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# THE CUTTING EDGE

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## A Newsletter for Women Living With Self-Inflicted Violence

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Welcome to this, the 34<sup>th</sup> issue of **THE CUTTING EDGE**. The compilations of years seven and eight of the newsletter have now been completed and will be available in the next several weeks. Please let me know if you are interested in them or any other back issues.

The next issue will be focused on the “triggers” for SIV, and how to heal them. Please send in your opinions, prose, poetry, or artwork by the end of September, 1998 for inclusion in that issue. If it suites you better, please feel free to e-mail me at [Rutamaz@aol.com](mailto:Rutamaz@aol.com).

### SIV: BIOLOGY AND MEDICINE

This has been a surprisingly difficult editorial. The literature that I collected on the subject of the biology of mental illness as it relates to Self-Inflicted Violence (SIV), as well as the recognition of the power of the business of psychopharmacology, frustrated me greatly. Yet this is why the topic must be explored in depth – the biology of mental illness is a broad and popular subject not only in American psychiatry, but in the popular culture as well. Also, the pharmaceutical industry stretches to touch not only physicians and patients, but also the general population, governmental agencies, academic and teaching institutions, and the research and policy development decision-makers. As reported in *Psychiatric News*, the pharmaceutical industry earned more than \$15 billion in 1996, making it the most profitable industry in the U.S.

Drugs are big business in the United States. We are the most medicated society on the planet. Many of us are comfortable with the concept of turning to chemical solutions for the resolution of various problems, including physical illnesses and emotional and mental difficulties. An increasing amount of research monies in mental health are directed towards drug research. Some psychiatric residency programs are dropping requirements that used to mandate residents to learn psychotherapy skills, leaving them trained only in biological treatments for the patients they serve. Some psychological organizations are fighting what appears to be a losing battle for the right to prescribe psychotropic drugs. The legal and medical worlds have even intertwined, leaving us in a country wherein drugging a person can be mandated and enforced by law regardless of the wishes of the person being drugged. Drug companies themselves fund psychiatric organizations, research grants, and consumer and family groups. One pharmaceutical giant in particular has been designated as one of the top five lobbyists of the federal government. Most psychiatric journals, including the publications of the American Psychiatric Association, are inundated with pharmaceutical advertisements. Marketing strategies abound. Drugs are a powerful and lucrative business.

A March 20, 1998 article in the *Psychiatric Times* (Newspaper of the American Psychiatric Association) titled "Prescriptions for Antidepressants, Stimulants Increase Dramatically" stated that antidepressant drug prescriptions rose from 12 million in 1985 to 25 million in 1994. How can this increase in drug prescription be explained? The answer is surprisingly simple. Drugs are biological agents. They are presumed to be solutions to biological problems. And all problems can be portrayed as having biological components. Therefore, all problems can ultimately be seen as possibilities for drug intervention. And we have many problems.

It is certainly not unusual for women living with SIV to experience many types of struggle in their lives. Those of us who recognize the roots of SIV to be anchored in a history of past trauma also recognize that trauma itself often has a global impact on the life of the survivor. Surviving trauma, especially childhood abuses, takes its toll, and often leaves one rather devastated for a time. Depressions and anxiety are normal repercussions for abuse survivors. The existence of a variety of coping methods, including SIV, can also be expected. The mental health industry becomes involved, via diagnostic labels and various treatments, in the lives of many persons who are living with such an assortment of struggles.

Current diagnostic practices rarely address trauma as the root of many difficulties. Some of the most common diagnoses given to people today, most of which are alleged to have biological roots, are Depression, Anxiety, Panic Disorder, Psychotic Disorders, and various personality disorders, including Borderline Personality Disorder. Disorders clearly linked to trauma, such as Post Traumatic Stress Disorder, are diagnosed much less frequently. Others, such as Dissociative Identity Disorder (formerly known as Multiple Personality Disorder), are the center of debates about whether they even truly exist. The "False Memory Syndrome Foundation" has placed a great deal of pressure on clinicians, survivors, and the general public to disavow survivors of their reports of past abuse, even by persons who never repressed their memories. Certainly the threat of lawsuits by these "FMS" people can lead many a clinician to avoid acknowledging childhood abuse, and psychiatrists in particular to choosing drugging over therapy as treatment of choice. The temptation is great to jump into biological reasons for diagnoses because it absolves the traumatic roots of the problems, simplifies most everything, and removes the need for confrontation of self, history, and others. When I spoke to psychiatrists who have a basic understanding of trauma and its consequences, I became aware that all of them learned what they now know not during their training, but from their patients as well as other resources they found later. Our current health care situation is leaving physicians less and less time with their patients, so the opportunity for learning is decreasing as well. With the current emphasis on biological treatments, the world of psychiatry is narrowing greatly. The disease concept of mental illness is robbing patients of their humanity, and physicians of their opportunities for connection.

What of the research that links SIV to biological origins? Current theories of brain dysfunction implicated in SIV are most often linked to supposed defects in the brain's production and/or utilization of various neurotransmitters (brain molecules that serve as messengers). Two of these neurotransmitters, serotonin and dopamine, are the most often mentioned. A whole host of various diagnoses are being linked to perceived abnormalities with those transmitters. It has been proposed that a shortage of either may be linked to SIV. The most recent focus has been on the relationship between serotonin and various disorders such as depression, panic disorder, obsessive-compulsive disorder, and eating disorders, as well as "self-mutilation." Of course, the most recent type of antidepressants invented impact serotonin utilization in the brain. This group, referred to as SSRI's (Selective Serotonin Reuptake Inhibitors), contains the popular Prozac, Zoloft, Paxil, and Luvox. The number of prescriptions for these drugs has been increasing exponentially over the years, and the profits to the pharmaceutical manufacturers have been great. Classified as antidepressants (Luvox is approved for use on obsessive-compulsive disorder in the U.S. but is determined to be an antidepressant in England), these drugs are being prescribed for an ever-increasing assortment of diagnoses, and most recently have been targeted for use in children and adolescents.

The theories linking biochemical imbalances to SIV are weak and inconsistent. Researchers vary in their opinions about the brain chemistry involved in SIV. Some blame neurotransmitters, others the chemicals known as endorphins (natural "morphine"). Some theorize that the wounds of SIV cause a release of endorphins, and that the person self-injuring is physically addicted to the endorphins. SIV is therefore presented as a form of chemical dependency. The fact that most wounds of SIV are not severe enough to

cause a great release of endorphins, or that the “drug effect” does not occur with accidental injury, are quietly disregarded. The most ignored aspect, however, is the common link found in many persons living with SIV – trauma.

Opinions in the mental health literature remain divided on the source of SIV. Some psychotherapists (and most persons living with SIV) point out the traumatic origins of SIV, and some acknowledge the psychic coping needs it serves. Others (particularly biopsychiatric researchers) view SIV in terms of abnormal brain physiology. A few have begun to explore the physiological consequences of trauma; however, the emphasis of this research remains on the pharmacological treatment of these brain changes. By far the most interesting article that I’ve recently come across in the mental health literature was one that reported on brain chemistry changes occurring as a result of psychotherapy. The researchers sounded amazed that therapy, not drugs, could also alter physiology. While this may not seem surprising to many of us, it sounded like a revelation to them. These psychiatrists were hopeful for more research on the subject, as am I. I doubt that this will happen in the near future, however; I am uncertain of the funding sources that could be found for research that may espouse nonpharmaceutical methods of healing.

Basically, drugs in almost any classification have been indicated for treatment of SIV at some point or another. Most often the focus has been on the various antidepressants, however; the antipsychotics are commonly prescribed as well. Other medications include mood stabilizers, antiseizure drugs, and opiate antagonists (the latter being utilized to reverse the chemical “high” of SIV). Not mentioned publicly are other fairly recent approaches to various diagnoses, such as brain surgery for severe obsessions and compulsions (which some clinicians believe SIV is part of), as well as the experimental use of rTMS (repetitive transcranial magnetic stimulation). This most recent invention is being touted by some as a biopsychiatric replacement to electroshock therapy, and one recent study targeted women with Post Traumatic Stress Disorder as candidates for this dramatic approach which impacts targeted brain tissue with magnetic energy. These developments should cause us all great concern, as it took years of concerted effort by many persons, within psychiatry as well as outside of it, to publicize the devastation caused by psychosurgery and shock therapy.

Perhaps the least openly discussed aspects of psychopharmacology presented to the lay public are the consequences of drug usage. People generally perceive that the various psychotherapeutic drugs they have been prescribed have been proven safe in the long term. This is, unfortunately and possibly tragically, untrue. Psychiatric drugs are powerful agents, and their use is encouraged even when they produce intense and occasionally permanent side effects. Many of these side effects are minimized by those who prescribed the drugs. Others are determined to be worth the risk as the drug effects are beneficial. What is known however; is that many harmful effects of various psychiatric drugs have gone unspoken for long periods of time. Several prime examples of this are previous beliefs that drugs such as Valium and Xanax were not addictive, and that the major neurological damage (known as tardive dyskinesia) caused by the typical antipsychotics was actually part of the “illness” rather than being a side effect of the medication. Now that there are new “atypical” antipsychotics on the market, the reality of the damage caused by the earlier drugs is being exposed. Yet reports are beginning to come in that the newer drugs cause damage as well. This should not surprise us.

What should surprise us are the repercussions caused by the more familiar and readily prescribed drugs such as the SSRI’s. It is unknown if the brain changes caused by these drugs are permanent, and recent psychiatric literature is starting to recommend that patients be maintained on these drugs permanently. Other recent research is disclosing that clinicians are noting various previously unforeseen and undocumented side effects from these drugs as people stay on them over time. Some antidrug psychiatrists, such as Dr. Peter Breggin, have been relating the harmful aspects of these drugs for years, but have basically been ignored by their peers and most of the press. In the meantime, more prescriptions are being written and the targeted population for the next wave of recipients is our children. The pharmaceutical industry is a powerful and savvy business.

Research does show that drugs do impact “self-mutilation,” as SIV is most commonly referred to. Certainly they do. So would a full body cast. The drugs are powerful and do change people. Some drugs make people feel “better,” others make them feel nothing. Had I been a research subject during the time I

was forcibly medicated, I would have been determined to be a successful outcome of drug therapy. Actually, the drugging I received, with its attendant discomfort, made me quick to hide my SIV, and present myself as a “good patient,” so that I could hurriedly make my way out of the system. The question becomes one not of drug efficacy, but of healing. Unfortunately the focus of most mental health care is behavioral appropriateness and societal functioning. Drugs are easy solutions to achieving these goals. They may even be seen as worthwhile by the patients that take them. But the concept of healing is easily ignored, and the belief that biology is the sole problem further negates the development of the whole person. Psychiatry seems to have become a place for the management of objects rather than the healing possibility of relationship.

As we explore the beliefs in the psychiatric community about the etiology as well as the treatment of “self-mutilation” we can recognize how important it becomes that we are aware of these current opinions. It is easy to tell someone living with SIV to “seek professional help.” It is crucial to educate ourselves about what that help entails. We must not remain naïve about the intentions of the “helping professionals” to be able to really provide for healing and we must not remain unaware of the financial connections between the pharmaceutical industry, the research aspect of medicine, and the mental health professionals. For persons living with SIV, the public and medical emphasis will always be on symptom management, not long term healing. We need to discover our own abilities for healing, including the ability to discriminate what is helpful and what is not, regardless of what we are told by external sources, even so-called experts. Let us not be tempted with simple solutions to complex problems. Although healing is a long and complex process, it is simply the best alternative to suffering that I know. If drugs are consciously chosen to assist in that process, so be it. But let the person choosing to take them be fully aware of her choices and the possible repercussions of them.

One of the reasons I wrote this editorial was to familiarize readers with the politics and business behind the traditional psychiatric approach to the treatment of self-injury. It is crucial to be a critical consumer in today’s society, and nowhere is that more important than when dealing with health concerns. Yet it is very difficult to explore the issues when one is struggling, and when people around you make claims for simplistic solutions. It is both fascinating and tragic that while physical medicine is continuously recognizing the interrelationship between the physical, emotional, spiritual and mental aspects of human beings, psychiatry is narrowing and constricting its focus. The Hippocratic Oath (the traditional oath of physicians) states, in part, “First, do no harm.” This is a profoundly important statement, especially when applied to mental health practices. Yet physicians can only work from the knowledge base they’ve been given. Pharmaceutical researchers and manufacturers take no oath, and their work is unarguably intertwined with what physicians are believing and doing. The prescription drug trade, and the insurance industry (which often supports drug therapy but not psychotherapy) are lucrative and powerful businesses. They impact mental health care providers in multitudinous ways. Some of their tactics are subtle, some direct. One of the most recent comical public relations tactics related to me by a dear psychiatrist friend was the arrival, at her home, of a box carrying three helium balloons touting the psychotropic drugs Prozac and Zyprexa (manufactured by Eli Lilly). What was she supposed to do with them, give them to her children?

The newsletter **MISSISSIPPI VOICES** runs a quote from the U.S. Advisory Board on Child Abuse and Neglect which says: “each year almost 2,000 American infants and young children – more than five each day – die at the hands of parents or caretakers. An additional 18,000 children a year are disabled permanently and 142,000 are seriously injured.” Consider that most people who live with SIV, and are survivors of childhood abuses, are not even included in the statistics – the abuse may not have been serious enough to permanently disable, or the injuries severe enough to be medically serious. In 1995, abuse reports were filed on 1 in every 25 children in this country. That is an incredible number of little people who are living very painful lives. Certainly they will all be impacted by their experiences. How will we look at the consequences of their trauma? What if those repercussions include SIV? How do hope that they are treated? It is my hope that the treatment for SIV will no longer be limited to simply stopping the behavior. Drugs, punishment, and force can accomplish that goal, but often at the cost of the recipient’s dignity and empowerment. Life without SIV is a possibility for us all, and occurs as an outcome of a healing process, one that alters a person holistically and not simply biochemically.

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Why Care

call me woman  
i'll swell in pride  
eating away at me still  
i am a survivor deep inside

call upon me anytime  
i've got courage and I've got guts  
with a razor I scratch myself to bleed  
just don't ever call me "nuts"

for about three and twenty years ago  
sexually molested to and fro  
hurt . . . anger . . . pain – a generated need  
my father wouldn't plead

now i watch  
as i place another mark upon my body bare  
if nobody else does  
why should i care  
if nobody else does . . . why should i care?

Charlene McNamara

When the Pain Returns

Double think, double talk,  
This half a life that is mine,  
As soon as I make some headway,  
My pain again I find.

Feel broke in half, in thirds, or less,  
I toil to survive my very best,  
Thoughts of many stay in lieu.

It's time to push on, to break this cycle,  
But I'm trapped here once again,  
But, damn it, I am safe in pain,  
This mental prison still my friend.

My chest feels heavy, aches from old,  
I struggle to save my very soul,  
Waiting for an answer that hasn't come,  
My secret past is where it's from.

Double think, double talk,  
God, help me pave the way,  
To share the lives within me  
And live but day to day.

Lynn Carmichael

*New Hampshire State Hospital, 1994*

*Feels like rage coming on. Toni's voice takes on a hard edge, and she pushes, pushes me farther and farther into the corner. I think of my therapist and I can't believe he's gone. I need him now. I need to hear him explaining, with his big words, just what is happening to my body, with my heart pumping faster, the rage building and building.*

*There was this big guy at the hospital. He wore new-looking sports outfits and he towered over everyone. With a crazed look on his face, he followed this longhaired girl around, touching her even after she begged him not to. They gave him so much Thorazine that his jaw locked up, and he carried a wet towel around for days, putting it on his face. The Thorazine made me dizzy in the mornings, after my smoke break. Once, I nearly passed out in front of the nurses' station. I sat down on the floor, unable to catch my breath. As I sat, spinning and lost in a fog, they didn't even look twice, though I knew they could see me. That terrified me most, their indifference, and I knew then that getting out of there was vitally important. To them I was just another body to feed and dope up. Their goal was to keep me calm, and to torment me so I would never come back.*

*I feel helpless when Toni's mad at me this way. I feel a sense of danger as her words become sharper and sharper. My mind begins to rip and tear at me, saying over and over, "Run. Hide quick! Don't say a word now; just keep your face blank. Nod your head, she's out of your reach now, there's nothing to do but agree." Sooner or later the rage consumes me. I try to tell her what is happening to me but she's too far back. Once the rage moves down my chest and into my limbs it's too late. There's absolutely no way for me to move past it. It will die it's own death and I'm never sure just when that is going to be.*

*This blond serious-looking woman in the room next to me went on and on, bitching from morning until night about how her family, a bunch of drug dealers, put her in there to stop her from turning them in. Her voice was high, like the whine of a car turning the corner too sharply. It pierced my ears until I finally yelled, "Shut the hell up, will you?" It made no difference. She stared at me, her eyes hot coals, burning slowly with some out of control thought, some stark fear. I couldn't decide whether she was delusional or if she was telling the truth. What if they were really doing this to her? Could people still do that sort of thing in this day and age? And if they could, what might happen to me? Survival was my only thought. Looking good, smiling politely, pretending to follow their odd agenda – that became the conquest of my days. I had to get out of there.*

*I forget that Toni will stop at some point and love me again. I imagine I will get in the car and drive away, take all my money from the bank, and get a good map. There's nowhere to go though. Florida maybe, but then again, it might not be safe at all. When I went to Disney world the tourists stared at my scarred arm. Not just the children, but the adults too. Then they whispered. I pretended not to see.*

*I tried to steal light bulbs from the lamps in the visitors' room. It felt like they weren't watching me sometimes but they would suddenly show up in a bunch. I'd turn toward the wall and try and break the glass fast so I could draw blood before they got me. When they attacked, I closed my hand tightly around the broken pieces hoping to do some damage before they took over completely. They pried my hand open and I could see it was no big deal. All that for nothing and then the hours in four-point restraints. They were always too tight and my hands went numb. This was terrifying for me. I begged them to loosen the leather straps but they ignored me. I wanted to be dead then, just to escape myself. I felt as if someone else had caused me to be there by some trick I didn't understand. I couldn't tell them this, but even if I wanted to, they never stopped long enough to hear me say more than a few words at a time. One guy gave me extra cigarettes out in the fenced in yard, but he never talked much. I thought he was nice and tried to explain myself to him. He just smiled. That was a gift in there. I knew that and I tried never to make him uncomfortable. He drove a big black truck to work. I complimented him on it and it made me feel human again but the fence lay between the truck and I, reminding me of where I was. Lenny, the guy who said he was an American Indian, threw his socks over the fence each day until he had no more. I held A.A. meetings with him so they would let me go home. He had dried medicine on the corners of his mouth and*

*stank. They took away his home privileges because he screamed at his girlfriend, berating her, abusing her with his words. I pretended to like him. I was disturbed, I wasn't stupid.*

*The rage moves around inside my body, looking for a place to settle in, build its nest, claim its rightful home. I know that I want it out, gone, over with, but it really isn't up to me. I imagine ways to get it out. A thought comes into my mind repeatedly, "Pain." It says, "Pain will clear this wreckage of anger out. Cutting, or even smashing of the face, always works. The more pain the better. You know it. You know that what I say is true." I resist because I think of my therapist and I know he believes this is not so. I want to trust him, to fight the rage, to believe myself that it will go away if I don't bring on the pain.*

*There was a tiny little Asian girl who spoke very little English. She heard voices telling her not to eat. She was so thin I gave her a wide berth walking down the hall. I felt that if I bumped into her I would break her tiny body into a thousand pieces. Another pretty girl threw a rubber ball up, catching it as it came down. She did this all day long. I sometimes said good night to her, or good morning. She looked right at me, speaking with a cheery word or two, but I felt as if I was interrupting her from something very important. One sleazy girl with a blue jean jacket and bad teeth hung out with me. She kept saying we'd get together after we were out of there. I could see she had a lot of power in that hospital so I became her sidekick, her pal. I gave her cigarettes when she ran out, but I swore deep inside to walk away from her as soon as I could and never look back. She was like the street people I hung with when I was a drug addict. I saw my past written all over her face. It made me feel ill.*

*Toni reaches out to take my hand in the car. I don't want her to. It hurts on my skin. I feel like a burn victim. It actually hurts. All I want is to be close to her again but something in my body makes it impossible. I know I love her. I know this. I feel as if I'm being punished and it makes me think of disappearing. Like on "Star Trek." I want to become a million particles and just disappear.*

*The person who had my life in her hands at the hospital was named Pat. I don't know what her title was but she had beady eyes and she was hyper, talking too fast, making bizarre statements. I didn't dare question her. I knew that she was way more crazy than any of the patients and more dangerous. I began to see my daily job as one of pleasing her, of making her think she was making me respond to her, and changing to her exact specifications. Other staff made little jokes about her, about her being on medicine, and her being whacked. But she still had control of me so it was serious business.*

*Life is hard for me. I run and run, from one chore to the next, but in the end I always mess up. I forget something I should have done or do it wrong. I say the wrong thing or don't say the right thing. Then there's an argument and the rage comes again. My therapist says some day it won't come but I find that hard to believe.*

*They took me there when I bought a gun and when Toni took that away I cut 90 stitches worth of cuts on my arm. I could have gone to a better hospital but I refused. I wanted to suffer because I knew I caused other people too much pain. I thought if I suffered enough I would stop doing it. On Wednesday mornings they took our sheets at six o'clock. That meant getting up before the first cigarette time. The t.v. in the open area blared and people talked over it. There was nowhere to go to get away from the sound which pounded in on me. I stood in a long line for meds and hoped someone would "go off" so it wouldn't be so boring. I laughed with some of the others, watching the crazier ones. It was not a nice thing to do but it meant survival for me. I knew if let the place get to me I would become truly insane and I may not ever pull it together again. This realization did not take away the craziness that I did have, it just made me realize that no one was going to help me and I would somehow have to deal with that craziness and not become crazy the way the other people were. One girl with glasses wore special green clothes that could not be torn. She cut herself and in the middle of the night she tried to strangle herself with the gauze they'd used to cover her wound. I got up and walked to her room because of all the commotion. They told me everything was all right. All right? I could hear her coughing for two hours. The next day her voice was gone. She smoked her cigarette by the wall, throwing little stones away from her. She didn't look anyone in the eye. They placed an aide by her side at all times. She even had to go to the bathroom with the door open. That had happened to me too, but they never made me wear the green clothes. I wouldn't have cared, they were kind of cool-looking.*

*Toni has been my friend and lover for over three years. She is closer to my heart than I really even understand myself. When she is angry with me or unfair in some way I first feel terrible fear and then the rage. I think the rage is the same rage I felt at my mother and that I have it for the same reason. I wanted my mother to love me and she couldn't. I want Toni to love me too, and she does, but when I think she doesn't the rage comes. It isn't Toni's fault. She didn't create the rage. Neither did my mother, I suppose. It came as a result of a need for it. It comes now because it has never gotten what it wants. What that is I do not know. I wonder if I'll ever know.*

*When Toni visited we had sex in the visitor's room. I had such a need to be close with her. When she left I watched the door click locked behind her. I knew I was in hell and that even when they let me out I might still be in hell because their hell was only a part of it. My hell was just as powerful and kept sending me back to those places because I was too terrified to be with the normal people. The crazies were safe in a way. They could attack me at any time. I knew this and still preferred it to the shame I felt when in the company of ordinary people who were obviously uncomfortable around me. I really didn't believe it would ever end but as much as I wanted to die and never have to feel the pain again I wanted to find peace more. The battle of these two feelings stormed constantly inside me.*

*The rage comes and makes my thoughts way out of control. At times I fight them and then I give in and I lay awake crying and speaking out loud in the dark. I'm not sure who this is who talks this way but I have to let it happen. Eventually, the crazy talking in my head stops and I am left with this rage that gives me a loneliness worse than any I would ever wish on another. I want to hold Toni, to tell her how much I love her. I don't know how to get there. I feel bound up inside. I get heartburn. I smoke too much.*

*I try never to go to New Hampshire now unless I really have to. If I don't go there I will not ever be put in their hospital again. Sometimes, at night, I think of that place and it's clear in my mind that it's frightening. I think about it trying to figure out how I did that to myself and no matter how I try, I don't understand why I bought the gun, why I went to that state to cut myself knowing they would put me back into that awful place. Thing is, I'd been there three times before. I knew what to expect. Still, I chose it for myself. Maybe I thought that if things were horrible enough the rage would go and take the depression and anxiety with it. I need to remember it didn't work. I never want to forget. If I forget I might try it again. That fear is always looming on my mind. Always at the edge of my vision. It's tiring really, keeping it at bay. I'm never quite safe with myself.*

T. S. Skater

“Once Upon A Time”

. . . I was a child. And for the rest  
of my life, a victim – mute and self-mutilating.

I remember lying on that cold tile floor,  
face down, stripped and spread-eagle  
as she hovered over me with her  
enema-prodder.

. . . so many family secrets I hide,  
the lies and deceit.  
“Et tu?” brothers and Dad.

Ann Nielsen

## LITERATURE REVIEW

**Pharmacotherapy of Borderline Personality Disorder.** Robert M. A. Hirschfield, M.D. *The Journal of Clinical Psychiatry*. 58: supplement 14, 1997, pg. 48-52.

This author's work, supported by a grant from Wyeth-Ayerst Laboratories, discusses the medicating of persons diagnosed with Borderline Personality Disorder (BPD). While describing BPD as "a loosely defined spectrum of symptoms," he differentiates those symptoms into four separate categories and then discusses the drugs he targets to manage them.

Only once in the discussion of differential diagnoses relating to the four categories (differential diagnosis is the cluster of diagnoses that may be applicable) is a trauma-related diagnosis mentioned, and that is multiple personality disorder. Whole assortments of other diagnoses are mentioned, however, and none of these are associated with trauma history.

Self-mutilation, one of the cornerstones of the diagnosis of BPD, is mentioned as falling into the "impulsive" category. The drugs mentioned as helpful for dealing with impulsivity are mood stabilizers (Lithium and Tegretol), Monoamine Oxidase Inhibitors (MAOI's, an older type of antidepressant), SSRI's (the newer type of antidepressant), and neuroleptics (also known as antipsychotics), particularly Haldol. From this we can expect that a person labeled with BPD will be medicated with an assortment of various drugs, some of which have proven side effects that may be severe. This paper basically validates the perspective of medicating a woman living with SIV with whatever drug may prove itself effective in making her behavior stop.

**Low-Dose Clozapine in Acute and Continuation Treatment of Severe Borderline Personality Disorder.** Francesco Benedetti, M.D., Laura Sforzini, M.D., Cristina Colombo, M.D., Cesare Maffei, M.D., and Enrico Smeraldi, M.D. *The Journal of Clinical Psychiatry*. 59:3, March 1998, pg. 103-107.

This paper discusses a research study on twelve patients diagnosed with BPD who received the new antipsychotic drug clozapine to manage "psychotic-like" symptoms. As to be expected, the drug was found to be useful for those symptoms, as well as on impulsivity. Basically, the results of this study support the consideration of clozapine as a possible treatment for BPD.

The interesting aspects of this study are several. The first is that measurements of symptom severity were made only by research psychiatrists, and not by the patients. There was no patient input regarding symptoms, and this was explained by statements concluding that patients with severe BPD were not capable of labeling their internal states, and that their symptom intensity varied too greatly over brief periods of time. Certainly it is very difficult to trust research that has no input from those who were the subjects of the research. Also, clozapine is indicated for usage as it is a new antipsychotic drug, an "atypical" one. The authors point out that it is much more beneficial than the typical, or older, antipsychotics, as those have neurologic side effects. The authors claim no such side effects from clozapine. The reality is that clozapine is such a new drug that study of its long-term effects is in its infancy. One of the twelve patients in the study had to have the drug withdrawn after six months due to the development of a severe hematological side effect. Certainly this drug is not as harmless as portrayed. It is simply in the limelight at this time as it is new and its consequences are not yet truly known nor publicized.

**The body can become addicted to self-injury.** Beth Azar, Monitor staff. From the web site of the American Psychological Association and the *APA Monitor*. Three pages.

This article superficially discusses several theories of self-injury, and then tries to link them together. The author mentions theories of addiction and neurotransmitter abnormalities as connected to people diagnosed with mental retardation, autism, and obsessive-compulsive disorder. In exploring these theories, the author states "it's clear from all these studies that self-injurious behavior is chemically mediated and often addictive . . . What researchers can document is a strong but complex relationship between the opiate, dopamine and serotonin systems." Such a global statement basically says nothing more than insinuating that SIV occurs in the general context of the brain. She does acknowledge that environment plays a role in self-injury and advocates for behavioral as well as chemical treatments. Unfortunately, she states "Behavioral treatments are based on the assumption that people who injure themselves are vying for attention or escaping from a demand, and need to learn alternative ways of communicating." This is a pejorative, minimizing, and inaccurate portrayal of many persons who live with SIV.

Nowhere in this piece is the word "trauma" mentioned. There is no regard for the impact of institutionalization as a traumatic precursor to SIV, much less the mention of abuse. This is particularly shameful when discussing groups of people, such as those with mental retardation, who are disabled and who experience abuse (sexual, physical, emotional abuse and neglect) at even greater rates than the general public. The absence of this understanding is truly frightening, as this article will lead to further misunderstanding and continued or increased maltreatment of SIV.

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Ruta Mazelis, Publisher

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