
THE CUTTING EDGE

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

Volume 9, Issue 4 (36)

Winter, 1998-1999

Welcome to this, the 36th issue of **THE CUTTING EDGE**. This issue concludes nine years of publication, and I warmly thank all of you who have encouraged and supported this work. Thank you for willingness to speak out about this difficult topic and for the donations that keep this newsletter going. **THE CUTTING EDGE** now travels throughout North America, and to Europe, Asia, Africa, Australia, New Zealand and the U.K. Please continue to support this global effort to provide a community for those who live with Self-Inflicted Violence.

SIV: TREATING VERSUS HEALING

The previous editorial of **THE CUTTING EDGE** discussed many of the reasons Self-Inflicted Violence (SIV) exists in the lives of women. Many meanings for SIV were illuminated, from the perspectives of those who live with SIV as well as those who treat persons living with SIV. This editorial will attempt to take on the issue of healing from SIV and the abundant perspectives that exist on that topic.

“Recovering from SIV” -- usually the next phrase after this topic header is “how to stop self-injury” without further thought. However, it is crucial that the terminology and definitions commonly used be explored. What is recovery? What is healing? How can these words be quantified, and who is to determine their meanings? Is recovery defined by the absence of active SIV? How long should someone live without SIV before they are considered healed? Are these the measures that seem appropriate or important? To whom are these measures important?

Women living with SIV have many concurrent struggles. SIV does not occur in a vacuum. There are several perspectives to consider when thinking descriptively about women living with SIV. The most popular is the medical – psychiatric – model in which the woman is seen through the filter of mental illness and its many labels. It is not unusual for women who have a history of trauma, and who are living with SIV, to be given many if not most of the following diagnoses: mood disorders (depression and bipolar, also known as manic-depression), anxiety disorder, panic disorder, one of several personality disorders (usually borderline personality disorder, but possibly also narcissistic, schizotypal, or histrionic personality disorders), obsessive-compulsive disorder, psychotic disorder (usually brief psychotic episodes), body dysmorphic disorder, some type of eating disorder, and chemical abuse or dependency (this can include alcohol, nicotine, and caffeine). On occasion she may also be given the label of post traumatic stress disorder, which is not as commonly appreciated by biopsychiatrists as it is by clinicians educated in trauma dynamics. Even more rarely she may be diagnosed with one of the dissociative disorders (particularly dissociative disorder not otherwise specified, or dissociative identity disorder, formerly known as multiple

personality disorder) which are also seen as trauma-based. Although treatment varies according to diagnosis for most problems, it is interesting to observe how SIV is addressed regardless of the label one receives.

A quick look through psychiatric and other mental health literature that mentions SIV indicates that the crucial focus is on the stopping of self-injurious actions. SIV is seen as a highly problematic behavior and a symptom of serious mental illness. The goal of the various treatments mentioned is frequently the cessation of the behavior, and research being done defines a positive outcome as the decreasing or elimination of SIV from the life of the person being studied. This is true whether the source of the SIV is believed to be purely biological versus trauma-based, versus the consequence of a personality disorder. There is some disagreement about what causes self-injury, but little argument about what should be done about it – it should be stopped. Therefore, treatments for SIV are focused on those that are most successful for quickly and fully eliminating it.

There are many treatments that effectively stop SIV. Most of them have been disparaged on the pages of this newsletter over the past nine years. Yet most of these methods continue to be the primary choices that mental health practitioners turn to when faced with a patient or client who self-injures. Drugs are the most common treatment recommendation, and can be from almost any psychotropic category although the use of minor tranquilizers (Valium and Valium-related drugs) has been discouraged by most practitioners. This means that the drugs could be any, and possibly many, of the following: antidepressants (the newer and very popular selective serotonin reuptake inhibitors {SSRI's} such as Prozac; the older monoamine oxidase inhibitors {MAOI's}, as well as others), antipsychotics (both the older, "typical" antipsychotics such as Haldol and Stelazine, and the new "atypical" drugs such as Risperdol and Clozaril), naltrexone (such as Revia), anticonvulsants (such as Depakote), and lithium. Some of these drugs have well-known and dangerous consequences, others are presented as not very harmful (though this is highly argued by researchers who are not supported by the pharmaceutical industry). Drugs can be suggested as the only treatment method, or can be part of a varied approach to managing SIV. Dosage recommendations vary, as do the effects of the chemicals. They are sometimes reported as helpful, but, not surprisingly, are often reported to serve more as chemical restraints rather than healing agents. The duration of treatment with these drugs is generally expected to be long term. Some psychiatrists are now suggesting that they might need to be used prophylactically for life.

A mental health practitioner who is very threatened by the presence of SIV can turn to the use of force to deal with the self-injury as well as their own discomfort. It is not uncommon for women who self-injure to be forcibly hospitalized "for their own good." If SIV should occur during the course of the hospitalization, then the woman might also be physically restrained (by other persons as well as straps) and secluded (seclusion rooms are padded cells). She may also be medicated against her will. This may or may not be related to a belief that the SIV is in actuality a suicide attempt, though in reality the vast majority of self-injury is by no means seriously injurious, much less potentially lethal. In essence, a woman living with SIV may be mistaken for a very incompetent suicidal person (though it is not uncommon for women living with SIV to want to die sometimes as well -- as a matter of fact, the SIV is often a means of ameliorating suicidal urges). One psychiatrist described his treatment for SIV as consisting of 24 hour supervision while keeping the woman an inpatient on a psychiatric unit, as well as the use of leather gloves to eliminate SIV. This type of treatment is coercive and disempowering, often retraumatizing, and serves the needs of the provider much more than the recipient of the services.

Therapeutic methods for treating women living with SIV vary, and may include behavioral therapies which focus on thought management – cognitive control of emotions, "therapeutic contracting," and conditioning strategies. The emphasis remains on eliminating the behavior of SIV and replacing it with alternative behaviors that are considered more acceptable. Contracting consists of a written contract between provider and client in which the client agrees not to hurt herself, to attempt a variety of substitute actions if she feels the urge to self-injure, and describes consequences if she does self-injure. It is not unusual for the consequence to be the termination of the therapy relationship, or agreement to hospitalization. On occasion a woman might also be effectively shamed into stopping SIV. If SIV is depicted as a weakness, or immature and highly manipulative behavior, the woman will feel ashamed about herself and her needs. That shame might be powerful enough to make her stop self-injuring, at least temporarily. Another method

of effectively shaming someone into stopping SIV has been described by Armando Favazza, MD, (his book, *Bodies Under Siege*, was reviewed in Volume 6, Issue 23), the self-proclaimed “father of self-mutilation,” who has written about analytically interpreting self-injury as something that would revolt the patient, in essence encouraging the patient to disgust herself into stopping. The example he used was interpreting the SIV as a form of masturbation (there are psychoanalysts who actually believe that the wounds from cutting represent vaginas). The woman’s strong and negative reaction to his interpretation was to be used against her, basically stating that the louder she protested against the interpretation, the more it applied. This example is a clear depiction of the extremes a clinician might go to to get the desired result of stopping SIV. Other extreme methods include the use of negative stimuli to condition the client to stop self-injuring. These methods are most often used with persons who are mentally retarded (who have very little choice about how they are treated in institutional settings). Some forms of punishment discussed in the literature include time-outs and electric shocks. Certainly these are highly coercive tactics geared to stopping the SIV regardless of the methods necessary to do so, and without much understanding about the purpose it serves. If stopping SIV is the only goal, then the ends will always seem to justify the means.

What happens to women who receive these types of treatments? Oftentimes, they eventually rebel against coercive, restrictive, and/or punitive methods and leave the system. Many women, when threatened with losing supports and resources because of their SIV, lie about it. A therapist may be otherwise helpful, but become adamant that therapy is contingent on stopping SIV. The client may then be forced to lie to keep her mostly beneficial relationship with the therapist. Unfortunately, doing so adds to the isolation and shame so common for most of us who have lived with SIV. For the professional, believing the lie results in a false sense of security about the methods used to stop SIV. Had I been a research subject during the time I was living with SIV and attempting to get help from the mental health system, I would have been a perfect example of a “success story.” I sought out help from mental health professionals, aware of some of my trauma history and openly wanting to deal with my problems. Being honest about the SIV in my life, I was “treated” with commitment, restraint, seclusion, drugging, contracts, and shaming. On paper, all those techniques would appear to have been effective in curing me of SIV. In reality I was further traumatized by those I had turned to for help. I lied about the SIV and behaved “appropriately” as I awaited my discharge. I then left the mental health system behind and slowly began the process of healing, without further involvement in the system.

Practitioners who are educated and experienced in trauma based therapies are likely to be the most helpful clinicians for women living with SIV. Certainly trauma is the causative factor of SIV. SIV is a coping mechanism used to manage the sequelae of the trauma (the profoundly discomforting emotional states, dissociation, inability to communicate, . . .). Most of the recent focus on self-injury has focused on the existence of childhood sexual abuse as a precursor to SIV. While certainly a great number of persons living with SIV have experienced sexual abuse, it is crucial that the perspective not become too narrow. There are many forms of trauma. Childhood sexual abuse is the most commonly identified trauma linked to a later need for SIV. However, abuse experiences such as physical violence (experienced by oneself or witnessed occurring to others), emotional abuse, and neglect have a tremendous impact on a person. Sexual and other violence in adulthood is also prevalent. Trauma can also take the form of war experiences, long-term invasive medical procedures, and extreme poverty. What is most important is that the impact of the trauma be acknowledged as the source of many of the various difficulties experienced by the person in later life. These problems, to the clinician aware of the impact of trauma, are logical outcomes of the survived experiences, and not simply a conglomeration of unrelated pathology.

Therapists who understand the holistic impact of trauma on a person can more easily understand the use of SIV as a coping tool to deal with trauma’s aftereffects. Trauma survival has many aftereffects and these require the use of coping mechanisms. SIV is simply one coping mechanism in the midst of many. If it is kept in perspective, it can be understood and ultimately healed. Difficulties arise when therapists are particularly reactive to the need for SIV, and therefore lose their focus on the greater picture. Effective trauma therapy (and I believe all healing) is based on the principle of empowerment. Trauma, reduced to its essence, is the experience of powerlessness, regardless of whether the source is childhood abuse or a natural disaster. Coercion, no matter how “in one’s best interest” it might seem, is disempowering, and a reenactment of the initial powerlessness. People need to grow into a newer sense of self, a self with greater awareness and choices. It is not helpful to mandate people into health. Simply replacing problematic

behaviors with more socially acceptable ones does not touch the core issues in need of healing. Substitute behaviors may serve as a bridge between needing to self-injure and the healing of the traumatic roots. Replacing some coping methods with ones that “look better” may appear attractive, but is that truly healing? Taken to an extreme, a person with lists of “what to do if I feel like drinking, using drugs, cutting, working compulsively, having unsafe sex, going back to an abusive relationship, binge eating, starving, smoking, . . .” can be a prisoner to the solutions she’s been given. What is most important is the recognition of the depth of the impact of trauma on one’s heart and spirit, and less focus on behavior that is seen as pathological. Most of the time SIV is healed by healing the reasons it became necessary in the first place.

Effective therapy for the repercussions of trauma can take a long time and be expensive. Yet the process of change and empowerment cannot be rushed. Healing from SIV requires the development of a relationship with one’s own strengths and abilities. This relationship is fostered by relationships with others who also recognize one’s strength, and who not only abhor coercion, but celebrate personal wisdom and experience. There are therapists who are absolute gifts to those of us struggling with SIV, who encourage us to trust our own wisdom and survival strategies. These therapeutic relationships are partnerships that develop over time, and in which the dynamics of the relationship itself are the critical healing factor. Yet it is becoming increasingly difficult for even the middle class to be able to afford long-term therapy. Most insurance plans provide for short-term therapy and limit the choice of therapists to those on their plan. These providers may or may not understand trauma. Economically disadvantaged people have even fewer resources.

Bigotry is a profound obstacle to openness about SIV. While it is seen as helpful to have recovering addicts work with people struggling with addiction, and women who have left violent relationships work with women who are currently being battered, nowhere can you find clinicians working with people who self-injure who are free to disclose their own histories of SIV. Labels of mental illness have a powerfully negative impact. Disclosing a history of SIV could cost a clinician her job. Coming out as a person who has used SIV to survive can cost many of us important relationships and opportunities. However, there is so much to gain from the simple and profound act of coming together to share a similar problem. Discovering that you are not alone with the secret and shame of SIV can be a life-changing experience, more important than any therapy tool available. While many of us see ourselves in a very negative light, we do not view other survivors the same way. If we come together, whether in person or on pages of newsletters such as this one, we can combat our own fears and self-hates by discovering the compassion and understanding we have for each other. This is an incredibly soothing balm to the spirit.

Therefore, we need to consider one other perspective on healing from SIV that is rarely, if ever, mentioned. Women and men living with SIV are healing every day without walking through clinic or hospital doors. Many of us have discovered our personal truths about SIV and have found others who share our experiences and hopes. This newsletter is one example of a collective group moving into healing from SIV. The newsletter itself provides that which I sought after the most for myself – a space, free from the threat of coercive reaction, where I could explore my own SIV: the reasons for it, my reactions and feelings about it, and how I was healing my life. Learning that I was not alone, in my SIV or my perspectives about its functions, was a great boost to my hope that I could guide my own healing. In connecting with others, I learned to have compassion for my own struggles and needs, as I was able to see myself as one of a community of persons who deserved respect and admiration rather than shame.

Let us remember that there are many of us actively and passionately healing from painful histories who do not access the traditional systems of care to assist the process. We are not limited to professional opinions to guide our healing. We are collectively empowering ourselves as we connect with each other. In this way not only can we individually continue our healing journeys, but we can push for progress in our communities and society. The time has come for the strengths of survivors, including those who live with SIV, to be acknowledged.

Struggling to Move Forward

Trying to heal,
 Growing,
 learning new ways to cope.

What happened to you? they ask.
It was the past –
 things are different now.
Please look at what's on the inside,
 not at the scars on the outside.

So hard to heal,
 scars screaming at me,
 people questioning me.
I want to forget,
 put it all behind me
 and move on.
Please let me.

L and the company et al

The voices come like twisted madness
Rain falls upon me, flooding sadness
 Sweep me into anger, grief
 Into despair without relief

Sometimes they come with mindless chatter
 And make my mind go pitter, patter
 Sometimes they tell me what to do
And oftentimes they make me feel blue

 They seem to always be there
 About my feelings, they don't care
 They often talk of my self-harm
 They love the scars upon my arm

 I wish I could make them go away
 But I think they permanently will stay
I guess I will have to live with the voices
But they leave me with not many choices

Maybe someday they will leave my mind
 And to myself, I will be kind
 I'll live a life of happiness and peace
 When these voices of mine cease.

My name is Trish and I am 22 years old. I have been living with SIV since I was 13 and since then I have been hospitalized 14 times, been diagnosed several different things, and I have been on a lot of different medication. I have been free of SIV for only a couple of weeks now but I don't credit the state hospital I am currently in. I give credit to The Cutting Edge, Living With Self-Injury Workbook, a good therapist, and my own self-perseverance. I hope that I have had my last experience with SIV.

It seems that the current trend is to hospitalize someone who lives with SIV. They are considered to be a "danger to themselves" and are sometimes subjected to involuntary treatment. While in the hospital any instances of SIV can mean being tied up in restraints or being put on 1:1 observations. Restraints can be a scary experience for anyone who has experienced trauma. It makes you feel powerless and in my opinion, it is not an effective means of preventing SIV in the long run. Being on 1:1 observation is having someone follow you around wherever you go. It can be a very degrading experience especially if the person assigned to follow you around feels you are being childish and only want attention. In the hospital I am at, they also will give you medication if you hurt yourself to help "calm you down." This, too, is often ineffective in making a person feel better. It just numbs you up even more.

From my experience, SIV is not always effectively treated in an inpatient program. Too often that person becomes tangled in the mental health system web that traps so many people living with SIV. A good therapist is an invaluable asset to someone who hurts themselves. It doesn't take away control that we victims of SIV are so desperately clinging to.

Trish

It's Not the Same . . . Now

You wanted me to play your game
feel your blame
live in shame

You thought you could keep me where I live my life
relying on a knife
fighting this fight

Well I've been there, lived the pain
felt the shame
while you live in vein

But it wasn't for you, and it's not for me
I decided now that I want to be free

I don't live my life with anymore lies
no more disguise
and with you I despise

But I'm moving forward, can't afford to be angry
Because for me that takes too much energy

. . . And because I have no more to say to you,
rest in peace, Dad. . . and I love you.

Tricia

I find myself perplexed about my self-injury. In my adulthood I have injured for close to ten years. It escalated over time and I've had lots of stitches and some plastic surgery. My semi-helpful attempts to stop included using drugs, going to AA, going to the Hartgrove Hospital program, as well as time just not trying.

In May of 1994 my ex-husband and father of my four children killed himself as a result of inadequate care for his childhood abuse. He had become cruel and abusive and the hurt overtook him.

Since then I haven't injured except for minor skin picking. I realize that I can't take the risk. That would be too much for my wonderful kids.

I don't believe that injuring is a choice and that if one really wanted to stop they would. I struggled too long to see this as just a decision one could make. Yet here I am not injuring.

Of course I still feel the urge. I don't find myself using "other strategies" any more than I tried to before. I initially got rid of my implements within days of his death but found it too much to grieve both my former lover as well as injuring. So now I keep blades and towels and xylocaine but I don't use them . . . I wonder why this is so different. I wonder if I'm finished with this. I guess I no longer have the identity as an injurer but know I may injure in the future and it won't mean a failure or a return to how central it had been in my life.

Ann

Scars But Healing

The scars on my body
show the war that I have
fought against myself.
The lines, engravings,
burns and sores. All show
the pain that I have felt
within. As I see my torn
apart body, I begin to
look inside at my heart,
so gentle, so sensitive. So
"Together." Out of all I have
suffered, my hand never
reached my heart. I know
now that I can mend
from outside to within.

Claudia S.

Am I Two People?

I watch as my hand cuts my thigh. I know it is my hand that holds the razor, but I do not feel any pain. It is not I, but an actor on stage that I see being cut. Yet, I know that it is my body that is being cut. I am just a bystander watching . . .

Why do I allow the self-inflicted violence? Maybe as a bystander, I don't know how to communicate. As a bystander, I can tell you what will happen or what has happened, but I feel helpless. It's like there's a glass wall between the real me and the scene where the abuse occurs . . . All I ever wanted to be was one person who could love and take care of myself.

Dorothy A. Bartley

RESOURCE REVIEW

Management of Self-Mutilation: Confrontation and Integration of Psychotherapy and Psychotropic Drug Treatment. Myriam Van Moffaert. *Psychotherapy and Psychosomatics*, Vol. 51, 1989, pp. 180-186.

I am reviewing this article mostly as an example of what is typically found in psychiatric literature on the topic of self-injury. The author attempts to extensively explore the various modalities being utilized to medically treat self-mutilation stating that "its (automutilative behavior) management requires the application of carefully chosen psychotherapeutical and behavioral approaches and the integration of psychotropic drugs." A variety of methods are then explored, singly and in combination, with the author ultimately concluding that psychiatrists and psychotherapists have to work closely together to provide a complex of treatments for the patient who self-mutilates.

Drug treatment includes the gamut of available psychotropic medications available to psychiatrists, and the psychotherapeutic techniques discussed include behavioral therapies, desensitization, aversion techniques, hypnosis, biofeedback, and assertiveness training. It is clear that the author believes that all possible treatment options are included in those mentioned. What is blatantly absent is any acknowledgement of trauma-based therapy for the patient. While traumatic histories of people who self-injure are mentioned briefly when the author discusses the prevalence of depressive symptoms in "self-mutilative syndromes," there is no further analysis of SIV's traumatic roots, nor the implications they might have for treatment.

This paper represents much of what is standard theory and practice in the treatment of SIV. The person living with SIV is minimized to be the carrier of a syndrome that requires a vast assortment of methods to be controlled. It is the beliefs represented by this paper that continue to misguide clinicians and the general public about SIV.

Self-Harming Clients: Techniques that open the door to recovery. Dusty Miller. *Networker*, Sept/Oct 1998, p.23.

This article is an excellent example of a clinician who understands the traumatic origins of SIV, and yet responds to it in a rigid and controlling manner. The author of *Women Who Hurt Themselves* (reviewed in Vol. 5, Issue 19), Dusty Miller reiterates her basic beliefs in this brief article. She identifies the correlation between childhood distress and self-injury, and clearly separates out self-cutting from suicidality. My concerns lie with her therapeutic methods wherein she clearly identifies methods by which to control a self-injuring client. She states that "Once the therapist becomes aware of the problem, it's important to help the client see that self-harming behaviors are dangerous and must stop," setting the tone for how the issue of SIV should be perceived. Techniques discussed for stopping SIV are the setting of limits and boundaries, substitute behaviors, the threat of hospitalization, limiting the focus on trauma, and shaming. The shaming Dusty Miller advocates is in the form of equating the woman living with SIV with her perpetrator. This oversimplification and blaming perspective may bring about a decrease in SIV, but it certainly does not serve to empower the client. Frankly, not much of what is written in this article can be construed as empowering or new in the field. I wonder if some of the clients treated with this approach, who find much benefit in the trauma work itself, need to lie about their SIV in order to get some of their other needs met. I keep expecting more from Dusty Miller's work, and I guess I'll have to keep waiting.

The Body Speaks, the Body Weeps: Eating Disorders, Self-Mutilation and Body Modifications.

Sharon Farber, Ph.D., B.C.D. *The Renfrew Perspective*, Vol. 4, Issue 2, Fall 1998, pp. 8-9.

I wasn't sure how I would feel when I learned of this article as I had given Dr. Farber's previous article, **Self-Medication, Traumatic Reenactment, and Somatic Expression in Bulimic and Self-Mutilating Behavior**, a lukewarm review in a previous issue of this newsletter. Fortunately, the concerns I previously had no longer exist in this article and I found myself praising the author for her current work.

Sharon Farber clearly identifies various forms of trauma that oftentimes occur in the histories of those who live with SIV. She acknowledges the power past experiences continue to have in the present lives of those who have suppressed them. For example, she writes "When the body weeps tears of blood, we need to wonder what terrible sorrows cannot be spoken." She addresses several needs SIV meets, including communication and self-regulation.

One of the greatest differences between this and other articles on the subject of SIV is that the author uses a case example to illustrate the process of healing for her client rather than the process of stopping self-injury. Sharon Farber acknowledges not only the traumatic roots of SIV, but also describes a process of growth and change for her client, a process that depicts empowerment rather than control of symptoms. The resultant change is much more than the client learning to manage symptoms. Rather, she describes the process of the therapeutic relationship producing profound life changes. Obviously this type of healing process takes considerable time and involvement for the therapist as well as the client. It is my hope that people living with SIV find therapists such as Sharon Farber to facilitate their healing.

Dateline NBC. October, 1998.

Some aspects of this program were reminiscent of previous network shows on the topic of self-mutilation. Addressing the topic as "the anorexia of the '90's," the reporter (Dawn Fratangelo) portrayed SIV as a new, mostly teenage epidemic in America. This flows with the current public thought that SIV is a new concept and is experienced mostly, if not only, by the young. It did, however, highlight the reality that most mental health professionals do not understand SIV, nor feel capable of working with people who self-injure.

The program highlighted the "dangerousness" and strangeness of SIV, once insinuating that continued self-injury leads to death. Most of the information provided was through the portrayal of one young white woman's life with SIV. It is here that there were some positive differences from previous shows on the topic. The exploration into the reasons for this woman's (identified as Jamie) SIV had greater detail than

many other programs. Jamie spoke of her cutting coming from a deep pain, feelings of terror of “not being good enough,” and of not knowing how to otherwise express difficult emotions. Her struggle with self-injury was followed over many months, and this is what makes this program unusual. Although Jamie went through inpatient self-injury treatment two times (and her mental health care costs were estimated to be \$30,000), the show did not end with treatment being her salvation. Instead the report followed her further and depicted Jamie’s continuing struggles until the point she came to believe that she really has a handle on her cutting. Ultimately what seemed to help Jamie stop her SIV was the acknowledgement of trauma in her past as well as a commitment to her own life choices in the present.

This report addressed several reasons people turn to SIV, mostly focusing on the easing of emotional pain or anxiety. The reporter broached the connection between previous trauma and later SIV, but did not examine this in much depth. For Jamie, her struggles in attempting to be a mature and perfect child in the wake of her parent’s divorce, loss of connection with her father, and the disabilities of her younger brother were finally identified as stressors. In dealing with these issues, both Jamie and her mother seemed to come to a greater understanding of the source of Jamie’s struggles and resultant SIV. This is much different than calling Jamie a victim of an epidemic who simply needs expensive inpatient treatment to learn to manage her SIV. For once, a program did at least slightly more than serve as a commercial for an inpatient program. For this I give the reporter credit. Given the pressure to demonize self-injury, it is certainly difficult to portray the topic humanely.

THE CUTTING EDGE, published quarterly, is a forum for women living with Self-Inflicted Violence and our allies. I am interested in your opinions and experiences, and in publishing the work of women who have lived with or are currently living with SIV. Please consider contributing to **THE CUTTING EDGE** in whatever way you can. Poetry, prose, art and opinion statements are welcome. Artwork is limited to that which can be reproduced by photocopying. Please include a written statement with your work giving me permission to publish. Please let me know if and/or how you wish to be identified. All communication is kept strictly confidential, as is the mailing list. Your work is needed, appreciated, and celebrated. The address for **THE CUTTING EDGE** is P.O. Box 20819, Cleveland, Ohio 44120 USA. I can also be reached via e-mail at Rutamaz@aol.com.

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Ruta Mazelis, Publisher

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