THE CUTTING EDGE

A Newsletter for Women Living With Self-Inflicted Violence

Volume 10, Issues 2/3 (38/39) **Summer/Fall, 1999**

I ask that the readership of *The Cutting Edge* accept my apology for the delay in completing this combined issue of the newsletter. A variety of circumstances, including taking on an additional job, as well as some health and computer struggles, prevented this issue from coming out on time. It is my intention to have the next, Winter 2000, issue completed within the next six to seven weeks, thereby getting closer to the usual publication schedule. I truly appreciate your patience and understanding.

Please feel free to contact the newsletter with your opinions, thoughts and ideas on this topic or any other related to living with Self-Inflicted Violence. Your contributions are always welcome. Please write to The Cutting Edge, P.O. Box 20819, Cleveland, Ohio 44120 USA, or via e-mail to Rutamaz@aol.com.

SIV: THE CONTEXT IS TRAUMA

Writing this editorial has been a difficult process, a struggle of trying to gather scattered thoughts together in a meaningful way. Initially I made little progress, until I finally recognized that I had turned an editorial into a debate, an attempt to prove my point, as if I were writing the conclusion section of a research article. This is, no doubt, a reflection of my past year of working on just that – a research project. However, *The Cutting Edge* is more than a research brief or a one-sided treatise. Beyond a study of research, this editorial is a collection of thoughts and opinions generated from personal experiences, my own and others, that I've gathered over the past ten years. It is the voices of those living with SIV that are most important to be heard, and yet whose voices often go unacknowledged or interpreted. The more closely we can listen to the voices of those who know the truth of their own lives, the sooner we will be able to acknowledge and listen to the voices of those who are begging to be heard in their suffering – the children of today.

The deepest thread in the past ten years of *The Cutting Edge* has been the correlation of Self-Inflicted Violence (SIV) in a woman's life with a history of some form of trauma in her recent or distant past. The word "trauma" is actually a fairly new buzzword, oftentimes used to replace the less clinical, or less palatable, "abuse." Trauma, by definition, is a more expansive word than abuse. Regardless, both are crucial concepts for understanding the meaning of SIV in women's lives.

If you ask the general public to venture a guess into the origins of SIV, most often you'll hear "It means someone is really sick. They're crazy." Ask an assortment of mental health professionals the same question and you'll get a variety of answers. Most clinicians will respond that SIV is a part of some

disorder, some diagnostic category of mental illness. Some will say SIV represents a psychotic disorder or Borderline Personality Disorder (BPD). Others, more enlightened, will discuss dissociative disorders and Post Traumatic Stress Disorder (PTSD). Whether aware of the implications of trauma or not, they will often speak the language of pathology and diagnostic labels.

Yet what are the voices of those who actually live with SIV saying? What can you hear if you ask, in an environment free from coercion, about the meaning of SIV from those who have lived with it? You will hear how SIV is a means of coping, in many varied and creative ways, with experiences that are overwhelming, abusive, traumatic.

You can ask what trauma has to do with SIV. You will hear that it has everything to do with it. Why do women burn and punch themselves? It's the trauma. Why do young girls cut themselves? It's the trauma. Why do children bang their heads? It's the trauma. Why do imprisoned men carve on themselves? It's the trauma. Time and time again this is what I've heard. Listen to the voices of those who live with SIV and you will listen to a discussion about trauma. And, much more often than not, the type of trauma identified is abuse. SIV is correlated with a history of abuse. How does that happen and why is it so hard for many people to accept it?

It is brutally difficult to accept the painfully real prevalence of childhood abuse in American society. The horror of this acknowledgment leads many people to dive their heads into the figurative sand. In many ways, we are a country of ostriches, our awareness safely tucked away from the wounding going on around us. Many people hurdle over understanding SIV and run only towards the goal of making it stop. We must ask why so many Americans, including psychiatrists and other mental health professionals, cling so strongly to the belief that "mental illness" is biologically based. Outside of the pharmaceutical industry (whose motive is profit driven) and possible profits to physicians (a January 24, 1999 article in the *Columbus Dispatch* reported that pharmaceutical industry promotions "represent a growing problem in the field of medicine, ethicists say – drug companies are pressuring doctors to prescribe their drugs") what reason do people have to accept research that doesn't prove anything? The answer appears simple – it's better than looking at the alternative. If the answer to the question "why are so many people suffering?" is "from their life experiences," then what will we do about the impact of that statement? It is tempting to run away.

The mental health system, particularly psychiatry, focuses almost exclusively on the biological etiology of the various problems they group into diagnoses, even though it is becoming more and more apparent that trauma histories have an enormous impact on peoples mental and emotional being. A report in the *Mental Health Weekly* (Vol. 8, No.45, 11/23/98) identified that studies show over 80 percent of women in state psychiatric institutions have a history of physical or sexual abuse. Yet human experience is often simplified into diagnostic categories and resultant medication combinations. Also we, as a culture, seem to be fixated on medicating problems which are, in actuality, complex human struggles. The oversimplification of biological reasons for psychological, emotional, and spiritual struggles demeans one's personal history and negates individuality. Treatment becomes a cookbook style approach that can take place over the phone, via supervision, or through videoconferencing. The common treatment method remains one of medicating symptoms. Whether you believe in biological origins of mental illness or not, this is bad medicine. Certainly, from an etiological perspective, women living with SIV are not suffering from a biological attack. If that were true, then the "illness" would strike randomly. Yet people living with SIV have a major commonality – the experience of severe trauma in their histories. As well, to consider SIV simply as a "symptom" is to dishonor the woman living with it. People who are dismembered into clusters of symptoms do not easily heal. Recovery is a holistic process, not a piecemeal one. I have met women whose symptoms are all "managed," and who appear outwardly "fixed," who say they feel that they are leading lives of internal desperation and confusion. They do not have any greater sense of themselves now than when their lives were outwardly chaotic and they were considered "highly symptomatic."

It is amazing how convoluted our thinking becomes when we avoid considering the impact and repercussions of abuse. When looked at through the lens of trauma, SIV makes sense. When that window is shuttered, SIV is seen as pathology, whether of the personality or the brain chemistry. Mental health clinicians and researchers who address SIV as one of the primary indicators of BPD utilize the

personality/characterological lens to view the person. Those who decide SIV is indicative of a brain chemistry imbalance, whether supposedly due to psychosis, depression, obsessive-compulsive disorder, or addiction to endogenous opioids, use the biological lens. Both of these lenses are clouded and reduce the person being viewed into an object, shrinking them down into either a broken personality or a broken brain. Individuality, including formative and profound life experiences, can then be readily ignored. The supposed separation between mental health diagnoses that are biological and those that are not is curious. Even many of those who recognize the impact of trauma on mental health often draw the line at working with people labeled schizophrenic and such. In reality, despite millions and millions of research dollars (the vast majority of which come from the pharmaceutical industry), there is no proof of the "biology" of psychosis or any other diagnosis currently associated with mental health. Multiple biochemical and genetic theories abound, yet none has yet been deemed valid. Actually, psychosis, and its forms of SIV, could be considered as a method of coping with trauma. Dr. Peter Breggin, a psychiatrist who disputes the biopsychiatric model and does not ever use drugs to treat patients, sees "schizophrenia" as arising from a psychospiritual crisis. With that perspective people are perceived as fully capable of healing, a different prognosis than the traditionalists have.

People who live with SIV are, usually, survivors of abuse. They have been deeply hurt and powerfully impacted by experiences of assault, rape, and neglect in many forms. Most are averse to perpetuating abuse, whether towards themselves or anyone else. That is not the purpose SIV serves for them. Most are struggling to cope, to survive, to manage and express the very difficult consequences of what was done to them. Many persons living with SIV have been deeply wounded. Many are seeking a means to heal.

Abuse survived stays in the soul and bones for a long, long time, especially if one has been impacted by abuse in childhood. A child is a very vulnerable and sensitive being, completely open to the people and world around her. How does abuse lead to SIV? In many creative and adaptive ways. Perhaps a way to depict this is to identify some of the repercussions of trauma, especially focusing on abuse, and correlate them with the reasons people turn to SIV.

Traumatic experiences can be abusive or not. They may be public or private, experienced in isolation or in community. The word is very general, yet recognizable. People who have survived plane crashes have experienced trauma. Mothers whose children have been murdered have been traumatized. Children who have been raped have been traumatized. This is clear. This same type of clarity is available for those living with SIV. To understand SIV, look at how people have managed the repercussions of the traumatic experiences they have survived. There will be a rich variety of ways people have struggled to apply meaning to their experiences and manage the emotional, physical, and spiritual repercussions. Some of these will include SIV. More often than not, the trauma will consist of childhood neglect or abuse. The repercussions of surviving abuse as a child include understanding the meanings a child attributes to her experiences as well as the environment in which her trauma occurs.

One of the most common struggles SIV manages is the overwhelming nature of intense emotions such as deep sorrow and loss, rage, grief, terror and, ultimately, helplessness. Where do these feelings arise from? Certainly trauma causes profound emotional responses. Abuse is a violation of a person's spirit as well as body, and is based in extreme helplessness. Imagine the terror, rage, and pain of an abused child who does not understand her experiences, much less the world around her. How can she manage what is happening to her, including the overwhelming emotions she is living with? Her will has no impact on the abuse she is experiencing – what does she do with the helplessness she is feeling?

People who have not experienced a safe world as a result of the abuse in their histories have great difficulty identifying and processing intense emotions, emotions that are natural aspects of their experiences. Abuse, by its nature, causes helplessness, the inability to prevent being victimized against one's will. If one is not free to stop the trauma, how can one feel free to experience the emotions arising from it? A girl being raped by her father cannot say "Daddy, this makes me angry." A neglected child cannot say, "I wish you'd choose to love me and that I mattered to you. Don't you think I have value?" A child is totally dependent on the adults around it to care for its many needs. For survival's sake she cannot question those adults

about their motivation or abilities to care for her. The feelings arising from the abuse, and the conflicts about it, make emotions a dangerous, untrustworthy, and unsafe experience. More often than not, the child is not in an environment where her emotions are acknowledged, validated, or nurtured. Therefore, where can rage go if one has never been allowed to protest, to scream, to rage on one's own behalf when faced with violence or dominance? How can tears be allowed to flow when the person crying has been shamed, patronized, minimized, or slapped for them? If a child has been objectified, her value dependent on her behavior or achievements, how can she not feel self-hateful and ashamed when she makes a simple error? And where are the self-hate and shame to go; what avenues of expression for shame does she have?

Children are totally dependent on the adults around them to care for their many needs. For survival's sake, they cannot question those adults about their motivations or abilities to care for them. Their internal logic might sound something like this: If I need you for survival, I cannot question you, and I cannot know that you really do not care for me. I must presume that you do. Therefore, when you do not care for me, or when you abuse me, I must assume that it has everything to do with me, and not you. Because if it's something about me, then I believe I can change that and I'm not helpless. If it's about you, then I can't. And then my survival is questionable.

If I need you to survive, and you abuse me, I still need you. How can I be angry with you? What might you do if I was? If I expressed it? What if you reacted with anger? Would you abandon me? Abuse me again? What if you told me that it was all up to me, that I really did control you? That what you did to me was something I made you do? "You made me mad and that's why I had to hit you." "You didn't listen and that is why I left you behind." "You aroused me and that is why I had sex with you." And what if you, the child, were five years old at the time? Certainly you would not be safe to feel, much less express emotions. So how could you contain them, especially as they build up over the years and experiences of your life? Certainly tears are not safe and assertiveness is unheard of. And the feelings remain, coming in cycles of intensity. Then you discover that you can change them. You feel incredible rage that has no place to flow, and you punch yourself, and it diminishes. You feel overwhelming grief, but are not allowed tears; you cut yourself, the blood serves as tears, and the sorrow eases. You do this in secret and find you have a measure for both control and expression. You feel some sense of power. You have found one antidote to helplessness. You have discovered a tool for psychic survival.

SIV also serves as a very useful tool in managing the disconnection between "self" and one's own physical body that is common in abuse survivors. When faced with an overwhelming situation, such as being a child being raped by an adult man, it is natural and helpful to feel disconnected from one's own body. This distancing supports survival in the moment. Clinically it is referred to as dissociation, and is a skill the survivor often retains after the abusive experiences have passed (actually many survivors of childhood abuses continue to experience abusive situations/environments into adulthood). A person living with SIV often discovers that the self-injury is a tool for managing the dissociation. Cutting oneself when feeling disconnected from the body can decrease dissociation, bringing the physical sense of self closer via a physical act. Blood can be viewed as proof that the body is real and has boundaries that are solid. Interestingly, many survivors also utilize SIV as a method for facilitating dissociation, particularly when feeling physically overwhelmed, such as times of flashbacks to previous abuse events.

Bessel van der Kolk, MD, has aptly said that, concerning trauma, "The body does not lie." Certainly the body stores its own physical memories of its experiences. The body, however, has very limited means of expression of the memories it contains. SIV serves as a form of communication for "body memories" of abuse, especially if the memories are hidden from the conscious mind. While the physical wounds of trauma or neglect may heal, the memory of those experiences does not easily leave the bones. The cells of the body remember. While the mind may remain ignorant to its history, the body retains the experiential memory of what it has endured. It demands recognition. SIV can be a means of expression for the body. With SIV, what may appear to others to be an act of masochism often turns out to be a physical reenactment, sometimes actual, sometimes symbolic, of the body's abuse history. SIV directed at the breasts or vagina is often connected to the physical expression of a sexual abuse memory. When the history is addressed, and the body is acknowledged, the urgency of that form of SIV often diminishes.

SIV might also be an expression or an outlet for feelings of self-hate. Why would a victim of trauma hate herself? She might feel responsible for the abuse that she survived, especially if she was young at the time and was told by the perpetrator that his/her actions were the victim's fault. She might, if sexually abused, be confused and ashamed about physiological feelings of arousal that are only natural with stimulation, whether of an abusive nature or not. Future feelings of arousal, even though desired and nonabusive, might trigger the abuse memories of old, and she might feel frustrated and deceived by her own body. SIV might then serve as a form of punishment, in the hope that enough punishment might "be enough" for the feelings to vanish.

Trauma in the present is often a trigger for SIV, especially if one has a history of abuse in the past. SIV is common in many psychiatric hospitals and prisons, institutions where people are often held against their will and have little power over their daily lives. This type of powerlessness and helplessness are often overwhelming, and can be diminished, at least in intensity of feeling, with SIV. The particular difficulty in this situation is that, when institutionalized, the person turning to SIV to cope is often perceived to be a problem and attempts are made to further control their behavior. This then escalates the helplessness and the need to cope. It is in this area of institutionalization that researchers are studying SIV (unfortunately for the animals involved). They have discovered that animals that are isolated in cages and do not receive stimulus, those that are placed in situations of helplessness and powerlessness, often self-injure. They might bang their heads or bite at their limbs. Certainly it should be no surprise that human animals respond in a similar way.

Perhaps one of the greatest tragedies experienced by trauma survivors who live with SIV is the reenactment of their trauma in mental health systems, the very places they turn to for help. It is no surprise that SIV is sometimes seen as an "epidemic" in psychiatric facilities. Years ago, when I worked in an adolescent treatment facility, it was common for many staff members to blame the "spread" of self-injury on one patient, and judge the behavior as an attention-seeking act without any other thought regarding its meaning. This attitude has not changed a great deal, as evidenced by Rene J. Muller, Ph.D.'s comments in the March 1999 issue of *Psychiatric Times* wherein he stated that "Attention-getting and trying to punish others are the most common explanations for self-injurious behavior given by patients in ER evaluations." I can only presume that it was the doctor, and not the patients, who were providing the information regarding reasons for self-injury.

Psychiatric inpatients caught self-injuring are often punished by the loss of already meager privileges at best, and many are forcibly restrained and/or medicated at worst. Unfortunately, it is still accepted practice to place women who self-injure in seclusion rooms and/or restraints, often against their will. This will always remain a possibility as long as mental health care providers have the legal power to assume control over a person. For those overreacting to self-injury, it is easy to interpret the SIV as being a "danger to self," and therefore justify coercive reactions. Medication to manage "problematic" behavior is also not uncommon. One of the few benefits to managed care practices, interestingly, is that it has become more difficult for providers to receive compensation for these forms of "intervention," and so they now often choose to react to SIV with less vigor. In the past year, there has been an increase in the attention paid by the mainstream press to the misuse of restraints, and resultant deaths and injuries, and currently there is legislation pending which would place greater restrictions on their use. Yet, in spite of this growing awareness, it is still not uncommon to see quotes such as "When a patient is threatening suicide or engaging in self-mutilation, restraint is a life-saving measure." This statement, made by psychiatrist Paul J. Fink, appeared in the June, 1999 issue of *Clinical Psychiatry News*. Clearly it is my hope that women living with SIV do not come across psychiatrists sharing this belief.

The use of restraints, seclusion rooms, forced medications and behavioral contracting disempowers and revictimizes the survivor of abuse. This can be in a very literal form, as when a rape survivor is placed in four point restraints, which literally means the tying down of the hands and feet, with the legs spread. Any form of coercion or direct control is reenacting of abuse, and an imbalance in power between mental health care provider and client is a situation fraught with opportunity for the misuse of power.

Unfortunately even providers who are aware of and interested in working with trauma survivors sometimes get caught up in reactivity and their own melodrama when faced with SIV. Although certainly SIV is not

necessarily easy to understand, many practitioners overreact to a client who acknowledges self-injury. Often therapists believe that a contract from the client promising to stop SIV is an appropriate solution, although the client may not necessarily agree with this idea. Some therapists also threaten to end the working relationship if the client does not agree to stop her self-injury. What is interesting, yet sad, about these situations is that the therapist, more likely than not, is often helpful with many other struggles, yet reacts authoritatively when faced with SIV. The desire to alleviate the therapist's discomfort, via changing the client's behavior, becomes the primary goal, replacing the empowerment of the client. When faced with these circumstances, some women choose to lie to their therapist about their SIV so that they can continue their work with that person. Of course, the need to lie for self-protection negatively impacts the relationship.

There are as many reasons for using SIV as there are ways people cope with trauma. SIV is a tool for managing the many repercussions of trauma. Abuse impacts the human body, mind, and spirit in countless ways. SIV is utilized as a coping tool in an assortment of ways as well, to manage these aftereffects. Women living with SIV might turn to SIV to deal with one or many struggles resulting from the past. SIV is simply a tool in the toolbox. The reason the topic of self-injury is so volatile is that SIV is judged to be a particularly "bad" coping choice by persons observing survivors from the outside. Most women living with SIV do not view it the same way, and many intuitively feel that there will be a time of healing in the future when SIV will no longer be necessary.

It is also important to acknowledge that there is great variety in the forms of SIV that survivors turn to. The most publicly discussed forms of SIV are often cutting of the skin and self-punching, yet there are many ways women self-injure. The form of self-injury is important only in the meaning it has for the woman using it. Some forms of self-injury have physical repercussion, such as burns or bruises, while others do not. More general forms of self-harm, not usually referred to as SIV, are also common threads in the lives of trauma survivors. Many women living with SIV also struggle with substance abuse, difficulties in their relationships with food, destructive relationships with their partners, and many other commonly acknowledged problems that arise from surviving a traumatic history. Perhaps the most societally accepted forms of self-harm are overwork, extreme dieting, and cosmetic surgery, yet many of these choices are promoted as positive and affirming ones.

When watching news coverage of events around the world, have you ever noticed the reaction of some people to traumatizing events such as bombings, earthquakes, and floods? People who have faced the destruction of their homes and communities, and the loss of their spouses, children, or parents, can be seen to pound their chests with grief, to hit their heads with their fists in disbelief, to collapse. This does not surprise us. Their experiences are profoundly impactful. In some way, many of us can understand their reactions. Certainly, many of us could have empathy for a woman pounding her hands into a wall upon learning that her husband had been captured and executed by an enemy militia. Or a survivor of a bombing raid which killed his family cutting his arms to "let out" some of his despair and anguish. Yet most people who do not live with SIV see the use of SIV as a coping strategy to deal with the repercussions of trauma as paradoxical. After all, if a person has been hurt in some form in the past, why would she later choose to do something that clearly looks like hurting herself in the present as well? Hasn't she been hurt enough? Has she become a masochist?

Certainly she has been hurt far more than "enough." No, she is not a masochist. She is, however, a victim. And she is a survivor. Surviving one's victimization is a creative process. The human spirit reacts to abuse as if to a poison – it shuts down unnecessary functions and focuses on survival. People who have been abused in childhood experience the toxicity of trauma – they adapt in ways to best ensure their survival. This process is a complex one, with many ongoing lessons. These lessons often include learning the following: trusting is dangerous and the world is unsafe; emotions experienced feel dangerous, and their expression is to be avoided; the realities of one's life are to be kept isolated within one's own self, and possibly even buried in the subconscious; the body is not likely an ally, it can be experienced as the enemy as it is the object of abuse.

The impact of abuse can be easily recognized, especially on the youngest of victims. In an article from a newsletter that provides shelter for abused infants, an author writes, "we see children who have never

experienced adult attention other than abuse. Some of our children will inflict pain upon themselves as well as others. Some will even cry out for the person who has inflicted pain on them." Yet the farther away, historically, that the trauma occurred, the more difficult it might be to identify it and its links to SIV in the present. Trauma, especially abuse, is a holistic injury – it impacts a person in emotional, physical, and spiritual ways. Physical abuse clearly brings about an emotional response. Neglect and emotional abuse (the diminishing of one's sense of self and worth) causes physiological changes. One's spirit, one's belief system, can be shaped by trauma. The degree to which a person is fractured depends upon the individual and the environment in which the trauma occurs. An adult who loses her home and community to a hurricane reacts differently to trauma than does a child who is abandoned and battered with no allies to help her. A person who has survived that sort of childhood will react differently to a later, adulthood trauma, than will a person whose childhood was supportive and congruent.

SIV comes into play most often when abuse is suffered early in life, if the abuse continues over time, and if it goes unacknowledged by others or is forced to be kept secret. SIV is a particularly viable method of managing the aftereffects of abuse that occurred very early in life, before the child has developed verbal skills. Without verbal language, the body is able to express its history via self-injury, an unusual form of language in its own right. Janice McLane, Ph.D., has so aptly discussed this role of SIV as "the voice on the skin." A wound, indeed, can replace a word or can carry meaning beyond one's ability to express in words. The same wound can serve as a message to the survivor and the external world about events in the past that have been sworn to secrecy. In that regard, SIV is an effective means of communication.

If you can accept and understand the most profound traumas and their consequences, you can comprehend the coping skills people utilize to manage the aftereffects. You can understand SIV. Once you comprehend the correlation between these you can shine this light of understanding upon your own past and present. You can trace your own responses to the trauma in your life and how you have managed its repercussions. You can respectfully acknowledge your own strength of survival and creativity in managing the difficulties that arise with experiences of trauma.

If you understand that "it" is the trauma, then you will discover that you need to find the traumatic roots of the SIV in your own life. One of my frustrations with the therapeutic community is its division of various forms of abuse as if they were separate. There is currently a focus on the correlation between childhood sexual abuse and SIV. While certainly sexual abuse is often a common factor in the lives of women living with SIV, it is not the only one. Women who do not identify sexual abuse in their histories, and yet live with SIV, may feel outcast or pressured by this focus. What are the traumatic roots in the lives of women living with SIV? Most often they are abusive childhoods, but may also include experiences of sexual assault in adulthood, harassment, loss of loved ones to violence, the brutality of racism, abandonment, the violence of poverty and other difficult experiences, such as the trauma of invasive, even though necessary, medical procedures,

Trauma impacts one's relationship to self, other beings, and the world at large. Yet the effects of trauma can often be healed to a great degree, and survivors are able to create a world of relative safety and freedom. The way to healing however, is not via an attack on symptoms and perceived weaknesses. No one can successfully force a survivor to heal. People around her, however, can offer validation, empathy, and respect for her survival and her strength to adapt and change. Healing is much more than the absence of symptoms. Certainly the process of healing does not demand the absence of SIV. The most important component to healing is the power to make choices without coercion, to decide what needs one has and how to meet them. The cycle of healing is a continually expanding spiral of empowerment, as the trauma loses its powerful impact, and life options grow and expand. This process cannot be controlled from the outside, but occurs within the survivor. A clinical setting may serve as either an asset or a deterrent to this process. A nurturing, empowering environment fosters the growth.

Healing from trauma occurs via relationships. The survivor may, for the first time in her life, begin to form a conscious relationship with her own self. Healing is a painful, beautiful, difficult, inspiring, profound process that impacts a person at every level of their being. Healing provides for the development of a relationship with self, others, and the world at large. It expands one's world view, and increases the capacity for experience, connection, emotion, and, ultimately, for compassion for oneself and others.

SIV is usually kept secret, and may remain such for many years, even when a woman is becoming more familiar with speaking out about other aspects of her life. The way SIV is reacted to when it is disclosed can strongly impact the relationship the woman has with the person she is speaking to. For example, the first time my SIV became public was in a therapist's office nearly 20 years ago. She was attempting to help me facilitate feelings stemming from the death of a beloved friend. She was hoping to help me tap into the anger that I must certainly have been experiencing somewhere deep inside myself. As she guided my hand to hit a pillow, to physically try to move my body to get in touch with a feeling, I suddenly swung and punched myself in the face. Her face was full of surprise and sorrow. She put her hand on mine and, of course, I didn't strike out again. It was a profoundly healing moment, as the compassion in her reaction fostered a connection. Unfortunately, that was not always the typical response to telling others of my struggle with SIV. Disclosing SIV can cost relationships with others; yet learning to be open about one's life can nurture one's relationship with self. And there are people who do respond with compassion and empathy, whether they are familiar with the topic or not.

In what I consider to be the finest text on trauma, *Trauma and Recovery: The aftermath of violence – from domestic abuse to political terror*, Judith Herman writes "Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery." SIV is often one of the tools a survivor uses to manage helplessness, and is an act that is most often done in isolation. Healing from SIV is facilitated by connection with others. How people respond to SIV therefore has a powerful impact on a woman's healing. Too often the reactions of others to SIV retraumatize the victim, return her to her isolation. Yet when people are able to connect around this issue, empowerment naturally flows, and healing is supported.

It is worth noting that healing does not necessarily mean going back to and through all the previous trauma. It is the knowledge that one's struggles ("symptoms") have a context and are present for a reason that is crucial. So is learning that one's fears of "being crazy" are unfounded, and that one's struggles have meaning. Beyond tending to physical and emotional wounds, healing must also address the spiritual injuries as well.

Healing provides for a physical sense of reality, for the ability to know one's body and emotions, and the recognition of one's strength of spirit. Healing is the capacity for the development of tenderness towards one's own history and a firm stakehold in the present. It brings with it a future, a learning that living can be more than surviving. Healing from SIV and healing from trauma are not separate issues, although there are people who regard the control of SIV as an indicator of healing from trauma. We are much more than our wounds, and we are much more than the absence of our wounds. The impact of trauma ebbs and flows, and so, oftentimes, does SIV. There may be times of passionate and difficult work done regarding the pain in the past. A return to SIV at these times does not imply a "relapse", nor does it indicate that healing is not occurring. Neither does the absence of SIV indicate health. Recovery does not occur in a linear fashion, nor should it. We are complex beings.

There are victims and survivors all around us. Violence, especially towards women and children, is rampant. A 1994 report by the U.S. Justice Department's Bureau of Justice Statistics stated that domestic violence is the leading cause of injury to women between the ages of 15 and 44. That fact is certainly an indicator of an epidemic. The U.S. Department of Health and Human Services, based on data from 1996, reported that almost one million children were identified as victims of abuse and neglect in that year, and over one thousand children died as a result. The National Committee to Prevent Child Abuse released results of a survey indicating that more than three million children were suspected of being victims of abuse and/or neglect in 1998. In this country, a child is reported abused or neglected every ten seconds. Every two hours, a child is a homicide victim. And every four hours, a child commits suicide. The clock keeps ticking, and it is past time that we recognize the epidemic that is permeating our society. Is it any surprise that there are people amongst us struggling to cope with brutal histories?

One possible, and very beneficial, aspect of healing from trauma is a desire within the survivor to impact her environment to help others. There is a great amount of work to be done. We must address the current plight of the many children who are recipients of various abuses and/or neglect. Adults must act on behalf

of these kids, as children have no political power. It is also imperative that people recognize the profound damage that abuse causes those who survive it. As important, we must spread the news that healing is possible and well worth the struggle.

It is time that people direct their horror not at SIV, but at the trauma that generated the need for it. As a society we must come to terms with the evils that exist in our midst. That is more difficult to do than to deny that they exist. It is easier to brand women living with SIV as diseased or insane, and disregard their voices which speak of their personal and collective journeys through trauma. Yet if we dare to collectively recognize the painful truths that refuse to go away, we shall also give testimony to the creative and enduring aspects of the human spirit that allow not only for survival, but for compassion and transcendence as well.

Scars

He stares at my scars
With that lingering question in his mind
Then he asks, “What did you do?”
As he realizes the main cause of such.
Oh the awkwardness that is felt between,
As his mind rushes with more questions of “why?”
Yet usually unable to break the silence,
Unsure if he even wants to know,
if he could even possibly understand.
“How could one cause such damage to their body?”
“Isn’t the pain unbearable?”
Not knowing that it is the emotional pain,
the unseen scars which are unbearable.
Unable to understand how such destruction could provide
Expression, an array of emotions
Once again temporarily pushed back
So I might carry on with my hopeless life,
The relief I feel as the blood rushes
Soothing the tension, the anger,
the self-hate that boils inside.
Those out-worldly scars will never heal,
Will the inner wounds I face, one day heal?
Or will these scars forever symbolize my inner wounds,
Forever filled with shame, guilt, anger, and punishment
For who I am.

Heidi Hamilton

When my mom died, I was angry at her for been so seemingly uncaring during our childhood. In her "old" age (65), she had become a very bitter and untrusting woman. I could never get through to her when she was alive, and now would never have the chance again.

I didn't feel anything except curiosity when my dad died. He was the main perpetrator during our years with him, raping, beating, humiliating us at every chance. My mom rounded it out with verbal and emotional abuse. We six kids were abandoned and neglected and abused while living with them.

As a grown woman, married with two small children, I swore I would ***never*** *be like either of them. I ended up beating my kids with a paddle that left bruises on their little bottoms and terror in their eyes from the anger, no – rage that seemed to come out of nowhere. Just like my dad did to us. I screamed at them, just like my mom. Then, out of shame and sorrow for what I was becoming, I stopped. That's when the cutting started. I hated myself and wanted to punish myself for being like them.*

It would take a mountain of writing to fill in the gap between then and now. The cutting continues, usually when I feel so stressed that I know I will explode if I don't cut. It's a tried and true method for me. There is so much inside that pushes to come out, I feel I'm living on the edge. Every muscle is tensed waiting for the "attack;" a sudden movement or noise makes me jump out of my skin. I guess I need more counseling.

That's the sad part. I've seen a number of therapists, some inept, some totally disinterested, some on the wrong track, and a small number helpful but not able to take the counseling to a deeper level. My last counselor was a clinical psychologist with a lucrative practice. I was able to begin to let him in and start rusting him, though he often complained that I " ***still*** *didn't trust him after all this time." His name was Doug. He couldn't handle the cutting. There were contracts, demands to stop, threats to put me into the hospital against my will, and finally, threats to stop seeing me. Through it all I kept asking why would he be willing to "walk through the steps of recovery" (his words) with abuse survivors who were alcoholics, used drugs, over- and under-ate, but not with me?*

When I began to lose it and cut my wrist to die, he strongly encouraged me to enter a psych ward at a hospital far away. I thought it was to give him a month's break. (That's how long the insurance lasted.) So I came home with a resolve not to cut. He was happy, my husband was happy. It was less than a year later when, having started cutting again, he told me to find another doctor. I was devastated!

I talked with a female counselor and spent the whole time crying about not being able to be with Doug anymore. I left after a year and haven't been back to anyone. That was three years ago.

A few months ago I read an article in our local paper about Doug. His license to practice psychotherapy in our state had been suspended due to a sexual affair with one of his clients. This is the same man who proudly told all of us in his sexual recovery group that very few psychologists have sexual problems with their clients, that it's usually psychiatrists. That if there's one client, there's usually more. He always said there was ***never*** *a good reason to give into temptation. But "it was the other woman's seductiveness that led him astray," he said. This is even a worse devastation.*

My cutting has escalated again. Too much stress, too much stuff trying to come out. And the sad thing is I feel like I'm becoming my mom – bitter and untrusting. I felt strongly that therapy with a man was important because of my problems relating to them. But now, I honestly can't see myself opening up to a deep level again because I now believe there is no such thing as a caring man; that the bottom line with a man, the final answer, the last hoorah is his penis, and that's all that counts for them ultimately.

As I grow older, I wonder how hard it will be to cut skin that is stretchy and wrinkled. ☺ They'd surely think I was batty. But it would be just me settled into a way of coping that works, that involves no one else. You just can't cry over spilt milk – you got to keep on going.

Netti

When I've felt all the pain I can handle
It's time to bleed
When I hurt so bad I stop feeling
It's time to bleed
When my tears drown my eyes
And stop me from breathing
It's time to bleed
When I want to pull the knife out of my heart
But it won't release
It's time to stab one in my leg
When you stop listening
and I stop reaching
I reach for what is always there to comfort me –
When everyone is gone and I'm left squirming
There is always something that never leaves me
Something I can count on through and through.
Overwhelmed by the agonizing pain
I rip my leg open
Until warm blood drips down my leg
like warm tears along my face.
I then pierce the wound with a razor
But I do not feel this pain –
It isn't even pain at all –
It releases me from the real pain –
which lies within my torn-up heart –
That is the true pain –
the pain I cannot cope with.
The pain that leaves and has left the real scars.

J. Porcello

Some notes on SIV in Germany:

According to the latest estimations, about 200,000 people are self-injuring in Germany; about 80% are female self-injurers. Unlike in the U.S., the role of trauma in the history of many of the self-injurers is generally approved and regarded as the most important origin/explanation for SIV...

*For those with a trauma history, there are many possibilities to find support. One professor of psychiatry, Prof. Sachsse of the University of G*ttingen, is very popular for his therapeutic approach. In his hospital there is a unit specializing in the treatment of trauma survivors who show the SIV symptoms. The patients are taught how to go back into the traumatic situation, to revive it, with the support of an experienced therapist within the clinical setting, in order to be able to let go of these memories after having gone through them a last time. Of course this action is prepared very well: the patients are shown how to create a place of refuge within themselves and how to go there deliberately if they feel too much hurt and pain. He came across this idea because of the ability of most SIV patients to dissociate. His aim is to use this ability in a fertile and protective way, which can be controlled. Also, there are a lot of self-help and support groups for survivors of sexual abuse and rape...*

The greatest problem for self-injurers evolves when they are admitted to psychiatric hospitals as an emergency case. There – in the emergency rooms as well as in the acute psych units – little is known about the background of self-injurers. There do exist a lot of prejudices, like in every country across the world. But they don't work with you. They just fixate you, whether on your bed or with meds, which all in all ends up all the same. And that's the point where precise information is needed badly. There should be something like an information campaign for the professional staffs at the hospitals about self-harming behaviour and how to deal with the patients.

Ann-Uta Beißwenger

Crawling along the cavern so deep
pretending all is well
Wondering why
and what
and how
You deserve this living hell

Cutting along the cut so deep
pretending all is well
You don't understand with this
comfort of plan
Why they lock you in a cell

Coming upon the knowledge so deep
understanding that all's not well
Doing your best to
work your way out
of this
Life you've known as Hell

Cutting, again, a cut so deep
still knowing that all's not well
The pattern continues
again and again
'til the day of
Salvation's Bell.

"The Clan"

5/23/99

I look at all the scars on my arm and wonder what kind of abhorrent monster I really am. Can such a creature as I, with 24 years of abuse under my belt, and 22 years of depression, truly heal? Can such a damaged mind and soul exist on this earth in a manner that is acceptable to society? Am I even capable of feeling happiness? What is contentment or peace of mind to a mistake like me? What can I possibly offer my beloved, intelligent, beautiful children besides knowledge of experience and the immense unconditional love that I will forever possess for them? There are times when the pain and depression are quite bearable. During these times I can almost feel "normal." In these intervals, I blend in with those around me. And the times when the pain and depression are unbearable? – I cannot put into words the horrible places that my mind takes me. My logic and intelligence turn against me. My insight becomes my enemy. My childhood demons scream of victory on the battlefield of my life. So what does all of this musing and pondering get me? Where am I now? One step ahead of my past and half a step from madness and/or hospitalization. Can I actually jump off of this tightrope? Will there be a safety net below? I am not ready to find out. For now, I cling desperately to this pitiful lifeline of mine while still praying for the peace and calm of death.

6/26/99

You can go ahead and push all you want and you know what? I could give a shit. How long has this brick wall been around my heart? Since I was five years old. I got the crap beaten out of me when I was two and a half. The whole wall wasn't up yet. Age five rape – yeah, that's when my wall went all the way up. It's been there fore 23 years. Do you really think that pushing against that wall is going to work? Save your breath. Only I know how to take that wall apart. But I ain't moving one brick while you're on the other side pushing, that's for damn sure. I ain't stupid you know. I don't want bricks toppling on my head, nor do I need you falling over on top of me either. That wall is staying put for now. So why don't you just have a seat, breathe, relax. You may be waiting for quite a while. Then again, you may decide it's not worth the wait. That's fine with me. People don't usually stay on the other side waiting for too long. For one thing, it's not very comfortable. For another, it's only me over here on the other side. There's no treasure, or big celebration awaiting you. Nothing but me. And besides, it looks pretty much the same over here as it does over there. Oh, there's some blood on the bricks from the times that I've run into them in the dark, or when I've tried to climb over the wall. And the light never shines over here. Sometimes the floor is wet from my tears. At times, I've heard strange whispering or evil laughter. But, all in all, it's my home and no one else's. I've been here an awfully long time and I've grown quite accustomed to it. I've learned to not try and climb it. I've learned not to cry so I don't get wet. I've learned to close my eyes so that I don't "notice" the darkness. I've learned to just sit so quiet and still that it's almost as if I don't exist. I've learned that if I ignore the whispering and laughter it will fade away for a while. I've learned a lot. I've had lot of time for that... learning. I've learned well.

Anonymous

I Can't Burn Anymore

I decided that it was time to visit with my daughter, Lisa, and my two grandbabies. On the way to Lisa and Brent's house, I got to thinking about the kids, perhaps in an effort not to think about why I was really going. I thought about Cherry, my little three-year-old who is as lively as a child can be. Her fine blond hair always hanging in her eyes; ponytails and barrettes slip out in moments, no matter how tightly set into that hair. I keep trying to convince Lisa that Cherry should have her hair cut in a pixie style; that way she would stay looking neat while she played on the swing set and did her aerobics in the living room, but Lisa always responds that it would make Cherry look like a boy, and Cherry is a girl and wants everyone to know she is a girl! Blossom is six months old already, I thought with disbelief. I smiled as I remembered the beautiful grins that Blossom so freely gave. I wondered how many times those dazzling smiles perked me up when I was feeling so terribly low. Her auburn hair is starting to thicken. That came from my side of the family, one of the few things I can be proud of about my family, I mused. Where do the girls get their eyes, I wondered. Cherry is so fair skinned with medium blue eyes, so often they have such a sad look, deep inside. I attribute that to the sexual abuse she received when only a year and a half old. "That damned day care!" I cursed it for the thousandth time. Cherry was only a baby! How COULD they do that to her? It hurt extra much because I had promised her and myself when she was born that she would never have to experience what I did. Cherry was going to grow up free! Lisa and I had both taken all the precautions we knew, but still my little baby, who had fought so hard to come into this world, had been wounded. Are some of us just plain born to pain and hardship in our lives? I questioned the thought, thinking how my own sexual abuse had started in infancy. Oh, how I pray that nothing will ever take the bright light from Blossom's dark blue eyes. They sparkle with life; you feel like you can see your soul in the depths of her eyes. Two little girls, both bright and beautiful, but so very different in temperament. One so innocent and trusting, the other with innocence stolen, struggles with trust and fear even while she plays on her swing and does acrobatics on the living room floor. Another of the constant aches in my heart.

I pulled the car into Lisa's yard, taking a deep cleansing breath. I needed to shake off the thoughts I'd been dwelling on while traveling. Not only that, but I had come here to tell Lisa something really life-changing. I hoped I wasn't telling her too soon. What if I went back to my old ways? That would be shameful, as well as disappointing to Lisa and the rest of the family. I will have failed again! I'm tired of failing! Another cleansing breath. Cherry ran out to greet me with her usual greeting. "Grandma! Grandma!" Where is Pa Pa?" I picked Cherry up and threw her over my shoulder, while she giggled all the way into the house.

"Hi mom, what's up? You here for a special reason?" I didn't plan to come into the house and blurt it out, but here was the opening, so ---- "Well yes, you'll be happy to know that I can't burn myself anymore." Lisa had Blossom on her lap and I saw her give the baby a little hug as a gentle smile crossed her face. The smile stayed but a look of puzzlement accompanied it. Lisa asked what I meant by "I COULDN'T burn myself anymore." I told her once again that when I burned in the past that I couldn't feel the burn while I was burning, nor after either. I used to always flick the ash off the cigarette until only the very hottest, red, glowing end remained, then I would put the burning butt on the skin and hold it there until a count of ten. I went on to explain that the last three times I tried burning myself, the pain was excruciating. I couldn't hold the cigarette on the skin for even a second and the resulting minor burn hurt for days after.

Wonderful, gentle, Lisa. She immediately comprehended my mixed feeling about this new development. She asked how I was going to cope now when the emotional pain got so terrible. Lisa pointed out that burning had been a release of that pain for quite a while. I honestly answered that I didn't know. Lisa also asked if I was sure the burning was over. Again I had to tell her that I just didn't know. "You can do it, mom, you're a strong lady. You can find other means of coping, something that doesn't hurt you or give you scars all over your body. I'm always here to talk to you." Lisa had been my main source of support for the past three years. I realized that we had reversed roles regularly. I wondered, for the umpteenth time, just how good this was for Lisa. I justified the role reversal by telling myself that we always parted with my being the mother. Lisa seemed to have an understanding of multiplicity that few have.

"It feels like the burning has ended for good, maybe that personality has integrated or left or something." I tried not to show my own fears of the burning returning. "How did this happen? Are you sure that person hasn't just gone deeper down?" Lisa quizzed. "I honestly don't know. All I know is that one day I'm burning myself and enjoying it and the next it's so painful, there's no way I can burn. Maybe the burning person has gone way down in, but like I told you, it feels like the burning is gone for good. I really don't think I'll be burning anymore," then as an afterthought I added, "I sure hope not." "Maybe I shouldn't ask this," Lisa voiced rather hesitantly, "but how do you think you will cope if you do relapse into the burning?" "I don't have the faintest idea. This seems to have happened all by itself, nothing I have any control over. I've got over one hundred burns and scars on my body and all of a sudden, I can't burn. It causes me some concern, knowing I didn't do this of my own desire or work, it just happened!" I nonchalantly lit a cigarette, trying to disguise the fear of failing and burning myself again. Lisa set Blossom on the floor to play, then turned back to me. "Mom, you do know that even if you do burn again, that I love you and I won't lose respect for you. Don't get me wrong, I don't want you to ever burn again, but if it does happen, you can still talk to me like always." I looked into her face and saw that she did truly understand.

Just then Cherry, who for a change had been playing quietly in the toy room, came up to me and started pulling on my hand. "Come on Grandma, quit talking. You promised you'd play in my room with toys! Grandma! Don't you hear me? Come on! We can have a picnic at my table!" "Ok! Ok! Give me a second here," I couldn't help but laugh at the look on Cherry's face while she tried to get off the chair. Lisa was laughing at the sight too, "You did promise, mom." I don't know if little Cherry is intuitive or what, but her timing was perfect and the break into laughter dispelled the intense atmosphere of the room.

**** It has been several months now since I last tried burning myself. There have been times that I really want to burn, but remembered how much it hurt those last three times. Another part of me doesn't want to burn anymore so at least, up until the writing of this story, I have been able to resist trying again to see if I can burn the way I used to.*

I have been coping without burning in a variety of ways. I try to find someone to talk to as soon as I realize I'm thinking about burning for the release of pain. I talk to Lisa, other family members, call the 24-hour crisis line; call a mental health worker, my doctor, or my therapist. I talk until the need is gone. Sometimes, I draw pictures of myself and carefully put in red marks at the places I would like to place them on my body. Mostly, I try not to dwell on the desire and deliberately get busy on anything that needs concentration. One thing I don't do is to deny to myself that I really would like to burn. So far this is working for me.

I have decided that I WILL NOT COME DOWN ON MYSELF if I do start burning.

Jo Finn

RESOURCE REVIEW

Female Sexual Abuse Survivors as Patients: Avoiding Retraumatizaton. Deborah Doob. *Archives of Psychiatric Nursing*, Vol. VI, No.4 (August), 1992: pp. 245-251.

This excellent article exposes the prevalence of abuse in the histories of psychiatric patients, and discusses the implications of that recognition. Basically, the author makes clear that treating people for mental illness without recognizing the impact of sexual trauma causes more harm than good. She discusses the common symptoms, including self-mutilation, found in abuse survivors. She explores the societal and professional denial that supports the silence around abuse, and which keeps the survivor in the role of patient. She writes: "The patients' sanity, the patient's fragments of accurate memory and expected response to trauma (anger and fear) in a world unwilling to accept such a reality, is viewed as insanity. The adult patient's accommodation (labeled dissociative, psychotic, affectively disordered, inappropriately distrustful, etc.) appears pathological in a world that responds with blindness to the abuse experience but not to the survivor's accommodation." She makes it clear that changing the perspectives of mental health professionals from denial to one of trauma awareness provides for optimistic outcomes for patients/survivors.

On Being Invisible in the Mental Health System. Ann Jennings, Ph.D. *The Journal of Mental Health Administration*, Vol. 21, No. 4 (Fall), 1994: pp. 374-387.

"From the age of 13 to her recent death at the age of 32, Anna was viewed and treated by the mental health system as 'severely and chronically mentally ill...' Principal diagnoses found in her charts included borderline personality with paranoid and schizotypal features, paranoia, undersocialized conduct disorder aggressive type, and various types of schizophrenia including paranoid, undifferentiated, hebephrenic, and residual. Paranoid schizophrenia was her most prominent diagnosis... Symptoms of anorexia, bulimia, and obsessive compulsive personality were also recorded. Treatments included family therapy; vitamin and nutritional therapy; insulin and electroconvulsive therapy; psychotherapy; behavioral therapy; art, music, and dance therapies; psychosocial rehabilitation; intensive case management; group therapy; and every conceivable psychopharmaceutical treatment including Clozaril. The use of psychotropic drugs comprised 95% of the treatment approach to her. Although early on there were references to dissociation, her records contain no information about or attempts to elicit the existence of a history of early childhood trauma."

Ann Jennings, Ph.D., in this article on the need for the mental health system to understand trauma, writes about Anna, a woman who survived the sexual abuse in her early life, but not the consequences of that abuse coupled with years of retraumatization, further abuse, in the mental health system. This extensive study takes a close look at the life and death of Anna, and how the psychiatric system perceived her, primarily through their biological lens. It is an incredibly moving and disturbing account, one written from a place of wisdom and compassion. This case study is exceptional, and professionally written and researched. And yet this article is so much more. The "case," Anna, is Ann Jennings' daughter. This paper is a tribute to her.

I encourage everyone to read this article. Included in it is a table that is particularly valuable. It compares early childhood trauma experiences with their parallel common mental health institutional practices. The similarities are striking. Please take a look at this.

"Dear American Psychiatric Association...." **Psychiatrist Loren Mosher Resigns APA**. *International Center for the Study of Psychiatry and Psychology Newsletter*, Fall 1998/Winter 1999 Double Issue: pp.4-5.

This article is the published resignation letter from Loren Mosher, M.D. to the American Psychiatric Association (APA), written in December of 1998. After over 20 years of membership in the organization, Dr. Mosher describes the current destructive state of affairs within his profession. Perhaps the best summary of his beliefs is the statement that "no longer do we seek to understand whole persons in their social contexts – rather we are there to realign our patients neurotransmitters. The problem is that it is very difficult to have a relationship with a neurotransmitter..." He later challenges the APA to "get out of bed" with the drug industry and organizations that support it, such as the National Alliance for the Mentally Ill (NAMI), and listen to ex-patients and psychiatric survivors. He writes that "NAMI, with tacit APA approval, has set out a pro-neuroleptic drug and easy commitment-institutionalization agenda that violates civil rights... For the most part we stand by and allow this fascist agenda to move forward." He goes on to say "I want no part of a psychiatry of oppression and social control."

Loren Mosher eloquently points out the ethical corruption behind the mentality of believing in biologically based "brain diseases." He writes "The fact that there is no evidence confirming the brain disease attribution is, at this point, totally irrelevant. What we are dealing with here is fashion, politics and money. This level of intellectual/scientific dishonesty is just too egregious for me to continue to support..."

I have never read a better brief criticism of modern psychiatry. For those who believe that criticism of biopsychiatry comes only from misguided, disgruntled patients, take a look at what this psychiatrist writes to his peers. For those seeking help from a psychiatrist, take a copy of this letter in with you, and ask the doctor what she thinks about it.

Risperidone for Aggression and Self-Injury. Case Series. *Psychiatry Drug Alerts*, Vol. XIII, No. 1 (January), 1999: p.1.

This brief, based on a longer published research article, espouses the efficacy of the drug risperidone (Risperdal) at controlling self-injury is a small research study group of 8 adults who were mentally retarded. This relatively new medication is an atypical antipsychotic, one of a category of drugs used to manage undesirable behavior. Observers of the patients reported an improvement in their behavior after 3 months of usage of the drug. Complications of its use were noted, most commonly being sedation and akathisia. None of the patients were asked about their response to the drug, nor were environmental factors mentioned. Those interested in studying the utilization of powerful psychoactive drugs to control the behavior of disempowered people would certainly benefit from looking at this article.

Sexual Abuse Survivors: Identifying Symptoms and Special Treatment Considerations. Kathleen L. Ratican. *The Journal of Counseling and Development*, Vol. 71 (September/October), 1992: pp. 33-38.

It was a pleasure to review this article, as it contains many positive elements from the world of mental health professionals. Kathleen L. Ratican is a Certified Professional Counselor with an excellent knowledge base about the impact of childhood sexual abuse and its treatment. In this article, she gathers information from a considerable number of references, and presents the reader with a comprehensive discussion about the symptoms typically associated with an adult who has experienced childhood sexual trauma. She mentions self-injurious behavior, whether occurring in childhood or adulthood, as one of an extensive list of symptoms. She also describes general therapeutic techniques, in the context of individual and group therapy, that are often helpful for survivors.

What was particularly refreshing to notice was the inclusion of SIV as a symptom of a client's possibly having a sexual abuse history. SIV took its place in the list of symptoms and was not given any greater degree of reactivity. This indicates a relative comfort with the topic in general, and a willingness to acknowledge its traumatic roots.

ICSPP Position Statement: The White House Conference on Mental Health. Peter R. Breggin, M.D. and Ginger Ross Breggin. *International Center for the Study of Psychiatry and Psychology Newsletter*, Spring/Summer, 1999: pp. 1-5.

I included a review of this article in *The Cutting Edge* because I believe it is important for all of us to be aware of the current political climate regarding mental health care in the U.S. This past summer's White House Conference on Mental Health was a prestigious gathering, and featured the President and Vice President, and their respective wives, as keynote speakers.

The special focus of this conference was on the mental health of this country's children. Unfortunately, as described in this article, it was "a showcase for biological psychiatry." Traumatic stressors were not mentioned as having an impact on children's mental health, and treatment was equated with psychiatric drugging. All in all, the summary of the conference seemed to be "Whether the White House embraced biological psychiatry out of naivete or because it has been influenced by the pharmaceutical corporations and other powerful interests that profit from the drugging of America's children and adults, our country has entered a dangerous era of social control through chemistry."

This article exposes the reality that at least several of the young men involved in recent years' school violence had already been taking psychiatric drugs, and that they are clearly not what America's children need. It counteracts the popular belief that these drugs curb violence. In fact, psychiatrist Peter Breggin has written extensively about the causal relationship between psychiatric drugs and violence. He clearly points out that what children need are authentic relationships and the addressing of their genuine needs, including larger societal issues as well. I certainly agree.

- Anyone interested in the International Center for the Study of Psychiatry and Psychology can contact them at 4628 Chestnut Street, Bethesda, MD 20814. The phone number is (301) 652-5580, and website is www.breggin.com.

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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