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# THE CUTTING EDGE

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

Volume 11 (40-42)

Winter-Summer, 2000

First of all, my apologies to all the readers and contributors who have waited so long for this issue to come to fruition. Unfortunate glitches and delays (including computer problems and a move) have kept me from publishing on schedule, and I am sincerely sorry. This combined issue is the only reasonable solution I could come up with to get back on schedule. The next issue, Fall 2000, will be mailed in the middle of October. Thank you all for your patience and understanding. Please note that I now have a new e-mail address: [rutamaz@eohio.net](mailto:rutamaz@eohio.net). The address for **THE CUTTING EDGE** remains the same: P.O Box 20819, Cleveland, Ohio 44120 USA.

Upcoming issues will include interviews with people I greatly respect who have helped me frame my beliefs about life with SIV. I remain greatly interested in your thoughts, opinions, artwork, poetry and prose, and encourage you to consider submitting them for publication. My thanks to all of you who have kept this work vibrantly alive for the past ten years.

### SIV: A 10 YEAR RETROSPECTIVE

The delays in getting this issue of **THE CUTTING EDGE** out have been very frustrating, as I have looked forward to this particular time for a long while. This issue celebrates ten years of publication of the newsletter, and has given me pause for reflection on the history of this work and some of the changes that have come over the past decade.

**THE CUTTING EDGE** was begun to maintain communication between participants in workshops on self-injury that took place in the late 1980's. I had organized those workshops as places where self-injury could be discussed without fear of ostracism or professional intervention. A surprising number of women came to them. In those brief groups I discovered many things. I learned that most of us had been keeping our lives with Self-Inflicted Violence (SIV) secret. Many of us were ashamed and feared we were mentally ill. Most were worried about losing friends and family if the SIV were discovered or disclosed. None of us had received great benefit from the mental health system. Many said that their experiences with psychiatry were brutal or devastating. Those of us who had been forcibly institutionalized, drugged, or restrained were very clear about the profound wounding those experiences had on our lives. Many of us had sworn off all help altogether. We were expert at hiding our wounds and our scars. The coming together of those

small groups brought many of us great relief, and it was clear that the desire to stay connected in some way was strong for many of us. Thus the beginning of this newsletter.

Remembering the beginnings of **THE CUTTING EDGE** has touched my heart with tender retrospection. This newsletter, now so wide in scope (traveling throughout North America, Australia and New Zealand, Asia, the United Kingdom, Europe and Africa), began in the midst of a circle of women who'd come together to speak the unspeakable. The newsletter arose from the desire we shared to stay connected with each other. My intention to stay in touch with those I felt understood me led to this role of publishing **THE CUTTING EDGE**. The first mailing of the newsletter was for less than 100 copies. Since then it has found its way to many corners of the world. Clearly I was not alone in my need.

Fifteen years ago there was little mention of self-injury in the mainstream media, and little in the professional community. Most of the available literature was from psychiatric publications. "Self-mutilation" was identified as a symptom of Borderline Personality Disorder (BPD) or psychotic disorders. People who "self-mutilated" were described as greatly troubled and having very poor prognoses for recovery.

At that time I had left the practice of physical therapy to work in a chemical dependency treatment facility with young people. I also spent time working in psychiatric settings, in the public as well as private sectors, and had observed how professionals reacted to SIV, particularly in the young. I'd already had my own experiences with forced treatment, and had hopes of making changes in the system. Of course, I was silent about my own life with SIV.

The first time I heard SIV mentioned in a meaningful way was in coming across a poem by Tracy Nagurski, titled "To Daddy," published in the book **Voices in the Night: Women Speaking About Incest** (© 1982 by editors Toni A. H. McNaron and Yarrow Morgan). In this poem the relationship was made clear between sexual abuse and cutting as an aftereffect. The connection I felt to the author was a tremendous gift, one that taught me there might be other women who shared the same secret life with SIV. A few years later, a little over ten years ago, SIV came into public light via talk shows on television. Certainly a dramatic topic, SIV was highlighted on several programs (The Phil Donahue Show and Oprah), and public and professional interests were piqued. While a few mental health professionals began making a name for themselves regarding this "dramatic" topic on these programs, the highlight of the show was the women they brought on as "self-mutilators." Women living with SIV were seen on television. Someone was no longer keeping this a secret. It was the beginning of awareness for many of us that we were not alone.

The book, **The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse**, copyrighted in 1988, became immensely popular after it was published. The authors, Ellen Bass and Laura Davis, helped the public acknowledge the immense suffering and courage of its daughters victimized by sexual assault. This book served as a groundbreaking guide to healing from childhood sexual abuse via chapters on various topics, including a section of biographies of women survivors. The publication of this book fueled the growing awareness of the prevalence of child abuse in the United States and other countries. It identified the sequelae of childhood sexual abuse with honesty and clarity, and presented healing as an option. This book was also one of the first nonprofessional publications to mention self-mutilation as a repercussion of childhood trauma. It helped lift the cloud of secrecy from this specific act as well as from sexual abuse in general.

The last 20 years have been a time of increasing awareness of the existence and harm done by trauma in a person's life. Initial focus on Vietnam War veterans, who bravely acknowledged the aftereffects of their war experiences, led to an identification of some of the problems caused by the impact of trauma. A subgroup of the mental health community took this information and awareness to heart and started, once again (historically), exploring the consequences of abuse and other forms of trauma, and began searching for what helps people heal from those experiences. Survivors also formed their own support services to help themselves and each other. The battered women's movement arose out of the needs and desires of survivors before becoming as professionalized as it is today. Its history is not dissimilar to the alcoholism

recovery movement begun by the founders of Alcoholics Anonymous, which has also become professionalized.

Over those years people became more aware that a variety of previously isolated “disorders” were connected, in fact, to women’s histories of surviving abuse in their lives, particularly abuse experienced in childhood. It became more common to hear the acknowledgement that experiences of depression, anxiety and panic, suicidality, eating disorders, multiple personalities, and self-hatred were connected to trauma. Yet, interestingly enough, the therapeutic community often balked at looking at the traumatic roots of other forms of struggle, one of these being SIV and another being psychosis. I venture to guess that the lack of understanding, and the emotional repercussions of listening to disclosures about self-injury, led many otherwise good and compassionate therapists to balk at the issue of SIV. This left many people, who were otherwise benefiting from therapy and/or self-help organizations, ostracized when it came to healing from self-injury. Many trauma-informed clinicians as well as trauma specialists referred women to the psychiatric community for intervention regarding self-injury and, generally, that group of practitioners did not acknowledge any connection between SIV and trauma. Instead, psychiatrists most often determined self-injury to be a classic symptom of borderline personality disorder, a label that identified the patient as highly problematic, unreliable as well as unbelievable, and irresponsible. It is still not at all unusual to hear the “borderline” label used as an indicator that the patient is “trouble.” Of course, this did not serve the woman who was struggling with SIV. In actuality, receiving that particular label is one of the most harmful repercussions women living with SIV risk if they seek out mental health expert opinions. It has been documented that the borderline label alters provider perceptions in a punitive direction and the consequences can go as far as the loss of the custody of one’s children. Certainly being open about SIV has historically led to much more harm than help from the professional community. In the past it almost guaranteed hospitalization, whether voluntary or involuntary. This practice has changed somewhat over the years, more as a result of managed care practices than enlightenment about the topic.

Perhaps one of the most difficult acts of the past ten years has been bearing witness to the punitive and destructive ways many women living with SIV have been treated at the hands of those who were claiming to be helpful and know best. So much of the treatment women living with SIV receive recapitulates the horrific abuse experiences that they have already survived, the trauma that has led to their need for SIV in the first place. It is still not uncommon to place a self-injuring woman in restraints and seclusion rooms, or to drug her so heavily that she doesn’t retain a sense of herself. It is not unusual that therapists attempt to control their self-injuring clients, not uncommonly with blatant or disguised threats of abandonment. At the same time, one of the most hopeful changes occurring in the past decade is the gradual involvement of therapists in learning about SIV and a resultant de-escalation in their reactivity to the idea. There are practitioners out there who are currently providing respectful and empowering help to their clients, and no longer evading the topic of SIV.

The hopeful changes in the mental health community have come from trauma specialists, who are beginning to recognize the source of SIV as being the abuse they are familiar with treating. Yet it is not unusual that they take exception to self-injury. I have often heard that “I really like the work I do with my therapist and, as long as I lie about the cutting, everything goes well. I don’t like having to lie about it, but I don’t want to lose what I have.” Often when self-harm comes in less direct forms, such as smoking, overeating, or workaholism, clinicians react compassionately and calmly. It is their reactionism to SIV that often prevents a similar response to SIV. However, they can certainly come to understand the context of SIV and their own responses, and come to view it as just another aspect of a woman’s abuse sequelae and coping tool kit. Fortunately this is happening, and will hopefully continue to do so as people learn to demystify SIV.

Yet there are current trends that are acting against this process of understanding and healing. The past ten years have seen the rise in power of organizations such as the False Memory Syndrome Foundation (FMS) and the National Alliance for the Mentally Ill (NAMI). The stance of the FMS attempts to negate many abuse survivors’ experiences and depicts them as either manipulative or vulnerable and naive victims of malicious therapists. Though not widely accepted, the excellent public relations skills of the organization have had an influence on both the general public’s perceptions as well as professional opinion. There have even been “false memory” conferences organized by prestigious psychiatric institutions (such as Johns

Hopkins University), although most clinicians do not seem to be so readily convinced that there is such a concept as a false memory. NAMI, an organization that claims to be the voice for the mentally ill, has as a majority of its membership family members of the “mentally ill.” As an organization they fully support a purely biological model of mental illness and are proponents of forced treatment. Not surprisingly, they receive a great deal of their funding from the pharmaceutical industry. It is the relatively recent trend towards the loosening of commitment standards and the practice of forced outpatient commitment that is the primary allegiance between this organization and mainstream psychiatry.

The increasing acceptance of the use of force as a “treatment” of people with various psychiatric labels is perhaps my greatest concern when considering the changes of the past decade. With the rise of managed medical care in the U.S. there has been a decrease in the ease of hospitalizing people in psychiatric facilities. People are not held as long, and do not get admitted as easily. Therefore, the idea of forcing treatment on people outside the inpatient setting has gained strong support and has been enacted in many states. It is no longer uncommon to learn of people being forced to take potent psychiatric drugs, many of which have powerful side effects and long term consequences, by order of the legal system. It is the intermingling of medicine and law that brings the most fear to my heart. Treatment that is not voluntary has not been proven to be effective, even if it could be thought of as conscionable. With the current fear of the mentally ill that exists in the general public, mixed with the extreme reactivity to women who live with SIV, it is certainly not unexpected to see women be forcibly medicated at an even greater rate than before. Consequentially, many people stay away from seeking mental health help of any sort out of fear of being forced to accept treatment they don't want.

While the use of psychotropic medications has increased exponentially (especially with children and adolescents), the opportunities to obtain long term psychotherapy are diminishing. Because an empowering relationship is one of the most significant influences on healing from SIV, this trend to shorten or eliminate therapy is catastrophic. Managed care companies, as well as public mental health providers, do not allocate for long term therapy, and the cost of such therapy is so prohibitive that it is not truly accessible to any but the financially well established. However, a very exciting development is the increase of consumer driven organizations, in which people provide support to each other at various levels. Co-counseling has gained in popularity, and people are discovering that receiving professional help is not the only way, certainly, to help oneself heal. As well, witness the growth of Survivors of Incest Anonymous.

Some of the most optimistic signs of progress regarding the issue of SIV are the growing awareness of SIV in the survivor/consumer/ex-patient movement, as well as recognition of the issue at the federal level here in the U.S. One particular groundbreaking conference, titled **Dare to Vision: Shaping the National Agenda for Women, Abuse and Mental Health Services**, took place during the summer of 1994. What overwhelmed me with relief and hope were the numbers of women who were able to openly criticize the current systems of care and speak out about the abuses women were experiencing in their homes and communities, as well as in psychiatric hospitals. I heard words there that I carry with me today, that still bring tears to my eyes. The keynote speaker, Pat Deegan, Ph.D., spoke to those of us gathered there that:

*Before we dare to vision, we must dare to see and to say the injustice and the oppression that exist within the mental health system. To dare to see and to say is to take the first important step in stopping the cycle of abuse. Abuse thrives only through the silent complicity of unseeing eyes and turned heads... Physical and chemical restraint is torture, it is not therapeutic. Seclusion is solitary confinement and it is not therapeutic. Forced drugging is experienced as rape and is not therapeutic. Coercing our compliance with threats of incarceration or loss of privileges is revictimizing and is not therapeutic... Working with professionals who insist on having power over us and who claim to know what is in our best interest is oppressive and is not therapeutic...*

Those words speak to many experiences shared by women in the mental health care system, and Dr. Deegan disclosed her own experience with SIV in the context of sharing her biography. This to a diverse national audience who applauded her words with passion.

The next keynote speaker, Susan Stefan, J.D., said that:

*We should look at who we have forgotten and who we have left unheard...These women remain institutionalized and medicated as sick in a society where silence about sexual abuse is the norm and the casualties are considered the social aberrations. We need to recognize that mental*

*institutions are the places where women pay the ultimate price for living in a society where incest is hidden and tolerated.*

Later in the day, during further proceedings, activist Judi Chamberlin asked us all to take a minute of silence for those who did not survive psychiatry. All of these moments were profound for me. Having the privilege to have gotten to know so many women living with SIV, I recognized that the women being talked about were those I knew, knew of, and one of whom was, of course, myself. The fact that these moments were taking place on a federal stage gives me hope to this day.

Certainly the words spoken at the *Dare to Vision* conference were not the first time I had heard those types of thoughts. What made the experience incredible was that these words were being said at a government-sponsored event, rather than in kitchens, shelters, or coffee shops. The conference was sponsored by The Center for Mental Health Services as well as the Human Resource Association of the Northeast. The list of co-sponsors included the American Medical Association and the American Psychiatric Association. I wondered if they knew what was truly being said in those rooms! It was a celebratory use of federal money.

Further work at the national level took place in the spring of 1998 at another meeting sponsored by the Center for Mental Health Services. Titled *Awakening from Silence: Self-Inflicted Injury in the Lives of Women and Girls*, it was described as a working group on women and self-injury. Rather than the classic and familiar type of discussion on self-injury, focusing on pathologies and interventions, this meeting focused on the voices of those living with self-injury, its relationship to trauma, and the need for enlightened and empowering systems of care to offer services to women and girls living with SIV. I was greatly surprised to find that the majority of the participants gathered there shared my opinions.

One of the most hopeful changes over the years has been the willingness of a minority of mental health professionals, including psychiatrists, to open themselves to learning about SIV in the context of understanding trauma. The readership of **THE CUTTING EDGE** consists of a diversity of people, and includes mental health professionals of all levels, policy makers, lawyers, sociologists, criminal justice experts, teachers and other persons who, while not living with SIV themselves, care deeply about those who do. When I consider the depth of problems in the mental health system I often feel frustrated and depressed. Yet when I recognize how many people within those systems are making remarkable changes for the better, my spirits lift and I feel sincerely hopeful.

Perhaps the most surprising and disappointing change of the past decade has been the staunch defense of biopsychiatry by some of its service recipients. Certainly I have been unrelenting in my incrimination of the psychiatric system, and I continue to be criticized for my “antipsychiatry” stance. The surprise has come that some of the support I now receive comes from professionals within that system, as well as those who have left it altogether. As well, the biological model is becoming seen as a limited and not necessarily pure one by some of those who are within the field itself. One recent surprisingly open statement made by the outgoing president of the American Psychiatric Association, Allan Tasman, M.D., (in the June 16<sup>th</sup>, 2000 issue of *Psychiatric News*) was “We are in danger of training psychiatrists who lack even the most basic psychotherapeutic skills or a framework for understanding mental health functioning from a psychological perspective.” Not a dramatic statement, but nonetheless unusual to find in a publication filled with drug ads. Yet the current publicity regarding the supposed biological roots of almost any and every emotional discomfort seems to be more and more accepted by the public at large. The pharmaceutical industry’s great investment in public relations has had a distinct impact on public perceptions and expectations. And I fill with sorrow when people write to me defending the “party line” – that they are pathological and likely hopelessly ill.

While the influence of the drug industry has had a powerful impact on both the general public and the psychiatric profession, there has also been increased interest and respect for the work of those who expose the fallacies of the biomedical model. In the past decade the work of Peter Breggin, MD has become increasingly popular, he being the author of **Toxic Psychiatry** and many other books exposing the mistakes made in mental health research by researchers whose work is funded and influenced by sponsoring pharmaceutical companies. He, in his psychiatric practice, prescribes no drugs with the exception of helping to detoxify his patients from the drugs they have received from others. He not only writes about

the importance of relationship in healing, he is one of a small and yet very moving minority of practitioners who are providing people in great pain with a true opportunity to heal. One of the greatest advantages of publishing this newsletter the past ten years has been gaining the opportunity to listen to and meet people like him and many others sharing similar beliefs.

The past decade has seen the emergence of a larger body of literature on the topic of SIV. For a long while Armando Favazza, M.D.'s book, **Bodies Under Siege**, a misguided and deprecating work, was seen as the critical writing on the topic (to the degree that Dr. Favazza has publicly announced himself to be "the father of self-mutilation"). In the last few years several books have appeared that are providing a great balance to those previously written, and more are on the horizon. As women living with self-injury are finding their way to each other and discovering their commonality, so are the clinicians that understand the nature of SIV. And they are beginning to speak their minds via articles, books, and lectures. The greatest hope lies in the allegiance of these people with the true experts – women who've lived with SIV. This powerful partnership has enormous potential.

What are some of the lessons learned from the past ten years? Perhaps the greatest is that there is a significant number of women around the globe that have a connection to each other that was previously unknown. Many of us had feared that we were alone with our secret of SIV. We were ashamed and isolated. In fact, our isolation fueled our shame. It seems that we can more easily recognize strength and courage in each other than in ourselves. Perhaps discovering each other's existence has fostered self-understanding and compassion for one's own struggle by bearing witness to that of another. In this newsletter we have the opportunity to speak and to bear witness. In the midst of all that has come and gone, **THE CUTTING EDGE** has survived thus far. Not only endured, but flourished. Just like other survivors.

The power of hope is limitless. We are hope – we are here at this moment, and for a great many of us the fact that we are still here is a brilliant display of courage, vision, perseverance, and resilience. Our voices, our stubborn strength, our tears, our connections, our spirits are our hope and healing. We have no idea where our hope might lead us. For me it led to a small circle of women breaking their silence, offering gifts to each other by our very presence. That was ten years ago. Today, that circle wraps itself around the globe. The strength and hope contained within it are immeasurable. Imagine that.

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#### THIS SCAR

The blood on the floor  
releases my soul ...  
can you see it?  
There should be more  
I try again ...  
Why can't I feel this?  
This is the answer  
to the unanswerable  
No one can really see  
the pain I hold onto  
Maybe this scar will tell  
what I'm unable to.

Darlene

“Hello”

*I cut to ease my loneliness. I cut, because my father raped me. Falling, falling... I know not where. Why? Now, I live with a body mutilated by eighteen years of self-abuse. Arm, leg, shoulder = broken bones. Entire body = cuts, bruises, torn muscles. Knives. Glass. Keys. Scissors. Screwdrivers. Hammers. Box cutters. Razor blades. Ripping. Slicing. Bleeding. Scars are forever. Rape. Incest. Abuse. Don't tell. You asked for it. You're not as good as other people. People like you and me – we don't fit in. You'll be locked up for being crazy. Do you know what they do to crazy people? You're too “sexy” for your own good. Too “pretty.” You were the prettiest child I had ever seen. You remind me of your mother, and she was the love of my life. Hit. Beat. Shook. Spit on. Thrown down. Left alone. Tied up. Bathed. Examined. Not enough food. Not enough heat. No phone. No address. “Whore.” “Slut.” Taken from my mother. She came for my baby sister. Not me. “The baby was defenseless. You were six. You could take care of yourself. I had issues. I couldn't take care of myself and you, too.” Later - - - “don't come. There's no room for you here.” Innocence lost – age nine. Anorexia. Multiple personalities. SIV. Major Depression. Obsessive-Compulsive Disorder. Psychosis. He finally tried to kill me – age twenty. Homeless. Starving. Self-mutilating to the edge of death. No sleep. No rest. Panic attacks. Pain. Pain. Pain. Alone. Ignorant – so many people. My aunt: “Get over it.” My mom: “Maybe she should be institutionalized.” My husband: “Why are you doing this to me?” My sister: “Go ahead and kill yourself.” Alone. Alone. Alone. So, I pretend. I let another personality take over. Meet Angel. She will protect the child. Now, I hear - - - My mom “You're so strong!” My sister: “I love my sister!” My aunt: “You are one incredible lady!” My husband: “You are too good to me.” They will themselves to be blind. Anger. Resentment. Forgiveness. They cannot understand. They are weak. I will fight for myself, and they will refuse to see the truth. Now, I take care of them. But, I'm dying inside. Perfection is what my world demands. No one cares. They don't know how. Angel. Death. Blind. - - - Pain slips through time like sand in an hourglass. I cry as a seagull waits on an empty shore. No more, I pray, oh please, no more. No more pain. No more tears. Twenty-seven now. Going to help others who are like me. Become a professional. Beat the system from the inside out. Follow my soul – my gifts – the arts: writing, acting, directing: creating. The truth is there. The knife is my best friend. Special. Punisher. Helps me to cry. Promises to be there if I can't go on. The power to end the pain forever. Roses spill into violet shades of blue. Red spills into violent shades of blue. Blood and bruises. Rain-soaked leaves on a winter day. Forgotten. Abandoned. So very cold. Fading through a time that is lost in childhood memories. My grave is waiting. Need – trust...to surrender...salvation...a kind hand...a gentle word...no judgments. I cannot stand, and yet, I walk. I cannot speak, and yet, I talk. Forgive the world. Those people are not worth my energy. I will not become vulnerable for them. Keep myself alive. I am dying. If just one person could understand... My time is running out. A body can only take so much. A soul can only be broken so many times. Deeper and deeper. People see what they want to see. Health. Youth. Beauty. Intelligence. Angel. My blood is on your hands. Help me. See me. Don't hurt me. I am the victim. I am suffering. Tell me it isn't my fault. Be stronger than my pain. Tell me I am pure. Tell me I am innocent. How can this nightmare be real? Wake me. Help me to heal. One-more-life-lost.....*

Linda Rae Richmond

*I thought you might be interested in my experience of living with self-harm in England, especially in Regional Secure Units and prison. When I was at an R.S.U. in Leicester, England I was "cutting-up" quite often, especially when we had my elderly dog put to sleep, when I needed a blood transfusion. I was on assessment by the courts. But the doctors refused to take me on section 37 full time because "I wasn't responding to treatment." So I got seven years in prison instead where my experience of cutting-up is even worse. If you self-harm in any way you have all of your property and furniture taken out of your cell and you are put in a "strip dress" and given just a "strip blanket" to keep warm. You are supposed to be observed every 15 minutes but sometimes it is hours before a nurse comes by. If you refuse to go into "strip conditions" the officers strip you off by force. All this goes on on the hospital wing. Thankfully, I have not self-harmed for 3 years now apart from one small incident a few weeks ago. I go home hopefully at the end of this year and hope also not to come back again. I wonder what conditions are like in U.S.A. prisons for people who self-harm.*

*Sue*

A HOLE

I need a hole  
one just large enough  
to bury my soul.  
No need to be long or deep  
just someplace to weep.  
Others would look for me  
still the pain they'd not see  
only to find me a bit bizarre  
fighting against one more scar.

Darlene

1.

*I am 37 years old. I have been cutting myself for 21 years.*

*I've been in so many hospitals that I've lost count.*

*When I was 17-18 years old I spent a year in a state hospital. I couldn't stop hurting myself. My agony was so intense sometimes I was mute.*

*One day I got my hands on a razor blade and I cut my arms. The orderlies screamed at me and degraded me. Then they tied Kotex to my arms. I was humiliated.*

*Dozens of times they would come after me. I would try desperately to fight them off, but I was outnumbered. They'd carry me kicking and screaming into the seclusion room, throw me on a smelly mattress, and pull off all my clothes. I tried to hold onto my clothes. I tried to bite them. They'd bring in a bed and put me in 4 point restraints. I'd lay there naked, bleeding, crying, screaming, enraged, for hours. Often overnight. I was ashamed when the male patients looked in the tiny window and laughed and said filthy things to me. Sometimes I had to urinate on myself.*

*It was like being raped over and over and over again.  
Hospital? Mental health?! Treatment?!*

*I have been in prison for the last five years. Three years ago I tried to kill myself. I cut my throat. It was serious. They put me in solitary confinement for 14 months. I didn't talk to anyone. I had a really hard time in there. I got extremely depressed.*

*I just cut myself an hour ago. Now I do it in the shower. I don't tell the prison shrink that I do this. It's too risky. I cut my thighs, stomach, or breasts, so I can hide it. I bandage myself with toilet paper and scotch tape. I will be released in two months. Until then I pray I don't get strip-searched for anything.*

*I don't want anyone to "help me" ever again.*

2.

*I was released from prison. I had a place to go, but they chained me up and brought me to a mental hospital because of my past. I hadn't done anything recently to cause this. But you know, because the scars don't fade, neither do the judgements. I've been here 7 weeks with no end in sight. I'm not cutting myself, suicidal, delusional, depressed, manic, hearing voices, no insomnia, eating disorders, mood disorders, thought disorders, etc... They don't want to take the responsibility of putting me on the street. The prison wouldn't and this hospital won't. The doctor said when I get out of here I'm not going home. He's sending me to a state hospital. He's passing the buck!*

*I'm trapped in the system and I can't get out. The doctor won't even talk to me. Even the director of the hospital won't make a decision. I don't take meds, I don't get therapy. I get along with others.*

*I hate my life. What's a girl to do? I've been on this merry-go-round for 22 years (I'm 38). Help! I want to get off!!!*

*d.t.*

## LITERATURE REVIEW

**Women Living with Self-Injury.** Jane Wegscheider Hyman. Copyright 1999. Published by Temple University Press, Philadelphia, PA. 214 pages.

Jane Wegscheider Hyman's gifts are many. To bear witness to fifteen women's stories about their lives with self-injury, and then to write them with incredible respect and compassion requires a very gifted person. Ms. Hyman eloquently conveys the complexity of self-injury to her readers without losing the presence of the human beings who are the self-injurers. The women about whom this book is written undertook the work with the intention of breaking their isolation. They have done so magnificently.

I know of no other person who has provided women such respectful freedom of expression in speaking out about living with SIV. It is sad but true that this book is truly radical: it allows for the voices of the women themselves rather than the analysis of the "other" as is so typically done.

There is not much more to say except that I encourage you to read this work and listen to the voices contained within it. The publication of this book is helping to turn the tide of misinformation about self-injury, and its arrival is to be celebrated.

**Self-Injurious Skin Picking: Clinical Characteristics and Comorbidity.** Sabine Wilhelm, Ph.D.; Nancy J. Keuthen, Ph.D.; Thilo Deckersbach, M.S.; Iris M. Engelhard, M.S.; Amy E. Forker; Lee Baer, Ph.D.; Richard L. O'Sullivan, M.D.; and Michael A. Jenike, M.D. *The Journal of Clinical Psychiatry*, Vol. 60, No. 7, July 1999: pp.454-459.

The authors' research consisted of testing 31 outpatient volunteer subjects who acknowledged engaging in "severe self-injurious skin picking." The research consisted of a variety of questionnaires and assessments to explore the behavior in detail. For example, subjects were questioned about the area of body picked at, the time of day it was done, the length of time it took to do. The subjects were also assessed for a variety of possible psychiatric diagnoses.

The authors concluded that "multiple factors" seemed to be involved in the etiology and maintenance of skin picking, and proceeded to discuss factors such as menstrual cycle, socialization, and observational learning. They also determined that all the subjects could receive at least one psychiatric diagnosis, such as obsessive compulsive disorder (OCD), body dysmorphic disorder, and borderline personality disorder amongst others. They did acknowledge that the prevalence of OCD might have something to do with the fact that the authors work in an OCD clinic and found most of their subjects there. They established that those who engaged in skin picking also had high rates of other forms of self-harm, such as substance abuse, trichotillomania, bulimia, and kleptomania. They disclosed that none of the subjects who had received treatment, either behavioral therapy or various psychotropic drugs or a combination of both, reported the treatment to be of benefit.

None of what is written in this article actually seemed remarkable. What was truly remarkable is what was not mentioned in this article – trauma history. There is no mention of any inquiry regarding a history of trauma, including any abuse experiences, anywhere in this research. There was no consideration of trauma-related diagnoses when the researchers were going about their psychiatric labeling process. Neither posttraumatic stress disorder nor dissociative disorders were considered, which I found particularly interesting as the researchers discovered that "feeling mesmerized" was part of the experience of skin picking for many of their subjects.

Frankly, it is amazing how hard the authors (so many of them) worked to miss the boat. This article is a great teacher of the lesson that current mental health researchers have dropped the ball when it comes to understanding, or even considering, the impact and consequences of abuse. This painful lesson should caution all of us when we are tempted to believe what "the research" has concluded.

**Clozapine Reduces Severe Self-Mutilation and Aggression in Psychotic Patients With Borderline Personality Disorder.** K.N. Roy Chengappa, M.D., F.R.C.P.C.; Tom Ebeling, M.D.; Jasbir S. Kang, M.D.; Joseph Levine, M.D.; and Haranath Parepally, M.D. *The Journal of Clinical Psychiatry*, Vol. 60, No. 7, July 1999: pp. 477-484.

While the piece reviewed previously was frustrating and amusing to read, this one was horrific. This article is representative of the part of this work that I dread – the reading of literature describing the current abuse of already abused women in the name of medicine.

This research consisted of a review of 7 patients' records while they were institutionalized in state psychiatric hospitals (and where some of them remain). The description of these seven women included sentences such as "most of the subjects in our report had gained notoriety within the two hospitals and consequently had engendered intense negative reactions from staff..." The women had also reportedly not responded to a "cocktail" of previous medications but, of course, the medication discussed here, Clozaril (a relatively new atypical antipsychotic known to sometimes cause a potentially lethal side effect), was determined to be effective in managing these patients. Not surprising when you learn that these authors participated in the trial study that led to the approval of clozapine (Clozaril is the trade name) in the U.S.

The authors determined that clozapine was effective in managing self-mutilation by assessing the number and amount of time the patients were placed in seclusion and restraints, and how many sedative drugs were ordered for them on an "as needed" basis. They determined that there were fewer incidents when the patients took the Clozaril, suggesting that it was therefore very beneficial for this group of patients. They did acknowledge that the "improvement" noticed might be due to the highly sedative effects of the drug, but then dismissed that thought by saying that the patients adjusted to the sedating properties of the clozapine over time. Never did they actually ever ask any of the patients for an opinion.

Interestingly and tragically, the researchers were aware that at least five of the seven women had histories of severe childhood physical and sexual abuse, yet did not pursue this whatsoever. This had no significance to them outside of having something to mention that they had read in the charts.

What we have here is a study that actually describes the brutality of the system, couched as being a professional and humane project. It seems that these researchers have proven, yet again, that a controlled patient is a good patient. What particularly amused me was that the descriptions of "severe" self-mutilation were no more than what I had lived with years ago. The recognition of the situation these women were in, and how similar it was to my previous circumstances, filled me with both grief and fear. The only worthwhile thing about this article is that it exposes a great deal about the system that some might not believe truly exists.

**Group Treatment for Adult Survivors of Abuse: A Manual for Practitioners.** Laura Pistone Webb and James Leehan. Copyright 1996. Published by Sage Publications, Inc., Thousand Oaks, CA. 196 pages.

This book is one of the best surprises that I've had in a long time. Intended for clinicians interested in developing group therapy skills for working with abuse survivors, it should appeal to a much wider audience. The extremely well thought out and sensitively described dynamics of abuse and its consequences have few peers. The attitude is one of compassionate understanding and the recognition of the strengths of survivors. Any abuse survivor would benefit from reading this book to increase their insight regarding the consequences of abuse. It might increase their sense of self-compassion as well.

Self-mutilation is mentioned one time in the whole book, in a section discussing the great degree of guilt many survivors feel. Yet the entire book can be related to SIV in many ways, as the various reasons people utilize SIV, whether the easing of distressing emotions, self-hate, or dissociation, are addressed throughout. This book lacks the extreme reactivity to SIV that many others are filled with. It is a vital resource, especially now as access to therapy is becoming increasingly limited, and group therapy may be a possible place of healing.

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Ruta Mazelis, Publisher

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