Feminist Therapy With People Who Self-Inflict Violence

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In this article, the authors describe how a feminist therapist approaches work with clients who practice self-inflicted violence (SIV). They begin by discussing feminist therapy, with its focus on empowerment of clients and the use of noncoercive strategies. The feminist perspective on understanding SIV behaviors is described, with SIV being defined as a coping strategy used by survivors of complex trauma as a means of self-care. Feminist therapy is illustrated with a case example of a woman who used SIV, and the challenges to a therapist wishing to promote client safety while empowering the client. Practice recommendations and cautions are advanced. © 2007 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 1121–1133, 2007.

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It is not uncommon for people to inflict violence upon themselves. Some forms of self-inflicted violence are socially sanctioned and even socially desirable within a given cultural context. Examples of this include elective plastic surgeries, piercings for the insertion of jewelry, and playing sports while in pain. Other forms of self-inflicted violence are generally viewed as evidence of psychopathology, and their eradication becomes an immediate focus of psychotherapy. Behaviors such as cutting or burning oneself, banging one's head against a wall, punching oneself, or forcing oneself to vomit are frequently observed in people with histories of severe and repetitive childhood maltreatment and invalidation, a phenomenon referred to here as *complex trauma* (Herman, 1992). Based on reviews of the literature, women appear to account for the bulk of those presenting in clinical settings who inflict harm on their own bodies (Mazelis, 2003; Zlotnick, Mattia, & Zimmerman, 1999),

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suggesting that gender and its enactments comprise some portion of the behavioral trajectory leading to self-harm.

Feminist therapy uses analysis of gender, power, and social location as a means of understanding the emotional distress and behavioral dysfunctions that trouble people who enter psychotherapy. Because of feminist therapy's initial emphasis on working with women, and the fact that many of the first cohort of therapists who worked with and wrote about survivors of interpersonal violence identified as feminists, feminist therapy has often been applied with clients who present to us as troubled by their own self-inflicted violent behavior, or those who come because others are troubled by that behavior. In this article, we will discuss how feminist therapy conceptualizes self-inflicted violence and illustrate how a feminist therapist might work with a person presenting with this as a distressing behavior.

A few comments are useful at this point. We have chosen to embrace a term developed by mental health consumers who do these behaviors—*self-inflicted violence* (*SIV*). The concept of SIV as a way of understanding the harm that some people do to themselves was first proposed by Mazelis (2003), after she led a workshop at a women's music festival for women who hurt themselves. She and other participant–observers of the phenomenon noted that, for most, it was a strategy for coping with the violence inflicted upon them by others. The use of the term *SIV* was proposed to make transparent the roots in previous interpersonal violence of the new wounds being inflicted, and to describe the phenomenon behaviorally, keeping judgments about its meaning or purpose out of the name. As Mazelis noted, "the purpose SIV truly serves is . . . an action of self-help" (2007, p. 2). In keeping with the feminist principle of empowering the authority of clients as namers and knowers of their experiences, we will also use this terminology in place of self-injury. We have found that therapy arising from this lens on SIV is markedly different from therapy that views this behavior as harmful, masochistic, punishing, or pathological.

We also believe that seeing these behaviors as self-inflicted violence is an important conceptual step in working with people who are using SIV as a coping strategy. As several authors (e.g., Mazelis, 2003; Miller, 1994) have noted, persons who practice SIV have often experienced their bodies as being legitimate targets for harm by others, including and especially intimate and care-giving others. Being cut, burned, and beaten have become commonplace in their lives. Moreover, perpetrators of sexual, physical, and emotional violence have often justified their abuse by blaming their victims for some alleged bad behaviors. Many people who engage in SIV thus experience a strong and enduring sense of themselves as deserving of harm, or even asking for it. They also, reasonably, experience themselves as victims of violence, not its perpetrators.

This article, like any other work of feminist therapy, does not speak on behalf of all feminist therapists. Within this theoretical orientation, a wide range of approaches and modalities arise; for example, a feminist therapist strongly influenced by Linehan's (1993) dialectical behavior therapy (DBT) would like take a somewhat different approach to SIV than we do. We also do not speak on behalf of anyone who experiences SIV. Each person who engages in it is the best expert on her particular experience.

Feminist Therapy and Self-Inflicted Violence

Feminist therapy is an integrative model in which theory and therapist epistemology most strongly informs the process. Feminist therapy is informed by feminist political philosophies and analysis and is grounded in multicultural feminist scholarship on the psychology of gender, power, and social location. This leads both the therapist and the client toward strategies and solutions advancing feminist resistance, as well as transformation

and social change in daily personal life, and in relationships with the social, emotional, and political environments (Brown, 1994, 2006).

Because feminist therapy locates pathology in the realm of the larger patriarchal social structure—outside of the individual, not within—the concept of psychopathology is generally eschewed. Instead, feminist therapy describes a person's distress (internal experience) and dysfunction (behavioral disturbance; Ballou & Brown, 2002; Brown, 1994, 2000). In keeping with this framework, SIV is not conceptualized as a manifestation of psychopathology, although it is almost always highly distressing to those interacting with the person, and sometimes distressing to the practitioner of SIV herself. The practice is seen rather as "resistance to experiences of oppression"—in this case, the oppression of repeated interpersonal violence—and as attempts to solve the problem of powerlessness (Brown, 1994). Within this framework, almost all symptoms are reframed as attempts at solutions that work more or less well.

Feminist therapy posits that all persons make attempts to solve the problems of their existence, but that not all strategies work as well as others. Effectiveness of a strategy will reflect such variables as age and developmental stage, with those strategies from younger ages usually leading to more problematic outcomes; whether the individual was required to invent the strategy alone, or had assistance and/or modeling, with individual efforts frequently leading to more difficulties for the person; or whether the strategy is one common to or dystonic with the culture and context in which the person lives, with culturally acceptable strategies usually giving better short-term outcomes and being less pathologized (Brown, 1994, 2000). Examples of socially acceptable coping strategies are overwork, high levels of exercise, and moderate amounts of plastic surgery. Self-inflicted violence, along with overuse of alcohol, use of nonprescription drugs, or sex with multiple partners, is placed into the unacceptable category.

Self-inflicted violence is described by almost all who practice it as a coping strategy developed to meet one or several functions. Those who practice it describe SIV as a highly effective form of emotion regulation that is not only more powerful than drugs, but free and not generally illegal. Many report that when they cut, burn, or otherwise do violence to themselves they become calmer, more capable of utilizing intellectual resources, and less suicidal. As noted earlier, this leads to an association of SIV with self-care and self-soothing in persons who have experienced chronic pervasive disempowerment and the absence of protection or soothing from others. Tending to present external wounds often helps soothe the internal wounds of the past.

The physiological mechanism by which SIV creates these effects is not established, but the phenomenon has been described so consistently by people who practice SIV that its effectiveness as a self-soothing technique is beyond question (Klonsky, 2007; Mazelis, 2003, 2007). Self-inflicted violence can also assist a person to regulate levels of dissociation, or may occur in the context of dissociation or in a planful effort to dissociate. Persons with dissociative coping strategies may utilize SIV as a means of orienting to the present by inducing sufficient physical pain to experience themselves in their bodies. A number of people who practice SIV have reported that it particularly assists in coping with suicidal ideation, reducing the internally experienced compulsion to die by replacing it with forms of nonfatal bodily harm in an effort to stay alive.

Some SIV may take the form of allowing the individual to assert control over the process of harm. If harm to self is experienced as inevitable, then being the one who does the harm, rather than helplessly allowing others to do it, can be experienced as a form of self-empowerment by someone practicing SIV. It may also be experienced as a form of self-protection from future violence; much like obesity can serve an adaptive function to deter further abuse in many with complex trauma, someone who practices SIV may

believe the resulting scars on her body will help avert potential harm. The person who believes herself deserving of punishment may also believe herself able to circumvent unpredictable punishment from others by inflicting it knowingly upon herself in a controlled and predictable fashion. Finally, some people who practice SIV find it a strategy for communicating about the degree of their pain to others (Mazelis, 2003; Miller, 1994), as a way to make visual and visceral their distress when language proves inadequate. As one woman told the first author:

> When people see my blood and the wounds they start to have some idea—not the whole idea, but at least some idea—of how bloody and wounded it feels inside of me. I don't know if they can believe how much I hurt inside if they don't see how hurt I am outside. Until I started cutting no one ever took it very seriously how much pain I was in, so I don't think I'm making this up.

Feminist therapy has several important overarching goals that can be found in all treatment. First and foremost is empowerment of the client. Power in feminist therapy is defined in terms of power in relationship to self. Among other attributes, but specifically germane to the discussion of SIV, empowered individuals know what they feel as they are feeling it and can use their feelings as a useful source of information. They are not numb; their current feelings are about current, not past or possible future experiences, and they are able to soothe themselves and contain their feelings in ways that are not harmful to themselves or others (Brown, in press). Thus, feminist therapy with a person practicing SIV must invite that person to develop ways to safely be in the body and to experience affect if that person is to develop alternatives to SIV.

In the service of the empowerment of clients, feminist therapists strive to create an egalitarian relationship. This egalitarian relationship is structurally situated so as to enhance client power, authority, and autonomy. It is one where the therapist invites the client to participate in a collaborative process in which the therapist's expertise at creating the conditions under which change is possible joins with the client's expertise at knowing what is best for her or his own life.

Noncoercion, though not an explicitly enunciated construct in feminist therapy, emerges from the concepts of empowerment and egalitarianism as central to therapy with people who practice SIV. Because SIV is frequently, although not exclusively, seen in the context of complex trauma and the extremes of interpersonal violence, it is particularly important that nothing resembling force or coercion become a part of the process in working with people who practice SIV. Not only does coercion fail, it may in fact intensify SIV as power and ownership of the client's body are involved.

Thus, feminist therapy with SIV requires a therapist to soothe her- or himself about the violence that the client is doing, and to engage respectfully with that coping strategy in a manner that acknowledges its complicated meanings and values. A therapist may wish her client to no longer practice SIV, but if this is not the client's agenda then a feminist therapist is not free to impose this therapeutic goal on the client. As expressed by one survivor of complex trauma who had practiced SIV since early childhood, "Nothing that any therapist has ever offered me calms me down as well as cutting myself. Nothing. And until some therapist is willing to be honest with me about that, I know that no therapist really understands what it's like to be me." Stopping the SIV is, consequently, rarely if ever the initial goal of therapy, unless, and only if, a client specifically identifies it as her or his own goal and is not under coercion from others to adopt that goal.

Many persons encountering this stance for the first time are uncomfortable or shocked. We have had numerous discussions with colleagues who have difficulty initially understanding this position, but who have acknowledged that for the most part, their attempts to impose "no self harm" contracts on clients meet with only minimal success. The striking

exception to this is with well-trained practitioners of DBT, who offer a complete treatment program with a full range of alternative strategies, high levels of support, and a working assumption that clients entering treatment are ready to give up SIV. For individuals wishing to stop, DBT is a treatment of choice, yet many people who practice SIV are at best ambivalent and more frequently quite reluctant to stop, and are often unable to make the necessary commitments required for DBT. With these individuals, we have found a feminist empowerment stance to be more effective because it addresses several of the goals and functions of SIV directly.

Case Illustration

Presenting Problem and Client Description

Heidi was a 32-year-old, Euro American woman born and raised in a small town. She lived below or close to the poverty line growing up and has been financially marginal in adulthood due to difficulties keeping a job. The eldest of three full siblings, her parents divorced when her mother was pregnant with the third; she has several half and step siblings from parents' previous and subsequent marriages. Her earliest memories are of her mother trying to smother her with a pillow. She was kidnapped by her father shortly after her third birthday; he began to sexually abuse her the first night she stayed with him. She can recall digital penetration and forced fellatio occurring regularly during the next 3 years.

Her father then apparently became active in a ring of parental pedophiles who met to share access to their children. From about age 6 until about age 9 she was forced into sexual activities with other children for the purposes of producing pornography. She was also traded with the other men in the group for sexual contact; this activity included sadistic acts of bondage, forced vaginal and anal penetration, as well as other forms of violence and humiliation. Heidi recalls beginning to dissociate around this time, describing it as "floating peacefully above it all and feeling very sad for that little girl. They were doing terrible things to her, but I was at peace. It was nice. I thought I was dead and that no one could see me."

Heidi thinks that it was around the time she was 9 years old that the pedophile ring was exposed; her father and step-mother were among those arrested. Her memories for the last year or so of that abuse are compromised by the effects of trauma as well as by the sedative hypnotic drugs she was given during that time to facilitate her participation as she grew older and more resistant. She was placed in foster care where she spent her childhood until around age 15. She described this foster home as not abusive, but as cold and formal.

Heidi began to practice SIV not long after she moved into the foster home. "I had slipped on some ice and fallen and it hurt really bad at first. Then FM [her name for the foster mother] came over, she was really nice to me for once. It was kind of cool. So I tried to see what happened if I did it on purpose. She stopped being so nice after a little while and told me I was clumsy. But it was hard to stop. It made me feel weird, kind of like I took a drug or something. Like it calmed me down." Heidi reported that her SIV became increasingly concealed after the foster mother's comment and noted that she never felt especially bothered or worried about what she did to herself because it always paled by contrast with what her biological parents and step-mother had done.

By midadolescence, Heidi was regularly piercing her skin with needles, cutting herself on her upper thighs and stomach (where the cuts were invisible to others), and punching herself on the head repeatedly until she became dizzy. She reported that her SIV methods depended in part on whether she was alone or in company, as she did not want anyone to notice her actions: "By then I knew this was weird." They also depended in

part on what she was attempting to accomplish. "Cutting is really good for calming myself down. I cut, I see the blood, and I feel like I can breathe again, like I can stay alive a little longer. I hit myself when I'm mad at myself, but cutting is sort of a nice thing I do for myself when I'm feeling numb or freaked out or want to die."

At age 15 Heidi ran away from the foster home and hitchhiked to a major city where she lived on the streets. She made money as a prostitute, but also eventually enrolled in community college to get her general equivalency diploma (GED), noting, "I thought it wouldn't be that hard to sell myself but it just made me need to cut myself more because it [prostitution] made me want to die. I was getting more disgusted with myself at that point and thought maybe I should try to get out of that life." After completing her GED she enrolled in an allied health care program, graduated with honors at age 19, and found a good job at a local hospital. While she continued to occasionally practice SIV when upset or frightened, she reported that her need to utilize it decreased during her early and mid-20s as she stabilized and improved her quality of life.

Five years before she started individual psychotherapy with the first author, Heidi became a target of sexual harassment in the workplace by a supervisor. As the head of the department, this man had been with the hospital for many years and was powerful and well-connected to the hospital administration, a fact that he frequently trumpeted to his staff. Heidi dates the onset of the harassment around the time that she had lost considerable weight. "I had started doing rock-climbing, so I was going to the gym and working out to get my upper body stronger. I think the sick S.O.B. hadn't noticed me until then 'cause I was a kind of dumpy little thing." The supervisor began by making suggestive remarks, which Heidi recalled laughing off, "I'd heard so much worse." He apparently took her response as encouragement and began to trap her in storerooms and press himself against her.

This sexual assault triggered Heidi's dormant posttraumatic symptoms and responses: paramount among those was not to resist when sexually coerced. "It was as if the entire previous decade of my life hadn't mattered. I was back where I'd been, being raped up against a wall somewhere." She reported that the day after the first assault she went home and cut herself again for the first time in several years.

The sexual harassment continued for 3 years, during which time Heidi became extremely symptomatic. She dissociated during the sexual assaults, increased her SIV, withdrew from her circle of friends, lost appetite and sleep. When her work suffered, her supervisor fired her for poor performance, telling her that she was no longer fun to have sex with anymore either. The firing and his comment sparked rage; Heidi decompensated and trashed the equipment room, which led to her arrest. Her defense attorney, sensing that something was amiss, sent her to a psychologist for an evaluation, in turn, uncovering the story of sexual harassment, although not Heidi's full history. When these details were made available to the attorney, she tracked down other previously fired employees who had similar stories to tell and went to the hospital administration, which then dropped the charges, fired the supervisor, and made an out of court settlement with Heidi.

Case Formulation

The forensic evaluator referred her to the first author for psychotherapy. Heidi entered the office as if she were not in her body; her face was almost devoid of expression, her voice low, and her eyes averted. She radiated shame and inertia. I knew that she had been sexually harassed and assaulted in the workplace, and that the harassment had been severe and highly traumatic. The therapy office dog, a bull terrier sensitive to people's distress, went to her and laid his head on her knee. Much of our first 2 years of therapy occurred

with Heidi touching the dog, either petting him, having him snuggled up against her on the couch, or lying in her lap. She would frequently address to him topics that she felt ashamed or fearful of bringing up more directly to me, for instance, asking him "What do you think your momma would say if I told her . . . ?" followed by a description of something difficult to share.

Feminist therapists invite clients to set the agendas for therapy. This was difficult for Heidi, as her capacity for agency was buried when we began to work together, and her fear of authority had been aggravated by her most recent experiences. Recall that both her biological mother and her step-mother had been involved in abuses against her. Consequently, my sex was not comforting. In fact, no humans felt safe to her at that time, so the dog's presence in the office was almost a necessary condition for her to tolerate staying there. However, simply because it was difficult for Heidi to articulate her own therapy goals did not mean that I came up with goals for her. Instead, I offered to her that I might want to ask her some questions about her life experience, the same questions I asked everyone. I told her that she was free to not answer me, and to not have to explain or justify her decision to withhold information, as it was her private life and I was still a stranger.

The no-coercion rule applies from the start. Although we want to gather a complete personal history from clients, we empower and equalize power by acknowledging the essential absurdity of the request that personal information be shared with a complete stranger on demand simply because of our job titles. The client-as-expert rule also applies immediately; if a person is yet unable to know what her goals are, the job of the feminist therapist is to create conditions under which her client can come to know those goals, rather than imposing her own.

Heidi had had prior experience of therapy while in foster care (something I didn't learn about until about 6 months into therapy) and she was suspicious of my stance, asking me if I weren't going to kick her out if she didn't tell me what I wanted to know. I persisted in my offering her the option of deciding what to share and what not, and validated that it might feel risky to her to say no to me because she had just had a terrible experience at work. I had no idea then just how terrible, or how many other terrible experiences of coercion were part of her life story, but she has told me since that my insistence on her right to refuse without penalty was, "besides the dog," the only reason she returned for a second session.

At the end of the initial session, I asked Heidi to consider if she wanted to continue to work with me, explaining to her that I would be glad to work with her, but that if I weren't feeling like a good fit, then or later on, she could ask me for a referral. "It won't hurt my feelings," I told her. "If you want to stay, the dog and I will be glad to work with you." I intentionally included the dog's name at that point as I'd already noticed her attachment to him, and was operating on a hunch about what history of abuse might lurk in her past based on her responses to me in this first meeting. I gave her a copy of my extensive informed consent document to take home and read, which covers many of my core philosophies of therapy, including clients' rights to refuse almost anything in therapy (www.drlaurabrown.com/resources.php). Seeing this policy restated in writing apparently reassured Heidi, whose faith in her own judgment was badly damaged by the events in her workplace. She came back to psychotherapy and stayed for a decade.

Course of Treatment

It took the better part of 3 months of meeting weekly before Heidi decided to tell me some details about her childhood and the abuse to which she had been subjected. During that time, Heidi and I focused largely on assisting her to cope with daily life, which had

become unmanageable for her in the wake of what initially looked like severe depression. Relationship development is key to the work of any therapy, but in feminist therapy with complex trauma, where disconnection and disempowerment are fundamental aspects of the person's experience, it is even more central. Heidi began her reports of childhood abuse with the least unusual details ("I was sexually abused as a kid,") and as time went on and I neither flinched nor patronized her, she revealed more and more. The entire story of her abuse history unfolded over the course of the first 2 years in therapy, and even during the last 2 years of that decade details emerged that amplified and clarified some aspects of what she had already disclosed. Many of her revelations were followed by an uptick in emotional distress, and thus the process of slowly learning her life narrative was interspersed with our beginning to collaborate on ways to reduce distress and improve her quality of life.

I used an empowerment strategy that entails working with people to anticipate the recovering or recounting of a trauma memory (Gold & Brown, 1997). I suggested to Heidi that (a) we knew that when she told me about something terrible she usually had a very difficult time for a few days, and (b) this would often lead to an increase in suicidality (and as I learned shortly thereafter, SIV). I offered to her the notion that before she shared new trauma history with me, we would work on strengthening her abilities to feel as safe as possible and have a protocol for what we would do afterward. She would wrap herself tightly in a throw that was on the couch, take out a crystal that she had found on a walk, and then focus on it while telling me her story. The dog was usually recruited after she shared information to assist her in being in the present by offering a tangible, safe, alive hugging object. We agreed that I would call her early in the evening after such a session to check in, and that she would go home and swaddle herself there until I called.

We also developed a plan for what she would eat, as she noticed that she often dissociated from her body and thus her nutritional needs after such an episode. The term I use with people struggling with food is "feed yourself as lovingly as you would feed . . . ," with the blank filled in with the name of someone who that person would always feed well and lovingly. As it turned out, all of these collaborative strategies for increasing self-care laid the groundwork both for her revelation of SIV, and for how we proceeded in response to that revelation.

Around Month 5, as I became more certain that Heidi was someone living with the consequences of complex trauma that predated the recent sexual assaults at her work, I decided to bring up the topic of SIV to her. By then I knew that she was often dissociative, both during our times together when she was recounting abuse experiences, and at times in the rest of her life where she would describe to me her experiences of detachment and depersonalization. "You know," I offered, "I've known a lot of people, clients and some friends, who've had lives as lousy as yours was growing up. Probably about 90% of them did stuff to themselves to help themselves cope, and 100% of those 90% felt totally ashamed to tell anyone. A lot of folks who go out of their bodies the way we know you do especially find this something they deal with. So in case there's something you might want to tell the dog about, well, it won't be the first time we've heard about it. Or the last, either, I think."

Inviting clients to share this sort of private, shameful information in this manner often normalizes the coping strategy, and by using descriptive, nonjudging language, it offers a less shaming way to communicate about it. Sometimes the dog is involved in therapy; sometimes people will bring art, or photos, or a poem. Feminist therapy was described early on as offering a "consciousness-raising group of two"; the therapist stands in for the group. As a shame-reducing strategy, she can offer information to clients about the common experiences of others.

Although feminist therapy does support therapists in the use of self-disclosure, I would not at that time have shared information about my own experiences of SIV, had

they existed. This is because I have learned that people with SIV frequently feel as if others who practice it are doing something perfectly sensible, but that their own practice of this coping strategy is more shameful in comparison. Although some survivors of SIV who are also therapists do share this kind of information upfront with clients or have written about their own experience of SIV, many others, including the second author, believe that any self-disclosure of personal experience with SIV would be appropriate only when or if it serves an individual client's interests by empowering the client. Because many individuals with a complex trauma history are excellent at switching attention from themselves to caring for others, particularly powerful others, knowledge of a therapist's SIV history risks evoking that dynamic of role reversal, which once again places the person practicing SIV in the one-down position.

Heidi and I then had several sessions in which she hinted that she might have something to tell me about SIV; I reminded her that she would do so if and only if it made sense to her. At one point, I apologized for possibly creating pressure for her to tell something, after which she became exasperated with me, saying "it's okay to be a little more pushy sometimes, you know. You're not trying to strangle me, so what's the big deal?" My tone was joking when I countered that strangling was so far below practice standards that I hated to think that anyone who didn't strangle her could do what they wanted. Although we both laughed, she later told me that this was another important point in our work together. "You actually thought I deserved to be treated with care. That I had boundaries to be respected. It was so shocking. I couldn't tell if you were naïve or just a pushover. But whatever, it was kind of nice to see that you wouldn't let me talk you into treating me badly. That was kind of cool in a weird way."

At our next meeting, Heidi came in with a sheaf of paper that she thrust into my hands, stating, "Read this first." She then curled up on the couch hugging the dog, her face buried in his fur. In the papers were descriptions of her SIV practices and what she used each one of them for. The writings ended with, "Now I know you'll get rid of me, because I can't stop this."

It feels hard to convey the magnitude of gratitude and respect I felt for Heidi at that moment, although I think I conveyed some of it to her. I told her how large a gift of trust she had given me by sharing this information, and I praised her for finding a way to do so that would allow her to feel somewhat protected by the dog while I took in the data. I told her that it was my belief that people practiced SIV (and this was the point at which I introduced the term to her) for good reasons, and that I had respect for those reasons because all of them were about finding ways to stay alive.

I laid out for her my philosophy of working with SIV. "If you don't want to stop, you don't have to stop. It can become a problem for some people to continue because they accidentally hurt themselves enough to require medical treatment and then the system starts to try to interfere with their lives and control their bodies. Some people miscalculate and can end up dead, which from what I'm reading here I don't think you want. Everyone I know who has ever done this has told me that the alternatives I can offer don't work as well as SIV does at first, and sometimes don't ever really work as well. If you want alternatives, or want to experiment with doing this less, we can do that, like we've come up with some ways to help you with dissociation. If you want to talk about it, you can do that. It's your body, Heidi."

So began a 6-year period in which SIV was on the table in therapy. It was not at the foreground most of the time, but it was always discussed. Heidi would tell me about using SIV, and I would ask her, in the service of empowerment, to become more aware of her feelings, thoughts, and situations before using SIV, as well as her responses to applying the solution to those difficulties. My belief as a feminist therapist is that behaviors done

outside of conscious awareness are disempowered behaviors, and that by inviting Heidi to become mindful in her use of SIV she was in a position of greater choice. It was via this method that she became able to understand the specifics of her SIV practice even better, and to appreciate how completely life-saving it had been for her. "If I hadn't started to cut myself again when that shithead [her supervisor] was raping me I probably would have killed myself."

Greater mindfulness also led to the possibilities of change. "You're spoiling it for me," she sputtered one day after I again inquired into antecedents and results. "Spoiling?" I queried back. "Yeah, as in, if I actually stop to pay attention and think about what I'm doing I gross myself out. What am I thinking?" she exclaimed dramatically.

"Uh, thinking is probably not part of how you figured this out," I replied in a matching humorous tone. More seriously, I commented that it was my experience, and I was beginning to think hers as well, that kids who do SIV come upon it by accident, and find out that it works before they have a chance to reflect on what they're up to. I offered her some writing I'd done about the concept of symptom-as-resistance-strategy, commenting that some people had found it useful. In feminist therapy, making information available to clients is common.

I also asked her at that point if she had any interest in any of the alternatives to SIV. "How about free-climbing?" she joked, referring to a risky rock-climbing practice that eschews the use of ropes and carries high risk for injuries or death. "How about mindfulness meditation?" I offered back. "How about we compromise, like, I could take kung fu. There's a school in town that offers classes to women only. I think I like the idea of moving around . . . I'd probably punch someone if I had to sit still and meditate."

Kung fu turned out to be the alternative to SIV that eventually worked for Heidi. Her school, owned and operated by a woman who was herself a survivor of interpersonal violence, had many students with scars like Heidi's, which they referred to, in a term invented by feminist author Alice Walker, as "warrior marks." As Heidi commented toward the end of our work together when her SIV was no longer a preferred coping strategy, "One of the things I realized, between you and kung fu, is that I was in combat all of my childhood, in terrible combat zones where I was wounded. Cutting myself and hitting myself were some of those wounds, but they weren't stupid and they weren't wrong. They were what I knew how to do at the time to survive the battle. And now I'm a veteran—but with no benefits," the last said jokingly. At her kung fu school she learned to be more disclosing of her history of SIV, which made major inroads into her shame, and she became less isolated and found ways to be in her body. Although this often frightened her, she was able to bring that fear into therapy and move forward rather than continue in posttraumatic avoidance.

This reframe of her experiences of abuse was only one component of what made the martial arts a good SIV alternative. Feminist therapists are not particularly prescriptive, and thus I would not prescribe a martial art, or any other particular alternative strategy. I will offer possibilities, based on what I know from research on effective strategies for people who have wished to stop using SIV, such as mindfulness meditation, self-soothing practices, and the movement and body therapies. I have worked with SIV practitioners who have turned to drumming, triathlons, studying for the rabbinate, writing books, or needlepoint (one woman created a piece which she titled, "Stuck in This Instead of Stuck in Me," referring to where the needles now went). Others, like Heidi, found martial arts to be effective alternatives to SIV. Heidi's process of changing her relationship to her body, which included continued practice and increasing mastery of her martial art, led her to develop and bring into our work more self-generated strategies for helping herself besides SIV, although she continued to practice it intermittently for most of our first 6

years of therapy. At one point, she became invested in making herself stop, which first led to an increase in frequency, and then to her own awareness that just as being forced by someone else to do something against her will was traumatizing to her, so, too, was self-imposed coercion or disrespect. We noted together that she was incorporating the values of feminist therapy into her relationship with herself.

At one point during her kung fu training, Heidi struggled through a period of injuries and needed to sit out classes for several months. We both commented on how unusual it was for her to notice pain and injury in her body and to respect her body's message to her requesting a rest; this was another important turning point in her process of moving out of SIV. She commented during this time that because she was trying to avoid using SIV, the enforced rest from kung fu pushed her into finding other ways to do self-care. "So guess what, I'm going to get a dog," she announced, beaming. "A rescue dog, you know, someone with complex trauma like me because I think I know how to care for someone like that."

During this time we also looked at the previous period of low levels of SIV in her life, which happened during her initial years in the workforce before the sexual harassment and assaults. When she decided that she wanted to go back to work, Heidi realized she wanted a job with more institutionalized power, and began to seriously consider the idea of going back to school as a premed student. "I love healing people, you know. I loved helping people breathe better, it felt like the best thing I'd ever done. But (her last position) is low person on the food chain." She felt excited and terrified by the prospect of applying to college, as no one in any of her families, biological or foster, had gone past high school, and because she was still uncertain of her intellectual capacities. Again, SIV peaked somewhat as her anxiety built, and again I helped normalize it and supported her in sharing her experiences and, equally importantly, the self-care that she was doing to support herself in her goal of letting go of SIV.

Outcome and Prognosis

The last 4 years of our work together coincided with Heidi's undergraduate career. She applied for and received a full-ride scholarship to a local university, allowing her to devote herself completely to school without having to tap further into the dwindling funds left from her legal settlement. At Heidi's urging, we involved her academic advisor in the loop of therapy at this point. Heidi wanted us working together as a team, which turned out to be excellent self-care on her part as her grades were less than stellar during her first term. Together the three of us were able to analyze how school had evoked various trauma-related affects and memories for Heidi, and together we strategized how to reduce those, and how to get her quick access to support on-campus during the day.

During those last years Heidi rose through the ranks in kung fu, and I had the pleasure of watching her black belt test 6 months before our work together ended. This willingness to extend outside of the office when the outside activity is itself an extension of therapy is also a component of feminist therapy—the person's strengths and competencies are recognized and made as important as their distress. I was also present at her graduation from college. She had been accepted into a medical program that had a strong emphasis on the social justice aspects of medicine, which excited her greatly. That summer we spent time reviewing our work together and making plans for how to support her in that transition. When I offered her the possibilities of referrals in her new city, she told me that she would rather wait to see how the transition went.

We had a few semi-emergency telephone sessions after Heidi moved; during the third call I once again invited her to consider finding a therapist where she was located,

pointing out that neither psychotherapy nor kung fu worked very well over the phone lines. Because she had busied herself finding a new place to train, she was open to this confrontation, and over the next month we worked together to facilitate transition of care to my colleague in her new town.

I receive phone calls now from Heidi about once a year. She is in her second year of a combined family practice/public health residency. She struggled with a recurrence of SIV around the time of her board exams midway through medical school, and has had to continue to find alternatives. Her complex trauma will always inform her life. She has chosen so far not to enter into intimate relationships, expressing her concern that either "I will blow up a relationship or a relationship will blow me up, so I'm going to finish med school first. Meanwhile I'm pretty happy with my dog." To some extent, Heidi has substituted the overwork and commitment of her profession for emotional connections with unpredictable others; consequently, she still has few close friends. She has continued in therapy, and anticipates that it will remain a constant in her life for many years to come as she continues to navigate the shoals of new experiences that evoke old wounds. Now, she rarely uses SIV to cope.

Clinical Issues and Summary

It is difficult to do justice to a decade of individual psychotherapy in a few pages, but the process of Heidi's therapy offers a good illustration of what clients have taught us about responding to SIV from a feminist frame. Any time either one of us attempted to be coercive or use power-over strategies in response to her SIV, she took power in the way she had always known, which was to control her body and what was done to it. Each time we respected that she was the person who owned her body, and then integrated that awareness and concept into improved relationship with that body, she was more able to find ways to reduce SIV, and eventually to make that her own goal.

Working with SIV from a feminist therapy perspective requires the development of a relationship of trust. We must trust the people with whom we work to be honest with us about the risks they take with their bodies and safety, and they must trust us not to panic or try to protect ourselves by controlling them. However, there are times when this strategy may not work well. For example, with individuals who have Dissociative Identity Disorder (DID), alter personalities may not engage in the project of therapy until fairly far into the process when co-consciousness has developed. Self-inflicted violence also can have different meanings and functions for people with DID, especially when there is a strong sense of separateness between alter personalities. One woman, who was speaking from a particular alter ego, told of how she was "going to go out and get HIV so that those others [younger alter egos of whom this one was contemptuous] will get sick and die and leave me alone for good." The groundwork for responding to SIV with that person required a number of years of working on co-consciousness and a new phenomenology of shared physical space before SIV could be addressed. This same alter ego commented later on, "If I'd known I was doing this to myself I would have stopped, because I wasn't the one who deserved to get hurt." All involved were relieved that she had not, in the interim, contracted HIV.

Often, people who have responded well to feminist noncoercion strategies have been in many other forms of psychotherapy in which they felt pathologized for this particular symptom, were required to sign no-harm contracts, and then felt shamed when they could not keep them, or were even fired for breaking them. As a one-time client of several psychotherapists, none of whom were feminist therapists, the second author experienced repeated failure by these therapists in their frightened and coercive efforts to stop behavior they deemed pathological. At present, there is no controlled research on whether

feminist therapy is effective in working with SIV, but we have many reports by people who practice or have practiced SIV about what has helped them (e.g., Abrams & Gordon, 2003, Harrison, 1997, Mazelis, 2003, 2007, Piran, 2001). Their narratives strongly support the feminist position as helpful, even when a therapist was not intentionally using a feminist perspective.

Working with people who practice SIV is challenging for therapists because it necessitates self-soothing, nonjudgment, and a compassionate understanding of the central functions of the practice SIV in each individual's life. It also involves being a witness to harms to the body. We urge therapists to put these harms into the context of our clients' lives. Persons who practice SIV have often had numerous unwitnessed harms inflicted upon them and countless experiences of violations of body ownership (Piran, 2001, p. 173). If as psychotherapists we can witness harm without imposing directives or violating body ownership, thus offering to our clients both visibility and autonomy in the healing process, we are, we submit, more likely to empower them to find a variety of alternatives to SIV.

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