health care professionals, a concept first introduced in Chapter Two. Included are concrete strategies "to guide the professional work of practitioners assisting clients with mental health and substance use (MHSU) concerns in British Columbia" (BC Provincial Mental Health and Substance Use Planning Council, p. introduction). Morrow's (2002) preference for gender-specific practice within a socio-cultural understanding of trauma goes unheeded in the guiding principles. I explore the TIP Guide (BC Provincial Mental Health and Substance Use Planning Council, 2013) further later in this chapter. Importantly, there is an emphasis on Indigenous historical trauma, treatment, and education of health care practitioners in the Guide. This notation's unintentional effect is the shaping of an Indigenous traumatized subject as a marginalized subject in need of healing.

The *Child, Family and Community Service Act* (CFCSA) incorporated domestic violence amendments on June 1, 2014. These amendments brought a sharper focus to

domestic violence's seriousness and gravity and clarity about when a child in a domestically violent situation needs protection (MCFD, 2016a, p. 18). Also of import is the directive to practitioners, "using a social-determinants-of-health lens can help practitioners broaden their understanding of the realities of many individual's lives and the numerous influences that impact an individual or family's ability to access services (poverty, homelessness, gender, etc.)" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 26). The mention of the social determinants of health lens is a brief recognition of the socio-political context within which violence occurs. The socio-political contextualization may shift the analysis from an individualized pathological conception of trauma to a socio-cultural perspective. However, my analysis of the TIP Guide (2103) reveals a missed opportunity to explore this critical contextualization.

In 2015, the province of BC published *Families at the centre: Through the Lens of Families and Children* , a follow-up report to the *Healthy Minds, Healthy People (2010)* plan, informed by both the *Taking Action on Domestic Violence* (2012) and *Trauma, Turmoil and Tragedy: Understanding the needs of children and youth at risk of suicide and self-harm (2012)* reports. The priority of a family-centred approach in policy reemphasizes the needs and protection of children. The Child and Youth Mental Health and Substance Use Strategic Coordinating Committee in 2009 addressed the specific needs of children whose parents have a mental illness (Province of BC & Family Mental Health and Substance Use Task Force, 2015, p. 1). The report relies on *BC's Provincial Domestic Violence Action Plan (2012)* and lists the *Trauma Informed Practice (TIP) Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) as a resource for practices that are consistent with family-centred care. *Families at the centre*

defines improved "access to coordinated health and social services for families impacted by parental mental health challenges, problematic substance use and/or intimate partner violence" (Province of BC & Family Mental Health and Substance Use Task Force, 2015, p. 6). The women impacted by this violence remain invisible in this report. The violence problem is constituted and solved as a family problem. Solutions incorporate practices directed towards the family as a unit and children. This representation loses sight of the material impacts of violence on women's lives. The traumatized female subject is shaped as one who is accountable for the protection of children and is constituted as the passive victim subject described in Chapter Three. The problem of male violence inflicted on women is characterized as a fixed problem with fixed solutions. The intersectoral solutions required for this complex, wicked problem are absent due to the limitations of this problem representation.

In November of 2016, coordinated by the BC Centre for Women's Excellence in Health, MCFD published *Healing Families, Healing Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families (November 2016).* This publication informed the work of leaders, system planners, and practitioners working with children, youth, and families that further entrenched the problem of trauma as a family dilemma (MCFD, 2016b, p. 2). Trauma informed approaches recommended to serve children, youth and families uphold the trauma ethos and "recognize how common the experiences of trauma are, and the wide range of effects trauma can have on both short- and long-term health and well being" (MCFD, 2016b, p. 2).

In summary, the BC government has disseminated to a broad audience of justice, health, education, and child protection professionals the characterization of trauma as a

fundamental problem with priority status, emphasizing the protection of children. As noted in the reports cited, the trauma ethos sets, in policies, guidelines, and protocols across the systems of care in the province of BC, governing practices and conducts the conduct of professionals in many service sectors. The majority of BC policies present violence against women as a corollary to the problem of trauma. Male violence against women is mostly invisible in government documents, even though men are the majority of those who inflict violence. The material day-to-day effects of violence in women's lives remain invisible.

The invisible female traumatized subject

I now examine more closely the report, *Trauma, Turmoil and Tragedy: Understanding the needs of children and youth at risk of suicide and self-harm (2012)*. This report is an example of a policy that demonstrates the travelling idea (Bacchi, 2009) that violence against women occurs outside of the socio-political context of women's material lives. The travelling idea is supported by guidelines that espouse trauma informed care as a policy solution excluding a gendered subject.

The report examines "89 suicide and self-harm incidents reported to the Representative for Children and Youth between June 1, 2007 and May 31, 2010. Each youth received services from the Ministry of Children and Family Development (MCFD)" (Turpel-Lafond, 2012, p. 3). The report conceptualizes youth trauma as a problem resulting from domestic violence, "a significant feature in the lives of more than half the youth" (Turpel-Lafond, 2012, p. 5). The role of parenting mothers is constituted as a problem of the mother's addiction to substances. Statistics that support this problematization are noted. "Seventy-five per cent of the mothers of the youth had

substance use issues" (Turpel-Lafond, 2012, p. 5). Fathers are constituted as invisible partners in parenting, “less information about substance use was available about the fathers because they were often absent from the family or did not play a consistent role in their children’s lives” (Turpel-Lafond, 2012, p. 5).

The impact on the youth's life of an absent father is not analyzed. No socio-political contextual analysis of the victim's domestic violence experience is provided, thus discounting the role of the perpetrator of the violence, the intersections of maternal substance use, victimization, poverty, and isolation, and the resulting impacts of the violence the women have experienced. The fathers are absent from the families. The report cites the family's instability as a destabilizing factor in the lives of children and youth who have self-harmed or completed suicide (Turpel-Lafond, 2012, p. 5). The focus on the substance-abusing mother rather than the absent violent father lays the responsibility for the family's destabilization with the mother. The resulting children's self-harm and suicide are also blamed on the substance-abusing mother, even though “more than half the families contended with physical abuse committed by fathers or male partners and witnessed by the children, often at an early age” (Turpel-Lafond, 2012, p. 14).

As I described in Chapter Two, feminism established the prevention of the abuse of children as a political priority. Feminists aligned themselves with the campaign to protect abused children and found legitimacy in the feminist agenda by speaking out against children’s abuse and trauma. The problematization of violence against women becomes women’s inability to intervene in the protection of their children. The female subject is constituted as a good protective mother or, in the mothers referenced in this

report, a bad substance-using mother. The protection of children rests within women's traditionally defined role as a responsible mother, nested in a fixed binary gender role distinction as adequate mothers and protectors of children.

> A significant proportion of the parents struggled with substance use, notably for 67 of the mothers. The fathers also had issues with substance use, but files contained less information on them because most fathers were absent from the family or did not play a constant role in their children's lives. A few prominent patterns appeared: fathers being present early in the child's life and then leaving the home; new partners and father figures; and domestic violence. More than half the families contended with fathers or male partners' physical abuse and witnessed by the children, often at an early age. (Turpel-Lafond, p. 14)

Women were present as the parent in the majority of cases as noted above and therefore the focus on parents further in the report implies that women are the parents not protecting the children in the home. A common notation in the records was that there was incomplete follow-through with services (for example, a parent's inability to finish drug and alcohol treatment or complete anger management programs (Turpel-Lafond, 2012, p. 20)

In this policy, male violence becomes, first and foremost, a danger to the children. The problem representation is of the mothers using substances and failing to protect their children. Mothers in this discourse are constituted as incompetent parents and blamed for neglecting their children. The feminist alliance supported the protection of children intended to draw attention to male violence, a strategy to advance the emancipation of women from violent relationships. This tactic became a dangerous practice for some

women who would be held accountable in criminal and family courts for not protecting their children (Strega & Janzen, 2013, p. 57). Gender is only recognized concerning the role of the mother and carries with its negative connotations. The Turpel-Lafond report avoids a gender or patriarchal power analysis.

Throughout the report, Turpel-Lafond (2012) refers to youth as a gender-neutral category; however, she admits that females make up nine of the fifteen successful suicides and fifty-five of the seventy-four reported incidents of self-harm (pp. 12-13). Despite this demonstrable gender disparity, gender is invisible in the analysis, foreshadowing the future trend of gender-neutral policy development. The report fails to comment on the gender imbalance reflected in the statistics, even though 89 percent of the children and youth studied are female. The report ignores intersections of race, culture, sexual identity and orientation. However, there is one mention of Indigenous youth in Turpel-Lafond's point that "[a] disturbingly high number of the youth (52, or 58 per cent) in the review were Aboriginal" (p. 4). Gender remains neutral in this category of Indigenous youth, even though 40 of the 52 or 77 percent of Indigenous youth referred to in the report are female (Turpel-Lafond, p. 13). The gender neutrality of this significant report serves to discourage gender-specific discourse and practices in future policies to address violence against women and girls.

Trauma informed practice (TIP) policies for the delivery of services to women who struggle with mental health and substance use concerns

In the following sections, I uncover the conceptualization of trauma in the Trauma Informed Practice (*TIP) Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) as a wicked problem. I analyze the power relations inherent in

the medical gaze utilized in the Guide. I explore the production of specific types of female traumatized subjects and the constitution of health care practitioners whose practice is shaped by the *TIP Guide* (2013). I reference the *SAMHSA Concept of trauma and the Guidance for a Trauma Informed Approach* (2014) to augment my analysis.

The BC Centre for Excellence in Women's Health, a woman-centred research institute, published with the BC Provincial Mental Health and Substance Use planning Council and the MOH the *Trauma-Informed Practice (TIP) Guide* (May 2013). Leaders and direct care staff interviewed for my study identified the *TIP Guide* (2013) as the document that guides their practice (more on this in Chapter Seven). The *TIP Guide* is a collaborative effort "to support the application of trauma-informed principles into practice and policy, by clinics, agencies, and groups assisting clients with mental health and substance use concerns in British Columbia" (p. introduction). This practice protocol was shared widely throughout cross-sectoral services in BC, producing a travelling idea and problem representation of trauma to encourage evidence-based practices in delivering services to clients with mental health and substance use concerns across BC. This broad-based guide influences disciplinary practices and the understanding of the problem of trauma (violence) in health care settings. The principles delineated in the MOH-sponsored *TIP Guide* have been applied and referenced in more recent government documents such as the *TIP Guide* published by the Ministry of Children and Family Development (MCFD, 2016b). The principles of trauma informed practice in the *TIP Guide* are trauma awareness, emphasis on safety and trustworthiness, the opportunity for collaboration, and choice and utilizing a strength-based and skill-building approach when providing services (BC Provincial Mental Health and Substance Use Planning Council,

pp. 13-14). The principles provide a framework for a trauma informed approach (BC Provincial Mental Health and Substance Use Planning Council, p. 13).

The TIP Guide and women

Although the *TIP Guide* lists women as a "specific population" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 23), they do not receive exclusive attention or recognition in the Guide, even though, significantly, the report estimates that between 63% and 90% of women who access services for substance use report that they are struggling with the effects of violence in their lives and experiencing trauma symptoms. The authors provide exemplars of women serving organizations, which speak specifically to a gendered experience of trauma (violence). Otherwise, the Guide remains gender-neutral in language throughout, using the terms clients, individuals, and people (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 23).

The *SAMHSA Concept of Trauma and the Guidance for a Trauma Informed Approach* (2014), a supporting guideline within the organizational location of my study in 2019, has a gender-neutral approach while describing the concept of trauma in broader terms and expanding on more principles for organizations wanting to implement TIP (p. 2). The SAMHSA (2014) principles correspond to the broader set of four principles within the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp. 9-10).

The gender-neutral approach in these guidelines begs the question: have women disappeared in the practice of treating violence against women (trauma)? What impact, if any, do gender-neutral policies have on the day-to-day lives of women receiving services

in health care environments in the aftermath of violence? What impact, if any, does the disappearance of women affected by gender–neutral policies have?

In the following section, I examine primarily the *TIP Guide* (2013), which stands as the guiding document for TIP in my study location. I augment this analysis with examples from the *SAMHSA Concept of Trauma and Guidance for a Trauma Informed Approach* (2014) as the secondary reference for the organization within which my study takes place.

TIP and Institutional legitimacy

The BC Provincial Health and Substance Use Planning Council, in consultation with researchers, practitioners, and health system planners across BC steered the preparation of the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013). The Guide's stated objectives are to enhance practitioners' awareness of clients with histories of violence and trauma, increase awareness of evidence-based practices; and better serve and improve outcomes for clients with mental health and substance use concerns (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4). The *TIP Guide* acknowledges the contributions of various practitioners across BC who provided input to the document, including a registered psychologist from the BC Ministry of Health. Health Canada funded the report, and organizational leaders endorsed it at all levels of the BC mental health and substance use system of care. The Guide provides a detailed and comprehensive list of all project teams and committee members, citing their professional affiliations and credentials. The attention to detail in the report for their endorsement and approval strongly suggests that the institutional legitimacy of the concept of trauma informed practice and its

representation in the *TIP Guide* (2013) is critical to the project team and the organizations they represent. The statement, "the project has the full endorsement of the Provincial Mental Health and Substance Use Planning Council and leadership at all levels of the BCMHSU system of care" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. acknowledgemtns), provides the reader with a fait accompli of the institutional legitimacy of the document. The power, status and legitimacy reflected in the listing of the credentials and the broad-based endorsement attaches the *TIP Guide* to institutional power, making it difficult for any traumatized subject or health care practitioner to contest and challenge its contents and proposals.

Institutional legitimacy or authority of a guideline makes it possible to say things that become truth and form knowledge within a field of practice. In the *TIP Guide* (2013), the stated truths of TIP align with medical discourse and the problem representation of trauma as an individualized medical concern requiring diagnosis and treatment. The knowledge formation under this medical gaze gives authority to and drives institutional practices. These institutional mechanisms indoctrinate the traumatized subject into a culture of TIP. TIP, accepted as a truth claim and supported by the institutional authority and the medical expert, grants these truth claims' institutional legitimacy.

Institutional legitimacy lends itself to the development of evidence-based policy (EBP). EBP discourse "privileges 'objective' scientific knowledge and has dominated the health and drug policy since the late 1990s" (Lancaster et al., 2017, p. 61) Institutional legitimacy leaves little room to insert the subjugated knowledges of marginalized, violated women. These knowledges remain invisible in the trauma policies that shape

care work with women. Subjugated knowledges are a "whole series of knowledges that have been disqualified as non-conceptual knowledges, as insufficiently elaborate knowledges, naïve knowledges, hierarchically inferior knowledges that are below the required level of erudition or scientificity" (Foucault et al., 2007, pp.7-8). The knowledge women carry of their experience of violence, and their material lives, the impacts of violence, institutional policies, and practices are made invisible by the medical discourse that permeates the health care system. The invisibility garners power for the expert health care practitioner and the system itself. These power relations permeate the relationship between practitioners and women receiving services. As I turn my attention to the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013), I examine how EBP and institutional legitimization of the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) are central to the production of specific traumatized female subjects, and the constitution of health care practitioners and the shaping of their practices.

Knowledge and power have a recursive relationship. Medical knowledge has long taken precedence over women's truth claims, as the experts, medical practitioners take up a position of hierarchical power and act on their knowledge in their practice. The traumatized subject, through these practices, is shaped to be an unknowing subject. The traumatized subject is constituted in the *TIP Guide* (2013), and the *SAMHSA Concept* (2014) documents policy when the problem of trauma is conceptualized or represented in specific ways.

What is the problem represented to be?

The problem of trauma is complex and wicked and is the most critical and primary problem

The WPR approach to policy analysis works backwards, in that WPR starts with analyzing the policy to determine the prevalent problem that the policy intends to solve; challenges the problem representations that have deleterious effects; and suggests new ways of looking at the problem (Bacchi, 2009, p. 44). A WPR approach "presumes that some problem representations benefit the members of some groups at the expense of others. It also takes the side of those who are harmed" (Bacchi, 2009, p. 44). In Chapter Three, I argued that violence is the problem that needs addressing and that violence is enacted upon women differentially in line with intersected social locators such as race and class.

The *TIP Guide* ((BC Provincial Mental Health and Substance Use Planning Council, 2013) presents a complex construction of the concept of trauma (Bacchi & Goodwin, 2016, p. 20), entirely displacing any exploration of women's differential experience of violence. Trauma is conceptualized as an individual problem explicitly described in both the *TIP Guide* and the SAMHSA *Concept* document as a problem for clients who have complex mental health and substance use issues (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 9; SAMHSA, 2014, p. 2). Violence is, at most, an infrequent side conversation, mentioned only twelve times in the eighty-six-page *TIP Guide* and eight times in the seventeen-page *SAMHSA Concept* document. The *TIP Guide* (2013) highlights the effects of trauma on individuals, further increasing the complexity of the problem, referring, for example, to experiences such as helplessness, powerlessness, listlessness, dysregulation of the brain and body systems,

chronic fatigue, and intrusive recollections (p. 7). The *TIP Guide* notes that these and other responses "can interfere with an individual's sense of safety, self-efficacy, as well as the ability to regulate emotions and navigate relationships" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 7). SAMHSA (2014) states, "traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful, consistent relationships in their families and communities" (p. 5). The solution for this complex problem relies on applying the medical gaze of psychiatry.

The medical model and the *TIP Guide* (2013)

Post-traumatic stress disorder is "one type of mental health disorder that can result from trauma" (SAMHSA, 2014, p. 7). The problem representation or characterization in the policy of trauma as an individual ill has a severe impact on healthcare practices. Firstly, the policy supports the idea that trauma is a disorder, one that can be diagnosed and treated through medical interventions such as psychotherapy. This model "focuses the source of the problem in the individual rather than the social environment" (Conrad, 2007, p. 8). The solution presented to address the problem of trauma is to empower the individual to address their trauma. As the solution addresses an individual problem, the intervention's focus opens space to present trauma central to one's development (BC Provincial Mental Health and Substance Use Planning Council, 2013, p.13; SAMHSA, 2014, pp. 3-5). Trauma has become the primary raison d'étre for a wide range of adaptations that people utilize to cope and survive.

The medical model left unchallenged, calls for individual interventions rather than social or political solutions to violence's lived effects in women's material lives. The

individual is characterized as maladaptive and unknowing. SAMHSA (2014) states, "emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders" (p. 2). This discourse hides the feminist political agenda once thought to be the source of eradicating violence against women. The *TIP Guide* (2013) constitutes the role of the practitioner as an expert "to better respond to the acuity and chronicity of these types of problems" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 12). It focuses on individual solutions to resolve the problem of trauma.

Although the *TIP Guide* (2013) evokes the health care practitioner as a knowledge expert, it also evokes the problem of the incompetent practitioner when managing institutional responses to the clients' experiences of violence. Trauma is conceptualized as a wicked problem that triggers physiological adaptations resulting in "a dysregulation of the brain and body systems," which "perpetuates mental, emotional and physical distress" and can be life-changing (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 7; SAMHSA, 2014, p. 5). The resolution to this problem lies with a "correct diagnosis" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 11), followed by the education of practitioners in the principles of TIP (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 13). The organizational system must steel itself to manage the traumatized female subject by teaching her new coping skills (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp.40-41) and calming down strategies (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 28). Staff members must be kept

safe from the ‘out of control, dysregulated dangerous client’ and debrief the experience of the interaction with a peer or supervisor (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). The governing of the out-of-control female traumatized subject becomes the responsibility of the now trauma informed competent practitioner.

Subjectification Effects

The female subject as a sexed subject raises questions related to agency, resistance, and the gender dichotomy of the male/female binary. Feminist post structuralism (FPS) seeks to advance the understanding of women's gendered reality within the context of their constituted subjectivity. In the following section, I explore the material reality of women constituted and governed by the TIP Guideline (2013).

FPS conceives the female subject as a fluid subject, one that is in continuous motion. The female subject exists in shifting contexts. Social identities and material constraints and opportunities occur within these contexts. However, the *TIP Guide* (2013) shapes the female traumatized subject as a fixed object in one moment of time, most often as a de-gendered non-racialized subject, except in the inclusion of the Indigenous traumatized subject (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 15). The FPS subject position of a plural subject, including identity intersections such as class, race, ethnicity, sexuality, gender identity, ability, and culture, is infrequently mentioned in the *TIP Guide*. When gendered, racialized, or sexually diverse subjects are mentioned, they appear as a list of possibilities of distinct individuals brought to the health care practitioners' attention (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4; p. 14; p. 23). The premises of the *TIP Guide* (2013)

can be summarized as follows; the traumatized female subject is a fixed static subject, a stable identity not to be understood as a "shifting conglomeration of physical, psychical, emotional, and intellectual characteristics" (Cahill, 2001, p. 107). This static representation allows the *TIP Guide* to maintain the female traumatized subject as helpless and broken, opening the opportunity for the *TIP Guide* to function as a disciplinary practice for the expert health care practitioners. This disciplinary practice supports medical knowledge formations and power relations in the field of practice. The traumatized victim characterized as a vulnerable subject serves to support the characterization of the health care practitioner as a knowledgeable expert. In this scenario, it is hard to imagine the evocation of an agentic subject as defined by FPS.

In contrast to the agentic, knowing subject constituted by feminist post structuralism, the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) constitutes the female traumatized subject as a comparatively helpless, largely non-autonomous subject, one in need of an expert to assist in her healing. This characterization portrays the subject as the problem, one who needs help and healing (Bacchi, 2009, p. 80). She is a broken subject who requires reparation (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 14), a traumatized subject with a broken brain. As the *TIP Guide* notes, the dysregulation of the brain and body systems created by the trauma experience “perpetuates mental, emotional and physical distress” (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 7).

The TIP Guide (2013) desires empowerment, self-care and choice (autonomy); however, "individuals chart their own course" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 29). The problem of the traumatized female

subject lies with the expert who exerts legitimized institutional social control onto the traumatized subject. The female traumatized subject is shaped as helpless, powerless, and unknowing, contrary to advancing individual autonomy or empowerment. Disciplinary practices enact medical social control; as Conrad (2007) notes, by "expanding medical jurisdictions, medicalization increases the amount of social control over human behaviour" (p. 8).

Disciplinary power targets individual bodies and uses surveillance and normalization techniques to produce legitimate subjects (Bacchi, 2009, p. 27). The power relations represented in the medical discourse within both documents are all-encompassing. References emphasize the relationship of trauma to substance use, physical health, and mental health concerns or, in other words, the entirety of a woman's life (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 7; SAMHSA, 2014, p. 5). In the area of my study, the female traumatized subject is also a subject who uses substances. The substance user is legitimized as a 'worthy, legitimate' subject in need of healing because the trauma she is experiencing explains her substance-using behaviour. This explanation serves to alleviate the stigma allotted to substance use in the medical field (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 28; SAMHSA, p. 13). Medical discourse, that positions trauma as a necessary precursor to substance use and mental illness, provides the expert practitioner with a theory. This theory explains the inflicted violence as a trauma reaction separate and distinct from the socio-cultural reality of violence against women.

Medical discourse in the *TIP Guide* (2013) characterizes substance use as a reaction to or resulting from trauma (BC Provincial Mental Health and Substance Use

Planning Council, 2013, p. 9). This predictive linear causal theory of substance-using excludes the feminist analysis of patriarchal oppression as a causal factor in violence and the resulting trauma. The 'root cause' argument supports medical interventions that target the traumatized subject as one who requires changing and shaping. Through this representation of the problem of trauma, a traumatized subject is characterized as a passive recipient of care, damaged, ill, and disempowered. She is characterized as having "difficulty trusting others and their intentions" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 25). She is out of control, as in the characterization that "they often seek help when in a state of crisis and extreme distress, they may have a bewildering array of symptoms or adaptations to their traumatic experiences which affect their ability to access, engage with, and benefit from mental health and substance use treatment" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36). The traumatized subject is maladaptive and has a permanent inability to cope or function in life (SAMHSA, 2014, p. 7).

The resulting material effects of this portrayal of the female traumatized subject are the medicalized responsibilization of the subject. The broken subject requires reparation; at the same time, however, the subject is expected to act on her behalf by taking up the practice of skill development (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp.40-41). This dividing practice creates a non-autonomous subject in charge of her healing. The normalizing practices section of this chapter explores further the topic of dividing practices.

The solution to the problem of trauma becomes the normalization of traumatized subjects' behaviour rather than the deconstruction of the mechanisms of power and

knowledge through the lens of gender-based violence. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) recommends that health care practitioners assist the traumatized subject in changing her approach to communication in her relationships, managing difficult emotions, and practicing self-control as she discloses the violence she has experienced (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). The instructions for health care practitioners include defining trauma-informed practice as a means of "working from a strength-based and empowerment approach that emphasizes establishing safety and building capacity for self-care and containment" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). Suppose the traumatized female subject is unable to enact or resists skill-building practices. In that case, she risks the label of non-compliant, untrusting (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 25), non-engaging (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36), or even dangerous client (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 13).

Resistance

The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) rarely notes the resistance of subjects to normalizing practices. In instances where resistance is apparent, it is described as a dangerous and challenging situation that the expert practitioner must manage. The Guide warns that the client's response and behaviours (resistance) take the form of verbal or physical aggression and intoxication that brings about unpredictable behaviour (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 13). If the female traumatized subject resists

the power relations within the context of health care service delivery, she may be a danger to others. The danger may take the form of physical violence and mental health effects on others charged with her care (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 13, p. 19, p. 20, p. 42, p. 52).

Dangerous clients produce traumatized staff members. The *TIP Guide* takes care to instruct practitioners who "may also need to strengthen their own safety, grounding, and self care skills as they support the empowerment of others" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). The intoxicated subject is out of control and unsafe (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 26). Staff members are characterized as fragile and unable to cope with erratic behaviour until experts have educated them in trauma informed practice. A warning is given to practitioners related to the subjects' traumatic response, "if there is no imminent danger, take a moment to observe one's own bodily and emotional response until settled with a sense of relative calm" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40). What is left unsaid is the implication that there is an imminent danger when meeting a traumatized subject. The *TIP Guide* highlights the contagion effect of trauma (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 20). Some authors have explored the contagion effect among patients (Moss & Prince, 2014, pp.7-8, pp. 34-56), however an analysis of the contagion effect of patients' trauma symptoms on caregivers is more challenging to locate in the literature (Reynolds, 2019). The discourse attached to the TIP Guide's traumatized subject claims that the traumatized subject may be so ill that being in contact with her infects staff

members. The common term for this trauma transfer effect is vicarious trauma (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40).

The discourse determines that working with the traumatized female subject is dangerous and constitutes staff subjects as burned out, unable to withstand their role as a knowledge expert and vicariously traumatized by clients' trauma. Trauma parlays to staff through interactions with clients (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 20). In effect, trauma is contagious. The traumatized female subject is shaped as someone who can damage staff if she resists normalizing practices; she becomes the source of an infection because she can infect staff with her trauma, causing vicarious trauma. In this viral scenario, the female traumatized subject is fundamentally different from the staff or the professional expert. The female traumatized subject is diseased. She is the 'other' (Bacchi, 2009, p. 91).

The other: the mentally ill and substance-using

The traumatized subject is constituted as the 'other' through the implication that only certain women are traumatized, those who are mentally ill and use substances. The expert practitioner knowledge holder is unlike this woman. The expert must keep her distance physically and emotionally, keep her boundaries intact for fear of being contaminated with trauma, and becoming one of the 'othered' (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 52). The problem representation becomes a dangerous female traumatized subject, and the solution is self-protection for staff. Stay clear of the damaged, ill subject because they can infect those in contact with her with trauma. You may then become one of these others, disempowered, damaged, and mentally ill. The discursive construction of the dynamic of the interaction of

traumatized subjects and constituted health care practitioners produces a dividing practice. This practice dictates to the practitioner: stay away for your safety and practice in a trauma informed way; collaborate; give choices, and empower the dangerous traumatized female subject.

The othering of the female traumatized subject is reminiscent of the stigma carried by sexual assault survivors and Indigenous colonized subjects, as discussed in Chapter Three. Beliefs grounded in racism, colonialism and built on patriarchal stereotypes and representations of women maintain that only certain women are – or can be - violated and traumatized. Clear messages and instructions are provided to the health care practitioner to assist the female traumatized subject to calm down, "what have you found helpful to calm down and get focused when you're feeling anxious?" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 28). The coping skills taught in the *TIP Guide* constitute a manual for normalizing practices (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 28). These practices produce a message of silence to the traumatized subject.

Normalizing practice

All clients are presumed to be trauma survivors. The prescriptive disciplinary practice (trauma informed practice) is applied, therefore, to all clients as they enter the system of care (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 54). Bacchi (2009) defines a population's treatment as a singular organic body as normalizing practice (p. 27). Authoritative knowledges in disciplines such as medicine delineate how subjects ought to be through the production of norms (Bacchi & Goodwin, 2016, p. 51). The norm established by the *TIP Guide* (BC Provincial Mental Health and

Substance Use Planning Council, 2013) is that the traumatized subject is maladaptive, perhaps dangerous, and requires a specialized medical setting to address her ills. According to the *TIP Guide* ((BC Provincial Mental Health and Substance Use Planning Council, 2013), trauma informed practice could "help individuals link their current difficulties to the self-protective coping responses used to adapt to overwhelming life experiences" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36). The problem is represented as the traumatized subject's maladaptive responses to violent experiences, even while recognizing that these life experiences are overwhelming (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36; SAMHSA, 2014, p. 5).

Discourse in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013), grounded in the governing concepts of self-determination and self-management, produces the normalized subject as a healthy coping autonomous subject. The traumatized subject is created as a problem in the Guide and is set apart from other normal subjects (Bacchi, 2009, p. 276). This traumatized subject is shaped as different from the normal subject through the following language tricks: strengthen resiliency, meaning normalized subjects are resilient (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 40); exercise choice and control, meaning normalized subjects regularly exercise choice and control to manifest healthy outcomes, (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36); and create meaning and develop new narratives, meaning providing a new explanation for the violence with a disregard for feminist patriarchal analysis in resolving the violence (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36). The

disregard of a feminist patriarchal analysis reveals an individual responsibilization effect in the policy that denies the structural socio-political context of male violence against women.

A normalizing tension exists between the *TIP Guide's* (BC Provincial Mental Health and Substance Use Planning Council, 2013) normalized subject and the traumatized subject. This tension opens space to contest the creation of the traumatized subject in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013). The construction of the opposition between the responsible, autonomous coping traumatized subject and the irresponsible maladaptive non-autonomous subject creates a dramatized version of failure that marks the female traumatized subject as 'other,' as, in the words of Bacchi & Goodwin (2016), "deficient in some way" (p. 51). Practices to repair the damaged subject emerge from the normalization of the traumatized subject. The expert practitioner legitimizes the traumatized female subject *if* she accepts the treatment as prescribed and adopts new personal change strategies. The subject is illegitimate *if* she resists the notion that she needs to change and insists that systems need to change. The lived effects for women, who resist treatment by discounting the knowledge of health care practitioners or by violating the legitimized institution's policies, are discharged from the treatment facility. If they cannot comply and learn new coping skills, communicate properly and be consistent as a legitimate compliant traumatized subject, they are othered. In extreme circumstances, they are judged and rejected from the service (personal experience).

The dividing practice of autonomy making

"Dividing practices are dynamic practices of differentiation and subordination, which prove to be vital governing mechanisms," according to Bacchi & Goodwin (2016, p. 51). The *TIP Guide* sets a goal of autonomy as a preferred state for the traumatized subject (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 33). The divided practice of autonomy-making insists that individuals become independent of medical professionals and responsible for their well-being (individual responsibilization). The trauma informed practice goal is to minimize vicarious trauma and support the practitioner's self-care while empowering, through expert knowledge, the traumatized female subject to act on her behalf (achieve autonomy) in overcoming the individual pathology of trauma. The medical expert prescribes a legitimate traumatized subject's appropriate responses, thereby shaping the traumatized subject and her responses. Within the context of power relations in the medical field of practice, the medical expert produces the provisional subject as a dependent subject. The female traumatized subject needs behavioural and character changes to live a life worth living (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 23).

The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) continues to evoke expert knowledge in its production of the traumatized subject's autonomy. The subject is constituted as non-autonomous and requiring the expert by the statement, "individuals actively participate and chart their own course of action. Guided by the practitioner's knowledge and experience" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 29). One of the TIP principles emphasizes collaboration between the client and the practitioner (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36). The practitioner shares their

expertise to empower the traumatized subject. Interactions with the expert empower individual clients.

The expert delivers autonomy in the form of medical knowledge formation bestowed upon the traumatized subject within the context of the "helping relationship". The delivery of autonomy onto the subject constitutes the subject as non-autonomous and only able to act 'as if' they are autonomous within the relationship with the medical expert. This discursive representation of the object of autonomy sets limits on what can be thought and said. In this instance, what can be thought and said is shaped by the expert practitioner inside of a mangle of power relations of the health care system (see Chapter Three).

TIP: an overarching solution

TIP is considered a solution to many ills. The *TIP Guide* claims that trauma-informed care principles address the effects of violence against women and substance use and mental health concerns (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4). TIP can "help the individual exercise choice and control and can provide significant relief from suffering, instill hope, create meaning, and help develop new narratives" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 36). The focus continues to be on the identified individual pathology of trauma, even though, as demonstrated in Chapter Three, violence inflicted on women is the problem that needs to be addressed. TIP principles focused on this individualized pathology ensure that patriarchal societal structures, left uncontested, continue to enact violence against women.

The *TIP Guide* recognizes different forms of violence (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 6) and explicitly names domestic violence. However, the discourse in both the *TIP Guide* and the SAMHSA *Concept of Trauma* (2014) document continues to be one of individual change and responsibilization rather than a proposal to set a social justice agenda for violence against women as suggested by Morrow and others. The embedded instruction is to change the violated person, not the patriarchal societal structure that enables violence. Reconstituting violence as trauma means we respond to 'trauma,' but we do nothing about violence. In conclusion, there is a political problem about patriarchy, which the policies refuse to name and therefore do not address. The naming of patriarchy as a political practice would recapture the feminist agenda and encourage a focus on the governing structures and power relations located in health care practices such as trauma informed practice.

Lived effects

In Chapter Three, I brought attention to the importance of policies' material effects from a feminist post structural perspective. Violence experienced by women has a critical impact on their lives. Exposing the discursive practices related to gendered violence in policy statements exposes what is made sayable and thinkable (Bacchi & Goodwin, 2016, p. 37). Discursive and subjectification effects are translated into the traumatized female subject's everyday lives, producing lived effects. The problem representation of the traumatized subject as maladaptive and unable to cope opens the possibility for the female traumatized subject to become hopeless, the inevitable consequence of being violated (Bacchi & Goodwin, 2016, p. 70). The normalization of

the maladaptive subject impacts women's long-term view of her life and the ways to take up self-management.

The *TIP Guide* (2013) intends to "increase capacity amongst MHSU practitioners and organizations to better serve people impacted by violence and trauma and thereby improve outcomes for clients of MHSU services in BC" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4). The goal is to "enact trauma informed practice" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 4) in individual interventions, organizations, and across systems. The material effects of trauma informed practice on individual women's lives are not mentioned. Instead, the focus is on the "use of language to de-stigmatize and normalize the individual's responses and reframe from a strength-based perspective" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 21). What are the lived effects for the traumatized female subject when she is conducted through trauma informed practice?

Trauma is a fixed object in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013). Trauma is also represented as an object that lives in the body and mind and results in underlying emotional, physical, and mental health distress (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 7). The medical discourse explains trauma as a scar, a wound that the female traumatized subject continues to struggle with throughout her life as the unknowing, unhealed, traumatized subject. The subject returns to the community and family post-treatment, with no or little acknowledgement of the threat of violence that may continue in her environment because, after all, trauma is an intrapsychic individual problem. The *TIP Guide's* newly formed narrative focuses on achieving self-actualization, which

becomes a present and real danger to individual women without the concomitant eradication of male violence.

The newly shaped traumatized subject believes that personal change translates to situational change. Societal patriarchal structures remain in place. In the absence of a socio-political analysis and a social justice response, access to resources to achieve health equity remains elusive. The pressure of chaotic, abusive relationships, poverty, lack of housing and discrimination remains.

The traumatized female subject may resist, challenging the abusive partner who may present a danger to her physically and emotionally, or she may seek chemical relief and relent, reaching for substances. Increasingly, she feels discouraged as the root causes of the violence continue. She may blame herself for not applying her newly acquired coping skills. She may recall her newly acquired knowledge of 'her broken brain,' which increases her feelings of powerlessness and helplessness. The autonomy she once believed was hers becomes an illusion. What she once thought would make a difference in her material life slips away like the presence of an expert who anointed her with autonomy. The lived effect is that the woman feels less capable, less knowledgeable, and in less control, blaming herself for the condition in which she lives. The feminist agenda of social change dampens as each woman succumbs to the myth that personal change without social justice action can impact patriarchal oppression's societal structures. The traumatized female subject becomes a relapse statistic.

Summary

The organization needs fixing

The *TIP Guide* is a guide to conduct the conduct of health care practitioners and organizations (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 47). The organization is required to have written guidelines to "provide services that are sensitive to the impact of trauma" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 47). This presupposition implies that the organization is insensitive. The *TIP Guide* demands a culture shift by applying trauma informed practices (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 24). TIP's evocation as a practice presumes to change a culture by conducting the conduct of the health care practitioner and presupposes that the organization does not meet the needs of the clients it is designed to serve (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 47). The problem representation of a non-responsive organization not attuned to client needs opens space to acknowledge the health care practitioners' incapacity for working with traumatized clients.

The traumatized subject is constituted as a complex problem that requires a specialized approach within these health care services (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 12; SAMHSA, 2014, p. 2). Leaders are constituted as not being able to lead, and staff are constituted as not understanding the clients' experience. Organizations are assumed to be unsafe and a dangerous place for clients that do not trust the system of care (BC Provincial Mental Health and Substance Use Planning Council, 2013, pp. 25-26). As an example, instructions guide the health care practitioner to debrief the client after a physical restraint. The debrief's intent is to

promote healing, recovery, and learning and re-establish the therapeutic relationship (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 3). The disciplinary practice is akin to the abuser debriefing the victim. With no sense of the power relations present in this interaction, the 'debrief' practice ensures the subject is governed into being a worthy legitimate trauma survivor whose conduct is conducted into compliance as the best way to ensure safety for the health care practitioners. Women faced with violence in intimate relationships are familiar with this compliance strategy because they know from their previous experience if they comply, violence does not occur (see Chapter Three). The feminist argument that brings to the forefront violence as a patriarchal problem, not a problem of women's behaviour before or after the assault, contradicts this tactic of imposing women's compliance after a physical restraint.

The health care practitioner is also constituted within the *TIP Guide* (2013). The *Guide* advises them to be calm and debrief with a peer or supervisor after an "event" with a client (BC Provincial Mental Health and Substance Use Planning Council, 2013, p.41). Specific claims are made, such as "the practitioner recognizes that an individual's reactions are not necessarily personal or about the practitioner's skills" (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 25). Calmness and emotional regulation are valued; outrage at the injustice of the violence is not recognized nor tolerated. The things we as a system, left unchallenged, have done to women who have experienced violence, including narrating violence as trauma, minimizes the patriarchal power structures that feed the phenomenon of violence against women.

In the following chapter, I utilize Bacchi & Bonham's post interview assessment guidelines in Bacchi & Goodwin (2016) to explore the direct care staff and the leaders'

first-person experience working with the *TIP Guide* (2013). I explore the discursive strategies that support TIP as an institutional truth claim, discourses that produce subjects, objects and places as legitimate and discourses that function to "install certain norms and subject positions" (Bacchi & Bonham, 2016, pp. 115-120).

Chapter Seven: Post Structural Interviews

In this chapter I analyze six interviews of Leaders and Direct Care staff who work under the guidance of the *TIP Guide* ((BC Provincial Mental Health and Substance Use Planning Council, 2013). The post structural interview analysis begins with the "initial premise that all knowledge practices are inherently political" (Bacchi & Goodwin, 2016. p.114). "The purpose of the approach is to highlight the contingency and politics involved in shaping the kind of person it is possible to become, hence to increase opportunities for contestation" of that concept or subject position (Bacchi & Goodwin, 2016, p. 120). The analysis of the interview text, in the context of trauma informed practice, politicizes personhood and, in doing so, contests the traumatized subject position.

The goal of the analysis is to politicize personhood by directing attention to the "heterogeneous strategic relations and practices involved in making what appears to be self-evident traits and dispositions possible" (Bacchi & Goodwin, 2016, p. 120). For example, in the *TIP Guide*, and as reflected in the interviews, normative implications are formularized of the maladaptive, mentally ill, aggressive traumatized subject who needs to be taught healthy coping skills to be a productive and safe member of society. The analysis highlights that reality is made in and through discursive practices and "that given the plurality and mutability of those practices, it can be unmade" (Bacchi & Goodwin, 2016, p. 121).

Analysis of the interview texts revealed several common discursive effects in the form of overarching themes of commonly held practices and beliefs:

- Enabling TIP as a legitimate knowledge (taken as true) in health care

- Enabling the medical model and scientific discourse;
- Creating trauma as an object producing a generic traumatized subject
- Production of a specific traumatized subject as complex, hard to manage and aggressive;
- Enabling the contagion effect of trauma supporting the production of the fragile staff subject; and
- Positioning the traumatized subject as the 'other' in juxtaposition to the fragile staff subject position.

I also explored the making of the adapted identity of the compassionate health care practitioner. The remainder of the chapter is dedicated to the exploration of these key discourse strategies highlighting participants' discourse that supports these strategies.

Key Discursive Effect: Enabling TIP as a legitimate knowledge (taken as true) in health care

In the previous chapter, I established that the *TIP Guide* is a common knowledge that has achieved institutional legitimacy in health care. The study participants supported this legitimized knowledge by referring to the *TIP Guide* as the document that guided their TIP. As one participant described,

> DC1: This [*TIP Guide*] is something that is important, and we need to make sure that we are consistent with it. Yes, I'm not exactly sure how she [the manager] got it, or what her directive was, but at least, how it was explained to me is, this guide came out, we need to really make sure that we, sort of--we are on top of this, and that our service is consistent with this.

The same participant added,

> DC1: The fact that there is a trauma-informed practice guide is like; this is really important; you need to do this. Yes, for sure. That is wonderful. Would we not be doing that, without the trauma-informed practice guide? I don't think so.

A leader confirmed this directive from the Ministry:

> L2: We need to provide education for all staff, [and we also] as a mandate from the Ministry, so this is how the conversation started.

The common knowledge of, and authority given to, the *TIP Guide* and the resulting practice was noted in each of the interviews with both direct care staff and leaders. The origin of the *TIP Guide* was noted to be the "Ministry" or "the government", a funding resource for the organization, thus ascribing a heightened importance to the *TIP Guide* as an instructional tool for the organization.

A leader spoke of TIP education for staff; she stated,

> L2: Actually I did it five times, all the new staff I educated, so I'm good [I have fulfilled expectations] as a leader because I can show you or the Ministry that I've done this.

indicating not only that the Guide is an assumed directive from the Ministry, but also that there is an accountability to the Ministry for this knowledge formation to be distributed to staff. Another leader confirmed that the Ministry had evoked accountabilities or direction around TIP in the past,

> L3: The Ministry of Health produced a trauma-informed practice guide. I think now about 5 years ago, and that guide was intended to, I think, lead the Health Authorities, and lead the healthcare system in embracing and implementing

> trauma-informed practice, but I don't hear anything about it from the Ministry now. I don't, like, there's no talk about trauma-informed practice in my interactions, so I feel a little bit like, it was one of the things that happened, but it has really been up to us to carry that forward as something we feel is important. I don't feel the Ministry is saying to me, 'You need to be trauma-informed.

This leader felt the direction to adopt TIP had faded in recent years; however, five participants noted TIP as a current directive and/or a strong accountability expected from the Ministry.

The dissemination of TIP as true and legitimate confirms the particular social arrangements involving politics "to mean the active shaping or making of the taken for granted" (Bacchi & Goodwin, 2016, p. 4). Recognition of TIP as a taken for granted truth claim opens "the complex and contradictory effects apparently benign policies may have" (Bacchi & Goodwin, 2016, p. 5). In their attempt to construct norms or ideal worlds based in social justice, these policies disguise the concrete functioning of power evident in the persistent application of a hierarchical medical model.

The indication that "the Ministry" continues to steer organizations in the direction of TIP is confirmed when two leaders connect TIP to resource allocations:

> L1: Putting the trauma-informed lens on that has been really helpful, and it has been really helpful in getting the resources needed to support those staff, having that guide because our organization puts so much weight on trauma-informed practice and that guide, it says it there in the guide, basically, you know, it's like, well here it is. This is what we need to do. And, so people find it really difficult t hen, to argue that we don't put the resources in place to support them.

L2: Yes, more funding [for programs]. Because we will begin to see the difference in the impact, especially as we work towards a new generation now because [of] the workforce, I mean the Millennials, right?

The interconnected idea of resources flowing from TIP contributes to the institutional legitimacy of this practice. Recalling from Chapter Six that institutional legitimacy lends itself to say things within an organization that are taken as true and form knowledge within a field of practice, it follows that TIP has become a legitimate knowledge formation in this organization. This legitimacy promotes a cyclical pattern of knowledge formation in the promotion of key discourses within TIP and the *TIP Guide*. Evidence based practices evolve from these discourses and are confirmed in future research projects. As one leader noted when bringing the *TIP Guide* to the staff,

L1: I talked to them about it, and it really made sense to them at once; and that's what I mean - that's the benefit it has given us - is it has given us something that I can take to them. It's got real evidence: this is the percentage of people that have trauma, this is how trauma impacts people, you know, this is how we can reduce the impact of trauma on people, and, you know, help people heal, [and] create a healing environment - this is how we prevent people from being re-traumatized.

A direct care staff confirmed the impact on her practice and other staff practices,

DC3: Oh, now I know why I am doing this, and here is the evidence behind this, and things like that and so, for staff, (I think) I think that it gives us a little bit more evidence in order to implement things.

The trend continues to impact the advancement of TIP discourse through the field of healthcare. As one leader participant stated,

> L3: I think there's more reading required, more exposure to implementation [and], research, you know, some of the things that we've done, are to look, (take a look) at the research in how trauma-informed practice is actually translated and used in different types of environments, like our environments, talking to others who've actually implemented it, and what they've done, [we need] self-reflection, education, I don't think the guidelines are enough.

A second leader supported TIP as an evidence-based practice:

> L1: Well, I'm assuming that they [the Ministry] anticipate better client outcomes from trauma-informed services. And I know there is some evidence that is emerging now that that is the case.

As Lancaster et al. (2017) point out, evidence-based discourse "privileges the much critiqued notion of 'objective' scientific knowledge" (p. 61). "The privileging of particular methods in the hierarchy of evidence espoused within **'**evidence-based**'** policy and practice produces tensions about the relative value of other ways of knowing" (Lancaster et al., p. 61). The evidence privileged in health care is medical knowledge carried by the experts, most often physicians and secondarily nurses.

Evidence based policy is a problematizing activity whereby governing of subjects takes place through certain problem representations (Bacchi & Goodwin, 2016, p. 10). Evidence based policies reflect the political rationality of the field of practice, medicine, (Bacchi & Goodwin, 2016, p. 43) and far from being a neutral concept, evidence based policy based in scientific evidence is " a powerful metaphor in shaping what forms of

knowledge are considered closest to the 'truth' in decision-making processes" (Lancaster et al., 2017, p. 61).

Within TIP discourse, underlying political rationalities of the medical model are reflected in the interviews as an important aspect of the TIP practices. These include individual responsibilization of the traumatized subject, the focus on individual pathology rather than socio-cultural factors including social determinants of health, lack of identity of diversity and a gender-neutral approach. These are all facets of governing subjects based in the medical model.

Key discourse strategy: enabling the medical model and scientific discourse

The knowledge formation known as TIP, an institutionally supported practice and discourse, continues to shape medical technologies and practices found in the TIP Guide. The practices are legitimized and therefore 'protected' under a veil of evidence within a seemingly benign policy framework. This notion of evidence-based practice is accepted by the health care organization and contributes to the growth of practices consistent with the medical model and discourses representing clients as particular traumatized subjects. The goal of equity and justice is elusive in the power relations that predominate the medical model. Many participants allude to this power dynamic.

. Allegiance to this knowledge establishes the health care provider's place in this hierarchy, carrying with it a certain prestige and privilege. Adherence to evidence based policies secures the rationalities of the medical model in practice, creating a recursive pattern of recruitment into this way of thinking and the enactment of governing practices which, in turn, continue the growth of the medical model as the knowledge of choice protected in evidence based policies.

Throughout the interviews, participants evoked norms reminiscent of the medical model. As a dominant knowledge, medicine shows up in practices described as skill building interventions in the TIP Guide (BC Provincial Mental Health and Substance Use Planning Council, 2013, p.18). These practices call for individual medical interventions such as psychotherapy and skill teaching and focus on the re-adaptation of an individual's behaviours and emotional regulation, rather than collective or social solutions (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 11; Conrad, 2007, p. 7). Statements by participants regarding healing and interventions are consistent with an individual responsibilization commonly underlying the medical model that does not consider structural causes of distress in individuals' lives.

One direct care staff comments that by teaching appropriate skills to clients they become healthy or normalized thereby inferring that the traumatized subject needs to take up the skills to be healthy.

> DC3: Our role, especially in a place where we are helping people rehabilitate with substance use, is to teach appropriate ways to have their needs met, healthy ways to cope with stressors, and healthy ways to have your needs met.

The participant goes on to comment that the individual client becomes adaptive if they take up teachings of TIP:

> DC3: So, intentional impact on client is they feel more safe, and they are able to effectively, and in a healthy way, and in an adaptive way, rather than a maladaptive way, have their needs met.

This participant points to the effect of taking on responsibility for individual actions regardless of the context of the struggle:

DC2: I see that vulnerability, I see that struggle, you know, like, even just like, I'll have someone stop by my office, "Hey, I'm having a hard moment. I'm having a hard day". It's like, "Oh, let's chat through that for just a minute". And, they go out, and they are better at what they are doing.

The trauma is identified as a learning barrier for the individual emphasizing the individualized problem of trauma is centred in the subjects' body—this embodied trauma requires a solution focused on individual responsibility for change.

DC2: You know, the potential of how trauma can create a learning barrier, and can this, you know, intervention can it help people settle their nervous systems, settle their increase sense of safety, choice, efficacy, creating their own stories. My hope is that it is helping the learning; it's helping to, kind of, open the doors to learning.

Another participant clearly identified this individual reponsibilization:

DC3: I think it's meant to address, and help with, the symptoms of active trauma, which, I mean like, people who experience trauma often have issues, like, (you know), emotional dysregulation, and things like that, and I think it's meant to, (kind of) empower people to be able, to (kind of move) past this trauma, and be able to interact appropriately.

A divided discursive practice began to take shape within this discourse. Such dividing practices "function to separate groups of people from one another and which can also produce governable subjects divided within themselves" (Bacchi & Goodwin, 2016, p. 23). On one hand, scientific knowledge of the neurobiology of the brain was evoked to support and justify practice interventions nested in the TIP discourse. This discourse

supports offering therapeutic services to clients based in scientific evidence. The subject produced in this case is the ill traumatized subject requiring healing. On the other, the medical model was considered to be interfering in the therapeutic relationship through inequality, a symbolic material division (Bacchi & Goodwin, 2016, p. 23) reliant on power imbalances between the health care practitioner and the traumatized subject within the hierarchical structures of the health care system. Direct Care staff and Leaders expressed their struggle with the provision of equitable care within the context of the medical model revealing their experience of a divided self. This divided self shows up again when the fragile staff subject is produced in a juxtaposed position to the aggressive traumatized subject. The ethical dilemma created in this phenomenon is discussed later in this chapter in the adapted identity of the compassionate health care practitioner.

Questions arose about the medical model and the potential of providing equitable care in a hierarchal model based in power relations of the knowing expert medical practitioner and the unknowing traumatized subject. Questioning of the practice and interventions "aims to reduce the deleterious consequences for the traumatized subject" (Bacchi & Goodwin, 2016, p. 23).

One leader questioned the ethics of the medical model as it relates to compassionate care and the heart of health care:

> L1: It used to be a vocation, like you know, like there was heart in it, there was heart and there was soul in healthcare, and there was a lot of emphasis put on the importance of the heart and soul of healthcare, and I think we moved away from it, and we became like scientists.

The same leader questions the shift in health care from a compassionate care approach to a scientifically grounded practice or what she calls nursing nursing. The implication is that the shift to scientificity creates deleterious consequences for the traumatized subject.

> L1: Mental health nursing is very grounded in science, and not so much in the arts. And, yeah, it is, I call it nursing nursing. Yes, it is nursing nursing. Oh, I'll give you a Band-Aid for that, (or I'll let you, you know,). I'll tend to your wound care, if you need medication I am here for you, but not the like, proactively going out, sitting with clients, being with clients, working, you know, alongside clients and really building their therapeutic relationships.

One direct care staff nested the idea of the medical model and the source of individualized responsibilization.

> DC1: I think the problem can be say, more the medical model, or sort of, a bit more psychopathological model, of you know, this is a diagnosis, and this is a personality manifestation. And then it really puts, sort of, everything that's challenging and wrong sits with the person, and not the environment, right? Because it's the diagnosis, it's the PTSD, it's the OCD, it's the substance use, that, sort of, sits in one person, rather than the environment.

The idea of the medical model nested with individual reponsibilization is enhanced when power relations inherent in the medical model come into play. A leader spoke to the power imbued medical model.

> L3: And if we're in an environment that's a little more hierarchical, I think it's harder. And, it's, some of it relates to medical hierarchy, and how much that

dominates what happens, and how that plays out. Some of that has to do with administrative hierarchy, and how that looks in different parts of our organization. And, some of it it's just, I think, people's value systems and their style, and what they bring as leaders, and whether or not they are willing to be challenged or make changes. It's hard work, and it's different, I think than, perhaps, many of us have been trained as leaders.

However, direct care staff supports the medical model with discourse evoking the embodiment of trauma; whereby the whole self becomes entangled in the scientific language. For example, here the participant lists the effects of trauma as she sees them and adjusts her expectations of herself and others, thereby co-constituting herself and others.

DC2: And, you know, so coming into a situation where, the clients we are working with have had so many barriers to full health, and, you know, have had diagnoses that go with that you know, chronic substance use, sometimes organic brain injury, sometimes cognitive deficits, like, so I really had to, kind of, rework my sense of like, what is my role, and drop some of those, I almost want to say, like virtual expectations of what everybody wants in life, right?

Another direct care staff nests the medical model knowledge formation in the form of diagnoses with the traumatized subject's behaviour and needs. This direct care staff utilizes the medical knowledge to support the position of the traumatized subject as incompetent and unknowing and as a result situates herself as an expert health care practitioner.

> DC3: There are people who maybe, typically have a diagnosis of like, Borderline Personality Disorder, which is like, some people find very challenging. I myself, find very challenging. And I know that sometimes when I am feeling very challenged, I say, like this person has experienced something in their life that has kind of taught them that this behaviour is the behaviour that helps them get their needs met. And so, I have to try and figure out what the need actually is, because they may not be, kind of, expressing that completely, or fully. And, trying to figure out what that is, and maybe try and talk about alternative ways to have that same need met.

This direct care staff extends the reach of the expert knowledge holder with an explanation of the thinking behind normalizing practices within the medical model.

> DC3: And yes, their actions may be a result of the trauma that they have experienced, and it may be a learned behaviour based on how they had their needs met in the past, but it doesn't mean its appropriate behaviour, and it doesn't and, our role is, kind of, to help people. I think a lot of people forget when we are doing trauma- informed, our role, especially in a place where we are helping people rehabilitate with substance use, is to teach appropriate ways to have their needs met, healthy ways to cope with stressors, and healthy ways to have your needs met. These people, quite often people who are involved, and people who have addictions, and suffer from those and concurrent disorders, have spent a long time getting their needs met in very inappropriate and unsafe ways. And I think we forget to hold them accountable to do these things safely, and it sometimes

results in like, trauma, for like, a whole kind of unit, as opposed to trying to save that one person..

The dividing practice which produces governable subjects divided within themselves appears when participants speak to the importance of scientific knowledge in their practice while at the same time criticizing the medical model for its power and hierarchal relationships. The scientific knowledge nested within TIP discourse is evoked readily to rationalize and explain the TIP approach to providing services to the traumatized subject. This Leader evokes the science of TIP to support her TIP practices when earlier she had called for a compassionate approach.

L1: The other thing about trauma-informed practice, that it goes beyond just being compassionate, is that whole stuff, that is, you know, the science background to it. So, you know, it's not just that people have had trauma in the past, and they are angry about it, there is actual physiological, you know, changes in the brain that will influence the way that a client can learn new information, can process new information, can manage certain levels of stress, and that it takes a period of time of healing, actual physical healing of the brain to be able to overcome trauma.

The dividing practice produces a governable subject who struggles with TIP as a science and also justifies TIP as a science, which embodies the trauma experience. This divided practice produces a governable staff subject and a traumatized subject position.

A direct care staff applies the science to her practice, and nests the idea of the science with compassion in order to reduce the dynamic tension of the divided practice.

DC2: My personal framework or belief in the world, is that I believe that every human has,within them, the ability to heal, given the right circumstances, and so it

> makes me feel really, kind of more passionate that, you know, when I sit with someone, and when they have a moment, I am regulating their nervous system, like, that's the right environment, like that's giving them the right tools to create that environment, so that they can, you know [among] other things can flourish within them[selves].

This staff links science, her practice and the traumatized subject. She nests the travelling idea of TIP in a summary statement that identifies the problem of the poorly behaved and resistant traumatized subject and the need for a solution. TIP is noted as an EPB and a solution to rationalize the normalized practice nested within the medical model.

> DC3: I guess, you know, that we as a field, have gotten to a place where, in mainstream healthcare, we are saying, you know, that we need to approach difficult behaviours, or "resisting" clients in a different way. What we have done isn't working, and so let's find something new, and I guess this is, I'm actually not fully aware of like, theoretically of the history of trauma-informed practice, and where it comes from, but my best guess is we're just at a place where some research has been done.

Some participants highlighted concerns with the medical model approach by reframing the problematization of trauma. These moments of transformation may be interpreted as resistance to the medical model in the context of the complex landscape of power including the mangle of truth claims of TIP, the traumatized subject and the compassionate staff subject. The visible material effects of the recursive power relations in the field of health care brings to light a dynamic tension between the heath care

practitioner and the medical model in the health care system. As one leader described this phenomenon,

> L3: I think that the problem is that we are as a system; we don't put patients first and at the center. We don't think about their lives and where they come from, and how that informs who they are and what they bring into our healthcare environments. And, we have a tradition of being interventionist and hierarchical, and medically oriented, and that tradition doesn't serve the patient or client well.

The interviews did not afford the opportunity to explore the explicit meaning of the roots of medical knowledge nor the historical structural knowledge formation related to trauma informed care. The post structural interview analysis unveils what is becoming, which type of subject is produced in the interview and what objects are created.

Key discourse strategy: creating trauma as an object producing a generic traumatized subject

Trauma as an object produced by practices is evoked by all of the participants. As noted in the previous chapter, the *TIP Guide* (BC Provincial Mental Health and Substance use planning Council, 2013) characterizes trauma as an individual ill, thus supporting the idea that trauma is a medical disorder with specific symptoms attached to it and one that can be treated through medical interventions such as psychotherapy. Trauma as a universal object is promoted in the *TIP Guide*. This universal portrayal of trauma reflects the trauma ethos, a set of ethics, principles, and beliefs about violence against women, and the accepted treatment modalities for the problematized effects of this violence. Of note is the gender-neutral language utilized in producing the traumatized subject. The mangle of realities of intersectionality and diverse identities are invisible in

the interviews. Therefore, identity politics are depoliticized (Bacchi & Goodwin, 2016; Crenshaw, 1991). One participant acknowledges,

> DC1: the trauma experience is universal, but that sometimes by saying it's universal, it's almost like you can minimize the experience of trauma.

Following are descriptions of the universal trauma experience and the generic traumatized subject, which disappears the female traumatized subject and renames violence as a generic trauma experience. The generic trauma experience is often linked to the generalized effects of trauma without the mention of violence.

The trauma ethos is pervasive in the production of the subject.

> DC1: We live in a world where trauma is really common, and we need to assume that everybody has lived through something difficult. And so, just, sort of, approaching things in that way when we have challenges, you know, with each other even when we don't even when we are in a good moment and it is just, sort of like for me, it is like, looking at, like, the vulnerability of being a human, and kind of keeping that a little bit more central in our perspective in our daily interactions. And I think that that makes us more connected.

One participant begins to connect the idea of the generic trauma experience, the trauma ethos and stigma or othering, defined as a dividing practice between one and the other; the health care practitioner and the traumatized subject.

> DC1: Trauma-informed care, and yes everyone has trauma, and that it can be minimized with, “Oh, well I have trauma too and I'm fine, therefore why can't they get it together?” Right? So, I think sometimes, by being so trauma-informed, and the ways we go about it, it can sometimes foster stigma.

The dividing practice of othering begins to shape the generic traumatized subject as being overwhelmed and unable to cope.

> DC3: Hey, I notice there are a lot of people who are having this, you know, emotional dysregulation problematic behaviour, risk-taking behaviour maybe, and the thing that I noticed about all of it is that they have had some sort of traumatic experience that really is pervasive to them, and if we do this, this may help, and it does help, with these, you know, symptoms.

The universal experience of the traumatized subject produces a life of suffering

> DC2: It is not a mistake that, you know, when people have been through that kind of trauma in their developmental years, then it sets a trajectory for increased suffering.

The complex traumatized subject evokes the wicked problem of trauma.

> L3: So, I strongly believe that, you know, we, you know, we, more than anybody, should be delivering trauma-informed care because we have the most traumatized. Again, I don't want to create a hierarchy of trauma, but I believe our clients, by virtue of the complexity of their illnesses, and their experiences, and what's going on in their lives, they are very marginalized. They face multiple barriers. They are generally people who have had lots of trauma, and they require, and need, and deserve, the best care.

The object of trauma is created within the mangle of trauma discourse and installs certain norms in the delivery of services. Evoking trauma as an object legitimizes trauma informed practice. Trauma, as universal to every human experience, evokes practitioners and, in my case, subjects as compassionate healers. The evocation of the object of trauma

gives focus and perspective to the healer who may be working in the most difficult of environments. The healer is different, separate and healthier than the traumatized subject, a discourse that produces a divided practice. This divided practice evokes a healthy healer in contrast to the other, an unmanageable traumatized subject. Trauma as an object is characterized as arousing certain behaviours in the traumatized subject and condones a deflection of ideas towards trauma, and away from the violence that has occurred in individuals' lives.

Normalizing disciplinary practices

During the course of the interviews, I noticed participants' narratives about their practice. Some of the comments were clearly describing normalization practices such as patient seclusion and restraint. Other comments were related to practices such as managing the clients' behaviour, observing the clients' responses to others and their environment, and comments about how the staff members enacted TIP. The interviews provide insight into the health care practitioners' enactment of normalizing disciplinary practices. Foucault et al. (2007) identified three forms of normalizing disciplinary practices. The first is hierarchical observation—always looking from a distance to monitor the patient.

Hierarchical observation is supported in medical settings and one participant noted,

> DC 1: We need to provide good care for them [clients], and manage them, and do some environmental things, so we can help manage them, and keep them in treatment, and provide them the best care, right?

From a distance, any violent incident is analyzed through hierarchical observation.

DC3: If there was any sort of violent incident, or anything like that, that would be a discussion as well afterwards to see if there was a way that we could have, kind of approached that differently.

The second normalizing disciplinary practice is the binary operation of normalizing judgement. Normalizing judgement "works by means of both conformity (the standard that each of us must strive to meet) and individuation (the requirement of a set of interventions on particular individuals in order to get them to achieve the norm)" (May, 2006, p. 74).

The normalizing judgment is taken up by the team being on the same page and validating interventions used with the traumatized subject.

DC1: We also have these learning huddles, which is what is a challenging situation that keeps coming up on the unit? Sort of an education, but also kind of validation and normalization, and getting the whole team all on the same page. We have those interventions. What else has been going on?

Normalized judgments are developed throughout time and space as the team's culture develops and shifts. This judgment is not necessarily intentional nor endorsed by the organization, however, can develop as practices emerge and strengthen. Generally, health care practitioners, as expressed by a direct care staff, accept the establishment of a workplace culture.

DC2: The concrete interventions I have seen, but then I think there are less concrete just more point of view perspective framework, that has, sort of, settled into the overall culture of the workplace.

The workplace culture itself becomes a normalizing practice, a way of doing, being and knowing.

The third normalizing disciplinary practice is examination. Examination is a common disciplinary practice in mental health facilities when attention is paid to minute elements of a person's behaviour. Once the behaviour is identified and named specific practices are targeted at the behaviour, "seeking to maximize it through rewards, punishments or other types of motivations" (May, 2006, p. 74). Normalizing practices can be identified in the participant interviews. This includes the use of seclusion as a behaviour change technique.

> DC2: I think some of the discussions that we've had so far are around, you know, so for example, when there's code whites, or having someone go to seclusion, what if instead we had a sensory room, where people could, go and self-soothe and self-calm, instead of sensory interventions and that's more of a supportive t hing than a punitive thing or presented that way.

These normalization practices produce dense transfer points of power relations among the health care practitioners and the clients, in turn producing knowledge and meaning making which characterizes violence, trauma and the traumatized subject in specific ways as discussed later in this chapter.

Gender invisibility

Throughout the interviews the female traumatized subject, who is over-represented in the statistics of those who have experienced violence in their lives, remained invisible until I asked a specific question related to women. If there was no previous mention of women in the participants' responses, I then posed a prompting: Has

the implementation of the TIP guidelines made a difference to the women (and in their lives) who have received services within your organization? Please describe? After the question was asked, one participant continued to speak in gender-neutral terms such as people and client (DC1). For example she stated,

> DC1:I think trauma informed care gives a much better language that's much more person-centered.

. When probed further for a gender specific response she stated,

> DC1: I think is, especially for women, I don't think they fall through the cracks, because that's always a risk, that's always something that we worry about. I think trauma-informed care has really made people think. We really need to make sure that women get these trauma-specific services, so I think trauma is then, right at the forefront of people's mind of what, in care planning, Are we going to address the trauma? Are we going to address the trauma?" Let's make sure that they [women] get their trauma at least started to be addressed while in treatment. So, I think it also helps with the care planning, and the care that they receive while they are here.

The gender-neutral responses in my interviews confirmed my hypothesis that women and violence against them is invisible in TIP practices as overseen by the TIP Guide. The violent acts experienced by the non-gendered traumatized subject were not named. The politicization of personhood is absent in this context. The trauma is an individual ill to be healed rather than a violent act to be eradicated. This characterization of trauma and violence is supported by the normalization practices described by the participants and enacted within the context of the medical model. The mangle of realities

of the diversely identified traumatized subject are disenfranchised and depoliticized in the *TIP Guide* and the interviews. The patriarchal social structures that produce the violence remain unchallenged and the health care system continues to treat the non-gendered traumatized subject with the same interventions (technologies and practices) one at a time within the hierarchical medical discourse.

Key Discourse Strategy: Producing and making available a particular traumatized subject

A set of heterogeneous discourses (Foucault, 1980, pp.194-196) throughout the interviews produced a traumatized subject, one who is maladaptive, complex, aggressive and difficult to manage. Participants described an unknowing traumatized subject, one who is disconnected from the knowledge of healthy coping and in need of learning new appropriate coping mechanisms to improve their behaviour. The participants provided an explanation for the traumatized subjects' poor behaviour. The dividing practice, characterizing the traumatized subject as unknowing and one who is a survivor, and a hero, are explored in this section.

Common threads in the discourse produced the traumatized subject. These key discourse themes in the interviews include the maladaptive subject in need of teaching; the complex subject in need of managing; and the aggressive subject who vicariously traumatizes staff, making space to produce the fragile traumatized staff subject position.

One participant summarized a view of the traumatized subject when asked, "What is the problem that trauma informed practice is intended to solve?"

> DC1: I think if we ask what is the problem? to most people, most people would say it's this person, who has mental health, including substance use problems, and their behaviour, their aggressiveness, in particular, and aggressiveness towards

others, namely hospital staff, but aggressiveness also towards their self in terms of self-harm and suicide that we see.

In this instance the traumatized subject is characterized as complex, maladaptive, aggressive and unknowing. The traumatized subject is one who has a permanent inability to cope or function in life or to understand their lives (SAMHSA, 2014, p. 7).

L1: Because, you know, you hear clients all the time, especially, you know clients with Borderline Personality Disorder, and they just, they freaking hate themselves because they just don't get it. It's like, "Why am I doing this? Why do, you know....why….why….why am I behaving like this?

The resulting material effects of this portrayal of the female traumatized subject are the individual responsibilization of the subject. The broken subject requires reparation, infantilizing the traumatized subject, producing an unskilled, non-autonomous, incompetent traumatized subject with a broken brain (as per Chapter Three). One to be healed by the healer. In the following sections I explore each of these subjectification effects.

The maladaptive traumatized subject

The traumatized subject is characterized as maladaptive and in need of teaching. As an example, one participant provides details of the maladaptive traumatized subject:

DC3: So, intentional impact on clients [of TIP] is they feel more safe, and they are able to effectively, and in a healthy way, and in an adaptive way, rather than a maladaptive way, have their needs met.

Our role, especially in a place where we are helping people rehabilitate with substance use, is to teach appropriate ways to have their needs met, healthy ways to cope with stressors, and healthy ways to have your needs met.

In the following example, the maladaptive female subject is produced as devaluing herself as the reason for entering the sex trade reflecting a nested idea that women need to be self-deprecating to work in the sex trade. This explanation does not consider the socio-cultural context of her life including the violence she has experienced.

DC3: I guess all people, but particularly women who have been marginalized, and have, maybe like, worked in the sex trade, and whatever, don't value themselves as much as maybe they should definitely it's not as much as they should, but also don't value, like their bodies, right? And so sometimes they do some things, I'm totally not putting it all on women but sometimes they make some choices that are, like maybe less safe for them, or more focused on, you know, feeling good in the moment, which is why people use drugs too.

The maladaptive traumatized clients are so complex, that through the neoliberal lens, they become a drain on resources.

L1: The complex clients that we work with, so like, you know, they are the most traumatized people, really, I think that we work with and they have a lot of contact with the police, with the courts, with, you know, the correctional system, with health care, with emergency departments, with, there's a big, I know it …sounds cynical, but I think the Ministry of Health just want to be nice people and make everybody happy, but it comes down to drain on resources, doesn't it? And the fact that, you know, our clients, if you tracked back, like, their contact

with Public Health, and public administration, it's actually a really huge drain on resources, I think.

The characterization of the poorly behaved traumatized subject is assumed to be contrary to the principles in the *TIP Guide*. However, upon close examination, as described in Chapter Six, the portrayal of the unknowing maladaptive and aggressive traumatized subject is consistent with the production of the incompetent traumatized, violent subject in the *TIP Guide* (BC Provincial Mental health and Substance Use Planning Council, 2013). There is a contradiction of the intent of the Guide's foundational principles of being strength-based and the discursive strategies arising from the application of those principles in practice. This contradiction reflects and produces subject positions in a mangle of power relations of the one who knows, the expert health care practitioner, and the unknowing, and of the one who can achieve and cope (the resilient and/or compliant subject) and the one who cannot, the traumatized subject. The expert knowledge broker holds the wisdom for the cure and the woman's knowledge of her experienced violence is subjugated within medical knowledge formations. The material effects of these power relations and contradictions are exponential in the matter of identity politics.

The deleterious effects in women's lives emerge when she is characterized as a traumatized subject who is not self efficacious, valuable nor worthwhile. This is a dangerous discursive practice. The patriarchal view that dictates that women must rely on an external source for safety and direction in life either from the medical expert or the violent male partner maintains a dependency. For many women this dependency is the root of their distress, that is, relying on a male partner who is violent and possibly at the

risk of her loss of life. Women's continued economic and social dependency is parlayed to a dependency on a dominant health care system that relies on compliance to receive service and/or the desired health outcomes.

The aggressive traumatized subject

The aggressive traumatized subject arose in interviews with five of the six participants who evoked clients as a risk to self and others. I have provided three examples:

> L1: There's always a certain level of risk that they [staff] are dealing with day-to-day, so it doesn't matter, you know, how settled the unit is today, there's always that potential, because our clients have that potential to act out through their mental illness, and hurt somebody.
>
> DC3: I think that if people who experience trauma didn't have problematic ways of trying to get their needs met, nobody would have thought to put this stuff together, and thought, "I need to do a study and develop a guide on how to help these people." So, I think, like, there had to have been something that was problematic, or unsafe, in order for it to have come into the forefront of somebody actually thinking about trying to help people.
>
> DC1: Let's say someone, they're being aggressive right? They have a lot of, sort of, verbal aggression. We want to meet them where they're at. We need to provide good care for them, and manage them, and do some environmental things, so we can help manage them, and keep them in treatment, and provide them the best care, right? And understand that their reactions--their aggressive reactions, make complete sense. At the same time, there are other clients who also have had

traumatic experiences and them being on a locked unit with someone who is so verbally and physically aggressive, is not being trauma informed for them, right?

The concern with aggression and poor behaviour is nested within trauma informed practice. The same nesting is evident in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013).

L3: You would see less aggression; you would see fewer events of violence and aggression in patients, because of trauma-informed practice.

L2: Acknowledging one's trauma does not mean we are not dealing with the problem of their behaviour. You know? So, showing the difference between the trauma and the behaviour that is the person is exhibiting, and I have to explain it again, it comes from providing some education. It's like, what you are seeing is a symptom of something. So, let's look at why is the person behaving the way they are behaving? So, I always use opportunities to provide further education.

DC1: But then, I think that when there's a real challenge of say, aggressive behaviours, and I include in that sexually aggressive behaviours, that's when I think priority decisions need to be made. Where being more trauma-informed, being really, sort of, trauma-informed for one person, would mean we might be neglecting respecting, and being informed for the traumas for others.

The problem is not represented as the act(s) of violence that produced the trauma, but rather the individual's aggressive response to the health care practitioner. Similarly, self-harm is identified as the problem rather than the trauma effects that produced the self-harming.

The material effects of characterizing the traumatized subject as aggressive are twofold. The traumatized subject becomes othered, one to be feared; they are kept at a distance or even secluded and faulted for lack of progress in the treatment of their trauma. They are individually responsibilized, held accountable for their situation with no or little consideration of the social construction of their experience and responses, including but not limited to gender identity. The discursive practice of individual responsibilization evokes a health care system that sees no need for self-reflection. Practices established to deal with an aggressive client make TIP a viable way of managing the aggressive traumatized subject. Practices and policies that may be ineffectual are uncontested. Normalization practices emerge and continue to support characterization of the traumatized subject as maladaptive and aggressive.

> DC3: (He) was feeling really frustrated and rightly so he wasn't having questions answered and, it was just like he wasn't sure what was happening, and feeling really frustrated was really angry at the staff, which is allowed, and he decided to express his anger by, like, kicking a chair. It wasn't directed towards anybody. He just like, needed to kick a chair, so he kicked the chair, and they secluded him, and I was like, "what? What just happened? Why are we doing that?" He is not like, violent, he is just frustrated, and sometimes when I am frustrated, I want to hit things.

The source of the aggression is assumed to be trauma. This meaning becomes a practice norm, a legitimate standard for individualizing care and control. The unintentional effect of this meaning making is rather than seeing the subject's resistance (aggression) as a response to a systems failure, or as an enactment of power relations in

institutional care, the aggression lives within the person. The medical model is upheld through individual responsibilization. The traumatized subject is constituted as the mentally ill addicted subject with a broken brain, who requires managing by the health care practitioner expert through TIP discourse practices.

The traumatized subject is villainized for the resistance displayed in aggressive acts of defiance and separated from the compliant traumatized subject. Sometimes they are excluded from treatment, an effect of this dividing practice.

DC1: I think there is still a bit of they are not appropriate for our service.

Acts of resistance are thus depoliticized, interpreted as personal and directed towards the healer who in turn is 'vicariously traumatized'.

The complex, hard to manage traumatized subject who traumatizes others

The traumatized subject is also characterized as complex, hard to manage. This characterization is supported in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and in the concept of trauma as a wicked problem.

> DC 2: The clients we are working with have had so many barriers to full health, and, you know, have had diagnoses that go with that you know, chronic substance use, sometimes organic brain injury, sometimes cognitive deficits, like, so I really had to, kind of, rework my sense of like, what is my role, and drop some of those, I almost want to say, like expectations of what everybody wants in life, right?
>
> DC1: I'd say mental health including addictions, and sort of the challenging behavioural problems that many people have said, "You know, that person is a j erk" or "That's messed up" or "Why are they being like that?" kind of thing, is

that all those reactions make so much sense when you put it in a framework of trauma-informed care.

DC3: [On using TIP]…if there were patients, who were like, maybe more difficult to manage, or had, like a higher needs than others.

All six participants interconnected the idea of the medical model with the complex client, pathologizing the client. The traumatized subject is additionally described as non-trusting.

DC2: I guess it is medical, right? Sort of very pathology-based, you know so, for example, like one little thing that I can think of is that, you know, they [staff] are taught around, sort of, charting, and things like "Client denies this and that," and, it's like, "Yeah, I know that in that framework, it really just means that they are just saying it's not happening".

L1: They're traumatized people. They've been massively traumatized by the system itself, and very often have a mistrust of people who are in positions of authority. And in health care, unfortunately, they have had some horrible experiences.

The dividing practice arises for the participants who recognize that the traumatized subject position enveloped in the trauma ethos is more than just their trauma. The risk of labeling the traumatized subject's experience is highlighted. The material effects of this characterization are the person is embodied by their trauma, they become the disorder to be changed and cured. This view does not rely on the strengths and attributes available to the traumatized subject as noted by two participants.

DC1: I think there is a risk that we are going to, kind of, perceive people as, sort of, being victimized, and that is not an empowering place to be. It is also not accurate, because, you know, a person is so much more, you know, than just someone who has been through trauma. Not only are you someone that has survived, you are someone with real grit.

DC2: And I think there is also a piece in there, in trauma-informed practice, around acknowledging the strengths of a person that, it is not, okay, this person has been through trauma oh poor them. It's like, they have been through trauma, and they have survived, and they have fought so hard that they have gotten themselves into treatment. Like, wow. I have to sit down and take notes, because this is a superhero in my midst right now.

Participants sometimes floundered with their explanations of the traumatized subjects' behaviour, attempting to speak in non-stigmatizing language, fully aware that the explanations rendered through trauma informed discourse led to the production of a traumatized subject in need of fixing. Contrary to the understanding of the client as complex, dangerous and unmanageable, participants recognized the stigma their clients carried in the outer world and conveyed an empathic understanding of the complex traumatized subject:

L3: Because those experiences of trauma have had a big impact on how they live their lives, and some of their challenges, the challenges they face and there's substance use. So, if you want to, you know, you want to make an impact on that in a positive way and seek change, and help people find change for themselves, the programming really has to be quite trauma-informed.

L1: Because the risk is even if someone hasn't been traumatized you can traumatize them anyway. Like, somebody could come into our services not that I don't know that any of clients do come in without trauma, but they could have minimal trauma in their life, and then we put them in a seclusion room for a week.

The traumatized subject as maladaptive makes available and contrasts with another subject position, that of the direct care staff who is compassionate, caring and fragile, one who can be exposed to aggression and become traumatized.

The fragile staff subject

The production of an aggressive traumatized subject, as in the comment

L1: Traumatized people can traumatize people.

This discourse producing the aggressive traumatized subject makes available the fragile staff subject position.

DC2: So, if we are looking at staff as, sort of, fragile, you know, shaping staff.

In discussing the material reality of staff working with the traumatized subject, a characterization of that staff subject is one of fragility that succumbs to the contagion effect of trauma.

The two subjects (the fragile staff subject and the other, the traumatized subject, the aggressive one) are characterized in particular ways. These characterizations led to a dividing practice enacted by the trauma informed, caring, compassionate caregiver becoming the defensive caregiver, ready to go hands on, distancing themselves from the client for their own safety juxtaposed to the traumatized subject who is aggressive and unmanageable. This dynamic can feed client mistrust of systems and health care professionals. The message through trauma informed practice is that

DC2: We need to approach difficult behaviours or resisting clients in a different way.

The client is restrained and secluded by the health care practitioner who has been restating,

DC2: We can have a more empathic, supportive understanding [response to] patient reactions.

In other words, I understand you and I want to help you. The client feels betrayed by the normalizing practice of seclusion and restraint. The lived effect for the client may be re-traumatization, a direct target for change in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013). The participants offer examples of the fragile staff subject.

L1: They get six hours of learning to defend themselves over somebody who can be really potentially really, really dangerous to them. And it's not enough. I mean those staff do not feel confident in themselves to manage a situation should it get to the stage where they need to go hands-on.

Then they're on a unit where there's violence being acted out, is very traumatizing too. And mental health units can be really scary places for people who haven't got particularly traumatized histories .

DC1: I'm getting all this kind of feedback that I should be trauma-informed for my clients, but what about my needs? And, I think giving them [staff] a language to start advocating, "This is what I need for me." And, you know, if my emotions and my behaviours are our scalpel, right? --for treatment, what do I need to keep my scalpel sharp?

The othering of the traumatized subject as different than and indeed a danger to health care staff feeds into the stigma experienced by people who struggle with mental health and substance use issues. The traumatized subject can vicariously traumatize staff members through the contagion effect as seen in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and explored in Chapter Six. The complexity and hard to manage characterization of the traumatized subject is an interconnected idea with the vicarious traumatization of staff members.

One participant summarizes this interconnection as follows

> DC3: The unintentional implications [of TIP] are like, we forget to hold people who are responsible, people get hurt, or people get frustrated, and with some of these problematic behaviours, they are very frustrating, right? So, they get more frustrated. I think for Leaders, it's nice, like intended, that they have more of a guideline of kind of how to encourage their staff. But, unintended, I think they focus a lot on, you know, individualized care, and then focus, again just like singularly, and just forget. There is a saying, don't forget the forest for the trees, there, like that, that's what I mean. And then I think that, [I mean,] I know for me, I, [you know,] got to the point where I was like, we are not doing this right. And, it is not okay, and people are not safe, like I felt as though, and I do still to some extent, feel that somebody is going to get seriously hurt, likely by a client, and it's likely going to be staff, and, because people are getting hurt, and it's not being taken seriously. And I think that that, unintentionally, is a thing that management

and Leaders have to hear about because people are frustrated and they are, you know, trying to feel safe, like people shouldn't feel unsafe going to work.

This direct care staff participant adds:

DC3: [As] staff we're getting assaulted on a weekly basis, and nothing was happening, because these people need to have their needs met, and then we are just demonstrating, like by being trauma-informed in a number of ways, we are demonstrating to patients and clients that this behaviour is acceptable and then staff are getting hurt, and I was going into work not feeling safe..

A leader observes:

L3: You know, it's the healing environment for the clients and patients, but it's also for everyone else too. Because the patients aren't the only ones who show up with trauma histories. It's like everybody, right?

The characterization of the fragile staff subject produces an effect of defensive action. The following participants supported the notion of staff needing to advocate for themselves and their work environment.

DC1: I think an unintentional impact is, I think, staff are better able to advocate for their needs, and perhaps the working environment that they need, and the policies and procedures around that.

DC3: I feel like a little bit, like trauma-informed is the way I govern myself, so I don't think that it has completely changed the way I think, because it feels very instinctual to me, like doing that, like trying to be empathetic, and not wanting to do more harm, and all of that stuff.

One of the leader participants noted:

> L1: The staff there definitely feel traumatized by their experiences. If you've got a staff working in an environment in which they don't feel safe, and feel that they're not equipped to deal with things if they do go wrong, then it is very hard to be therapeutic when you are afraid yourself.
>
> Contrary to a trauma informed culture described as
>
> DC2: just more point-of-view perspective framework that has, sort of, settled into the overall culture of the workplace

The dividing practice of the defensive fragile staff subject and the compassionate healer co-exist in the same health care setting. This divided practice within these subject positions produces and supports the pervasive way of thinking, othering and stigmatizing those who struggle with mental health and substance use challenges contributing to an ethical dilemma for the health care practitioner. As one Leader stated,

> L1: it is a disservice [to the clients] to think this is all there is.

Transformative potential

Post structural interview analysis recognizes that subjects are in process throughout an interview. One interesting aspect of this process was the self-reflection of the participants, specifically the leaders, as they advanced through the questions. It seemed that by asking the questions, self-reflection was spontaneous and invited further critique of what the problem is represented to be and specifically why trauma informed care has been implemented.

> L2: Now that I have spoken with you, I am rethinking why we do this? [TIP] and what does it mean?

. Other Leaders transformational reflection arises spontaneously during their interviews.

L3: I would have to say I don't believe our healthcare system is trauma-informed, and that's a challenge for leaders, because if you want to be trauma-informed, you are kind of swimming against the current, in a sense.

L1: It's very hard to articulate it, you know, it is really, really hard to say, but it is, I think, doing an injustice to us as a discipline to think that that [TIP] is all that we need to consider is and that is kind of the way that it has been presented, that this how you [leaders], that this [TIP] is everything. You are just trauma-informed.

L1: I think that [on the] whole, I think that it's trying to, I think it's trying to redress that balance of the whole, you know, the science thing I was talking about, that people aren't automatons and you know, mental health is a lot more nuanced and complex than coming go to this group, take this course of pills. You know, I think it's kind of recognized that there's a lot more going on for people than just that [trauma]. And so, for that reason, it's a great thing, because, anything that helps us and our leaders and the government recognize that it's a good thing.

Another transformational thought related to the medical model indicates how one may resist a system of beliefs in service to the traumatized subjects.

L3: I mean look around us, like, our clients and patients are people who've struggled with all kinds of issues, and have and, I don't know what the statistics are, but a high proportion of our clients have trauma histories. And, we have to understand that, and operate with that as our base, you know that, that's where

we're coming from. But, maybe some people don't believe that. Maybe, maybe there are belief systems that, you know, this is really, you know, these are biological illnesses, and that's, you're treating a biological illness, and that's, you know, that's a belief system.

Another participant evoked the importance of re-examining the characterization of the problem when describing the limitations of trauma informed practice. The question of the root causes of the problem of trauma begins to recognize that there may be a sociocultural context to the problem of trauma and violence. The participant's reflection indicated there is more to take into consideration, such as the social determinants of health and identity intersections. This was a transformational moment in the interview for the participant to spontaneously consider what the problem is represented to be?

L2: So, if we deal with the foundation, like the analogy of the river, there's babies being thrown in the river and we are picking, and we are washing, and we are collecting, and saving the babies from the river and the river is going, How much can you collect to save and pick and save the babies? It's good we are doing that, but we need to go back and find who is throwing the baby into the river in the first place? So, that's there's a link there going back to find what is causing the problems and when we get that, it's going to solve a lot of problems rather than saving the babies. Right now, what we're doing is saving the babies from the river.

By questioning trauma informed practice and its role in the health care system, these leaders began to challenge a pervasive way of thinking about the care provided to the traumatized subject.

L1: I just wish they hadn't hung their whole hat on trauma-informed practice. I wish it had gone further than that. I really do, because I worry that all we, like it's crazy, it's trauma-informed crazy.

These transformational thoughts arrive from the self-reflections and allow for mutations of subject positions. Given that all three Leaders questioned the role of TIP in their organization, this discursive practice may be disrupted or serve as a resource for further transformational potential (Bacchi & Goodwin, 2016, p. 119).

Adapted identity of the compassionate health care practitioner

The subjectification of the traumatized subject and fragile staff subject produce an effect that enables staff to adapt an identity of a compassionate health care practitioner. Butler's (2007) reference to gender identities as governed by regulatory practices constructs identities which are socially instituted and maintain norms of intelligibility (p. 23). Bacchi (2005) agrees, "people's identity projects are shaped within webs of culturally produced understandings" (p. 205). "The culturally emired subject negotiates its constructions, even when those constructions are the very predicates of its own identity" (Butler, p. 195). The proposition of a constructed or adapted identity opens space for a subject who co-produces, adopts, resists, and transforms available understandings of the world and themselves (Bacchi, p. 205).

The subject uses specific structures and constraints to produce variations of their subject positions. The contestation of these subject positions takes place in these identity constructions. Bacchi (2005) describes a dual problematic, the "power of discourses to delimit meanings of topics of analysis and the power to *make/deploy discourses*" (p. 207, italics in the original). Within this context " less dominant political actors actively deploy

concepts for a political purpose" (Bacchi, p. 207). Subjects shape issues within discursive limits (Bacchi, p. 207). It is with this understanding that the subjectification effects emanating from the fragile staff subject position produce the compassionate health care provider adapted identity. This adapted identity is a result of the pervasive understanding that the traumatized subject is aggressive, dangerous and maladaptive. The fragile staff subject experiences an internal ethical incoherence of identity. It appears as twofold; fear of the clients and the institutionalized practice expecting the health care practitioner to treat the traumatized subject with compassion and empathy. One participant identified this ethical dilemma.

> L1: Where is the, you know, unconditional positive regard, the empathy, the, you know, the being genuine with people? Like, the rest of what it takes to work with people that are suffering from mental health and addiction problems. Where is the rest of it?

The disciplinary practice of seclusion noted by four of the six participants creates an ethical dilemma for the fragile staff subject. TIP makes room for the contestation of the practice. The fragile staff subject position is abandoned to the compassionate health care practitioner adapted identity. The adapted identity of the compassionate health care practitioner makes available the opportunity to contest the practice creating an internally coherent worldview of the health care system as caring and healing. The adapted identity is a proactive use of discourse by the fragile staff subject. It is an empowering agentic position that confronts the helplessness of the fragile staff subject position most prevalent in the witnessing of the seclusion of the traumatized subject. As a direct care staff notes,

> DC1: We have not been good, and we have failed them in the past and that trauma-informed care helps us realize that we are the problem that we haven't done this very well, and that we are creating these problems, right? As we are not offering early intervention to address, you know, attachment difficulties, or to address trauma early on. And, how we respond to these repeated ER visits fosters these challenging behaviours later, which make complete sense, and are entirely predictable, and yet this is what the system, kind of, has created and fostered.

The participants yearned for this compassionate health care practitioner, one whose worldview is positive, non-confrontational and who heals the most tragic of emotional wounds.

> DC2: Like, we can have a more empathetic, supportive, understanding, of patients' reaction.

The healing eradicates the suffering, the violence. In this scenario of the adapted identity of the compassionate health care practitioner, the danger in the world in the form of male violence against women is not a reality nor do the structural patriarchal causes need to be confronted in the world of the compassionate heath care practitioner.

Summary

This chapter identified and explored key discursive themes that arose in the leaders and direct care staff interviews. These themes included: enabling TIP as a legitimized practice and lending authority to this practice; truth claim and knowledge formation enabling the medical model and creating trauma as an object enabling a generic traumatized subject. Additional themes included the production of a specific traumatized subject as complex, hard to manage and aggressive and the enabling the

contagion effect of trauma supporting the production of the fragile staff subject. A key discourse supports dividing practices and positions the traumatized subject as the 'other' in juxtaposition to the fragile staff subject position. Making visible the fragile staff position makes space for the adapted identity of the compassionate healer.

The traumatized subject position is characterized throughout the interviews as unknowing, unmanageable, aggressive, violent and incapable of self- actualization. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) discourse supports this characterization. The irony is that the *TIP Guide* intends to foster empowerment and autonomy through the application of its principles of practice. The participants portrayed the traumatized subject as a divided subject; violent and unknowing; heroic and courageous. This dividing practice leads the participants to express practice concerns, which identify a dividing practice of the feared traumatized subject and the revered traumatized subject; this poses an ethical dilemma. This ethical dilemma evokes an opportunity for modification of the staff subject position. One mutable position explored in detail was the adapted identity of the compassionate health care practitioner formed to achieve internal coherence of the fragile staff subject position. Bacchi defines the analytic task of the interview as providing support to practitioners in developing alternative approaches to a program or project they wish to challenge. The interviews produced a health care practitioner subject that was supported to contest trauma informed practice. The contestation was evidenced in the transformative potential of the leaders' comments, and the direct care staff noticing of ethical dilemma. These comments and noticing supported the production of newly framed identities such as the adapted identity of the compassionate health care practitioner (Bacchi & Goodwin, 2016,

p. 114). In the final chapter, I bring together my critique of TIP policies, and post structural interviews, and present proposals for change.

Chapter Eight: Discussion

I have been working within the trauma informed practice (TIP) guidelines in the health care field for over 14 years. I first learned of TIP while working in a health care facility providing treatment for clients struggling with mental health and substance use issues. I was attracted to the philosophical underpinnings of TIP, which aligned with my social work practice values. I travelled to Portland, Oregon and completed a TIP certificate course in 2008, the only one I could find at that time on the west coast of North America.

I brought this TIP approach back to my workplace and inserted the concepts and principles into my program's clinical practice. In many ways, it was transformational. I was energized when I revisited these common principles of client-centred care, collaboration and empowerment. Around the same time, TIP began to appear internationally and across sectors (see Chapter Four). In BC, the government sponsored the creation of documents and published the *TIP Guide* in 2013, and organizations utilized these frameworks to guide practice within healthcare.

I continued practicing within the TIP framework, participated in conferences, taught TIP principles to others and served on committees to advocate for TIP in our organization. My initial intention in my doctoral program was to define the positive health outcomes that resulted from the adoption of TIP. I explored my assumptions about TIP during my studies. One of the questions that arose for me in this exploration concerned the evidence base of trauma-informed care policies: how have researchers assessed TIP's effectiveness? Although I presumed that evidence lay at the foundation of the organization’s introduction of trauma-informed care policies, I temporarily set the

question about the exact nature of that evidence aside. The *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) delineates four principles of care that, on face value, are a philosophical approach, assumed to be neutral or at best beneficent to client care, consistent with social work practice values.

As I explored the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) in more detail, other questions arose about the discourse reflected in the *TIP Guide*(BC Provincial Mental Health and Substance Use Planning Council, 2013). I began to think about the underlying presumptions and meanings of the discourse. How did discourse shape the traumatized subject; what were the material effects of this shaping? I was curious about the representation of the concept of trauma and the characterization of women who had experienced trauma (violence). To explore these questions, a deeper analysis of the underlying meanings required a critique. I summarize these representations and characterizations later in this chapter. My experience and my understanding of feminism as described in Chapter Two led me to a theoretical approach for analysis that supported my feminist thinking, Feminist post structuralism (FPS) (Chapter Three), and to a methodological approach, WPR or What's the problem presented to be? in Chapter Five.

As part of the WPR methodology and congruent with FPS, I completed a genealogy of trauma, inclusive of TIP, early on in my analytical process (Chapter Four). In writing the genealogy, I uncovered many government-sponsored reports and program documents that supported TIP. However, none of these cited research evidence specific to TIP's effectiveness, nor did any documents satisfy my queries regarding the representation of the problem of women's trauma. My research for my genealogy led me

to the internet, where the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) is publicly available. I found other guides that cited the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and government documents that mentioned TIP in BC. I analyzed this grey literature as part of my policy analysis in Chapter Six. I explored trauma literature in Chapter Four, the genealogy of the concept of trauma. I explored other related literature to write a feminist analysis of violence in Chapter Three, a feminist post structural approach. Upon completion of this research the same question arose for me; what stands as a foundation for the TIP guidelines and practices cited as evidence-based and adopted by many organizations across people serving sectors? Has the effectiveness of TIP been studied?

Having concluded my feminist post structural analysis and my WPR approach to policy analysis, I uncovered the representation of the concept of trauma, the problem of trauma in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and the characterizations of the traumatized subject and the staff working with them, summarized in chapter seven. During this analysis, it became clear that it was necessary to confront one of the most compelling arguments for TIP, namely, the claim that there is an evidence base demonstrating TIP's efficacy, both in general terms and for the people with whom my research is most concerned. Women who have experienced male violence and struggle with mental health and substance use concerns.

Parameters of literature review

I sought to uncover evidence on TIP effectiveness because my policy review had highlighted a plethora of reports and guidelines that recommended and cited TIP as though there was a foundation of evidence behind it compelling its introduction into

programs and services. I focused my attention on any critiques made of TIP, specifically any discourse analysis or questioning of TIP and its underlying presuppositions. I was unsuccessful in my search for peer reviewed TIP evaluation articles in the scholarly, literature finding instead an extensive opinion literature that advocates for TIP or the expansion of TIP on various ideological bases. This lack of evidence piqued my curiosity further; what is the foundation for TIP? I began to explore scholarly literature that evaluated TIP and proposed a policy foundation for TIP. I focused on Canadian literature, as it is most relevant to my BC-located policy analysis.

The terms 'trauma informed care' and 'trauma informed practice' are used interchangeably in the literature and literature review. I have focused my literature review on peer-reviewed articles and synthesized literature reviews. I included synthesized literature reviews in my search due to the scarcity of literature addressing TIP's effectiveness and evidence base. I also needed to ensure that I captured other authors' searches on TIP to gather evidence of TIP's efficacy. I have excluded the grey literature in this literature review because it is an integral part of my trauma genealogy in Chapter Four. I also excluded trauma informed program reports produced by government ministries in this focused literature review because Chapter Six contains the most relevant of these as a part of my TIP policy analysis.

Before conducting the review, I consulted with my supervisor and the relevant subject librarian at the University of Victoria to define search parameters and databases relevant to the review. I searched four databases (PUB Med, Medline, PsycINFO, and Google Scholar) using the following search terms most likely to yield relevant sources; *trauma informed care evaluation in Canada* and *trauma informed care health policies in*

Canada. The term trauma informed care yielded articles that referred to trauma informed care and trauma informed practice because the terms are interchangeable in the literature. The search resulted in 364 articles. I screened each result against these inclusion criteria: article subject to the peer review process; trauma informed care/practice focus; health care or social service setting; includes comments on evaluation and policy. Table 8.1 describes the algorithm for my search. I located twenty articles (nineteen peer-reviewed articles and one report that contained a critical appraisal of a trauma informed care approach) that met these criteria across all the databases. I conducted a detailed review of each of these articles to confirm, if they included a critique of TIP, a statement on TIP's effectiveness or an evidence-based foundation for TIP. I determined which ones were Canadian (8); US researchers wrote one article; however, the setting studied is in Canada, so it is included in the detailed review. I searched for evidence for TIP in the Australian and American articles. Eight articles recommend TIP with no foundation of evidence; three articles utilize quantitative measurements to assess TIP's effectiveness. I review in detail six Canadian articles evaluating TIP's implementation (1); addressing TIP's effectiveness through a social justice lens (1) and an intersectional analysis (2); a critical discourse analysis of policies impacting experiences of intimate partner violence and recommending a trauma and violence informed approach (1), and a politicized trauma informed intervention (1). I did not locate any articles that provided a discourse analysis of TIP.

A brief review of Australian and American articles

The first reading of the sourced literature located nine articles in the US and two in Australia. Three US-based studies begin to consider an evaluation of TIC and are worth a more detailed review.

The two Australian authors agree that TIP is a useful universal concept (Isobel, 2016; Muskett, 2014). Muskett (2014) focuses on nursing practice and the elimination of seclusion and restraint and recommends a TIC approach with no analysis of TIC. Isobel notes that TIC is incorporated into public health documents; however, she warns that it may become rhetoric "without careful consideration of intent and implication" (p. 589). She insists that TIC arose from studies of women who have been traumatized and therefore surmises that the TIC evidence base lies in significant research on women who have experienced trauma. However, Isobel (2016) fails to provide a clear definition of TIC and its efficacy related to women survivors of violence. She concludes that if women suffer trauma, we must have a trauma informed approach to working with them. She goes on to address the principles of a TIC approach; however, she states, "the dominant biomedical models of psychiatry are one of the identified obstacles to implementing widespread TIC in mental health services" (p. 589).

Isobel (2016) acknowledges that TIC is a radical shift in thinking for clinicians and services and interventions or practice (p. 590). Muskett (2014) agrees, stating TIC is "an emerging value that is seen as fundamental to effective contemporary mental health nursing practice" (p. 51). Neither author met my inclusion criteria of offering an evaluation or foundational policy or evidence base for TIC.

Nine American articles accepted the TIP premise, six of these without investigation or evaluation. I highlight significant authors' statements from six of these

studies to illustrate their disparate views surrounding TIC. Five of the six articles state TIC is a way of acknowledging clients' trauma (Clark et al.; 2008; Elliot et al., 2005; Machtinger et al., 2015; Muzik et al., 2013; Raja et al., 2015). Some of the authors list TIP principles from SAMSHA (2014). Three articles translate value statements related to client care into self-prescribed TIC principles (Elliot et al., 2005; Machtinger et al., 2015; Raja et al., 2015).

Elliot et al. (2005) state, "some might say that they [TIP principles] simply represent high quality, empowering practice and are not specific to the treatment of trauma, and to some degree, we agree" (p. 464). Muzak et al. (2013) emphasize that trauma should be the focus of treatment, but the details of the traumatic experiences ought to be de-emphasized. Weissbecher et al. (2007) emphasize TIP because trauma is damaging and pervasive. Muzak et al. (2013) state TIP is characterized as a hopeful neutral practice, while Machtinger et al. (2015) state, "at its core, TIC is good patient centered care" (p. 196). Raja et al. (2015) acknowledge, "although TIC is widely used, it is not well understood there is not a clear consensus on how to apply this concept in daily health care practice" (pp. 216-217).

Elliott et al. (2005) call for an evaluation of TIC with operational measurements (p. 474). Clark et al. (2008) recommend that as TIC integrates into services, it is essential to make sure our measurements keep pace (p. 86). The generalized and sometimes varied statements confirm my findings that TIP is a generalized concept, interpreted differently with little attention paid to the underlying assumptions or meanings of the practice. Each article defends the practice without providing any evidence for its effectiveness.

Three American articles evaluate TIP effectiveness

I found that three American articles that include an evaluation of TIP: Amaro et al., 2007; Gatz et al., 2007; Sullivan et al., 2017. Amaro et al. (2007) and Gatz et al. (2007) utilize the data collected in the Women and Co-occurring Disorders and Violence Study (WCDVS), sponsored by SAMHSA in 2000. Gatz et al. (2007) compared trauma-specific groups, and integrated trauma informed treatment groups, to women who only received substance use treatment. They found that integrated trauma treatment had modest outcomes for retaining women in treatment longer (Gatz et al., p. 820), but TIC did not indicate corresponding improvements for substance use severity (Gatz et al.,p. 821).

Gatz et al. (2007) expressed modest optimism for the integrated TI model developed for the WCDVS. “As a result of participation in integrated, TI services, women with mental health and substance use disorders who had been victims of traumatic violence stayed in treatment longer, experienced meaningful gains in both physical and mental health, and, quite importantly, were able to contribute to their children’s well-being” (Gatz et al., p. 821). They encouraged these types of trauma treatment specific models (Gatz et al., p. 821). They concluded, "they seemed to make a difference” (Gatz et al., p 822). It is important to note here the differences between trauma-specific services and trauma informed services. TIC is a generalized value-based way of providing services, and trauma-specific services include treatment interventions that address each woman's trauma. The Gatz et al. (2007) study measured the latter.

Amaro et al. (2007) concluded that a trauma-enhanced substance abuse treatment model increased retention with clinically modest outcomes (p. 856). The authors did not frame their recommendations as TIC but rather a trauma enhanced services approach.

The authors state, "future studies are needed to assess the relative contribution of various treatment components in this intervention" (Amaro et al., p. 858). The authors recommend an integrated treatment model addressing mental health and substance use concurrently for women struggling with these concerns (Amaro et al., p.858). This specific recommendation does not mention TIC.

The third article, entitled 'Evaluation of the effects of receiving Trauma-informed Practices on Domestic Violence Shelter residents' (Sullivan et al., 2017), is a stand-alone study compared to Gatz et al. (2007) and Amaro et al. (2007). The latter utilized the WCDVS data as a basis for their articles. Sullivan et al. (2017) included TIC principles in the article, which mirror the *TIP Guide's* principles (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 1). There was no consensus on the definition of TIC services in these three studies. Sullivan et al. (2017) note there is no consensus definition of TIC. However, they supported two ideas--anyone can experience trauma and that systems of care need to recognize, understand, and counter the sequelae of trauma to facilitate recovery (Sullivan et al., p. 2). They state, even though there is "a proliferation of these practices, little is known about their effects on survivors" (Sullivan et al., p. 1). Sullivan et al. (2017) studied women who resided for 30 days in a domestic violence shelter. From the participants' perception, TIC was associated with increased self-efficacy and safety-related empowerment but had no impact on depressive symptoms (p. 1). Sullivan et al. (2017) note, the findings may result from the shelter experience alone; however, the participants did report improved outcomes in self-efficacy and self-empowerment due to receiving trauma informed services (p. 6).

The authors note the need for more research, as this was a small pre-post evaluation with no comparison group. The study only included self-selected shelter residents and did not include those who left the shelter prematurely; shelter staff collected the data, so there was no information on how many participants declined to be involved; and finally the four study sites self-selected into the study based on their commitment to providing trauma informed services (Sullivan et al., 2017, p. 6). The authors recommend more evaluation beyond shelter programs for future studies; more robust methods that do not require shelter staff to collect data from service users; and the inclusion of service users who opted out of the program early (Sullivan et al., 2017, p. 7). Despite these study limitations, according to Sullivan et al. (2017), "this study offers support for the continued integration of trauma informed practices into the daily operations of domestic violence programs" (p. 7).

These eleven articles did not define TIP consistently, even though they shared common values and themes when outlining the TIP principles. The articles assumed that TIP is a valuable and noteworthy approach with no analysis of the discourse in the principles themselves. Sullivan et al. (2017) acknowledge the lack of TIP evaluation and attempt to evaluate outcomes as recounted by the service users. It is difficult to understand the comparison of the four study sites, given there was no clear consensus on the TIP definition or meanings underlying the TIP principles (p. 2). It follows that the TIP practices flowing from the disparate understanding of TIP principles may have differentiated the services provided between sites. The data were presented as though they were homogeneous. The authors acknowledge that their study had limitations because it did not capture those who did not speak to staff members and left the shelter

early. There may have been a bias in adopting the TIP approach identified by the shelters self-selecting into the study and the staff being in a dual relationship of researcher/ service provider with the study participants (Sullivan et al., p. 6).

It was essential to review these Australian and US peer reviewed articles to ensure that I did not negate any evidence-based claims for TIP in literature outside of Canada. In these articles, there is not a shared definition of TIP, and some authors define TIP as trauma enhanced practice (Amaro et al., 2007) patient centred practice (Machtinger et al., 2015), integrated care (Weissbecker et al., 2007) and trauma-specific treatment (Amaro et al. 2007). Isobel (2016) questions how to "navigate the integration of TIP into a specialty built upon treating psychological distress; creating dismissive reactions of patronizing approach and paradoxical radicalism" (p. 589) and asks is "TIC: a radical shift or basic good practice?" (p. 589). She concludes that TIC "ensures provision of care that is neither merely good practice nor a radical shift but rather an evidence based humanised and considered" care (Isobel, p. 590). She bases this conclusion on practice guidelines and her opinion that there are elements of psychiatric practice that are inherently trauma informed (Isobel, p. 590).

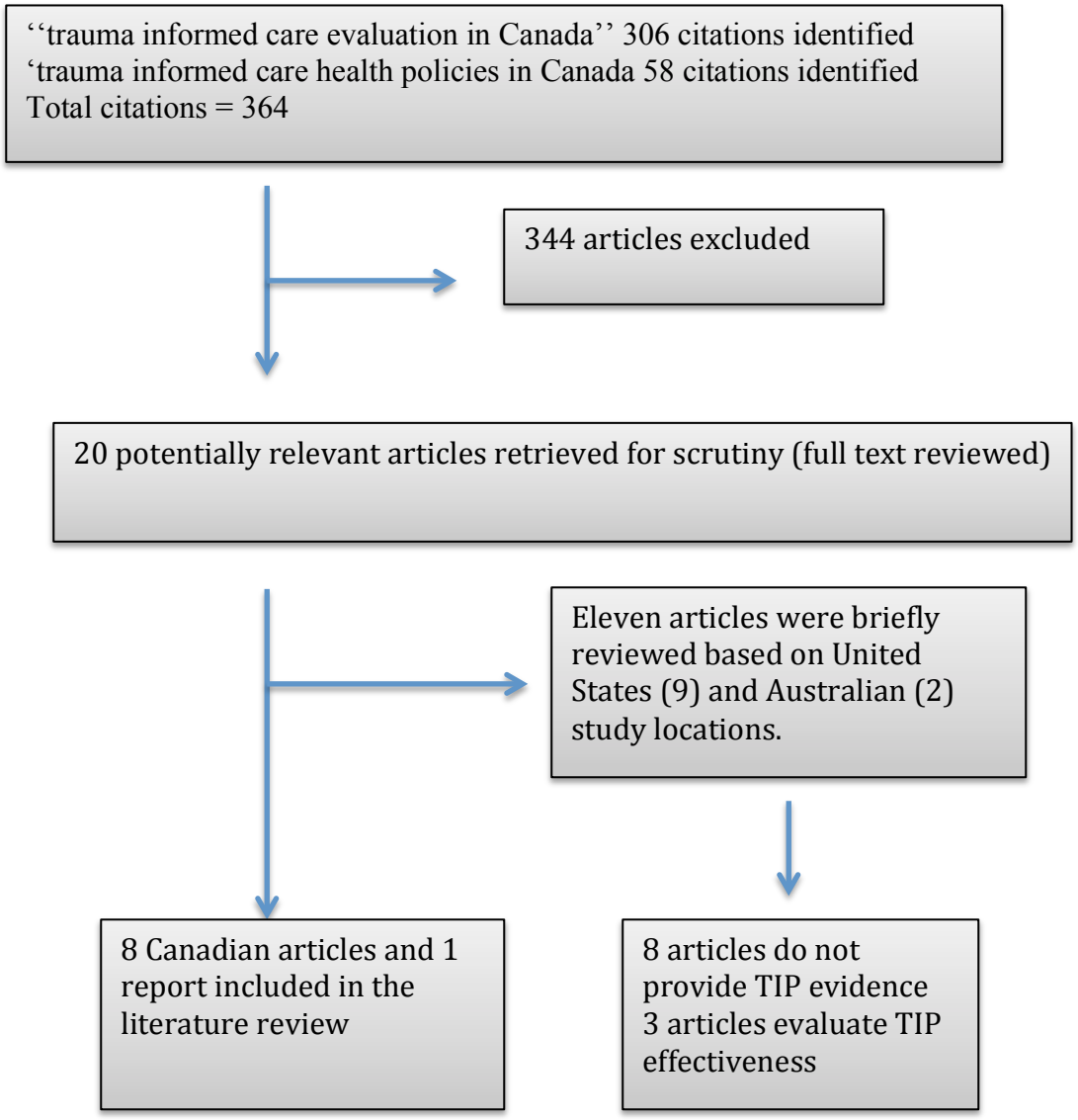
The authors recommend TIP based on the presuppositions that TIP as a hopeful, evidence-based practice without demonstrating or citing the evidence allegedly attached to it. Based on these findings, the authors of each of the articles recommend TIP as a practice across sectoral boundaries. My study focuses on TIP policies in BC, and therefore I chose to focus a more detailed literature review on Canadian sources.

Eight Canadian articles and one report

Eight articles and one report remained from my literature review. I clustered these nine articles/document into two themes for further review.

The first cluster of articles makes recommendations for other studies and research into TIP (4 articles). The second cluster of articles and one report speaks to the foundation of TIP to advance practice through the disruption in language and an examination of power. These articles contain a critique of TIP (3 articles and one report, which includes a synthesized literature review). I examine these articles more closely for their evaluation, policy foundation, and relationship to my query of the problem represented in trauma-informed policies.

Table 8.1 Algorithm for Literature Search



Cluster 1: Articles recommending further TIP research and study

Three peer reviewed articles (Baker et al. 2017; Bryson et al., 2017; Torchalla et al., 2014) and one summary of a critical appraisal of trauma informed care, which summarizes a literature review (Williams & Frey, 2018), are included in this first cluster of articles. These articles recommend further study and research into TIP.

Bryson et al. (2017), based in Vancouver, BC, completed a systematic realist literature review (p. 1). They focus on practical strategies for implementing trauma-informed care in youth inpatient and residential treatment settings. They state, "psychiatric and residential facilities have embraced trauma informed care (TIC)" (Bryson et al., p. 1). The authors investigated factors instrumental in implementing TIC "to discern which foci were associated with effective TIC implementation" (Bryson et al., p. 1). Early on in the article, Bryson et al. (2017) focus on seclusion and restraint in youth mental health facilities and the adverse harmful effects of this intervention (p. 3). They acknowledge, "the science regarding the *implementation* of trauma-informed care among youth in out home settings is modest" (Bryson et al., p. 3) (italics in the original). The authors point out "there is a dearth of experiential research demonstrating how to reduce violent and coercive practice in such settings" (Bryson et al., p. 3) one of the foundations of TIP (*TIP Guide*, 2013).

Bryson et al. (2017) come to an essential question in their paper: "*What is it about trauma-informed care that works, for whom, in what circumstances, in what respect and why*?" (italics in the original) (p. 3). At the beginning of the article, the authors set the stage for the support of TIC "as an accepted organizational change strategy which aligns service delivery with treatment principles" (Bryson et al., p. 1). They establish the assumption that TIC is the solution for their concerns about youth

restraint and seclusion in inpatient settings. They rely on the Adverse Childhood Experiences study (Felliti et al., 1998) to argue the prevalence of trauma in youth and justify the TIC approach.

According to Bryson et al. (2017), they sought to identify common elements of successful TIC implementation rather than to "determine the most efficacious model of trauma informed care" (p. 5). They systematically reviewed scholarly literature on trauma informed care in psychiatric inpatient and residential programs for youth. They included 13 peer review articles "if the initiative or intervention 1) involved a change in organizational milieu, 2) was explicitly described as involving a trauma informed approach; and 3) had been evaluated, even preliminarily, using pre-determined measures" (p. 5). In the discussion section of the paper, the authors highlight the desired effects of TIC to be a reduction of seclusion and restraint rates, fewer injuries for staff and patients, and increased staff and patient satisfaction.

Bryson et al. (2017) found that nine studies demonstrated targeted effectiveness in achieving the reduction or elimination of seclusion and restraint (p. 11). Bryson et al. (2017) call upon TIC to solve mental health treatment facilities' concerns causing harm to youth through seclusion and restraint practices (p. 1). Even though Bryson et al. (2017) identified TIC as an organizational change strategy, they highlighted that achieving a more profound and long-lasting change requires additional resources and attention to adopting the TIC principles (Bryson et al., p. 14). The authors identified the problems of lack of resources and staff feeling torn about letting go of old practices (Bryson et al., p. 14). Identifying these additional problems brings to light the question of what the problem is represented to be in TIP policies in BC.

Bryson et al. (2017) fall short of a critical analysis of TIP concepts, including an absence of an analysis of their mention of longstanding organizational issues of power (p.14). The authors mention a power dynamic within the culture of psychiatry and define it as an underlying struggle to acknowledge TIC principles and enact them within the context of power relations in a medical setting. This observation is reminiscent of Isobel's (2016) comments about the dominant biomedical models of psychiatry (p. 589). Bryson et al. (2017) believe that in psychiatric practice, "perceived efficiencies of using physical and chemical seclusion and restraint versus interventions that require substantial time and skill e.g. collaborative problem solving" may impact the implementation of TIC (p. 14). Power relations are not questioned or explored in the article, even though the authors spend much time discussing seclusion and restraint of patients, which they identify as "a potentially traumatizing practice" (Bryson et al., p. 3).

In their conclusion, Bryson et al. (2017) state, "data from their review suggest that TIC initiatives are comprehensive, theoretically grounded, and developmentally informed and align all facets of treatment in the principles of safety, choice, and collaboration" (p. 14). They support this statement by reviewing literature based on reducing seclusion and restraint, and patient and staff injury rates (Bryson et al., p. 11). Bryson et al. (2017) insist that "a theoretically based model should be adopted, as a theory builds analytic capacity and increases staff understanding of the difficult behaviours they encounter" (p. 13). My understanding of this recommendation is that there is a knowledge gap, and the missing link is analytical thinking about TIC. Bryson et al. (2017) argue that TIC can resolve concerns of patient safety in inpatient youth psychiatric settings while improving

long-term treatment outcomes. The question remains, what is the problem represented to be in TIC? What is TIC meant to resolve or address?

The second article in this cluster is a qualitative study completed in Vancouver's Downtown Eastside (Torchalla et al., 2014). The authors interviewed 27 postpartum women receiving services in a community-based harm reduction service in an impoverished neighbourhood in Vancouver, BC. The purpose of the study was "to explore themes and subjective perspectives of trauma and gender-based violence in women who lived in an impoverished neighbourhood and struggled with substance use during pregnancy and early motherhood" (Torchalla et al., 2014, p. 1). The authors recommend integrating trauma informed care into the community organization's current services (Torchalla et al., 2014, p. 1). These recommendations are consistent with those made by Bryson et al. (2017). Torchalla et al. (2014) rely upon authors who provide trauma treatment to define and espouse TIP, including the *TIP Guide* (BC Provincial Mental Health and Substance use Planning Council, 2013) itself, to support their argument for TIC. The participants in the Torchalla et al. (2014) study avoided engaging in trauma counselling (p. 8), so the authors conclude that researchers and clinicians adopt a "comprehensive trauma informed approach" as outlined by the *TIP Guide* (p. 9).

In contrast to Bryson et al. (2017), Torchalla et al. (2014) focus on gender-based and structural violence, which captures "experiences of stigmatization, and gender-based psychological violence from the health care system" (p. 6). Transgenerational trauma and trauma-specific services are also highlighted (Torchalla et al., p. 6). Torchalla et al. (2014) open space for further discussion of these other identified systemic problems. The authors discuss the environmental and structural factors that contribute to their

participants' harm beyond individualized factors. They conclude with an argument to extend the program's focus of harm reduction activities with individual therapeutic focus to include a socio-political and structural approach (Torchalla et al., p. 7). The article is one of the few that provides some comments on the social determinants of health as contributory factors to participants' life experiences, thus reframing the individual women's experience of violence to a socio-cultural phenomenon (Torchalla et al., pp. 7-9).

Torchalla et al. (2014) find shortcomings of the program model due to the exclusion of the social determinants of health. They conclude, "it is also necessary to shift the focus from the individual to include environmental, social, economic and policy factors on multiple levels and from issues of drug use and reduction of drug-related harms to include issues of gendered vulnerabilities and human rights" (Torchalla et al., p. 9). The authors recommend both trauma-specific interventions with this shift. (Torchalla et al., p. 9). This shift in focus implies that the authors support a move away from individual responsibilization of social justice issues. Torchalla et al. (2014) describe "individual and environmental/structural conditions that mutually intensify each other" (p. 1). They identify multiple and continual forms of adversity such as poverty and gender oppression that are not resolved through TIP's therapeutic techniques. Resolution of these structural conditions requires a shift in thinking to a social justice perspective (Torchalla et al., p. 1). Notwithstanding this shift in focus, the authors recommend adopting TIP; however, they do not define TIP but cite the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) as a reference for a definition.

The third article in this cluster explores the implementation and effect of TIC within a residential youth service in rural Canada (Baker et al., 2017). American researchers conducted this study. The authors acknowledge that youth-serving institutions have adopted TIC, and there is a limited research base linking TIC with improved outcomes (Baker et al., p. 666). Baker et al. (2017) incorporate other curricula in the evaluation (Risk connection and Restorative Approaches). They note, "the TIC movement grew out of the reality that settings servicing trauma survivors have failed to integrate the research on trauma and its effects into their approaches" (Baker et al., p. 666). They reiterate some disagreement about what constitutes the critical elements of TIC (Baker et al., p. 666). The authors claim that their study bolsters the evidence for TIC by citing improved staff attitudes when staff is trained in TIC (Baker et al., p. 672). Their focus is on TIC implementation and its effects on staff. The authors were surprised to discover that TIC training increased staff reporting of vicarious traumatization (Baker et al., p. 672). The focus on servicing traumatized clients translated into a discussion of how clients traumatize staff. The result is not surprising to me given my findings of the production of the fragile staff subject position.

This case study research was limited in that it occurred in one setting, lacked a control or comparison group, and collected measures over a relatively short time frame (Baker et al., 2017, p. 673). The authors focused on TIC implementation and its effect on staff members who reported positive changes in their relationships with coworkers, supervisors and outside professionals. This article did not provide any additional insights into the effectiveness of TIP nor the foundation of TIP practices.

I reviewed a fourth document, a report entitled 'Trauma-informed care for adults involved in the Correctional System: A review of the clinical effectiveness, cost-effectiveness, and guidelines', published by the Canadian Agency for Drugs and Technologies in Health (CADTH) (2018). I selected it because it includes a literature review of clinical effectiveness, cost-effectiveness, and evidence-based guidelines for the use of trauma informed care for adults involved in the correctional system (Williams & Frey, 2018, p. 4). A board of directors governs this non-for-profit organization, and provincial ministries of health across Canada appoint the majority of Board members to this organization (cadth.ca/about-cadth). The report listed key findings of the literature review, which located a single-center, randomized controlled trial and one prospective, nested non-randomized study that addresses the clinical effectiveness of trauma informed care for adults in the correctional system. "The results of these studies suggested, that there was a trend toward higher program completion rate and lower incidence of recidivism with trauma informed care relative to treatment as usual" (Williams & Frey, 2018, p. 4). However, in the literature review, no clear impact on substance use was found. "No formation was found on change of symptoms, safety, or harms associated with trauma informed care" in either study (Williams & Frey, 2018, p. 4).. There were no relevant studies on cost effectiveness and "no relevant evidence-based guidelines were found" (Williams & Frey, 2018, p. 4). Williams & Frey (2018) recommend that additional random control trials and prospective non-randomized studies to evaluate TIC programs and outcomes in Canada are necessary to address the limitations of the current studies and achieve confidence in clinical effectiveness findings (p. 4).

Williams & Frey (2018) note that the literature they reviewed for the report fails to critique TIC, supporting my findings that very few Canadian studies exist which evaluate TIP. Those available do not evaluate the presuppositions or meanings underlying the premise of TIP. I could not locate literature available from a feminist post structural perspective related to my literature review parameters. I then turned to articles that broaden the discussion of TIP's effectiveness and include an evaluation of TIP as a practice and framework.

Cluster 2: Articles that open space for a detailed examination of TIP

The previous cluster of articles accepted TIP at face value with no analysis of the approach's harms or benefits. At times, even though there was no shared meaning of the TIP concepts, the authors recommend TIP for further implementation across service sectors. This second cluster of articles is important to my study because the authors ask the reader to challenge forms of structural oppression that uphold cultures of violence (Thomas-Skaf & Jenny, 2020, p. 1). They call for a politicized trauma informed intervention (McKenzie-Mohr et al., 2012, p. 136), incorporate a trauma informed intersectional analysis (Roche at al., 2020, p. 1; Shimmin et al., 2017, p. 1;) and use a critical discourse analysis through a critical feminist intersectional lens (Mantler et al., 2020, p. 1). These five Canadian peer reviewed articles are relevant to my study because they open space for a critical review of TIP integrated with politicized socio-cultural understandings of violence.

Thomas-Skaf & Jenney (2020) analyze trauma informed care utilizing a social justice and critical disability studies perspective. Shimmin et al. (2017) use a trauma informed intersectional analysis to discuss more inclusive patient and public involvement

in health research. Roche et al. (2020) expand on Shimmin et al.'s (2017) analysis and refine a trauma informed intersectional and critical reflexive framework for patient engagement (p. 1). McKenzie-Mohr et al. (2012) politicize trauma-informed interventions involving youth homelessness. Mantler et al. (2020) utilize a critical discourse analysis of policies affecting the intersection of rural women's health experiences of intimate partner violence in Ontario. I review each of these articles in detail and comment on their relevance to my study.

Thomas-Skaf & Jenney (2020) focus on bringing social justice into trauma informed care work with children with disabilities. They confirm that many health care organizations are interested in TIC. The authors utilize a TIP definition, which coincides with the *TIP Guide's* principles (BC Provincial Mental Health and Substance Use Planning Council, 2013). However, Thomas-Skaf & Jenny (2020) contend that for trauma informed policies to be genuinely trauma informed, they need to challenge systemic and structural oppression that upholds cultures of violence (p. 1). This contention is consistent with my arguments presented in Chapter Three. Thomas-Skaf & Jenny (2020) conducted two extensive literature reviews in 2019 and 2020. They found only 3 of the 65 peer reviewed articles addressed ableism and disableism (p. 10), connecting trauma to systemic oppression experiences (Thomas-Skaf & Jenny, p. 2).

Thomas-Skaf & Jenny (2020) develop a nuanced understanding of the operation of power and oppression in the lives of children with disabilities (p. 3). They critique TIC utilizing an embodiment approach, which recognizes the body as a critical site impacted by systems of political and social dominance (Thomas-Skaf & Jenny, p. 3). I refer to the embodiment analysis, reminiscent of Cahill (2001), in my analysis in Chapter Three.

Thomas-Skaf & Jenny (2020) insist that trauma is not just an individual experience; it is infused with social and political meaning (p. 3). Moreover, their focus on the medicalization of non-abled bodies is reminiscent of the concerns for constructing the structural conditions of women's lived experiences raised by Torchalla et al. (2014), and which I discussed in Chapter Three. "The medicalization of non-abled bodies puts the focus on the individual and their failure to fit able-bodied norms. Rather than the way able bodies are constructed to perpetuate social and political dominance" (Thomas-Skaf & Jenny, p. 3). Thomas-Skaf & Jenny's (2020) critique is rooted in critical disability studies. It challenges the construction of "ableness" and the way this shapes social and political institutions (Thomas-Skaf & Jenny, p. 3).

Thomas-Skaf & Jenny (2020) use several post structural concepts and disrupt language in ways that resonate with my work in critically appraising TIP policies. For example, the binary of abled/disabled "effectively erases the inherent diversity in the human bodies by creating an able/disabled dichotomy (binary)" (Thomas-Skaf & Jenny, p. 3). Similarly, the gender binary, explored in Chapter Three, categorizes women and functionally erases the intersectional diversity inherent in race, ethnicity, sexual orientation and gender. The gender binary opposes one to the other and impacts understandings of the construct of gender. The dichotomies of male/female shaped programs and institutions that provide services under the guise of TIP (see Chapter Three).

The construction of categories is an essential aspect of my policy analysis. I attend to how these constructions produce women's lived experience from a feminist post structural perspective (Chapter Three). Thomas-Skaf & Jenny (2020) are concerned with

the othering of persons with disabilities, which mirrors my concern with the othering of women who have experienced violence. “Disableism involves the proliferation and maintenance of discourses and practices that construct people with disabilities as the Other relative to able-bodied and species-typical norms” (Thomas-Skaf & Jenny, p. 4). Similarly, misogyny and heterosexism construct women and gender diverse people as Others relative to typical gender norms. My critique of the shaping and the constitution of the female subject (Chapter Six and Seven) to comply with the norms set in organizational policies and practices relies on some of the same theoretical concepts utilized by Thomas-Skaf & Jenny (2020).

Thomas-Skaf & Jenny (2020) insist that researchers address their internalized ableism, “lest they become unknowingly complicit in maintaining the systemic oppression that upholds the violence” (p. 12). In much the same way, reflective practice is vital to my study with health care providers and their complicity in oppressive health care policies and practices. What is the problem represented to be approach requires constant self-reflection during policy analysis (see Chapter Five).

Thomas-Skaf & Jenny (2020) emphasize “structural violence can be understood here as the material manifestations of structural and social inequalities. Structural violence manifests as unequal access to necessary resources and support for marginalized individuals and communities that further compound their experience of marginalization” (Thomas-Skaf & Jenny, p. 7). This understanding of structural violence applied to policies such as children with disabilities and TIP helps in understanding reactions that were once judged as non-normative behaviours and perceived as deliberately challenging and defiant (Thomas-Skaf & Jenny, p. 11). Blaming persons for the violence imposed

upon them "individualizes the experience of violence rather than locating it in systems of power and dominance that marginalize people with disabilities" (Thomas-Skaf & Jenny, p. 11). The location of violence within systems of power requires knowledge formation grounded in this power analysis. "It is impossible to understand incidences of violence without highlighting the oppressive attitudes and systems that allow these experiences to occur" (Thomas-Skaf & Jenny, p. 11). My analysis is grounded in the location of violence discourse in TIP, the lack of naming male violence against women and the effect on women who have experienced that violence (Chapter Six and Seven). These effects include holding he women accountable for systemic oppression within health care services and in their relationships by teaching emotional regulation and coping skill (Chapter Six).

Thomas-Skaf &Jenny (2020) concede that the knowledge produced in a Western context is "highly medicalized and is assumed to be universal and neutral" (p. 12). This critique of knowledge is admirable; however, the authors do not deepen their analysis of the knowledge produced in TIP. Instead, they promote TIP as a solution for achieving equity without analyzing TIP discourse or the foundational policy. Consistent with the other cited authors, Thomas-Skaf & Jenny (2020) adopt TIP while adding a structural analysis similar to McKenzie-Mohr et al.,(2012), Torchalla et al., (2014) and Shimmen et al., (2017).

Thomas & Jenny (2020) fail to critique the effect of TIP discourse lying behind a structural framework. They fail to determine if TIP can incorporate a structural analysis given the inherent assumptions built into it as a policy. I uncover TIP discourse and its effects on women who have experienced male violence in Chapter Six. I completed a

more in-depth analysis of a TIP guideline from a feminist post structural lens to reveal these foundational assumptions. In Chapter Seven, I explore interview texts and identify TIP discourse utilized by leaders and direct are staff that mirrors the discourse in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013).

Shimmen et al. (2017) concur with Thomas-Skaf & Jenny et al. (2020). They emphasize that by essentializing the patient's identity as a homogenous group, it denies the reality "that the individuals' economic, political, cultural, subjective and experiential lives [and how they] intersect in intricate and multifarious ways" (Shimmen et al., p. 1). They contend that to have a more inclusive and meaningful approach that does not merely reiterate existing health inequities; it is essential to re-conceptualize patient engagement through a health equity and social justice lens by incorporating a trauma informed intersectional analysis (Shimmin et al., p. 1). Shimmin co-published another article with Roche et al. (2020) that reiterates this focus and develops a "valuing all voices approach" for research. Roche et al. (2020) refined critical elements of TIC and intersectional analysis with the participation of people with lived experience (p. 9). The authors continue on the trajectory of recommending the importance of trauma informed approaches with no critique of them (Roche et al., p. 11).

Shimmin et al. (2017) begin with the foundation of TIP principles such as collaboration, strength-based approaches, empowering clients to make choices and understanding the impact of trauma (SAMHSA, 2014, p. 4) and add on an intersectional analysis. The authors state they must add an intersectional analysis to TIC because it does not account for racialized groups and Indigenous experiences of colonization (Shimmin et al., p. 5). Their approach indicates that TIC falls short of including the social gradients

of health; “social and economic conditions and their effects on peoples’ lives determine their risk of illness; the actions they are able to take in order to prevent themselves from becoming ill and treating the illness when it occurs” (Shimmin et al., p. 2)

Shimmin et al. (2017) agree with Thomas-Skaf & Jenny’s (2020). They acknowledge the medicalization and objectification of bodies (in need of fixing), specifically labelling intellectual and physical disability. Shimmin et al. (2017) explain that the objectification of bodies functions "as a means to regulate and discipline non-conformist bodies, i.e. objectified by the medical gaze, the oppression and then internalized and made manifest through self-regulation and policing derived from feelings of shame and guilt” (p. 2). The discipline of non-conformist bodies reflects my analysis in Chapter Four of women who resist regulation by programs influenced by TIP.

Shimmin et al. (2017) incorporate an intersectional analysis with TIC as a framework to deconstruct the shaping of these bodies. Like Thomas & Jenny (2020), Shimmin et al. (2017) provide no direction on how one might deconstruct the presuppositions underlying the TIC policy. They assume that using trauma informed intersectional analysis speaks to the social gradients of health and health inequities for those with complex health needs (Shimmin et al., p. 3). Shimmin et al. (2017) assume the TIC approach achieves meaningful and authentic involvement with people with lived experience in health research (p. 5). The authors also state that TIC helps to recognize and acknowledge an over-representation of Indigenous children in the child welfare system (Shimmin et al., p. 5). These lofty goals are accomplished, according to Shimmin et al. (2017), with trauma informed intersectional analysis though they do not clarify how the tenets of trauma informed care policy influence the attainment of these goals. Even

though Shimmin et al. (2017) neglect a more in-depth analysis of the TIP principles, they include some concepts that assist in furthering a social justice perspective, including the intersectional social dimensions of health and health equity, the discussion of power and the construction of subjects.

Shimmin et al. (2017) note that integral to the utilization of TIC intersectional analysis is the “examination of how subjects construct, develop, and negotiate their own social locations and those of others in social contexts of power” (p. 6); however, the authors do not pursue this area of inquiry in their article. The discussion of power is helpful in their goal of public involvement in health research, and the authors espouse “an ongoing dialogue around the dynamic nature of systems of power and their effects upon the partnership between researchers and public research partners" (Shimmin et al., p. 6).

Shimmin et al. (2017) advocate for discursive reflexivity as an "important component of an intersectional analysis in the exploration of power" (p. 5). However, they provide no reflexive discussion related to the SAMHSA (2014) concept of trauma document upon which they set the foundation of their trauma informed intersectional analysis (Shimmin et al., p. 4). There are some comments related to power that deserve some attention. For example, the authors speak to powerlessness when it comes to public involvement in health research. "Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, a system or a force) has power over another " (Shimmin et al. p. 4). "It is important in interpersonal interactions that these feelings of powerlessness are not reproduced or reconstituted in anyway” (Shimmin et al., p. 4).

Similar to Thomas-Skaf & Jenny's (2020) discussion of the construction of the bodies of persons with disabilities, Shimmin et al. (2017) speak "to the need to disrupt and trouble the socially-constructed discursive practice of binary categorization of what is deemed as worthy vs. unworthy bodies" (p. 6). In these points of critique, the authors could have taken the opportunity to apply their analysis to the meanings constructed in TIC policies. This analysis would have benefitted the reader in exploring the power relations in TIC fully, the construction of the body in TIC guidelines, and identifying what the problem is represented to be in TIC.

McKenzie-Mohr et al. (2012) write about youth homelessness and the need to politicize trauma informed intervention (p. 136). McKenzie-Mohr et al. (2012) include a social justice and intersectional health equity approach. "A politicized understanding of trauma is taken up to explore the complex psychological, relational, and social/political challenges experienced by many young persons facing homelessness" (McKenzie-Mohr et al., p. 136). Similar to Shimmin et al. (2017), McKenzie-Mohr et al. (2012) add on a social justice focus to TIC to ensure the "provision of adequate services and also to address root causes of youth homelessness"(p. 136). The authors contend that trauma informed service provision requires an infusion of "social and political analysis to guide more effective trauma-informed solution building in responses to the issue of youth homelessness" (McKenzie-Mohr, p. 136).

McKenzie-Mohr et al. (2012), unlike the other authors, explicitly define the limitations of the current conceptualization of trauma informed care; in particular, "it's less political framing of trauma and lack of attention to addressing root causes of social problems" (p. 137). According to McKenzie-Mohr et al. (2012), TIC is a necessary but

insufficient adaption to service delivery for homeless youth because of the propensity of trauma theory (p.138), which the medical model strongly influences, i.e., PTSD diagnosis decontextualizes and depoliticizes the traumatic response to homelessness (McKenzie-Mohr et al., p. 136). The context within which trauma occurs, when ignored, further heightens the potential for stigmatization (McKenzie-Mohr et al., p. 136). The current conceptualization of TIC, “its less political framing of trauma," is unjust without considering the root causes of social problems youth have endured (McKenzie-Mohr et al., p. 137). The authors contend that the individualized construction of the trauma experience distracts from the problem's social and political roots, including the experience of oppression (Mckenzie0Mohr et al., p. 136), neglects policy and legislative solutions and thus further harms youth (McKenzie-Mohr et al., p. 140).

McKenzie-Mohr et al. (2012) are concerned with conceptualizing trauma-informed care principles based on an individualized and depoliticized framing of trauma (p. 139). TIC "offers a reactive and mainly ameliorative approach to assisting individuals. It lacks focus on collective, proactive approaches and does little to achieve primary prevention” (McKenzie-Mohr et al., p. 139). The individualized and medical approach falls short in attending to communities' needs and the needs at the societal level (McKenzie-Mohr et al., p. 137). Interventions must connect the personal to the political through policy responses that redress inequities in power and decision-making (McKenzie-Mohr et al., p. 137). The authors admit that some characteristics of TIC, including its "empowerment focus, reduction of power imbalances, and commitment to client participation align with anti-oppressive organizational practices and have the potential to support transformational work. However, the current TIC framework stops

short of broad societal change targets" (McKenzie-Mohr et al., p. 140). The authors concede that without an equity-based model attached, TIC does little to address the problem of youth homelessness. I come to the same conclusion in my analysis of women's experiences of male violence. As I demonstrated in Chapter Six, TIP does little to address this concern and may harm those being cared for under this guideline (Chapter Seven).

In their 2020 article, Mantler et al. attempt a critical discourse analysis of intimate partner violence policies. They focus on intersections of health. They recommend women-centred and violence-sensitive policies (Mantler et al., p. 2). Mantler et al. (2020) recognize, consistent with other authors in this cluster that TIC focuses on change at the individual level. However, despite asserting that they are conducting a *critical* discourse analysis, Mantler et al. (p. 6) focus on the outcomes of intimate partner violence rather than consideration of social justice issues or a societal change model. Mantler et al. (2020) state, TIC "aims to construct care practices that are built on comprehending effects of trauma in terms of health and behaviour" (p. 7). The authors include violence in the title of the approach, transforming it into trauma and violence informed care (TVIC), in order to extend "the TIC approach by integrating the impact of interpersonal and systemic violence as well as structural inequities on individuals' health" (Mantler et al., p. 7). According to Mantler et al., the TVIC re-conceptualization recognizes "inherent barriers stemming from power relations in health and social services" (p. 8).

Mantler et al. (2020) recognize that power dynamics in health care settings are typical and well documented (p. 2). However, in opposition to their observation, the authors recommend psychiatry as a way of increasing access to support for women who

have experienced intimate partner violence even though they criticize the medical model, claiming it does not meet the needs of women who have experienced violence (Mantler et al., p. 3). The authors recommend a hospital policy to address intimate partner violence despite their view of the medical model of service delivery as power imbued (Mantler et al., p. 6).

Mantler et al. (2020) are critical of empowerment or what they call affirmative action approaches, which “reify existing power dynamics by taking a hands-off approach to the solution, placing the onus on the women and individuals working within the system to change the structure of the system--an unrealistic goal" (p. 6). I share concerns with the medicalization of trauma resulting in individualized responsibilization of medical issues. I review the medicalization of trauma in Chapters Three and Four.

Mantler et al. (2020) use what they name a "critical feminist intersectional lens" (p. 1) to review policies, but I could not locate their claimed critical discourse analysis of TIP policies in their work. Instead, the authors mention the creation of meanings within themes (p. 4). Mantler et al. (2020) acknowledge that, “each policy represented the problem from a different perspective, and this led to a degree of ambiguity” (p. 5).

Conclusion of literature review

The literature review yielded few peer-reviewed articles that evaluate or critique trauma informed care policies in Canada's health care system. Most of the TIC literature reviewed are opinion pieces advocating for TIC or adding on to TIC rather than providing evidence for its effectiveness. The literature revealed that many organizations have been adopting TIP into health care service delivery. Five Canadian articles reviewed here begin to apply health equity principles to an analysis of services for children with

disabilities, youth experiencing homelessness, patient engagement in health research and women experiencing domestic violence. The authors are motivated to complete their enquires based on the prevalence of violence and trauma for women; children with disabilities; homeless youth (Mantler et al., 2020; McKenzie-Mohr et al., 2012; Thomas & Jenny, 2020); and the lack of consideration of the role of trauma in peoples' lived experience (Roche et al., 2020). "A meaningful approach that does not simply reiterate existing health inequities is important to re-conceptualize patient engagement through a health equity and social justice lens" (Shimmin et al., 2017). The authors add to TIC a social justice lens (Thomas-Skaf & Jenny, 2020) and an intersectional analysis (Roche et al., 2020; Shimmin et al., 2017). Mantler et al. (2020) complete a critical discourse analysis while incorporating a TIC approach, and McKenzie-Mohr et al. (2012) call for a politicized trauma informed intervention for youth homelessness. Two articles highlighted the need for a socio-cultural political context in TIP policies (McKenzie-Mohr et al., 2012; Roche et al., 2020). The medicalization of trauma and the medical model itself constructs subjects, and the power relations inherent in the medical model exclude a mention of trauma and violence informed care (Mantler et al., 2020). The concerns raised by these authors lead to questions about why adopt TIP when there is an absence of a structural, political, systemic and social justice lens on trauma. The question of why to adopt TIP without a structural, political analysis underpins my examination of TIP as practice in health care.

In the next chapter, I summarize how I have determined that trauma discourse has resulted in lived effects for women who have experienced male violence. I discuss the resulting implications and my recommendations for future policy and research.

Chapter Nine Summary and Discussion

My journey began with my personal experience of oppression as a woman in a misogynistic patriarchal culture. Like most women, I accepted these normalized practices until I learned otherwise. My education began in university with my understanding of feminism. My insight grew and contributed to my work in the non-profit sector with women who had experienced male violence. I became committed to my beliefs; violence against women can only exist in a patriarchal, oppressive society, and one achieves change through systemic and political means. I have carried this belief throughout my career in health care.

As a Journeyer (Daly, 1979/1990), I have learned that the journey is everlasting. The cerebral spin (Daly 1979/1990) must continue as we take up the fight and resist compromise. As Catherine McKinnon states, "from experience, women often assume that any opposition to power will produce retaliation followed by retrenchment: not only that any progress made will be clawed back, but that those pushing for it will be punished" (2019). Speaking to the #Mee Too movement, McKinnon acknowledges that retaliation is real.

I sat in fear of retaliation at many points in my career. I moved into a comfortable existence and became less enthusiastic about the risk of taking action against systemic oppression. I now recognize that the "fear of blowback can impede insistence on change and the collective mobilization it requires. Anxiety about backlash, however well founded, keeps one's antennae endlessly attuned to giving power what pleases and please pacifies it. This contributes to keeping dominance in place" (McKinnon, 2019).

My introduction to TIP policies was in the context of my work with women within the health care system; it felt like a breath of fresh air trauma was acknowledged. The *TIP Guide* (BC Provincial Mental Health and Substance Use Council, 2013) supported the idea that women have experienced traumatic events. As I walked the path along with women receiving services, I realized that the system continued with hierarchical, patriarchal, othering and demoralizing practices to women in care. I became concerned and curious. How could it be with a TIP policy that we continued to witness women's distress within programs designed to assist them?

I began to think about the early days of my discovery of feminism. I began to read the TIP Guide (2013) more closely. I moved out of my complacency and began to challenge sections of the policy with a critical lens. I began to honour my integrity, previously lost in my complacency with practices and policies that give rise to unintentional consequences for women who had experienced male violence. I came to realize that unexamined policies and practices leave space for unconscious bias. The biases innate in policies are unrecognized unless there is a concerted effort to examine them. My journey to analyze TIP policies began with curiosity about the unconscious biases not yet revealed in the TIP policies in BC. The problem of trauma as represented in TIP policies carries the weight of unconscious bias about women who receive services in health care.

Trauma as a problem in trauma policies

The problem of trauma is a backdrop to many initiatives, including program development, therapeutic interventions and policies. I have demonstrated a wide acceptance and usage of the category of trauma in the health care sector. Several

definitions of trauma appear across service sectors and programs. Some of these include trauma as ubiquitous, as in the ACES study (Feletti et al., 1998); the exploration of intergenerational trauma (Million, 2013) and clients' re-traumatization within systems of care; and staff being traumatized by clients as seen in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013). Trauma has been identified as the gateway for chronic disease, stress, as a precursor to incarceration, and mental health and substance use concerns. The regulation in the *TIP Guide* targets change in the system of care and with the individual receiving services. It regulates the health care system in an effort to meet clients and staff needs. Policies intend to fix things, and by their very nature, "they presume the existence of a problem that needs fixing or solving" (Bacchi, 2015, p. 132) and, in the case of TIP, the problem identified is a non-responsive health care system.

Trauma has been established in history as a wicked problem, a problem that is notoriously difficult to solve. I have discussed how normalization practices, including hierarchical observation, normalizing judgment and examination, have produced particular types of subjects. The traumatized female subject is of primary interest in my study. As I explored the material effects in the lives of traumatized female subjects by analyzing TIP policies in BC, the fragile staff subject emerged. The fragile staff subject opened space for the emergence of the adapted identity of the compassionate staff person.

The problem of trauma represented in the *TIP Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013) and confirmed by the participants in my study, is a medical intra-psychic problem. However, I have provided a critique of the *TIP Guide* and participant interviews that support a widely held differing identity of the

problem; problems of a health care system unable to manage the traumatized subject and one that renders invisible the violated traumatized female subject. The traumatized subject is characterized as aggressive, unknowing and violent. The central role of health care leaders and staff within this representation of the traumatized subject within TIP policies is to reconstitute traumatized subjects from non-conforming, deregulated individuals to those whose lives are lived in accordance with prescribed social standards and attitudes that are both deserving and required (Bacchi, 2015, p. 141).

The representation of the problem of trauma in TIP policies in BC directs our attention away from a socio-cultural understanding of male violence against women. Nested within this problem representation is the characterization of the traumatized subject who needs to self-regulate, needs to reshape their lives, and poses a significant risk to self and others. The assumed problem of trauma is an individualized medical issue. "It is individualizing because through a variety of measures and means it disciplines the bodies of specific citizens often through targeting their behavior" (Bacchi, 2015, p. 132). The proposal for solutions shape and characterize problematizations that support a current dominant paradigm, the medical model. The medical model supports evidence-based policy, which targets the individual client and emphasizes individualized responsibilization of the effects of male violence in women's lives (Bacchi, 2009, pp. 252-255).

Governing practices in TIP policies

The practices of regulation and governing pay little attention to the shaping of the circumstances of women's lives and produce individuals who are self-regulating (Bacchi, 2015, p. 132). The message to the traumatized subjects and those who work with them is

that risks exist in the work with trauma, and those risks are self-inflicted or can be solved with individual change, leaving the individual responsible for reshaping their lives through treatment to address those risks (Bacchi, p. 132). Individualized responsibilization is contrary to a social justice view, which requires a societal culture shift in power among individuals. The individualization of trauma negates the accountability for the true source of these risks: men who are violent towards women. I acknowledge that women require a safe space to gather and rethink how they may address the problem of violence in their lives. However, TIP is harmful in these settings when it serves to decant the responsibility of a patriarchal system of power and control, insisting on self-regulation, individualizing and reshaping of self, despite the violence endured. I have shown that this representation of violence turned into trauma, has devastating subjectification and lived effects for the most marginalized, and most highly traumatized women struggling with mental health and substance use concerns; and through colonization effects with Indigenous people in particular.

How do TIP policies impact women who have experienced male violence?

Feminist post structuralism offers a theory to assist in the analysis of TIP policies. Discourse emerged in the TIP Guide and participant interviews that characterized the traumatized subject as aggressive, unmanageable and unknowing, creating damaging effects for women who have experienced male violence. I demonstrated three dividing practices that took shape within the trauma discourse and resulted in damaging effects. Dividing practices "function to separate groups of people from one another and (which) can also produce governable subjects divided within themselves" (Bacchi & Goodwin 2016, p. 23). The first dividing practice produced the traumatized subject as governable.

The traumatized subject was produced as a courageous hero and helpless, unknowing, aggressive, unmanageable and unable to cope. The effect on the traumatized subject in the TIP policy created space for rewarding the compliant subject while rejecting the resistant subject from treatment. The staff subject also divided into a competent, expert subject and a fragile staff subject unable to cope with the aggressive traumatized subject. This dividing practice opened space for the development of the adapted identity of the compassionate staff subject who is complicit in the enactment of the TIP discourse in TIP policies. The third dividing practice functioned to separate the leaders and direct care staff from the traumatized subject, a stigmatizing practice of othering that upheld the power relations that distinguish between women who work within services and women who utilize the services. The practice of othering opens a space for the stigmatization of women who have been open about the male violence they have endured. This practice's effect is the silencing of the violence against women narrative that impact all women in a patriarchal, misogynistic culture.

What is the problem represented to be?

There is a problem inherent in perpetuating a societal system that continues to prey on the most vulnerable of our citizens. Is it a problem of trauma? Or is it perpetuating beliefs supported by continued misogyny, heterosexism, anti-Indigenous racism, anti-black racism, and colonialism? The problem representation of trauma in TIP policies in BC avoids examining a health care system that failed Brian Sinclair, an Indigenous man who sat in the emergency room and died because he was presumed to be drunk rather than in a diabetic crisis and was ignored to death (Geary, September 18, 2017). Or questioning a system that killed Chantel Moore, fatally shot when a mental

wellness check went wrong as she called for help when struggling with mental health concerns (CTV News, June 5, 2020).

The story of the genesis of violence to trauma should not be oversimplified. It is a story of the minimization of culturally supported violence and stigma and the story of a power imbued failed health care system shifting the responsibility to individual women for societal failure to address the root causes of male violence. It is the failure of societal recognition and alleviation of social inequities such as poverty and homelessness. It is the story of distancing and othering the traumatized female subject to protect self as a health care provider for fear of the knowledge of becoming a victim who has experienced male violence because if it happened to her, it could happen to me. It downplays the importance of social determinants of health perspective and supports a lack of social justice solutions for violence against women and children.

The trouble with TIP is that it silences the violence narratives. Those shared narratives empower women to speak out against male violence and the patriarchal beliefs that support these violent acts. There is trouble with research and studies that support TIP without critique. Adding TIP discourse on to a politicized context such as an intersectional analysis or critical disability viewpoint as some authors have attempted only serves to continue the framing of TIP as a neutral feel good policy. The unintentional consequences of such a policy remain hidden. The adding-on to the TIP policies is similar to rebuilding a home on a faulty foundation; eventually, it falls over and harms those it intended to protect and serve.

This is a challenge to future policymakers and researchers to examine the representation of the problem in policies and ensure the delivery of knowledge that

carries a political contestation of competing representations. Further, the challenge is to ensure underlying assumptions are examined and dismantled to avoid stigmatization of those the policy is intended to support. To ensure a policy framework that conveys underlying assumptions of a knowing agentic subject empowered to make change individually and collectively. To call out and insist on the displacement of problems such as poverty, homelessness, wage equity, racism and stigma. To name violence. And, always to ask, what is the true problem of trauma for women who have experienced male violence, represented to be?

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Appendices

Appendix A: Participant Consent Form

University of Victoria

Trauma Informed Care Policies in British Columbia: A Feminist post structural policy analysis

You are invited to participate in a study entitled TRAUMA INFORMED CARE Policies in BC that is being conducted by Terri-lee Seeley.

Terri-Lee is a graduate student in the program Social Dimensions of Health at the University of Victoria and you may contact her if you have further questions by calling (email address and phone number removed)

As a graduate student, I am required to conduct research as part of the requirements for a PhD. It is being conducted under the supervision of Dr. Susan Strega. You may contact my supervisor at School of Social Work, University of Victoria (email address and phone number removed)

Purpose and Objectives

The purpose of this research project is to examine the Trauma Informed Care (TIC) policy and its impact for women who have received treatment for substance misuse and mental health concerns, direct care staff who work in these services and the leaders of the organization that use the policy in the delivery of services.

Importance of this Research

Research of this type is important because while trauma informed care has been widely accepted as an important goal in health care and other systems, few studies explore the intended and unintended consequences of these policies. My work will make a contribution to future policy development that is based in the experiences of women in the field of mental health and substance use.

Participants Selection

You are being asked to participate in this study because you are currently employed and have been for the proceeding 24 months in a programme that identifies TIC as a guiding policy.

What is involved

If you consent to voluntarily participate in this research, your participation will include a personal interview to be held in a workplace conference room or an offsite public location of

your choice, the interview will take approximately one to two hours. The interview will be audiotaped and I will also take written notes. A paid transcriptionist who has signed a confidentiality agreement will complete a transcription of the audiotape. Both the transcribed notes and written notes will be kept in a locked filing cabinet for one-year post the completion of my study. The audio recording will be deleted once the transcribed notes are checked for accuracy.

Examples of questions to be asked in the interview

Does your organization have a TIC policy, protocol or guideline? Please describe?

How did you come to know about this policy (protocol, guideline)? How is the policy applied

in your workplace?

What meaning does it have for you generally and specifically in your day-to-day work?

Inconvenience

Participation in this study may cause some inconvenience to you, including time for the interview, disruption to your daily routine at work. I have received permission to complete your interview during your work time.

Risks

There are some potential risks to you by participating in this research and they include becoming upset when thinking about your work in providing trauma informed care. To prevent or to deal with these risks the following steps will be taken

- You will be provided with a resource list for support services
- The researcher is available for debriefing after the interview
- You may pause or discontinue the interview at anytime without explanation

Benefits

The potential benefits of your participation in this research include

- Participants will be given voice to comment on the policies that drive service provision and as a result influence future direction of these policies.
- The study will increase societal understanding of the services provided to individuals who have experienced violence and the system responses to these experiences
- The research will advance the state of knowledge about violence against women and specifically the situation of women struggling with mental health and substance use concerns.
- The research will explore policy proposals that may benefit women receiving these services from the perspective of the women receiving services, those providing the services and those leading the services.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be given a $10 gift card If you consent to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation were not offered, then you should decline.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data up to the point of withdrawal will be used in the study. If the interview has begun and you withdraw you will receive the gift card regardless of the completion of the interview.

Researcher's Relationship with Participants

The researcher may have a relationship to potential participants as a colleague. There is no direct reporting relationship with any participants. To help prevent this relationship from influencing your decision to participate, the following steps to prevent coercion have been taken

- Your participation or choice not to participate in the study will remain confidential.
- You can withdraw from the study at anytime without explanation.

Anonymity

In terms of protecting your anonymity all comments made will remain anonymous with pseudonyms utilized for any direct quotes in the final dissertation. No identifying information for participants will be included in the study.

Confidentiality

Limiting access to the data to the transcriptionist, the researchers and the academic supervisor will protect your confidentiality and the confidentiality of the data. No identifying information will be recorded on the audiotape or in my written notes. All data will be stored in locked filing cabinet. Transcriptions will be stored on a password word protected encrypted USB which will also be stored in a locked filing cabinet.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways

1) Dissertation
2) PHSA presentations
3) Professional and scholarly presentations
4) Publications (articles and books)

Commercial Use of Results

This research will not lead to a commercial product or service.

Disposal of Data

Disposal of data includes; erasing audio files and shredding paper copies of transcriptions from this study after one year post dissertation completion.

Contacts

Individuals that may be contacted regarding this study include
Terri-Lee Seeley, (contact info removed)
Dr. Susan Strega, my supervisor at School of Social Work, University of Victoria (contact info removed)

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and the researcher will take a copy.

Appendix B: Transcriber's Confidentiality Agreement

Date

I_____ have been hired to transcribe audio recorded interviews by Terri-Lee Seeley. I understand that all of the information that I have access to is confidential. I agree not to disclose any of this information to anyone other than Terri-lee Seeley including the names of the participants or any other identifying information if disclosed during the interviewing or transcription process.

I will ensure that the completed transcript will be stored on the provided password protected encrypted USB drive provided for this purpose and will be stored in a secured filing cabinet until provided directly to Terri-Lee Seeley.

Signed _____
Printed name _____

Witmessed _____

Date _____

Appendix C: Interview Guide A: Leaders and Direct Care staff

An interview guide will be developed for the one to one semi structured interviews with leaders and direct are staff including but not limited to the following questions:

1. Review of informed consent and confidentiality
2. What is your title and role in this organization and how long have you been in this role? (leader, direct care staff),
3. Does your organization have a TIC policy, protocol or guideline? Please describe?
4. How did you come to know about this policy (protocol, guideline)?
5. How is the policy applied in your workplace?
6. What meaning does it have for you generally and specifically in your day-to-day work?
7. What problem or problems is this policy meant to address?
8. Can you think of a way this problem could be thought of differently?
9. What values, philosophies are inherent in the TIC policy, protocol, and guidelines?
10. Has the implementation of this policy made a difference in your role, in your work and/or in your life? Please describe?
11. Has it made a difference to the women (and in their lives) who have received services within your organization? Please describe?
12. Are there instances when it is difficult to apply this policy or where others disagree about the policy? What are your thoughts about this?
13. Are there other instances when you believe that the policy ought not to apply?
14. Are there instances when you believe that the policy ought to apply but is not applied? Thank you and review confidentiality and follow up support