
THE CUTTING EDGE

A Newsletter for Women Living With Self-Inflicted Violence

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Welcome to this, the 46th issue of **The Cutting Edge**. I am delighted to bring you an inspiring interview as this month's special topic. My thanks go out to Dr. Lisa Gilbert, a psychiatrist who shows a tremendous respect for the struggles many people share, including living with self-inflicted violence. I am very grateful for the time and energy she has given to provide the newsletter with an interview.

Once again, my thanks to all of you who contribute to keep **The Cutting Edge** in publication. It is amazing that a newsletter that survives on the donations of its supporters has found its way around the world. May we take comfort and hope in knowing that there are many who share in struggle and in healing. **The Cutting Edge** is now read throughout North America, as well as the United Kingdom, Australia, Europe, Africa, and Asia. My best to all.

SIV: AN INTERVIEW WITH PSYCHIATRIST LISA GILBERT, M.D.

Not long ago a colleague asked me if I opposed all psychiatrists. I answered that I oppose the vast majority of what they say and do. I then, to make the conversation more positive, talked to her about the psychiatrists I do hold in high regard. Granted there were few names to mention. Yet there are some psychiatrists out in the world who truly serve as allies in the healing of deep, soul-bending wounds. They are the ones who are not afraid of nor despise the people who walk into their offices. They are the ones who acknowledge that they have as much to learn as they have to give, and that healing is more of a matter of relationship rather than expertise.

Dr. Lisa Gilbert is one such physician. Towards the end of completing a traditional psychiatric residency at the Cleveland Clinic Foundation, she found her way to a different belief system than much of what she was taught. In her journey of helping others she has taught me that even psychiatrists can change their minds and beliefs. Anyone who knows me knows that I wasn't ever sure that this was truly possible.

Dr. Gilbert works in community mental health as well as her own private practice. She has years of experience in working with people who live with Self-Inflicted Violence (SIV). The following is an interview she gave **The Cutting Edge** about her practice.

THE CUTTING EDGE (TCE): In your psychiatric training, what were you taught about working with patients who have survived abuse as well as those who self-injure?

Dr. Lisa Gilbert (LG): Our core curriculum included only one lecture on Post Traumatic Stress Disorder that mostly gave statistics on Viet Nam War veterans. There was no formal training regarding survivors of childhood abuse, or domestic violence for that matter. SIV was used to make a diagnosis of Borderline Personality Disorder and was an indicator that a patient was, most likely, “manipulative.”

TCE: How have your beliefs changed since then?

LG: During my fourth year of residency I used my elective time to study with a trauma-informed therapist working outside of our hospital system. Since then I’ve come to align my beliefs towards that of Peter Breggin, MD, in that “mental illness” is a psychospiritual crisis. I see trauma as the root of a great deal of the difficulties (“pathologies”) that my patients experience.

TCE: What led to this change?

LG: I chose to pursue trauma information when I discovered that one of my psychotherapy patients had Dissociative Identity Disorder (formerly known as Multiple Personality Disorder).

TCE: What is your belief about how people heal?

LG: People heal in a variety of ways, with or without the help of mental health professionals. People who choose to heal are creative and resilient. What we “helpers” sometimes fail to realize is that all people are healing/growing/evolving. Patients who seem to be “resistant” may be simply on a slower or more arduous healing path than we expect. When a process takes a lifetime it is sometimes hard for us, driven by academic success, the system, HMOs etc., to sit back and allow the time that is needed. Even patients/clients/people themselves often are impatient and forget to honor the process and time needed.

TCE: What has been helpful for you and your patients who live with SIV? What has been hurtful?

LG: First I should say that I’d prefer that you ask them. I don’t like to speak for them. My best estimation of what has been helpful is that we work together and form an alliance. I believe in the Stone Center’s (Wellesley College) philosophy of mutualism – simply, I try to eliminate the power-over dynamics of the doctor-patient relationship. Respect and unconditional positive regard go a long way. Judgments, authoritarian directives, forced or coerced hospitalizations – disempowerment goes against our oath to “do no harm,” and is quite hurtful.

TCE: What advice would you offer a woman living with SIV?

LG: Look within yourself first. You’d be surprised at how many answers are already there. Establish safety in your life – safe home, safe relationships, and economic safety. Learn that setting boundaries is helpful, and guilt is your “Achilles’ heel.” Let go of guilt! Then let go of abusive people (or at least distance from them).

TCE: What are the common beliefs held by psychiatrists regarding SIV and mental illness?

LG: The common beliefs are pejorative. SIV is seen as manipulative behavior in a “Borderline.” It is seen as a symptom to be controlled with meds or behavior modification, like contracts, and even seclusion and restraints.

TCE: What is it about acknowledging abuse that makes so many psychiatrists squirm?

LG: It is not just psychiatrists that get squeamish. Our culture has a taboo regarding the topic of abuse. Judith Herman, MD, in her book *Trauma and Recovery*, delineates this very well. We don't like to expose our terrible secrets. Our cultural beliefs grow out of many sources, including television. The Cleaver family was the ideal -- no abuse was seen there. But it was a fantasy. Families have all kinds of struggles. Our frontier-based attitude, so strong in the roots of the American culture, pushes the idea of independence. Fierce independence has led to social isolation of families and, therefore, children. It is behind this veil of independence that the hidden abuses occur. Children are the property of parents to do with as they see fit. Laws against abusing animals were established before laws against abusing children.

Psychiatrists are a product of our culture. The medicalization of mental health has fostered the growth of biopsychiatry fueled by dollars from the pharmaceutical industry. Given the choice between Freud, who turned 180 degrees on the topic of abuse and called abuse histories fantasies, versus a biological model that provides the doctor with an arsenal of chemical weapons to fight the enemy imbalances -- the psychiatric community shifted toward the more modern biological approach. Slowly pockets of mental health providers are beginning to understand the link between trauma and the distress they see in the patients. Just as slowly our culture is beginning to expose trauma on talk shows and in movies and even some anti-abuse commercials aired between Sunday football games.

You see, we as a culture are healing and growing. It too is a long evolutionary process that takes generations of time. We are a young culture with lots to learn. We as a people could learn a lot from the grandmother cultures of indigenous peoples.

TCE: What helps people tolerate the slow process of healing?

LG: Besides a good therapist, an individual struggling with healing from abuse would do well to pursue a passion. I often ask people to describe themselves when they were children. I try to see if we can discover who they were before the worst of the abuse occurred. Ask yourself what you were like, or ask a trusted relative. Then focus on reclaiming any lost characteristics, things like playful, curious, headstrong, carefree, inquisitive. Take those core personality traits and put them into your adult life. What usually follows is the discovering of a passion -- sports, music, art, teaching, acting, etc. Sometimes it helps to ponder the question (or journal about it) "Who would I be if I had never been abused?" Once you have an inkling, pursue that path -- it may lead to another discovery or it may be just where you needed to go. Either way once you've found your passion your soul will feel like the world that was turned upside-down by abuse has been righted. The woundedness heals and also serves you because you'll have wisdom from the process. It is deep wisdom that is invaluable and will continue to serve you and others.

TCE: How do you manage to do your work?

LG: I have a loving family and friends who give me tremendous support. What also helps me manage to do my work is that I follow my own advice. I love soccer. I started playing at the age of 25; I am now 42 and still playing. I also have a passion for nature and photography. I moved out into a rural area and my photographic work has blossomed. I also balance the mainstream education, often overweight with biopsychiatry, with information from alternative medicine groups as well as ex-patient activist education.

TCE: What would you like to share with other psychiatrists and therapists?

LG: It's hard to accept that some of what we learned and used in our practice is actually harmful to patients. Most of us believe that we only help people, but we need to scrutinize ourselves and our practices more thoroughly. Seclusion and restraint are nearly identical mechanisms used to abuse children. Restraining a woman in four-point restraints (arms and legs) is often exactly the position in which she was

held when raped. This is a direct re-enactment. There are many such re-enactments to be avoided. For more in-depth information, see *“On Being Invisible in the Mental Health System”* by Ann Jennings, Ph.D.

Therapists often realize that the therapy needed and the time needed to take a person from beginning to end is far beyond what we can offer. The limitations imposed by agency rules, health maintenance organizations, etc., don't allow us to give all the time that is needed. But I like to believe that we can still make a significant difference. I like to refer to a story about a woman who was hospitalized under the belief that she would be helped with her SIV. After experiencing seclusion, forced meds, disempowerment and judgment it seemed that this experience was a disaster. But there was one bright light during this horrific experience. It came in a very brief interaction. (HMOs would love this – five minute therapy!) The young woman was weeping in great despair alone in her hospital room. The housekeeper came in. She sat down on the bed next to her. She witnessed her pain and said “I'm sorry that it's so hard.” She stayed only several minutes. That healing exchange carried the patient for many years. You *can* help clients even if your time is limited.

TCE: Do you prescribe drugs to survivors?

LG: Yes, I do prescribe medication, but I tell my patients that medications are just one tool of many. It is my hope that the medication will temper the distressing, sometimes debilitating, symptoms long enough for the survivor to do the healing work necessary to make change and growth in her life. It has been my experience that a woman with life-long depression can in fact eliminate depression and the need for medication by pursuing therapy and her own healing resources. This, of course, goes against the biopsychiatric belief that if a person experiences three bouts of major depression then he/she should be given antidepressants the rest of his/her life (for prevention of recurrence).

I do not use medication to try to stop SIV or any other coping behaviors. I do treat symptoms of Post Traumatic Stress Disorder/anxiety, insomnia and depression to foster the survivor's ability to cope with the healing process.

I do not consider memory fragments and flashbacks to be hallucinations. Frequently survivors will have been put on many antipsychotics, even at high doses, without a change in their symptoms. Dissociation and trauma memories do not go away with antipsychotics. The tranquilizer will only numb the patient, but not eliminate the trauma sequelae. It is important to distinguish trauma symptoms from thought disorder symptoms. For example, hypervigilance (constantly checking the environment for safety) is not the same as paranoia. Hypervigilance does not need to be treated with an antipsychotic.

Finally, I'd like to make this even grayer by saying that even true psychotic symptoms can be rooted in trauma and, if addressed early, may be resolved without antipsychotic medication. I do not use antipsychotic medication judiciously. When I do prescribe it, I still see it as a tool rather than a cure.

As an afterthought let me add that it greatly distresses me to see the number of children medicated for alleged diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and depression. I rarely see Post Traumatic Stress Disorder even considered. It saddens me greatly when children's struggles are minimalized to issues of supposed biological pathology, and when their developing nervous systems are besieged by powerful stimulants and other drugs. I hope that we work our way out from this mentality soon, and address children in a relational context. This would identify their strengths and specialness while helping them with their limitations. This would greatly aid in the development of a new society of less troubled and wiser, hopefully more compassionate, people.

TCE: Thank you so much for this interview!

B-OK

You make me hate
You make me bleed
Now I want a lover
To show me how to feel
I have been strapped down by wires of pain
All I want is to be me

Put down the knives and razors
I don't want to see my reflection anymore
Can you see with blinders
Of what I feel of who I am
Scars dancing on past-white flesh
Only she can see

She says it will be OK
Those beasts will not release me
Gripped by fear, tied by hate
It can only be, only be their way
She said I would be OK, she said.....

Troy Michael

Unstable

Questions come and go with confusion
I wonder if I did this to myself
Or truly they did this to me
Feeling unstable, confused, and hopeless
The day after seeing the rapist
But she is good for me
Helping

I have felt that I have fallen, beaten, bruised and sore
Unstable and unhealthy
Feeling sick brings worry and fear

I doubt myself in childhood past
But the scars are symbols
Of a reality I cannot face
A reality of a future that is filled
With more hurt than joy
A reality of being alone
In a shell so fragile
That I could break

Troy Michael

I'm sitting in one of my intensive outpatient groups, listening obsessively to this woman talk about her most recent hospitalization due to her fresh cuts she created on her body. As she talked, I began to feel this sensation; a sense of electric relief. I had never heard of such a thing before – this cutting and burning oneself, but somehow I weirdly related.

I am sitting in the same outpatient group, listening this time to my voice. My voice telling the entire group that I, too, am a cutter and burner. I am listening to myself tell a complete lie.

That lie started a cycle of exhilarating, chaotic hell. It created the beginning of many battles in my life. The battle between emotions and mind, a battle between numbness and feeling, a battle between illness and recovering, a battle to find the worth inside myself to no longer hurt myself. The battles still go on today.

At first my burns were small and simple. Most of the time they wouldn't even leave scars. To get the feeling of much needed relief, of peace, of numbness, my burns began to get bigger and not so simple. They definitely scarred. There came a point where burning alone wasn't working any more. It wasn't producing the pure ecstasy of feeling physical pain over the deep inner agony that persisted in my whole being, my whole soul. So I did the one thing I said I would never do to get that feeling back – I cut my own skin, I created my own blood. Very quickly, that didn't work either. The relief would only stay for brief minutes. Not long enough at all. So I began to consume large amounts of alcohol (causing me to relapse in my sobriety) which led me to "coming to" with a knife in my hand, a burning cigarette in preparation, and blood and blisters everywhere. But the pain of being alive was still there. I couldn't stop. I don't know if I wanted to or not. All I knew is that I wanted the pain that filled my whole being to go away. I just wanted cutting and burning to continue to work, and it wasn't, and I still couldn't stop.

I'm sitting on the ground, outside of where I work, having just burned myself twice with a cigarette on my left arm. I am going to have to tell my therapist I broke another safety contract. That feeling of peace, of awe, and of relief did not flow through my body. Just like it didn't work the other times I hurt myself since that day I "came to" with a knife in hand, cigarette burning, and blood flowing.

I am walking to my car on my way to therapy, knowing I need to tell my therapist that I burned myself today. Knowing that if I don't, these simple burns will quickly turn to cuts, to blood, to the consumption of a lot of alcohol. I can't stop burning today, but I want to.

I want to. This simple but powerful statement is what helps me fight the constant battles that go on in my head. The battle between the lie my history tells me, and the truth of being in recovery. Yes, cutting and burning did at one time save my life. It did help me keep going. It did give me a much-needed respite from by deep inner emotional misery. It doesn't anymore, and a part of me really wishes it still did. The more harm I did, the less relief I got, and to tell the truth, the more mental anguish I receive, and thus the cycle begins.

Today I am sitting on a plane, having thought about slicing my arm, maybe my leg. Thinking about that feeling of calmness, of the amazing sensation that comes when the blood begins to flow.

Today I am still sitting on the plane, without fresh cuts or burns. Today I can stop. I want to stop. Today, just today, or to be more truthful, just for this moment. For this moment I listen to the voice of recovery. Just for this moment.

Suzanne Gaverich

Inside Out

I do not live in the past
The past lives in my artificial skin
You were the soul murderer
Now I am the walking corpse
I look outwardly calm
When dancing intertwined

I am the thin white slave
In a cyanide suicide case
My sexual experience has been sabotaged
By my inner innocence
It has tainted my soul in irreparable ways
Then again, we must have what we cannot obtain

You may see the physical scars on my skin
What you will never see
Are the emotional scars that burn within me
My scars are stories, history born to the pale white flesh
The skin becomes a battle ground
A canvas of internal mayhem

The place where the self meets the world
Is displayed as art of how torn a soul can be
Unacknowledged trauma is a wound that never heals
I pay such a price for my sins
And now the outside matches the inside

Troy Michael

RESOURCE REVIEW

The Future of Psychotherapy. Barry Duncan. *Psychotherapy Networker*, July/August 2001.

This is a wonderfully informative and eye-opening article for therapists and consumers of psychotherapy alike. In this time of greatly changing health care in the United States, it is disconcerting to realize that new developments may lead to more harm than helpfulness. Mr. Duncan examines both the positive and negative possibilities that might come about as a result of “integrated” health care, care that would more strongly link the medical with the mental health aspects of a person. Certainly, in my mind, the harm potential outweighs the possible benefits, especially when considering that economics are the operating framework of health care.

Of particular interest was the example outlined in the article to exemplify potential harm from a system that would tightly watch over a patient, and in which care is based on rigid practice guidelines. The author uses the example of a young woman who is hospitalized repeatedly, as well as medicated with increasing

amounts of drugs, in the attempt to control a particular symptom, this being SIV. With these interventions, based on the integrated and supposedly most “scientific” model of care, the young woman would not heal. Healing comes from a different form of action, in this case one initiated by the young woman’s school that results in in-home care with the family as a focus. The priority of this type of intervention becomes the patient herself, including her desires and her history, and uncovering a history of sexual abuse. With that focus the healing potential is facilitated, but the method is outside of the main health care system.

This article begins to identify the politics and financial interests behind recent developments in health care administration and policy. I particularly liked the discussion delineating that what helps a client heal most is not any particular form of intervention, but the strengths the client brings with him/herself to the therapy, as well as the quality of the therapeutic relationship. Thus, what is really helpful is the mutuality of the relationship between the service provider and the client, and not whatever cookbook approach is being touted at present. I find this article particularly useful in its identification of the fact that cognitive behavioral therapy, the most recent “rage” in the mental health community, especially in discussion of managing self-injury as well as in recovery from abuse, is not as helpful as it is touted to be. The author points out that the popularity of this intervention is based on the ease of researching it that comes because it is so structured. The more structured an approach, the easier it is to forget that the focus needs to be on the quality of the relationship. This validates that people need other people, and not manuals, to help themselves.

My gratitude goes to the author for bringing what seems so complex to simple terms, for reminding us that many solutions are not based in technology but in human contact. We can only hope that the future of psychotherapy will provide consumers a person to connect with..

...Remains. Songs written and arranged by Yvonne Rousseau. Copyright 1997. \$10 cassette, \$15 CD. For information write to: Yvonne Rousseau, P.O. Box 47, Midland, MI 48641-0047.

I am grateful to the person who sent me this tape to introduce me to it. This collection of 12 songs is a unique and inspiring tribute to survivors of abuse, and is an uplifting expression of the pain and the beauty of survival.

Yvonne Rousseau composed, arranged, and performs the songs in this collection. Her voice is rich and expressive and her performance is professional. Beyond her performance and composition talents, she is gifted in finding words to express a variety of emotions and experiences that arise from surviving childhood abuses.

Ms. Rousseau performs songs that bring out the depth of the wounds that come from abuse. Her song *It Never Affected Me* touched me deeply as she sang words that resonated with my own experience. The tears I cried when listening to her sing: “Except for how I sell myself it never affected me/Except for how I cause my wounds I’ve never felt a thing/Except for hiding all my life from life itself, you see/What happened might’ve hurt someone else, but it never affected me.” Yet the tears I was crying were ones of connection and validation and not just grief.

Ms. Rousseau also sings in tribute to the strength and beauty of survivors. Her recording takes the listener from the pain to the strength that comes with the process of surviving and healing. In *One Choice One Voice* she sings: “Life gives us the reasons to be where we want to be./Take the weight off your shoulders, let it all down./Set yourself free./Stand up to the darkness./Hold onto the strength you call./Once choice makes a difference./One voice can say it all.” Her music, her voice, can help each of us find our own. Bravo!

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@eohio.net.**

The future of **The Cutting Edge** is entirely dependent upon your contributions and donations. I am very grateful for the donations I have received. No one is turned away from receiving this publication because of an inability to pay. If you wish to receive the newsletter, please make a donation of \$10 - \$30 per year. I request that professionals and others with financial resources make donations of at least \$20 - \$30 per year. Also, back issues are available. I request a donation of \$10 - \$20 for the compilation of the first two years of publication as well as the following yearly compilations. In order to avoid high bank fees for processing checks from outside the U.S., I respectfully request that international donors send money orders in U.S. dollars. Once again, thank you!

Ruta Mazelis, Publisher

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